

The Patient with Obsessive-Compulsive Disorder

Peggy M.A. Richter and Steven Selchen

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INTRODUCTION

Obsessive-Compulsive Disorder (OCD) is a relatively common and frequently severe psychiatric condition that tends to be overlooked by comparison to other psychiatric disorders. Although the lifetime prevalence is estimated at 2.5%, it is far more frequently encountered in general practice because of its chronicity and relative severity. Patients may often go more than a decade before symptoms are recognized and an accurate diagnosis made. An additional problem is that OCD requires a somewhat unique treatment approach with specific adaptations required compared to both routine pharmacotherapy (i.e. for mood or other anxiety disorders) and psychotherapy; therefore greater knowledge and awareness may make a very significant difference in outcomes for these individuals.

OCD was historically thought of as an anxiety-based condition but in DSM-5 is now separated from the anxiety disorders and is in its own new category of “Obsessive-Compulsive and Related Disorders”(OCDs), which also includes Body Dysmorphic Disorder, Hoarding Disorder, Trichotillomania (Hair-Pulling Disorder), and Excoriation (Skin-Picking) Disorder. These conditions are generally characterized by specific types of preoccupations and/or repetitive behaviours. It is important that the clinician be aware of all of these related conditions, as they must be differentiated from one another, and also share high comorbidity amongst them. Moreover there are significant differences in treatment approaches to these various disorders.

The cardinal features of OCD are obsessions and/or compulsions. Obsessions are defined as intrusive, repetitive thoughts, urges, images or impulses that trigger anxiety and that the individual is not able to suppress. Compulsions are repetitive behaviours or mental acts that occur in response to an obsession or must be done according to rigidly applied rules and are intended to reduce the distress caused by obsessions. It is important to bear these definitions in mind when differentiating OCD from other conditions.

DIFFERENTIAL DIAGNOSIS

Anxiety Disorders: Although individuals with anxiety disorders may complain of recurrent thoughts or worries, these are typically about readily understandable real-life concerns. For example, an individual with generalized anxiety disorder may express excessive worries about losing their job or about the health and welfare of their family members. In social phobia, the content is focused on exaggerated but understandable concerns about embarrassing themselves in social interactions. By contrast, obsessions are typically either very exaggerated and/or about unrealistic or irrational concerns, and will usually be accompanied by compulsions.

Major Depressive Disorder: Depressed individuals may express ruminations that are typically mood-congruent and not usually experienced as intrusive.

Other Obsessive-Compulsive and Related Disorders: There are specific differences in content and character for each of these conditions. In body dysmorphic disorder the focus is exclusively on perceived

defect(s) in their appearance, both in terms of thoughts and any repetitive behaviours (such as checking appearance in mirrors, seeking reassurance, time-consuming grooming behaviours). Hoarding disorder is exclusively about difficulty with discarding and the accumulation of belongings that result from this. In trichotillomania and excoriation disorder, the focus is on repetitive hair pulling or skin picking respectively, and not accompanied by triggering obsessions.

Eating Disorders: In eating disorders, preoccupations are exclusively focused on food, weight or body image.

Illness Anxiety Disorder: This is characterized by recurring thoughts that are exclusively related to fear of currently having a serious disease. By contrast, in individuals with somatic obsessions the concern is typically about contracting the illness in the future, and other obsessional content will also be present.

Tic Disorders: Tics are sudden, rapid, recurrent, non-rhythmic behaviours such as blinking, touching, grimacing or sniffing, and are not triggered by obsessions.

Psychotic Disorders: Although people with OCD may have poor insight or even be delusional with regard to the obsessions, they will not have hallucinations or formal thought disorder.

Obsessive Compulsive Personality Disorders: Although the names are similar, these two disorders are not directly related to one another. The personality disorder is characterized by a long-standing pattern of perfectionism and rigidity, but will be perceived by the individual as appropriate, rather than complained of as 'intrusive' the way obsessions are experienced. These individuals will not have frank obsessions or compulsions.

DIAGNOSTIC CRITERIA (DSM-5)

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

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

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

Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

- B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behavior, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder).

Specify if:

With good or fair insight: The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.

With poor insight: The individual thinks obsessive-compulsive disorder beliefs are probably true.

With absent insight/delusional beliefs: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

Specify if:

Tic-related: The individual has a current or past history of a tic disorder.

SCREENING FOR OCD

Screening Questions:

1. Do you experience unwanted thoughts, images or impulses that repeatedly enter your mind, despite trying to get rid of them? For example, worries about dirt or germs, or thoughts of bad things happening?

(Screening for obsessions)

2. Do you ever feel driven to repeat certain acts over and over? For example, repeatedly washing your hands, cleaning, checking doors or work over and over, rearranging things to get it just right, or having to repeat thoughts in your mind to feel better?

(Screening for compulsions)

3. Does this waste significant time or cause problems in your life? For example, interfering with school, work or seeing friends?

(Does the individual potentially meet DSM-5 criteria?)

ASSESSMENT OF INSIGHT

Insight can fluctuate in OCD from good to absent or even frankly delusional. It is important to assess specifically, as degree of insight will help determine which kind of treatment is best. It is important to keep in mind that many individuals may initially present their concerns as realistic. A useful way to ask about insight is:

“I understand that in the moment when you are triggered your <obsessions or compulsions> feel absolutely real to you. Sitting here in my office now, do you think that your <thoughts or behaviours> are logical? What do you think would happen realistically if you didn’t do <your ritual>?”

It is important to be mindful that obsessions can range from the mundane (“did I lock the door?”, or “I may get other people’s germs if I touch shopping mall doors”) to the frankly bizarre in content (“because I thought about my mother dying while I pushed the elevator button, I need to push it again to prevent this happening”, or “I may go into an alternate reality if I think the wrong thought”). However it is the quality of the thoughts as intrusive, unwanted, and difficult to suppress that makes them obsessions, rather than delusions. See Table for descriptions of common themes for obsessions and compulsions. OCD has often been termed ‘the doubting disease’, as pathological doubt fuels the symptoms for most individuals.

Common Obsessions	Descriptions/Examples
Contamination	Concerns about dirt, germs, body waste, illness
Symmetry	Needing things “just so”, even, or lined up a certain arbitrary way
Aggressive	Most commonly focused on inadvertent harm, such as being responsible for a fire or break-in; also includes horrific thoughts or images of deliberately harming others, such as stabbing a loved one or pushing a stranger in front of a car
Sexual	Disturbing sexual thoughts that are not consistent with an individual’s orientation or cultural norms, such as someone with a same-sex preference having unpleasant hetero-erotic thoughts, or unwanted inappropriate sexual thoughts about children
Religious	Examples include thoughts about selling one’s soul to the devil, deliberately thinking inappropriate thoughts about major religious figures, or committing mortal sins
Somatic	Exaggerated fears of contracting a serious illness such as hepatitis, or a brain tumour in the absence of any identifiable high risk

Common Compulsions	Descriptions/Examples
Washing	Excessive hand-washing, showering, or cleaning activities
Checking	Repeatedly turning the stove on and off; re-reading all emails to ensure content is appropriate; driving around the block to ensure didn’t hit someone; asking for repeated reassurance
Ordering	Folding clothes “just so”, or arranging all cans in the cupboard so the labels are facing out
Counting	Performing actions a certain arbitrary number of times, such as tapping each foot 4 times when getting out of bed
Repeating	Repeatedly going up and down the stairs or flushing the toilet; typically done to “cancel” out a bad thought or until it feels “right”

TREATMENT OPTIONS

There are only two recognized first-line treatments for OCD: pharmacotherapy with selective serotonin reuptake inhibitors (SSRIs) and cognitive-behavioural therapy (CBT). While these modalities are used

broadly for the treatment of mood and anxiety, there are a number of key differences to keep in mind when applying to OCD.

Pharmacotherapy: There is good level 1 evidence for all of the SSRIs in OCD (technically citalopram is off-label for OCD in Canada, although indicated in the US and Europe). These medications also have the advantage of working on the common comorbid mood and anxiety disorders. There are two major distinctions in the way these medications should be used for OCD as compared to depression:

- 1) Dosing is generally most effective at the upper end of the tested dose range for OCD, which can be higher than the dose range tested for depression
- 2) There is a longer therapeutic lag before benefits are seen in OCD, generally 6-10 weeks.

For these reasons, it is generally best to discuss the target dose with the patient, stressing that they should aim for the upper end of the dose range or until significant side-effects occur, after which it will be important to allow at least a further 6-10 weeks to assess response. For this reason, drug trials in OCD typically require 12 weeks or more.

Medications	Recommended Dose Range
<i>First-line</i>	
fluoxetine (Prozac)	20-80 mg daily
fluvoxamine (Luvox)	150-300 mg daily
sertraline (Zoloft)	100-200 mg daily
paroxetine (Paxil)	20-60 mg daily
citalopram (Celexa)	20-80* mg daily
escitalopram (Cipralex)	10-40** mg daily
<i>Second-line</i>	
clomipramine (Anafranil)	150-250 mg daily
venlafaxine (Effexor)	225-375 mg daily
desvenlafaxine (Pristiq)	100-200 mg daily
mirtazapine (Remeron)	30-45 mg daily
* Health Canada advises ≤ 40 mg daily	
** Health Canada advises ≤ 20 mg daily	

Although the recommended dose range in OCD for citalopram and escitalopram exceeds the Health Canada warnings because of risk of QTc prolongation on ECG, this effect is typically modest, and can be managed easily with serial ECG monitoring, ensuring individuals do not exceed the recommended safety thresholds.

There are a number of published guidelines for OCD, including CPA, APA, and NICE. The most recent are the Canadian Clinical Practice Guidelines from BMC Psychiatry in 2014 (see Resources). Keep in mind that response to pharmacologic treatments can differ significantly between OCD and the OC Related Disorders. For OC Related Disorders, see disorder-specific references below.

Only 60% of patients will typically respond to the first SSRI tried, so most individuals will need to try at least a second SSRI. (*Treatment algorithm inserted about here*) It is

important to be aware that there is clear evidence that clonazepam and bupropion (Wellbutrin) do not

Starting Pharmacotherapy in OCD – Practical Tips

- Clarify expectations at the start!
 - High doses work best
 - Increase regularly to highest dose comfortably tolerated or target dose
 - 6-8 weeks to see benefits, allow 12 weeks/drug
- Start at usual dose, then increase every 5-7 days, i.e.:
 - Escitalopram 10 mg → 20 mg
 - Sertraline 50 mg → 100 mg → 150 mg → 200 mg
 - Paroxetine/Fluoxetine/Citalopram 20 mg → 40 mg → 60/80/80 mg
- Allow 10 weeks at maximal dosage/12 weeks total
- Monitor for change:
 - Self-report YBOCS/ 2-3 behavioural targets...

work in OCD, and should be avoided for this indication. If a second SSRI fails, most guidelines recommend moving on to a second-line option, such as clomipramine or venlafaxine. Another frequently recommended option is augmentation with atypical antipsychotics. While there is level 1 evidence for this, in a randomized controlled trial SSRI partial responders did far better when randomized to receive CBT as compared to an atypical agent, raising a question about this alternative.

Treatment is normally continued for at least one year, as there is a very significant relapse risk with early discontinuation. Most experts would recommend referral for CBT to reduce risk of relapse if this is available. In patients with very severe illness, or in cases where a number of previous medications were ineffective, many suggest long-term continuation of an effective medication for maintenance of stability.

Psychotherapy: Cognitive-behavioural therapy (CBT) is the most effective treatment in OCD. CBT integrates behaviour therapy with cognitive approaches. Behaviour therapy was the original gold-standard treatment, and is based on the principles of exposure to anxiety-provoking triggers without performance of rituals (often termed 'Exposure and Response-Prevention'). This is now generally combined with cognitive approaches in which the patient identifies and learns to modify exaggerated or maladaptive thoughts and beliefs.

In practice, there are a number of factors that must be taken into consideration in determining if CBT is the best option for a given patient. Insight (i.e. recognition that the OCD is excessive or unreasonable) is important, as those with poor insight may be unwilling to challenge their rituals. The extent of comorbid conditions needs to be considered; for example, mild depression may not be a barrier, but more severe depression or active suicidal ideation generally would be. Similarly, personality disorders, if significant, may also complicate CBT. Motivation is, in many ways, the single biggest factor to consider. For CBT to succeed, patients need to be committed and actively engaged in therapy. Regular practice of homework is a key requirement for success.

If all the above requirements are met, CBT would be the best first-line option. If you do not have access to a therapist to provide CBT (and do not have the skills yourself), consider regularly scheduled appointments with a patient to supervise them in bibliotherapy. There are a number of excellent self-help workbooks which will take people through the basics of CBT for OCD (see list below). In our experience, patients are far more likely to follow through on the reading and homework if they are reporting back to someone regularly. There are also a number of online CBT programs and apps (see resources below).

Monitoring treatment: it can be very helpful to monitor treatment outcome relatively objectively at regular intervals. There are a number of self-report measures that can be used to track changes, such as the self-report Yale-Brown Obsessive-Compulsive Scale (YBOCS), the Florida Obsessive-Compulsive Inventory (FOCI)(<http://www.aafp.org/afp/2009/0801/afp20090801p239-s2.pdf>), and the Obsessive-Compulsive Inventory – Revised (OCI)(<http://www.veale.co.uk/wp-content/uploads/2010/10/Obeessive-Compulsive-Inventory-OCI.pdf>; <http://www.veale.co.uk/wp-content/uploads/2010/10/Obeessive-Compulsive-Inventory-OCI.pdf>). However an even easier alternative is to identify a few key symptoms to track, such as number of handwashes/day, duration of showers, length of time to perform checking ritual when leaving the house, etc. Be mindful that some patients will initially underestimate the impact of their OCD, so as they become more aware of their symptoms, these estimations may initially increase.

Psychoeducation: Psychoeducation is vital for patients with OCD, as they may often be laboring under the belief that they are alone in having “ridiculous” and/or “horrible” (e.g. violent, sexual etc.) thoughts. It is therefore very important to normalize and destigmatize from the beginning, by explaining that we all have bizarre or inappropriate thoughts crossing our minds routinely and that no one can control their thoughts to prevent this. It is important to explain the first-line therapeutic options, and to discuss the relative risks and benefits of medication as compared to CBT. *(insert Meds or CBT about here)*

It is important to recognize that the interaction between the patient and their family can serve to maintain or worsen OCD symptoms. Family accommodation refers to how the family adapts their routines to enable the individual with OCD to avoid triggers or minimize rituals. Often family members will try to help their loved one by providing regular reassurance, or by accommodating; for example, locking the front door when leaving together, or doing decontamination rituals to satisfy their relative. These behaviors, although well-intended, will unfortunately serve to maintain the obsessional fears. Family-based psychoeducation and interventions to reduce accommodation have been shown to effectively reduce OCD.

MEDS OR CBT?

	<u>Medications</u>	<u>CBT</u>
Pros	<ul style="list-style-type: none">○ Easy to take○ Safe○ Help OCD & ...○ Readily available	<ul style="list-style-type: none">○ Very effective○ Safe○ Long-acting!
Cons	<ul style="list-style-type: none">○ Limited benefits○ Side effects○ Relapse!	<ul style="list-style-type: none">○ Requires: motivation+ hard work○ Difficult if dealing with multiple problems○ Can be difficult to access

WHAT IS REASONABLE TO EXPECT OF A PRIMARY CARE CLINICIAN?

- screen for OCD symptoms routinely
- be aware of the obsessive-compulsive related disorders
- discuss probable diagnosis
- provide psychoeducation
- identify and address family accommodation
- provide pharmacological treatment
 - be familiar with first-line and at least two second-line options
 - comfort with augmentation with an antipsychotic is an asset
- help patients make an informed treatment choice about medications and/or CBT, even if you do not have CBT training yourself
- if not able to provide CBT, initiate referrals to CBT early
- discuss and support the use of self-help/bibliotherapy options

WHEN TO REFER TO A SPECIALIST

- diagnostic clarification when needed
- complex/comorbid presentations
- for specialized CBT if available locally
- refractory illness that has failed several drug trials
- consider urgent/emergency evaluation if OCD is so severe that patients are not eating regularly, able to take medications, attend to their medical needs, or leave the home

Please see below for resources.

COMMUNITY RESOURCES

- [Mood Disorders Association of Ontario](http://www.mooddorders.ca/)
<http://www.mooddorders.ca/>
- [Canadian Mental Health Association](http://www.cmha.ca/)
<http://www.cmha.ca/>

ONLINE RESOURCES

For OCD

- [Frederick W. Thompson Anxiety Disorders Centre](http://sunnybrook.ca/content/?page=frederick-thompson-anxiety-disorders-centre)
<http://sunnybrook.ca/content/?page=frederick-thompson-anxiety-disorders-centre>
- [Anxiety Disorders Association of Canada](http://www.anxietycanada.ca/)
<http://www.anxietycanada.ca/>
- [Anxiety Disorders Association of America](https://www.adaa.org/landing)
<https://www.adaa.org/landing>
- [International Obsessive-Compulsive Foundation website](https://iocdf.org/)
<https://iocdf.org/>
- [National Institutes of Mental Health](https://www.nimh.nih.gov/index.shtml)
<https://www.nimh.nih.gov/index.shtml>

For OC Related Disorders

- [International Obsessive Compulsive Foundation – Hoarding resources](http://hoarding.iocdf.org)
hoarding.iocdf.org
- [Children of Hoarders](http://childrenofhoarders.com)
childrenofhoarders.com
- [The TLC Foundation for Body-Focused Repetitive Disorders](http://bfrb.org)
bfrb.org
- [Trichotillomania Support Online](http://trichotillomania.co.uk)
trichotillomania.co.uk
- [Canadian Body-Focused Repetitive Disorders Support Network](http://www.canadianbfrb.org)
www.canadianbfrb.org

BOOKS FOR PHYSICIANS AND PATIENTS

For OCD:

- *Getting Over OCD: A 10-Step Workbook for Taking Back Your Life.*
Abramowitz, J.S. (2009)
- *Freedom from Obsessive-Compulsive Disorder: A Personalized Recovery Program for Living with Uncertainty.*
Grayson, J. (2004)
- *Obsessive-Compulsive Disorders: A Complete Guide to Getting Well and Staying Well*
Penzel, F. (2000)
- *Overcoming Obsessive Thoughts: How to Gain Control of Your OCD*
Purdon C. & Clark, D.A. (2005)

BOOKS FOR PHYSICIANS AND PATIENTS (continued)

For OCD:

- The OCD Workbook: Your Guide to Breaking Free From Obsessive-Compulsive Disorder, 3rd Edition.
Hyman, B.M, Pedrick, C. (2010)
- When Perfect Isn't Good Enough: Strategies for Coping with Perfectionism, 2nd edition
Antony, M. M. & Swinson, R. P. (2009)
- Loving Someone with OCD: Help for You and Your Family
Landsman, K.J., Rupertus, K. M., & Pedrick, C. (2005)

OC Related Disorders:

- Help for Hair Pullers: Understanding and Coping with Trichotillomania
Keuthen, N.J., Stein, D.J., & Christenson, G.A. (2001)
- Trichotillomania: An Act-Enhanced Behavior Therapy Approach Workbook (Treatments That Work) Woods, D.W. & Twohig, M.P. (2008)
- Treatment for Hoarding Disorder, 2nd Edition (Workbook)
Steketee, G. & Frost, R. (2014)
- Buried in Treasures: Help for Compulsive Acquiring, Saving, and Hoarding, 2nd Edition
Tolin, D. F., Frost, R. O. & Steketee, G. (2013)
- Feeling Good about the Way You Look: A Program for Overcoming Body Image Problems
Wilhelm, S. (2006)
- The Bdd Workbook: Overcome Body Dysmorphic Disorder and End Body Image Obsessions
Claiborn, J. & Pedrick, C. (2002)
- Overcoming Body Image Problems Including Body Dysmorphic Disorder: A Self-help Guide Using Cognitive Behavioural Techniques. Willson, R. & Veale, D. (2009)

MOBILE APPLICATIONS

- [OCD Challenge](http://www.ocdchallenge.com)
www.ocdchallenge.com
- [Live OCD FREE](http://www.liveOCDfree.com)
www.liveOCDfree.com
- [Anxiety Coach](https://itunes.apple.com/ca/app/anxietycoach/id565943257?mt=8)
<https://itunes.apple.com/ca/app/anxietycoach/id565943257?mt=8>
- [nOCD](http://www.treatmyocd.com)
www.treatmyocd.com
- [Pull Free](https://itunes.apple.com/us/app/pull-free-hair-pulling-helper/id626207050?mt=8)
<https://itunes.apple.com/us/app/pull-free-hair-pulling-helper/id626207050?mt=8>
- [Skin Pick](http://www.skinpick.com/stop-picking-my-skin)
<http://www.skinpick.com/stop-picking-my-skin>
- [Stop Picking](http://ww2.stoppicking.com/)
<http://ww2.stoppicking.com/>
- [HabitAware](http://www.habitaware.com)
www.habitaware.com

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- [Mataix-Cols D](#). Clinical practice. Hoarding disorder. *N Engl J Med*. 2014 May 22;370(21):2023-30.
- Woods DW, Houghton DC. [Diagnosis, evaluation, and management of trichotillomania](#). *Psychiatr Clin North Am*. 2014 Sep;37(3):301-17.
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- Grant JE, Odlaug BL. [Update on pathological skin picking](#). *curr Psychiatry Rep*. 2009 Aug;11(4):283-8.

GUIDELINES

For OCD:

- Katzman MA, Bleau P, Blier P, Chokka P, Kjernisted K, Van Ameringen M; Canadian Anxiety Guidelines Initiative Group on behalf of the Anxiety Disorders Association of Canada/Association Canadienne des troubles anxieux and McGill University., Antony MM, Bouchard S, Brunet A, Flament M, Grigoriadis S, Mendlowitz S, O'Connor K, Rabheru K, Richter PM, Robichaud M, Walker JR. [Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders](#). *BMC Psychiatry*. 2014;14 Suppl 1:S1. doi: 10.1186/1471-244X-14-S1-S1.

For Trichotillomania:

- [Expert Consensus Treatment Guidelines](#)
https://www.bfrb.org/storage/documents/Expert_Consensus_Treatment_Guidelines_2016w.pdf

For OCD and BDD:

- [Obsessive-Compulsive Disorder and Body Dysmorphic Disorder: Treatment](#)
<https://www.nice.org.uk/guidance/cg31?unlid=7198711632016271326>

For Hoarding:

- [What Are Effective Interventions for Hoarding?](#)
http://eenet.ca/wp-content/uploads/2016/06/EENet-Rapid-Review_Hoarding-Interventions_June2016.pdf