An Intensive Outpatient Approach to the Treatment of Obsessive-Compulsive Disorder: Case Exemplars

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Key Words: obsessive-compulsive disorder, treatment, cognitive-behavioral therapy, case report, psychotherapy, exposure and response prevention

Abstract

Two case reports are presented that describe daily cognitive-behavioral treatment for Obsessive-Compulsive Disorder in adults. Specific therapeutic interventions for each patient are discussed, highlighting the potential benefits of an intensive treatment approach, particularly for those who have been treatment refractory. These cases provide preliminary support for the effectiveness of this treatment approach and future directions for research in this area.

Obsessive-compulsive disorder (OCD) is a chronic and impairing condition with an estimated lifetime prevalence in adults of 2.5% (American Psychiatric Association, 1994). OCD is often associated with significant social, occupational, and familial dysfunction, which is thought to be related to the considerable distress and amount of time and effort associated with ritual engagement (Steketee, Chambless, & Tran, 2001). In addition, comorbid emotional and behavioral disturbances are common, with approximately 60% of patients also meeting criteria for a depressive or anxiety disorder (Steketee, 1993).

Controlled treatment trials have demonstrated cognitive-behavioral therapy (CBT) to be effective for OCD in adulthood (see Franklin & Foa, 2002 for a review). This therapeutic approach for treating OCD can be broken down into two general components. First, in exposure and response prevention (ERP), patients are gradually exposed to anxiety-provoking stimuli while refraining from engaging in compulsive behaviors or rituals (Meyer, 1966). Such extended exposure to anxiety-provoking stimuli results in the habituation of anxiety. Further, exposures provide the patient with objective data that contradict his or her inaccurate expectations of harm and responsibility that often motivate rituals (Foa & Kozac, 1996). Second, cognitive

therapy teaches the patient to identify and reframe anxiogenic cognitions. The proposed mechanism for change is that objective cognitions that are not linked to obsessive-compulsive anxiety will result in a reduced need to perform compulsive acts. Controlled studies of CBT with adult OCD have reported positive success rates extending upwards of 83% (Abramowitz, 1997; Foa & Kozak, 1996; Franklin, Abramowitz, Kozak, Levitt, & Foa, 2000; Himle et al., 2001).

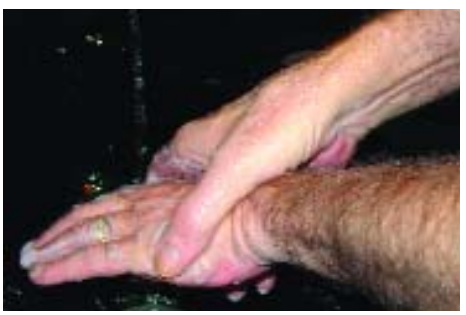
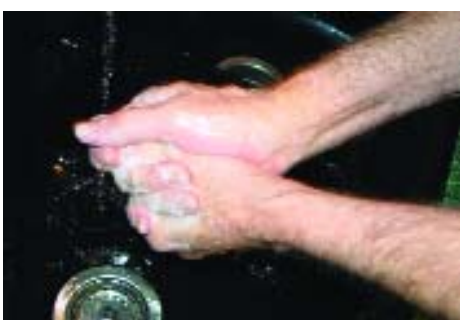
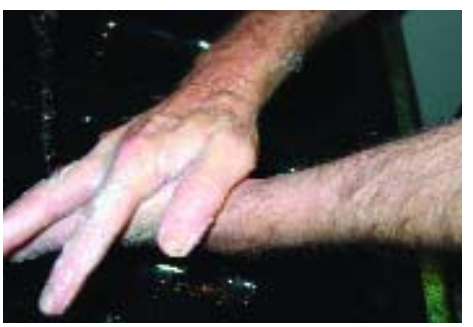
The OCD Program in the University of Florida Department of Psychiatry is based on the principles of CBT and is designed to meet the needs of adult patients with OCD. Our intensive program provides CBT services to adults on an inpatient and outpatient basis. Intensive outpatient treatment involves moving to Gainesville, Florida for several weeks, which usually requires staying in a hotel, unless the person has friends or relatives living in the area. Patients are seen 5 days per week for approximately 3 to 4 weeks. Sessions typically involve exposure and response prevention in conjunction with cognitive therapy, as outlined by Franklin and Foa (2002). Family members are involved in treatment as deemed necessary to assist in the completion of homework assignments and, when appropriate, to address familial behaviors that may reinforce the patient's symptomatology (e.g., attention, escape from aversive tasks). To our knowledge, only one report of intensive outpatient treatment for OCD has been published (Foa, Kozak, Steketee, & McCarthy, 1992). In that study, patients received either placebo or imipramine for 6 weeks. Following that, all patients received daily treatment involving ERP for 3 weeks. This was associated with clinically significant treatment effects, regardless of which medication condition they were assigned.

While Foa et al.'s (1992) study of the intensive treatment was a controlled trial and the present article is a case report on 2 patients, it is important to note the differences in the treatment protocols. First, half of Foa et al's (1992) patients received a trial of imipramine for 6 weeks prior to treatment, while our study maintained the individual psychopharmacological regimens of the patients throughout the protocol. Almost half of Foa et al.'s (1992) patients were hospitalized, while both patients in our study were treated on an outpatient basis. Foa et al.'s (1992) protocol provided supportive therapy in follow-up, while our protocol maintained active treatment in follow-up. Our protocol involved cognitive therapy, while Foa et al.'s (1992) did not. Moreover, in terms of measurement, Foa et al. used the Compulsive Activity Checklist, while our protocol used the Yale-Brown Obsessive-Compulsive Scale (YBOCS; Goodman et al., 1989; Goodman, Price, Rasmussen, & Mazure, 1989), making direct comparison of results difficult.

Despite the relative success of weekly outpatient treatment, there are a number of incremental benefits that an intensive program for OCD may offer. First, existing outpatient interventions typically achieve treatment gains over a 15- to 20-week period. The present program typically lasts between 2 to 4 weeks, and thus may present as a more timely, cost-effective, and efficient means of treatment for some individuals. Second, given that many people may not have access to mental health professionals who are trained in empirically grounded interventions for OCD, the present treatment setting allows patients to receive appropriate state-of-the-art care. In the two cases we report, the lack of well-trained mental health professionals in the patients' geographic area made this intensive OCD treatment program a viable option for a concentrated treatment. Third, intensive time-limited programs may enhance the patient's motivation by becoming the primary focus for several weeks, which may not be the case with standard weekly treatment (Foa & Steketee, 1987). The two cases presented are illustrations of adult males with OCD treated within an intensive cognitive-behavioral treatment program lasting 3 to 4 weeks.

Case 1: Paul

Paul was a 29-year-old Caucasian male referred for intensive OCD treatment by his psychiatrist. Paul lived 3 hours from the University of Florida and expressed dissatisfaction with prior attempts to reduce OCD symptoms. At the time of referral, Paul was prescribed 10 mg of Prozac®, but reported that he was going to stop taking the medication because of side effects and negligible benefits. Paul noted that the initial manifestation of OCD symptoms occurred when he was 15 years old and spent a year in a foreign country. He reported feeling mistreated by his host

family and socially isolated by his peers. Following his return to the United States, Paul found himself increasingly concerned with organizing his possessions and noted that certain numbers began to have "negative associations" and acted as forewarnings of future catastrophe. Following high school, Paul had multiple jobs over several years, frequently changing positions because he felt that the atmosphere at work had become too negative. At presentation for treatment, he was working full-time as a sales associate for a local retailer.

Paul noted that his negative associations increased in severity and that he felt overwhelmed when he had to leave his house. He was unable to go to the grocery store because he felt that many of the food labels contained negative associations. He managed to engage in recreational activities with his coworkers, but acknowledged a significant preoccupation with thoughts that he would be caught staring at their genital areas and subsequently ostracized by the group. As a result, he reduced the amount of time that he spent with friends.

As per protocol, the initial goals of treatment were response prevention and exposure to feared stimuli. In session, Paul identified several objects that contained negative associations, including themes containing excessive amounts of sexual content or words associated with poor fortune. Paul was asked to discuss these items in detail and repeat the words that he felt were overly threatening. This task created significant anxiety for Paul, although he acknowledged some anxiety reduction because he was being "forced" to comply. Other in-vivo tasks included taking trips to the supermarket, where Paul placed anxiety-provoking items into his basket. Initially, this did not increase anxiety, but when he was asked to place these objects on a different shelf, his anxiety increased. Trips were also made to Paul's hotel room, where his therapists rearranged items in his cabinets, bathroom, and kitchen, and asked him to refrain from returning them to their original places. Paul admitted that while he was able to tolerate the vast majority of items being out of place, there were several things that he felt compelled to return to their initial locations. For these tasks, homework was completed until habituation to exposure was complete.

After 10 sessions over 2 weeks, Paul reported a significant reduction in the intensity of his anxiety related to his rituals. He was able to shop independently and relax in his hotel room without engaging in significant organizing behaviors. However, despite meeting many initial treatment goals, he stated that he felt more depressed than he had earlier. He noted that he was concerned about his financial and occupational situation, and felt hopeless that he would ever be able to move out of his house and initiate an intimate relationship. His obsessions about staring at his friends' genitals remained present and he was concerned that he could never be happy in the presence of others.

Cognitive therapy was initiated during the final 2 weeks of treatment, with the goal being improved self-esteem and the reduction of negative self-thoughts. Paul rehearsed playing the role of his friends and considering what he would think if he saw someone he knew staring at him. He also rehearsed conversations with other males where he was instructed to maintain eye contact. During these rehearsals, self-thoughts were examined, which often resulted in Paul realizing that he was over-catastrophizing. He acknowledged that his concern was unreasonable and that the obsessions were most prominent in large group settings, when he felt uncomfortable making small talk with people that he did not know well. He also admitted that it was far more likely that his friends would be upset with him for skipping social functions than they would be because they perceived that he was staring at them sexually. Social-skills training was initiated to help Paul feel more comfortable in large groups. Based on Paul's needs, this approach focused on enhancing his ability to initiate and maintain conversations, use adaptive body language (e.g., maintain eye contact, smile), and assert himself (see Storch & Masia-Warner, in press, for a review of social-skills training).

Following 4 weeks of intensive treatment, it was agreed that, given his 3-hour distance from the clinic, Paul would return for follow-up sessions bimonthly. Over the next 4 months, Paul reported that his compulsion to arrange his possessions remained, although at a significantly reduced level as compared to pre-treatment. Paul stated that he had temporarily moved out of his mother's home but was forced to return due to financial difficulties. He started looking for higher-paying and "less stressful" employment and noted



improved relations with co-workers. He also reinitiated a relationship with a former girlfriend. In addition, Paul reported that his depression was significantly reduced. His Yale-Brown Obsessive-Compulsive Scale (YBOCS) score was reduced by approximately 34%, from 29 at intake to 19 at follow-up. His score on the Beck Depression Inventory – Second Edition (BDI-II; Beck, Steer, & Brown, 1996) decreased by 60%, from a pre-treatment score of 15 to a follow-up score of 6.

Case 2: George

George was a 56-year-old male referred by his psychiatrist due to a long history of depression and severe OCD that had been present for over 20 years and had intensified over the past 18 months. George had enrolled in a retirement program that required him to retire from his current job as a business administrator within 5 years. He acknowledged that the thought of being out of work before the onset of Social Security had led to his "breakdown," as he was frightened that he might not be able to find a new job in his sixties. During this time, George stated that he felt angry and "out of control" for most of the day. He noted that he felt that his OCD was overwhelming his life. At the time of referral, he was taking 2 mg of Risperdal® and 100 mg of Prozac. George was washing his hands for over 30 minutes at least six times a day. He was also spending close to an hour in the shower and had a particular order regarding how he washed himself. He noted that each time he went to the bathroom he spent approximately 20 minutes ensuring that the zipper on his pants was completely closed. George also reported a compulsive need to confess to his wife whenever he looked at or spoke with another woman. He denied ever having an extramarital affair, but noted that he felt that he had "cheated" on his wife by looking at another woman.

George lived at home with his second wife. He had two sons, both of whom had recently moved away from home. George noted that his first marriage had ended when his wife became interested in someone else and moved out. He stated that she was frustrated with his OCD, but that there were other problems as well. George stated that he had trouble communicating with others, and that he often had little to say to people, even to those he loved. He stated that he enjoyed the company of his second wife, but that they had grown apart in recent years because he felt that they had little to discuss with each other. They were currently sleeping in separate rooms, and George noted that their relationship had evolved into a good friendship, rather than an intimate relationship. He admitted to some distress over this change, but was unwilling to make significant changes at home.

George attended 3 weeks of intensive treatment. The first week of treatment focused on the reduction of his rituals. George was immediately instructed to decrease his hand washing time during bathroom visits from 30 minutes to 1 minute. In clinic, George was timed in the bathroom to demonstrate that he could be successful. He was instructed to place a timer with an alarm in the bathroom and immediately stop washing when the alarm sounded. The following day, a similar plan was enacted in which his shower time was limited to 10 minutes. Given that in vivo practice for this assignment was not possible in this clinic, imaginal practice was used. The third day, George was instructed that he could not recheck his zipper after he closed it the first time. Again, imaginal exposure was used to rehearse this task in session. By the end of the first week, George reported significant reduction in his rituals. He acknowledged that he was extremely anxious at times and that significant depression was still present.

The second week of treatment focused on alleviating depression via cognitive and behavioral techniques. George was given a behavioral goal each day to engage in a pleasurable activity. Initially, George reported that he could not think of any enjoyable activities, and as such, activities were assigned to him by the therapist. During the course of the week he was assigned to go to the movies, spend 2 hours reading the newspaper, go out for dessert, and shop at the mall. He completed his behavioral homework 4 out of the 5 days of therapy, and reported enjoying having the free time. In conjunction with the behavioral therapy, cognitive techniques were employed to help George keep his anxiety in perspective. Cognitive restructuring techniques were used to help George feel less stressed at work and less concerned that he was going to have to change his job. Therapy focused on helping George view his impending

change of occupation as positive, given both the financial benefits of the retirement package and the reduced stress of a non-administrative job. Social-skills training was addressed in two sessions to help George feel more comfortable conversing with family members and colleagues at work. By the end of the second week, both George and his therapist subjectively noted that his rates of ritual engagement remained very low.

The primary goal of treatment during the final week was to address George's living situation and his obsessions regarding confessing about other women. George acknowledged that he and his wife had not been intimate for a long time and he had thoughts of extramarital relationships. He steadfastly denied that he would ever pursue an affair and stated that he found thoughts about other women to be intrusive. As an exposure exercise, George visited a shopping mall with the directive to sit at a table in the food court and discreetly glance at women as they passed him. He agreed to refrain from calling his wife that night. George stated that the urge to confess was very strong, and he broke down and called his wife, but did not confess. This exercise was assigned for two more days, in different locales. By the end of the third assignment, George stated that his urge to call his wife had lessened significantly. He admitted that his need to confess may have been a poor attempt at communication with his wife. He agreed that he and his wife needed to spend more time out of the home, engaged in enjoyable activities.

Following termination of the program, George agreed to return weekly for 4 weeks, and biweekly for the next 3 months. Over those 4 months, George reported small relapses in his rituals, but the severity did not approach pre-treatment levels (e.g., hand washing for 3 minutes, double checking his zipper). His urge to confess had not returned following his discharge from the program. George stated that he felt better, although he believed that some depression remained. He and his wife attempted to spend more time together, but when she was unwilling, George initiated pleasurable activities independently. His job remained stressful, but George claimed that his anxiety was reduced because he recognized that there was little he could do about his next job until he was ready to apply for a new one. Overall, George stated that he felt that he benefited from the program. At follow-up, his YBOCS score declined by over 56%, from 32 before treatment to 14 after treatment. His BDI-II score was reduced by 20%, from 15 before treatment initiation to 12 at follow-up.

Discussion

These case examples suggest that intensive outpatient CBT may be an effective treatment for adults with OCD. Consistent with Foa et al. (1992), both patients reported clinically significant improvements in OCD-related impairment, and one patient reported marked reductions in levels of depression. Importantly, the use of cognitive therapy within our treatment program differed from the behavioral protocol used by Foa et al. (1992). There were numerous differences between the protocol used in this study and that of Foa et. al. (1992) reviewed in the introduction. Our findings are also notable as both patients had received previous pharmacotherapy without significant improvement.

These cases are important for several reasons. First, given where they lived, neither Paul nor George had access to mental health professionals who were trained in empirically supported psychological interventions for OCD. Evidence suggests that limited access to clinical care is a major barrier to treatment for OCD patients (Simonds & Elliot, 2001), highlighting the importance for methods of intervention that vary from standard outpatient care. Second, upon presentation, both patients were experiencing considerable occupational and social impairment associated with their condition. While existing treatment protocols in which weekly sessions are scheduled may have effectively addressed such impairment over time, the current intensive program offers unique benefits, as we were able to quickly target problem areas resulting in a rapid return to premorbid functioning. Third, both patients had been considered refractory to pharmacological interventions prior to treatment. As up to 30% of patients in clinical trials of weekly CBT either do not respond or terminate treatment prematurely (Jenike & Rauch, 1994; Keijsers, Hoogduin, & Schaap, 1994), the present treatment protocol may prove to be an effective alternative for such patients.

This study has several noteworthy limitations to consider when interpreting the above results. First and most notably, we present 2 uncontrolled cases as preliminary evidence for the effectiveness of this intensive intervention for OCD. Thus, findings must be interpreted cautiously and need to be replicated with more patients and under more controlled conditions. Further study of this intervention is planned in our setting. Second, quality of life measures and reports from significant others were not included in the protocol, thus preventing an objective assessment of the external validity of the intervention. However, both patients' subjective reports and responses on the YBOCS and BDI-II, as well as clinical observations by the therapists, indicated marked improvements in social and occupational functioning. Third, although ratings of symptom severity were based on patient reports, treating clinicians made the ratings and were not blinded. Fourth, patients were followed for several months post-intervention to ensure that treatment gains were maintained. While this practice is recommended as a part of existing treatment protocols for OCD (Foa &

Steketee, 1987), this may not always be possible in applied clinical practice. On a related note, our follow-up was based on subjective report rather than objective assessment. Thus, we are unable to be certain of the extent to which treatment gains were maintained. Finally, the existing treatment protocol used in the intensive OCD treatment program at the University of Florida incorporates both exposure and response prevention and cognitive interventions. Given this, it is difficult to assess the relative contributions of each modality during the treatment course. Within these limitations, these case examples suggest that daily cognitive-behavior therapy applied in an outpatient setting may be an effective treatment approach for some patients with OCD. It also provides an alternative approach for those who have failed previous treatments.

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