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Treatment-Resistant Obsessive-Compulsive Disorder: An Updated Clinical Review

Christian Jonathan Haverkampf

Narrative Clinical Review

Abstract—Obsessive-compulsive disorder (OCD) can remain severely impairing after treatment, but apparent resistance often reflects incomplete diagnosis, inadequate exposure and response prevention (ERP), an insufficient medication trial, poor adherence, family accommodation, adverse effects, or unrecognized comorbidity. This narrative clinical review updates earlier JPPC discussions using guidance and evidence available through 30 May 2023. Assessment should confirm OCD, impairment, risk, and differential diagnoses and reconstruct every prior treatment. Adequate first-line care consists of disorder-specific cognitive-behavioral therapy with ERP and/or a serotonin reuptake inhibitor (SRI), selected collaboratively. ERP requires repeated exposure to relevant triggers, prevention of overt and covert rituals, and attention to reassurance and accommodation; supportive discussion alone is not equivalent. Medication trials may require higher tolerated doses and longer evaluation than depression trials, under medical supervision. After limited response, options include optimizing or combining ERP and SRI treatment, switching SSRI or cautiously using clomipramine, and specialist augmentation. Evidence most consistently supports low-dose risperidone or aripiprazole augmentation for selected SRI nonresponders, with adverse-effect monitoring and discontinuation if ineffective. Deep transcranial magnetic stimulation may help selected adults; deep brain stimulation and ablative neurosurgery are reserved for extremely severe, chronic, refractory OCD after independent multidisciplinary review. Communication-focused work may supplement, but not replace, established care. Persistence should prompt a diagnosis and treatment-fidelity audit before greater complexity or invasiveness.

Index Terms—obsessive-compulsive disorder, treatment resistance, ERP, SSRIs, antipsychotic augmentation, deep TMS, DBS

I. INTRODUCTION

OCD is characterized by obsessions, compulsions, or both. Obsessions are recurrent intrusive thoughts, urges, or images experienced as unwanted; compulsions are repetitive behaviors or mental acts performed according to rigid rules or to reduce distress or prevent a feared event. The content can concern contamination, harm, responsibility, sexuality, religion, symmetry, relationships, health, or other themes. The disorder is defined by process, time, distress, and impairment, not by one topic.

When symptoms persist after treatment, patients can lose hope and clinicians can move quickly toward complex medication combinations. Yet an administrative record stating "CBT failed" or "three antidepressants failed" is insufficient. The CBT may not have included ERP; medication may have been stopped early; covert rituals may have continued; the diagnosis may be wrong; or severe depression, tics, substance use, autism, trauma, or family accommodation may prevent progress.

Earlier JPPC articles discussed treatment-resistant OCD and a communication-focused approach to OCD (Haverkampf, 2014; Haverkampf, 2017a). The present review retains the useful emphasis on individualized formulation but updates several clinical priorities. ERP is the psychological treatment with the strongest disorder-specific evidence. Psychodynamic exploration or a communication framework may add understanding but should not be presented as evidence-equivalent substitutes. Medication choice and augmentation should follow current evidence and monitoring rather than historical preference.

Christian Jonathan Haverkampf, M.D., LL.M., is a psychotherapist working in private practice in Dublin, Ireland. Correspondence: jonathanhaverkampf@gmail.com. Website: www.jonathanhaverkampf.com.

Haverkampf, C. J. (2023). Treatment-Resistant Obsessive-Compulsive Disorder: An Updated Clinical Review. J Psychiatry Psychotherapy Communication, 2023 Jun 30;12(2):41-50

Core clinical propositions

- Verify OCD and measure severity before calling it resistant.
- "CBT" is not an adequate OCD treatment unless the active program includes ERP or another evidence-supported disorder-specific protocol.
- Overt rituals, mental rituals, reassurance, avoidance, and family accommodation can all prevent corrective learning.
- SRI adequacy in OCD requires careful attention to tolerated dose, duration, adherence, and adverse effects.
- Antipsychotic augmentation has a limited, selected role; benefit should be measured and harm actively monitored.
- Neuromodulation and neurosurgery require specialist, multidisciplinary governance and do not bypass foundational treatment.

II. SCOPE AND METHOD

This review draws on guidelines, reviews, meta-analyses, trials, and neuromodulation guidance available through 30 May 2023. It covers diagnosis, resistance, ERP, CBT, SRIs, augmentation, family accommodation, and advanced interventions, prioritizing guidance, syntheses, and trials. It is not an individualized prescribing or neurosurgical protocol.

III. DEFINE RESISTANCE PRECISELY

Definitions differ across studies and services. Some use failure of one adequate SRI; others require several SRIs, clomipramine, and ERP before declaring refractory illness. Advanced-intervention programs apply much stricter thresholds. The label should therefore state what failed: "persistent severe OCD after two adequate SSRI trials and therapist-delivered ERP" is more informative than "resistant OCD."

Nonresponse, partial response, relapse, intolerance, and nonadherence should be separated. A partial response can justify optimization or augmentation; complete nonresponse may favor switching and diagnostic review. A patient who stops because of sexual dysfunction or activation has not demonstrated biological nonresponse. A patient unable to access ERP has not failed ERP.

The Yale-Brown Obsessive Compulsive Scale (Y-BOCS) is widely used to rate severity and track change, but scoring should accompany clinical assessment. Time, distress, interference, resistance, and control can change differently. Functional outcomes—washing-related injury, lateness, school attendance, independent living, relationship participation—are equally important.

Table 1. A hierarchy of treatment-status descriptions

Status	Evidence required	Implication
Unverified prior treatment	Name or record lacks procedures, dose, duration, or outcome	Reconstruct before drawing conclusions
Inadequate trial	ERP dose/fidelity or SRI dose/duration was insufficient	Deliver or complete first-line care
Intolerance	Adverse effects prevented an adequate trial	Switch or modify safely; do not call pharmacologic nonresponse
Partial response	Meaningful improvement with residual OCD and impairment	Optimize, combine, or targeted augmentation
Nonresponse	Little improvement after an adequate matched treatment	Reassess diagnosis; switch or combine
Relapse	Recurrence after response	Restore effective components and examine maintenance
Refractory OCD	Severe chronic impairment after multiple verified evidence-based treatments	Specialist multidisciplinary advanced-care review

IV. CONFIRM THE DIAGNOSIS

Intrusive thoughts occur in the general population and across disorders. In OCD, they are linked to distress, appraisal, neutralization, ritual, or avoidance. The clinician identifies the trigger, obsession, feared consequence, responsibility or meaning, compulsion, immediate relief, and delayed cost. Mental acts—reviewing, praying, replacing thoughts, counting, testing feelings—may be invisible and must be asked about directly.

Differential diagnosis includes generalized worry, depressive rumination, psychosis, illness anxiety, body dysmorphic disorder, eating disorders, autism-related routines, tic disorders, trauma-related symptoms, impulse-control disorders, and obsessive-compulsive personality traits. Delusional conviction can occur with poor-insight OCD, but psychosis requires separate assessment. Sexual or violent obsessions are not evidence of desire or intent simply because their content is disturbing; risk assessment focuses on phenomenology, behavior, and actual intent rather than content alone.

Medical and substance review is also necessary. Neurological illness, medication effects, stimulant or cannabis use, sleep disruption, and abrupt symptom change may alter the presentation. Pediatric acute-onset syndromes and perinatal OCD require age- and context-specific expertise beyond a generic adult algorithm.

Comorbidity affects outcome. Major depression can reduce energy and hope; tics may predict a different response to antipsychotic augmentation; autism can require concrete adaptation; hoarding disorder has its own treatment considerations; substance use may become a ritual aid or avoidance strategy. Suicidal thinking is not rare in severe

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OCD and should be asked about directly. A resistance review begins by re-establishing the OCD diagnosis, specifiers, severity, and differential diagnosis using current criteria and a disorder-level synthesis of phenomenology and treatment evidence (American Psychiatric Association, 2022; Stein et al., 2019).

V. THE FUNCTIONAL OCD CYCLE

An intrusive event becomes clinically important through interpretation and response. A thought such as "What if I left the door unlocked?" produces uncertainty. Checking lowers distress and creates temporary certainty. The relief reinforces checking, while the absence of catastrophe is attributed to the ritual. The next doubt therefore arrives without corrective learning.

Compulsions can be subtle. Reassurance seeking asks another person to neutralize doubt. Avoidance prevents contact with triggers. Rumination attempts to solve an unanswerable question. Confessing seeks moral certainty. Replacing a "bad" thought with a "good" one is a mental ritual. ERP must identify the actual response; otherwise the patient can complete visible exposure while continuing covert neutralization.

The feared consequence and feared self should be distinguished. Contamination may mean illness, harming a child, moral irresponsibility, or permanent uncertainty. Relationship OCD may involve checking feelings rather than an external event. A hierarchy based only on surface content can miss the central prediction.

Table 2. Hidden barriers to ERP

Barrier	Example	Clinical response
Covert ritual	Mentally reviewing whether harm was intended	Define and prevent the mental response
Reassurance	Asking therapist or partner whether the thought is normal	Validate distress without supplying repeated certainty
Partial exposure	Touching the trigger but washing immediately afterward	Agree on response prevention and observe the full sequence
Safety signal	Exposure only with a trusted person or medication ritual	Fade the signal collaboratively when safe
Overwhelming hierarchy	Starting with an intolerable task without rationale	Rebuild graded, values-linked tasks
Wrong feared outcome	Treating contamination when the fear is moral responsibility	Formulate the meaning and design a relevant experiment
Actual danger	Ignoring reasonable hygiene, medical, or safeguarding standards	Define ordinary safety before exposure
Poor alliance	Patient experiences ERP as coercion or ridicule	Restore consent, rationale, pacing, and collaboration

VI. ADEQUATE EXPOSURE AND RESPONSE PREVENTION

ERP involves planned contact with obsessional triggers and prevention or reduction of the compulsive response. The goal is not to prove absolute safety or to force anxiety to zero. Contemporary learning models emphasize expectancy violation, inhibitory learning, variability, and the capacity to tolerate uncertainty. Habituation may occur but need not occur in every session.

An adequate course includes a shared formulation, hierarchy or menu of tasks, in-session and between-session practice, identification of overt and covert rituals, review of learning, and generalization across contexts. Dose cannot be inferred solely from the number of appointments. Brief weekly discussion with little practice is not equivalent to ERP.

The clinician and patient define ordinary safety. Exposure to household dirt may be appropriate; exposure to toxic material is not. Response prevention means resisting excessive ritual, not refusing medically indicated behavior. Cultural and religious consultation can help distinguish customary practice from compulsive repetition without asking a therapist to decide theology alone.

Values improve relevance. A patient may tolerate uncertainty not for its own sake but to care for a child, return to work, practice faith freely, or regain intimacy. Outcome is measured by changed response and recovered life, not by how dramatically distress is provoked.

A. When ERP appears to fail

Review whether the tasks addressed the core fear, whether rituals continued, whether practice was frequent, and whether the therapist inadvertently reassured. Examine depression, dissociation, tics, sensory sensitivity, cognitive limitations, family accommodation, and environmental instability. Intensive or residential ERP may be considered for severe impairment where available, but intensity without fidelity is not a solution.

Motivational interviewing principles can clarify ambivalence without requiring the patient to claim certainty. The costs of OCD and the costs of treatment are both real. A patient can choose a smaller step while retaining ownership. Coercive exposure risks harm and dropout. Exposure should be assessed for sufficient dose, response-prevention fidelity, inhibitory learning, and generalization (Craske et al., 2014; Carpenter et al., 2018). Randomized augmentation studies show that expert ERP can improve outcomes after an

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incomplete SRI response and can outperform risperidone augmentation, with benefit maintained at six months for responders (Simpson et al., 2008; Simpson et al., 2013; Foa et al., 2015).

VII. FAMILY ACCOMMODATION

Relatives often participate in rituals, answer repeated questions, modify routines, or complete avoided tasks. Accommodation reduces acute distress and conflict, which makes it understandable and reinforcing. It can also increase impairment and burden. Family involvement should explain the cycle without blaming relatives for causing OCD.

An accommodation plan identifies specific behaviors, prioritizes one, and reduces it gradually alongside ERP. The relative validates distress and supports the agreed coping response but does not debate every obsession. New practical information is still answered; the aim is not emotional withdrawal.

Household safety and power matter. Abrupt refusal can provoke severe distress or aggression. If violence, coercion, self-harm threats, or risk to dependants is present, specialist safety planning is required. A family member is not an unpaid therapist and needs boundaries and support.

VIII. ADEQUATE SRI TREATMENT

SSRIs are first-line pharmacologic treatments for OCD, and clomipramine is also effective but generally carries greater anticholinergic, cardiovascular, seizure, interaction, and overdose concerns. Network meta-analysis supports both pharmacological and psychological treatments, with individual and group CBT containing ERP among effective options (Skapinakis et al., 2016). Selection depends on severity, preference, access, comorbidity, and risk.

Contemporary diagnostic and treatment reviews similarly identify ERP and SRIs as the core evidence-based treatments and emphasize systematic assessment of comorbidity and risk (Hirschtritt et al., 2017). These foundations remain relevant before specialist augmentation or neuromodulation is considered.

OCD often requires a longer trial and, when tolerated, higher SSRI doses than depression. “High dose” is not an instruction to exceed product guidance without specialist judgment. Verify gradual titration, duration at a therapeutic dose, adherence, response, and harms. Improvement may continue over weeks; waiting indefinitely without measurement is not adequate care.

Medication review includes activation, gastrointestinal effects, sexual dysfunction, bleeding risk, hyponatremia, interactions, pregnancy, bipolar history, and discontinuation symptoms. Abrupt stopping can produce withdrawal and apparent relapse. Shared decisions should address which adverse effects the patient considers acceptable.

Combining ERP and an SRI is reasonable in more severe illness, partial response, or patient preference, and is included in stepped-care guidance (National Institute for Health and Care Excellence, 2005). Combination does not compensate automatically for weak ERP or an unverified medication trial; both components should remain assessable.

IX. SEQUENCING AFTER AN INITIAL SRI

After partial response, optimize the current SRI if benefit, tolerability, and trial parameters support doing so; add high-fidelity ERP if it has not been delivered; or strengthen residual-target work. After verified nonresponse or intolerance, another SSRI can be tried. Clomipramine may be considered with attention to contraindications, ECG and other monitoring as clinically indicated, interactions, toxicity, and careful switching.

Combining clomipramine with an SSRI can raise pharmacokinetic, serotonergic, cardiac, and seizure risks and is a specialist decision, not a routine shortcut. Medication changes should generally be made one at a time with a defined target and review. More agents can make the treatment history less interpretable.

A 2014 JPPC review mentioned specific sequencing preferences (Haverkampf, 2014). Current practice should not assume that paroxetine is the default first SSRI or that one SSRI is universally superior. Drug choice should reflect current guideline recommendations, licensed indications, interaction and withdrawal profiles, patient preference, and individual prior response. Likewise, psychotherapy modalities should not be described as equally evidenced for core OCD symptoms when ERP has the strongest disorder-specific support.

The post-first-line decision sequence

- Confirm OCD, severity, insight, risk, comorbidity, and the patient's current priorities.
- Audit ERP for relevant exposure, response prevention, covert rituals, homework, and family accommodation.
- Audit every SRI for dose, duration, adherence, adverse effects, and measured outcome.
- Correct an inadequate trial before escalating, unless safety or preference prevents it.
- Optimize a meaningful partial response; switch after verified nonresponse or intolerance.
- Combine high-fidelity ERP and an SRI when indicated and acceptable.
- Consider augmentation only after the target, evidence, harms, monitoring, and stop rule are explicit.
- Refer for advanced intervention only after independent multidisciplinary confirmation of severe refractory illness.

Haverkampf, C. J. (2023). Treatment-Resistant Obsessive-Compulsive Disorder: An Updated Clinical Review. J Psychiatry Psychotherapy Communication, 2023 Jun 30;12(2):41-50

X. ANTIPSYCHOTIC AUGMENTATION

Adding a low-dose antipsychotic to an adequate SRI has evidence for a subset of patients with persistent OCD. Meta-analysis supports antipsychotic augmentation overall, with the most consistent evidence for risperidone and aripiprazole; benefit is not universal (Dold et al., 2015). Patients with comorbid tics may have a higher probability of response in some analyses, but this is not a sufficient indication by itself.

The trial should be time-limited and measured. Baseline weight, waist, blood pressure, glucose or glycated hemoglobin, lipids, movement symptoms, prolactin-related symptoms, ECG risk, and other parameters are considered according to the agent and patient. Akathisia can be mistaken for worsening anxiety. Sedation may lower distress without reducing compulsions.

If no meaningful benefit appears after an adequate augmentation trial, the agent should not continue by inertia. Tapering and stopping require medical supervision. Long-term metabolic and neurological risk matters especially when average benefit is modest.

Olanzapine and quetiapine have less consistent evidence for OCD augmentation and substantial metabolic or sedative burdens. Historical enthusiasm should not be treated as class equivalence. The rationale for a chosen agent should cite the actual evidence and patient-specific risk. Guidelines and meta-analytic evidence support antipsychotic augmentation only for selected SRI-resistant cases, with modest aggregate benefit and important adverse-effect monitoring rather than routine use (Baldwin et al., 2014; Katzman et al., 2014; Bloch et al., 2006).

XI. GLUTAMATERGIC AND OTHER EXPERIMENTAL STRATEGIES

Glutamatergic agents have been studied because cortico-striatal circuitry and glutamate are implicated in OCD. Trials and small syntheses have examined memantine, N-acetylcysteine, lamotrigine, topiramate, ketamine, and others. Results are mixed, samples are often small, and methods differ. No such strategy should be presented as a routine evidence-equivalent next step after an SSRI.

Experimental prescribing requires specialist oversight, a clear target, review of interactions and adverse effects, and an explicit statement of uncertainty. Apparent large effects in small studies can shrink with replication. Supplements also have pharmacology and quality-control issues; “natural” does not mean risk-free.

Other agents, including ondansetron, pindolol, buspirone, and opioid-related strategies, have been explored with limited or inconsistent evidence. A long list of possibilities can create false confidence. The clinical priority remains verifying ERP and SRI adequacy and using better-supported augmentation before experimental approaches.

XII. DEEP TRANSCRANIAL MAGNETIC STIMULATION

Deep TMS uses externally applied magnetic stimulation designed to influence deeper or broader cortical networks than conventional coils. Carmi et al. (2019) reported benefit of high-frequency deep TMS over sham in adults with OCD using symptom provocation before treatment. Regulatory clearances and protocols vary by jurisdiction and date.

Average benefit is modest, and not every patient responds. Selection should verify persistent OCD after established care, contraindications, seizure and device risks, ability to attend repeated sessions, and the exact protocol. Common adverse effects include scalp discomfort and headache; seizure is rare but serious. Marketing claims should not outrun trial evidence.

Symptom provocation is part of the studied protocol, not a generic instruction. Treatment should be delivered by an appropriately trained service with outcome measurement. Deep TMS does not eliminate the need for ERP, medication review, or functional rehabilitation.

XIII. DEEP BRAIN STIMULATION

DBS involves surgically implanted electrodes connected to a pulse generator. It is reserved for extremely severe, chronic, disabling OCD after multiple verified evidence-based treatments. Systematic review and meta-analysis of published cases and series suggests that a proportion of carefully selected patients achieve substantial symptom reduction, while emphasizing heterogeneity and invasive risk (Alonso et al., 2015).

Candidate evaluation is multidisciplinary and typically includes independent diagnostic confirmation, rigorous treatment-history review, capacity and consent assessment, neuropsychological and medical evaluation, realistic expectations, and a plan for long-term programming and psychiatric care. DBS is not a one-time cure. Programming may take months and concurrent psychotherapy may be needed as avoidance becomes newly possible to challenge.

Risks include hemorrhage, infection, hardware complications, seizures, mood or behavioral effects, cognitive concerns, and burdens of repeated follow-up and battery management. Blinded evidence is limited compared with common first-line treatments. Ethical governance must address irreversibility of implantation, device dependence, access, privacy, and the possibility of partial benefit.

Guidelines from neurological surgery have reviewed evidence for DBS targets and emphasize the limited evidence base and specialized context (Staudt et al., 2021). Local

Haverkampf, C. J. (2023). Treatment-Resistant Obsessive-Compulsive Disorder: An Updated Clinical Review. J Psychiatry Psychotherapy Communication, 2023 Jun 30;12(2):41-50

regulatory status and center experience must be verified at the time of referral.

XIV. ABLATIVE NEUROSURGERY

Anterior capsulotomy, cingulotomy, and related procedures create targeted lesions in circuits implicated in OCD. Modern stereotactic and radiosurgical techniques differ, but all are irreversible. Evidence largely comes from observational series rather than large randomized trials. Potential benefits must be balanced against neurological, cognitive, psychiatric, seizure, and personality or motivational effects.

Ablative procedures are considered only in highly specialized programs for chronic, severe, otherwise refractory OCD. Independent review should establish that less invasive evidence-based options were truly adequate. Consent requires time, capacity, discussion of alternatives, and freedom from the idea that refusal means abandonment.

XV. A COMPLETE RESISTANCE AUDIT

The audit begins with records. For each psychotherapy, document provider expertise, number and duration of sessions, in-session exposures, between-session practice, response prevention, family work, reason for stopping, and measured change. For each medicine, document exact dose trajectory, duration, adherence, effects, adverse effects, and taper. Memory alone is vulnerable to the illness's long course.

Next, observe the current cycle. A live description often reveals rituals not present in earlier notes. Ask about mental review, internet searches, confession, comparison, avoidance, reassurance, and rules about therapy itself. Some patients perform treatment "perfectly" as a compulsion. ERP then targets flexible engagement rather than flawless homework.

Finally, review access and relationship. Did cost, transport, language, disability, shame, or therapist turnover interrupt care? Did the patient understand the rationale? Were exposures collaboratively chosen? Was family accommodation addressed? A 2023 systematic review identified pretreatment severity, prior CBT, avoidance, working alliance, and adherence as potential predictors of CBT response, but heterogeneous measures and risk of bias preclude a deterministic rule (McDonald et al., 2023). A failure of the system is not resistance located in the patient.

Table 3. Resistance-audit record

Domain	Minimum record	Common hidden problem
Diagnosis	Obsessions, compulsions, avoidance, insight, differential, severity	Theme mistaken for another disorder or covert rituals omitted
ERP	Formulation, hierarchy, in-session practice, homework, response prevention, outcome	Supportive therapy labeled CBT; reassurance continues
Medication	Agent, dose, duration, adherence, adverse effects, measured change	Brief low-dose exposure listed as a failed trial
Accommodation	Who participates, how often, immediate and delayed effects	Family blamed without a reduction plan
Comorbidity	Depression, tics, autism, trauma, substance use, bipolarity, sleep, medical issues	Primary barrier remains untreated
Function and risk	Self-care, school or work, relationships, skin injury, suicidality, aggression	Score change obscures severe disability
Access and preference	Cost, travel, culture, consent, prior rationale, treatment burden	Nonattendance interpreted as unwillingness
Advanced care	Independent reviews, verified failures, governance, aftercare	Escalation before foundational treatment is complete

XVI. COMMUNICATION-FOCUSED FORMULATION

Haverkampf (2017a) proposed Communication-Focused Therapy (CFT) for OCD as an author-developed way to explore how thoughts, feelings, meanings, and interpersonal responses are communicated. The model may help identify the meaning assigned to an intrusion and how reassurance circulates within a relationship. It is not supported by the same disorder-specific evidence as ERP and should not delay or replace ERP.

An obsession can be described as information that is given excessive threat or moral significance. A thought occurs; it is interpreted as danger, responsibility, or identity; a compulsion communicates that the thought requires action; relief reinforces the interpretation. Communication analysis can help separate event, appraisal, and response, but ERP supplies the crucial behavioral test.

Interpersonal communication is particularly relevant to reassurance. The patient may ask "Am I a bad person?" while seeking impossible certainty; the relative hears a request for compassion and answers repeatedly. An alternative response validates distress and supports willingness: "I know this uncertainty hurts, and I do not want to help OCD conduct another trial." The wording should be agreed in treatment and delivered without ridicule.

Haverkampf, C. J. (2023). Treatment-Resistant Obsessive-Compulsive Disorder: An Updated Clinical Review. J Psychiatry Psychotherapy Communication, 2023 Jun 30;12(2):41-50

Communication work also protects alliance. A clinician who says “Do not ritualize” may be heard as “Your suffering is foolish.” Explaining the learning model and inviting correction can preserve consent. The framework is useful when it improves ERP engagement or values-based action, and should be revised if it becomes abstract rumination.

XVII. SPECIAL CLINICAL FACTORS

A. Insight and overvalued ideas

Insight varies over time and by theme. Poor insight can reduce willingness to test beliefs but does not exclude OCD. The clinician avoids direct endless debate and uses collaborative experiments scaled to available doubt. Marked fixed beliefs, disorganization, or hallucinations require assessment for psychosis and comorbidity.

B. Tics

Tic-related OCD may have earlier onset and different symptom patterns. The presence of tics can affect augmentation decisions and may require habit-reversal or comprehensive behavioral intervention for tics in parallel. Compulsions and tics can overlap phenomenologically; urge, purpose, and feared consequence help differentiate them.

C. Autism and sensory factors

Autistic repetitive behavior may be pleasurable, regulating, or preference-based rather than driven by obsessional threat. OCD can coexist. Treatment may need concrete formulation, predictable structure, sensory adaptation, and involvement of supporters with consent. Exposure should target OCD rather than extinguish harmless autistic regulation.

D. Pregnancy and postpartum

Perinatal intrusive thoughts can be profoundly distressing and are often concealed. Intrusive harm thoughts in OCD are not equivalent to intent, but assessment must distinguish obsessional fear from depression, psychosis, and actual risk. Medication decisions weigh maternal illness, fetal or infant exposure, breastfeeding, and prior response with specialist input.

XVIII. RECOVERY, REHABILITATION, AND RELAPSE

Symptom reduction can uncover practical deficits created by years of avoidance. The patient may need graded return to education, work, relationships, driving, or independent living. Rehabilitation is not evidence that treatment failed. It translates newly available behavioral freedom into life.

Relapse planning identifies early ritual expansion, renewed avoidance, family accommodation, stress, sleep disruption, and medication changes. The plan specifies which ERP exercises to restore, who to contact, and how to distinguish a lapse from a complete relapse. Medication should not be stopped abruptly.

Recovery can include residual intrusive thoughts. The target is a changed relationship to these thoughts and less control by compulsions. A patient who experiences an intrusion and returns to valued action has achieved something clinically important even if the mind is not silent.

XIX. ERP WHEN DISTRESS DOES NOT FALL

Patients are often taught that anxiety will rise and then habituate. When it does not fall during a session, they can conclude that exposure failed. Habituation is one possible observation, not the only goal. The patient may learn that distress can coexist with action, that the feared event did not occur within the observed period, or that uncertainty is survivable without ritual.

Review whether the task was relevant and whether covert neutralization continued. If distress remained extreme without learning, reduce intensity or change context while preserving the core uncertainty. More distress is not automatically more treatment. Repeated overwhelming exposure can increase avoidance.

The therapist should also review actual consequences. If an exposure produces a reasonable adverse outcome—an item is damaged or another person is inconvenienced—the learning is not that nothing bad happens. It is that ordinary consequences can be repaired without compulsive control. Exposure should model realistic responsibility, not magical invulnerability.

XX. PARTIAL RESPONSE: WHAT SHOULD BE ADDED?

Partial response is the most common complex decision. If an SRI helps but rituals remain, high-fidelity ERP may add a different mechanism without increasing pharmacologic burden. If ERP helps but severe symptom intensity blocks practice, an SRI may facilitate engagement. If both were adequate and partial, a specialist can consider antipsychotic augmentation, intensified ERP, or another sequence.

The residual symptom is examined. Continued lateness from checking suggests response prevention; severe depression suggests depression treatment; family conflict suggests accommodation work; inability to organize practice may require executive support. “Add something” should mean add the missing active component, not automatically another drug.

The patient's preference and prior burden matter. Someone who experienced severe metabolic effects may reasonably choose intensive ERP over another antipsychotic. Someone without access to specialist therapy may need advocacy or digital support. Evidence cannot be separated from feasibility.

Haverkampf, C. J. (2023). Treatment-Resistant Obsessive-Compulsive Disorder: An Updated Clinical Review. J Psychiatry Psychotherapy Communication, 2023 Jun 30;12(2):41-50

Haverkampf's discussion of treatment-resistant anxiety emphasized renewed formulation when an initial plan fails (Haverkampf, 2017b). The same principle applies here, but OCD-specific evidence determines the active treatment. Communication, meaning, and relationship can explain barriers; they do not replace response prevention.

XXI. CHILDREN, ADOLESCENTS, AND FAMILIES

OCD often begins before adulthood. Developmental assessment distinguishes rituals from age-appropriate routines and considers tics, autism, learning, school, and family context. Pediatric ERP uses developmentally appropriate language and active caregiver participation without assigning blame.

Parents may provide reassurance, complete rituals, or permit school avoidance to prevent distress. A graded accommodation plan helps them support approach. Reward can acknowledge effort and response prevention rather than promise that anxiety will vanish. School staff may need a clear plan that supports attendance without facilitating compulsions.

Medication decisions in children require specialist attention to evidence, licensed status, activation, suicidal thinking, growth, and family preference. Advanced invasive interventions have exceptionally high ethical and developmental thresholds and are outside ordinary pediatric care.

Transition to adult services is a point of risk. Treatment history, effective exposures, medication response, and family roles should be transferred in a structured record so that resistance is not inferred from incomplete notes.

XXII. THE THERAPEUTIC RELATIONSHIP

OCD can recruit the therapist into certainty. The patient may ask whether the diagnosis is correct, whether an exposure was completed perfectly, or whether a thought proves danger. The therapist can answer genuine treatment questions while identifying repetition. A warm refusal is part of treatment, not withdrawal.

Ruptures are common when the patient feels pushed or the therapist feels that rituals are being hidden. The clinician can say what was observed, invite the patient's interpretation, and renegotiate the task. Concealed rituals are expected within a disorder organized around shame and relief; discovery should improve formulation rather than trigger punishment.

Therapist competence includes awareness of taboo themes. Visible shock or unnecessary risk escalation can reinforce shame. At the same time, the clinician conducts a real risk assessment when behavior or intent warrants it. Phenomenological precision protects both safety and dignity.

Supervision is important in refractory cases. A fresh observer can detect reassurance, an irrelevant hierarchy, or drift into supportive therapy. The patient can be told that consultation is a quality measure, not evidence that the case is hopeless.

XXIII. MEASUREMENT-BASED FOLLOW-UP

The Y-BOCS provides a common language for severity and response, but the same total can conceal different burdens. Time spent may fall while distress remains, or control may improve while avoidance continues. Item-level review and a brief functional profile make the score interpretable.

The patient identifies two or three recovery behaviors: prepare food with standard hygiene, leave home after one check, attend worship without repeating, hold a child without reassurance, or complete work on time. These are reviewed alongside symptoms. An intervention that changes a number but not any chosen life activity deserves scrutiny.

Adverse effects are measured with equal seriousness. Weight, metabolic markers, movement symptoms, sexual function, sleepiness, cognition, and quality of life may determine whether an average symptom gain is worthwhile. Advanced interventions add surgical, device, and neuropsychological outcomes.

Measurement frequency should not feed OCD. Repeated daily scoring can become checking. A planned weekly or visit-based interval is often sufficient, with urgent reporting of defined safety concerns. The patient should know that ordinary fluctuation does not require an immediate treatment change.

After each trial, the record uses one of a small number of conclusions: inadequate exposure, intolerable, no response, partial response, response, remission, or relapse. The evidence for that conclusion is stated. This prevents future clinicians from repeating an ineffective intervention or overlooking a partially effective one.

Table 5. Minimum outcome set in refractory OCD

Domain	Measure	Why it matters
OCD severity	Clinician-rated Y-BOCS with item-level review	Common response language and symptom pattern
Compulsions and avoidance	Time, frequency, covert rituals, reassurance, avoided contexts	Detects maintenance hidden by the total score
Function	Patient-selected activities, self-care, work, education, relationship	Shows whether life is widening
Accommodation	Specific behaviors performed by relatives and associated burden	Guides family intervention

Haverkampf, C. J. (2023). Treatment-Resistant Obsessive-Compulsive Disorder: An Updated Clinical Review. J Psychiatry Psychotherapy Communication, 2023 Jun 30;12(2):41-50

Domain	Measure	Why it matters
Adverse effects	Agent- or procedure-specific physical, cognitive, sexual, and emotional effects	Determines net benefit and stop decisions
Risk	Suicidal thinking, injury, malnutrition, aggression, inability to meet basic needs	Determines urgency and setting

XXIV. SAFETY AND ETHICS

Severe OCD can cause skin damage, malnutrition, dehydration, inability to use sanitation, hazardous checking, loss of housing, or suicidal thinking. Risk assessment should be direct and repeated. Emergency or inpatient care may be needed when basic needs or safety cannot be maintained.

ERP must not require actual contamination with dangerous material, illegal action, nonconsensual sexual behavior, abandonment of necessary medical care, or violation of reasonable religious practice. The therapist's confidence does not replace a safety standard. Consultation can clarify ambiguous risks.

Advanced interventions require independent governance because desperation can affect consent. The service should disclose evidence limits, alternatives, conflicts, aftercare, and financial burden. Patients who decline an invasive intervention remain entitled to care.

XXV. LIMITATIONS AND RESEARCH NEEDS

Resistance definitions vary, psychotherapy fidelity is incompletely reported, and pharmacologic augmentation trials are often short. Advanced-intervention evidence relies substantially on selected samples and open follow-up. Publication bias and center expertise affect apparent outcomes. Findings from severe specialist cohorts do not apply automatically to ordinary outpatient nonresponse.

Research needs standardized resistance stages, head-to-head sequencing trials, longer harm monitoring, better ERP fidelity reporting, and outcomes beyond Y-BOCS. Patient priorities, family burden, cognitive and personality effects, and access equity should be measured. Communication-focused hypotheses need controlled evaluation.

XXVI. CONCLUSION

Treatment-resistant OCD calls for a careful reconstruction of what has actually been tried: diagnosis, overt and covert rituals, severity, function, ERP content and dose, medication exposure, adherence, tolerability, and comorbidity. Adequate ERP and SRI treatment remain the foundation. Verified nonresponse then supports a staged discussion of optimization, combination, switching, selected antipsychotic augmentation, specialist stimulation, and—in exceptionally severe, chronic cases—neurosurgical options. For a person exhausted by repeated trials, another audit may feel like further delay; it should instead prevent avoidable repetition, acknowledge prior burden, and produce a sequence the patient can understand and influence. Experimental agents remain uncertain, and a communication-focused formulation can support alliance without replacing ERP evidence. Persistence deserves collaboration, measured endpoints, and continued care, never blame or an automatic escalation to polypharmacy or invasive treatment.

XXVII. DISCLOSURES

Conflicts of interest—The author developed Communication-Focused Therapy® and has related publications. It is identified here as an author-developed supplementary framework and is not presented as a replacement for ERP or established evidence-based treatment. No other conflicts were reported.

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XXVIII. REFERENCES

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