OCD

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Obsessive-Compulsive Disorders (OCD) can interfere significantly with a patient's life but has a reputation of being more difficult to treat. However, with a combination of psychotherapy and medication the success rates are quite high, and in the clear majority of cases a significant reduction in obsessive thoughts and/or compulsive behaviors can be achieved. Communication-Focused Therapy (CFT) as developed by the author is a therapeutic approach which focuses on the awareness, analysis and change of unhelpful internal and external communication patterns.

Keywords: OCD, obsessive-compulsive disorder, communication-focused therapy, CFT, cognitive-behavioral therapy, CBT, psychodynamic psychotherapy, treatment, psychotherapy, medication, psychiatry

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Introduction

Obsessive thoughts and compulsive behaviors, or both, can significantly interfere with a person's life, whether at the workplace or in the relationship, or in another area of life. Obsessive thoughts are not necessarily the intrusive thoughts, which most people have to some degree, but the anxious reaction to them and the constant preoccupation with them. Compulsive behaviors are behavioral patterns which are repeated to give the patient a short relieve from a heightened state of anxiety. However, neither the preoccupation with obsessive thought nor the engaging in compulsive rituals brings about a decrease of the associated anxiety in the long-run. Rather, repeated engagement with the thoughts and behaviors leads to tolerance and their anti-anxiety effect declines. In the long-run, this leads to a greater need to engage with obsessive thoughts and compulsive rituals.

Psychotherapy and medication in combination are frequently the required approach to the successful treatment of OCD. Psychotherapy alone does work in the long-run, but patients often need a reprieve also in the short run to avoid serious consequences on the job, in the relationship or in another important setting in life. However, even medication can take days to months to work, and there is also no guarantee that a particular drug works. In several cases, switching to another medication or an augmentation with another substance appears necessary.

Overvalued Ideation

Overvalued ideation, particularly the idea that the own OCD is special and has a deeper value, is frequently seen. These overvalued ideations probably make the OCD more resistant to treatment. It may even be that the patient does not seek treatment in the first place, unless the symptoms have reached a level where they are significantly interfering with the patient's life.

In a 2006 study by Tolin et al, relative to patients with anxiety and non-clinical controls, OCD patients more strongly endorsed beliefs related to threat estimation, tolerance of uncertainty, importance and control of thoughts, and perfectionism, but not inflated responsibility. Using revised, condensed subscales, OCD patients differed from patients suffering from anxiety on beliefs about perfectionism and certainty and about importance and control of thoughts, but not on beliefs about threat estimation and inflated responsibility. When controlling for depression and trait anxiety, the OCD and anxiety group did not differ on most belief domains,

except for a belief that it is possible and necessary to control one's thoughts. (Tolin, Worhunsky, & Maltby, 2006)

Obsessions

Obsessions and compulsions are not hypothesized to occur simultaneously, but rather sequentially. The presumed temporal sequence of obsessions and compulsions has been pivotal to diagnostic accounts of OCD, including the DSM-5 (APA, 2013) stipulation that compulsions are behaviors that individuals feel "driven to perform in response to an obsession" (APA, 2013, p. 237), as well as cognitive behavioral frameworks, where obsessions are interpreted as being particularly meaningful, thus producing distress, and compulsions are then performed to reduce that distress (Purdon, 2008; Rachman, 1997, 1998; Rachman & Hodgson, 1980; Salkovskis, 1985; Taylor, Abramowitz, & McKay, 2007).

After examining four competing models of the relationship between obsessions and compulsions, data from the current study revealed that the goal-directed model was the best fit, demonstrating bivariate longitudinal coupling and confirming the directional, functional relationship between obsessions and compulsions. This finding lends support for the long-presumed DSM criteria that individuals with OCD feel driven to perform compulsions in response to their obsession. (Laposa, Hawley, & Grimm, 2018) It is not entirely clear, however, that this confirms the assertion of the CBT model that obsessions increase anxiety, and individuals with OCD manage the anxiety resulting from their obsessions by engaging in compulsions.

Internal and External Communication Patterns

OCD makes causal links between a thought or a ritual and a desired outcome seem more real than it could be. A belief in possibilities, including that a thought can turn into real change in the world, is in itself not a bad thing, and there may be evolutionary arguments for a benefit from overestimating one's abilities in this regard, but the obsessive thoughts and compulsive rituals do not lead to anything constructive in the world that could help the patient. They merely suppress the anxiety and tension a patient is experiencing. In that respect they can bring short-term relief, but lead to a 'dose' escalation and tolerance in the long-run. As dopaminergic pathways also seem to play a role in OCD, a semblance to addiction may not be so surprising.

Internal communication and external communication are tightly linked.(Haverkampf, 2010a, 2012, 2018b, 2018h) Whether one is communicating through a compulsion with the outside world or in spiraling thought loops on the inside the repetitive patterns rather than the content are what seems to relieve a measure of anxiety. One may ask what distinguishes these communication patterns from the ones we use all the time. In OCD there is no other, neither oneself nor another person. The individual suffering from OCD engages in external and

internal communication patterns which do not communicate a message to another. They are more akin to self-soothing exercises which spin into nowhere, and over time do not soothe.

Working on internal and external communication patterns, creating awareness, reflecting on them and experimenting with change allows to adjust these patterns so that they can be helpful again. The process also raises the sense of efficacy and self-confidence in the patient.(Haverkampf, 2010b, 2017g, 2018c, 2018b)

Symptoms

Obsessive–compulsive disorder (OCD) is a mental disorder where people feel the need to

- check things repeatedly
- perform certain routines repeatedly (called "rituals"), or
- have certain thoughts repeatedly.

Patients are unable to control either the thoughts or the activities for more than a short period of time. If one tries to suppress the urge to do or think something, nervousness, anxiety and uneasiness occur.

There is still a major debate on the subtypes of OCD. However, subtypes that are frequently mentioned are as follows:

- Checking
- Contamination / Mental Contamination
- Symmetry and ordering
- Ruminations / Intrusive Thoughts
- Hoarding

The behaviors and thoughts can occur in many different forms. There are some common themes, which are encountered frequently, such as the fears that one is contaminating oneself, intense repeating worries about carrying out pedophilic acts or counting up and down numbers. Behaviors may be touching things, skipping certain markings on the floor or carrying out behaviors repeatedly. Some may have more obsessive thoughts, others more compulsive behaviors, while a third group experiences both about equally.

Often there is anxiety provoking thought or feeling in the beginning, while over time the rituals become more or less automatic. But in any case, if one tries to suppress them, the anxiety and nervousness goes up. It is as if the ritual has become the norm. However, since it does not lead to any constructive change, it is experienced as something empty which then leads to even more of the behavior to ‘make it work’.

Epidemiology

Obsessive–compulsive disorder may not be detected by other people as it is often attached with shame and guilt. It affects about 2% to 3% of people at some point in their life. Half of people develop problems before twenty, and it is rare to occur for the first time after age thirty-five. Males and females are affected about equally. If it occurs at a more advanced age, it is always advisable to search for other non-psychiatric explanations.

Diagnosis

The diagnosis is based on the symptoms and requires ruling out other drug related or medical causes. [2] It is best assessed in the communication between therapist and patient. (Haverkampf, 2010b) External communication and internal patterns are quite specific for OCD. Even if a patient does not engage in a ritual visibly, there are certain features which are also apparent when interacting with the patient for a while. There also seems to be a higher than expected frequency of OCPD in first degree relatives of OCD probands, which suggests that OCD associated with OCPD may represent a specific subtype of OCD. (Coles, Pinto, Mancebo, Rasmussen, & Eisen, 2008).

Obsessive-Compulsive Personality Disorder (OCPD)

Although the relationship between obsessive-compulsive disorder (OCD) and obsessive-compulsive personality disorder (OCPD) has long been debated, there seem to be some distinguishing features between the two.

Obsessive-compulsive personality disorder (OCPD) is a personality disorder that's characterized by extreme perfectionism, order, and neatness. OCPD is defined as the preoccupation with perfectionism, orderliness, and control. Individuals with OCPD tend to be inflexible and rigid. They pay extreme attention to details and rules so much so that it can interfere with their ability to complete a task. They become so excessively devoted to work and being 'productive,' that they neglect their friends and family. Their preoccupation leaves little room for recreational or leisurely pursuits. Some traits of individuals suffering from OCPD are as follows:

- They find it hard to express their feelings.
- They have difficulty forming and maintaining close relationships with others.
- They're hardworking, but their obsession with perfection can make them inefficient.
- They often feel righteous, indignant, and angry.
- They often face social isolation.
- They can experience anxiety that occurs with depression.

OCD and OCPD patients both show impairment in psychosocial functioning and quality of life, as well as compulsive behavior, but only subjects with OCD reported obsessions. In a study by Pinto et al, Individuals with OCPD, with or without comorbid OCD, discounted the value of delayed monetary rewards significantly less than OCD and healthy control subjects. This excessive capacity to delay reward discriminates OCPD from OCD and is associated with perfectionism and rigidity. (Pinto, Steinglass, Greene, …, & 2014, n.d.) Less temporal discounting is probably suggestive of excessive self-control. Individuals with substance use disorders, for example, show greater discounting, which is suggestive of impulsivity.

Rating Scales

There are several rating scales of OCD, although the most prominent one among them is the Yale-Brown Obsessive Compulsive Scale (Y-BOCS). However, it should be kept in mind that the diagnosis always requires the actual interaction between diagnostician and patient. (Haverkampf, 2014) Observing internal and external communication dynamics is an important part of the process, particularly in view of a first therapeutic approach.

Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

was designed to remedy the problems of existing rating scales by providing a specific measure of the severity of symptoms of obsessive-compulsive disorder that is not influenced by the type of obsessions or compulsions present. The scale is a clinician-rated, 10-item scale, each item rated from 0 (no symptoms) to 4 (extreme symptoms) (total range, 0 to 40), with separate subtotals for severity of obsessions and compulsions. In a study involving four raters and 40 patients with obsessive-compulsive disorder at various stages of treatment, interrater reliability for the total Yale-Brown Scale score and each of the 10 individual items was excellent, with a high degree of internal consistency among all item scores demonstrated with Cronbach's α coefficient.(Goodman et al., 1989)

Toronto Obsessive-Compulsive Scale (TOCS)

Compared to previously developed OC scales, the Toronto Obsessive-Compulsive Scale (TOCS) is a reliable, dimensional measure of OC traits with the following advantages: (1) a scale which allows the measurement of a wider distribution of OC traits; (2) items which comprise a comprehensive, multidimensional measure of OC traits; and (3) a way to collect information from both children and parents. In conclusion, the TOCS demonstrated sound psychometric properties. (Park et al., 2016)

Co-Morbidity

OCD seems to be more common in patients suffering from anxiety and/or depression. Some OCD like symptoms may also appear in psychosis. However, OCD can often does occur by itself, especially in cases of predominantly intrusive thoughts.

Anxiety

Anxiety is often present in patients suffering from OCD. In DSM-III, DSM-III-R, and DSM-IV, obsessive–compulsive disorder (OCD) was classified as an anxiety disorder. In ICD-10, OCD is classified separately from the anxiety disorders, although within the same larger category as anxiety disorders (as one of the "neurotic, stress-related, and somatoform disorders"). Ongoing advances in our understanding of OCD and other anxiety disorders have raised the question of whether OCD should continue to be classified with the anxiety disorders in DSM-V. However, empirical evidence supports the recommendation that OCD be retained in the category of anxiety disorders but that this category also includes OC-spectrum disorders along with OCD. (Stein et al., 2010)

Causes

The etiology of OCD seems to be multifactorial. So far, no single mechanism has been found which could explain OCD to a large extent. There appear to be some genetic components with both identical twins more often affected than both non-identical twins. OCD seems to have a large genetical component, which can affect the likelihood of certain patterns of processing information. The most important early step in therapy is to create awareness for how information is processed and the communication patterns that are being used. At the same time, medication can be a support to be free enough from anxiety and engaging in time consuming rituals to allow awareness, insight and experimentation.

Neurobiology

Differences in processing in the cortico-striato-thalamo-cortical feedback loops may play a role in OCD. This has also been referred to as the Executive Dysfunction Model. However, since the networks in the brain are highly interconnected, influences from other brain centers may trigger and maintain the phenomenology of the typical OCD symptoms. Anxiety, for example, plays a large role in OCD, and if patients feel more anxious OCD like behavior seems to increase. Suppressing OCD rituals, on the other hand, often leads to an increase in anxiety.

Life Experiences

Most adults realize that the behaviors do not make sense. However, often the rituals have common themes, that can frequently by traced to a patient's individual history or current situation. This is then the task of psychotherapy.

Medical Issues

Some cases of OCD have been documented to occur following infections, and then frequently in a more severe form. In these cases, treating the infection has priority. Lyme diseases (borreliosis) in later stages appears associated with a higher incidence of OCD. Unfortunately, in the latter case, and possibly in all those cases with permanent tissue changes, OCD can be more therapy resistant, drug combinations may have to be used to make the OCD manageable and the response time can be longer.

Treatment

Treatment involves psychotherapy and counselling, such as psychodynamic (psychoanalytic) psychotherapy and cognitive behavioral therapy (CBT) and, and quite often medication, typically selective serotonin reuptake inhibitors (SSRIs). The psychotherapy should lead to a long-term remission, while the medication can offer considerable support in the face of the often very unsettling and life interfering symptoms. However, it is also important to keep in mind that in the majority a full remission is usually not to be expected. In many cases if the symptoms decrease by at least 40% this is often seen as a success. However, in individual cases it is often in clinical practice possible to achieve more substantial remissions. The communication between therapist and patient and a greater focus on internal and external communication seems to play significant roles.

Psychotherapy

There are various psychotherapeutic approaches that have shown a mild to moderate effectiveness when it comes to the treatment of OCD. In many cases, a partial remission, even if it is only at 40%, is seen as a success. Treatment success also does not seem to depend as much on the therapeutic approach used, but more on factors within the person of the therapist and patient, as well as the interpersonal interactions and relationship between them. Communication-Focused Therapy® (CFT) as developed by the author addresses this through greater awareness of and influence on the communication level. (Haverkampf, 2018c) As communication can be analyzed on the levels of information, meaning and dynamics, this therapeutic approach has also a good inherent fit between theory and practice. (Haverkampf, 2018a, 2018f)

CFT has been used successfully in a large number of psychiatric conditions, from anxiety to psychosis. (Haverkampf, 2017f, 2017c, 2017g, 2017i, 2017h, 2017e, 2017d) An overview of the treatment of different conditions (Haverkampf, 2018c) and techniques (Haverkampf, 2017j, 2018d, 2018e) has been provided the author elsewhere.

Cognitive-Behavioral Therapy (CBT)

CBT for OCD involves increasing exposure to what causes the problems while not allowing the repetitive behavior to occur. However, it could also take an approach more targeted at the cognitions, the thoughts themselves. CBT uses a broad catalogue of techniques and manuals. One potential drawback of CBT is that its effect may not persist as long and in intervals 'booster' sessions may be required.

Psychodynamic Psychotherapy

Psychodynamic (psychoanalytic) psychotherapy looks at possible causes for the OCD. Often, there are intrapsychic processes that maintain the rituals and obsessive thoughts. In most cases, people are not aware of repressed emotions or inner conflicts that maintain the OCD. In therapy, these processes can be made aware, which frequently leads to a gradual remission of the symptoms.

The psychodynamic approach often takes longer and involves a greater number of sessions. However, as people develop a greater sense of their condition and themselves, this can be helpful in reducing OCD rituals, as well as levels of anxiety and even mood disorders. Underlying emotional conflicts, and psychological stress in general, in clinical practice usually frequently increases anxiety and the urge to engage in obsessive thoughts or compulsive rituals.

Communication-Focused Therapy® (CFT)

Communication-Focused Therapy (CFT) was developed by the author to focus more precisely on the mechanism which underlies many forms of psychotherapy, communication. Focusing more closely at the communication patterns of the patient, beginning with the ones that can be observed and reflected upon in the therapeutic session, strategies for better communication with others and oneself can be developed. While patients are usually unsuccessful in thinking themselves out of an obsessive thought, they can develop an understanding for it, which then often lowers the level of obsessive thinking considerably. This, however, requires a better connection and flow of information with oneself.

CFT acknowledges the tight link between internal and external communication, where communication is the encoding, transfer and decoding of meaningful messages. Meaning,

once it is extracted form a message, always leads to a change in the receiver of the message. Thus, working with meaning can lead to therapeutic success if it is used correctly.(Haverkampf, 2010b, 2017b)

Manualized therapies have not shown the success they were at some point believed to promise. (Schiepek, 2009) A communication focused approach is more individualized because communication patterns vary among people, internal factors and external situation. However, they all adhere to underlying rules and structures which can be observed, investigated and understood. (Haverkampf, 2010a, 2017b, 2018a)

In an interpersonal interaction, as in a therapy session, one observes the external communication, which, however, reflects internal communication in many ways. Internal and external communication are not mirror images of each other, but they depend on each other and are linked in more or less predictable ways. Understanding these links is helpful to patient and therapist in a therapeutic setting. (Haverkampf, 2010a, 2012, 2013, 2018g)

Meaning

Meaningful information induces changes in the recipient, and this is also what defines a message as potentially meaningful. Humans need to induce change in themselves and their environment in order to fulfil their needs, values and aspirations. A seemingly simple, but all too often overlooked need is, for example, happiness. Communicating meaningful messages with oneself and others can bring about the changes that lead to greater happiness and contentment, even if the message is that one needs to accept the current state and has no control over it. CFT looks at the encoding and decoding of information and messages, but focuses also on the communication patterns individuals use to send and receive information internally and externally. (Haverkampf, 2017b)

OCD and the Individual

The person is born form communication, while the self comes from the awareness of communication flows. (Haverkampf, 2010a) As the communication patterns one uses internally and externally determine the communication flows with other people, and the success or failure of one's interactions with them, communication-focused therapy focuses on greater awareness, reflection, insight and experimentation in relation to them. (Haverkampf, 2010b, 2017b) The condition can thus be used to learn more about oneself and evolve and develop as a human individual.

Anxiety Reduction

A direct causal link between anxiety and OCD has not been demonstrated. However, in clinical practice it is frequently observed that a decrease in anxiety symptoms is usually correlated with a decrease in OCD symptoms. One cannot necessarily derive from this a causal relationship form one to the other, but it at least means that something has changed further upstream in a helpful way. CFT aims at accomplishing this by removing not only conflicts but also by helping the patient suffering from either anxiety or OCD or both to have a greater sense that the own needs, values and aspirations are met internally and within the external environment. (Haverkampf, 2014) This is supported by the frequent clinical observation that OCD and anxiety are related to interpersonal experiences and triggers, whether in the present or in the form of memorized information, or as an imagined view or reflection of the future.

Communication Patterns and Structures

CFT works through interactions, communication among people, which reflect interpersonal information flows. (Haverkampf, 2018d) Feedback, which plays an important role, comes in the form of different communication patterns. But, at the same time, feedback, is only one group of communication patterns, as there are many others. Various tools can help to increase the awareness for and reflect on these communication patterns, followed by experimentation with them in the real world, which also has an effect on internal communication patterns.

One foundation of CFT is that meaningful information brings about change in the recipient. (Haverkampf, 2010b, 2017a) Since meaningful information is after all information that is being communicated, how an individual communicates information internally and externally plays a significant role.

CFT vs CBT

The argument has been made by this author that cognitive and behavioral approaches are effective because they inherently bring about a change in internal and external communication patterns, albeit indirectly. Several empirical studies have shown that ERP and cognitive restructuring are effective in reducing the symptoms of OCD, anxiety and other conditions. (Rosa-Alcázar, Sánchez-Meca, Gómez-Conesa, & Marín-Martínez, 2008) Organisms use information to organize, equilibrate and evolve internally and in interactions with their environment. As the plasticity of the brain allows for new meaningful information to change networks and properties of individual connections that are involved in the processing of future information, so are physical, chemical, biological and psychological processes ultimately based on information and its communication. Communication-focused therapy aims at elucidating the patterns, mechanisms and structures that are common where information is communicated. (Haverkampf, 2018d)

From a communication perspective it may be that the communication relationship between therapist and patient is at least as effective as actually carrying out the ERP instructions. The important criterion is to what extent internal and external communication patterns become aware and change can be induced through meaningful messages.

Patient Perspectives, Beliefs and Expectations

Perspectives, beliefs and expectations are a result of information and of how this information is processed by the individual. At the same time, they influence and modulate how information will be processed in the future. Just supplying different information is often not as helpful. The patient needs to see what is happening. Sometimes an explanation can be helpful, but this is mostly only in support of greater awareness of the communication patterns the patient uses. Through techniques that are used in CFT, this process of generating greater awareness, insight and experimentation with communication can integrate with the own autoregulatory processes, and so lead to a highly individualized therapy, which can then even be continued by the patient with occasional consultations with the therapist.

Mindfulness

Fighting or trying to think oneself out of a spiraling thought usually just means an even greater engagement with the obsessive thoughts. Another strategy is to let the thoughts pass by as if one were sitting at a train station and letting the train pass by rather than getting on it. Research and empirical observations show that if one disengages from the thoughts, they tend to become less over time, although there may be a temporary increase and peak in the beginning.

Medication

On the medication side, the selective serotonin reuptake inhibitors (SSRIs) should be considered first line of treatment. The tricyclic antidepressant clomipramine appears to work as well as the SSRIs, but it has greater side effects than the SSRIs, probably because it is less selective. Atypical antipsychotics may be useful when used in addition to an SSRI in treatment-resistant cases but are also associated with an increased risk of side effects. However, it is not entirely clear how useful antipsychotics are in the treatment of depression, and which are the more effective ones.

Selective serotonin reuptake inhibitors (SSRIs) remain the pharmacological treatment of choice for most patients and are associated with improved health-related quality of life. However, discontinuation is associated with relapse and loss of quality of life, implying that

they should always be combined with psychotherapy as a long-term approach, and if they are discontinued this is best done gradually over weeks, but better even over months to reduce.

A substantial minority of patients fail to respond to SSRI. Such patients may respond to strategies such as increasing the dose or adding on an antipsychotic, although long-term trials validating the effectiveness and tolerability of these strategies are relatively lacking. Still, it should be kept in mind that the dose required of an SSRI to achieve a clear response is mostly at the higher end, such as 150-200 mg sertraline, 60 mg fluoxetine and so forth. Newer compounds targeting other neurotransmitter systems, such as glutamate, are undergoing evaluation. (Fineberg, Brown, Reghunandanan, & Pampaloni, 2012)

Selective Serotonin Reuptake Inhibitors

Medication can take weeks, and in the case of OCD often months until a patient feels a clear positive effect. SSRIs can frequently lead to an increase in OCD symptoms in the first days or the first week. Some patients may have to wait several months for a significant effect, while there is research that shows that it may even take half a year or longer in a number of cases. The time lag can make it difficult to decide whether to stay on the current medication or switch it for another one. In such cases, it is usually helpful to assess the situation by looking at the whole picture of changes since the medication was started. A small positive effect in the beginning, as well as transient diffuse side effects early on, can be signs for justified hopefulness a couple of weeks or months further down the road. However, this should always be viewed with the particular individual in mind.

There is considerable empirical evidence that clomipramine is effective against obsessive thoughts in adults and children and that it is superiority over tricyclic antidepressants and monoamine oxidase inhibitors. (Fineberg et al., 2012) The most sensible explanation that the effectiveness of clomipramine was related to its highly serotonergic properties marked an important step away from the use of tricyclic antidepressants and monoamine oxidase inhibitors, which could have considerable side effects, and particularly the latter required caution with certain foods, for example.

Given that the more highly selective SSRIs are also beneficial and show a similar slow, incremental effect on OCD symptoms, their anti-obsessional actions are likely to be related to their serotonergic effect. Effectiveness has been shown for fluvoxamine, sertraline, fluoxetine, paroxetine and citalopram.

Stein et al showed in their multicenter study in 2007 that escitalopram 20 mg/day was superior to placebo on the primary and all secondary outcome endpoints, including remission. The improvement in Y-BOCS total score was significantly better than in the placebo group as early as week 6. More paroxetine-treated patients withdrew due to adverse events than escitalopram- or placebo-treated patients. (Stein, Wreford Andersen, Tonnoir, & Fineberg, 2007) Escitalopram is probably the most selective and thus best tolerated SSRI. A post-hoc factor analysis by the authors showed escitalopram to be effective for most symptom dimensions of OCD, but the hoarding/symmetry subtype was associated with a relatively poor

response. In the study by Stein et al, headache, fatigue and nausea were with one in five not uncommon. However, in clinical experience these side effects can often be avoided or reduced by increasing the dose slowly.

Second Generation Antipsychotics

As many as half of obsessive-compulsive disorder (OCD) patients treated with an adequate trial of serotonin reuptake inhibitors fail to fully respond to treatment and continue to exhibit significant symptoms. Second generation antipsychotics are often added on to a serotonergic antidepressant to increase the pharmacological effectiveness against the obsessive symptoms.

In a systematic review by Bloch et al in 2006, the efficacy of antipsychotic augmentation in treatment-refractory OCD was evaluated. (Bloch, Landeros-Weisenberger, & Kelmendi, 2006) The meta-analysis of several studies demonstrated a significant absolute risk difference (ARD) in favor of antipsychotic augmentation of 0.22. The subgroup of OCD patients with comorbid tics had a particularly beneficial response to this intervention, ARD = 0.43. There was also evidence suggesting OCD patients should be treated with at least 3 months of maximal tolerated therapy of a serotonin reuptake inhibitor before initiating antipsychotic augmentation owing to the high rate of delayed treatment response to continued serotonergic monotherapy (25.6%). One-third of treatment-refractory OCD patients showed a meaningful treatment response to antipsychotic augmentation. There was sufficient evidence for the efficacy of haloperidol and risperidone, while evidence regarding the efficacy of quetiapine and olanzapine was inconclusive.

In another meta-study in 2010, comprising 396 participants, Komossa et al investigated the effects of adding three different second-generation antipsychotics to serotonergic antidepressants, mostly SSRIs. The duration of all trials was less than six months. Two trials had examined olanzapine and found no difference in the primary outcome (response to treatment) and most other efficacy-related outcomes. Quetiapine combined with antidepressants was also not any more efficacious than placebo combined with antidepressants in terms of the primary outcome, but there was a significant superiority in the mean Yale-Brown Obsessive Compulsive Scale (Y-BOCS) score at endpoint. There were also some beneficial effects of quetiapine in terms of anxiety or depressive symptoms. Risperidone was more efficacious than placebo in terms of the primary outcome (number of participants without a significant response) and in the reduction of anxiety and depression. (Komossa, Depping, Gaudchau, Kissling, & Leucht, 2010)

It should be added that there are reports of de novo development or exacerbation of obsessive-compulsive symptoms in patients with schizophrenia treated with atypical antipsychotics. Kulkarni et al reported in 2012 of a patient, who had been treated with olanzapine and consequently developed obsessive thoughts with an YBOCS of 18. The medication was stopped, and aripiprazole was started. The patient's psychotic symptoms worsened, but the OCD symptoms improved drastically with the YBOCS score reaching 4. Considering the worsening of psychotic symptoms, olanzapine was restarted. While the

patient's psychotic symptoms improved again dramatically, the obsessive symptoms reemerged with the same intensity as earlier, but were later treated successfully with fluoxetine. (Kulkarni, Narayanaswamy, & Math, 2012) There is still some discussion as to the frequency of this phenomenon and what may be causing it.

In a 2014 systematic review and meta-analysis by Veale et al, two studies found aripiprazole to be effective in the short-term. There was a small effect-size for risperidone or anti-psychotics in general in the short-term. However, they found no evidence for the effectiveness of quetiapine or olanzapine in comparison to placebo. The authors conclude that risperidone and aripiprazole can be used cautiously at a low dose as an augmentation agent in non-responders to SSRIs and CBT but should be monitored at 4 weeks to determine efficacy. (Veale et al., 2014)

Antiepileptics

In a group of 11 patients, who were not or only partially responding to treatment with SSRIs, adjunctive topiramate (up to 400 mg/d; mean dose 253 mg) were found to be globally clinically improved (van Ameringen et al. 2006). However, a parallel group trial suggested that augmentation with topiramate may be beneficial for compulsions, but not for obsessions. Modifications in glutamatergic function may be responsible for the anti-compulsive effect. (Berlin et al., 2010)

Uzun et al reported a case of treatment-resistant OCD that was successfully treated with a pharmacological augmentation of the glutamatergic agent lamotrigine plus clomipramine. The 59-year-old patient was on clomipramine (225 mg/day) when she was started on lamotrigine (up to 150 mg/day). After 10 weeks of this treatment, her clinical condition remarkably improved, as indicated by a significant decrease of the Yale-Brown Obsessive-Compulsive Scale. (Uzun, 2010)

Summary

OCD is treatable, but it requires a combined approach. While over the long-term psychotherapy is what gets the job done, medication can be a valuable support in the short to medium term.

A focus on communication is important to understand and treat OCD successfully. Reducing the sense of anxiety and that something in life is not working in the patient requires a closer look at the underlying wishes, values and aspirations he or she is holding. A focus on greater connectivity with oneself is an important element in this process. Communication-Focused Therapy works towards this in its focus on communication patterns, awareness, insight and experimentation.

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