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, ...
In obsessive–compulsive disorder, 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.
Financial & competing interests disclosure

The authors have no relevant affiliations or financial involvement with any organization or entity with a financial interest in or financial conflict with the subject matter or materials discussed in the manuscript. This includes employment, consultancies, honoraria, stock ownership or options, expert testimony, grants or patents received or pending, or royalties.

No writing assistance was utilized in the production of this manuscript.

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