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S3-Guideline Obsessive Compulsive Disorder – Short Version

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On behalf of the

German Association for Psychiatry, Psychotherapy and Psychosomatics (DGPPN)

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Diagnostics and Classification

(see chapter 3 long version)

Recommendation	Strength of Recommendation
3-1 All patients who are suspected of suffering from a psychiatric disorder or who show signs (for example hand eczema) suggestive of a psychiatric disorder should be asked the following OCD screening questions: (1) Do you wash and clean a lot? (2) Do you check things a lot? (3) Do you have distressing thoughts that you want to get rid of but cannot? (4) Do your daily activities take you a long time to complete? (5) Are you concerned with symmetry and putting things in order? Strength of recommendation: expert consensus	**Expert Consensus**
3-2 In suspected cases, the presence of the diagnostic criteria according to ICD-10 should be assessed and possible comorbidity clarified. In cases of diagnostic uncertainty, it is recommended that the assessment be done using an ICD-10-based examination tool. Strength of recommendation: expert consensus	**Expert Consensus**
3-3	**Expert Consensus**

If there were corresponding anamnestic and/or clinical indications of a relevant general medical condition/disease, it is recommended that the additional diagnostic steps described (chapter 3.5.2) be taken. Strength of recommendation: expert consensus	
3-4 It is recommended that, after determining the mental status at baseline, the follow-up diagnostics described in the text (e.g., Y-BOCS, chapters 3.2 and 3.4) be performed. Strength of recommendation: expert consensus	**Expert Consensus**
3-5 It is recommended that, in addition to symptomatology, the impact of the disease on agency (capacity to understand, communicate and act), life activities, participation in society, quality of life, and interpersonal functioning always be assessed (at the beginning of treatment, for the purpose of goal setting and during the course of treatment as well as at the end of treatment, for the purpose of evaluation). Strength of recommendation: expert consensus	**Expert Consensus**
3-6 It is recommended that caregivers, close family members/relatives or close relationships be involved in the assessment of the patient's daily life, level of participation in society, and quality of life, if the patient(s) consent(s) to their involvement.	**Expert Consensus**

Strength of recommendation: expert consensus	
3-7 Patients with obsessive-compulsive disorder with onset at over 50 years of age should undergo a neurological and neuroradiological diagnostic work-up. Strength of recommendation: expert consensus	**Expert Consensus**

Psychotherapeutic Approaches

(see chapter 4 long version)

Recommendation	**Strength of Recommendation**
4-1 Patients with obsessive-compulsive disorder should be offered disorder-specific cognitive behavioral therapy (CBT), including exposure, as first-line psychotherapy. Strength of recommendation: A	**A**
4-2 Treatment of patients with obsessive-compulsive disorder with cognitive behavioral therapy including exposure (CBT) is recommended to comprise relapse-prevention strategies (e.g., booster sessions to reinforce and refresh therapy content, self-help group, transitioning strategies to outpatient psychotherapy after inpatient treatment).	**Expert Consensus**

Strength of recommendation: expert consensus	
4-3 If it is possible to choose between treatment with selective serotonin reuptake inhibitors (SSRIs) or clomipramine and cognitive-behavioral therapy with exposure, then preference is given to cognitive-behavioral therapy (CBT) with exposure. Strength of recommendation: B	**B**
4-4 Acceptance and commitment therapy (ACT) may be considered for treatment of obsessive-compulsive disorder. Strength of recommendation: 0	**0**
4-5 Group cognitive behavioral therapy (CBT) should be considered in the treatment of obsessive-compulsive disorder, especially when individual therapy is not available. Strength of recommendation: B	**B**
4-6 If the option of conducting high-frequency exposure with response management is available (block exposure on immediately consecutive therapy days, however, at least two long-exposure	**B**

sessions per week), this therapeutic intervention should be considered. Strength of recommendation: B	
4-7 If patients have shown response to cognitive behavioral therapy (CBT) with exposure, it is recommended that this be continued until clinical remission is achieved (Y-BOCS total score at end of therapy <12, and improvement in quality of life). Strength of recommendation: B	**B**
4-8 During cognitive behavioral therapy (CBT), patients should be offered exposures in the company of therapists, and transfer to patient self-management should be targeted. Strength of recommendation: expert consensus	**Expert Consensus**
4-9 It is suggested that exposure in the context of cognitive behavioral therapy (CBT) be delivered by therapists in the home setting or in compulsion-inducing situations (outside of practice/clinic) if compulsive symptoms were not elicited in the practice or clinic setting. Strength of recommendation: expert consensus	**Expert Consensus**
	Statement

4-10 Inpatient therapy that provides cognitive behavioral therapy (CBT) with exposure and response management as part of multimodal treatment programs specialized for obsessive-compulsive disorder is effective for obsessive-compulsive disorder and achieves high-effect sizes. Strength of recommendation statement	
4-11 The involvement of caregivers, close family members/close relatives, or close relationships in the delivery of cognitive behavioral therapy (CBT) is recommended. Strength of recommendation: expert consensus	**Expert Consensus**
4-12 Group mindfulness-based cognitive therapy (MBCT) may be considered for the treatment of obsessive-compulsive disorder if there has been no prior adequate response to (C)BT. Strength of recommendation: 0	**0**
4-13 Group mindfulness-based exposure may be considered for treatment of obsessive-compulsive disorder. Strength of recommendation: 0	**0**

4-14 Metacognitive therapy approaches may be considered for the treatment of obsessive-compulsive disorder. Strength of recommendation: 0	**0**
4-15 Inference-based therapy may be used for patients with reduced insight into the irrationality of compulsive content. Strength of recommendation: 0	**0**
4-16 There is a lack of sufficient evidence of efficacy for several other therapy variants (EMDR, schema therapy, association splitting, saturation therapy, DIRT). Strength of recommendation: statement	**Statement**
4-17 In case of limited treatment availability (e.g., regional supply shortages) or to bridge waiting times, it is suggested that CBT-based therapies (including self-help) be made available via internet. Strength of recommendation: B	**B**
	Statement

4-18 There is evidence that the effects of internet-based cognitive behavioral treatment services can be enhanced by increasing the frequency of therapist contact. Strength of recommendation: statement	
4-19 If it is not possible to perform CBT in direct face-to-face contact with the therapist (e.g., for organizational reasons, due to long distances, due to pandemic, etc.), the use of CBT via video consultation/treatment may be considered. Strength of recommendation: expert consensus	**Expert Consensus**
4-20 Exposure via video consultation /treatment or with telephone accompaniment may also be considered for CBT that is primarily conducted in a face-to-face setting if specific exposures with therapist accompaniment are not possible in the home setting. Strength of recommendation: expert consensus	**Expert Consensus**
4-21 Psychoanalysis and psychodynamic psychotherapy approaches are used to treat patients with obsessive-compulsive disorder. No evidence for the efficacy of these approaches is available from randomized controlled trials. Strength of recommendation: statement	**Statement**

4-22 Other psychotherapy methods are used to treat patients with obsessive-compulsive disorder. There is insufficient evidence for the efficacy of these psychotherapeutic approaches from randomized controlled trials. Strength of recommendation: statement	**Statement**
4-23 Therapists are recommended to promote and monitor patients' adherence (implementation of agreed-upon exposure exercises between therapy sessions) during cognitive-behavioral therapy (CBT) to ensure good therapy outcomes. Strength of recommendation: expert consensus	**Expert Consensus**

Complementary Psychosocial Therapies

(see chapter 5 long version)

Recommendation	**Strength of Recommendation**
5-1 Sport and exercise therapy interventions such as endurance training may be a useful addition to guideline-based treatment. Strength of recommendation: expert consensus	**Expert Consensus**

5-2 Ergotherapy may be a useful addition to guideline-based psychotherapy by providing concrete practice of everyday activities and exercises in the home environment. Strength of recommendation: expert consensus	**Expert Consensus**

Psychopharmacotherapy

(see chapter 6 long version)

Recommendation	**Strength of Recommendation**
6-1 Monotherapy with medication is indicated if: • cognitive behavioral therapy (CBT) is declined by the patient, or CBT cannot be conducted due to the severity of symptoms; • CBT is not available due to long waiting times or lack of resources; or • this treatment can increase the patient's motivation/ readiness to engage in further therapy (CBT). Strength of recommendation: expert consensus	**Expert Consensus**
6-2 Monotherapy with medication may be offered if it is requested/preferred by the patient and/or if the patient has had a positive experience with a good response to a pharmacotherapeutic intervention in the past.	**Expert Consensus**

Strength of recommendation: expert consensus	
6-3 If a pharmacotherapy is indicated, SSRIs (citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline) should be offered. However, citalopram is not approved in Germany for the treatment of obsessive-compulsive disorder. Strength of recommendation: A	**A**
6-4 During treatment with SSRIs, attention should be paid to • nausea, diarrhea • sexual dysfunction • hyponatremia, especially in elderly patients (SIADH = increased production or action (effect) of the antidiuretic hormone ADH) • a significant increase in motor agitation • anxiety and agitation • suicidal thoughts • predisposition/risk for bleeding, especially with concomitant administration of anticoagulant medications, including nonsteroidal anti-inflammatory drugs • discontinuation difficulties after prolonged SSRI use. Patients should be informed as to the possibility of these adverse/unwanted effects at the start of treatment, and they should seek medical attention if the unwanted/adverse effects occur. Monitoring during pharmacotherapy should be performed according to Table 6.1. Strength of recommendation: expert consensus	**Expert Consensus**
6-5	**Expert Consensus**

The decision for pharmacotherapy treatment (seeking and obtaining informed consent for pharmacotherapy treatment) should be made in a shared-decision joint process, after informing the patient about the different treatment options, the expected benefits of success and risks and the likelihood that the benefits and risks will occur and after making sure that the patient understands the different treatment options, benefits and risks through discussions and sharing of information. Strength of recommendation: expert consensus	
6-6 Because all SSRIs have a comparable clinical efficacy, SSRI selection should be based on the profile of adverse effects and potential drug-drug interactions. Strength of recommendation: expert consensus	**Expert Consensus**
6-7 It is recommended that the SSRIs citalopram (off-label use), escitalopram, fluoxetine, paroxetine or sertraline be administered up to the maximum approved therapeutic doses, based on the course of symptoms and unwanted/adverse effects, given that higher efficacy is expected with higher doses. Strength of recommendation: B	**B**
6-8 If therapy with SSRI is effective, it is recommended that maintenance therapy be continued with the last effective SSRI dose if the last effective dose is well tolerated and contraindications for continuing the medication at the last effective dose are absent (see Recommendation 6-27).	**B**

Strength of recommendation: B	
6-9 Although clomipramine is comparably effective to SSRIs, it is recommended that it not be used as first-line treatment for patients with obsessive-compulsive disorder because of adverse effects. Strength of recommendation: A	**A**
6-10 During treatment with clomipramine, attention should be paid to • dry mouth • constipation, severe constipation • eye accommodation disorders • dizziness, hypotension with circulatory problems and palpitations, cardiac arrhythmias • weight gain • problems with urination • sexual dysfunction • intestinal obstruction • glaucoma • cognitive disorders • confusion/delirium • seizures • hyponatremia especially in elderly patients (SIADH = increased production or effect of the antidiuretic hormone ADH) • significant increase in motor agitation • anxiety and agitation • suicidal ideation • predisposition/risk for bleeding, especially with concomitant administration of anticoagulant medications including nonsteroidal anti-inflammatory drugs • difficulties in discontinuing clomipramine after prolonged use.	**Expert Consensus**

Patients should be informed as to the possibility of these unwanted/adverse effects at the start of treatment and they should seek medical attention if the unwanted/adverse effects occur. Monitoring during pharmacotherapy should be performed according to Table 6.2. Strength of recommendation: expert consensus	
6-11 Intravenous administration of clomipramine does not have superior efficacy compared with oral administration and is recommended not be used primarily. Strength of recommendation: B	**B**
6-12 Tricyclic antidepressants (except for clomipramine) are not effective for treating patients with obsessive-compulsive disorder and therefore should not be used for treatment of obsessive-compulsive disorder. Strength of recommendation: A	**A**
6-13 It is recommended not to use venlafaxine as a first-line medication.[1] Strength of recommendation: B [1]It is not approved for the treatment of obsessive-compulsive disorder in Germany.	**B**

6-14 Mirtazapine should not be used for medication monotherapy in patients with obsessive-compulsive disorder.[1] Strength of recommendation: A [1]It is not approved for the treatment of obsessive-compulsive disorder in Germany.	**A**
6-15 Buspirone[1] should not be used. Strength of recommendation: A [1]It is not approved for the treatment of obsessive-compulsive disorder in Germany.	**A**
6-16 Clonazepam[1] and other benzodiazepines[1] should not be used for the treatment of obsessive-compulsive disorder: They carry a risk of developing dependence. Strength of recommendation: A [1]They are not approved for the treatment of obsessive-compulsive disorder in Germany.	**A**
	Expert Consensus

6-17 If a patient with obsessive-compulsive disorder does not respond to treatment with SSRI/clomipramine with a reduction in obsessive-compulsive symptoms of at least 25%, then it is recommended that causes for this course of treatment be evaluated. These causes may include poor cooperation of the patient, inadequate dose of medication, and a drug serum level that is too low. Strength of recommendation: expert consensus	
6-18 It is recommended that the duration of treatment with SSRI/clomipramine last for at least 12 weeks. It is recommended that a maximum approved dose be reached by the sixth to eighth week of treatment, unless remission[1] or clinical remission has already been achieved. Strength of recommendation: expert consensus. [1](Y-BOCS < 12)	**Expert Consensus**
6-19 If a patient with obsessive-compulsive disorder does not respond to SSRI therapy with a reduction in obsessive-compulsive symptomatology of at least 25%, an increase in dose, including a level that exceeds the maximum approved dose, may be considered on an individual basis.[1] The administration of medication at doses exceeding the maximum approved doses requires close medical supervision of the patient with monitoring for possible adverse effects (see 6-4).[2] Strength of recommendation: 0	**0**

[1]Patients must be thoroughly informed about the special risks of off-label use prior to seeking informed consent to treatment, which also entails a particular physician's duty of care. [2]For Germany, the provision of §2, Abs. 1a SGB V must be considered in terms of reimbursement law.	
6-20 If a patient with obsessive-compulsive disorder does not respond to SSRI/clomipramine therapy with at least a 25% reduction in obsessive-compulsive symptoms, he/she may be switched to another SSRI or clomipramine. Strength of recommendation: 0	**0**
6-21 If treatment trials of adequate duration and dose-range with two or more different SSRIs have been ineffective (see 6-18), treatment with clomipramine may be offered. Strength of recommendation: 0	**0**
6-22 When treatment trials of adequate duration and dose-range with two or more different Serotonin Reuptake Inhibitors (SSRIs/clomipramine) have been ineffective (see 6-18), combined treatment with an SSRI and clomipramine may be considered.[1] Strength of recommendation: 0 [1]CAVE: higher risk of serotonergic syndrome.	**0**

6-23 In the treatment of patients with obsessive-compulsive disorder, the following agents are not indicated for augmentation of SSRI/clomipramine therapy: Glutamate modulators (such as riluzole, N-acetylcysteine), lithium, noradrenergic antidepressants (e.g., desipramine), buspirone. Strength of recommendation: A	**A**
6-24 If there is no response or an inadequate response to guideline-based treatment with SSRIs/clomipramine that was administered for at least 12 consecutive weeks (see 6-20 to 6-22), it is suggested that additional therapy with the antipsychotics aripiprazole[1] or risperidone[1] be offered as an augmentation strategy. If there is no response to augmentation treatment, it is suggested that the antipsychotics be discontinued after 6 weeks. Strength of recommendation: B [1]It is not approved for the treatment of obsessive-compulsive disorder in Germany.	**B**
6-25 Monotherapy with antipsychotics cannot be recommended for the treatment of patients with obsessive-compulsive disorder due to lack of evidence of efficacy and potential side effects. Strength of recommendation: expert consensus	**Expert Consensus**
	A

6-26 Augmentation of exposure therapy with D-cycloserine[1] does not enhance the effect of exposures and should not be used. Strength of recommendation: A [1]off-label	
6-27 If there is a response to SSRI treatment, it is recommended that the SSRI-treatment be continued for 1-2 years to prevent relapse. It is recommended that the discontinuation of treatment with SSRIs take place over a period of several months while regularly monitoring symptoms. Strength of recommendation: expert consensus	**Expert Consensus**

Combination of Psychotherapy and Psychopharmacotherapy

(see chapter 7 long version)

Recommendation	**Strength of Recommendation**
7-1	**A**

Psychopharmacologic therapy for obsessive-compulsive disorder with SSRIs/clomipramine should be combined with cognitive behavioral therapy (CBT) with exposures. Strength of recommendation: A	
7-2 Guideline-recommended psychopharmacotherapy with SSRIs or clomipramine may be added to cognitive behavioral therapy (CBT) with exposure to achieve a more rapid onset of action and/or in the presence of a comorbid depressive episode of at least moderate severity. Strength of recommendation: 0	**0**
7-3 In cases of inadequate treatment response to pharmacotherapy or presence of clinically still relevant obsessive-compulsive symptomatology, patients with obsessive-compulsive disorder should additionally be offered guideline-based cognitive -behavioural therapy (CBT) with exposure. Strength of recommendation: A	**A**

Biological, Non-Pharmacological Methods for the Treatment of Patients with Refractory Obsessive-Compulsive Disorder (see chapter 8 long version)

Recommendation	**Strength of Recommendation**

8-1 Repetitive transcranial magnetic stimulation (rTMS) may be used in patients with obsessive-compulsive disorder with inadequate/insufficient response to first-line treatment interventions with the goal of achieving short-term symptom relief. Strength of recommendation: 0	**0**
8-2 It is recommended not to apply transcranial direct current stimulation (tDCS) in patients with obsessive-compulsive disorder due to insufficient evidence of efficacy. Strength of recommendation: B	**B**
8-3 It is recommended not to use electroconvulsive therapy (ECT) to treat patients with refractory obsessive-compulsive disorder. Strength of recommendation: B	**B**
8-4 Bilateral deep brain stimulation may be performed after critically and carefully weighing the benefits and risks in severely ill patients with obsessive-compulsive disorder with lack of response to multiple guideline-based treatments[1]. [1]see statement 8-5	**0**

Strength of recommendation: 0	
8-5 The treatment indication for deep brain stimulation is made by psychiatric centers with expertise in this treatment intervention. Strength of recommendation: statement	**Statement**
8-6 Bilateral deep brain stimulation in severely ill patients with refractory[1] obsessive-compulsive disorder should be preferably performed only in specialized centers. Strength of recommendation: expert consensus [1]After exhaustion of guideline-compliant psychotherapeutic and medication/somatic standard treatment approaches (interventions) (strength of recommendation A) incl. recommended treatment approaches for addressing treatment resistance (esp.: Were enough exposure sessions carried out? Has inpatient treatment in a specialized center taken place? Has augmentation treatment taken place?)	**Expert Consensus**
8-7 It is not recommended to use ablative neurosurgical procedures in patients with refractory obsessive-compulsive disorder because of severe and partly irreversible side effects. Strength of recommendation: B	**B**

Treatment Goals and Involvement of Patients and Relatives

(see chapter 9 long version)

Recommendation	Strength of Recommendation
9-1 Education and information-sharing represent a high priority in the treatment of patients with obsessive-compulsive disorder and should take place as early as possible as part of the diagnostic process and to establish a trusting relationship. Strength of recommendation: expert consensus	**Expert Consensus**
9-2 It is recommended to use plain, easily understandable language and explain specialized medical terms in conversations with patients and/or their relatives. Strength of recommendation: expert consensus	**Expert Consensus**
9-3 It is recommended that psychoeducation be part of every treatment. It is recommended that caregivers, close family members/relatives and/or close relationships be involved in psychoeducation whenever possible. Strength of recommendation: expert consensus	**Expert Consensus**

9-4 It is suggested that, in addition to symptom reduction, the improvement of subjective quality-of-life of patients with obsessive-compulsive disorder be a treatment goal, including agency/activities, participation, and impact on interpersonal functioning. Strength of recommendation: expert consensus	**Expert Consensus**
9-5 Patients should be actively involved in diagnostic-therapeutic decision-making processes. Strength of recommendation: expert consensus	**Expert Consensus**
9-6 It is recommended that caregivers or close family members/relatives or close relationships be involved in the therapeutic process as much as possible. Strength of recommendation: B	**B**

Special Treatment Aspects

(see chapter 10 long version)

Recommendation	**Strength of Recommendation**
	Expert Consensus

10-1 Female patients of childbearing age with obsessive-compulsive disorder should be informed and counselled as to the importance of effective contraception before starting pharmacotherapy. The administration of psychotropic medications in patients of childbearing age should follow careful consideration of benefits and risks. Strength of recommendation: expert consensus	
10-2 Cognitive behavioral therapy (CBT) with exposures should be used as the treatment of choice for female patients with planned pregnancy, pregnant patients, and patients in the postpartum period. Strength of recommendation: expert consensus	**Expert Consensus**
10-3 It is recommended that the medication treatment only be initiated in individual cases in female patients with planned pregnancy. Patients should be informed about the possible increased risk of teratogenicity (risk of malformation) and the possible postpartum complications and should be able to understand the possible increased risk of teratogenicity (risk of malformation) and the possible postpartum complications through discussions and sharing of information. Strength of recommendation: expert consensus	**Expert Consensus**
10-4	**Expert Consensus**

The administration of psychotropic medication during pregnancy and lactation should follow a careful benefit-risk analysis and assessment that considers the individual's history, previous response to medications, the availability and potential benefits of CBT, and the preference of the affected women. Strength of recommendation: expert consensus	
10-5 To protect the foetus, it is suggested that pregnant patients with obsessive-compulsive disorder have their existing psychopharmacological therapy reduced to the lowest (absolutely) necessary therapeutic dose and it is recommended that they avoid , if possible, taking medication in the first trimester of pregnancy. Strength of recommendation: expert consensus	**Expert Consensus**
10-6 If pharmacotherapy is to be administered to pregnant patients, preference should be given to SSRI monotherapy. Attention should be paid to the following: • the lowest effective dose of SSRI should be chosen • the impact of fluctuating medication plasma levels during pregnancy should be considered • regular monitoring of drug plasma/serum levels should be performed, and a low effective drug level should be aimed for • an abrupt discontinuation of medication should be avoided. Strength of recommendation: expert consensus	**Expert Consensus**
10-7 If pregnant patients receive pharmacotherapy with SSRIs, it is recommended that a foetal sonographic fine diagnosis be	**Expert Consensus**

performed in the 20th week of gestation. It is recommended that the possible implications of the examination findings be discussed in advance with the patient and, if applicable, her partner. Strength of recommendation: expert consensus	
10-8 All psychotropic medications can elicit pregnancy and birth complications and lead to central nervous, gastrointestinal, and respiratory adaptation disorders in the newborn. If there is foetal exposure to psychotropic medications before birth, it is recommended that labor and delivery take place in a clinic with immediate access to an affiliated neonatology unit/department. Strength of recommendation: expert consensus	**Expert Consensus**

Treatment of Psychiatric and General Medical Comorbidity

(see chapter 11 long version)

Recommendation	**Strength of Recommendation**
11-1 Patients with obsessive-compulsive disorder with comorbid depressive disorder should be offered cognitive behavioral therapy (CBT) with exposure. Strength of recommendation: A	**A**
11-2	**Expert Consensus**

It is recommended that patients with obsessive-compulsive disorder with a comorbid psychiatric disorder (e.g., major depression, eating disorder, substance dependency disorder, emotionally unstable personality disorder, posttraumatic stress disorder) that substantially complicates treatment of obsessive-compulsive disorder with CBT initially receive guideline-based treatment of the comorbid disorder before treatment of obsessive-compulsive disorder. Strength of recommendation: expert consensus	

Coordination of Patients‘ Care

(see chapter 12 long version)

Recommendation	**Strength of Recommendation**
12-1 Inpatient treatment in a specialized treatment facility should be provided for obsessive-compulsive disorder, if at least one of the following criteria is fulfilled: • absence of or nonresponse to guideline-based disorder-specific outpatient treatment • danger to life • severe neglect or abandonment • the existence of compulsive and avoidant behavior that is either so severe or so habitual that carrying out a normal daily routine and engagement in outpatient therapy are no longer possible • the presence of severe distress and severe impairment of psychosocial functioning • the presence of psychiatric or general medical comorbidities that make outpatient treatment considerably more difficult • the existence of a home environment that is highly conducive to illness Strength of recommendation: expert consensus	**Expert Consensus**
	Expert Consensus

12-2 Individuals with severe obsessive-compulsive disorders who are severely impaired, especially in social and occupational functional domains, due to the compulsions and their potential sequelae, should be offered to receive intensive, especially multi-professional, outreach treatment. Strength of recommendation: expert consensus	
12-3 If there is inadequate response to treatment, it is recommended to carefully monitor whether guideline recommendations for treatment have been applied. Strength of recommendation: expert consensus	**Expert Consensus**
12-4 Culture- and migration-specific factors should be considered in the context of anamnesis, diagnosis, and treatment of obsessive-compulsive disorder. Strength of recommendation: expert consensus	**Expert Consensus**
12-5 Consideration of culture-specific models of illness and treatment in the context of shared joint decision-making facilitates treatment acceptance and therapeutic cooperation (treatment adherence). Strength of recommendation: statement	**Statement**

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