Medications for OCD

SSRIs at higher doses, clomipramine, atypical augmentation, and ERP as the therapy anchor. Reviewed against current guidelines as of June 8, 2026.

SSRIs at higher doses than typical for depression are first-line for OCD, alongside exposure and response prevention (ERP). Clomipramine matches or slightly beats SSRIs in some meta-analyses at the cost of a heavier side effect burden. When SSRI plus ERP isn't enough, low-dose atypical antipsychotic augmentation is the standard next step. Companion to the full guide at psychiatryrx.org/guides/medications-for-ocd/.

First-line options

Drug	Class	Notes
Fluoxetine	SSRI (FDA-approved)	20 to 80 mg. Higher end (60 to 80 mg) is common in OCD. Long half-life.
Sertraline	SSRI (FDA-approved)	50 to 200 mg. Practical default. Cheap and tolerable.
Fluvoxamine	SSRI (FDA-approved)	100 to 300 mg divided. Strong CYP1A2 inhibitor, many interactions.
Paroxetine	SSRI (FDA-approved)	20 to 60 mg. Works but side effect and discontinuation profile limits use.
Escitalopram	SSRI (off-label)	10 to 40 mg. Higher doses have been used off-label in OCD with QT caution.
Citalopram	SSRI (off-label)	QT cap (40 mg most adults, 20 mg over 60) limits headroom.
Clomipramine	TCA (FDA-approved)	100 to 250 mg. Strong serotonergic. Matches or slightly beats SSRIs in some meta-analyses. TCA side effect burden. Baseline ECG.
ERP therapy	Psychotherapy	The therapy anchor for OCD. Larger effect than medication in most trials. Combined outperforms either alone.

Second-line and augmentation

Drug	Class	When to consider
Risperidone	Atypical antipsychotic	0.5 to 2 mg. Most trial evidence for OCD augmentation. Particularly effective in tic-related OCD.
Aripiprazole	Atypical antipsychotic	5 to 15 mg. Evidence for OCD augmentation with favorable metabolic profile.
Haloperidol	First-gen antipsychotic	0.5 to 2 mg. Evidence in tic-related OCD.
SSRI plus clomipramine	Combination	Refractory OCD. Careful monitoring for serotonin syndrome and cardiac effects. Fluvoxamine plus clomipramine needs level monitoring.
N-acetylcysteine (NAC)	OTC glutamate modulator	2400 to 3000 mg divided. Small trials, particularly for trichotillomania and BFRBs.
Memantine	NMDA antagonist	10 to 20 mg. Small trials as augmentation with mixed results.
dTMS (Brainsway)	Neuromodulation	FDA-cleared for OCD.
DBS or gamma knife capsulotomy	Neurosurgery	Severe refractory OCD after multiple failed trials. FDA humanitarian device exemption for DBS.

Special considerations

- Doses run higher than in depression. Sertraline 200 mg, fluoxetine 60 to 80 mg, fluvoxamine 200 to 300 mg are common endpoints. Stopping at typical depression doses without full response is a common miss.
- Timeline: OCD response is slower than depression response. Give a therapeutic dose 10 to 12 weeks before judging.
- Pediatric OCD: sertraline and fluoxetine are FDA-approved for children. Fluvoxamine has approval in children and adolescents. CBT with ERP is first-line in children. PANDAS/PANS is a separate consideration in abrupt-onset OCD.
- Pregnancy: sertraline is the most-studied. Fluoxetine has extensive reproductive data. Paroxetine is avoided in the first trimester.
- Older adults: escitalopram and sertraline are usually well-tolerated. Fluvoxamine's interactions limit use. Avoid clomipramine (Beers, anticholinergic).
- Bipolar comorbid: SSRIs at high doses in undiagnosed bipolar can trigger mania. Mood stabilizer first, then SSRI titrated cautiously.
- Tic-related OCD: atypical augmentation is particularly useful.

What tips the choice

Newly diagnosed OCD with no strong comorbidity signal: sertraline or fluoxetine, titrated to the high end. Give it 10 to 12 weeks. Prefer once-daily dosing: fluoxetine or sertraline. Tic-related OCD: SSRI plus low-dose risperidone or aripiprazole. Partial response after adequate trial: augment with an atypical, or switch to a different SSRI or to clomipramine. Two SSRI failures: clomipramine, plus atypical augmentation. Refractory to all first and second line: intensive ERP program, dTMS, or specialty referral for DBS. Pediatric: CBT with ERP first, add sertraline or fluoxetine for moderate to severe. Pregnancy: sertraline or fluoxetine.

Watchouts

- Bupropion does not work for OCD and can worsen anxiety. Wrong pick if OCD is dominant.
- Chronic benzodiazepines interfere with ERP extinction learning. Avoid as chronic treatment.
- Clomipramine: anticholinergic burden, orthostasis, weight gain, cardiac risk in overdose, seizure risk at higher doses.
- Fluvoxamine plus clomipramine: 1A2 inhibition raises clomipramine levels. Check levels.
- Higher SSRI doses raise QT risk. Citalopram and escitalopram caps matter here.
- Hoarding disorder (separate DSM-5 diagnosis) responds less to SSRIs than OCD does. Hoarding-specific CBT is primary.

Reviewed against current guidelines as of June 8, 2026. Educational reference, not medical advice.