

was patient rated (rather than clinician rated) is even more worthwhile to highlight. The patient's point of view is increasingly sought because, in the end, it is the patient not the doctor who must take the medication.

Differences between the full versus the per-protocol sample are common because clinically important events, such as poor efficacy or unpleasant side effects, can cause patients to withdraw from a study prematurely, such that the final per-protocol results do not reflect the important differences between the interventions. However, the difference in CGI efficacy index (CGI minus side effects at 6 weeks) was significant, suggesting that the index is driven by a side-effect difference.

Further analyses could explore whether the quality-of-life differences were mediated by changes in extrapyramidal symptoms. Unfortunately, the subjective well being under neuroleptic treatment (SWN-K) scale (high with FGAs) was not given at each visit, which might have shed light on the mechanisms.

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The road to improvement in obsessive-compulsive disorder



An important study by Petros Skapinakis and colleagues¹ in *The Lancet Psychiatry* compares the efficacy of pharmacological and psychotherapeutic treatment strategies for adults with obsessive-compulsive disorder. The authors should be commended for having systematically reviewed just over 36 years of literature (1980–2016) and for using a new analytical approach—network meta-analysis—which allows for simultaneous comparison of several treatments in a single model and has been previously applied to other mental disorders.² The network meta-analysis¹ included 54 randomised controlled trials (RCTs) and 6652 participants.

This comprehensive, carefully done study¹ is an example of how obtaining of evidence-based information to guide clinical practice is challenging, even in a well explored research area. Despite the large number of published RCTs, important clinical questions remain unanswered concerning obsessive-compulsive

disorder treatment. As properly acknowledged by the authors, several gaps in knowledge remain to be addressed in future research. One of these gaps is that no potential differences in the efficacies of individual SSRIs or between SSRIs as a group and clomipramine could be shown; they seemed to be equally effective. The mean Yale-Brown Obsessive Compulsive Scale difference was –3.49 (95% credible interval –5.12 to –1.81) for SSRIs and –4.72 (–6.85 to –2.60) for clomipramine. The authors could not examine whether higher doses of the same drug are associated with greater treatment responses. Likewise, when studies that used waiting list control groups were excluded, the effects of recommended psychotherapies were similar in magnitude. The mean Yale-Brown Obsessive Compulsive Scale difference was –10.41 (95% credible interval –14.04 to –6.77) for behavioural therapy, –9.45 (–13.76 to –5.19) for cognitive therapy, and



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–7.98 (–11.02 to –4.93) for cognitive behavioural therapy. Therefore, the specific aspects of these approaches that are most effective are unclear.

Another point is that although the effect of psychotherapeutic interventions was greater than that of medications, pure psychotherapeutic and pharmacological treatments could not be compared directly because most studies of psychotherapy included patients taking stable doses of antidepressants. Considering the short median duration of the RCTs included in the analysis (12 weeks [IQR 10–12]), medium-term and long-term responses to treatment are important aspects warranting further study. Obsessive-compulsive disorder is usually a long-lasting condition, and consistent clinical improvement might take much longer than 3 months to achieve. Almost all of the RCTs included in the analysis involved interventions recommended for obsessive-compulsive disorder in current guidelines (SSRIs, clomipramine, and behavioural and cognitive therapies). The effectiveness of other medications and forms of psychotherapy (eg, psychodynamic therapies) therefore remains largely unknown.

Individual and group formats of behavioural or cognitive interventions were not compared. In trials that used both formats, data were extracted only for groups with the individual format. Nevertheless, some characteristics and therapeutic factors of group psychotherapy (eg, universality, instillation of hope, altruism, socialising, and interpersonal learning)³ might be particularly important for patients with obsessive-compulsive disorder who are usually ashamed of their symptoms and feel hopeless and socially isolated.⁴ Obsessive-compulsive disorder is a mosaic of diverse phenomenological manifestations, and some symptom dimensions (eg, hoarding symptoms) seem to have a worse response to treatment than do other symptoms.⁵ Thus, possible phenotypic differences in treatment response are a relevant yet underexplored clinical aspect. Even though comorbidities (except for schizophrenia and bipolar disorder) were allowed in most RCTs included in the analysis, the authors could assess only the effect of depression—the most common comorbidity in obsessive-compulsive disorder—because of an absence of information. Other disorders (including anxiety, somatoform, impulse control, trauma-related,

substance use, and personality disorders) are very common among patients with obsessive-compulsive disorder and can affect adherence and response to treatment.⁶

Several other factors that can influence treatment response should be explored in future research, including the quality of the professional-patient therapeutic alliance;⁷ level of insight,^{8,9} which varies considerably between patients and within the same patient over time or according to symptom dimensions; and family accommodation to the symptoms.^{9,10} Family accommodation is a very common phenomenon in obsessive-compulsive disorder and has been associated with treatment refractoriness.^{9,10} Skapinakis and colleagues' network meta-analysis focused on adults with non-refractory obsessive-compulsive disorder; future studies are warranted for children and adolescents. For refractory patients, several alternative interventions have been investigated, mostly in the last decade, including pharmacological (eg, adjunctive antipsychotics, memantine, riluzole, ketamine, ondansetron, lamotrigine, topiramate, pregabalin, and gabapentin),^{9,11} somatic (eg, deep-brain stimulation, transcranial magnetic stimulation, and limbic surgery),^{9,11} psychological (eg, psychoeducation, family and motivational interventions, and intensive residential psychotherapy),⁹ and mixed approaches (eg, d-cycloserine as an augmentation strategy of behavioural therapy).⁹ Beyond symptom reduction, improvement in quality of life is a crucial treatment goal to be monitored, as well as factors associated with relapse after successful treatment. This secret, complex, chronic, and debilitating disorder requires increased identification and improved access to evidence-based treatments in the first place.¹² Delayed help seeking⁴ and an inadequate number of well trained health professionals are important problems to be addressed. For all of these reasons, "a long and winding road" still lies ahead before the distress of patients with obsessive-compulsive disorder and their families is really alleviated.

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Psychosocial interventions to prevent repeated self-harm



More than 800 000 people die by suicide every year, and for each suicide there are at least 20 others attempting suicide. Intentional self-harm is often repeated and associated with risks for future suicide. According to WHO,¹ prevention of suicide is a global imperative, as suicide and suicidal behaviours constitute a growing problem in most countries and health-care systems require large amounts of resources to address them.

Hawton and colleagues' systematic review and meta-analysis in *The Lancet Psychiatry* on the efficacy of psychosocial interventions after self-harm in adults is both meticulous and a necessary update of an earlier review of psychosocial and pharmacological treatments in the prevention of repetition of deliberate self-harm.^{2,3} The present publication points to the effectiveness of both cognitive behavioural therapy and dialectical behaviour therapy in the prevention of repetition of self-harm. These results will hopefully assist policy makers and clinical practitioners to choose evidence-based options for treatment.

Cognitive behavioural therapy recognises the central role of cognitive factors in the development and maintenance of suicidal behaviour, whereas dialectical behaviour therapy emphasises emotion dysregulation and interpersonal dysfunction. In the prevention of suicide, such therapies focus on training of problem-solving skills, alongside the improvement of social capacity by monitoring situations that

provoke anxiety, depressive feelings, and destructive thoughts and behaviours. Moreover, they provide help with cognitive restructuring, improve interpersonal relationships, reinforce adaptive behaviours, and emphasise commitment to change the destructive behaviour. Hopelessness is reduced when a suicidal individual perceives increased self-efficacy in solving problems. A sense of hope is conveyed through psycho-education and increased knowledge about how to diminish distress, while increasing assertiveness, emotional regulation, and motivation through discussion of reasons for living.

Psychosocial therapies are contact oriented. The opportunity to discuss existential problems in a safe environment with a professional who pays attention is probably one of the key components of therapeutic success.⁴ The fact that this therapy includes encouragement by a therapist who actively responds to difficulties matters, because suicidal people often do not have attention and encouragement in their lives; many are tormented by traumatic childhood experiences and an absence of positive role models.³ Suicidal behaviour is triggered by the interplay of social, cultural, psychological, economical, biological, societal (environmental), and existential factors. With this in mind, the need for meaningful human interactions cannot be underestimated.⁵

Interestingly, Hawton and colleagues show that there are other promising psychosocial interventions or

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