BAP GUIDELINES FOR THE MANAGEMENT OF OBSESSIVE-COMPULSIVE DISORDER

1st Edition, 2022

বাংলাদেশ এসোসিয়েশন অব সাইকিয়াট্রিস্টস (বিএপি)
Bangladesh Association of Psychiatrists (BAP)

Scientific Partner:
GENERAL Pharmaceuticals Ltd.

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BAP Guidelines for the Management of Obsessive-Compulsive Disorder

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General Physicians
General practitioners from different organizations took part in the focus group discussion and shared their knowledge on the management of OCD.

Patients/Carers
Patients and their carers took part in the focus group discussion and shared their views.

Focus Group Discussion Facilitators
Dr. Md. Harun Ul Morshed and his team.

Preface to the first edition

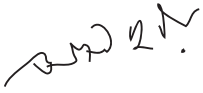
Obsessive-Compulsive Disorder (OCD) is a common and chronic disorder characterized by uncontrollable, reoccurring thoughts and/or behaviors that the individual feels the urge to repeat over and over. It usually begins before age 25 years and often in childhood or adolescence, is associated with other comorbid mental illnesses, has a long treatment gap, compromises an individual's productivity and well-being and has a detrimental impact on the lives of the both patients and their families. The Bangladesh Association of Psychiatrists (BAP) felt the need to develop a management guideline for psychiatrists and also for physicians working in non-specialized settings to improve quality of clinical practice while recognizing, assessing, diagnosing and treating OCD.

This guideline is based on available evidence on epidemiology, diagnosis and treatment of OCD and obtained mainly through desk review of established guidelines. The suggestions in this guideline represent the view of BAP, arrived after careful consideration of different evidence. However, we expect that the users will exercise their judgement, alongside with the individual needs, preferences and values of the patients. This guideline is intended to augment not replace sound clinical judgment.

I sincerely appreciate the hard work of the working committee members during the development of this guideline. Their effort to collect and compile information from different sources and experts is praiseworthy. I hope they will continue their excellent work despite our limitation and constrains. I would also like to thank the other experts who worked rigorously during this guideline development process.

I offer my special thanks and gratitude to Professor Sultana Algin, Convener, Working Committee; Dr. Mohammad Tariqul Alam, Coordinator of this guideline development project and Dr. Ahsan Aziz Sarkar, Writing Consultant of this OCD management guideline.

I believe this guideline will serve as a source of information for patients, their carers and health care professionals.



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Acknowledgement

We would like to express our gratitude towards the BAP members for their continued support and encouragement; the psychiatrists, general physicians, patients and their caregivers who participated in focus group discussions and gave their time and valuable feedback; the health care professionals involved in the management of obsessive-compulsive disorder. A heartfelt thanks to General Pharmaceuticals Ltd., scientific partner of OCD guideline development project for offering us logistical and financial support.

Contents

Symbols and abbreviations

CBT	Cognitive behavioral therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECT	Electroconvulsive therapy
ERP	Exposure and response prevention
ICD	International Classification of Diseases
LFTs	Liver function tests
NICE	National Institute for Health and Care Excellence
SSRIs	Selective serotonin reuptake inhibitors
TCAs	Tricyclic antidepressants

PART 1
BACKGROUND

1.1 Introduction

Obsessive-compulsive disorder (OCD) is characterized by presence of obsessions and/or compulsions. Obsessions are defined as recurrent, persistent and intrusive thoughts, images or urges that cause marked anxiety. Compulsions are defined as repetitive behaviors or mental acts that the patient feels compelled to perform to reduce the obsession-related anxiety. The obsessions or compulsions are time consuming and cause significant impairment in social or occupational functioning. OCD is likely to be a multifactorial illness where there is dysfunction in serotonin and glutamatergic pathways. Heritability plays an important part in its causation.

Patients with OCD experience prejudices and biases and also many individuals suffer from self-stigma. Fear of stigmatization and lack of knowledge regarding their illness may deter patients from seeking adequate help. Medication non-adherence, religious and cultural explanation of the illness, inadequate dosing and need for long-term treatment are also some of the worrying facts associated with OCD.

In DSM-5, OCD is placed under the category of Obsessive-Compulsive and Related Disorders which also include body dysmorphic disorder, hoarding disorder, trichotillomania, excoriation (skin picking) disorder, substance/medication-induced obsessive-compulsive and related disorder, obsessive-compulsive and related disorder due to another medical condition, etc. In this guideline we have focused only on OCD.

1.2 Epidemiology

Evidence suggested that prevalence of OCD in the community varies considerably due to geographical, gender, age, racial differences, treatment access and also due to methods of estimation.

Table 1: Prevalence of OCD

Prevalence	Bangladesh*	Globally
Adults	0.7%	1.2%
Men	0.5%	0.5%
Women	0.9%	1.8%
Children	0.1%	1%

** From Bangladesh National Mental Health Survey 2019*

OCD can begin at any time from preschool age to adulthood. The mean age of onset is 19.5 years and one-third to one half of adults report that it started during childhood. Onset after 35 years is uncommon but does occur. Males have an earlier age of onset and 25% males have onset before age 10 years. Heritability for OCD can be as high as 45% to 65% in children and 27% to 45% in adults. It often goes unrecognized in primary care and on average may take 10 years to receive a correct diagnosis.

1.3 Rationale

OCD has a profound impact with a high disease burden. It is the 10th leading cause of disability of all medical conditions in the world. Schizophrenia, major depression and OCD are among the top ten disorders associated with the greatest quality-adjusted life years (QALY) loss at population level. It often begins in childhood or adolescence, is associated with other comorbid mental illnesses, has a long duration for treatment seeking, compromises an individual's productivity and well-being and has a detrimental impact on the lives of the both patients and their families. Considering the long-term distress and disability associated with this disorder, Bangladesh Association of Psychiatrists (BAP) has felt the need to develop a national clinical management guideline for the psychiatrists and other physicians. Till date there is no single uniform and comprehensive management guideline for OCD in Bangladesh.

From focus group discussions with patients, general physicians and psychiatrists, several key facts had also emerged that revealed the necessity of such a guideline.

- First, facilities and trained manpower to provide cognitive behavioral therapy (CBT) is difficult to obtain.
- Second, general physicians are not trained and skilled enough to diagnose and manage OCD.
- Third, patients delay in seeking help and there is no clear referral system at work in Bangladesh.
- Fourth, patients and their family members have little understanding of the etiological background; often OCD is seen as personal failure to control thoughts or religious punishment.

Features of this guideline:

Diagnosis can be confirmed by psychiatrists as well as by other physicians working in low resource settings.

- The concepts, assessment, management and referral pathways are clearly described here.
- The clinical features, ranging from mild to severe illness and special population with OCD (children and adolescent, pregnant and lactating mother, person with physical comorbidity, etc.) are considered in this guideline.
- The evidence-based principle of management was developed here after considering country context, cultural compatibility and available resources.
- This guideline comprises information to be used in both inpatient and outpatient settings.
- A comprehensive management plan including follow up and compliance issues are also discussed here.
- This guideline will be updated periodically.
- All those things have made this guideline unique and uniform and very much compatible with Bangladesh context.

1.4 Objectives

Figure 1: BAP OCD management guideline

a. To provide clear, concise and uniform information to all psychiatrists and other physicians on the current concept in the management of OCD considering the context of Bangladesh.

b. To lay out necessary directives and primary management algorithm along the referral pathways for the general practitioners and physicians other than psychiatrists.

c. To make it user friendly for psychiatrists to ensure advanced and updated management of OCD as well as to advance a primary care model for physicians working in limited resource settings.

1.5 Target users

Psychiatrists	Physicians working in non-specialized setting and other specialists
✓ Advanced and updated management protocol for clinical practice	✓ Primary management protocol [what to do and what not to do]
✓ Covers all aspects of OCD.	✓ Referral pathway [when to refer, where to refer, how to refer]
✓ Management in special population and situations	

This guideline is made by BAP to provide a uniform protocol for the members of this organizations. Psychiatrists are the key target users of this clinical management guideline; however, a brief but comprehensive portion is also added for the physicians working in non-specialized setting (general practitioners, specialists other than psychiatrists) to guide them through initial management and referral issues. Allied mental health professionals like psychologists, counselors, clinical social workers, mental health nurses can also use the guideline to get a good understanding of clinical practices involved at different stages of OCD management.

1.6 Methodology

This guideline has been developed after considering the desk review of updated clinical practice guidelines from several authorities like American Psychiatric Association (APA), NICE guidelines, Anxiety Disorders Association of Canada, Indian Psychiatric Society (IPS), British Association of Psychopharmacology (BAP), American Academy of Child and Adolescent Psychiatry (AACAP), etc., and expert consensus, clinical experience and the findings from the focus group discussions with the psychiatrists from Bangladesh, general practitioners and person with living experience of OCD.

Table 2: Definition of levels of evidence criteria used in OCD treatment recommendations

Level	Evidence	BAP evidence gathering
I	Systematic review/meta-analysis of all relevant randomized controlled trials	Obtained from desk review
II	One or more properly designed randomized controlled trial	
III	Well-designed prospective trial (non-randomized controlled trial); comparative studies with concurrent controls and allocation not randomized; case-controlled or interrupted time series with a control group	
IV	Case series, either post-test or pretest/post-test	
V	Expert opinion	Consensus among experts, focus group discussion with experts

Treatment recommendations used in this guideline were created by considering the efficacy of each treatment across various phases of illness as well as safety and tolerability, obtained from levels of evidence from various types of studies. We recommend that drugs listed higher in the hierarchy be tried first, unless there are patient specific reasons for choosing a drug lower in the hierarchy. Within the same line of recommendations, there is no marked difference in efficacy (unless stated otherwise), so, any one of them could be prescribed.

PART 2
MANAGEMENT

2.1 Diagnostic convention

The essential feature required for the diagnosis is recurrent obsessional thoughts or compulsive acts. In addition, to establish the diagnosis of OCD secondary conditions like another medical, mental or substance use disorder that can cause OCD symptoms needs to be ruled out. For detailed information about diagnostic conventions readers are advised to consult the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) or the International Classification of Diseases, Eleventh edition (ICD-11).

Table 3: List of common obsessions and compulsions

Common obsessions	Common compulsions
Contamination - fear of dirt, germ, concern or disgust with bodily secretions and waste such as stools and urine	Cleaning- excessive handwashing, bathing, cleaning household items, floor, etc.
Sexual- unwanted, forbidden thoughts, images or urges	Checking- lock, stoves, doors
Aggression/harm related obsession- fear of harming self or others, violent or horrific imagery	Counting- money, floor tiles
Religious - blasphemous thoughts, concern about right-wrong, morality	Dressing- series of dressing and undressing steps
Hoarding- thoughts about acquiring possessions and having difficulty discarding them	Hoarding- getting and saving an excessive number of items like clothes, books, newspaper, food
Symmetry- concern about things is not properly arranged, perfect, exact	Mental rituals- praying, replacing bad thought with good thought

Obsessions can be manifested as thought, image, or impulse and compulsion as behavioral ritual or mental prayer; urge and mental rituals are much common in our country; hoarding is less common than western culture.

2.2 Principles of management

Common component of managing OCD include the followings

1. Detailed assessment
2. Decision on treatment setting
3. Psychoeducation to patient and involvement of family members
4. Treatment choice (Pharmacological and/or psychological)
5. Follow up plan

1. Detailed assessment

Detailed assessment should include evaluation of principal symptoms, identification of associated compulsions, avoidance and safety behaviors, determination of the level of insight and risk and family accommodation of patient's rituals. Severity of OCD can be documented by number of hours per day spent obsessing and performing compulsive behaviors, the degree of effort applied to trying to escape the obsessions and to resisting the behaviors and recording actively avoided items or situations. These measures will provide a useful baseline against which change can be measured. For detailed information about diagnostic conventions readers are advised to consult DSM-5 or ICD-11.

Appropriate examinations and investigations need to be conducted on an individual basis. The purpose of these are three folds. First, to exclude medical diagnoses that can produce similar features; second, to see whether the patient is fit for commencing psychotropic drugs and third, to establish a baseline parameter to compare with future examinations and investigations.

Table 4: Assessing OCD

Clinical features	Severity	Degree of insight	Course	Onset	Remission state
Nature of obsessions Nature of compulsions	Mild Moderate Severe	Good/fair Poor Absent or delusional belief	Episodic Continuous Deteriorating	Early Late Peripartum Puberty	Partial remission Full remission Resistant

Additionally, structured or semi-structured interviews and rating scales can be used. Bangla validated version of the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) is considered gold standard and can be used to measure symptom types and severity of OCD in both adults and children. The Dimensional Obsessive-Compulsive Scale (DOCS-B) is a 20-item self-report instrument that can also be used to assess the severity of OCD symptoms along four theme-based dimensions. Another scale, The Family Accommodation Scale for OCD (FAS-B) assesses the extent to which relatives of patients with OCD engage in different types of accommodating behaviors, can be handy in some situations.

OCD is often comorbid with other psychiatric disorders and rates can be as high as 90%. Assessment of all patients for psychiatric comorbidities is important as comorbidities affect treatment outcome. It is strongly associated with suicidal behavior and the risk of committing suicide is approximately ten times higher than that of the general population. Assessing the risk of self-harm and suicide is necessary, especially if the patient has also been diagnosed with depression.

Common psychiatric comorbidities in OCD are-

a. Mood disorders (major depressive disorder, dysthymia, bipolar disorder)

b. Anxiety disorders (panic disorder, generalized anxiety disorder, social anxiety disorder)

c. OCD related disorders (body dysmorphic disorder, hoarding disorder, trichotillomania, skin picking disorder)

d. Illness anxiety disorder

e. Tic disorder

f. Attention-deficit/hyperactivity disorder

g. Oppositional defiant disorder

h. Obsessive-compulsive personality disorder

2. Decision on treatment setting

Outpatient treatment is usually sufficient for most OCD patients who are mild to moderately ill and those who are likely to be adherent to treatment. Hospital treatment may be indicated by suicide risk, danger to others, an inability to provide adequate self-care, intolerance to side-effects, treatment resistance, presence of medical conditions that requires hospital admission and presence of severe depression, mania or psychosis that may be comorbid with OCD.

3. Psychoeducation to patient and involvement of family members

Detailed psychoeducation of the patient and family member(s) about nature, biology, course, treatment options including duration of treatment are necessary. Discussion on the side effects of drugs, in women risks vs. benefits of drugs during pregnancy and post-partum periods, should be included. Involvement of family members is important to identify and reduce family accommodation.

4. Choice of treatment

SSRIs or Cognitive behavioral therapy (CBT), alone or in combination is the initial choice of treatment in OCD. Whether to recommend an SSRI, a form of CBT, or combined treatment depends on nature and severity of the symptoms, nature and severity of comorbid physical or psychiatric conditions, availability of CBT, patient's past treatment history and response, current medications and preferences.

5. Follow up plan

Short-term treatment goals are to achieve clinical response and if possible remission with successful management of comorbidities if present and side effects of drugs. Long-term treatment goals include achieving recovery, reducing family accommodation, restoring and enhancing quality of life and preventing relapses. Patients may be followed-up initially at once or twice in a month and subsequently at longer intervals depending upon the response to treatment, tolerability and side-effects.

Box 1: Suggested routine baseline investigations for patients with OCD

- CBC
- RBS
- Serum creatinine, Urine R/M/E
- SGPT
- ECG (>40 years or if indicated)
- Pregnancy test (if relevant)

2.3 Treatment of OCD

Choosing initial treatment modality for adults

Whether to recommend an SSRI, a form of CBT or combined treatment will depend on a number of factors. These include

- Nature and severity of the patient's symptoms
- Comorbid psychiatric and medical conditions
- Availability of CBT
- Patient's past treatment history, current medications, preferences

A good number of drugs have been found to be effective at various steps of OCD management. They are summarized below.

Table 5: Recommendations for pharmacotherapy for OCD

First-line*	Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine Sertraline
Second-line	Clomipramine
Third-line	Venlafaxine, Mirtazapine, very high dose SSRIs (selected cases only)
Augmenting agent	First-line - Aripiprazole, Risperidone Second-line - Memantine, Lamotrigine, Haloperidol, Ondansetron Third-line - Amisulpride, Quetiapine, Olanzapine, Mirtazapine, Granisetron, N-Acetylcysteine, Topiramate
Others	Benzodiazepines (short-term use for anxiety, agitation, insomnia, etc.)

*There is no significant difference in efficacy between individual SSRIs

Treatment for OCD in acute phase

- The first-line treatment options for OCD are SSRIs and CBT (with ERP) (See table 5).
- CBT can be brief or intensive, in individual or group format and should include exposure and response prevention (ERP) therapy.
- One of the following SSRIs can be chosen as initial agent for pharmacotherapy-citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline.
- All SSRIs have near equal efficacy in the treatment of OCD. Choice of a particular SSRI should be based on previous response, comorbidity, tolerability, adverse effects, cost and drug interaction.
- SSRIs are more efficacious in OCD when used at high doses (i.e., higher dose than major depressive disorder).
- An SSRI alone is recommended for a patient who has previously responded well to a given drug or prefers treatment with an SSRI alone. An SSRI alone may also be necessary if CBT is not accessible or available.
- CBT (with ERP) is the only form of psychotherapy for OCD whose effectiveness is supported by controlled trials. For adults with OCD, it enhances long-term symptom reduction. For adults living with their family or carers, involving a family member or carer in the treatment process is appropriate and recommended.
- Dose titration is usually recommended, with patients remaining at the lowest effective dose levels for several weeks and reassessed before gradually increasing up to the maximum licensed doses according to observed efficacy and tolerability.
- Benzodiazepines (e.g., clonazepam, alprazolam, lorazepam) are often used to manage anxiety, agitation, insomnia, comorbid mood and anxiety disorders and to manage side effects of drugs. However, alone they are not effective in the treatment of OCD. As dependence is a concern, when prescribed they should be used for short-term only.
- It needs time to observe the clinical effects of the drugs; clinicians might have to wait for 6 to 12 weeks to see improvement of symptoms. OCD responds to drug treatment in a characteristically slow, gradual way and improvements can take many weeks and months to develop.
- Adequacy of the treatment response following drug therapy should be assessed over a 12 weeks period which should include prescribing the drug at maximum tolerable dose for 4-6 weeks.
- Following remission drug treatment should be continued for at least one year.

12 weeks	→	To assess efficacy of a drug therapy
4-6 weeks within this 12 weeks at maximum tolerable dose	→	If response is initially inadequate
At least 1 year	→	Continue treatment after remission

Table 6: Suggested treatment for OCD in acute phase

Clinical criteria	Treatment Modality
Mild functional impairment and/or the patient prefers	Brief CBT (with ERP)
Mild functional impairment in which brief CBT proved inadequate or Moderate functional impairment	An SSRI or Intensive CBT (with ERP) (An SSRI alone may also be necessary if CBT is not accessible or available)
Severe functional impairment	An SSRI + CBT (with ERP)

Table 7: Suggested dosage for SSRIs and clomipramine in OCD

Drug	Starting dose (mg/day)	Usual target dose (mg/day)	Usual maximum dose (mg/day)
Citalopram	20	40-60	60
Escitalopram	10	20-30	30
Fluoxetine	20	40-60	80
Fluvoxamine	50	200	300
Sertraline	50	200	200
Paroxetine	20	40-60	60
Clomipramine	25	100-250	250

Inadequate response to SSRI or CBT alone

- For adults with OCD, if there has been no response to a 12 weeks course with an SSRI, healthcare professionals should reassess the diagnosis, check that the patient has taken the drug regularly, in the prescribed dose, whether any comorbidity is present and that there is no interference from substance use.
- A board review should be conducted if non-adherence is ruled out. Following the review, for adults with OCD, if there has not been an adequate response to treatment with an SSRI alone (within 12 weeks) or CBT (including ERP) alone, one of the following strategies can be employed
  a. Switching to a different SSRI
  b. Combining an SSRI with CBT (with ERP)
  c. Switching to clomipramine
- Clomipramine can be considered in the treatment of adults with OCD
  - after an adequate trial of at least one SSRI has been ineffective or poorly tolerated
  - if the patient prefers clomipramine or
  - had a previous good response to it
- Adequacy of the treatment response following combination or switching should be assessed over a 12 weeks period (including 4-6 weeks at maximum tolerable dose).
- Following remission drug treatment should be continued for at least one year and regular follow up is required.

Inadequate response after combination (SSRI+CBT) or switching

- If there has been no response after full trial of combined treatment with CBT (with ERP) and an SSRI or full trial of a switched to SSRI or a switched to clomipramine, then one of the following strategies could be employed
  a. Adding an antipsychotic to an SSRI or clomipramine
  b. Combining an SSRI with clomipramine
  c. Additional CBT (with ERP)
- Such combination therapy should only be initiated by psychiatrists.
- Antipsychotics should be used in low dose (e.g., risperidone 1-3 mg, aripiprazole 5-10 mg) for a period of at least 8 weeks to see the efficacy. Long-term treatment with antipsychotics should be considered after assessing the benefits and risks of long-term use.
- If there is inadequate or no response with combination of SSRI and clomipramine or after adding antipsychotic to SSRI or clomipramine-one of the following drugs can be used.

a. Memantine
b. Lamotrigine
c. Ondansetron/Granisetron

- Augmentation strategies should be employed before trying a third-line drug suggested in table 8. Adjunctive strategies early in the treatment confer better treatment outcome.

Table 8: Suggested dosage for augmenting drugs

Drug	Dosage (per day)
Aripiprazole	5-10 mg
Risperidone	1-3 mg
Haloperidol	2.5-10 mg
Memantine	10-20 mg
Lamotrigine	100 mg
Ondansetron	2-4 mg twice a day
Granisetron	1 mg twice a day

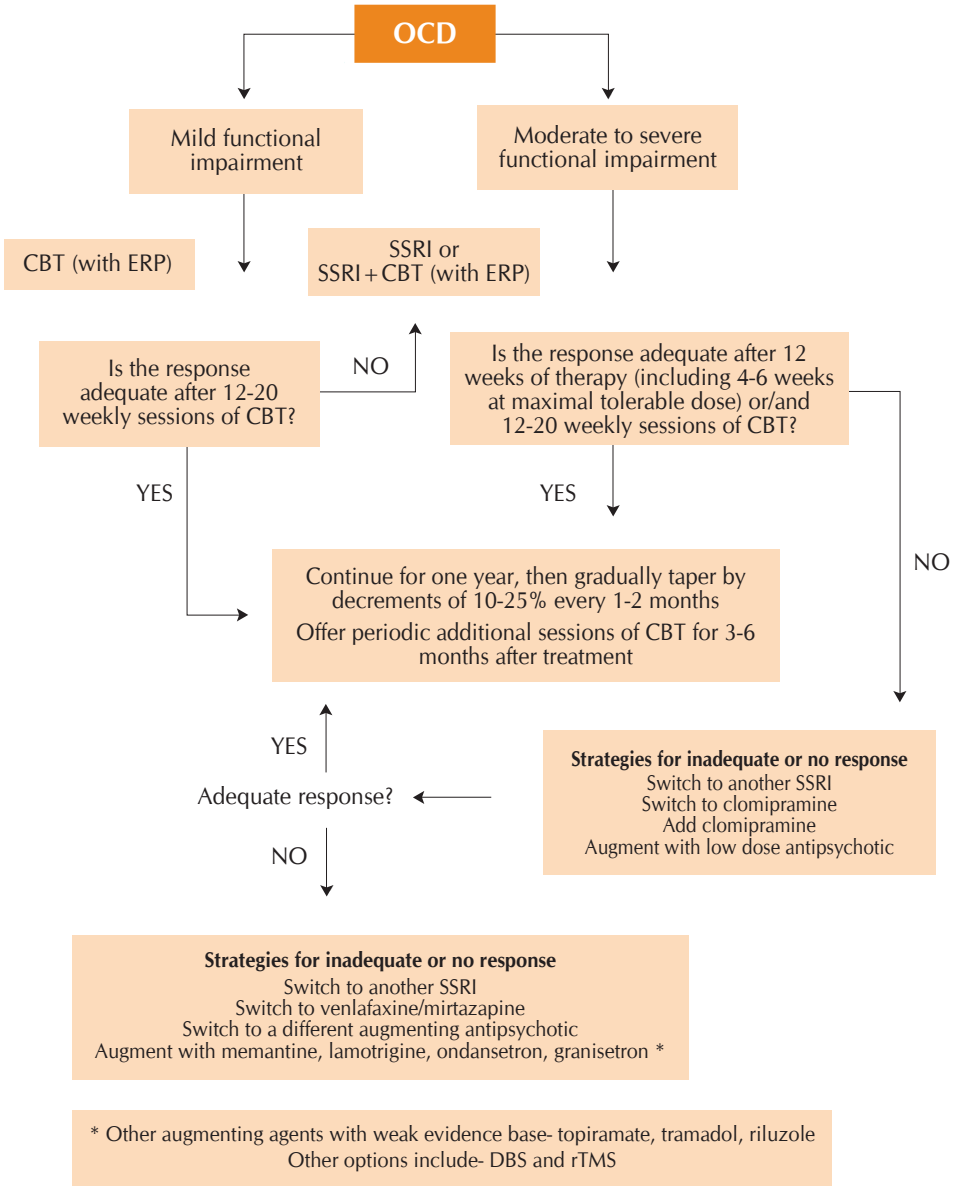


Figure 2: Treatment algorithm of OCD

When hospital admission may be required

- People with severe, chronic, treatment-refractory OCD could be offered hospital inpatient-based treatment.
- A portion of people with OCD may require hospital admission when there are
  - Self-harm and suicide risk
  - danger to others
  - an inability to provide adequate self-care
  - intolerance to side-effects
  - treatment resistance (i.e., patients who do not respond or show unsatisfactory results after receiving two SSRIs (or one SSRI and clomipramine) at an adequate dose, the maximum tolerated dose, for an adequate duration of treatment (12 weeks total and at least 6 weeks at the maximal dose).
  - presence of medical conditions that requires hospital admission and
  - presence of severe depression, mania, psychosis, absent insight, etc.

Management plan during recovery

- When a person of any age with OCD is in remission (i.e., symptoms are not clinically significant and the person is fully functioning for 12 weeks), he or she should be reviewed regularly for 12 months by a mental health professional.
- At the end of the 12-month period if recovery is maintained the person can be managed by general physician or other specialties.
- OCD can have a fluctuating or episodic course, or relapse may occur after successful treatment. Therefore, people who have been successfully treated and discharged should be seen as soon as possible if re-referred with further occurrences of OCD.
- For those in whom there has been no response to treatment, care coordination (or other suitable processes) should be used at the end of any specific treatment program to identify any need for continuing support and appropriate services to address it.
- Successful medication treatment should be continued for at least one year. Before discontinuing medication risk of relapse should be assessed thoroughly. When decision is taken to stop pharmacotherapy, a gradual taper by decrements of 10-25% every 1-2 months while observing for symptom return or exacerbation is recommended.

2.4 Psychological treatment for OCD

Cognitive behavioral therapy (CBT) with exposure and response prevention (ERP) is the first-line treatment option for OCD. When available it should be tried first in OCD with mild functional impairment. CBT (with ERP) can also be tried as first-line augmentation strategy in patients who have shown inadequate or no response to initial SSRI therapy.

Other psychological treatment employed in OCD are acceptance and commitment therapy (ACT), stress management and relaxation technique and mindfulness based cognitive therapy. However, they have non-specific effects and no evidence suggests their efficacy in treatment of OCD.

Family members should be included in the treatment process to improve family functioning and facilitate behavioral therapy. Targeting family accommodation related to OCD symptoms leads to better treatment outcomes. Next, there is a brief description of common psychological techniques used in OCD.

Table 9: Recommended psychological treatment for OCD

First-line	CBT with ERP
Others	Family accommodation therapy Acceptance and commitment therapy Stress management and relaxation techniques Mindfulness based CBT

Psychoeducation

Psychoeducation can be individual, family or group based. The predominant focus of psychoeducation will depend on patient's state and can be compliance/adherence focused, illness focused, treatment focused, and rehabilitation focused. Common elements of psychoeducation are given in Box 2. Some information for psychoeducation can be given as below.

Box 2: Elements of psychoeducation sessions

Etiology of OCD

Common signs and symptoms

Early signs of relapse/recurrence

How to cope in different situations

Available treatment options

When and how to seek treatment

Need for adherence to treatment

Side effects of medications and how to manage them

Birth planning

Long-term course and outcome

Dos and don'ts for family members while dealing with the patient

Clearing myths and misconceptions about the illness and dispelling stigma

Cognitive behavioral therapy (CBT)

CBT employs a combination of cognitive and behavioral techniques to target maladaptive thinking, deficits and factors predisposing to and perpetuating obsessive-compulsive symptoms. It focuses on the reciprocal relationships between thinking, behavior and emotions to decrease symptoms and relapse risk.

CBT includes

- Assessment – at the start of therapy the therapist can use the Y-BOCS symptom checklist to help the patient create a list of target symptoms, including obsessions, compulsions, and items or situations that are avoided because of OCD concerns. The patient will rank the listed items from least to most anxiety provoking.

- Formulation
- Goal settings
- Identification of specific cognitive distortions and restructuring the cognitions
- Challenging the dysfunctional beliefs by evidence seeking
- Preparing the patient for behavioral experiments

CBT sessions should be scheduled at least once weekly. The number of sessions, their length and the duration of an adequate trial have not been established but expert consensus recommends 13-20 weekly sessions for most patients.

When a good response is not achieved after 13-20 weeks of weekly CBT, 3 weeks of daily CBT should be planned. The psychiatrist should decide with the patient when, whether and how to alter the treatment. This decision will depend on the degree of suffering and disability the patient wishes to accept. However, it is important to consider that illness can bring secondary gains and that depressed mood can diminish hopefulness; the psychiatrist may have to address issues such as these when patients are not well motivated to pursue further treatments despite limited improvement.

Exposure and response prevention (ERP)

ERP is a form of cognitive behavioral therapy (CBT) that involves providing psychoeducation to the patient, helping the patient confront fears or discomfort related to their obsessional thoughts, and having the patient resist performing compulsions.

- Patients are taught to confront fear situations and objects (i.e., exposure) and to refrain from performing rituals (i.e., response prevention).
- Exposure may include in vivo confrontations (e.g., touching objects in bathrooms) and imaginal confrontations of feared consequences (e.g., imagining becoming dirty from contamination).
- Exposure that provokes moderate anxiety are prescribed first, followed as quickly as tolerate by exposures of increasing difficulty. Moving at too slow a pace can diminish faith in the treatment and motivation to continue.
- Patients must face their fears for a prolonged period without ritualizing, allowing the anxiety or discomfort to dissipate on its own (habituation).
- The goal is to weaken the connections between feared stimuli and distress and between carrying out rituals and relief from distress.
- The ERP will be delivered in 1-hour session once or twice a week for up to 12 weeks.

Adding cognitive therapy to ERP

Cognitive therapy is added to ERP to help reduce the catastrophic thinking and exaggerated sense of responsibility for unwanted events, overestimation of the probability of feared events, the assumption that thoughts are morally equivalent to actions or inevitably lead to action (thought-action fusion), perfectionism, the belief that anxiety/discomfort will persist forever, and the need for control often seen in those with OCD. For example, a person might have a thought that if he does not donate money to mosque his mother may die. CT can help him challenge the faulty assumptions in these obsessions. Evidence seeking and alternate ways of thinking can be important parts of CT.

Group therapy

Group psychotherapy or group therapy is a form of psychotherapy in which one or more therapists treat a small group of clients together as a group. As individual therapy is sometimes expensive and patients drop out at some stage is significantly high, and there is some evidence in favor of group therapy, it can be a very good option in our context.

- Therapy groups must have a specific focus such as ERP or CT.
- Members will learn from each other and aided by therapist support and guidance.
- Therapist's role is to facilitate discussion among group members and sometimes to lead, direct and teach.

In family therapy, following things should be implemented carefully

- Proper psychoeducation to all family members.
- Identification of Family Accommodation Behaviors (assistance from the family to do the rituals just to keep the peace) and its reduction.
- Ensuring support to the patient and compliance to treatment.

2.5 Prognosis

If OCD is untreated, the course is usually chronic, often with waxing and waning symptoms. Some individuals have an episodic course, and a minority have a deteriorating course. Without treatment, remission rates in adults are low. Onset in childhood or adolescence can lead to a lifetime of OCD. However, 40% of individuals with onset of OCD in childhood or adolescence may experience remission by early adulthood. The course of OCD is often complicated by the co-occurrence of other disorders.

Following treatment, about 20-30% of patients show significant improvement, 40-50% moderate improvement and 20-40% either remain ill or their symptom worsen. Good prognostic factors include good social and occupational adjustment, presence of a precipitating event before onset and episodic nature of symptoms.

2.6 Psychiatric comorbidities

Depression

- Major depression is the most common psychiatric comorbidity in OCD.
- Pharmacotherapy for OCD also works for depression. An SSRI (citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine or sertraline) that the patient had responded to or will be used for OCD should be prescribed.
- An SSRI + Lithium or an SNRI (venlafaxine) could be tried in case of non-response to initial therapy.
- Severe depression with high suicidal intent needs thorough evaluation and ECT may be an option if indicated.
- Withheld CBT (including ERP) for OCD until the patient recovers from depression.

Tic disorder

- Research indicates that a great number of patients with OCD have a lifetime history of tics (nearly 60%).
- Augmentation of SSRI treatment with alpha 2 agonists (e.g., clonidine) is a treatment option.
- Another option is adding low-dose antipsychotic (aripiprazole, risperidone, haloperidol) to the ongoing SSRI.
- Habit reversal training (HRT) is also a first line treatment alone or in combination with pharmacotherapy.

Attention-deficit/hyperactivity disorder (ADHD)

- Treat both OCD and ADHD concurrently when they are both present and severe enough to warrant biological and psychological treatments.
- Standard treatments for both, such as SSRIs for OCD and psychostimulants such as methylphenidate for ADHD should be used.
- There is evidence that CBT + ERP improves attentional symptoms of OCD.
- When both conditions are present, an alternative option is SSRI + Atomoxetine.

Autism spectrum disorder (ASD)

- It is estimated that 17–37% of young people with ASD also experience OCD symptoms.
- SSRI and CBT including ERP are effective for the management of OCD in these cases. Psychosocial interventions targeting symptoms of ASD are also recommended.

Bipolar disorder

- OCD is a comorbid condition in 10%-20% of patients with bipolar disorder and may be more common in children and adolescents.
- Symptoms of OCD may precede or follow mood symptoms and the severity of OCD symptoms tends to fluctuate with mood changes. OCD symptoms often appears or increases in depressive episodes but improves during mania or hypomania episodes.
- Lithium, anticonvulsants alone or with atypical antipsychotics (olanzapine, risperidone, quetiapine, aripiprazole) may be adequate to control symptoms.
- If OCD persists beyond mood episodes, CBT is preferred over SSRIs.
- Antidepressants might not be necessary for the majority of patients; if used, SSRIs are preferred over other antidepressants. When the patient requires an SSRI, it has to be prescribed under the cover of mood stabilizers (lithium, valproate) or an atypical antipsychotic (olanzapine, risperidone, quetiapine, aripiprazole).

Schizophrenia

- Obsessive–compulsive symptoms (OCS) can manifest in those at high risk for psychosis, during prodromal psychotic state, in the first episode of schizophrenia, during the course of chronic schizophrenia and after treatment with atypical antipsychotics.
- Up to 25% of the schizophrenia patients report clinically significant OCD symptoms.
- Antipsychotics such as amisulpride and aripiprazole which have negligible serotonergic properties appeared somewhat useful in treating OCD symptoms in schizophrenia.
- Monotherapy with olanzapine is also found to be effective in reducing both OCD and psychotic symptoms.
- Another option is the combination of an SSRI with antipsychotic; escitalopram (20 mg) is the preferred SSRI; others include fluoxetine and paroxetine. Fluvoxamine and clomipramine may worsen psychosis.
- Treatment of second-generation antipsychotic (olanzapine, risperidone, clozapine) induced obsessive-compulsive symptoms or OCD involves one of the possible steps if indicated.
  - reduction of antipsychotic dose (if feasible)
  - change to another antipsychotic such as aripiprazole, amisulpride or haloperidol
  - addition of aripiprazole
  - addition of SSRI
  - CBT

Anxiety disorders

- Comorbid anxiety disorders contribute to poor treatment response.
- CBT in addition to SSRIs are suggested for comorbid anxiety disorders.

Personality disorder

- Obsessive-compulsive, narcissistic and anxious avoidant personality disorders are the most common personality disorders comorbid with OCD.
- They can be associated with poor treatment outcome.
- Medication in combination with psychotherapy are suggested for their management.

Table 10: Recommended management for comorbid psychiatric disorders in OCD

Depression	Pharmacotherapy for OCD also works for depression SSRI + Lithium SNRI (Venlafaxine)
Tic disorder	Clonidine Low dose Aripiprazole, Risperidone, Haloperidol Habit reversal training (HRT)
Attention-Deficit/Hyperactivity Disorder (ADHD)	Methylphenidate Atomoxetine
Autism spectrum disorder (ASD)	Psychosocial interventions
Bipolar disorder	Lithium Valproate Lithium/Valproate + Atypical antipsychotics (Olanzapine, Risperidone, Quetiapine, Aripiprazole)
Schizophrenia	Amisulpride Aripiprazole SSRI (Escitalopram, Fluoxetine, Paroxetine) + Antipsychotic
Anxiety disorders	CBT + SSRI
Personality disorder	Psychological treatment

2.7 Medical comorbidities

Neurological disorders

- OCD involves problems in communication between orbital cortex and basal ganglia. Cortico-striato-thalamo-cortico circuitry which could be involved in diseases like Parkinson's disease, Sydenham's chorea, traumatic brain injury, stroke, Tourette syndrome, Huntington's disease, epilepsy, carbon monoxide poisoning, manganese poisoning can manifest with obsessive-compulsive symptoms.
- In such cases, treat the underlying condition first; then, if necessary, treat OCD.

Hepatic impairment

General guideline for prescribing in hepatic impairment

- Use lower than usual starting doses.
- Be cautious with drugs that are extensively metabolized in liver.
- Avoid drugs with long half-lives, that are very sedative and very constipating.
- Treat with a single drug whenever possible.
- Choose a low-risk drug and initially (first six weeks) monitor liver function tests weekly.
- CBT with ERP is the first treatment choice in patients with hepatic impairment.

Box 3: Recommended medications in hepatic impairment

SSRIs - Sertraline (first-line); Escitalopram, Fluvoxamine and Paroxetine (second-line)
Antipsychotics - Aripiprazole, Risperidone

Note:

Aripiprazole - No dosage reduction in mild to moderate impairment.

Sertraline, escitalopram, fluvoxamine, paroxetine, risperidone - Start at half of the recommended dosage in mild to moderate impairment; maximum dose may be half of usual maximum dose.

Severe impairment - more caution required (e.g., 75% dose reduction).

Renal impairment

General guideline for prescribing in renal impairment

- Avoid drugs that are extensively renally cleared.
- Start at a low dose, increase gradually
- Avoid long-acting drugs, drugs with anticholinergic effects (-urinary retention), drugs that prolog QTc interval.
- Use Creatinine clearance and ACR (albumin to creatinine ratio) to decide about dose range and titration frequency.
- Usual dosing: GFR 10-50 ml/min - use normal dose; GFR $<$10 ml/min – use1/4 to 1/2 of normal dose.
- If drug treatment is necessary, sertraline and citalopram are the preferred choices in patients of OCD with renal impairment.

Cardiovascular disease

- Cardiovascular adverse events are usually mild and are unlikely to occur with SSRIs at therapeutic doses.
- Orthostatic hypotension, mild bradycardia and QT interval prolongation have been reported under SSRIs and usually in those cases patients had preexisting conditions like long QT syndrome, recent myocardial infarction, hypokalemia, hypomagnesemia, etc. Also, SSRIs interacts with warfarin and other anticoagulants.
- SSRIs may have antithrombotic cardioprotective properties through blocking the serotonin reuptake during platelet aggregation.
- If drug treatment is necessary, sertraline and fluoxetine are the preferred choices in patients of OCD with heart disease.
- At usual dose range, aripiprazole and risperidone have no effect on QT interval.

Table 11: Recommended drugs for OCD with comorbid medical conditions

Neurological disorders	Treat the underlying condition; then, if necessary, treat OCD.
Hepatic impairment	SSRIs – Sertraline (first-line); Escitalopram, Fluvoxamine and Paroxetine (second-line) Antipsychotics - Aripiprazole, Risperidone
Renal impairment	SSRIs - Sertraline, Citalopram Antipsychotics - Aripiprazole, Risperidone
Cardiovascular disease	SSRIs - Sertraline, Fluoxetine Antipsychotics - Aripiprazole, Risperidone

2.8 Special population

Children and adolescents

- CBT is the first-line treatment for OCD in children.
- In children, SSRI (fluoxetine, sertraline or fluvoxamine) should be the preferred choice of treatment when CBT facilities are not available.
- An adequate trial of medication (SSRI or clomipramine) should be continued for at least 12 weeks at optimum dose. Most patients show gradual improvement over several weeks.
- At the beginning of treatment with SSRI, careful monitoring is required for possible appearance of suicidal behavior, self-harm or hostility.
- Medication should be continued for at least 6 months post remission.
- Stopping or reducing the drug dosage can be considered when remission is achieved as evidenced by child is symptom free or have no clinically significant symptoms and fully functioning. Before that the patient and the family members should be informed about discontinuation syndrome and risk of relapse.
- Dose should be tapered gradually over several weeks (particularly for SSRIs) considering the ongoing dose, drug half-life and appearance of discontinuation syndrome.
- Antipsychotics should not be used in children without the supervision of psychiatrists.
- Hospital admission may be indicated when there is risk to life, severe self-neglect, extreme distress or functional impairment, no response to adequate trials of pharmacological/psychological/combined treatments over long period of time, presence of additional diagnoses - severe depression, anorexia nervosa or schizophrenia, or compulsions and avoidance behavior are so severe or habitual normal activities are not possible.
- The approved medications in children include sertraline (6 years and older), fluoxetine (8 years and older), fluvoxamine (8 years and older) and clomipramine (10 years and older).
- Treatment recommendations are given below

Table 12: Treatment recommendations of children and adolescents with OCD

Clinical criteria	Treatment Modality
Functional impairment is mild	Guided self-help; support and information for the family or caregivers.
Mild functional impairment and guided self-help is ineffective or refused Or Moderate to severe functional impairment	CBT (with ERP) It should involve family members of caregivers and adapted according to the child's developmental age.
Patient is unable to engage with psychotherapy Or Psychotherapy appeared inadequate or ineffective	Combine an SSRI (fluoxetine, sertraline or fluvoxamine) with ongoing psychological treatment. Multidisciplinary review should be carried out before starting the SSRI.
Severe impairment	Combine CBT with an SSRI (fluoxetine, sertraline or fluvoxamine).
Treatment with an SSRI in combination with CBT (with ERP) involving the family or caregivers is unsuccessful/not well tolerated	Use another SSRI or clomipramine with careful monitoring for side effects.
Successive trial of two or three SSRIs are unsuccessful	Augment with low dose antipsychotic (risperidone or aripiprazole).

Pregnancy

- Treatment of OCD during pregnancy should plan in pre-conception period with involvement of obstetrician and should involve pregnancy planning, folate supplementation, careful monitoring, discussion with family members and benefit vs. risk of the medication to the developing fetus.
- If the woman is symptom free for long period (i.e., 1-2 years), an attempt may be made for gradual withdrawal of drug/s.
- For newly diagnosed OCD during pregnancy, during first trimester and post-partum period – CBT with ERP is the preferred treatment.
- If decision is taken to continue or prescribe drug, then SSRIs are the preferred options. SSRIs as a group are not major teratogen. However, there are inconsistent data regarding paroxetine. While prescribing always consider previous drug response pattern.
- Benefit vs. risk of continuing SSRIs during pregnancy should be assessed and discussed taking into consideration that discontinuation may lead to relapse.
- Pharmacotherapy should be maintained for at least one year after therapeutic response.

Lactating mothers

- Mothers should be encouraged to continue breastfeeding their infants.
- Sertraline, fluvoxamine and paroxetine are present in very low concentrations in breast milk; one o them should be preferred for lactating mothers.
- Pharmacotherapy should be maintained for at least one year after therapeutic response.

Elderly

- OCD is less common in the elderly than in younger patients.
- When obsessive compulsive symptoms start for the first time in an elderly patient, always consider an organic or a neurological diagnosis first.
- If the diagnosis of OCD is confirmed, choose CBT with ERP as first treatment option.
- If drug treatment is necessary, choose one of the SSRIs.
- Clomipramine should only be used when trials with two SSRIs have failed as it is associated with sedation, orthostatic hypotension and may precipitate fall in elderly patients.

Box 4: Neurological disorders associated with obsessive-compulsive disorder

Complex partial (temporal lobe) seizures

Encephalitis

Gilles de la Tourette's syndrome

Head trauma

Huntington's disease

Cerebral hypoxia

Parkinson's disease

Sydenham's chorea

Supranuclear palsy

Table 13: Recommended therapy in special population

Children and adolescents	Sertraline, Fluoxetine, Fluvoxamine Clomipramine Risperidone, Aripiprazole
Pregnancy	CBT Consider previous drug response SSRIs – Sertraline, Fluoxetine, Citalopram, etc.
Lactating mothers	Sertraline, Fluvoxamine, Paroxetine
Elderly	SSRIs

PART 3
OTHER ISSUES

3.1 Management in non-specialized setting

Algorithm for management of OCD in primary health care

Common symptoms of OCD

Obsessions

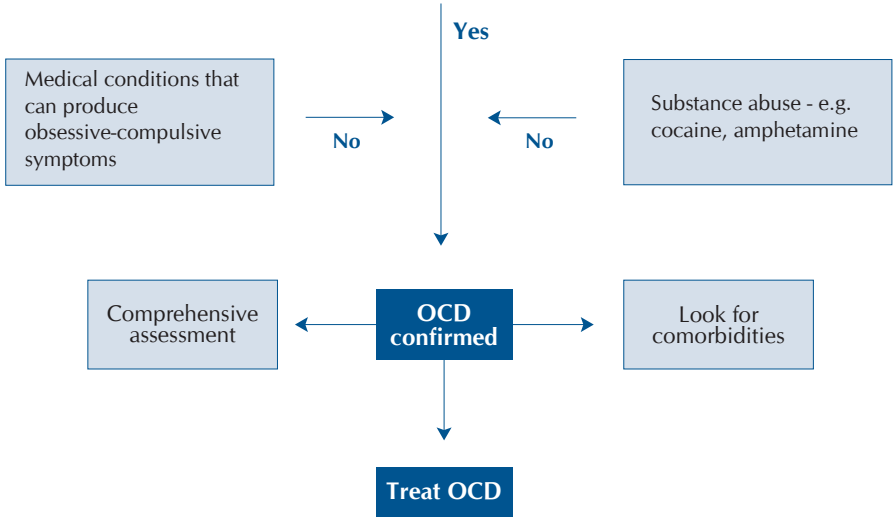
Fear of contamination or dirt, doubting and having difficulty tolerating uncertainty, needing things orderly and symmetrical, aggressive or horrific thoughts about losing control and harming yourself or others, unwanted thoughts, including aggression, or sexual or religious subjects.

Compulsions

Cleaning and hand washing, checking, counting, ordering and arranging, hoarding, asking for reassurance, repeating words in their head

Screening questions for OCD

- Do you wash or clean a lot?
- Do you check things a lot?
- Is there a 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?



Treatment of OCD in primary care

Choose an SSRI – for example	Common side effects	Caution
Sertraline Initially 25/50 mg daily, then increased in steps of 50 mg at intervals of at least 1 week if required; maximum 200 mg per day **Fluvoxamine** Initially 50 mg daily, dose to be taken in the evening, dose is increased gradually, if necessary, after several weeks, increased if necessary up to 300 mg daily; maintenance 100–300 mg daily, doses over 150mg daily are given in divided doses **Fluoxetine** 20 mg daily, increased if necessary up to 60 mg daily, daily dose may be administered as a single or divided dose, dose to be increased gradually	Anxiety Nausea Dyspepsia Palpitation Confusion Diarrhea Constipation Dizziness Drowsiness Insomnia	Cardiac disease History of bleeding disorders History of mania Hyponatremia

If the patient doesn't improve in 8-12 weeks, refer him/her to a psychiatrist.

3.2 FGD findings

During the development of this guideline several focus group discussions with psychiatrists were held. The participant psychiatrists talked about their drug preferences in OCD. We found, their most common preferences in OCD are fluvoxamine, sertraline, clomipramine and escitalopram. Sertraline + clomipramine, fluvoxamine + clomipramine, SSRI + low dose antipsychotics were found as their preferred combinations. Multiple drugs are prescribed when initial medication showed partial or no response, when patients had sleep problems, suicidal ideation, delusions, lack of insight, etc.

Although most of the patients recognized OCD as a mental health problem there was no clear consensus among them about its causation. Patients described genetics, lack of willpower, conspiracy of devil, excessive anxiety, indecisiveness as the reasons for OCD. They showed inadequate knowledge about disease course and prognosis; non-compliance was also an important issue. These findings emphasize the importance of providing detailed psychoeducation to patients while initiating treatment.

Glossary

Obsessive-Compulsive Disorder

DSM-5 diagnostic criteria

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).

ICD-11 diagnostic criteria

- Presence of persistent obsessions and/or compulsions.
  - Obsessions are repetitive and persistent thoughts (e.g., of contamination), images (e.g., of violent scenes), or impulses/urges (e.g., to stab someone) that are experienced as intrusive and unwanted, and are commonly associated with anxiety. The individual typically attempts to ignore or suppress obsessions or to neutralize them by performing compulsions.
  - Compulsions are repetitive behaviours or rituals, including repetitive mental acts, that the individual feels driven to perform in response to an obsession, according to rigid rules, or to achieve a sense of 'completeness'. Examples of overt behaviours include repetitive washing, checking, and ordering of objects. Examples of analogous mental acts include mentally repeating specific phrases in order to prevent negative outcomes, reviewing a memory to make sure that one has caused no harm, and mentally counting objects. Compulsions are either not connected in a realistic way to the feared event (e.g., arranging items symmetrically to prevent harm to a loved one) or are clearly excessive (e.g., showering daily for hours to prevent illness).
- Obsessions and compulsions are time-consuming (e.g., take more than 1 hour per day) or result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.
- The symptoms or behaviours are not a manifestation of another medical condition (e.g., basal ganglia ischemic stroke) and are not due to the effects of a substance or medication on the central nervous system (e.g., amphetamine), including withdrawal effects.

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Annexures

Table 14: Side effects of SSRIs

GIT	Nausea, anorexia, dry mouth, diarrhea, constipation, dyspepsia, vomiting, weight loss
Central nervous system	Headache, insomnia, dizziness, anxiety, fatigue, tremor, impaired concentration, somnolence, extrapyramidal side effects, seizures, manic excitement, akathisia, restlessness
Others	Suicidal ideation, delayed orgasm, anorgasmia, rash, pharyngitis, dyspnea, serum sickness, hyponatremia, alopecia, arthralgia, serotonin syndrome, severe cutaneous adverse reactions (SCARs), syndrome of inappropriate antidiuretic hormone secretion (SIADH), thrombocytopenia

Table 15: Side effects of clomipramine

GIT	Dry mouth, constipation, weight gain
Central nervous system	Drowsiness, sedation, seizure, cognitive impairment
Cardiovascular	Tachycardia, postural hypotension, cardiac conduction defects, arrhythmias, oedema
Others	Blurred vision, glaucoma, urinary retention, sexual dysfunction, rash, leucopenia, elevated liver enzymes

Side effects	Management strategies
GIT symptoms	Can be minimized by starting with low doses If mild queasiness or nausea occurs, it will usually disappear within 1–2 weeks at a constant dose Proton pump inhibitors
GIT bleeding	Use with caution when aspirin, NSAIDs or anticoagulants is co-prescribed
Insomnia	Taking medication in the morning Following standard sleep hygiene practice Benzodiazepines or zolpidem
Fatigue or sleepiness	Can be minimized by starting with low doses Night dosing Addition of modest doses of modafinil
Agitation	Increase the dose gradually Benzodiazepine
Sweating	Low doses of anticholinergic agents such as benztropine or with clonidine, cyproheptadine and mirtazapine
Sexual side-effects	Can be minimized by starting with low doses or reducing the dose to the minimal effective dose Drug holiday: trying a once-weekly, one-day drug holiday before engaging in sexual activity Switching to another SSRI Adding a counteracting pharmacologic agent: • For restoring libido - Amantadine, Bupropion, Buspirone, Yohimbine, Ginkgo Biloba extract, Methylphenidate • For erectile problem - Sildenafil, Tadalafil and Vardenafil • For delayed ejaculation – Cyproheptadine

Side effects	Management strategies
Hyponatremia	Common in elderly Correct electrolyte imbalance Monitor patients Refer if serum level < 125 mmol/L
Weight gain	Dietary modification and exercise Topiramate may be tried If significant, switch to another SSRI
Suicidal behavior	Children and adolescents may show increase in suicidal thoughts Monitor specially during the first 10 days
Fatigue or sleepiness	Can be minimized by starting with low doses Night dosing Addition of modest doses of modafinil
Agitation	Increase the dose gradually Benzodiazepine
Sweating	Low doses of anticholinergic agents such as benztropine or with clonidine, cyproheptadine and mirtazapine

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