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Unmet needs of the patients with obsessive-compulsive disorder

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Abstract

BACKGROUND: Obsessive compulsive disorder (OCD) is a disabling mental disorder with the chronic and difficult course. The disorder is accompanied by numerous limitations in personal and interpersonal functioning. OCD decreases the quality of life and the chance to maintain relationships and professional status. The patients with OCD often experience a severe disabling course of the disorder. Even the individuals, who follow treatment advice, are often still highly symptomatic. In the last decade, the concept of the needs has been assessed as an extent of the traditional outcome evaluation in order to focus on the identification of the specific needs of the patients and their relatives, improve the patients´ overall mental condition and quality of life, and also to increase the treatment effectiveness of the mental disorders. The objective of the article was to review the current literature about unmet needs of the OCD patients and their caregivers.

METHOD: A computerized search of the literature published between January 2000 and June 2016 was conducted in MEDLINE, and additional papers were extracted using keywords "obsessive compulsive disorder","needs", "pharmacotherapy", "CBT", and "family" in various combinations. Primary selection selected the total of 449 articles. According to the established criteria, 168 articles were chosen. After a detailed examination of the full texts, 53 articles remained. Secondary articles from the reference lists of primarily selected papers were read and evaluated for the eligibility and added to the final list of the articles (n = 107).

RESULTS: The needs of the OCD patients might differ at various stages and severity of the disorder. Four sets of the needs were identified: the needs connected with the symptoms, the treatment, the quality of life, and the family. The patients suffering from OCD often experience many limitations in the fulfillment of their fundamental human needs such as disturbed patients´ functioning in the common life, family, at work, in the ability to realize their goals, skills, potential, capacity to follow prescribed treatment, take medication, cooperate in addressing the root causes of their problems, reduce obsessive thoughts and compulsive behavior, as

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well as their willingness to realize exposures with the desire to resolve the situation.
CONCLUSION: Monitoring the patients´ needs may be relevant for the treatment of the individuals suffering from OCD. A bigger focus on the patients´ needs could be beneficial and should be targeted in the treatment.

INTRODUCTION

Obsessive-compulsive disorder (OCD) is a chronic, often severe and disabling neuropsychiatric disorder characterized by intrusive, recurrent thoughts (obsessions) joined with repetitive behavior or thoughts that try to reduce negative emotions connected with these thoughts (compulsions). The disorder is accompanied by marked impairment in interpersonal and occupational functioning, decreased the quality of life, and poor long-term prognosis (Hollander *et al.* 2010). With a lifetime prevalence of approximately 2–3%, OCD belongs among the most common psychiatric disorders. A half of the diagnosed patients experience severe symptomatology (Rasmussen & Eisen 1992, Kessler *et al.* 2005, Sheth *et al.* 2013). Comorbid depression and suicidal ideations are also not rare among patients with OCD (Pallanti & Quercioli 2006).

Even when the patients follow treatment advice, they often experience considerable difficulties. The cases of the patients with the residual symptoms or without any significant changes of the symptomatology despite several treatment attempts are not uncommon, as reflected by the guidelines. Thus, many patients, who follow treatment advice, are still symptomatic. In the last decade, the concept of the needs has been assessed as an important factor that may influence the treatment outcomes. The idea of the needs has also been facilitated by increased awareness of the discrepancy between the demands of patients and their families and the services provided to them. Thus, the evaluation of the needs involves the information from the patients, caregivers, and physicians and focuses on what could be done to improve the overall mental condition of the patients. Based on the relevant data, we have identified insufficient or missing approaches in OCD patients within the global outcome evaluation. These could be understood as unmet needs in OCD patients within their global everyday functioning.

The objective of this article was to summarize the current understanding of the needs of patients with OCD, mainly connected with the diagnosis and treatment, as well as well-being and quality of life.

METHOD

The PubMed database was used to search for papers published from January 2000 to June 2016 using the following terms: „obsessive compulsive disorder“ and “unmet needs” in successive combination with “pharmacotherapy”, or “psychotherapy”, or “cognitive behavioral therapy”, or “family” or “quality of life”. Furthermore, the included studies had to meet the criteria for inclusion (1) published in peer-reviewed journals; (2) the articles could have been prospective or retrospective original studies in humans; or (3) reviews on the relevant topic; (4) the subjects had to be at least 18 years old, (5) the papers were published in English. The criteria for exclusion were (1) conference abstracts; (2) books and book chapters; (3) commentaries, and dissertations (4) studies with subjects younger than 18 years old. We utilized a flow diagram to summarize the total number of screened papers and the number of those included in the review process.

The total of 449 articles was selected by primary selection using keywords in various combinations. According to the inclusion criteria, 168 articles were chosen. After a detailed examination of the full texts, 53 papers remained. Secondary articles from the reference lists of the primarily selected articles were searched, evaluated for the eligibility, and added to the primary list of the articles (n = 76). We applied a flow diagram (Figure 1) to summarize the whole quantity of screened papers and the number of selected papers included in the review process, as suggested by the PRISMA Guidelines (Moher *et al.* 2009).

RESULTS

Because of the vast diversity of the needs, the results were divided into four groups according to their common elements: the needs connected with (1) the symptoms, (2) the treatment, (3) the quality of life, and (4) the family. Within these categories, we described especially those of the patients´ needs, which present a significant problem in clinical practice and a significant burden in the patients´ life.

Needs connected with the symptoms

Many unmet needs are linked to the OCD symptoms. The patients may express distress about enduring symptoms and the struggle in dealing with them. In general, the OCD patients´ needs tend to be analogous to the needs of the family and the psychiatrist, since they all want to make the symptoms disappear (Stengler-Wenzke *et al.* 2006). Additionally, the patients wish for more tolerance and empathy from others, to enhance feelings of hope for improvement, safety, help with decreasing feelings of guilt, and endurance that they have not presented by themselves (Vyskocilova *et al.* 2016).

Despite the significant progress in pharmacotherapy and cognitive-behavioral therapy of OCD, many patients exhibit persistent symptoms after acute treatment, which limit daily functioning (Prasko *et al.* 2009, Vyskocilova *et al.* 2016). A substantial number of the patients experience only partial remission or recurrence of the symptoms (Prasko *et al.* 2009).

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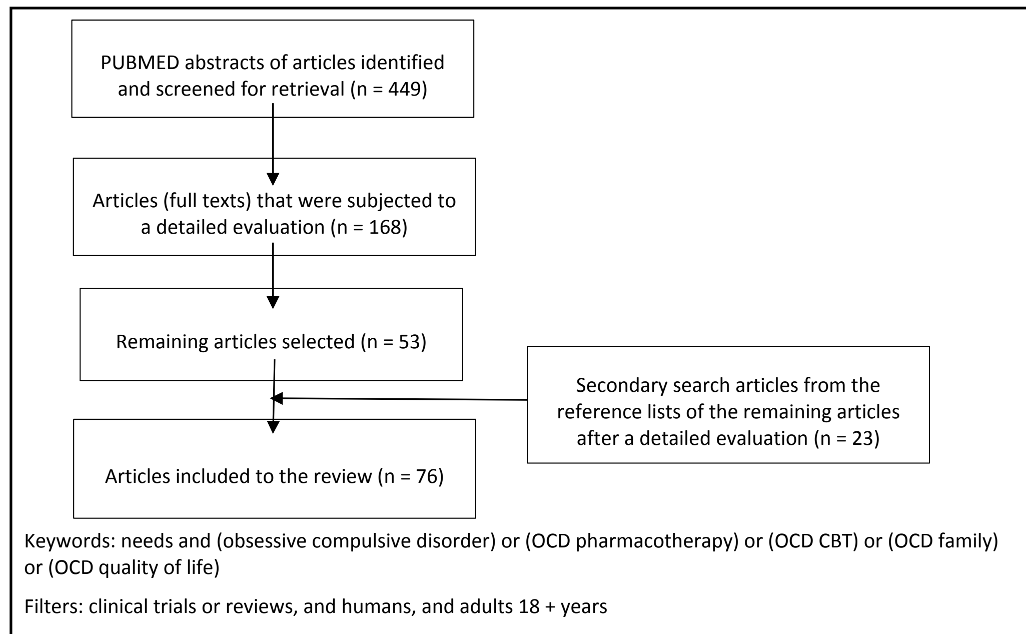

Figure 1. Summary of the selection process

Some patients with a low level of insight believe that their compulsions are the best response to obsessions and display the excessive need for control. This may lead to lower compliance during the treatment. Sometimes they want others to perform compulsions as well and seek the reassurance from their therapist. These wishes then may be in conflict with the standard aims of the therapy. In such cases, the patients strive to decrease anxiety and discomfort, but not to reduce the compulsions (Vyskocilova *et al.* 2015a). Apart from not being sufficiently compliant due to the lack of understanding that compulsions maintain the disorder, they might avoid reduction of the compulsions because of the lower willingness to be exposed to tension and other negative emotions. These attitudes then could compromise the treatment.

In summary, the most significant unmet needs associated with the symptoms are the increasing of insight for the patient and his/her family, good collaboration with the therapists, and coping with persistent symptoms. Some patients´ wishes related to the needs in this area may be counterproductive, such as the need to feeling well at all costs. When this happens, a therapist has to explore the patient´s beliefs and schemas that underlie these wishes. Failing to do so, the patient´s mental state will most likely not improve and will hinder the treatment success.

Needs connected with the treatment

The most common unmet needs related to the treatment are family support, early recognition of the disorder, and the encouragement of decision to seek and undergo the treatment. The long-term patients´ needs, which relate to most of them, are the reduction or elimination of the OCD symptoms and the proper treatment. The primary needs are related to the proper timing of treatment intervention – one that is useful, promptly efficacious, not difficult, without side effects and harmless, not requiring the hospitalizations, and not disturbing the daily routine (Cordioli *et al.* 2008). All these treatment qualities can rarely be reached, but it is essential to do the best. To fulfill these needs, it is crucial to look for the optimal treatment and manage adherence to it. However, the need for the treatment, such as CBT (cognitive behavioral therapy) with exposure therapy, is mostly in the conflict with the current tension and desire for calm. Some patients do not have adequate insight and do not seek the treatment because of this reason. Sometimes there is a much higher need for the treatment displayed by the family than by the patients themselves (Stengler-Wenzke *et al.* 2004, Ociskova *et al.* 2013). To start the treatment, the OCD patients must have developed the satisfactory level of insight and trust their therapist (Ociskova *et al.* 2013).

Furthermore, even when the patients arrive in the therapists´ office, many of them are unsure about the treatment. On the one hand, they suffer from lack of time and have paid too much money (for example because of higher usage of water and disinfections), but on the other side, they would like to maintain a good mood without tension and change the long-term habits connected with the compulsions. Thus, many individuals with OCD experience ambivalent feelings at the start of the treatment (Eisen *et al.* 1999). For the therapist, it is necessary to discuss the advantages and disadvantages of obsessions and compulsions with the patient as well as pros and cons of “being without

OCD" (Praško *et al.* 2007, Voon *et al.* 2015). It is also suggested to accelerate decision-making and behavior and support patients with treatment choice (Ociskova *et al.* 2013).

Selective Serotonin Reuptake Inhibitors (SSRIs) and/or CBT with exposure and response prevention (ERP) are the first-line treatments for OCD, but about 40–60% of patients fail to respond (Hohagen *et al.* 1998; de Koning *et al.* 2001; Foa *et al.* 2005, Albert *et al.* 2012, de Barardis *et al.* 2012; Romanelli *et al.* 2014). Regardless of the optimal cognitive behavioral therapy and augmentation of pharmacologic treatment, about 10% of the patients stay treatment-resistant (Riestra *et al.* 2011). Treatment-resistant OCD remains an important cause of suffering and disability associated with mental disorders (Prasko *et al.* 2006). The second-line treatments include augmentation treatment with antipsychotics, electroconvulsive therapy, transcranial magnetic stimulation, and deep brain stimulation (DBS) (de Berardis *et al.* 2012, Blomstedt *et al.* 2013).

Despite the level of treatment, the greatest unmet need of the OCD patients and their families is the problem to find the adequate treatment of OCD with the access to appropriate pharmacotherapy and/or cognitive behavioral therapy. The problem could also be the treatment affordability, adequate doses of pharmacy and information about the possible treatment response and the relapse prevention (Stengler-Wenzke *et al.* 2006). There are many inadequate treatment experiments with inappropriate medication, dosages, duration of administration and also with inappropriate psychotherapeutic approaches. There is also a need for accessibility of different treatment in a situation of resistance to obvious treatment strategy, using approaches like DBS or psychosurgery, which are not available in many countries (Prasko *et al.* 2006, Blomstedt *et al.* 2013, Chang *et al.* 2013, Mantione *et al.* 2013). DBS is a promising new treatment method for treatment-refractory OCD, but the experience is limited, and the most DBS patients show only a partial response (Bruffaerts *et al.* 2004). CBT could augment the effects of DBS in OCD patients. Following the addition of CBT to DBS, a significant reduction in OCD symptoms was observed (Bruffaerts *et al.* 2004).

Patients confronted with the range of complications to taking medications, including too much-prescribed medicines, disproportional doses, and experience difficulties comprising incompetence to pay for medication or get transport to appointments (Ociskova *et al.* 2013). Many patients with OCD noted difficulties with taking medications and sometimes did not believe in the effect of taking drugs. Others describe ambivalence about the importance of psychopharmacs and being unable to remember to take drugs, both leading to the nonadherence to treatment. The others found twice-daily drug regimen as problematic to remember. Troublesome side effects involved several somatic complaints or specific problems, such as tiredness.

The patients with OCD can also be confronted with the difficulties of living in the community, and their psychiatric management has to take these problems into account. As mental health services enlarged in extension and diversity, the organization of the treatment turns into more service-oriented approaches. Simplifying the access to social contacts, job, and housing is included in the management of OCD, together with the previ¬ously recognized clinical aspects (Wahl 2000).

In summary, the most significant unmet need connected with the treatment is more efficacious medication without adverse effects, the need for accessible psychotherapy, especially experts in cognitive behavioral therapy focused on the OCD treatment and a wider spectrum of psychosocial intervention.

Stigmatization

One of the most critical needs of the OCD patients and their families is to be a valuable person and not to be stigmatized (Ociskova *et al.* 2013). The mass media show a central role in building the image of psychiatry and the patients with mental disorders, and thus, secondarily subsidize the coping responses of families with relatives suffering from OCD (Hoffmann-Richter 2000). The general public often learns about OCD through popular magazines. However, the stereotypes and negative prejudices of the psychiatric patients, which media and society bring, might be confusing Gray 2002). Many articles under the target headings of OCD focus on incidents of "stalking" of famous people by "obsessed" fans. It is partially due to a still prevalent stereotype that people with mental disorder are dangerous, impulsive, and aggressive (Goffman 1986, Nawka *et al.* 2012, Nawková *et al.* 2012,).

Stigmatization affects the patients but also their family members. The explanations for the interpersonal rejection that many patients experience can stem from a socially bizarre behavior of the individuals with the OCD skewed information about the diagnosis or erroneous knowledge about the psychiatric treatment (Ociskova *et al.* 2013). The rejection that comes from the awareness of the patient's mental health problems could also arise in situations when the patient acts normally. The simple label of mental health issues can be a trigger of stigmatization. The patients may then be stigmatized and rejected in various social situations, including work and familial relationships (Stengler-Wenzke *et al.* 2004). Even the patients, who already finished the treatment, can be overtly observed. People around them may act cautiously, judge his or her behavior, and relate it to the labels they hold (Trosbach *et al.* 2003). Every unexpected behavior, related to the disorder or not, is directly qualified as the indications of the disorder. It is truly a catch-22 situation that brings significant tension and stress in the lives of the patients.

The worry of being a target of the stigma is the reason why people suffering from the obsessive compulsive disorder are often fearful of the psychiatric

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diagnosis to such degree that they might actively avoid looking for proper help (Ociskova *et al.* 2013). In the case of OCD, the lay persons (including the patients themselves) mostly believe that personality flaws cause OCD. Many of them believe that the individuals with OCD somehow wrong, week, or perverse (Praško *et al.* 2007, Ramos-Cerqueira *et al.* 2008, Ociskova *et al.* 2013, Kusalaruk *et al.* 2015). These erroneous assumptions lead to avoidant or hostile behavior, self-blame and a decrease of self-esteem of the patients.

Stengler-Wenzke *et al.* (2004) described four areas of stigmatization characteristic for families of patients with OCD – characteristics of the beginning of disorder, keeping the disorder undisclosed, stigmatization among healthcare workers, and retrospective stigmatization. The authors conclude that stigmatization of the OCD patients and their families can be decreased by co-operation of the patients, their families, and medical professionals in a way that is free from common prejudices and stereotypes.

Families can similarly experience stigmatizing responses in the health care system itself. The pathway to the diagnosis can be lengthy and tiresome. The families from the research of Stengler-Wenzke *et al.* (2004). disclosed that they might have stigmatized their close one, particularly at the beginning of the disorder when they lacked proper education about the disorder. These family members ascribed their behavior to the lack of knowledge, insecurity, and helplessness. The family members were also repeatedly taking part in performing rituals which, from a long-term point of view, led to increased irritability, negativism, loss of interests, and deficits in other social roles. It was difficult for them to be permanently supportive and empathetic when their family member was losing hope because they were distressed themselves (Stengler-Wenzke *et al.* 2004).

In summary, the most significant unmet needs associated with stigma is the change of public opinions to the people with mental disorders and the programs orientated to the decreasing of the self-stigma.

Barriers to help-seeking

Very often, the treatment is started with a significant delay, which prolongs the suffering of the patient. The patients and their caregivers have reported mental health services as inaccessible, and the search for professional support as an additional stressor (Stengler-Wenzke *et al.* 2006, Ociskova *et al.* 2013). Sometimes, the treatment is initiated in degrading way (the patients are brought to the psychiatrist under the influence of family pressure), when the relatives want the treatment, but the patient does not want it or is quite ambivalent (Stengler-Wenzke *et al.* 2006).

The domineering role of the family members can also influence the family situation and the view of the family members on the need for treatment in case of the OCD problems. There are many factors that affect the attitudes toward use of the medication: the patient´s self-concept and the wish to cope with everything without outside assistance, insight into the symptoms of mental disorder (in some patients with OCD are only partial or none), cognizance of the need to use of psychopharmacs, previous experience, and myths regarding the treatment of psychiatric disorders in the public and also the stigma of psychiatric disorder (Ociskova *et al.* 2013).

In summary, the most significant unmet need connected with the barriers to help-seeking are the accessible health and social services and more appropriate information for the families.

Unmet needs during outpatient treatment

For many patients in remission, it is imperative to increase the self-esteem and decrease self-stigma (Ociskova *et al.* 2013). No less important is also adherence to treatment, regular use of the medication and regular check by the treating psychiatrist. The patients with OCD can be confronted with the difficulties of living in the community, and their psychiatric management has to take these problems into account. As mental health services enlarged in extension and diversity, the organization of the treatment turns into more service-oriented approaches. Simplifying the access to social contacts, job, and housing is included in the management of OCD, together with the previously recognized clinical aspects (Wahl 2000).

In summary, the most significant unmet needs during the outpatient treatment are increasing of adherence to the treatment, the improvement of the patients´ self-esteem, and effective social network.

Needs connected with the quality of life

This type of the needs could be delineated as any distress or difficulties that patients recognized as not related to managing the symptoms of OCD, but those that negatively affected their ability to integrate into the community after treatment and their quality of life. School, employment, economic situation, family conflicts, and the desire for more daily activities are examples of the concerns expressed by the patients (Ociskova *et al.* 2013). Some individuals with OCD deal with issues of abuse (physical, emotional, and sexual), divorce, loss of children, and distancing from the abusive family members. Many of patients have the problems to find a job, have a rent and suffer from financial problems. For the students can be difficult to go to school, have problems be present at school at the time, during the lessons problems with concentration. The disorder markedly interferes with life experiences of many patients, who reported interference with study plans, interpersonal relationships, career, the establishment of the own family (Praško *et al.* 2007).

Thus, the most significant unmet need connected with the quality of life is the help with the integration into

the community and improving the factors that influence the quality of life.

Needs related to the family

Restrictions that come along with the progress of the OCD symptoms increase the dependence of the patients on their relatives. The individuals suffering from OCD are increasingly incapable of managing their everyday tasks, due to numerous obsessive thoughts, indecisiveness, diminished self-esteem, and avoidant behavior. Apart from taking over everyday responsibilities, the families of the patients usually take part in the rituals that their relatives perform and thus present a crucial factor among maintaining factors of the disorder (Praško *et al.* 2007, Ramos-Cerqueira *et al.* 2008). From this point of view, the families with the patients suffering from OCD can be clearly distinguished from the relatives of the patients with other disabling psychiatric issues. Particularly family members living in the same household with the patient (such as partners, parents, children, and other relatives) are involved in daily rituals of them (Calvocoressi *et al.* 1995, Steketee 1997, Karp & Tanarugsachock 2000).

Increasing preoccupation in the relative´s rituals and related behavior gradually dominates family life and leads to the accumulation of tension and disagreements about how to behave. It is also not only rituals what adversely affect family relationships and functioning. Depression, blame, grief, substance abuse, social stigma, and other secondary symptoms are parts of the image, as well (Stengler-Wenzke *et al.* 2006). Stigma upsets patients with psychiatric disorders as well as their relatives. Thus, the fact, that a family member has been identified as a mentally ill takes into a family other alterations. The relatives start to deal with the stigma and the fear of it (Kusalaruk *et al.* 2015). There is no surprise that family has a tendency to keep the OCD diagnosis undisclosed. Truly, the psychiatric disorder is a secret that is not being shared. Taboo also comprises unique burden related to the care of a relative with OCD (Stengler-Wenzke *et al.* 2006).

The partners might oversee the symptoms because they want to sustain the relationship. The children of the patients with OCD might not be capable of identifying the symptoms of the psychiatric disorder while being too young. The development of OCD can be slow to the such extent that family just do not notice dysfunctional alterations in the patient´s behavior. Gradually, the family adjusts to the rituals that are more and more enormous and complex. In such cases, the relatives tend to interpret rituals and obsessions as personal eccentricities or tics (Calvocoressi *et al.* 1995, Stengler-Wenzke *et al.* 2006).

The OCD symptoms, explicitly rituals, might look unfamiliar or bizarre. If they are performed publicly, relatives might be embarrassed and concerned about possible labeling reactions. The fear of social devaluing and exclusion is further reinforced by the existence of a psychiatric diagnosis. All of this builds the significant distress that families of OCD patients need to deal with. The development of accepting and understanding the attitude towards the family member with OCD might be challenging and represents a long-term task rather than a matter of a quick adjustment. It is not an exception when it takes entire time of the treatment for relatives to cope with it (Calvocoressi *et al.* 1995, Stengler-Wenzke *et al.* 2006, Ociskova *et al.* 2013).

According to Calvocoressi *et al.* (1995), such forms of behavior can be found in one-third of all families with the individuals with OCD. There was also an effort to detect the most disturbing symptoms (Cooper 1996).

The family members have become more important in the psychiatric care in the last decades. The caregivers were found to be often involved in severe burden; e.g. interference with domestic activities, leisure time, and career, tense family relations and reduced social support, decreased mental health, subjective distress, and burnout (Ociskova *et al.* 2013).

The patients also value such support as being comfortable in talking with family members about their illness. The majority of caregivers experience a modest level of burden. This burden is linked to symptomatic behavior, reduced performance in tasks regarding the individual being cared for and negative costs for family and household. The belief that people with OCD are principally able to control their psychiatric disorder has been found to be linked with the higher levels of burden and disappointment with the relationship (Stengler-Wenzke *et al.* 2006).

In summary, the most significant unmet needs connected with the family are the support leading to the functional and independent life, help with the management of the everyday tasks, and to stop reassuring together with decreasing of the stigma of the whole family.

Implications for pharmacotherapy

Medication that is effective in the treatment of OCD, include selective serotonin reuptake inhibitors (SSRIs), clomipramine, mirtazapine, and venlafaxine (Kaplan & Hollander 2003, Koran *et al.* 2005, Antidepressants lead to improvement in about 65–70% of the patients (Abramowitz 1997). Apparent treatment effect can be observed after 2–3 months of using the highest tolerated dose of antidepressants. Many authors even recommend "supramaximal doses" of SSRIs in the treatment-resistant patients (often twice as high as the recommended maximum dose) (Alonso *et al.* 2001; Praško *et al.* 2014). However, there is about 40–60% of the patients suffering from OCD, who do not respond sufficiently to the first-line treatments with antidepressants, CBT, or their combination (Pallanti & Quercioli 2006, Abudy *et al.* 2001, Walsh & McDougle 2011, Abdel-Ahad & Kazour 2013, Marazziti *et al.* 2010). In the clinical practice, the

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needs of the patients may interfere mainly with the side effects of the psychopharmacs, the efficacy of the treatment, and adherence to pharmacotherapy.

Dosages and side effects

Some studies have declared that OCD patients, who do not respond to usual antidepressant doses, might respond to much higher doses (Bandelow *et al.* 2012). Also, guidelines for the pharmacological treatment of obsessive-compulsive disorder recommended supramaximal doses in the case of pharmacoresistant (Abudy *et al.* 2001, Praško *et al.* 2010). However, high doses can lead to more side effects greater severity. Among the most bothersome side effects belong tremor, weight gain, a decrease in libido, delayed ejaculation, inability to achieve orgasm, and anhedonia.

The problems with side effects are clinically typically higher in the patients with somatic obsessions and with a comorbid anxiety disorder, but there are no specific research data on this issue.

Combinations

Several augmentation strategies have been developed, including the use of atypical antipsychotics and combinations of antidepressant (Saxena *et al.* 2009, Praško & Látalová 2012, Sayyah *et al.* 2012). Other clinically powerful strategy is intensive daily CBT with exposure and response prevention (O'Neill *et al.* 2013, Oldfield *et al.* 2011). Intensive daily therapy also offers a pragmatic alternative to the in-patient admission for those living in geographically distant locations (March *et al.* 1997). In clinical routine, medication and CBT are often combined (Cottraux *et al.* 1990). However, this approach does not necessarily lead to greater efficacy than CBT alone, as shown by numerous studies (Kozak *et al.* 1988, Van Balkom *et al.* 1998, Cottraux *et al.* 2001, de Koning *et al.* 2001, Foa *et al.* 2002, Kampman *et al.* 2002). Still, the higher effect of the combination was observed in a recent meta-analysis that calculated the side effects in studies, which compared medication with behavioral therapy, and separate studies without direct comparison (Albert *et al.* 2012). In pharmacotherapy, treatment discontinuation is often followed by a relapse. If medication is combined with CBT, the patients could be protected against relapse even if they discontinue the pharmacotherapy (Flückiger *et al.* 2012).

Adherence to pharmacotherapy

The various unmet needs related to the pharmacological treatment, such as a) to develop more rapid-acting treatments with better side effects profiles; b) to identify drugs for the adequate management of resistant OCD, and c) to determine pharmacological treatments targeting the comorbidity, are an important task for the future (Simpson *et al.* 2006, Praško & Látalová 2012, Walsh & McDougle 2011, Praško *et al.* 2014, Westermann *et al.* 2015). Without a psychiatric understanding of the reasons why a patient with OCD may or may not adhere to the recommended treatment, it is hard to develop interventions that could be addressed the nonadherence. The patients´ behavior under the label of "medication refusal" might primarily serve to satisfy the need for not to be controlled or be autonomous (Westermann *et al.* 2015). Furthermore, other patients might "forget" to take medication to avoid being reminded of being ill. This, in turn, protects his or her self-esteem. Moreover, other patients may simply want to avoid the negative side effects, and this is why they skip their medication (Simpson *et al.* 2006). Sometimes, the individuals with OCD, who lack an adequate understanding of the disorder and the treatment, may think that there is no need to use the pills continuously because they already feel better. Thus, poor adherence to the pharmacotherapy may be an expression of many unmet needs (Stengler-Wenzke *et al.* 2006).

Implications for psychotherapy

The efficacy of CBT with exposure with response prevention remains still limited. Considerable rates of the patients do not respond to it or respond only partially, undergo relapses or withdraw from the therapy. At least 35% of the patients do not respond to the treatment recommended by the current guidelines regarding the reduction of symptoms severity. Also, the likelihood of the relapse during a 2-year period after achieving remission has been found in 48% of the individuals with OCD (Vyskocilova *et al.* 2016). Specifically, for the smaller group of the patients, who do not adequately benefit from CBT with exposure, response prevention, complementary or alternative treatment strategies should be developed.

The patients´ needs necessarily influence the course of psychotherapy and its outcome (Bram & Björgvinsson 2004). Some of the needs are related to the attitudes that are discussed as schemas in CBT. Attitudes could be governed by values, their personal prominence, and cultural adaptation, primarily to the social context of the person (Vyskocilova *et al.* 2015b).

Research suggests that by itself or as an adjunct to pharmacotherapy, CBT involving exposure with response prevention is an effective treatment for OCD. Nevertheless, there is a lack of therapists trained in this type of psychotherapy. Although many psychodynamic oriented therapists treat individuals with OCD by using a traditional therapy that may assist them to create and maintain their relationships, there is little evidence that such therapy is effective in improving the OCD symptoms. Since there is a vital need for more specialists skilled in CBT for OCD, it might be useful for practitioners trained in psychodynamic or other psychotherapy modalities to learn (and practice) at least exposure with response prevention (Goff *et al.* 1992). Such cross-theoretical training involves some challenges. These include the therapist's worries about exposure with response

prevention, understanding resistance, and capacity to reconsidering therapeutic boundaries.

Adherence to psychotherapy

Approximately 50% of the patients do not respond optimally to purely behavioral approaches, even in combination with pharmacotherapy. A higher degree of dissociation may prevent the effect of CBT (Prasko *et al.* 2009, Rufer *et al.* 2006, Spitzer *et al.* 2006) and psychodynamic psychotherapy to take place (Bram & Björgvinsson 2004, Salkovskis & Harrison 1984). One of the factors associated with resistance to the treatment is that the patients do not fully participate in exposure with response prevention because of their beliefs that the prevention of the rituals will lead to a tragedy. Insufficient insight and severe depression have also been shown to be potential restraints in the treatment using exposure with response prevention (Basoglu *et al.* 1988, Foa 1997, Steketee & Shapiro 1995, Steketee *et al.* 2011, Blomstedt *et al.* 2013, Kamaradova *et al.* 2015). However, a lack of insight may not always be a predictor of poor therapeutic response (Steketee & Shapiro 1995, Kamaradova *et al.* 2015).

CONCLUSION

The patients suffering from OCD often experience many limitations in the fulfillment of their fundamental human needs. The symptoms of the illness disturb the patients´ functioning in the common life, in the family, at work, in the ability to realize their goals, skills, and potential. The symptoms also disturb their capacity to follow prescribed treatment, take medication, cooperate in addressing the root causes of their problems and reduce obsessive thoughts and compulsive behavior, as well as their willingness to realize exposures with the desire to resolve the situation. The patients with OCD have, as the consequences of their disorder, many unmet needs. It is a question if and what kind of the patients´ basic needs were unmet before the development of the disorder because the OCD symptoms may protect them from awareness of the deeply ingrained patterns and schemas. Anyway, the topic of needs of the patients with OCD is an important area for better understanding this particular psychiatric condition. It can also help the healthcare providers, the patients themselves and their families to cope with the mental disorder problems towards improving the patient's condition and their quality of life.

CONFLICT OF INTEREST STATEMENT

The authors declare that the article was done in the nonappearance of any commercial or economic relationships that could be understood as a potential conflict of interest.

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