WORKSHOP

[W-04]

Obsessive-Compulsive Disorder: From Frustration to Success. Pharmacological and Psychotherapeutic Treatment Approaches

Axel Würz

Guest Lecturer,Department of Psychiatry, Marmara University, Istanbul - Turkey
E-mail address: kontrolsende@kontrolsende.org

Obsessive-compulsive disorder (OCD) is characterized by obsessions (intrusive thoughts) and compulsions (repetitive ritualistic behaviours). OCD is linked with underlying dysregulation of the fronto-striatal, but also the amygdalo-cortical circuitry. Despite this progress in understanding the pathophysiology in OCD many patients' treatment remains insufficient.

Available pharmacological treatments such as SSRIs have a rate of non-responders of more than 40% and even responders often show only a partial improvement. A considerable number of patients do not improve even with pharmacological augmentation strategies. Psychotherapeutic treatments in form of Cognitive Behavioural Therapy (CBT) with Exposure and Response-Prevention (ERP) have a success rate of up to 80% in patients who complete an adequate course of treatment, but availability of trained therapists and drop-outs from therapy are a challenge.

Further obstacles to effective treatment are delays in diagnosis and commencement of treatment as well as insufficient implementation of existing treatment guidelines.

In order to avoid frustration for the doctor as well as for the patient it is useful to see OCD as a chronic vulnerability that can best be successfully managed if the patient is empowered to understand how both OCD and available treatment 'work'. This means that even if pharmacological treatment is chosen, thorough psychoeduction about OCD and the treatment is essential. Both for the doctor and the patient it is an important step to understand that medications in OCD (e.g. SSRIs or clompiramine) take several weeks to show effects. Together with the need to increase the dose stepwise this means that starting and adjusting medications in OCD is a process that requires time and patience. As understandable as the urge to quickly start, stop and combine medications is, it runs the great risk of counterproductive polypharmacology, where the potential usefulness of the individual substances remains unclear and the risk of side-effects is high. While there are efforts being made to explore the possibilities of new agents in OCD that e.g. act on glutamate receptors, the base of pharmacological therapy is still constituted by SSRIs, clomipramine and if needed a combination with dopamine-blocking agents. There have been some valuable attempts to take the use of e.g. dopamine-blocking substances from the level of case-reports and 'expert opinions' to the level of randomized controlled trials and meta-analyses.

Even for moderate to severe OCD cognitive behaviour therapy has been demonstrated to be effective in between 60 to 80% of patients. In very severe OCD a combination therapy of CBT and medication is often used, although the exact benefit of a combined approach is not fully known. Current research tries to determine the relapse-preventing effect of CBT and gain insight in moderators of treatment success. Furthermore, attempts are being made to increase availability of CBT in various formats.

A crucial component of CBT is psychoeducation to help the patient understand how OCD develops and is maintained. Together with motivational strategies and goal-setting it is helpful to reduce drop-our rates during the 'Exposure and Ritual Prevention' exercises that form another key component. Further components are cognitive strategies (e.g. learning about cognitive distortions in OCD) and family-interventions (how should family members react to obsessions and compulsions) and relapse prevention strategies. Optional components that can be integrated according to the individual patient are distancing techniques, treatment-buddy system and paradoxical interventions.

Patients even with severe OCD can in the majority of cases regain a fulfilling life, which is a rewarding experience for any treating psychiatrist but to achieve this it is necessary to help the patient to understand OCD and its treatments and follow treatment guidelines with care and patience aiming at long-term success.

Key words: Obsessive-compulsive disorder, treatment

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