










# Combination treatment of behaviour therapy and medication significantly reduces obsessive-compulsive symptoms in people who have responded to pharmacotherapy

Tenneij NH, van Megen HJGM, Denys DAJP, *et al.* Behavior therapy augments response of patients with obsessive-compulsive disorder responding to drug treatment. *J Clin Psychiatry* 2005;66:1169-75.

**Q** Does the addition of behaviour therapy to continuing medication benefit people with obsessive-compulsive disorder who have responded to drug treatment?

## METHODS

	<b>Design:</b> Randomised controlled trial.
	<b>Allocation:</b> Unclear.
	<b>Blinding:</b> Single blinded.
	<b>Follow up period:</b> Twelve months.
	<b>Setting:</b> University Medical Centre Utrecht, the Netherlands; October 1998 to June 2002.
	<b>Patients:</b> Ninety six adult outpatients with DSM-IV obsessive-compulsive disorder (OCD) who had responded to three months of medication ( $\geq 25\%$ reduction in score on Yale-Brown Obsessive Compulsive Scale (Y-BOCS)) with venlafaxine (300 mg/day) or paroxetine (60 mg/day). Exclusion criteria: comorbid Axis I disorder during past six months; Hamilton Rating Scale for Depression score $> 16$ ; and cognitive and/or behaviour therapy within six months of randomisation.
	<b>Intervention:</b> People were allocated to continuing drug treatment (300 mg/day venlafaxine or 60 mg/day paroxetine) plus behaviour therapy (18 sessions at 45 minutes each), or continuing drug treatment alone for a further six months; the latter group subsequently received behaviour therapy for additional six months.
	<b>Outcomes:</b> Severity of obsessive-compulsive symptoms (Y-BOCS); remission rate (Y-BOCS $\leq 8$ ).
	<b>Patient follow up:</b> 61% completed the study.

## MAIN RESULTS

Addition of behaviour therapy to medication reduced obsessive-compulsive symptoms compared with drug treatment alone after six months (Y-BOCS score change for study completers:  $-3.9$  with combination therapy *v*  $3.9$  with drug treatment alone;  $p \leq 0.001$ ). Six months of behaviour therapy after drug treatment alone led to a non-significant reduction in obsessive-compulsive symptoms (Y-BOCS

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score change:  $-2.7$  for study completers;  $p =$  not significant). Addition of behaviour therapy increased remission rate compared with drug treatment alone (remission rate (intention to treat analysis): 19/47 (40%) with combination therapy *v* 7/48 (15%) with drug treatment alone;  $p < 0.0001$ , *v* 13/36 (36%) with delayed combination therapy;  $p =$  not significant compared with combination therapy).

## CONCLUSIONS

The addition of behaviour therapy is worthwhile for people with OCD who respond to drug treatment irrespective of the timing, although the benefit is greater when it is added immediately after drug response.

## Commentary

The clinical management of obsessive compulsive disorder rests on potent selective serotonin reuptake inhibitors (SSRIs) and cognitive behaviour therapy (CBT), used separately, sequentially, or concurrently. Although guidelines to clinical decisions with refractory patients have been proposed,<sup>1</sup> the response rate is still too low, and some people remain refractory to any kind of treatment. This highlights the importance of joint efforts from psychological and biological teams to develop new treatments. Data on whether combining pharmacological and psychological approaches can reduce treatment non-response or relapse remain scarce. Since 1988 only seven studies have been published. Our own study found people who received CBT with or without medication were less likely to relapse.<sup>2</sup>

In this context, the paper by Tenneij *et al* brings new interesting conclusions on the combined approach. The novel approach used in this RCT was to initiate CBT in people who were responders to an adequate trial of venlafaxine or paroxetine. At six month follow up, medication plus CBT was better than medication alone, with a higher rate of people in remission. The average Y-BOCS score of participants was 25 upon drug trial entry, indicating moderate OCD severity. However, the improvement seen with medication, of 25% in the average Y-BOCS score, left room for further improvement with CBT. These results validate the current clinical recommendations to add CBT when the response to medication is limited. Other clinical recommendations should be addressed in further trials. For example, is CBT alone the best initial treatment of choice in mild OCD, and are the experts right to recommend the combination of medication plus CBT as the initial treatment in more severe OCD, or is medication alone equally effective?

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1 Pallanti S, Hollander E, Bienstock C, *et al.* Treatment non-response in OCD: methodological issues and operational definitions. *Int J Neuropsychopharmacol* 2002;5:181-91.

2 Cottraux J, Bouvard MA, Milliere M. Combining pharmacotherapy with cognitive-behavioural interventions for obsessive-compulsive disorder. *Cog Behav Ther* 2005;34:185-92.