

**NATIONAL INSTITUTE FOR HEALTH AND CARE
EXCELLENCE**

Guideline

**Obsessive compulsive disorder and body
dysmorphic disorder: assessment and
management**

Draft for consultation, September 2026

This guideline covers assessing and managing obsessive compulsive disorder (OCD) and body dysmorphic disorder (BDD) in children, young people and adults. It aims to improve care by helping healthcare professionals offer people the right treatments and support, taking into account the person's individual preferences.

It does not cover:

- further-line treatment after no or limited response to treatment (including switching and augmentation strategies)
- relapse prevention.

This guideline will update NICE guideline CG31 (published November 2005).

Who is it for?

- Healthcare professionals, including those who provide cosmetic procedures (surgeons, doctors, dentists, dental care professionals, nurses or pharmacists)
- Commissioners and providers
- People with OCD or BDD, their families and carers

What does it include?

- the recommendations
- recommendations for research

- rationale and impact sections that explain why the committee made the recommendations and how they might affect practice.

Information about how the guideline was developed is on the [guideline's webpage](#). This includes the evidence reviews, the scope, details of the committee and any declarations of interest.

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Using this guideline

People have the right to be involved in discussions and make informed decisions about their care, as described in [NICE's information about shared decision making](#).

Healthcare professionals should follow our general guidelines for people delivering care:

- [Antenatal and postnatal mental health](#)
- [Babies, children and young people's experience of healthcare](#)
- [Decision-making and mental capacity](#)
- [Medicines adherence](#)
- [Medicines optimisation](#)
- [Mental health problems in people with learning disabilities](#)
- [Multimorbidity](#)
- [People's experience in adult social care services](#)
- [Service user experience in adult mental health](#)
- [Shared decision making](#)
- [Transition between inpatient mental health settings and community or care home settings](#)
- [Transition from children's to adults' services for young people using health or social care services](#)

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

General principles of care

1.1 Communication

1.1.1 Explore and address potential feelings of stigma, shame, embarrassment and guilt experienced by people with suspected or confirmed obsessive compulsive disorder (OCD) or body dysmorphic disorder (BDD) and their

families and carers, and encourage them to be open about their thoughts and feelings, by:

- treating them without judgement, and with sensitivity, compassion and empathy
- explaining that OCD or BDD is a recognised condition that can be treated, and that recovery with a good quality of life is possible
- acknowledging that they may find it difficult to share their thoughts and feelings
- explaining that OCD or BDD is not a sign of weakness, or the person's or their family's fault.

See also the [section on avoiding stigma and promoting social inclusion in NICE's guideline on service user experience in adult mental health](#).

Adults

When discussing OCD or BDD with adults (and their families and carers, when appropriate), follow the recommendations in the [sections on relationships and communication](#) and [providing information in NICE's guideline on service user experience in adult mental health](#).

Children and young people

When discussing OCD or BDD with [children](#) and [young people](#) (and their families and carers, when appropriate), follow the recommendations in the [section on communication and information in NICE's guideline on babies, children and young people's experience of healthcare](#).

Why the committee made this recommendation

Evidence shows that people with OCD or BDD commonly experience stigma, shame and embarrassment. This can prevent them from disclosing symptoms, seeking help and engaging with treatment. Evidence also shows that they may lose hope in the potential for recovery, which can further reduce motivation to seek or continue with treatment. The committee's experience suggests that people with OCD or BDD, and their families and carers, also often feel guilt and blame themselves. So, the committee recommended addressing these negative feelings to support people to discuss their experiences more openly.

Full details of the evidence and the committee's discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#).

1

How the recommendation might affect practice

Non-judgemental, compassionate communication when supporting people with OCD or BDD is consistent with good clinical practice. So, implementing this recommendation is unlikely to need significant additional resources. It may help improve disclosure of symptoms, engagement with treatment and people's overall experience of care.

2 **1.2 Involving families and carers**3 **Adults**

- 4 1.2.1 Discuss with adults with OCD or BDD if and how they would like their
5 families or carers to be involved in their care, in line with the
6 recommendations in the [section on involving families and carers in NICE's](#)
7 [guideline on service user experience in adult mental health](#).

8 **Children and young people**

- 9 1.2.2 Involve parents or carers in the care of children and young people with
10 OCD or BDD, in line with the [sections on involvement of parents or carers](#)

1 and [competence in NICE's guideline on babies, children and young](#)
2 [people's experience of healthcare](#).

Why the committee made these recommendations

Evidence shows that involving families and carers can help improve access to, and engagement with, treatment for people with OCD or BDD. In the committee's experience, this is particularly important for children and young people, whose parents and carers are often key to recognising symptoms, accessing services and engaging with treatment. The committee also discussed that families and carers often accommodate symptoms, such as compulsive behaviours and avoidance, which can have negative consequences despite good intentions. So, helping them to understand and manage the problem is important. This is also consistent with evidence that shows that psychological treatments involving parents for children and young people with OCD or BDD is particularly effective.

Full details of the evidence and the committee's discussion are in [evidence review A: interventions for treating OCD in children and young people](#) and [evidence review D: accessing and engaging with treatment for OCD and BDD](#).

How the recommendations might affect practice

These recommendations are consistent with good clinical practice and align with current NICE guidance on involving families and carers in people's care, when appropriate. Implementing these recommendations is unlikely to need substantial additional resources, and may help improve access to services, engagement with treatment and support for delivering psychological interventions.

1.3 Seeking additional expertise

1.3.1 Healthcare professionals, including those who provide [cosmetic procedures](#), who think that someone may have OCD or BDD but do not have training or experience in assessing, diagnosing or treating these

- 1 conditions (especially less typical presentations), should seek advice
- 2 from, or refer the person to, a healthcare professional who does.

Why the committee made this recommendation

Evidence shows that OCD and BDD are not always recognised in routine clinical practice. Symptoms may be misunderstood, minimised or attributed to other conditions, especially when they are less common or less visible (for example, obsessions related to rules, fairness, honesty, or 'doing the right thing'). Evidence also shows that people's confidence in healthcare professionals' specialist knowledge and understanding of OCD or BDD can help improve engagement with treatment, particularly when the care that is offered is perceived as well-informed. The committee agreed that limited confidence, training and experience among some healthcare professionals may delay appropriate assessment and management, which can have significant consequences for people with OCD or BDD, their families and carers, and the healthcare system. The committee also discussed the importance of people being assessed and managed by healthcare professionals with appropriate expertise in OCD and BDD, including those providing cosmetic procedures to people who may have BDD.

Full details of the evidence and the committee's discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#).

3

How the recommendation might affect practice

The recommendation clarifies expectations around recognising the limits of professional expertise in OCD and BDD across both healthcare and cosmetic practice settings. This may support more timely referral to appropriate services and improve consistency in assessment, diagnosis and management. Although this could increase referrals to professionals with relevant expertise in some areas, this would be through existing routes rather than new services or separate assessment processes. So, the recommendation is not expected to need substantial new resources, but there may be some impact on capacity in specialist services if referrals increase.

1 1.4 Caring for children and young people

2 1.4.1 Assess children and young people with suspected OCD or BDD within
3 mental health services specifically for children and young people.

4 1.4.2 Involve mental health services specifically for children and young people
5 when planning and delivering treatment for children and young people
6 with OCD or BDD.

Why the committee made these recommendations

Evidence shows that getting an accurate diagnosis of OCD or BDD for a child or young person can be difficult, and parents and carers are often concerned about missed or incorrect diagnoses and unsure where to seek help. The committee agreed, based on their experience and the evidence, that while OCD or BDD in children and young people may first be suspected in primary care, formal assessment should take place within mental health services specifically for children and young people (for example, Children and Adolescent Mental Health Services or Mental Health Support Teams in schools), which have the appropriate expertise. This will help ensure that they get an accurate diagnosis and appropriate treatment recommendations. This is particularly important because treatment decisions, including about medicines, are based on a thorough assessment.

Treatment may be planned and delivered in a range of settings depending on the child's or young person's needs and local service arrangements. Evidence shows that some parents and carers lack confidence in the support provided and have concerns about treatment, including medicines. So that specialist expertise is available when needed to support safe and appropriate care in any setting, the committee agreed, based on their experience and the evidence, that mental health services specifically for children and young people should be involved in treatment planning and delivery.

Full details of the evidence and the committee's discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#).

How the recommendations might affect practice

Children and young people with OCD or BDD are already commonly assessed within Children and Adolescent Mental Health Services or other mental health services specifically for children and young people. So, the recommendation about assessment is unlikely to substantially change current practice.

The treatment recommendation reflects current practice in many areas and supports access to specialist expertise without requiring all treatment to be planned and delivered exclusively within specialist services. So, the recommendation is not expected to result in a significant resource impact. It may help improve consistency of care and confidence in diagnosis and treatment decisions.

Identifying and assessing OCD and BDD

See also the [section on communication](#), and the [section on assessment in NICE's guideline on service user experience in adult mental health](#).

1.5 Identifying OCD and BDD

1.5.1 If you think that someone may have obsessive compulsive disorder (OCD), ask them (and their families or carers, if appropriate) if they:

- experience distressing thoughts, images, urges, impulses or doubts that are intrusive (in other words, that are unwanted, difficult to control, interrupt what they are already thinking or feel overwhelming so that they cannot think of anything else)
- feel they have to do things repeatedly or carry out compulsive behaviours or mental acts.

If they reply 'yes' to 1 or both of these questions, follow the recommendations in the [section on assessing OCD](#).

1.5.2 If you think that someone may have body dysmorphic disorder (BDD):

- ask them (and their families or carers, if appropriate):
 - if they experience overwhelming and distressing thoughts or worries about their appearance that are intrusive (in other words, appearance-related thoughts that are unwanted, difficult to control, interrupt what they are already thinking or they cannot think of anything else)
 - feel they have to do things repeatedly or carry out compulsive behaviours or mental acts.
- look for visual cues that may suggest they are trying to conceal or alter their appearance, such as wearing clothing that seems unusual for the context or covering their face.

If they reply 'yes' to 1 or both of these questions, or show visual signs of trying to conceal their appearance, follow the recommendations in the [section on assessing BDD](#).

1.5.3 Explain to people with possible OCD or BDD that almost everyone experiences distressing and intrusive thoughts, images, impulses or doubts occasionally, but for some people this is much more frequent and can negatively impact quality of life.

1.5.4 Explore whether people with possible OCD or BDD may need additional support or information, particularly if they may have difficulty accessing mental health services, or if they face stigma or discrimination when using them. Provide support, information, or adjustments to meet their needs. This may be especially relevant for certain groups, for example people who are:

- from an ethnic minority background
- LGBTQ+
- on a low income or living in a deprived area
- pregnant or in the postnatal period (see the [section on principles of care in pregnancy and the postnatal period in NICE's guideline on antenatal and postnatal mental health](#)).

See also the [section on avoiding stigma and promoting social inclusion in NICE's guideline on service user experience in adult mental health](#) and the [section on accessing healthcare in NICE's guideline on babies, children and young people's experience of healthcare](#).

1.5.5 Consider assessing for OCD or BDD in those who may be at higher risk, including people:

- with:
 - depression or anxiety
 - thoughts of self-harm or suicide, actual self-harm or suicidal intent
 - an eating disorder
 - a history of OCD or BDD
- with autism or attention deficit hyperactivity disorder (ADHD)
- who misuse alcohol or use drugs
- seeking:
 - help for irritant contact dermatitis
 - a [cosmetic procedure](#) (including dermatological or dental).

See the [sections on assessing OCD](#) and [BDD](#).

Why the committee made these recommendations

Evidence shows that healthcare professionals do not routinely ask about or explore whether people have intrusive thoughts, images, urges, impulses, doubts, or worries about appearance, which may contribute to under-recognition of OCD and BDD. In the committee's experience, people often find these experiences distressing and may not disclose them unless specifically asked. Evidence also shows these experiences can be misinterpreted or misunderstood, by both the people experiencing them and their healthcare professionals, which may contribute to delayed or missed diagnoses. The committee also noted that, in their experience, healthcare professionals are often reluctant to ask about BDD specifically because of sensitivities around body image. They agreed that attempts to conceal or alter appearance may reflect underlying body image concerns in BDD, so can be an important cue for healthcare professionals to explore further.

The committee agreed that healthcare professionals should ask people who they think may have OCD or BDD about intrusive and distressing cognitions, look for visual signs of possible BDD, and normalise people's experiences as much as possible. This will improve identification of clinically significant symptoms and help distinguish these experiences from the occasional intrusive thoughts that are common in the general population.

Stigma, shame and fear of judgement are strong themes in the evidence. Many people have difficulty disclosing symptoms, worry about being taken seriously and fear discrimination or other consequences, such as the involvement of social services. This can lead to delayed help-seeking and incomplete assessments. The committee agreed that healthcare professionals should be sensitive, acknowledge distress and be particularly aware of additional barriers faced by certain groups. The listed examples of groups most likely to face these barriers are based on evidence showing how people from different ethnic and socioeconomic backgrounds access services differently. Based on the committee's experience, they also agreed people who are pregnant and in the postnatal period, and LGBTQ+ people, face specific barriers.

The committee used their experience, the [ICD-11 on OCD](#) and [BDD](#), and recommendations from the 2005 OCD and BDD guideline to determine which groups may be at higher risk for OCD or BDD and so may need an assessment.

Full details of the evidence and the committee's discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#) and [health inequalities report A](#).

1

How the recommendations might affect practice

The recommendations support a more structured and consistent approach to identifying people who may have OCD and BDD. This may lead to more complete and accurate assessments, because people may be more open to sharing their experience. It may also improve identification of clinically significant symptoms that are not routinely volunteered. This may ultimately help reduce under-recognition and delays in diagnoses, especially for groups who may experience additional barriers to help-seeking or communication. These changes may make access to appropriate assessment and diagnosis more equitable without requiring substantial additional resources. Some adjustment to routine practice may be needed.

2 1.6 Assessing OCD

3 The following recommendations on assessment can be used to determine a
4 diagnosis of OCD and inform a treatment plan.

5 1.6.1 Ask people with suspected OCD and those who may be at risk of OCD
6 (see recommendation 1.5.5), and their families or carers (if appropriate),
7 the following questions:

- 8 • Are there any persistent thoughts, images, urges, impulses or doubts
9 that bother you, cause anxiety and that you would like to get rid of but
10 cannot?

- 1 • Are there behaviours or repetitive mental acts that you have to do over
2 and over to feel right?
- 3 • On a typical day, do obsessions (persistent thoughts, images, urges or
4 impulses) or compulsions (repetitive behaviours or repetitive mental
5 acts) take up a lot of time (for example, more than 1 hour)?
- 6 • Do obsessions or compulsions get in the way of day-to-day life (for
7 example, make it hard to do work or go to school, be with friends or join
8 activities) or cause distress?

9

10 See also the [section on involving families and carers](#).

11 1.6.2 When assessing [children](#) with suspected OCD, take into account that
12 compulsive behaviours may be easier to recognise than obsessions.

13 1.6.3 If a person with suspected OCD is experiencing aggressive, sexual or
14 death-related obsessions, explain that obsessions in the context of OCD
15 are not indicative of risk to themselves or others.

16

17 See also the [section on seeking additional expertise](#), if needed.

Why the committee made these recommendations

Evidence shows that OCD symptoms are often overlooked or not recognised as OCD, especially when they are less common or less visible (for example, obsessions related to rules, fairness, honesty, or 'doing the right thing'). Asking people with suspected OCD a set of questions covering all core OCD symptoms may support early and accurate diagnosis. The committee agreed that focused questions, rather than a descriptive list of features alone, will better support disclosure and identification of symptoms, particularly during the initial assessment. This is because OCD presentations are highly varied and people may not readily identify their experiences as symptoms of OCD unless prompted in a structured but open way. Children and young people may also have greater difficulty in verbalising their symptoms, therefore in addition to these focused questions, clinicians should also look for compulsive behaviours when assessing. The specific questions are based on the 2005 OCD and BDD guideline, the [ICD-11 on OCD](#) and the committee's experience.

Evidence also shows that people with aggressive, sexual or death-related obsessions often fear serious consequences if they disclose these. Some worry about being judged, reported to authorities or considered a risk to others. Unnecessary risk assessment can be distressing and harmful, reinforcing OCD-related beliefs. These thoughts are a recognised feature of some people with OCD and, on their own, do not indicate risk to the person or others in the context of OCD.

Full details of the evidence and the committee's discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#).

How the recommendations might affect practice

The assessment questions provide a structured way for healthcare professionals to identify symptoms across different presentations of OCD. They may prompt earlier recognition of OCD in settings where it is not routinely considered, such as primary care or services assessing a wider range of common mental health problems. Because the recommendations are intended to support and structure assessment, rather than introduce a separate assessment process, they are not expected to need substantial additional resources.

1.7 Assessing BDD

The following recommendations on assessment can be used to determine a diagnosis of BDD and inform a treatment plan.

- 1.7.1 Ask people with suspected BDD and those who may be at risk of BDD (see recommendation 1.5.5), and their families or carers (if appropriate), the following questions:
- Do you worry a lot about your appearance, or find yourself preoccupied with it, and wish you could think about it less?
 - If you worry about your appearance, what are your specific concerns?
 - On a typical day, how long do you think about your appearance or how long is it on your mind for more (for example, more than 1 hour)?
 - How much time do you spend checking or comparing your appearance to others (including online)?
 - How much time do you spend trying to change, hide or conceal your appearance?
 - What effect do your thoughts about your appearance have on your life? For example, do you repeatedly:
 - try to avoid social situations?
 - check your appearance in reflective surfaces?
 - compare yourself with other people?

- Do thoughts about your appearance get in the way of day-to-day life (for example, make it hard to do work, be with friends or join activities) or cause distress?

See also the [section on involving families and carers](#).

1.7.2 If a person with suspected or confirmed BDD mentions interest in a cosmetic procedure:

- discuss their expectations of the procedure and
- explain that cosmetic procedures rarely improve BDD symptoms and may sometimes worsen them.

1.7.3 When a person with suspected or confirmed BDD explains how they think and feel about their appearance, treat their response with empathy and do not:

- comment (either positively or negatively) on their appearance or
- directly challenge their perception.

See also the [section on communication](#).

Why the committee made these recommendations

Evidence for BDD was limited. In the committee's experience, BDD symptoms are often under-recognised. People with BDD may not describe their symptoms unless asked directly, and healthcare professionals may feel unsure about how to ask about body image. Asking people with suspected BDD a set of questions covering all core BDD symptoms may support early and accurate diagnosis. The committee agreed that focused questions, rather than a descriptive list of features alone, will better support disclosure and identification of symptoms, particularly during the initial assessment. This is because BDD presentations are highly varied and people may not readily identify their experiences as symptoms of BDD unless prompted in a structured but open way. The specific questions based on the 2005 OCD and BDD guideline, the [ICD-11 on BDD](#) and the committee's experience.

The committee noted from experience that people with BDD may look to cosmetic procedures as a solution to their symptoms. They agreed that understanding the person's expectations of the procedure is an important part of discussing its potential benefits and limitations. But because these procedures rarely address the underlying condition and can sometimes lead to harm or worsening of symptoms, people should be made aware of these limitations.

Based on their experience, the committee agreed that healthcare professionals should not comment on a person's appearance, either positively or negatively, because this can feel dismissive or disingenuous. Instead, they should acknowledge the person's distress and assess their symptoms.

[Research on barriers and facilitators to accessing and engaging with treatment experienced by people with BDD is recommended](#) to address the limited evidence in this area.

Full details of the evidence and the committee's discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#).

How the recommendations might affect practice

The initial assessment questions may improve recognition of BDD by encouraging healthcare professionals to routinely and directly ask people with suspected BDD symptoms about body image concerns. This may help identify people who might not otherwise disclose their concerns and reduce under-recognition in clinical practice. The recommendations may also promote a more sensitive and consistent approach to assessment by discouraging responses that could be perceived as dismissive and encouraging acknowledgement of distress. Implementation is not expected to need substantial additional resources but may need some adjustment to assessment practice and communication styles.

1 Assessing for BDD before cosmetic procedures

1.7.4 Healthcare professionals with expertise in BDD and healthcare professionals providing [cosmetic procedures](#) should work together to support the identification, assessment and referral of people with BDD in cosmetic procedure settings by:

- developing or adopting resources to support assessments for BDD in cosmetic procedure settings and
- agreeing local referral pathways to mental health services.

1.7.5 Healthcare professionals providing cosmetic procedures should:

- ask the people seeking their services the BDD assessment questions (see recommendation 1.7.1) and
- document the findings.

1.7.6 If the person's responses to the BDD assessment questions indicate they may have BDD, the healthcare professional should:

- not carry out the procedure
- explain the decision not to carry out the procedure in a sensitive and supportive way and discuss any concerns that the person may have and

- 1 • refer the person to a healthcare professional with expertise in BDD, in
2 line with agreed referral pathways (see recommendation 1.7.4).

Why the committee made these recommendations

In the committee's experience, people with BDD may seek cosmetic procedures with the hope of reducing distress associated with self-perceived appearance defects. Co-designing assessment resources and agreeing referral pathways will support safe and consistent identification of BDD in cosmetic procedure settings, where healthcare professionals may not have expertise in recognising BDD.

The committee agreed that healthcare professionals should assess people seeking a cosmetic procedure for BDD, and record their findings to support consistent decision-making and audits. If BDD is suspected, they should not perform the procedure because it may reinforce or worsen BDD-related distress and behaviours. The committee agreed that explaining this decision sensitively and discussing the person's concerns is important to reduce distress, support understanding and help maintain trust. Healthcare professionals providing cosmetic procedures should also refer the person to a healthcare professional with expertise in BDD to ensure that underlying psychological needs are assessed and managed appropriately.

Full details of the evidence and the committee's discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#).

3

How the recommendations might affect practice

These recommendations may increase the detection of BDD in cosmetic procedure settings and lead to more referrals to mental health services. To support implementation, services providing cosmetic procedures need to work with healthcare professionals with expertise in BDD to develop assessment resources and establish clear referral pathways which will need time and resources.

Training and experience in identifying BDD currently varies among healthcare professionals providing cosmetic procedures. So, some may need additional support to implement routine assessment. Although the recommendations may increase demand on mental health services through additional referrals, this could be offset by improved outcomes associated with earlier identification and access to appropriate treatment.

1.8 Risk assessment

1.8.1 In addition to carrying out a [standard risk assessment](#), assess people with suspected or confirmed OCD or BDD for risks that are:

- particularly relevant to OCD and BDD, such as:
 - self-neglect (and follow [NICE's guideline on decision-making and mental capacity](#) if there is concern about this)
 - restricted fluid or dietary intake
 - compulsive behaviours that are potentially dangerous to the person or others
 - physical health harms related to symptoms or compulsions (for example, skin damage from excessive washing or cleaning)
 - difficulties accessing or engaging with healthcare because of obsessions, compulsions or avoidance (for example, being unable to attend appointments or follow treatment plans)
- particularly relevant to BDD specifically, such as:
 - pursuing potentially unnecessary or dangerous cosmetic procedures or practices (for example, cosmetic surgery or skin bleaching)

- attempting to perform cosmetic procedures themselves
- common to multiple mental health conditions, such as:
 - thoughts of self-harm or actual self-harm
 - thoughts of suicide or attempted suicide (particularly for BDD).

1.8.2 If the person is at risk of any harm, particularly of self-harm or suicide:

- inform all healthcare professionals involved in their care and
- make a safety plan with the person.

For recommendations on self-harm and suicide risk assessment and management, see [NICE's guidelines on self-harm](#) and [preventing suicide in community and custodial settings](#).

1.8.3 If a child or young person is at risk of inadvertent harm (including neglect) because of the compulsive or avoidant behaviour of a parent, carer or family member with suspected or confirmed OCD or BDD, as soon as possible:

- seek advice from a health professional with expertise in OCD or BDD if in primary care (see the [section on seeking additional expertise](#))
- discuss the case with the multidisciplinary team or clinical lead with expertise in OCD or BDD if in secondary care
- consider contacting the local authority or organisational safeguarding team for advice
- assess the parent, carer or family member with OCD or BDD and offer urgent treatment, if appropriate (see the [section on planning and delivering treatment](#)).

Why the committee made these recommendations

Evidence shows that people with OCD or BDD may not disclose the severity or nature of their symptoms unless specifically asked. Some people may seek care only when symptoms have become severe or they are in crisis. This is consistent with the committee's experience. They noted that this may be particularly relevant for people with suspected or confirmed BDD, including those presenting after self-harm or suicide attempts. So, based on their experience, they agreed on specific risks that should be assessed for.

Although evidence was limited, the committee agreed, based on their experience, that compulsive or avoidant behaviours associated with OCD or BDD can inadvertently affect not just the person but also children and young people living in the same household. In some cases, these behaviours contribute to environments that place children and young people at risk of emotional harm or adverse developmental or mental health outcomes, particularly when the person's OCD or BDD symptoms are severe. These situations should be recognised early as potentially complex and requiring coordinated professional input. Appropriate expertise in OCD or BDD should be initially sought when the risk is being assessed in primary care so that the best approach for the unique situation can be taken. In secondary care, a discussion with a clinical lead or multidisciplinary team is needed for the same reason. Safeguarding advice may be needed to ensure that risks to children and young people are appropriately understood and managed. The committee also agreed on the importance of ensuring that the person with OCD or BDD is offered timely assessment and treatment because reducing symptom severity is likely to reduce the associated risks to others.

Full details of the evidence and the committee's discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#).

How the recommendations might affect practice

These recommendations may lead to more comprehensive and condition-specific risk assessment for people with suspected or confirmed OCD or BDD by prompting consideration of risks that may not be identified through a standard mental health risk assessment alone. This may improve recognition of serious but less commonly assessed risks associated with compulsions, avoidance behaviours and BDD-related appearance concerns.

The recommendations may also increase identification of self-harm, suicide risk and safeguarding concerns, which could lead to increased use of urgent mental health, safeguarding or multidisciplinary input in some cases. But this is expected to involve existing risk assessment, referral, safeguarding and multidisciplinary involvement pathways rather than new services or separate assessment processes. So, the recommendations are not expected to need substantial additional resources, and earlier recognition and management of risk is likely to improve safety and outcomes.

1 Planning and delivering treatments

2 1.9 Planning treatments

3 1.9.1 When developing the treatment plan with a person with obsessive
4 compulsive disorder (OCD) or body dysmorphic disorder (BDD), review
5 the following biopsychosocial factors:

- 6 • mental health conditions, including:
 - 7 – anxiety disorders
 - 8 – depression
 - 9 – eating disorders
- 10 • mental health treatments (and their responses to them)
- 11 • the person's understanding of, and beliefs about, their symptoms (for
12 example, their level of insight)
- 13 • neurodivergence, such as autism or attention deficit hyperactivity
14 disorder (ADHD)

- physical health problems
- the impact of the person's symptoms on family members (see recommendation 1.9.2)
- any barriers to delivering treatments, such as language or any disabilities or communication difficulties
- personal and family circumstances.

See also the [section on involving families and carers](#).

1.9.2 Assess the impact of the person's OCD or BDD symptoms on others and factor this into their treatment plan. Specifically, assess how much other people accommodate the person's symptoms, for example by:

- repeatedly giving reassurance
- changing their own behaviours or routines to reduce the person's distress.

1.9.3 For people with suspected OCD or BDD who are also autistic, have ADHD, or have a comorbid mental health condition, address their care needs in the treatment plan by also following the relevant recommendations in NICE's guidelines on:

- [anxiety](#)
- [ADHD](#)
- [autism](#)
- [bipolar disorder](#)
- [depression](#)
- [drug misuse](#)
- [eating disorders](#)
- [personality disorders](#)
- [post-traumatic stress disorder](#)
- [psychosis and schizophrenia](#).

Why the committee made these recommendations

OCD and BDD can vary in severity, complexity and functional impact. In the committee's experience, effective care planning requires a structured understanding of the person's current presentation and wider clinical context.

Evidence shows that people's confidence in healthcare professionals' specialist knowledge and understanding of OCD or BDD can help improve engagement with treatment, particularly when the care that is offered is perceived as well-informed. Negative perceptions of available treatment options, including uncertainty about their effectiveness or suitability, may act as a barrier to accessing and engaging with care. So, assessing people holistically before starting treatment is important.

Evidence consistent with the committee's experience also shows that coexisting physical and mental health conditions are common and may influence presentation and treatment choice. The committee noted that OCD and BDD may be influenced by a range of mental health, physical health and psychosocial factors, as well as neurodivergence. Previous treatment history and responses are also important for informing subsequent decisions and avoiding repetition of ineffective or poorly tolerated interventions. Someone's level of insight into their OCD and BDD symptoms should also be considered during treatment planning, as this can affect their level of engagement with treatment. The committee agreed that, in their experience, barriers such as language differences, disabilities or communication difficulties may affect access to and engagement with treatment if not identified early. So, these factors should be routinely considered when developing a treatment plan to support personalised and equitable care. All of these factors may affect presentation, treatment planning and outcomes.

In the committee's experience, OCD and BDD can have a significant impact on family members and others close to the person, who may accommodate symptoms in an attempt to reduce distress. These responses can unintentionally reinforce symptoms and increase dependence on reassurance or behavioural adaptations over time. Assessing the extent of this accommodation is important for understanding the impact of the condition on the wider support network and for

informing treatment planning. This includes identifying when family members or carers may need support or involvement in treatment.

Evidence also shows that people can ‘fall through gaps’ between services, particularly when they have coexisting mental health conditions. So, implementing recommendations in other relevant NICE guidelines to support integrated assessment and management of OCD or BDD alongside any coexisting conditions is important.

The committee made a [research recommendation on barriers and facilitators to accessing and engaging with services experienced by people with OCD or BDD from underserved populations](#) to address the limited evidence on this topic.

Full details of the evidence and the committee’s discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#).

How the recommendations might affect practice

These recommendations are expected to promote a more consistent and structured approach to treatment planning for people with OCD or BDD by encouraging consideration of coexisting conditions, broader psychosocial factors and the impact of symptoms on others. This may improve formulation, care planning and coordination of support across services.

Assessing family or carer accommodation of symptoms, such as obsessions, compulsions and avoidance behaviours, may increase healthcare professionals' awareness of interpersonal factors that maintain symptoms and support more tailored intervention planning. Although implementing these recommendations may lengthen assessments in some settings, more comprehensive assessments are likely to improve diagnostic accuracy and treatment planning leading to better outcomes. So, any additional resource needed to deliver assessments is expected to be offset elsewhere in the service.

Overall, the recommendations may improve person-centred care by supporting treatment plans that are better aligned with clinical need, previous experience of services, and factors that influence trust and engagement, including perceptions of healthcare professional expertise and treatment acceptability.

OCD and BDD treatments

We have not reviewed evidence specifically for people with a current episode of OCD or BDD that has not responded to at least 1 adequate trial (in terms of length, quality, and intensity or dose) of a treatment option included in this section. So, we cannot say whether the recommendations in this section are applicable to that population.

OCD treatment for adults

1.9.4 For adults with OCD, use the following [matched care approach](#) to match the treatment options to their clinical needs, treatment history and informed preferences:

- Identify which treatment option or options in [table 1](#) match the person's clinical needs and treatment history (see recommendation 1.9.1).
- Discuss the identified treatment option or options with the person to understand which are aligned with their informed preferences.
- Offer the appropriate treatment or, if more than 1 treatment option is appropriate, offer the appropriate treatments in the order listed in table 1.
- If both psychological and pharmacological treatments are appropriate, consider these in combination (depending on the person's clinical needs, treatment history and informed preferences).

See also the [section on involving families and carers of adults](#).

Table 1 Treatment options for OCD in adults (ordered based on clinical- and cost-effectiveness evidence and safety)

Treatment	Delivery	Key features	Other considerations
Individual therapist-administered (TA) cognitive behavioural therapy (CBT) or cognitive therapy (CT)	• Usually 12 to 14 weekly sessions, but more sessions may be needed • Delivered in line with current treatment manuals	• Grounded in psychoeducation and individualised cognitive behavioural formulation • Involves exposure and response prevention or behavioural experiments aimed at confronting obsessional fears and resisting compulsive behaviours • Additional cognitive techniques used as appropriate • Relapse prevention	• Requires regular attendance and engagement with structured sessions, including tasks between sessions • Can be adapted to individual needs • Exposure and response prevention or behavioural experiments will cause temporary distress, so careful timing and active

		technique integrated towards the end	support is needed
Self-administered CBT with therapist support	- Usually 8 to 12 weekly sessions, but more sessions may be needed - Content mirrors TA CBT protocols - Therapists provide weekly synchronous or asynchronous check-ins (completion of tasks and implementation of strategies) providing encouragement and support, reinforcing key techniques, and addressing problem-solving difficulties - Delivered in line with current treatment manuals	See individual TA CBT or CT	- Requires engagement with structured tasks - Lower level of therapist input needed compared with individual and group TA CBT - Can be adapted to individual needs - Particularly suitable for OCD associated with less severe functional impairment - May not be suitable for OCD associated with severe functional impairment or that has not responded to CBT in a previous episode - Exposure and response prevention or behavioural experiments will cause temporary distress, so careful timing and active

			support is needed
Group TA CBT	- Delivered by 2 practitioners (with at least 1 with therapy-specific training and competence) - Usually 10 to 12 weekly sessions, but more sessions may be needed - Usually 6 to 8 participants in a group - Delivered in line with current treatment manuals	- Goal-oriented and structured - Focuses on resolving current issue - Includes psychoeducation about OCD and CBT formulation - Involves exposure and response prevention or behavioural experiments aimed at confronting obsessional fears and resisting compulsive behaviours - Involves normalisation of symptoms and experiences	- The adult must be willing to discuss their obsessional thoughts and compulsions in a group setting - May allow peer support from others who may be having similar experiences - May not be suitable for OCD associated with severe functional impairment or that has not responded to CBT in a previous episode - Exposure and response prevention or behavioural experiments will cause temporary distress, so careful timing and active support is needed
Selective serotonin reuptake inhibitor (SSRI) In September 2026, this was an off-label use of citalopram. See NICE's information on	- The goal is to titrate gradually to reach the maximum tolerable dose - Treatment should be continued for at	Affects communication between brain cells	Generally well tolerated but there are some side effects, so active

prescribing medicines .	least 12 weeks to evaluate response • A review, usually within 2 weeks, should be done to check for side effects and adherence • A review after 1 week, and no later than 4 weeks, should be done if it is a new prescription for someone aged 24 and under or if there is a particular concern for risk of suicide • Typically taken for at least 12 months (including after symptom remission or partial remission), with regular reviews See the sections on starting and stopping pharmacological treatments for more details on regular monitoring, when reviews will happen during treatment and continuing treatment after remission to prevent relapse.		support is needed • Minimal time commitment but regular reviews are needed (especially when starting and stopping) • Benefits should be felt within 8 to 12 weeks • Some adults may find it difficult to later stop their SSRI (see NICE's guideline on medicines associated with dependence or withdrawal symptoms)
Clomipramine	• Typically started under specialist supervision • The goal is to titrate gradually to reach the maximum tolerable dose • Needs regular physical health monitoring (for example, for	• Affects communication between brain cells	• Benefits should be felt within 8 to 12 weeks • Should only be prescribed based on the adult's informed preferences and clinical needs, or they have had a good

	cardiovascular effects) • A review after 1 week, and no later than 4 weeks, should be done if it is a new prescription for someone aged 24 and under or if there is a particular concern for risk of suicide • Typically taken for at least 12 months (including after symptom remission or partial remission), with regular reviews See the sections on starting and stopping pharmacological treatments for more details on regular monitoring, when reviews will happen during treatment and continuing treatment after remission to prevent relapse.		response to it in a previous episode • Side effects, safety in overdose and the need for closer physical health monitoring should be taken into account • Other treatment options may be more suitable for adults at risk of suicide • Some adults may find it difficult to later stop clomipramine (see NICE's guideline on medicines associated with dependence or withdrawal symptoms)
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Why the committee made this recommendation

In the committee's experience, deciding on treatment for OCD in adults is complex and cannot be adequately achieved using a traditional stepped care model in which people progress through a predefined hierarchy of treatments. Symptom severity and functional impact can vary widely, and adults with OCD may present to services having had different prior treatment responses that need to be taken into account. Adults who are already having treatment for OCD may also present to services. The committee also noted that offering an intervention that does not adequately meet a person's needs may affect engagement with subsequent treatment. So, a matched care approach is more appropriate. This allows treatment decisions to be tailored to the adult's clinical needs, treatment history and informed preferences, rather than following a fixed sequence of interventions or basing decisions on service capacity or availability.

The committee used clinical-effectiveness evidence, cost-effectiveness evidence (including the network meta-analysis [NMA] and economic modelling) and safety to inform the relative ordering of treatments in table 1. The committee did not review evidence specifically for people with a current episode of OCD that has not responded to at least 1 adequate trial of a treatment option in table 1. So, they cannot say whether the recommendations are applicable to that population.

Evidence shows that individual TA CBT and CT are the most effective treatment options for reducing OCD symptoms in adults. They are also the most cost effective. So, individual TA CBT or CT are likely to be the most appropriate options for many adults with OCD. Therapist-supported self-administered and group TA CBT are generally less effective than individual TA CBT and CT. But they still show benefit, are cost effective compared with pharmacological treatments and GP care, and may be appropriate for some adults depending on their needs, preferences and level of functional impairment. Also, the economic analysis suggests that therapist-supported self-administered CBT is highly cost effective for adults with less severe symptoms. So, the committee agreed it is particularly suitable for adults with OCD associated with less severe functional impairment.

Evidence shows that SSRIs are effective but have significantly smaller effect sizes and lower cost-effectiveness rankings compared with psychological therapies. So, they are positioned lower in the table. The committee agreed that SSRIs remain an important treatment option within a matched care approach.

The committee also discussed the need to consider adverse effects and monitoring requirements when prescribing medicine. Evidence shows clomipramine is more effective than SSRIs (but less effective and cost effective than psychological therapies). In the committee's experience though, clomipramine is associated with a higher risk of adverse effects and greater toxicity in overdose compared with SSRIs, and needs closer physical health monitoring. They also noted that it is typically started under specialist supervision. This higher resource use relative to SSRIs is reflected in the lower cost-effectiveness ranking of clomipramine compared with SSRIs. So, clomipramine is positioned below SSRIs in the table. This reflects a balance between potential benefits and risks, and how the treatment is delivered in practice.

Some studies of psychological treatments included adults who were already taking stable pharmacological treatment (often SSRIs). These studies contributed to the evidence on psychological treatments, but they did not evaluate combined psychological and pharmacological treatment as a distinct intervention or show whether starting both treatments together provides additional benefit. So, the committee did not include combination treatment as a distinct option in table 1 (for example, CBT plus an SSRI). But they agreed that combined psychological and pharmacological treatments could be considered within the matched care approach when both are appropriate, based on the adult's clinical needs, treatment history and informed preferences. Because there is no evidence on the effectiveness and cost effectiveness of combined psychological and pharmacological treatment for OCD, the committee made a [research recommendation to address the lack of evidence for combination treatments](#) (in particular, CBT in combination with SSRIs).

The committee agreed that combining the matched care approach with an evidence-informed ordering of treatments and clear supporting information would

provide the most useful and transparent basis for decision making. Evidence shows that people value having flexible treatment options. Access and engagement may be improved when treatments can be personalised and adapted to individual circumstances, including needs and preferences for treatment intensity, duration and mode of delivery. So, they used their knowledge and experience to provide detail on each treatment option in table 1. This information will support implementation of a matched care approach and shared decision making, by helping healthcare professionals and adults with OCD compare options in a structured way.

The committee made a [research recommendation on neuromodulation as a treatment option](#) because of the insufficient evidence in the NMA.

Full details of the evidence and the committee's discussion are in [evidence review B: interventions for treating OCD in adults](#).

How the recommendation might affect practice

The recommendation is expected to support a more individualised and transparent approach to treatment decision making for adults with OCD. It may improve person-centred care by explicitly linking treatment choice to both evidence on effectiveness and cost effectiveness and the adult's clinical needs, preferences and prior experiences. It may also improve consistency in how treatment options are presented and prioritised, while allowing sufficient flexibility to accommodate individual needs.

The introduction of a matched care approach is a shift away from stepped pathways. This will encourage healthcare professionals to consider a broader range of factors at the outset (including symptom severity, functional impact, treatment history and the person's preference) when evaluating treatment options with the person. Services that are currently organised around stepped care will need adjusting, but this approach aligns more closely with how OCD is managed in specialist settings.

The ordering of treatments within the table may influence clinical decision making by highlighting the relative effectiveness and cost effectiveness of interventions. In particular, the higher positioning of individual TA CBT and CT may support increased use of psychological therapies where these are available. This could impact service capacity and workforce planning, particularly if demand for high-intensity CBT increases. Although TA individual CBT has a higher initial cost than pharmacological therapies, it has a lower total cost at 5 years and is more cost effective overall.

At the same time, the recommendation maintains flexibility and choice, recognising that not all treatments will be suitable or acceptable for every adult. Pharmacological treatments such as SSRIs remain an option and are likely to continue to be used in practice, particularly where psychological therapies are not available, or not suitable or acceptable.

1 OCD treatment for children and young people

1.9.5 For [children](#) and [young people](#) with OCD, use the following [matched care approach](#) to match the treatment options to their clinical needs, treatment history and preferences:

- Identify which treatment option or options in [table 2](#) match the child or young person's clinical needs and treatment history (see recommendation 1.9.1).
- Discuss the identified treatment option or options with the child or young person (and their parents or carers, when appropriate) to understand which are aligned with their informed preferences.
- Offer the appropriate treatment or, if more than 1 treatment option is appropriate, offer the appropriate treatments in the order listed in table 2.
- If both psychological and pharmacological treatments are appropriate, consider these in combination (depending on the person's clinical needs, treatment history and informed preferences).

See also the [sections on involving families and carers of children and young people](#) and [caring for children and young people](#).

Table 2 Treatment options for OCD in children and young people (ordered based on clinical- and cost-effectiveness evidence and safety)

Treatment	Delivery	Key features	Other considerations
Family-based therapist-administered (TA) cognitive behavioural therapy (CBT) or cognitive therapy (CT)	• Usually 12 to 14 weekly sessions, but more sessions may be needed • Delivered in line with current treatment manuals	• Involves the child or young person working with their parents or carers, with parent or carer involvement actively encouraged • Includes individualised psychoeducation for both the child or young person	• Requires regular attendance and engagement with structured sessions (including tasks between sessions) for both the child or young person and their parents or carers, so active support is needed • Not suitable if family

		and their parents or carers • Focuses on supporting the family to find alternatives to accommodating symptoms • Involves exposure and response prevention or behavioural experiments aimed at confronting obsessional fears and resisting compulsive behaviours, adapted for the child or young person's developmental level • Additional cognitive techniques used as appropriate • Supports parents or carers to reinforce therapeutic strategies in everyday settings • Relapse prevention technique integrated towards the end	involvement is not possible or appropriate • Can improve outcomes when the family accommodates symptoms often • May need coordination with school or other services • Exposure and response prevention or behavioural experiments will cause temporary distress, so careful timing and active support is needed
Individual TA CBT or CT	• Usually 12 to 14 weekly sessions, but more sessions may be needed • Involvement of parents or carers, with the extent of	• Grounded in psychoeducation and individualised cognitive behavioural formulation • Involves exposure and	• Requires regular attendance and engagement with structured sessions, including tasks

	involvement tailored to the child or young person's developmental level and other factors, such as how much the parents or carers accommodate symptoms Delivered in line with current treatment manuals	response prevention or behavioural experiments aimed at confronting obsessional fears and resisting compulsive behaviours - Additional cognitive techniques used as appropriate - Relapse prevention technique integrated towards the end	between sessions - Can be adapted to individual needs - Exposure and response prevention or behavioural experiments will cause temporary distress, so careful timing and active support is needed
Self-administered CBT with therapist support	- Usually 8 to 12 weekly sessions, but more sessions may be needed - Content mirrors TA CBT protocols - Therapists provide weekly synchronous or asynchronous check-ins (completion of tasks and implementation of strategies) providing encouragement and support, reinforcing key techniques, and addressing problem-solving difficulties - Involvement of parents or carers in line with individual TA CBT - Delivered in line with current	See individual TA CBT or CT	- Requires engagement with structured tasks - Lower level of therapist input needed compared with individual and group TA CBT - Parents and carers should be given information about how they can be supportive - Can be adapted to individual needs - May be suitable for OCD associated with less severe functional impairment - Is not suitable for OCD associated with severe functional impairment or that has not responded to

	treatment manuals		CBT in a previous episode Exposure and response prevention or behavioural experiments will cause temporary distress, so careful timing and active support is needed
Group TA CBT	- Delivered by 2 practitioners (with at least 1 with therapy-specific training and competence) - Usually 10 to 12 sessions, but more sessions may be needed - Usually 4 to 6 participants in a group - Delivered in line with current treatment manuals	- Goal-oriented and structured - Focuses on resolving current issue - Includes psychoeducation about OCD and CBT formulation - Involves exposure and response prevention or behavioural experiments aimed at confronting obsessional fears and resisting compulsive behaviours - Involves normalisation of symptoms and experiences	- The child or young person must be willing to discuss their obsessional thoughts and compulsions in a group setting - May allow peer support from others who may be having similar experiences - May not be suitable for OCD associated with severe functional impairment or that has not responded to CBT in a previous episode - Exposure and response prevention or behavioural experiments will cause temporary distress, so careful timing and active support is needed
Selective serotonin reuptake inhibitor (SSRI) In September 2026 only fluvoxamine and	The goal is to titrate gradually to reach the	Affects communication between brain cells	Generally well-tolerated but there are some side effects, so

sertraline were licensed for use in OCD in children and young people (fluvoxamine for ages 8 to 17 and sertraline for ages 6 to 17). See NICE's information on prescribing medicines.	maximum tolerable dose • Treatment should be continued for at least 12 weeks to evaluate response • A review, usually within 2 weeks, should be done to check for side effects and adherence • A review after 1 week, and no later than 4 weeks, should be done to assess for risk of suicide • Typically taken for at least 12 months (including after symptom remission or partial remission), with regular reviews See the sections on starting and stopping pharmacological treatments for more details on regular monitoring, when reviews will happen during treatment and continuing treatment after remission to prevent relapse.		active support is needed • Minimal time commitment but regular reviews are needed (especially when starting and stopping) • Benefits should be felt within 8 to 12 weeks • Some children and young people may find it difficult to later stop their SSRI
Clomipramine In September 2026, this was an off-label use of clomipramine. See NICE's	• Typically started under specialist supervision • The goal is to titrate gradually	• Affects communication between brain cells	• Benefits should be felt within 8 to 12 weeks • Should only be prescribed based on the

information on prescribing medicines.	to reach the maximum tolerable dose • A review after 1 week, and no later than 4 weeks, should be done to assess for risk of suicide • Needs regular physical health monitoring (for example, for cardiovascular effects) • Typically taken for at least 12 months (including after symptom remission or partial remission), with regular reviews See the sections on starting and stopping pharmacological treatments for more details on regular monitoring, when reviews will happen during treatment and continuing treatment after remission to prevent relapse.		child or young person's informed preferences and clinical needs, or if they have had a good response to it in a previous episode • Side effects, safety in overdose and the need for closer physical health monitoring should be taken into account • Other treatment options may be more suitable for children and young people at risk of suicide • Some children and young people may find it difficult to later stop clomipramine
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Why the committee made this recommendation

In the committee's experience, deciding on treatment for OCD in children and young people is complex and cannot be adequately achieved using a traditional stepped care model in which people progress through a predefined hierarchy of treatments. Symptom severity, functional impact and developmental needs can vary widely, and children and young people may present to services having already had treatment. The committee also noted that offering an intervention that does not adequately meet a person's needs may affect engagement with subsequent treatment. So, a matched care approach is more appropriate. This allows treatment decisions to be tailored to the child or young person's clinical needs, developmental context, treatment history and informed preferences, as well as the preferences of their parents or carers when appropriate, rather than following a fixed sequence of interventions or basing decisions on service capacity or availability.

The committee used clinical-effectiveness evidence, cost-effectiveness evidence (including the network meta-analysis [NMA] and economic modelling) and safety, to inform the relative ordering of treatments in table 2. The committee did not review evidence specifically for people with a current episode of OCD that has not responded to at least 1 adequate trial of a treatment option in table 1. So, they cannot say whether the recommendations are applicable to that population.

Evidence shows that psychological therapies are the most effective treatment options for reducing OCD symptoms in children and young people. They are also among the most cost effective. Of the psychological therapies, family-based TA CBT is the most effective- and cost-effective option. The committee agreed, based on their experience, that family involvement in treatment for children and young people is often important to support engagement with treatment, reduce family accommodation of symptoms and help with behavioural change. So, they agreed that family-based TA CBT is likely to be the most appropriate option for many children and young people with OCD. Evidence also shows individual TA CBT to be effective and cost effective compared with most other options. So, they included it high in the table.

There is no direct evidence for TA CT in children and young people. But the committee agreed that its effects can reasonably be extrapolated from the evidence for CBT (family-based or individual) in children and young people because of the shared theoretical basis and overlap in techniques.

Evidence shows that therapist-supported self-administered and group TA CBT are generally less effective than family-based and individual TA CBT. But they still show benefit, are cost effective compared with pharmacological treatment and GP care, and may be appropriate for some children and young people depending on their needs, preferences and level of functional impairment. Also, the economic analysis suggests that therapist-supported self-administered CBT is highly cost effective for children and young people with less severe symptoms, but still less cost effective than family-based TA CBT. So, the committee agreed it may be suitable for children and young people with OCD associated with less severe functional impairment.

Evidence shows that SSRIs are effective but have smaller effect sizes and lower cost-effectiveness rankings compared with psychological therapies. So, they are positioned lower in the table. The committee agreed that SSRIs remain an important treatment option within a matched care approach.

The committee also discussed the need to consider adverse effects and monitoring requirements when prescribing medicine for children and young people. Evidence shows clomipramine is more effective and cost effective than SSRIs (but less effective and cost effective than psychological therapies). In the committee's experience though, clomipramine is associated with a higher risk of adverse effects and greater toxicity in overdose compared with SSRIs, and needs closer physical health monitoring. They also noted that it is typically started under specialist supervision. So, clomipramine is positioned below SSRIs in the table. This reflects a balance between potential benefits and risks, and how the treatment is delivered in practice.

The committee did not include combination treatment as a distinct option in table 2 (for example, CBT plus an SSRI). But they agreed that combined psychological and pharmacological treatments could be considered within the matched care

approach when both are appropriate, based on the child or young person's clinical needs, treatment history and informed preferences. Because there was limited evidence on the effectiveness and cost effectiveness of combined psychological and pharmacological treatment for OCD, the committee made a [research recommendation to address the lack of evidence for combination treatments](#) (in particular, CBT in combination with SSRIs).

The committee made a [research recommendation on neuromodulation as a treatment option](#) because of the insufficient evidence in the NMA.

The committee agreed that combining the matched care approach with an evidence-informed ordering of treatments and clear supporting information would provide the most useful and transparent basis for decision making. Evidence shows that people value having flexible treatment options. Access and engagement may be improved when treatments can be personalised and adapted to individual circumstances, including needs and preferences for treatment intensity, duration and mode of delivery. So, they used their knowledge and experience to provide detail on each treatment option in table 2. This information will support implementation of a matched care approach and shared decision making, by helping healthcare professionals, children and young people and their parents or carers compare options in a structured way.

Full details of the evidence and the committee's discussion are in [evidence review A: interventions for treating OCD in children and young people](#).

How the recommendation might affect practice

This recommendation is expected to support a more individualised, transparent and developmentally appropriate approach to treatment decision making for children and young people with OCD. It may improve person- and family-centred care by explicitly linking treatment choice to both evidence on effectiveness and cost effectiveness and the child or young person's clinical needs, preferences and developmental context. It may also improve consistency in how treatment options are presented and prioritised, while allowing sufficient flexibility to accommodate individual needs.

The introduction of a matched care approach is a shift away from stepped pathways. This will encourage healthcare professionals to consider a broader range of factors at the outset (including symptom severity, functional impact, developmental needs, family context, treatment history and the child or young person's, and their parents' or carers', preferences) when evaluating treatment options with the child or young person and their parents or carers. Services that are currently organised around stepped care will need adjusting, but this approach aligns more closely with how OCD is managed in specialist settings.

The ordering of treatments within the table may influence clinical decision making by highlighting the relative effectiveness and cost effectiveness of interventions. In particular, the higher positioning of family-based TA CBT and CT may support increased use of family-based psychological therapies where these are available. This could impact service capacity and workforce planning, particularly if demand for therapists with expertise in family-based interventions increases. TA CBT (family-based or individual) have lower initial costs and are more cost effective overall than pharmacological treatments.

At the same time, the recommendation maintains flexibility and choice, recognising that not all treatments will be suitable or acceptable for every child or young person. The range of treatment formats, including individual, group-based and therapist-supported self-administered CBT, may help improve access to treatment while allowing care to be tailored to individual needs and circumstances.

Pharmacological treatments such as SSRIs remain an option and are likely to continue to be used in practice, particularly where psychological therapies are not available, or not suitable or acceptable.

For children and young people, the recommendation emphasises the importance of adapting treatment delivery to developmental needs and involving parents or carers when appropriate. This may support more consistent incorporation of family involvement in the treatment of children and young people with OCD.

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2 **BDD treatment for adults, children and young people**

3 1.9.6 For people with BDD, use the following [matched care approach](#) to match
4 the treatment options to their clinical needs, treatment history and
5 preferences:

- 6 • Identify which treatment option or options in [table 3](#) match the person's
7 clinical needs and treatment history (see recommendation 1.9.1).
- 8 • Discuss the identified treatment option or options with the person (and
9 their families, when appropriate) to understand which are aligned with
10 their informed preferences.
- 11 • Offer the appropriate treatment or, if more than one treatment option is
12 appropriate, offer the appropriate treatments in the order listed in table
13 3.
- 14 • If both psychological and pharmacological treatments are appropriate,
15 consider these in combination (depending on the person's clinical
16 needs, treatment history and informed preferences).

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18 See also the [sections on involving families and carers](#) and, if
19 applicable, [caring for children and young people](#).

1 Table 3 Treatment options for BDD in adults, children and young people
2 (ordered based on clinical- and cost-effectiveness evidence and safety)

Treatment	Delivery	Key features	Other considerations
Individual therapist-administered (TA) cognitive behavioural therapy (CBT) or cognitive therapy (CT)	- Typically a minimum of 12 to 14 weekly sessions, but more sessions are often beneficial - Involvement of parents or carers for children and young people, with the extent of involvement tailored to the child or young person's developmental level and other factors, such how much the parents or carers accommodate symptoms - Delivered in line with current treatment manuals	- Grounded in psychoeducation and individualised cognitive behavioural formulation - Addresses distorted beliefs about appearance and associated behaviours (for example, checking, avoidance or concealing) - Involves exposure and response prevention or behavioural experiments aimed at confronting avoided situations (for example, social situations) and resisting compulsive behaviours - Additional cognitive techniques, including imagery rescripting, used as appropriate - Mirror retraining used as appropriate - Relapse prevention techniques integrated towards end	- Requires regular attendance and engagement with structured sessions (including tasks between sessions) for the person and their parents or carers (if involved), so active support may be needed - Can be adapted to individual needs - Exposure and response prevention or behavioural experiments will cause temporary distress, so careful timing and active support is needed
Self-administered CBT with therapist support	Typically a minimum of 8 to 12 weekly sessions, but more sessions	See individual TA CBT or CT	- Requires engagement with structured tasks - Lower level of therapist input needed compared with

	are often beneficial • Content mirrors TA CBT protocols • Therapists provide weekly synchronous or asynchronous check-ins (completion of tasks and implementation of strategies) providing encouragement and support, reinforcing key techniques, and addressing problem-solving difficulties • Involvement of parents or carers for children and young people in line with individual TA CBT • Delivered in line with current treatment manuals		individual and group TA CBT • For children and young people, parents and carers should be given information about how they can be supportive • Can be adapted to individual needs • Particularly suitable for BDD associated with less severe functional impairment • May not be suitable for BDD associated with severe functional impairment or that has not responded to CBT in a previous episode • Exposure and response prevention or behavioural experiments will cause temporary distress, so careful timing and active support is needed
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Group TA CBT	- Delivered by 2 practitioners (with at least 1 with therapy-specific training and competence) - Typically a minimum of 10 to 12 sessions, but more sessions are often beneficial - Usually 4 to 6 participants in a group for children and young people, and 6 to 8 for adults - Delivered in line with current treatment manuals	- Goal-oriented and structured - Focuses on resolving current issue - Includes psychoeducation about BDD and CBT formulation - Involves exposure and response prevention or behavioural experiments aimed at confronting avoided situations (for example, social situations) and resisting compulsive behaviours - May include exercises targeting appearance-related obsessional thoughts, such as mirror retraining and behavioural experiments in social situations - Involves normalisation of symptoms and experiences	- The person must be willing to discuss their appearance-related obsessional thoughts in a group setting - May allow peer support from others who may be having similar experiences - May not be suitable for BDD associated with severe functional impairment or that has not responded to CBT in a previous episode - Exposure and response prevention or behavioural experiments will cause temporary distress, so careful timing and active support is needed
Selective serotonin reuptake inhibitor (SSRI) In September 2026, this was an off-label use of SSRIs. See NICE's information on prescribing medicines.	- The goal is to titrate gradually to reach the maximum tolerable dose - Treatment should be continued for at least 12 weeks	Affects communication between brain cells	- Generally well-tolerated but there are some side effects, so active support is needed - Minimal time commitment but regular

	to evaluate response • A review, usually within 2 weeks, should be done to check for side effects and adherence • A review after 1 week should be done if it is a new prescription for someone aged 24 and under or if there is a particular concern for risk of suicide • Typically taken for at least 12 months (including after symptom remission or partial remission), with regular reviews See the sections on starting and stopping pharmacological treatments for more details on regular monitoring, when reviews will happen during treatment and continuing treatment after remission to prevent relapse.		reviews are needed (especially when starting and stopping) • Benefits should be felt within 8 to 12 weeks • Some people may find it difficult to later stop their SSRI (for adults, see NICE's guideline on medicines associated with dependence or withdrawal symptoms)
Clomipramine In September 2026, this was an off-label use of clomipramine. See NICE's information on	• Typically started under specialist supervision • The goal is to titrate gradually to reach the	• Affects communication between brain cells	• Benefits should be felt within 8 to 12 weeks • Should only be prescribed based on the person's

prescribing medicines .	maximum tolerable dose • Needs regular physical health monitoring (for example, for cardiovascular effects) • Typically taken for at least 12 months after remission, with regular reviews See the sections on starting and stopping pharmacological treatments for more details on regular monitoring, when reviews will happen during treatment and continuing treatment after remission to prevent relapse.		informed preferences and clinical needs, or they have had a good response to it in a previous episode • Side effects, safety in overdose and the need for closer physical health monitoring should be taken into account • Other treatment options may be more suitable for people at risk of suicide • Some people may find it difficult to later stop clomipramine (for adults, see NICE's guideline on medicines associated with dependence or withdrawal symptoms)
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Why the committee made this recommendation

In the committee's experience, deciding on treatment for BDD is complex and cannot be adequately achieved using a traditional stepped care model in which people progress through a predefined hierarchy of treatments. Symptom severity, functional impact and comorbidity can vary widely, and people with BDD may present to services having already had treatment. Evidence for BDD is also more limited than for OCD, particularly for children and young people. The committee also noted that offering an intervention that does not adequately meet a person's needs may affect engagement with subsequent treatment. So, a matched care approach is more appropriate. This allows treatment decisions to be tailored to the person's clinical needs, treatment history and informed preferences and, for children and young people, their developmental context and family circumstances, rather than following a fixed sequence of interventions or basing decisions on service capacity or availability.

To inform the relative ordering of treatments in table 3, the committee primarily used clinical-effectiveness evidence from the network meta-analysis [NMA], which included only psychological interventions for adults with BDD. They also used evidence from pairwise comparisons (which included pharmacological interventions for adults with BDD and psychological interventions for children and young people with BDD), evidence from economic modelling, (informed by the NMA results), and other factors (such as acceptability and delivery). The evidence underpinning the NMA and, consequently, the economic analysis is limited, with interventions informed by a small number of small studies. There is wide uncertainty around effect estimates. The uncertainty and limitations of the NMA are also reflected in the economic analysis. So, the committee decided to also extrapolate from the OCD analyses.

The committee did not review evidence specifically for people with a current episode of BDD that has not responded to at least 1 adequate trial of a treatment option in table 1. So, they cannot say whether the recommendations are applicable to that population.

The NMA and economic analysis suggest that several CBT-based approaches are effective and cost effective in reducing BDD symptoms, although the relative ordering differed from that observed in OCD. In particular, individual TA CBT appeared lower in the ranking than therapist-supported self-administered CBT and group TA CBT. These findings are highly uncertain because of the small number of studies and limited connectivity within the NMA evidence network, affecting also the economic analysis.

Evidence from OCD shows that individual TA CBT is the most effective intervention, followed by group TA and self-administered CBT. The committee agreed that the OCD evidence was more reliable because it included more studies, larger sample sizes and more consistent findings. Because of the substantial overlap in underlying mechanisms and treatment approaches between OCD and BDD, they decided to extrapolate the OCD evidence to BDD.

So, the committee agreed that it is more clinically plausible that individual TA CBT is at least as effective as, and likely more effective than, self-administered CBT-based interventions for BDD. But they agreed that these lower-intensity options, remain important options. They are associated with clinically important reductions in symptoms in the available evidence for BDD and may be particularly appropriate when access to TA CBT is limited or a lower-intensity approach better matches the person's needs and preferences.

There is no evidence for TA CT in BDD. But the committee agreed that its effects can reasonably be extrapolated from the broader CBT evidence base and from OCD data, because of the shared theoretical basis and overlap in techniques.

Evidence for pharmacological treatments in BDD is limited. Only 1 study assessed the effectiveness of SSRIs in adults. Its results could not be combined with the other studies in the NMA. In the committee's experience, SSRIs are used to treat BDD. But their relative effectiveness and cost effectiveness compared with psychological therapies could not be estimated. So, SSRIs are recommended as a treatment option but are positioned after psychological interventions based on OCD evidence.

There is no evidence for clomipramine. But the committee agreed that it is reasonable to extrapolate from the OCD evidence because of the overlap in underlying mechanisms and pharmacological treatment approaches between OCD and BDD. They also agreed that including clomipramine as an option will support equitable access to a similar range of pharmacological options as for OCD. In the committee's experience though, clomipramine is associated with a higher risk of adverse effects and greater toxicity in overdose compared with SSRIs, and needs closer physical health monitoring. They also noted that it is typically started under specialist supervision. So, clomipramine is positioned below SSRIs in the table. This reflects a balance between potential benefits and risks, and how the treatment is delivered in practice.

The committee did not include combination treatment as a distinct option in table 3. But they agreed that combined psychological and pharmacological treatments could be considered within the matched care approach when both are appropriate, based on the person's clinical needs, treatment history and informed preferences.

There was only 1 study for children and young people with BDD. So, the committee agreed not to develop separate recommendations based on age. The limited available evidence did emphasise parental involvement as a core component of treatment. The committee agreed, based on their experience, that family involvement in treatment for children and young people is often important to support engagement with treatment and addressing behaviours that may reinforce symptoms, such as avoidance or reassurance seeking. So, the committee highlighted the involvement of parents or carers in the treatment descriptions within the table.

The committee agreed that combining the matched care approach with an evidence-informed ordering of treatments, based on both the limited BDD evidence and extrapolation from the more robust OCD evidence base, provides the most appropriate and transparent basis for decision making while reflecting the uncertainties in the available evidence. Evidence shows that people value having flexible treatment options. Access and engagement may be improved when treatments can be personalised and adapted to individual circumstances, including

needs and preferences for treatment intensity, duration and mode of delivery. So, they used their knowledge and experience to provide detail on each treatment option in table 2. This information will support implementation of a matched care approach and shared decision, by helping healthcare professionals, people with BDD and, when appropriate, their families or carers to compare options in a structured way

The committee made a [research recommendation on treatments for BDD](#) to address the limited evidence. They also made a [research recommendation on neuromodulation for BDD](#) because there is no evidence on this topic.

Full details of the evidence and the committee's discussion are in [evidence review C: interventions for treating BDD](#).

How the recommendation might affect practice

The recommendation is expected to support a more individualised and transparent approach to treatment decision making for people with BDD across all age groups. It may improve person-centred care by explicitly linking treatment choice to the available evidence while maintaining flexibility when evidence is limited. It may also improve consistency in how treatment options are presented and prioritised, while allowing sufficient flexibility to accommodate individual needs.

The introduction of a matched care approach is a shift away from stepped pathways. This will encourage healthcare professionals to consider a broader range of factors at the outset (including symptom severity, functional impact, treatment history, comorbidity, the person's preference and, for children and young people, developmental needs and family context) when evaluating treatment options with the person. Services that are currently organised around stepped care will need adjusting, but this approach aligns more closely with how BDD is managed in specialist settings.

The ordering of treatments within the table may influence clinical decision making by highlighting the relative effectiveness of interventions. In particular, the emphasis on TA CBT-based approaches may support increased use of psychological therapies where these are available. This could impact service capacity and workforce planning, particularly if demand for high-intensity CBT increases. But the economic analysis shows that all TA CBT-based approaches are cost effective compared with waitlist.

At the same time, the recommendation maintains flexibility and choice, recognising that not all treatments will be suitable or acceptable. The inclusion of therapist-supported self-administered CBT and group TA CBT may help improve access to treatment and provide a broader range of interventions that can be matched to individual needs and preferences. Pharmacological treatments such as SSRIs remain an option and are likely to continue to be used in practice,

particularly where psychological therapies are not available or, not suitable or acceptable.

For children and young people, the recommendation emphasises the importance of adapting treatment delivery to developmental needs and involving parents or carers when appropriate. This may support more consistent incorporation of family involvement in the treatment of children and young people with BDD.

1.10 Delivering psychological treatments

1.10.1 When offering psychological treatment for OCD or BDD, discuss with the person:

- the reasons for offering the treatment
- how it can be delivered (if there is more than 1 suitable option)
- the likely number of sessions and duration
- the possible benefits, including how the treatment may help the person achieve their goals
- the possible challenges, including:
 - time needed outside sessions
 - that it will cause temporary distress, but there will be active support for this
- any concerns they have about the treatment.

1.10.2 If a psychological treatment for OCD or BDD has a waiting list:

- tell the person:
 - how long the wait is likely to be
 - who to contact if their symptoms worsen while they are waiting
 - who to contact to ask about their progress on the waiting list
- update the person about their place on the waiting list at regular intervals
- provide information about support resources that may help while they are waiting, such as online resources and support organisations.

1 1.10.3 Use psychological [treatment manuals](#) to plan the person's treatment,
2 including the format, how long the course of treatment will last, and when
3 it will end.

4 1.10.4 Healthcare providers and commissioners should develop competency
5 frameworks from psychological treatment manuals.

6 1.10.5 Adapt psychological treatments for neurodivergent people or people with
7 learning disabilities, in line with [NICE's guidelines autism](#), [ADHD](#) or
8 [mental health problems in people with learning disabilities](#).

9 1.10.6 Discuss with people are nearing the end of a course of psychological
10 treatment how they can maintain the benefits of treatment and ensure
11 their ongoing wellness.

12 **Specific advice for children and young people**

13 1.10.7 When delivering psychological treatments for children and young people,
14 work with other professionals involved in their care and education, as
15 needed, including other healthcare professionals, social workers and
16 teachers.

17
18 For guidance on transitioning from children's to adult services, see [NICE's](#)
19 [guideline on transition from children's to adults' services for young people](#)
20 [using health or social care services](#).

21

Why the committee made these recommendations

The committee agreed that timely access to psychological treatment is important for people with OCD and BDD. In practice, there can be a wait for therapist-administered (TA) psychological treatments, particularly individual cognitive behavioural therapy (CBT). The committee noted that the expansion of NHS Talking Therapies services has improved access. But availability and waiting times still vary across services and geographical areas.

Evidence from OCD shows that barriers to accessing and engaging with treatment include limited availability of healthcare professionals with specialist knowledge of OCD, poor recognition and understanding of OCD in primary care settings, and negative perceptions of treatment because of concerns about effectiveness or previous poor experiences of care. In the committee's experience, this also applies to BDD because knowledge about BDD is even more limited. The committee agreed that providing clear information about waiting times, routes to seek help if symptoms worsen, and where to find additional support can help reduce uncertainty, improve engagement, support continuity of care during waiting periods, and reduce the risk of deterioration.

Evidence also shows that people's confidence in healthcare professionals and belief in the therapeutic process are important facilitators of engagement with treatment for OCD. The committee agreed this also applies to BDD. In their experience, delivering psychological treatments using evidence-based treatment manuals and competence frameworks supports high-quality and consistent treatment, helps with adherence to treatments shown to be effective, and increases people's confidence in their care.

Based on their experience, the committee also agreed that psychological treatments should be adapted for neurodivergent people and people with learning disabilities to improve accessibility, engagement and acceptability of care, consistent with existing NICE guidance.

Discussions towards the end of treatment about maintaining treatment gains and supporting ongoing wellness are important, in the committee's experience,

because OCD and BDD are often chronic or relapsing conditions. Helping people plan for maintaining progress after treatment may support longer-term recovery and self-management.

In the committee's experience, when a child or young person is having a psychological treatment, liaising with other professionals involved in their care and education may support engagement, consistency and the implementation of treatment strategies across settings. Teachers, social workers and other healthcare professionals may play an important role in recognising difficulties, supporting attendance and participation in treatment, and helping to reinforce therapeutic approaches in day-to-day environments. Collaborative working can help ensure that care is coordinated and responsive to the broader needs of the child or young person.

Full details of the evidence and the committee's discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#).

How the recommendations might affect practice

The recommendations are expected to reinforce good practice and improve consistency in the quality of psychological treatments across services. Some services may need to strengthen processes for communicating with people while they are waiting for treatment, including providing regular updates and information about additional sources of support.

Using treatment manuals and competence frameworks are current practice in many NHS psychological treatment services, including specialist OCD or BDD services and talking therapies services. So, these recommendations are unlikely to need substantial additional resources in most settings.

Adapting treatments for neurodivergent people and people with learning disabilities is expected to support more equitable access and engagement with psychological treatments. These recommendations may encourage services to consider accessibility and individual needs more consistently when planning and delivering care.

Liaising with professionals involved in the care and education of children and young people is expected to reinforce collaborative working that already occurs in many child and adolescent mental health services and educational settings. In some cases, it may increase communication and coordination between services, schools and other professionals involved in care. This is unlikely to need substantial additional resources and may improve continuity and coordination of support for children and young people receiving psychological treatment for OCD or BDD.

1 1.11 Delivering pharmacological treatments

- 2 See also the [sections on delivery of treatments in NICE's guideline on depression in](#)
- 3 [adults](#) and [starting a dependence-forming medicine or antidepressant in NICE's](#)
- 4 [guideline on medicines associated with dependence or withdrawal symptoms](#).

Starting pharmacological treatments

1.11.1 When offering medicine to treat OCD or BDD, discuss with the person:

- the reasons for offering the medicine
- the choices of medicine (if there is more than 1 suitable option)
- the dose, and how it may need to be adjusted
- the possible benefits, including how the medicine may help the person achieve their goals
- the possible harms, including possible withdrawal effects and side effects
- any concerns they have about taking or stopping the medicine (also see the [section on stopping pharmacological treatments](#)).

1.11.2 When prescribing a medicine for treating OCD or BDD, explain to the person:

- how they may be affected when they first start taking the medicine
- that the goal will be to achieve the maximum tolerable dose
- that it can take up to 12 weeks from reaching the maximum tolerable licensed dose to see the medicine's full effects but they may have a response earlier than this
- when their first review will be (usually within 2 weeks to check for any side effects)
- why regular monitoring is needed, and how often they will have reviews
- the importance of taking the medicine as instructed
- how they can self-monitor their symptoms, and how this may help them feel involved in their own recovery
- that the medicine is typically taken for at least 12 months, including after symptom [remission](#) or [partial remission](#)
- that some side effects may persist throughout treatment
- what withdrawal symptoms are and how these can be minimised (see also the [section on stopping pharmacological treatments](#)).

Why the committee made these recommendations

These recommendations are based on the committee's clinical knowledge and experience, [principles of delivering treatments from NICE's guideline on depression in adults](#) and [principles of starting a dependence-forming medicine or antidepressant from NICE's guideline on medicines associated with dependence or withdrawal symptoms](#). Discussions about starting pharmacological treatment for OCD or BDD should support shared decision making and enable people to make informed choices about their care. The committee agreed that many of the considerations relevant to prescribing antidepressants in other mental health conditions also apply to OCD and BDD.

Evidence shows that people's concerns about medicines, including fears about side effects and uncertainty about benefits, can be a barrier to people accessing and engaging with care. The committee agreed that providing clear information about the purpose of treatment, expected benefits, possible harms and the likely duration of treatment can help support informed consent, reduce uncertainty and improve adherence to treatment. They also agreed that discussing side effects will support person-centred care and help guide treatment choice when more than 1 option is suitable.

In the committee's experience, explaining that pharmacological treatments for OCD and BDD may take longer to show full benefit than in some other conditions, and that higher doses are usually needed to achieve optimal responses, is important. People may stop treatment early if they are not prepared for the delayed onset of effect or early side effects. People should also be given information about withdrawal symptoms. Early conversations can help people distinguish these effects from relapse, support safer prescribing practices and reduce anxiety about stopping treatment in the future.

The committee agreed that encouraging people to monitor their own symptoms and progress may help increase involvement in their care, support shared decision making and help healthcare professionals determine treatment effectiveness or adjustments.

Full details of the evidence and the committee's discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#).

1

How the recommendations might affect practice

The recommendations are unlikely to need substantial additional resources because they mainly formalise and standardise approaches that are already used in many services. They may encourage more consistent and comprehensive discussions, which may need some additional consultation time in certain settings. But improving understanding and involvement in decision making may support adherence, reduce early stopping of treatment and improve people's experience of care. Early review and ongoing monitoring is also expected to reinforce existing good practice.

2 Specific advice for people aged 24 and under, or people of any age who may 3 be at risk of suicide

4 1.11.3 When prescribing medicine to treat OCD or BDD in people aged 24 and
5 under, or people of any age who may be at risk of suicide (for example,
6 because they have a history of suicidal thoughts or attempts):

- 7 • assess their mental state and mood before starting the medicine
8 (ideally in person, or by video or telephone call if preferred by the
9 person or an in-person assessment is not possible)
- 10 • develop and implement a risk management strategy for suicidal
11 thoughts, self-harm and suicide risk in the early stages of treatment
12 (see the [section on risk assessment](#))
- 13 • check in with the person about how they are feeling and to see if they
14 are having any thoughts about, or if they feel that they are at risk of,
15 self-harm or suicide:
 - 16 – 1 week after starting the medicine or increasing the dose (ideally in a
17 face-to-face appointment, or by video or telephone call if preferred
18 by the person or if an in-person review is not possible) and

- 1 – as often as needed after the first week review, but no later than
- 2 4 weeks after the appointment when the medicine was started
- 3 • base the frequency and method of ongoing review on:
- 4 – the person’s circumstances (such as the availability of support,
- 5 housing situation or life events) and
- 6 – any changes in the person’s risk of self-harm or suicide
- 7 • review whether measures to reduce overdose risk are needed (for
- 8 example, limiting the quantity supplied or arranging more frequent
- 9 dispensing) based on the person’s risk of suicide attempts related to
- 10 overdose.

Why the committee made this recommendation

This recommendation is based on the committee's clinical knowledge and experience, [principles of delivering treatments from NICE's guideline on depression in adults](#) and [principles of starting a dependence-forming medicine or antidepressant from NICE's guideline on medicines associated with dependence or withdrawal symptoms](#).

Evidence from these guidelines shows there is a small increased risk of suicidal thoughts and behaviours in people aged 24 and under when starting an SSRI or clomipramine. There is a known increased vulnerability in this group, and the potential for changes in agitation, mood or suicidal ideation in early treatment phases. So, SSRI and clomipramine prescribing in children and young people requires particular care. Closer initial review, proactive risk management planning and clear escalation pathways are important to support safe prescribing and early identification of deterioration. The possibility of overdose in someone who is suicidal should also be thought about, and appropriate steps should be taken to reduce the risk of this.

Evidence also shows that concerns about medicines, including fear of side effects and worsening mental state, may act as barriers to people starting treatment. Structured early follow-up may help address this, improve engagement with treatment and provide reassurance during the initial phase of prescribing.

Full details of the evidence and the committee's discussion for adults are in the following [evidence reviews for NICE's guideline on medicines associated with dependence or withdrawal symptoms](#):

- evidence review A: patient information and support
- evidence review B: optimum prescribing strategies or interventions delivered alongside prescribing
- evidence review C: safe withdrawal
- evidence review D: withdrawal symptoms.

How the recommendation might affect practice

The recommendation is expected to strengthen and standardise existing good practice. Many services already undertake early follow-up after starting SSRIs or clomipramine. The recommendation may lead to more consistent implementation of reviews within the specified timeframes and clearer documentation of risk management strategies.

Early assessment, structured follow-up within 1 week of starting or adjusting a medicine, and review within 4 weeks may increase the frequency of early contacts in some services. This could impact workload, particularly in settings with high caseloads. But this is proportionate given the need to improve safety during a higher-risk period.

Tailoring review frequency based on individual circumstances and risk is expected to support more flexible and person-centred care, while maintaining a clear minimum standard for follow-up. These changes are likely to improve early detection of deterioration, enhance patient safety and support more responsive management of emerging risk.

1 Specific advice for children and young people

- 2 1.11.4 Consider starting a medicine for treating OCD or BDD in children and
- 3 young people at lower than the usual adult starting dose for the first week,
- 4 especially in younger children.

Why the committee made this recommendation

The committee agreed, based on their clinical knowledge and experience, that children and young people may be more vulnerable to adverse effects, dosing errors and variable treatment response when starting medicines for OCD or BDD than adults. This may be particularly relevant for younger children. Evidence also shows that parents and carers may have concerns about the impact of medicines on their child's symptoms and may be reluctant for their child to use medicines. Starting at a lower dose may improve tolerability, reduce early adverse effects and support engagement with treatment. This is consistent with established psychopharmacology principles in paediatric practice and with the need for cautious, individualised prescribing in children and young people.

Full details of the evidence and the committee's discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#).

1

How the recommendation might affect practice

The recommendation reinforces cautious prescribing practice when starting medicines for OCD or BDD in children and young people. Starting at a lower dose, particularly in younger children, may lead to additional titration steps in some cases. But this approach is consistent with safe prescribing principles and is unlikely to have substantial resource implications.

2 Specific advice for starting clomipramine

3 In September 2026, this was an off-label use of clomipramine for children and young
4 people. See [NICE's information on prescribing medicines](#).

5 1.11.5 Consider prescribing clomipramine under specialist supervision, for
6 example from a healthcare professional with expertise in OCD or BDD.

7 1.11.6 Carry out an electrocardiogram (ECG) and check blood pressure before
8 prescribing clomipramine for:

- 1 • adults at significant risk of cardiovascular disease and
2 • all children and young people.
- 3 1.11.7 When prescribing clomipramine:
- 4 • limit the quantity supplied and
5 • monitor the person closely.
- 6 1.11.8 Continue clomipramine for OCD or BDD for at least 12 months after
7 remission or partial remission.
- 8 1.11.9 For people taking clomipramine whose symptoms have not adequately
9 responded to the standard dose and who have no significant side effects,
10 consider gradually increasing the dose in line with the schedule suggested
11 by the summary of product characteristics.

Why the committee made these recommendations

These recommendations are based on the committee's clinical knowledge and experience, [principles of delivering treatments from NICE's guideline on depression in adults](#) and [principles of starting a dependence-forming medicine or antidepressant from NICE's guideline medicines associated with dependence or withdrawal symptoms](#).

The committee agreed that clomipramine can be an effective treatment option for OCD and BDD, but that it needs additional safety precautions compared with SSRIs because of its side-effect profile, cardiovascular effects and toxicity in overdose. This is particularly important for children and young people, because clomipramine use for OCD and BDD is off label in this age group. So, treatment decisions need to be made with particular care, including clear discussion of the potential benefits and harms, specialist involvement and appropriate monitoring. Limiting the quantity supplied and monitoring the person closely can help reduce the risk of harm in the committee's experience, particularly when there are concerns about self-harm or suicide. These precautions also support safer prescribing while the person's response, side effects and adherence are being assessed.

In the committee's experience, people at significant risk of cardiovascular disease and all children and young people need additional checks before starting clomipramine to identify factors that may increase the risk of harm. So, they recommended an ECG and blood pressure check before prescribing clomipramine for these groups.

The committee agreed that pharmacological treatments for OCD and BDD often need to be continued after symptoms have remitted or partially remitted to reduce the risk of relapse and support sustained recovery. So, clomipramine should usually be continued for at least 12 months after remission or partial remission, consistent with the approach used for other pharmacological treatments in this guideline.

The committee also agreed that some people may not have an adequate response to a standard dose of clomipramine but may still benefit from further dose optimisation if they are not experiencing significant side effects. Because clomipramine has important safety and tolerability considerations, any dose increase should be gradual and follow the schedule in the summary of product characteristics.

Full details of the evidence and the committee's discussion for adults are in the following [evidence reviews for NICE's guideline on medicines associated with dependence or withdrawal symptoms](#):

- evidence review A: patient information and support
- evidence review B: optimum prescribing strategies or interventions delivered alongside prescribing
- evidence review C: safe withdrawal
- evidence review D: withdrawal symptoms.

How the recommendations might affect practice.

These recommendations are expected to reinforce safe prescribing and monitoring practices for clomipramine. ECG and blood pressure checks before prescribing clomipramine may increase physical health monitoring in some services, particularly for children and young people, and adults at significant risk of cardiovascular disease. But this is standard practice and is not expected to need additional resource. The cost of the ECG was also included in the economic model for children and young people with OCD.

For children and young people, the recommendations may also support more consistent communication about off-label use and the need for specialist oversight and monitoring. This is expected to strengthen informed decision making and safe prescribing rather than introduce a substantially different approach to care.

Limiting the quantity of medicine supplied and monitoring the person closely may increase the need for follow-up contacts or more frequent dispensing in some cases. This could have some workload implications, particularly when there are concerns about overdose risk. But these measures are proportionate to the safety risks associated with clomipramine and are expected to support safer prescribing.

Continuing clomipramine for at least 12 months after remission or partial remission may extend treatment duration for some people. This could increase the number of ongoing reviews, but may reduce relapse and the need for further treatment. Gradual dose increases in line with the summary of product characteristics are consistent with current prescribing practice and are unlikely to need substantial additional resources.

1 Stopping pharmacological treatments

2 See also the [sections on making shared decisions about withdrawing medicines](#) and
3 [information and support for people withdrawing from a medicine in NICE's guideline](#)
4 [on medicines associated with dependence or withdrawal symptoms](#).

5 1.11.10 Discuss stopping medicine for OCD or BDD with people if they:

- 1 • have been in remission for at least 12 months and
2 • want to stop taking the medicine.
- 3 1.11.11 Explain to people taking medicine for OCD or BDD who want to stop that:
- 4 • there is a risk of symptoms recurring
5 • most people stop medicine for OCD and BDD successfully but it is
6 usually necessary to reduce the dose in stages over time (taper)
7 • if they stop taking the medicine abruptly or do not take a full dose, they
8 may have withdrawal symptoms, but these do not affect everyone
9 • withdrawal symptoms can vary in type and severity, and may be:
10 – mild, appearing within a few days of reducing or stopping medicine
11 and usually going away within 1 to 2 weeks
12 – moderate, lasting longer (sometimes several weeks and occasionally
13 several months)
14 – severe, particularly if the medicine is stopped suddenly.
- 15 1.11.12 Assess whether the person (and their parents, family or carers, if
16 applicable) has fears or concerns about stopping their medicine (for
17 example, because of the possibility of withdrawal symptoms or their OCD
18 or BDD symptoms returning).
- 19 1.11.13 If the person (and their parents, family or carers, if applicable) has fears or
20 concerns about stopping their medicine, particularly if previous attempts
21 have not been successful or have led to withdrawal symptoms, support
22 them to stop the medicine successfully by providing:
- 23 • additional online or written resources
24 • increased support, such as regular check-in phone calls, seeing them
25 more frequently or providing advice about sleep hygiene.
- 26 1.11.14 While stopping a medicine for OCD or BDD, continue with any ongoing
27 psychological treatment, if applicable.
- 28

Why the committee made these recommendations

In the committee's experience, stopping pharmacological treatment for OCD and BDD can be complex. It should be done in a stable phase of recovery to reduce the risk of relapse and support sustained benefit from treatment. So, medicine for OCD or BDD should generally only be stopped once remission has been achieved and maintained for a period of time. It requires careful planning, information sharing and support. People may wish to stop treatment for a range of reasons, including improved symptoms, side effects, or concerns about long-term medication use. So, clear communication about how stopping treatment is managed in practice is important to support informed decision making and reduce anxiety about stopping treatments.

The committee used [evidence](#) and [recommendations from NICE's guideline on medicines associated with dependence and withdrawal symptoms](#), which highlight that withdrawal effects can occur with a range of psychotropic medicines and that gradual dose reduction is generally safer and better tolerated than abrupt discontinuation. The committee agreed that these principles are also relevant to medicines used for OCD and BDD.

In the committee's experience, people with OCD or BDD, and their parents, family or carers if applicable, often have concerns about medicines, including fears about withdrawal symptoms and the possibility of relapse. Evidence also shows there are often parental concerns about the impact of medicine on their child's symptoms and general reluctance to use medicines. These concerns can act as barriers to both starting and continuing pharmacological treatment. Proactively addressing these concerns, including distinguishing withdrawal symptoms from relapse and explaining their typical time course, may help reduce uncertainty and support people to make informed decisions about stopping treatment when appropriate.

Some people may find stopping treatment difficult because of previous unsuccessful attempts or distressing withdrawal symptoms. So, the committee supported providing additional information and increased clinical support when needed to improve the likelihood of stopping a treatment successfully.

Medicine changes, including stopping medicines, can cause symptoms to fluctuate. So, any ongoing psychological treatments should be continued while doses are being reduced to help maintain treatment gains, reinforce coping strategies and provide continuity of therapeutic support.

Full details of the evidence and the committee's discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#) and in the following [evidence reviews for NICE's guideline on medicines associated with dependence or withdrawal symptoms](#):

- evidence review A: patient information and support
- evidence review B: optimum prescribing strategies or interventions delivered alongside prescribing
- evidence review C: safe withdrawal
- evidence review D: withdrawal symptoms.

How the recommendations might affect practice

The recommendations are expected to standardise and strengthen current practice around stopping pharmacological treatment for OCD and BDD, particularly related to structured tapering, monitoring and education. They provide greater emphasis on ensuring stability before the medicine is stopped. In some cases, this may lead to a longer duration of maintenance treatment before stopping is considered. They are likely to improve safety, consistency and patient experience, and align with broader NICE principles on safe prescribing and medicines associated with dependence and withdrawal symptoms.

Healthcare professionals discussing fears and concerns about stopping treatment with people, and offering additional support, may need some additional clinical time but is expected to improve patient experience and reduce distress while stopping a treatment.

Continuing with ongoing psychological treatment while stopping medicine is broadly consistent with current practice in many services and is expected to reinforce coordinated working between prescribing and psychological therapy teams.

These recommendations are unlikely to need substantial additional resources and are expected to support safer and more stable discontinuation of pharmacological treatment.

1 Monitoring treatment

2 1.12 All treatments

3 1.12.1 Review the following with people having treatment for obsessive
4 compulsive disorder (OCD) or body dysmorphic disorder (BDD):

- 5 • how well the treatment is working
- 6 • if and how they are following the treatment plan (for example, taking
- 7 medication as prescribed or completing agreed therapeutic tasks
- 8 between sessions)

- 1 • any side effects, harms or challenges of the treatment
- 2 • any suicidal ideation, particularly in the early weeks of treatment (see
- 3 also the [section on risk assessment](#)).
- 4 1.12.2 Use [routine outcome monitoring](#) with validated sessional outcome
- 5 measures:
- 6 • at the first appointment for starting treatment (to establish a baseline)
- 7 and
- 8 • at each follow-up appointment.

Why the committee made these recommendations

In the committee's experience, ongoing review and monitoring is necessary to assess treatment response, support adherence and identify any adverse effects or emerging risks. This supports safe, person-centred and responsive care throughout treatment.

The treatment response should be reviewed within the first few weeks after starting treatment to allow healthcare professionals to identify if a treatment is beginning to have benefit, or if any adjustments or additional support are needed. Reviewing whether and how the person is able to follow the treatment plan is also important because factors such as side effects, anxiety related to treatment tasks, practical barriers or concerns about treatment acceptability can affect engagement. Monitoring side effects, harms and suicidal ideation, especially during the early stages of treatment, is also important because some treatments may initially increase distress or anxiety.

In the committee's experience, routine outcome monitoring using validated measures, such as the Obsessive Compulsive Inventory-Revised (OCI-R) or Body Image Questionnaire (BIQ), is essential to support clinical decision making and discussions about progress over time. Sessional outcome measures help healthcare professionals and people with OCD or BDD identify improvement, monitor symptom severity and inform decisions about whether treatment should continue or be changed. So, validated measures appropriate to OCD or BDD should be used, but they should support rather than replace clinical judgement and individualised discussions.

How the recommendations might affect practice

These recommendations are expected to support more consistent, structured and safe monitoring of treatment for people with OCD or BDD. They reinforce the importance of regular review early in treatment. This may encourage services to ensure that appropriate follow-up arrangements are in place during the early stages of both psychological and pharmacological treatment.

The recommendations may also increase the use of routine outcome measures in clinical practice. This could support more consistent assessment of symptoms and treatment progress over time. It may also help inform shared decision making about whether treatment should be continued or changed.

The recommendations are largely consistent with existing clinical practice, so they should not need substantial changes to service organisation. But some services may need to consider how validated outcome measures are incorporated into routine care pathways and clinical review processes.

1

2 Additional support

3 1.13 Involving peers

4 1.13.1 Explore whether people with obsessive compulsive disorder (OCD) or
5 body dysmorphic disorder (BDD) would like to join, and would benefit
6 from, peer support groups.

7 1.13.2 Peer support groups should:

- 8 • be facilitated and supervised by people with experience and knowledge
9 of OCD or BDD and
10 • provide information and help to access services.

Why the committee made these recommendations

Evidence suggests that peer support can help improve access to and engagement with treatment for some people with OCD or BDD. Benefits include opportunities to share experiences, feel understood, and gain insight into coping strategies used by others. But evidence also showed that peer support is not always suitable. Some people with OCD or BDD are concerned about group dynamics and the potential for unhelpful reinforcement of symptoms or behaviours (for example, fear of 'catching' OCD-related thoughts or behaviours). There was limited evidence on the benefits compared with harms of peer support.

In the committee's experience, peer support can be helpful if delivered appropriately. But it can potentially be harmful, for example, by reinforcing appearance-related concerns in BDD. Peer support is also often provided in third-sector settings, which may vary in structure and oversight. So, the committee agreed that peer support may be beneficial for some people but should be offered in a way that ensures appropriate facilitation and signposting.

Full details of the evidence and the committee's discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#).

How the recommendations might affect practice

The recommendations formalise an existing but variable component of care, particularly in third-sector services, and encourage more consistent consideration of peer support as part of care planning. Services will need to ensure that any peer support offered is appropriately facilitated and supervised, and that risks relating to group dynamics and symptom reinforcement are managed. In some settings, this may need closer collaboration with third-sector providers and clearer pathways for signposting and service access.

Access

1.14 Access to services

Commissioners

1.14.1 Commissioners should enable people with suspected or confirmed obsessive compulsive disorder (OCD) or body dysmorphic disorder (BDD) to enter and move through care pathways in a timely way by:

- providing multiple routes into services (for example, GP referral, self-referral to talking therapies, and referral from other settings such as schools, or dermatology and cosmetic services) and
- ensuring clear referral pathways between services, including specialist care and
- offering a choice of treatment delivery methods, including in person, remote or digital.

1.14.2 Commissioners should plan and resource services to ensure equitable access across geographies, with targeted action to improve availability in areas with lower current provision.

Providers

1.14.3 Providers should monitor key aspects of the OCD and BDD care pathways within their services (for example, referral routes, waiting times,

proportion of people diagnosed, initiation of evidence-based treatment, treatment outcomes and missed appointments), and analyse these by:

- age
- ethnicity
- gender
- index of multiple deprivation (IMD).

1.14.4 Providers should work in partnership with community and faith groups that are representative of the local population to support engagement with services and development of routes into care pathways, for example by:

- providing information about:
 - the range of OCD and BDD symptoms
 - how to get into services (including self-referral routes such as into NHS Talking Therapies)
- addressing:
 - stigma
 - concerns about disclosing symptoms
 - limited information about psychological and pharmacological treatments.

Why the committee made these recommendations

Improving access to services is an important part of care for people with suspected or confirmed OCD or BDD. Providing more flexibility, monitoring inequalities and supporting community engagement may help promote more equitable and accessible care.

Evidence shows that people value flexible access to and delivery of care, and that this may improve engagement with services and treatment. In the committee's experience, people with OCD or BDD may experience barriers to accessing care because of stigma, shame, concerns about being misunderstood or difficulties attending appointments in traditional healthcare settings. So, the committee agreed on ways that commissioners can introduce more flexibility to address some of these barriers. Reducing these barriers may help people enter services earlier, move between services more smoothly and access care in a format that is acceptable and practical for them.

The committee noted that variation in local service availability can lead to differences in how quickly people are identified, assessed and offered treatment, which may worsen distress and contribute to unequal outcomes. Evidence from a bespoke analysis of real-world data from the Clinical Practice Research Datalink (CPRD) dataset shows that there are inequalities across the care pathway related to factors including age, ethnicity, gender and deprivation. For example, psychological referral rates are lower in the most deprived groups compared with the least deprived groups. Rates also differed by ethnicity, with higher psychological referral rates in some non-White groups but lower SSRI prescribing for Black people in the combined incident and prevalent adult population. So, the committee agreed that local monitoring of referral routes, waiting times, diagnosis, treatment initiation and outcomes by demographic characteristics may help services identify where access differs and target quality improvement activity.

Building on the CPRD analysis, the committee discussed that services should use local data to understand where access to OCD and BDD services may differ between groups, and use this information to inform improvement activity. In their experience, community and faith groups can be important sources of local

knowledge and trusted communication channels in some areas. So, they agreed that providers working in partnership with local community and faith groups may help improve awareness of OCD and BDD, support understanding of treatment options and develop clearer routes into care for the local population.

The committee also discussed the [NHS Race and Health Observatory report on ethnic inequalities in improving access to psychological therapies](#), which showed differences in access to these services between ethnic groups. This reinforced the importance of ensuring that partnership working is informed by local population needs and local evidence of inequalities, including based on ethnicity, so that engagement activity is relevant and appropriately targeted.

Full details of the evidence and the committee's discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#) and [health inequalities report A](#).

How the recommendations might affect practice

These recommendations are expected to support more timely, flexible and equitable access to services for people with suspected or confirmed OCD or BDD. Commissioners may need to review whether local pathways provide multiple routes into care, clear referral routes between services and a choice of delivery methods, including face-to-face and virtual options. They may also need to assess geographical variation in provision and take targeted action where access is lower. This may have resource implications in some areas, but could help reduce delays and make access more consistent.

Providers may need to strengthen data collection and review processes across OCD and BDD care pathways. Monitoring specific indices should help services identify inequalities and target local quality improvement activity.

Providers may also need to develop or strengthen partnerships with local community groups and faith organisations. This may need additional coordination, but could improve awareness of OCD and BDD, address stigma and concerns about disclosing symptoms, and support clearer routes into care for communities that may experience additional barriers to accessing mental health services.

Overall, the recommendations may need some additional service planning, data analysis and partnership working, but they are consistent with wider NHS priorities on reducing health inequalities and improving access to mental health services.

1 1.15 Access to treatments

2 Providers

3 1.15.1 Providers should address identified inequalities in access to, and uptake
4 of, OCD and BDD treatments, by:

- 5 • reviewing referral pathways
- 6 • adapting how services are delivered, including reviewing resources
- 7 • supporting staff to recognise and address barriers to engagement,
- 8 including practical, cultural and socioeconomic factors

- making reasonable adjustments to improve engagement and access to treatment, in line with the Equality Act 2010.
- developing key performance indicators that cover referral, treatment initiation and completion of OCD and BDD treatments (particularly cognitive behavioural therapy [CBT]), stratified by deprivation level
- implementing targeted improvement support for underperforming localities
- targeting engagement or outreach in underserved groups
- developing commissioning contracts and service specifications that support improvements in access to, uptake of and completion of OCD and BDD treatments, particularly for underserved groups.

Healthcare professionals

1.15.2 Healthcare professionals should address inequalities in access to, and uptake, of OCD and BDD treatments by:

- monitoring who is assessed for OCD and BDD
- monitoring who is receiving OCD and BDD treatments
- identifying groups that are eligible for treatments but have lower uptake
- engaging with groups with lower uptake to improve understanding of OCD or BDD treatment options.

Providers

1.15.3 Providers should consider implementing engagement and retention strategies to improve uptake and completion of treatment, such as:

- choice of healthcare professional (when feasible)
- flexible hours
- signposting to childcare and transport support
- using reminders (for example, text or messaging services) in the person's preferred language
- making contact after missed appointments to support re-engagement.

Why the committee made these recommendations

Evidence from a bespoke analysis of real-world data from the Clinical Practice Research Datalink (CPRD) dataset shows that there are inequalities in access to, and uptake of, OCD and BDD treatments. These inequalities are related to factors including deprivation, age, ethnicity and gender. For example, psychological referral rates are lower in the most deprived groups compared with the least deprived groups. Referral rates decrease with age in the combined incident and prevalent adult population, while antipsychotic use increases with age. The committee agreed that delayed or reduced access to evidence-based treatment may worsen symptoms, increase distress and contribute to unequal outcomes.

Another analysis shows that individual CBT is estimated to generate substantially larger population health gains than SSRIs despite lower uptake. In the deprivation analysis, increasing individual CBT uptake to match observed SSRI uptake is estimated to produce the largest additional net health benefits in the most deprived groups. This supports the committee's view that reducing inequalities in access to CBT is likely to improve outcomes and represent an efficient use of resources.

In the committee's experience, practical issues, such as appointment times, childcare, transport and missed appointment processes, may be barriers to some people accessing and completing treatment. Cultural, socioeconomic and communication barriers, concerns about disclosure, stigma, and limited understanding of OCD or BDD treatment options may also contribute. The committee agreed that addressing these barriers through adapted service delivery, reasonable adjustments, outreach and engagement with underserved groups could improve uptake and completion of treatment.

The committee also agreed Identifying and engaging with groups with lower treatment uptake could help services understand local barriers and improve how information about psychological and pharmacological treatment options is communicated.

Full details of the evidence and the committee's discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#), [health inequalities report A](#) and [health inequalities report B](#).

How the recommendations might affect practice

These recommendations may lead services to take a more structured and proactive approach to identifying and addressing inequalities in access to, uptake of and completion of OCD and BDD treatments. Providers may need to review referral pathways, routine data collection, service specifications and local performance indicators, particularly in relation to CBT access and completion. This may need additional planning and analytical capacity, especially where demographic and deprivation data are not currently collected or reviewed consistently.

Services may also need to adapt how care is delivered, for example by offering more flexible appointment times, using reminders in people's preferred language, signposting to childcare or transport support, and contacting people after missed appointments to support re-engagement. Some services may need to provide additional staff support or training to help healthcare professionals recognise and address practical, cultural and socioeconomic barriers to treatment.

Although these actions may need some additional resource and service coordination, the committee agreed that improving access to CBT is likely to improve outcomes and may provide net health benefit. Earlier and more equitable access to effective treatment may also reduce the longer-term impact of untreated or undertreated OCD and BDD, including ongoing distress, functional impairment and repeated contact with services.

Overall, the recommendations are expected to support more equitable access to evidence-based treatment, improve uptake and completion of CBT and other appropriate treatments, and help services target quality improvement activity where local data show lower access or poorer engagement.

1 Terms used in this guideline

- 2 This section defines terms that have been used in a particular way for this guideline.

1 **Children**

2 People aged 11 years or under.

3 **Cosmetic procedures**

4 Surgical or non-surgical procedures (including aesthetic) undertaken primarily to
5 alter appearance rather than for the treatment of disease, disorder or injury. In this
6 guideline, the term refers to interventions provided by regulated healthcare
7 professionals (surgeons, doctors, dentists, dental care professionals, nurses or
8 pharmacists).

9 **Matched care approach**

10 An approach to treatment decision making in which people are offered the
11 appropriate, clinically- and cost-effective treatment that best matches their assessed
12 clinical needs (such as symptom severity, degree of functional impairment, and
13 nature and complexity of the condition), treatment history and preferences. This is in
14 contrast to the stepped care approach in which people progress through a
15 predefined hierarchy of treatments.

16 **Partial remission**

17 Symptom improvement, but there are some symptoms remaining.

18 **Remission**

19 Symptom resolution such that the person no longer meets criteria for a diagnosis.

20 **Routine outcome monitoring**

21 A system for monitoring treatment outcomes that involves regular assessment
22 (usually at each contact, referred to as sessional) of symptoms, or personal and
23 social functioning, using a validated scale. It can inform both the person with OCD or
24 BDD and the healthcare professional of treatment progress. It is often supported by
25 computerised delivery and scoring of the measures, which ensures better completion
26 of the questionnaires and service level audit and evaluation. Alternative terms, such
27 as 'sessional outcome monitoring' or 'sessional outcomes', may also be used, which
28 emphasise that outcomes should be recorded at each contact.

1 **Standard risk assessment**

2 A structured clinical process that evaluates the likelihood and severity of harm to self
3 or others, considering historical, current and contextual factors. It is used to inform
4 risk management and care planning and is standard practice in the context of mental
5 health assessment.

6 **Treatment manuals**

7 The manuals used in the trials that provided the evidence for the efficacy of
8 treatments recommended in this guideline (see [evidence review A: interventions for](#)
9 [treating OCD in children and young people](#), [evidence review B: interventions for](#)
10 [treating OCD in adults](#) and [evidence review C: interventions treating BDD](#)).

11 **Young people**

12 People aged between 12 and 17 years.

13 **Recommendations for research**

14 The guideline committee has made the following recommendations for research.

15 **Key recommendations for research**

16 **1 Accessing and engaging with treatment for body dysmorphic disorder**

17 What works well, and what could be improved, in terms of accessing and engaging
18 with treatment for body dysmorphic disorder (BDD)?

Why the committee made the recommendation for research

Evidence on accessing and engaging with treatment for BDD is very limited. Only 1 qualitative study focuses on the experiences of people with BDD. Most of the evidence is for OCD. Although OCD and BDD may share some barriers and facilitators to access and engagement with treatment, the committee agreed that BDD has specific features, such as appearance-related shame, concerns about disclosure, and contact with cosmetic or dermatology services, that may affect how people access and engage with treatment. More qualitative evidence from people with BDD, their families and carers, and healthcare professionals will help identify what supports or prevents access to and engagement with treatment, and inform improvements to care pathways and treatment delivery.

Full details of the evidence and the committee's discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#).

- 1 **2 Accessing and engaging with treatment for obsessive compulsive**
- 2 **disorder and body dysmorphic disorder by people in underserved**
- 3 **populations**
- 4 What works well, and what could be improved, in terms of accessing and engaging
- 5 with treatment for people with obsessive compulsive disorder (OCD) or body
- 6 dysmorphic disorder (BDD) in underserved populations?

Why the committee made the recommendation for research

Evidence on accessing and engaging with treatment for people with OCD or BDD in underserved populations is very limited. Only 1 study provided evidence specifically relating to underserved populations. So, there was not enough evidence to understand how barriers and facilitators may differ across groups or how services can best respond to these differences. The committee agreed that people in underserved populations may face additional barriers to accessing and engaging with treatment, including stigma, discrimination, practical barriers, cultural or language differences, socioeconomic factors, and concerns about disclosure or being misunderstood. More qualitative evidence from people with OCD or BDD from a range of underserved populations, and from healthcare professionals and families or carers when appropriate, would help identify what works well and what could be improved to make access to services and engagement with treatment more equitable.

Full details of the evidence and the committee's discussion are in [evidence review D: accessing and engaging with treatment for OCD and BDD](#).

- 1 **3 Treatments for body dysmorphic disorder**
- 2 What is the effectiveness (including at longer-term follow-up) and cost effectiveness
- 3 of treatments for body dysmorphic disorder (BDD)?

Why the committee made the recommendation for research

Evidence on the effectiveness and cost effectiveness of treatments for BDD was limited and uncertain. Although some evidence was available, the studies included in the network meta-analysis were not well connected and there was limited evidence for some interventions, age groups and longer-term outcomes. So, some recommendations for BDD were informed by extrapolating from the OCD evidence. The committee agreed that more robust evidence is needed on the effectiveness of all BDD treatment options to clarify what works best for people with BDD and how this may differ from treatment for OCD.

Full details of the evidence and the committee's discussion are in [evidence review C: interventions for treating BDD](#).

- 1 **4 Combination treatments for obsessive compulsive disorder**
- 2 What is the effectiveness and cost effectiveness of cognitive behavioural therapy
- 3 (CBT) plus a selective serotonin reuptake inhibitor (SSRI) for treating obsessive
- 4 compulsive disorder (OCD) compared with:
 - 5 • CBT alone?
 - 6 • an SSRI alone?

Why the committee made the recommendation for research

There is no evidence on the effectiveness and cost effectiveness of CBT plus an SSRI as a combined treatment for OCD compared with CBT alone or an SSRI alone. Some studies of psychological treatments include people who were already taking stable pharmacological treatment, but these studies do not evaluate combined treatment as a distinct intervention or show whether using CBT and an SSRI together provides additional benefit. The committee noted that CBT plus an SSRI is often used in clinical practice when both psychological and pharmacological treatment are appropriate. So, research is needed to determine whether the combination improves outcomes compared with either treatment alone, and whether any added benefits justify the additional resource use and potential treatment burden.

Full details of the evidence and the committee's discussion are in [evidence review A: interventions for treating OCD in children and young people](#) and [evidence review B: interventions for treating OCD in adults](#).

- 1 **5 Neuromodulation for obsessive compulsive disorder**
- 2 What is the effectiveness and cost effectiveness of neuromodulation for treating
- 3 obsessive compulsive disorder (OCD) compared with:
- 4 • cognitive behavioural therapy (CBT)
- 5 • SSRIs?

Why the committee made the recommendation for research

Evidence on neuromodulation for treating OCD is limited and uncertain. Although neuromodulation studies are included in the evidence, they are not well connected to the wider network meta-analysis, making it difficult to estimate their relative effectiveness and cost effectiveness compared with other active treatments. The committee agreed that comparing neuromodulation with CBT or SSRIs would help determine whether it offers benefits relative to established effective treatments.

Full details of the evidence and the committee's discussion are in [evidence review A: interventions for treating OCD in children and young people](#) and [evidence review B: interventions for treating OCD in adults](#).

1 6 Neuromodulation for body dysmorphic disorder

- 2 What is the effectiveness and cost effectiveness of neuromodulation for treating
- 3 body dysmorphic disorder (BDD) compared with sham neuromodulation?

Why the committee made the recommendation for research

There is no evidence on neuromodulation for treating BDD. The committee agreed that, before neuromodulation can be compared with other active treatments for BDD, research is needed to establish whether it is effective and cost effective compared with sham neuromodulation. Evidence from well-designed studies will help determine whether neuromodulation has a clinically important treatment effect for people with BDD and whether further research comparing it with other interventions is warranted.

Full details of the evidence and the committee's discussion are in [evidence review C: interventions for treating BDD](#).

4 Finding more information and committee details

- 5 To find NICE guidance on related topics, including guidance in development, see the
- 6 [NICE topic page on mental health, behavioural and neurodevelopmental conditions](#).
- 7 For details of the guideline committee see the [committee member list](#).

1 **Update information**

2 **September 2026**

3 This guideline is an update of NICE guideline CG31 (published November 2005) and
4 will replace it.

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