

**Obsessive-compulsive disorder: core  
interventions in the treatment of obsessive-  
compulsive disorder and body dysmorphic  
disorder**

**NICE guideline**

**Second draft for consultation, May 2005**

If you wish to comment on the recommendations, please make your  
comments on the **full** version of the draft guideline.

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## **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 which 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.

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.

## **Key priorities for implementation**

### **All people with OCD or BDD**

- PCTs, mental healthcare trusts, and children's trusts that provide mental health services should have access to a specialist obsessive-compulsive disorder (OCD) or body dysmorphic disorder (BDD) multidisciplinary healthcare team offering care across an individual's lifespan. These teams would perform the following functions: increase the skills of mental health practitioners in the assessment and evidenced-based treatment 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 across the lifespan.
- Specialist mental healthcare professionals who work with people with OCD and BDD should collaborate with local and national voluntary organisations to increase awareness and understanding, and to improve access to high quality information about OCD and BDD. Such information should also be made available to primary and secondary care professionals, and to professionals from other public services who may come into contact with people of any age with OCD or BDD.
- 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 or family. Healthcare professionals should help people with OCD or BDD, and their families where appropriate, understand the involuntary nature of the symptoms caused by the disorder by providing accurate information in an appropriate format on current psychological and/or biological accounts of the disorder.
- Because OCD and BDD often have an impact on families and carers, healthcare professionals should promote a collaborative approach with the

person with OCD or BDD and their family or carers, wherever this is appropriate and possible.

- As OCD and BDD can have a fluctuating or episodic course or relapse may occur after successful treatment, people who have been successfully treated and discharged should, if re-referred with further occurrences of OCD or BDD, be seen as soon as possible rather than placed on a routine waiting list.

### **Children and young people with OCD**

- 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 cognitive-behavioural therapy (including exposure and response prevention) involving the family and 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, if a **child** (8 to 11 years) with OCD or BDD with moderate to severe functional impairment does not respond adequately to CBT(including ERP) involving the family, the addition of a selective serotonin reuptake inhibitor (SSRI) to ongoing psychological treatment may be considered with careful monitoring, particularly at the beginning of treatment.
- Following multidisciplinary review, if a **young person** (12 to 18 years) with OCD or BDD with moderate to severe functional impairment does not respond adequately to CBT (including ERP) involving the family, an SSRI should be offered with careful monitoring in addition to continuing psychological treatment.

### **Adults with OCD**

- In the initial treatment of adults with OCD or BDD, 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 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).
  - computer guided ERP with brief scheduled contacts with a trained support worker.

Current research suggests that the delivery of cognitive behavioural therapy via a computer interface (CCBT) may be of value in the management of anxiety and depressive disorders. This evidence is, however, an insufficient basis on which to recommend the general introduction of this technology into the NHS.

- 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 (of more than 10 therapist hours per patient) that includes ERP 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 (of more than 10 therapist hours per patient) that includes ERP because these treatments appear to be comparably efficacious.

**BDD**

- All children and young people with BDD should be offered CBT (including ERP) involving the family and adapted to the developmental age of the child or young person as first-line treatment.
- Adults with BDD with moderate to severe functional impairment should be offered the choice of either a course an SSRI or more intensive CBT (of more than 10 therapist hours per patient), including ERP that addresses key features of BDD such as checking, comparing, avoidance and preoccupation.

The following guidance is evidence based. The grading scheme used for the recommendations (A, B, C or good practice point [GPP]) is described in Appendix A; a summary of the evidence on which the guidance is based is provided in the full guideline (see Section 5).

## **1 Guidance**

### ***1.1 Good practice points relevant to the care of all people with OCD or BDD and their families***

#### **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 or family. Healthcare professionals should help people with OCD or BDD, and their families where appropriate, understand the involuntary nature of the symptoms caused by the disorder by providing accurate information in an appropriate format on current psychological and/or biological accounts of the disorder. **[GPP]**

1.1.1.2 When assessing a person with OCD or BDD, healthcare professionals should sensitively explore the hidden distress and disability commonly associated with OCD and BDD, 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. **[GPP]**

#### **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. **[GPP]**

1.1.2.2 As OCD and BDD may occur across the lifespan, particular care should be given to a seamless transition between services destined for 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 agreement among individual healthcare professionals about the responsibility for monitoring and treating people with OCD and BDD. This agreement should be in writing, where appropriate using the Care Programme Approach (CPA), in collaboration with the individual and where appropriate, their family and carers. Where appropriate, healthcare professionals should liaise with other professionals involved in providing care and support to the person with OCD or BDD. **[GPP]**

### **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. They should have the opportunity to make informed decisions about their care and treatment. Where patients do not have the capacity to make decisions, healthcare professionals should follow the Department of Health guidelines – *Reference guide to consent for examination or treatment* (2001) (available from [www.dh.gov.uk](http://www.dh.gov.uk)). **[GPP]**

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. **[GPP]**

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

#### **1.1.4 Religion and culture**

- 1.1.4.1 Where obsessive-compulsive symptoms involve a person's religion, such as religious obsessions and scrupulosity, or cultural practices, healthcare professionals should, with the consent of the person with OCD, consider seeking the advice and support of an appropriate religious or community leader to support the therapeutic process. **[GPP]**

#### **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 the person with OCD or BDD and their family or carers, wherever this is appropriate and possible. **[GPP]**
- 1.1.5.2 In the treatment and care for people with OCD or BDD, family members and carers should be provided with good information (both verbal and written) about the disorder, its likely causes, its course and treatment. **[GPP]**
- 1.1.5.3 Assessment and treatment plans for people with OCD or BDD should, where appropriate, involve relevant family members and 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 appropriate to liaise with professionals from these organisations. Assessment should include assess the impact of rituals and compulsions on others (especially including

dependent children) and the degree to which carers are involved in supporting or carrying out behaviours related to the disorder. **[GPP]**

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 and/or the child's involvement in such activity, independent assessment of the child should be requested and, if carried out, the parent should be kept informed at every stage of the assessment. **[GPP]**

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. **[GPP]**

## 1.2 Stepped care for people with OCD or BDD

The stepped-care model of OCD and BDD draws attention to the different needs of people with OCD and BDD, depending on the characteristics of their OCD or BDD, their personal and social circumstances, 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).

Who is responsible for care?	What is the focus?	What do they do?
<b>Step 6:</b> Inpatient care or intensive treatment programmes (CAMHS Tier 4)	OCD or BDD with severe distress or disability, risk to life or severe self-neglect	Reassess, discuss options, care coordination, SRI, CBT (including ERP), or combination of SRI and CBT including ERP, augmentation strategies, consider admission or special living arrangements
<b>Step 5:</b> Multidisciplinary care with expertise in OCD or BDD (CAMHS Tier 3/ 4)	OCD or BDD with significant comorbidity, or more severely impaired functioning and/or treatment resistance, partial response or relapse	Reassess, discuss options: SRI, CBT (including ERP), or combination of SRI & CBT (including ERP); consider care coordination, augmentation strategies, admission social care. For children and young people: reassess, discuss options: CBT (including ERP)/ SSRI/clomipramine/ combined treatment. For young people consider referral to specialist services outside CAMHS if appropriate
<b>Step 4:</b> Multidisciplinary care in primary or secondary care (CAMHS Tier 2/3)	OCD or BDD with comorbidity or moderately impaired functioning or poor response to initial treatment	Assess & review, discuss options: For adults: ERP, SSRI, alternative SSRI or clomipramine, consider CBT (including ERP), combined treatments. For children and young people: CBT (including ERP), then consider CBT (including ERP)/ SSRI/clomipramine/ combined treatment
<b>Step 3:</b> GP/primary care team, PCMHW (primary care mental health worker)/ family support team (CAMHS Tier 1 or 2)	Management and initial treatment of OCD or BDD	Assess & review, discuss options. For adults according to impairment: guided self-help, computerised ERP, individual or group CBT (including ERP), SSRI, or consider combined treatments; consider involvement of the family. For children and young people: guided self-help, CBT (including ERP), involve family and consider involving school
<b>Step 2:</b> GP, practice nurses, school health advisers, general health settings (including hospitals) (CAMHS Tier 1)	Recognition/ assessment	Detect, educate, discuss treatment options, signpost voluntary support organisations, provide support to individuals, families, work/ schools, or refer to any of the appropriate levels
<b>Step 1:</b> Individuals, public organisations, NHS	Awareness/ recognition	Provide, seek, share information about OCD or BDD and its impact on individuals & families

**Figure 1. The stepped care model**

Stepped care attempts to provide the most effective but least intrusive treatments appropriate to a person's needs. It assumes monitoring of the course of a person's difficulties and referral to the appropriate level of care. Each step introduces additional interventions; the higher steps normally

assume interventions in the previous step have been offered/attempted, but there are situations where an individual may be referred to any appropriate level.

The guidance follows these six steps:

1. awareness and recognition of OCD or BDD by individuals, public organisations, and the NHS
2. recognition and assessment of OCD or BDD in primary care, schools, and general hospital settings
3. management and initial treatment of recognised OCD or BDD in general practice
4. involvement of multidisciplinary care in primary and secondary care for OCD or BDD
5. involvement of multidisciplinary teams with specific expertise in the management of OCD or BDD
6. involvement of inpatient care or intensive treatment programmes for OCD or BDD where there is risk to life, severe self-neglect, severe distress or disability.

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

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

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 may have expertise in the recognition, assessment, diagnosis and treatment of the less common forms of OCD and BDD.

1.3.1.1 PCTs, mental healthcare trusts, and children's trusts that provide mental health services should have access to a specialist OCD and BDD multidisciplinary healthcare team offering care across an individual's lifespan. These teams would perform the following functions: increase the skills of mental health practitioners 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 . **[GPP]**

1.3.1.2 Specialist mental healthcare professionals who work with people with OCD and BDD should collaborate with local and national voluntary organisations to increase awareness and understanding, and to improve access to high-quality information about OCD and BDD. Such information should also be made available to primary and secondary care professionals, and to professionals from other public services who may come into contact with people of any age with OCD or BDD. **[GPP]**

1.3.1.3 Specialist OCD/BDD teams should collaborate with people with OCD or BDD and their families and carers to provide training for all mental health workers, cosmetic surgery, and dermatology professionals in the recognition, basic epidemiology, assessment and treatment of people with OCD and BDD. Such training should be for all mental health workers, and cosmetic surgery and dermatology professionals.**[GPP]**

## **1.4 Step 2: recognition and assessment**

Given that people with OCD and BDD may have difficulty in disclosing their symptoms, people with disorders known to be commonly associated with OCD or BDD should be specifically assessed for these conditions and the possibility of comorbidity, especially those with depression and anxiety. People with comorbid depression should be assessed for the risk of self-harm and suicide.

### **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: **[C]**

- Do you wash or clean a lot?
- Do you check things a lot?
- Is there any thought that keeps bothering you that you'd like to get rid of but can't?
- 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 the person has also been diagnosed with depression. Given that some forms of OCD such as hoarding are associated with behaviours that can cause risk to the health and safety of the person with OCD or others, a complete risk assessment should be

conducted. Other comorbid conditions and psychosocial factors that may contribute to risk should also be considered. **[GPP]**

1.4.1.3 If healthcare professionals are uncertain about the risks associated with intrusive sexual, aggressive or death-related thoughts reported by a person with OCD, they should consult mental health professionals with specific expertise in the assessment and management of OCD. In adults as well as children and young people, these themes are common in OCD, and are often misinterpreted as indicating risk. **[GPP]**

## **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 seeking cosmetic surgery or attending dermatology clinics, healthcare professionals should routinely consider and explore the possibility of comorbid BDD. **[GPP]**

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 it 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? **[GPP]**



- 1.4.2.3 In people who have been diagnosed with BDD, healthcare professionals should assess risk of self-harm and suicide, especially if the person has also been diagnosed with depression. Other comorbid conditions and psychosocial factors that may contribute to risk should also be considered. **[GPP]**
- 1.4.2.4 People with BDD who are seeking cosmetic surgery or dermatological treatment should have a mental health assessment by the Community Mental Health team or preferably a specialist in liaison psychiatry or psychology. Mental healthcare specialists 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. **[GPP]**
- 1.4.2.5 People with suspected BDD attending dermatology departments should be referred for a comprehensive mental health assessment. **[GPP]**
- 1.4.2.6 People with suspected BDD seeking cosmetic surgery should be assessed by mental health specialists in BDD prior to surgery. They should be advised that diagnosis of BDD makes the outcome of cosmetic or dermatological procedures unpredictable. Where symptoms are mild, such procedures may lead to satisfaction especially when the desired outcome is unambiguous (e.g. mammoplasty reduction). But individuals with severe symptoms of BDD are unlikely to improve in their symptoms of BDD. Where there are multiple concerns, then the preoccupation is likely to transfer to a different area of the body **[GPP]**

### ***1.5 Steps 3–5: interventions 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 or BDD.

### **1.5.1 Initial treatment options**

Irrespective of level of care, the following recommendations should be taken into account when selecting initial treatments for people with OCD or BDD. The specific recommendations as to 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 of 18 years or over. But individuals mature at different rates and young adults are at a higher background risk of suicidal behaviour than older adults, so as a precautionary measure young adults treated with SSRIs should be closely monitored. 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 adolescents in all indications. Consequently, the recommendations about the use of SSRIs for people with OCD or BDD have taken account of the position of regulatory authorities.

#### ***Adults***

In the current regulatory context, offer adults with milder impairments low intensity cognitive behavioural therapy (CBT) first, reserving higher intensity CBT and specific drug treatments for those with greater impairment. The intensity of psychological treatment has been defined as the hours of therapist input per patient. By this definition most group treatments meet the definition

of a low intensity treatment (less than 10 hours of therapist input per patient), although each patient may be receiving a much greater number of hours of therapy. Professionals offering psychological treatments should have received appropriate training for the intervention they are offering.

1.5.1.1 All healthcare professionals offering psychological treatments to people 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* (DOH, 2004) **[GPP]**

1.5.1.2 In the initial treatment of adults with OCD or BDD, 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 CBT (including ERP) using structured self-help materials **[C]**
- brief individual CBT (including ERP) by telephone **[C]**
- group CBT (including ERP, note; the patient may be receiving more than 10 hours of therapy in this format) **[C]**
- computer guided ERP with brief scheduled contacts with a trained support worker. **[C]**

Current research suggests that the delivery of cognitive behavioural therapy via a computer interface (CCBT) may be of value in the management of anxiety and depressive disorders. This evidence is, however, an insufficient basis on which to recommend the general introduction of this technology into the NHS. **[NICE 2002]<sup>1</sup>**

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<sup>1</sup> This recommendation is included until update of NICE Technology Appraisal 51 Depression and Anxiety – Computerised cognitive behaviour therapy (CCBT) has been published

1.5.1.3 Adults with BDD with mild functional impairment should be offered a course of CBT (including ERP that addresses key features of BDD such as checking, comparing, avoidance and preoccupation) in individual or group formats, depending upon the patient's preference.

**[B]**

1.5.1.4 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 (of more than 10 therapist hours per patient) that includes ERP because these treatments appear to be comparably efficacious. **[C]**

1.5.1.5 Adults with OCD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive CBT (of more than 10 therapist hours per patient) that includes ERP because these treatments appear to be comparably efficacious. **[B]**

1.5.1.6 Adults with BDD with moderate to severe functional impairment should be offered the choice of either a course of an SSRI or more intensive CBT (of more than 10 therapist hours per patient), including ERP that addresses key features of BDD such as checking, comparing, avoidance and preoccupation. **[B]**

1.5.1.7 Adults with OCD or BDD with severe functional impairment, or for whom psychological or pharmacological treatments have proved ineffective, should be offered combined treatment with an SSRI and CBT (including ERP). **[C]**

### ***Children and young people***

In the current regulatory context regarding prescribing SSRIs, offer children and young people with OCD or BDD psychological treatments first.

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. **[C]**

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) involving the family and 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. **[B]**

1.5.1.10 If psychological treatment is declined by children or young people with OCD and their families, or they are unable to engage in treatment, an SSRI may be considered with specific arrangements for careful monitoring of adverse events. **[B]**

1.5.1.11 All children and young people with BDD should be offered CBT (including ERP) involving the family and adapted to the developmental age of the child or young person as first-line treatment. **[C]**

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 ill-health, may be factors if the child or young person's OCD or BDD is not responding to 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. **[C]**

## **1.5.2 How to use psychological interventions for adults**

Cognitive behavioural treatments including exposure and response prevention are effective treatments for OCD and BDD. The format and delivery of such therapy should take into account specific features of problems experienced by the person with OCD or BDD and the interventions should be adapted accordingly.

- 1.5.2.1 For people 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. **[B]**
- 1.5.2.2 For adults with OCD, cognitive therapy adapted for OCD may be considered as an addition to ERP to enhance long-term symptom reduction. **[C]**
- 1.5.2.3 For people 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 the person with OCD and the family member or carer. **[B]**
- 1.5.2.4 For people with more severe OCD who are housebound, unable or reluctant to attend a clinic, or have significant problems with hoarding a period of home-based treatment may be offered. **[C]**
- 1.5.2.5 For people with more severe OCD who are housebound and unable to undertake home treatment because of the nature of their symptoms (such as contamination concerns or hoarding that prevents therapists' access to the person's home), a period of CBT by telephone may be considered. **[C]**
- 1.5.2.6 For people with OCD who refuse, or do not engage with, treatments that include ERP, individual cognitive therapy specifically adapted for OCD may be considered. **[C]**
- 1.5.2.7 When family members or carers of people with OCD or BDD have become involved in compulsive behaviours, avoidance or reassurance seeking, treatment plans will need to help them reduce their involvement in these behaviours in a sensitive and supportive manner. **[GPP]**

- 1.5.2.8 People 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. **[GPP]**
- 1.5.2.9 For adults with BDD, group or individual CBT (including ERP) should be offered based on treatment protocols that address the specific features of BDD; the decision to use group or individual formats should be jointly decided by the individual with BDD and the healthcare professional. **[GPP]**
- 1.5.2.10 Towards the end of treatment, healthcare professionals should inform people with OCD or BDD about how the principles learned can be applied to the same or other symptoms if they occur in the future. **[GPP]**
- 1.5.2.11 When people 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, etc.) they should be informed that there is as yet no convincing evidence for a clinically important effect of these treatments **[C]**

### **1.5.3 How to use psychological interventions for children and young people**

Psychological treatments for children and young people should be collaborative and engage the family. Always consider the wider context and the other professionals involved with the child. Rewards to encourage the child can be helpful. When working with young people, the recommendations on the use of psychological interventions for adults may also be considered when appropriate.

- 1.5.3.1 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
- maintaining optimism in both child or young person and family
- collaboratively identifying initial and subsequent treatment targets with the child or young person
- actively engaging the family in planning treatment and in the treatment process, especially in ERP where, if appropriate, they may be asked to assist the child or young person
- encouraging the use of ERP if new or different symptoms re-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
- after completion of CBT, offering one or more additional sessions if needed at review appointments. **[GPP]**

1.5.3.2 In the psychological treatment of children and young people with OCD or BDD, healthcare professionals should consider adding and/or including rewards in order to enhance the child's motivation and reinforce desired behaviour changes. **[C]**

#### **1.5.4 How to use pharmacological interventions for adults**

Current published evidence suggests that SSRIs are effective in treating people with OCD and BDD, although evidence for the latter is limited and less certain. However, SSRIs may increase the risk of suicidal ideas 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 their use until evidence for differential safety



has been demonstrated. Appropriate and careful monitoring is therefore needed, especially when initiating treatment and around dose changes. Patients should also be warned about, and monitored for, relapse and discontinuation/withdrawal symptoms when stopping or reducing SSRIs.

### ***Starting the treatment***

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

### ***Monitoring risk***

1.5.4.2 People 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 at an appropriate and regular basis agreed by the patient and the healthcare professional, and this should be recorded in the notes. **[GPP]**

1.5.4.3 Because of the potential increased risk of suicidal thoughts and self harm associated with the early stages of SSRI treatment, people with OCD or BDD who are younger adults (under 30 years of age),

are depressed, or are considered to present an increased suicide risk, 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. This should be recorded in the notes. **[C]**

- 1.5.4.4 For people with OCD or BDD at high risk of suicide, a limited quantity of medication should be prescribed. **[C]**
- 1.5.4.5 When a person with OCD or BDD, especially when combined with depression, is 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, especially during the first weeks of treatment. **[C]**
- 1.5.4.6 For people 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 these are at all distressing. **[C]**
- 1.5.4.7 People with OCD or BDD should be monitored around the time of dose changes for any new symptoms or worsening of their condition. **[C]**

### ***Choice of drug treatment***

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

- 1.5.4.8 For adults with OCD, the initial pharmacological treatment should be one of the following SSRIs: fluoxetine, fluvoxamine, paroxetine, sertraline or citalopram. **[A]**
- 1.5.4.9 For adults with BDD the initial pharmacological treatment should be fluoxetine as there is more evidence for its effectiveness in BDD than other SSRIs. **[B]**

- 1.5.4.10 In the event that a person 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. **[C]**
- 1.5.4.11 Healthcare professionals should be aware of the increased risk of drug interactions when prescribing an SSRI to people with OCD or BDD who are taking other medications. **[GPP]**
- 1.5.4.12 When OCD or BDD symptoms fail to respond 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. **[GPP]**
- 1.5.4.13 If the response to a standard dose of an SSRI for a person with OCD or BDD is inadequate, and there are no significant side effects after 4 to 6 weeks, a gradual increase in dose should be considered in line with the schedule suggested by the Summary of Product Characteristics. **[B]**
- 1.5.4.14 For people 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 **[GPP]**
- 1.5.4.15 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 **[B]**
- 1.5.4.16 When a person with OCD or BDD has taken an SSRI for 1 year after remission, healthcare professionals should review with the patient the need for continued treatment. This review should consider the severity and duration of the initial illness, number of previous

episodes, presence of residual symptoms, and concurrent psychosocial difficulties. **[GPP]**

1.5.4.17 If treatment for OCD or BDD with an SSRI is continued for an extended period beyond 12 months, the need for continuation should be reviewed at regular intervals, agreed between the patient and the prescriber, and written in the notes. **[GPP]**

1.5.4.18 For people with OCD or BDD, to minimise discontinuation/withdrawal reactions 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 starting dose, drug half-life and particular profiles of adverse effects. **[C]**

1.5.4.19 Healthcare professionals should encourage people with OCD or BDD who are discontinuing SSRI treatment to seek advice if they experience significant discontinuation/withdrawal symptoms. **[C]**

### ***Other drugs***

With the exception of clomipramine, other antidepressants should not normally be used in the treatment of OCD or BDD. Most other drugs have limited or no use in this context.

### **Tricyclic antidepressants**

1.5.4.20 Tricyclic antidepressants other than clomipramine should not normally be used for treating OCD. **[B]**

### **Tricyclic related antidepressants**

1.5.4.21 Tricyclic related antidepressants should not normally be used for treating OCD. **[C]**

### **Serotonin and noradrenaline reuptake inhibitors (SNRIs)**

1.5.4.22 SNRIs, including venlafaxine, should not normally be used for treating OCD. **[B]**

### **Monoamine oxidase inhibitors (MAOIs)**

1.5.4.23 MAOIs should not normally be used for treating OCD. **[B]**

### **Anxiolytics**

1.5.4.24 Anxiolytics should not normally be used for treating OCD, except cautiously for short periods to counter the early activation of SSRIs.  
**[B]**

### **Antipsychotics**

1.5.4.25 Antipsychotics as a monotherapy should not normally be used for treating OCD. **[B]**

1.5.4.26 Antipsychotics as a monotherapy should not normally be used for treating BDD or its delusional variant. **[C]**

## **1.5.5 Poor response to initial treatment for 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, including supporting and collaborating with those professionals already involved in an individual's care.

1.5.5.1 If a person with OCD or BDD has not responded adequately to treatment with an SSRI (within 12 weeks) or CBT that includes ERP (of more than 10 therapist hours per patient), a multidisciplinary review should be carried out. **[GPP]**

1.5.5.2 If a person with OCD or BDD has not responded adequately to treatment with an SSRI (within 12 weeks) or CBT that includes ERP (of more than 10 therapist hours per patient), he or she should be offered combined treatment with CBT (including ERP) and an SSRI.  
**[C]**

- 1.5.5.3 If a person with OCD or BDD has not responded adequately after 12 weeks of combined treatment with CBT (including ERP) and an SSRI, or has not responded to an SSRI alone or engaged with CBT, he or she should be offered either a different SSRI or clomipramine. **[C]**
- 1.5.5.4 Clomipramine should be considered in the treatment of 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. **[C]**
- 1.5.5.5 If an adult with OCD or BDD has not responded to a full trial of at least one SSRI, a full trial of combined treatment with CBT (including ERP) and a full trial of clomipramine, he or she should be referred to a multidisciplinary team with specific expertise in the treatment of OCD/BDD for assessment and further treatment planning. **[GPP]**
- 1.5.5.6 The assessment of people with OCD and 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 carers and personality factors. **[GPP]**
- 1.5.5.7 For adults with OCD who have not responded to a full trial of at least one SSRI, a full trial of combined treatment with CBT (including ERP) and a full trial of clomipramine, 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 (CT) **[C]**
  - adding an antipsychotic to an SSRI or clomipramine **[C]**
  - combining clomipramine and citalopram. **[C]**

1.5.5.8 For adults with BDD who have not responded to a full trial of at least one SSRI, a full trial of combined treatment with CBT (including ERP) and a full trial of clomipramine, 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 CT **[GPP]**
- adding buspirone to an SSRI **[C]**
- combining clomipramine and citalopram. **[C]**

1.5.5.9 Treatments such as combined antidepressants and antipsychotic augmentation should not be routinely initiated in primary care. **[GPP]**

***How to use clomipramine for adults***

Clomipramine can be offered as a second line drug for OCD or BDD. Always do an ECG and check blood pressure before starting treatment if there is significant risk of cardiovascular disease. Dose changes should be gradual.

1.5.5.10 For people with OCD or BDD who are at a significant risk of suicide, healthcare professionals should only prescribe small amounts of clomipramine at a time and monitor the patient regularly until the risk of suicide has subsided because of the toxicity of clomipramine in overdose. **[GPP]**

1.5.5.11 An ECG should be carried out and blood pressure measurement taken before prescribing clomipramine for a person with OCD or BDD at significant risk of cardiovascular disease. **[C]**

1.5.5.12 For people with OCD or BDD, if the response to the standard dose of clomipramine is inadequate, 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. **[C]**

1.5.5.13 For people with OCD or BDD, treatment with clomipramine should be continued for at least 12 months if the treatment appears to be effective and because there may be further improvement. **[B]**

1.5.5.14 For people with OCD or BDD, when discontinuing clomipramine, doses should be reduced gradually in order to minimise potential discontinuation/withdrawal symptoms. **[C]**

### **1.5.6 Poor response to initial treatment in children and young people**

If CBT (including ERP) involving the family has not produced an adequate response in terms of a clinically significant reduction in symptoms and increase in functioning within 12 sessions, then review and consider further options according to the age of the child as described below.

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. However, with depression SSRIs can cause significant adverse reactions, including increased suicidal thoughts and self-harm, but it is not known whether this same risk occurs with their use in OCD. They may be safer in depression when combined with psychological treatments (see NICE depression in children guideline). Given that the UK regulatory authority has advised that similar adverse reactions can not be ruled out in OCD, appropriate caution should be observed, especially in the presence of comorbid depression.

1.5.6.1 If a child or young person with OCD or BDD has not shown an adequate response to a full trial of CBT (including ERP) involving the family within 12 sessions, a multidisciplinary review should be carried out. **[GPP]**

1.5.6.2 Following multidisciplinary review, if a **child** (8 to 11 years) with OCD or BDD with moderate to severe functional impairment does not respond adequately to CBT (including ERP) involving the



family, the addition of an SSRI to ongoing psychological treatment may be considered with careful monitoring, particularly at the beginning of treatment. [B]<sup>2</sup>

1.5.6.3 Following multidisciplinary review, if a **young person** (12 to 18 years) with OCD or BDD with moderate to severe functional impairment does not respond adequately to CBT (including ERP) involving the family, an SSRI should be offered with careful monitoring in addition to continuing psychological treatment. [B]

1.5.6.4 If treatment with an SSRI, in combination with CBT (including ERP) involving the family, for a child (8 to 11 years) with OCD or BDD is unsuccessful or is not tolerated because of side effects, consideration may be given to the use of another SSRI or clomipramine with careful monitoring, especially if the young person has had a positive response to these alternatives in the past. [B]<sup>3</sup>

1.5.6.5 If treatment with an SSRI, in combination with CBT (including ERP) involving the family, for a young person (12 to 18 years) with OCD or BDD is unsuccessful or is not tolerated because of side effects, consideration may be given to the use of another SSRI or clomipramine with careful monitoring, especially if the young person has had a positive response to these alternatives in the past. [B]<sup>4</sup>

### **1.5.7 How to use pharmacological treatments in children and young people**

In adults with OCD treated by medication, there is clinical trial evidence that supports practice on the onset of therapeutic response, dose needed, rate of increase of dose, duration of treatment, likelihood of relapse on discontinuation. Trials of these aspects have not been done in children and/or

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<sup>2</sup> For BDD the recommendation is grade C.

<sup>3</sup> For BDD the recommendation is grade C.

<sup>4</sup> For BDD the recommendation is grade C.

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***

- 1.5.7.1 When antidepressant medication 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 must be made for careful monitoring of adverse events. **[C]**
- 1.5.7.2 Children and young people with OCD or BDD started on SSRIs should be carefully and frequently monitored and seen at an appropriate and regular basis agreed by the patient, his or her family and the healthcare professional, and this should be recorded in the notes. **[GPP]**
- 1.5.7.3 If an SSRI is to be prescribed to children and young people with OCD or BDD, it should only be following assessment and diagnosis by a psychiatrist who should also be involved in decisions about dose changes and discontinuation. **[GPP]**
- 1.5.7.4 When an SSRI is prescribed to children and young people with OCD, it should be a licensed medication, sertraline or fluvoxamine, except in cases with significant comorbid depression, when fluoxetine should be used (because of current regulatory requirements). **[A]**
- 1.5.7.5 When an SSRI is prescribed for children and young people with BDD it should be fluoxetine. **[C]**
- 1.5.7.6 For children and young people with OCD or BDD who also have significant depression, the NICE recommendations for the treatment of childhood depression should be followed ('Depression in children: identification and management of depression in children and young people in primary care and specialist services', publication expected August 2005), and there should be specific monitoring for suicidal thoughts or behaviours. **[GPP]**

- 1.5.7.7 Children and young people with OCD or BDD started on SSRIs should be informed about the rationale for the drug treatment, the delay in onset of effect (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 child/young person's and family's needs. **[GPP]**
- 1.5.7.8 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. **[C]**
- 1.5.7.9 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 (that is, up to 12 weeks) and the age of the patient. Maximum recommended doses for children and young people should not be exceeded. **[C]**
- 1.5.7.10 Children and young people prescribed SSRIs should be carefully and closely monitored for the appearance of suicidal behaviour, self-harm or hostility, particularly at the beginning of treatment by the prescribing doctor and the professional delivering the psychological intervention. Children and young people and their families should be advised that if there is any sign of new symptoms of these kinds, they should make urgent contact with the prescribing doctor. **[GPP]**
- 1.5.7.11 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 (symptoms that are not clinically significant and full functioning for at least 12 weeks). **[C]**

***How to use clomipramine in young people***

- 1.5.7.12 Young people with OCD or BDD and their parents should be advised about possible side effects of clomipramine, including toxicity in overdose. **[C]**
- 1.5.7.13 Before starting to treat a young person with OCD or BDD with clomipramine, an ECG should be carried out to exclude cardiac conduction abnormalities. **[C]**
- 1.5.7.14 If the response of the young person with OCD or BDD to the standard dose of clomipramine is inadequate, and there are no significant side effects, a gradual increase in dose may be cautiously considered. **[C]**
- 1.5.7.15 Treatment of a 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. **[B]**

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

- 1.5.7.16 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 6 months, and if this is their wish. Patients and their family should be warned that relapse and/or discontinuation/withdrawal symptoms may occur, and advised to contact their medical practitioner should symptoms of discontinuation/withdrawal arise. **[C]**
- 1.5.7.17 For children and young people with OCD or BDD, to minimise discontinuation/withdrawal reactions on reducing or stopping SSRIs, the dose should be tapered gradually over several weeks according to the individual's need. The rate of reduction should take into account starting dose, drug half-life and particular profiles of adverse effects. **[C]**

1.5.7.18 Children or young people with OCD or BDD should continue with psychological treatment throughout the period of drug withdrawal because this may reduce the risk of relapse. **[C]**

***Other drugs***

1.5.7.19 Tricyclic antidepressants other than clomipramine should not be used to treat OCD or BDD in children and young people. **[C]**

1.5.7.20 Other antidepressants (MAOIs, SNRIs) should not be used to treat OCD or BDD in children and young people. **[C]**

1.5.7.21 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. **[C]**

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

OCD and BDD can usually be treated managed in the community and in primary care. However, people with severe and/or chronic problems that have not responded adequately to treatment should be referred to multidisciplinary teams with specialist expertise in the treatment of OCD/BDD. Occasionally inpatient treatment may be needed for children, young people or adults who are at particular risk or whose ability to function is severely impaired. Special support may be needed, especially for young adults with impaired autonomy and personal functioning as a result of severe OCD with onset in childhood or adolescence. Neurosurgery is not recommended as a treatment for OCD, although it is recognised that some people may wish to consider this option when all else has failed to produce an adequate response.

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

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

- there is risk to life
- there is severe self-neglect
- there is extreme distress or impairment
- a person has not responded 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 day-time therapy impossible
- the compulsions and avoidance behaviour are so severe or habitual that they cannot undertake normal activities of daily living. **[GPP]**

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. **[GPP]**

1.6.1.4 If neurosurgery were to be considered for severe refractory OCD among adults, the following should be taken into consideration.

- Existing published criteria (such as Matthews and Elmajel, 2003) 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 and CT, including very intensive and/or inpatient treatments.

- Standardised assessment protocols should be used at 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 **[GPP]**

1.6.1.5 Children and young people with severe OCD or BDD with high levels of distress and/or impaired functioning and who have not responded to adequate treatment in outpatient settings, or those with significant self-neglect or risk of suicide, should be offered assessment for intensive inpatient treatment in units where specialist treatment for children or young people with OCD or BDD is available. **[GPP]**

## ***1.7 Discharge after recovery***

After full recovery, children, young people and adults with OCD or BDD should be followed up for a year. After discharge, those re-referred should be seen quickly and should not be placed on a routine waiting list.

1.7.1.1 When a person with OCD or BDD is in remission (symptoms that are not clinically significant and full functioning for 12 weeks), he or she should be reviewed regularly for 12 months by a mental

healthcare professional. The exact frequency of contact should be agreed between the professional and the person with OCD or BDD and/or the carer and recorded in the notes. At the end of this period if recovery is maintained the person can be discharged to primary care. **[C]**

- 1.7.1.2 As OCD and BDD can have a fluctuating or episodic course, or relapse may occur after successful treatment, people who have been successfully treated and discharged should, if re-referred with further occurrences of OCD or BDD, be seen as soon as possible rather than placed on a routine waiting list. **[GPP]**

## **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; it is available from [www.nice.org.uk/page.aspx?o=212178](http://www.nice.org.uk/page.aspx?o=212178)

This guideline is relevant to people aged 8 years and over with OCD or BDD, to their 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 for people with a diagnosis of OCD or BDD, including psychiatrists, clinical psychologists, mental health nurses, community psychiatric nurses, social workers, practice nurses, secondary care medical staff, and paramedical staff, occupational therapists, pharmacists, paediatricians, other physicians, general medical practitioners and family/other therapists.
- 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 with a diagnosis of 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/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 the implementation timeline 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 template that local communities can use ([www.nice.org.uk/CGXXXcosttemplate](http://www.nice.org.uk/CGXXXcosttemplate)). **[Note: the costing information will be available when the guideline is published.]**

#### **3.2 General**

The Healthcare Commission considers implementation of clinical guidelines to be a developmental standard. 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, which is available from [www.dh.gov](http://www.dh.gov).

### **3.3 Audit**

Suggested audit criteria are listed in Appendix D. These can be used as the basis for local clinical audit, at the discretion of those in practice.

## **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).

### **1.1 CBT treatment formats among adults with OCD**

Appropriately blinded, randomised controlled trials should be conducted to assess the efficacy (including measures of social function and quality of life) and the cost-effectiveness of different delivery formats of CBT for adults with OCD (that include ERP), 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 non-OCD specific psychological treatments (e.g. Anxiety Management Training) in a broadly based sample of people diagnosed with OCD 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.

Importance of recommendation

#### **1. Relevance to NICE**

The answer to this question would allow more specific recommendations about which delivery format should be used as first-line treatment.

#### **2. Importance to patients or the population**

People with OCD will be treated with the most appropriate therapy for their circumstances.

3. Relevance to the NHS

The answer to this question would allow the most cost-effective treatment to be implemented first.

4. National priorities

The question is relevant to Standard 4 of the NSF.

5. Lack of current evidence

There is a paucity of head-to-head trials of different delivery formats of psychological therapy used to treat OCD. Little is known about whether severity of the problem or the degree of functional impairment moderates the effectiveness of treatment.

6. Feasibility

The GDG believe that the proposed research is both ethically and technically feasible, and is realistic in terms of timescale and cost.

**1.2 Treatment of BDD among adults**

Appropriately blinded, randomised controlled trials should be conducted to assess the efficacy (including measures of social function and quality of life) and the cost-effectiveness of CBT and SSRIs, alone and in combination, that are compared with each other and with appropriate control treatments for both the psychological and pharmacological arms in a broadly based sample of adults diagnosed with BDD across a range of functional impairment (using minimal exclusion criteria). The trial should be powered to examine the effect of treatment for combined versus single-strand treatments and involve a follow-up of 1 and 2 years. Any treatment received in the follow-up period should also be recorded.

Importance of recommendation

1. Relevance to NICE

The answer to this question would allow more specific recommendations about which delivery format should be used as first-line treatment for BDD.

2. Importance to patients or the population

People with BDD will be treated with the most appropriate therapy for their circumstances.

3. Relevance to the NHS

The answer to this question would allow the most cost-effective treatment to be implemented first.

4. National priorities

The question is relevant to Standard 4 of the NSF.

5. Lack of current evidence

There are no head-to-head trials of psychological and pharmacological therapy for BDD nor there trials of BDD to date that have compared CBT to a psychological control condition.

6. Feasibility

The GDG believe that the proposed research is both ethically and technically feasible, and is realistic in terms of timescale and cost.

**1.3 CBT for adolescents with OCD**

An appropriately blinded, randomised controlled trial should be conducted to assess the efficacy (including measures of social functioning and quality of life as well as OCD) and the cost-effectiveness of individual CBT and CBT involving the family compared with each other and with a credible non-OCD specific psychological treatment (e.g. Anxiety Management Training) in a broadly based sample of children and young people diagnosed with OCD

(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.

Importance of recommendation

1. Relevance to NICE

The answer to this question would allow more specific recommendations about which form of CBT should be used as first-line treatment.

2. Importance to patients or the population

Young people will be treated with the most appropriate therapy according to their circumstances.

3. Relevance to the NHS

The answer to this question would allow the most cost-effective treatment to be implemented first.

4. National priorities

The question is relevant to Standard 9 of the Children's NSF.

5. Lack of current evidence

There is a paucity of adequately controlled of different formats of CBT used to treat OCD in children and young people. Little is known about whether age moderates the effectiveness of treatment for children (less than 12 years) and young people (12–17 years).

6. Feasibility

The GDG believe that the proposed research is both ethically and technically feasible, and is realistic in terms of timescale and cost.

**1.4 CBT for adolescents with BDD**

An appropriately blinded, randomised controlled trial should be conducted to assess the efficacy (including measures of social functioning and quality of life

as well as BDD) and the cost-effectiveness of individual CBT compared to a credible non-BDD specific psychological treatment (e.g. Anxiety Management Training) control in a broadly based sample of young people diagnosed with BDD (using minimal exclusion criteria). The trial should be powered to examine the relative efficacy of treatment and involve a follow-up of at least 1 year.

Importance of recommendation

1. Relevance to NICE

The answer to this question would allow recommendations to be made about CBT for young people that are not extrapolated from adult data.

2. Importance to patients or the population

Children and young people will be treated with appropriate therapy for their age group and circumstances.

3. Relevance to the NHS

The answer to this question would allow cost-effective treatment to be implemented.

4. National priorities

The question is relevant to Standard 9 of the Children's NSF.

5. Lack of current evidence

There are no trials of CBT for BDD among young people.

6. Feasibility

The GDG believe that the proposed research is both ethically and technically feasible, and is realistic in terms of timescale and cost.

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

An appropriately blinded, randomised controlled trial 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 treatment (that includes both ERP and cognitive therapy elements) compared to 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 or 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.

#### Importance of recommendation

##### 1. Relevance to NICE

The answer to this question would allow evidence-based recommendations for additional psychological treatment among those who have not responded to previous treatment.

##### 2. Importance to patients or the population

People with OCD who have not responded to initial treatments will be treated with the most appropriate therapy format for their circumstances.

##### 3. Relevance to the NHS

The answer to this question would allow cost-effective treatment to be implemented.

##### 4. National priorities

The question is relevant to Standard 4 of the NSF.

##### 5. Lack of current evidence

There are no adequately controlled trials of different delivery formats of CBT for people with OCD who have not responded to initial treatment.

##### 6. Feasibility

The GDG believe that the proposed research is both ethically and technically feasible, and is realistic in terms of timescale and cost.

### **1.6 Screening for OCD**

Appropriately designed studies should be conducted to compare validated screening instruments for the detection of OCD 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, and take into account cultural and ethnic variations in communication, and family values.

Importance of recommendation

#### 1. Relevance to NICE

The answer to this question would allow more specific recommendations about the use of screening instruments.

#### 2. Importance to patients or the population

The use of appropriate screening instruments will increase the chance of correctly identifying a child, young person or adult who has OCD and lead to faster and more satisfactory treatment and decrease the chance of increasingly impaired function that can be associated with longer periods without treatment.

#### 3. Relevance to the NHS

The use of appropriate screening instruments will increase the chance of correctly identifying a child, young person, or adult who has OCD and lead to more efficient use of resources, especially if early detection results in faster response to treatment.

#### 4. National priorities

The question is relevant to Standard 2 of the NSF.

#### 5. Lack of current evidence



There is a paucity of evidence regarding screening of OCD in children, young people and adults. It is not known which screening instrument is most effective.

## 6. Feasibility

The GDG believe that the proposed research is both ethically and technically feasible, and is realistic in terms of timescale and cost.

### **1.7 Screening for BDD**

Appropriately designed studies should be conducted to establish the specificity and sensitivity of screening instruments for the detection of BDD in specific populations such as young people or adults who consult in dermatology or plastic surgery and those with other psychiatric disorders. An emphasis should be placed on examining those that use computer technology, assess both symptoms and functioning, and take into account cultural and ethnic variations in communication.

Importance of recommendation

#### 1. Relevance to NICE

The answer to this question would allow more specific recommendations about the use of screening instruments in these populations.

#### 2. Importance to patients or the population

The use of appropriate screening instruments will increase the chance of correctly identifying a young person or adult who has BDD and lead to faster and more satisfactory psychological or pharmacological treatment and decrease the chance of unnecessary medical interventions that could result in a worsening of the individual's psychological well-being.

#### 3. Relevance to the NHS

The use of appropriate screening instruments will increase the chance of correctly identifying a young person, or adult who has BDD and lead to more

efficient use of resources, especially if early detection results in faster response to treatment and avoids unnecessary medical interventions

4. National priorities

The question is relevant to Standard 2 of the NSF.

5. Lack of current evidence

There is a paucity of evidence regarding the sensitivity and specificity of screening of BDD young people and adults. It is not known which screening instrument is most effective.

6. Feasibility

The GDG believe that the proposed research is both ethically and technically feasible, and is realistic in terms of timescale and cost.

## 5 Other versions of this guideline

The 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.

The booklet *The guideline development process – an overview for stakeholders, the public and the NHS* has more information about the Institute's guideline development process. It is available from the Institute's website and copies can also be ordered by telephoning 0870 1555 455 (quote reference N0472).

### 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 [website details to be added], the NICE website ([www.nice.org.uk/CGXXXfullguideline](http://www.nice.org.uk/CGXXXfullguideline)) and the website of the National Library for Health ([www.nlh.nhs.uk](http://www.nlh.nhs.uk)). **[Note: these details will apply to the published full guideline.]**

### **5.2 Quick reference guide**

A quick reference guide for health professionals is also available from the NICE website ([www.nice.org/CGXXXquickrefguide](http://www.nice.org/CGXXXquickrefguide)) or from the Department of Health Publications Order Line (telephone 0870 1555 455; quote reference number N0XXX). **[Note: these details will apply when the guideline is published.]**

### **5.3 Information for the public**

A version of this guideline for people with OCD or BDD and their carers, and for the public, is available from the NICE website ([www.nice.org.uk/CGXXXpublicinfo](http://www.nice.org.uk/CGXXXpublicinfo)) or from the NHS Response Line (0870 1555 455); quote reference number N0xxx. **[Note: these details will apply when the guideline is published.]**

## **6 Related NICE guidance**

Computerised cognitive behaviour therapy (CCBT) for the treatment of depression and anxiety (review of existing NICE Technology Appraisal No.51). (Publication expected September 2005.)

Depression: management of depression in primary and secondary care. *NICE Clinical Guideline* No. 23 (December 2004). Available from [www.nice.org/CG023](http://www.nice.org/CG023)

Depression in children: identification and management of depression in children and young people in primary care and specialist services. *NICE Clinical Guideline*. (Publication expected August 2005.)

Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and

community care. *NICE Clinical Guideline* No. 22 (December 2004). Available from [www.nice.org/CG022](http://www.nice.org/CG022)

## **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

<b>Hierarchy of evidence and recommendations grading scheme</b>			
Level	Type of evidence	Grade	Evidence
I	Evidence obtained from a single randomised controlled trial or a meta-analysis of randomised controlled trials	A	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
IIa	Evidence obtained from at least one well-designed controlled study without randomisation	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
IIb	Evidence obtained from at least one other well-designed quasi-experimental study		
III	Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies		
IV	Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities	C	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
		GPP	Recommended good practice based on the clinical experience of the GDG.
Adapted from Eccles, M. & Mason, J (2001). How to develop cost-conscious guidelines. <i>Health Technology Assessment</i> 5: 16; Mann T (1996) <i>Clinical Guidelines: Using Clinical Guidelines to Improve Patient Care Within the NHS</i> . London: Department of Health.			

## **Appendix B: The Guideline Development Group**

**Professor Mark Freeston** (Chair Guideline Development Group)

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

**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

**Ms Gillian Knight**

People with OCD, London

**Dr Karina Lovell**

Senior Lecturer, School of Nursing, Midwifery and Social Work, The University of Manchester, Manchester

**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

**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 take 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, Astra Zeneca

### **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 overleaf



Recommendation	Measured by	Exception	Definition
<p><b>1. Access to specialist OCD/BDD multidisciplinary team</b></p> <p>PCTs, mental healthcare trusts, and children’s trusts that provide mental health services should have access to a specialist obsessive-compulsive disorder (OCD) or body dysmorphic disorder (BDD) multidisciplinary healthcare team offering care across the an individual’s lifespan. These teams would perform the following functions: increase the skills of mental health practitioners in the assessment and evidenced-based treatment 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 across the lifespan</p>	<p>100% of PCTs, mental healthcare trusts, and children’s trusts which provide mental health services will have access to a specialist OCD/BDD team</p>	<p>None</p>	<p>Operational policies in PCTs, mental healthcare trusts, and children’s trusts which provide mental health services will specify procedure for accessing specialist OCD/BDD team.</p>
<p><b>2. Collaboration with voluntary organisations to increase access to high quality information</b></p> <p>Specialist mental healthcare professionals who work with people with OCD and BDD should collaborate with local and national voluntary organisations to increase awareness and understanding, and to improve access to high quality information about OCD and BDD. Such</p>	<p>100% of specialist mental healthcare teams who work with children and young people and adults with OCD/BDD will collaborate with voluntary organisations.</p>	<p>None</p>	<p>Operational policies will identify and specify the collaborative links with voluntary organisations</p>

<p>information should also be made available to primary and secondary care professionals, and to professionals from other public services who may come into contact with people of any age with OCD or BDD</p>			
<p><b>3. Explanation about OCD or BDD</b></p> <p>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 or family. Healthcare professionals should help people with OCD or BDD, and their families where appropriate, understand the involuntary nature of the symptoms caused by the disorder, and the shame and distress experienced by providing accurate information in an appropriate format on current psychological and/or biological accounts of the disorder.</p>	<p>100% of people with OCD/BDD (and where appropriate families and carers) will be provided with a detailed explanation of OCD/BDD including course, nature and distress of the disorder by a healthcare professional.</p>	<p>None</p>	<p>Clinical notes will indicate that a detailed explanation has occurred and that the person with OCD or BDD and families/carers have been offered the opportunity to ask questions regarding the disorder</p>
<p><b>4. Collaborative approach with family and/or carers</b></p> <p>Because OCD and BDD often has an impact on families and carers, healthcare professionals should promote a collaborative approach with the person with OCD or BDD and their family or carers, wherever this is appropriate and possible</p>	<p>100% of healthcare professionals working with people with OCD or BDD will promote a collaborate approach with family/carers</p>	<p>Where a person with OCD or BDD explicitly states that they do not want family/carer involvement</p>	<p>Clinical notes will indicate that a discussion has taken place with carer's/families and the level of involvement will be specified.</p>

<p><b>5. Timeframe for re-referral</b></p> <p>As OCD and BDD can have a fluctuating or episodic course or relapse may occur after successful treatment, people who have been successfully treated and discharged should, if re-referred with further occurrences of OCD or BDD, be seen as soon as possible rather than placed on a routine waiting list.</p>	<p>100% of people with OCD or BDD who have lapsed following successful treatment should be seen by a healthcare professional within 6 weeks of re-referral</p>	<p>Person with OCD or BDD refuses re-referral</p>	<p>Operational policies will indicate the re-referral pathway within a 6 week timeframe.</p>
<p><b>6. CBT for children and young people with moderate to severe functional impairment</b></p> <p>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 cognitive-behavioural therapy (including exposure and response prevention) involving the family and 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</p>	<p>100% of children and young people with OCD or BDD who have moderate/severe impairment or not responded/refused GSH will be offered CBT (including exposure and response prevention)</p>	<p>Children and young people who refuse CBT</p>	<p>Clinical notes indicate that person was informed of possibility of CBT. Clinical notes will identify the clinical outcome of CBT.</p>

<p><b>7. SSRI for children with moderate to severe functional impairment who does not respond to CBT</b></p> <p>Following multidisciplinary review, if a <b>child</b> (8 to 11 years) with OCD or BDD with moderate to severe functional impairment does not respond adequately to CBT(including ERP) involving the family, the addition of a selective serotonin reuptake inhibitor (SSRI) to ongoing psychological treatment may be considered with careful monitoring, particularly at the beginning of treatment.</p>	<p>100% of children with OCD or BDD who fail to respond to CBT will attend a multi disciplinary review (with families/carers) where the use of an SSRI will be considered in addition to ongoing psychological treatment</p>	<p>Children who respond to CBT</p>	<p>Clinical notes will indicate a multidisciplinary review occurred and identify that the use of an SSRI in addition to ongoing psychological treatment was explored in detail</p>
<p><b>8. SSRI for young person with moderate to severe functional impairment who does not respond to CBT</b></p> <p>Following multidisciplinary review, if a <b>young person</b> (12 to 18 years) with OCD or BDD with moderate to severe functional impairment does not respond adequately to CBT (including ERP) involving the family, an SSRI should be offered with careful monitoring in addition to continuing psychological treatment.</p>	<p>100% of young people with OCD or BDD who fail to respond to CBT including ERP will attend a multi disciplinary review where the use of an SSRI will be considered in addition to ongoing psychological treatment</p>	<p>Young people who respond to CBT</p>	<p>Clinical notes will indicate a multidisciplinary review occurred and identify that the use of an SSRI in addition to ongoing psychological treatment was explored in detail</p>

<p><b>9. Initial low intensity psychological treatments for adults</b></p> <p>In the initial treatment of adults with OCD or BDD, 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:</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> <li>• computer guided ERP with brief scheduled contacts with a trained support worker</li> </ul> <p>(Current research suggests that the delivery of cognitive behavioural therapy via a computer interface (CCBT) may be of value in the management of anxiety and depressive disorders. This evidence is, however, an insufficient basis on which to recommend the general introduction of this technology into the NHS.)</p>	<p>100% of people with mild OCD or BDD, or those who express a preference will receive a low intensity CBT including ERP intervention</p>	<p>People with moderate severe OCD or BDD</p>	<p>Clinical notes will indicate that people are informed of low intensity treatment options.</p> <p>Clinical notes will indicate the clinical outcome of low intensity interventions</p>
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<p><b>10. SSRI or more intensive CBT for adults with OCD with mild functional impairment who fail to respond or refuse low intensity treatment</b></p> <p>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 (of more than 10 therapist hours per patient) that includes ERP because these treatments appear to be comparably efficacious.</p>	<p>100% of people with mild OCD who fail to respond /refuse low intensity treatment will be offered intensive CBT including ERP or an SSRI</p>	<p>People improved with low intensity interventions</p>	<p>Clinical notes will indicate that people have been informed of the possibility of intensive CBT or an SSRI.</p> <p>Clinical notes will indicate the clinical outcome of the intervention offered.</p>
<p><b>11. SSRI or more intensive CBT for adults with OCD with moderate functional impairment</b></p> <p>Adults with OCD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive CBT (of more than 10 therapist hours per patient) that includes ERP because these treatments appear to be comparably efficacious.</p>	<p>100% of people with moderate OCD will be offered intensive CBT including ERP or an SSRI</p>	<p>None</p>	<p>Clinical notes will indicate that people have been informed of the possibility of intensive CBT or an SSRI.</p> <p>Clinical notes will indicate the clinical outcome of the intervention offered.</p>



<p><b>12. CBT with ERP for children and young people with BDD</b></p> <p>All children and young people with BDD should be offered CBT (including ERP) involving the family and adapted to the developmental age of the child or young person as first-line treatment.</p>	<p>100% of children and young people with BDD should be considered for CBT including ERP</p>	<p>Those who request or have taken up the offer of another intervention.</p>	<p>The notes should indicate that the healthcare professional responsible has discussed the need for CBT with ERP and an arrangement has been made.</p>
<p><b>13. CBT with ERP or an SSRI for adults with BDD with moderate to severe functional impairment</b></p> <p>Adults with BDD with moderate to severe functional impairment should be offered the choice of either a course an SSRI or more intensive CBT (of more than 10 therapist hours per patient including ERP that addresses key features of BDD such as checking, comparing, avoidance and preoccupation).</p>	<p>100% of people with moderate to severe BDD will be offered intensive CBT including ERP or an SSRI</p>	<p>None</p>	<p>Clinical notes will indicate that people have been informed of the possibility of intensive CBT or an SSRI.</p> <p>Clinical notes will indicate the clinical outcome of the intervention offered.</p>

### ***Calculation of compliance***

Compliance (%) with each measure described in the table above is calculated as follows.

$$\frac{\text{Number of patients whose care is consistent with the **criterion** **plus** number of patients who meet any **exception** listed}{\text{Number of patients to whom the **measure** applies}} \times 100$$

Clinicians should review the findings of measurement, identify whether practice can be improved, agree on a plan to achieve any desired improvement and repeat the measurement of actual practice to confirm that the desired improvement is being achieved.