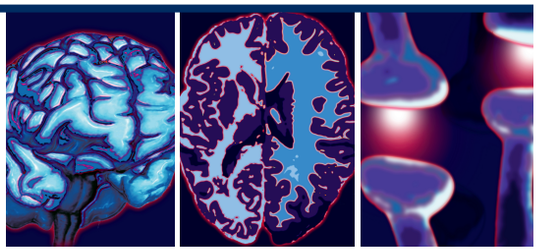
EDITORIAL



Obsessive–compulsive disorder: how should we manage treatment nonadherence?

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"...obsessive–compulsive disorder frequently results in significant costs and reduced quality of life for those affected and their families."

Obsessive–compulsive disorder (OCD) is characterized by recurrent and persistent thoughts, urges or images that are difficult to resist and cause marked anxiety or distress, and/or repetitive behaviors or mental acts that are performed to reduce the anxiety or according to specific rules [1]. According to a review on the epidemiological studies reporting OCD related data, the 1-month prevalence of OCD ranges from 0.3 to 3.1% of the general population [2]. Importantly, OCD frequently results in significant costs and reduced quality of life for those affected and their families [1,3]. In a recent study, OCD ranked 10th on the Global Burden of Mental, Neurological and Substance-Use Disorders, a position based on the number of future years of healthy life that are lost as a result of the premature deaths or disability occurring in a particular year [4]. Pathophysiological models of OCD involve a complex interaction between genetic diathesis and environmental factors (e.g., birth complications, traumatic events and infections) leading to neurochemical abnormalities (involving serotonin and dopamine) and increased activity of brain corticostriatal circuits [5,6]. In OCD, treatment entails administration of serotonin-reuptake inhibitors (SRIs) and/or cognitive-behavioral techniques, including psychoeducation, exposure and response prevention (ERP), and cognitive restructuring [1].

The first question in the treatment of OCD is which treatment should be tried first, SRIs or ERP? Although some have suggested that ERP should be tried first, there is conflicting evidence on its efficacy for depressed patients with OCD [7]. Since many patients with OCD exhibit comorbid major depression, particularly those who seek treatment in specialized services [8], SRIs are frequently the treatment of choice, especially among patients with severe OCD and multiple comorbid conditions. Different SRIs were tested and proved effective in the treatment of OCD, including clomipramine, fluoxetine,

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fluvoxamine, paroxetine, sertraline, citalopram and escitalopram [9]. It is now known that these drugs should be administered in high doses for at least 3 months before any judgment on treatment resistance is made [9]. If patients show no response, a trial with a second SRI should be performed. If there is partial response, augmentation strategies, such as atypical antipsychotics, can help some patients. Whether ERP can be added, if needed, in later stages of treatment is an interesting question. Controlled studies suggest that ERP is superior to stress management therapy for the first 2 years of SRI-resistant OCD [10]. Conversely, SRIs (fluvoxamine) have also been proven to be superior to cognitive therapy among patients who did not respond favorably to ERP [11].

Although it is reasonable to speculate that poor treatment adherence in OCD prolongs suffering and increases economic costs, no clear information on the clinical, functional and economic impact of treatment nonadherence is currently available [12]. Identifying the correlates and/or risk factors for treatment nonadherence in patients with OCD would help guide clinicians to develop more effective strategies to maintain patients on an established therapeutic plan. Nevertheless, treatment adherence has only been investigated rarely. Regarding ERP, which is the main psychotherapeutic intervention for OCD, there are only a few studies but they have consistently shown that better adherence to assignments between sessions is associated with better outcome in both the short and long term [13,14]. Although it is highly intuitive that compliance with pharmacological treatment might have the same effect in regards to outcome, this has not been systematically assessed.

As expected, in OCD, predictors of better adherence to psychotherapeutic treatment include better therapeutic alliance and higher treatment readiness [15]. Hoarding symptoms have been associated with poor adherence to ERP [15] and to greater chance of refusing ERP [16]. Poor insight and greater severity have been associated with higher medication refusal [16]. Regarding the chance of abandonment of pharmacological treatment, comorbid major depression has been decribed to diminish the chance of abandonment [17]. While another study has shown that comorbid agoraphobia, social phobia, generalized anxiety disorder and somatization disorder increase the chance of abandonment [18].

In OCD, as in other medical conditions or psychiatric disorders, working to improve patients' compliance with professionals' advice is, to say the least, challenging. Some work has been carried out to evaluate if motivational interviewing techniques adapted from the drug and alcohol dependence protocols could help to better engage OCD patients with treatment. Simpson *et al.* were unable to show that adding motivational interviewing to an ERP protocol yielded better adherence or outcome than when the ERP protocol was applied alone [19]. Several factors may have contributed to these negative results, including the small sample size (n = 30, 15 in each intervention group) and good baseline adherence to ERP assignments in both groups. Consequently, there was not much room for improvement of adherence to start with, this is also called a ceiling effect. On the other hand, previous studies have shown that adding motivational interview to ERP protocols could yield better treatment acceptance among patients who have refused ERP before [20] and accelerate improvement [21]. Therefore, motivational interviewing is still a promising intervention to improve adherence in OCD for those who show poor baseline adherence. The efficacy of this intervention should be further investigated in controlled trials.

Regarding pharmacological intervention, there is some evidence that reducing the length of intervals between medical appointments (seeing patients every 2 weeks instead of every month) might be helpful to prevent early treatment abandonment [18]. Likewise, as OCD patients with comorbid generalized anxiety and somatization disorder are more prone to abandon treatment due to medications' side effects, it might be helpful to assign these patients to psychotherapy whenever possible and to carefully choose drugs with better side-effect profiles for each specific patient [18]. There is also evidence that selective SRIs are associated with better treatment adherence than clomipramine due to the side-effect profile of the later [22].

In summary, OCD patients may not respond to treatment as a consequence of poor adherence at least as frequently as in other psychiatric disorders. Some factors have been shown to predict higher chance of low adherence, treatment refusal or abandonment. Add-on motivational interviewing and reduced intervals between consultations are the most promising interventions for improving adherence, and decreasing refusal and abandonment.

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