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Individualized Intensive Treatment for Obsessive-Compulsive Disorder: A Team Approach

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Exposure and response prevention (ERP) is well-established as an effective treatment for obsessive-compulsive disorder (OCD), yet its availability is often limited by a shortage of trained mental health providers. ERP is most frequently provided on a weekly or twice weekly basis; however, research has demonstrated that intensive ERP for OCD is equally efficacious compared to longer-term weekly treatments (e.g., Oldfield, Salkovskis, & Taylor, 2011). Although intensive ERP can provide patients without access to weekly treatment an opportunity to receive treatment in an alternative format, its availability is also limited as most outpatient psychiatry clinics are not structured or experienced with offering this type of service. The goal of the current paper is to provide mental health providers with information and guidance on implementing—through the illustration of a case study—a short-term intensive individualized ERP program for OCD within an outpatient psychiatry clinic that does not routinely offer these services. Special considerations and potential challenges that should be considered when offering this type of intensive treatment are discussed. The overarching goal of the paper is to improve access to ERP for OCD by increasing the availability of intensive programs.

Obsessive-compulsive disorder (OCD) is marked by the presence of recurrent and intrusive thoughts, urges, or images causing distress (obsessions), and/or repetitive behaviors or mental acts performed in response to the obsession in an attempt to decrease distress (compulsions; American Psychiatric Association, 2013). The lifetime prevalence of OCD is 2.3% in community samples, with 90% of these individuals having comorbid psychological disorders (Ruscio, Stein, Chiu, & Kessler, 2010). Typically, OCD has a chronic course if left untreated, and is associated with markedly reduced quality of life and high levels of impairment across several life domains (American Psychiatric Association, 2013).

Exposure and response prevention (ERP) is well-established as an effective treatment for OCD and involves the patient's direct contact with situations, thoughts, and images related to the obsession(s) and subsequent prevention of compulsive behaviors that serve to neutralize and/or reduce the distress. A meta-analysis of ERP demonstrated large mean effect sizes from pre- to posttreatment (Abramowitz, 1996), and beneficial treatment outcomes have been found across both research and clinical settings (Abramowitz & Arch, 2014). Unfortunately, the majority of patients tend to have residual symptoms upon treatment completion (Abramowitz, 1998), with symptom reductions of about 48% on average (Abramowitz, Franklin, & Foa, 2002). Additionally, up to 25% to 30% of patients drop out of ERP prematurely (McDonald, Marks, & Blizard, 1988). Finally, it is important to note that the availability of ERP is often limited.

ERP is most commonly administered as once or twice-weekly individual outpatient therapy. Residential treatment or intensive outpatient programs (IOPs) provide a viable alternative for patients with residual symptoms, those who are not able to commit to a longer-term weekly program (e.g., those who are geographically distant from a treatment center or whose schedules cannot afford weekly appointments), or individuals whose level of functional impairment warrant a more intensive approach. Intensive ERP for OCD has been demonstrated to be equally robust compared to once or twice-weekly therapy sessions (Abramowitz, Foa, & Franklin, 2003; Oldfield, Salkovskis, & Taylor, 2011). Moreover, intensive ERP appeared to be superior to the twice-weekly sessions in the short term, but equivalent at follow-up (Abramowitz et al., 2003). Additional strengths of existing intensive OCD programs include closer supervision of exposure practices, easier identification of problems with treatment compliance, and settings that are conducive to patients focusing exclusively on therapy with minimal distractions, such as childcare or job responsibilities (Abramowitz et al., 2003). Finally, these programs may be advantageous when psychosocial stressors, such as at-risk

Keywords: obsessive-compulsive disorder; cognitive; therapy; exposure

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employment status, demand rapid symptom reduction (Bevan, Oldfield, & Salkovskis, 2010).

Unfortunately, the availability of IOPs specific to intensive ERP for OCD is also limited. Currently, only 18 states in the United States are known to have at least one facility offering intensive treatment for OCD (i.e., IOP/partial hospitalization or residential facility). Further, only five known facilities in North America offer residential treatment programs for OCD (International OCD Foundation, 2012). Additionally, there are few clinicians in rural communities with training and expertise in providing ERP for OCD. In fact, residential treatment programs were originally developed to address the need to provide OCD treatment services to those with limited access (Osgood-Hynes, Riemann, & Björgvinsson, 2003).

Aim of the Current Paper

The goal of the current paper is to offer mental health providers information and guidance on the implementation of a 9-day individualized ERP program for OCD within an outpatient psychiatry clinic that does not routinely offer these services.

Unique Aspects of Our 9-day Intensive Outpatient Treatment Program

In addition to addressing current limitations of existing treatment programs and providing an alternative to patients with OCD, the IOP treatment approach outlined in this paper offers many unique features. First, whereas existing IOP and residential treatment facilities often assign one clinician to facilitate ERP with multiple patients, the current program used a team approach consisting of a psychiatrist, a psychologist, and five advanced clinical psychology graduate students to treat one patient. Because our site was not developed to support intensive treatment, the team approach enabled the provision of a total of 30.5 hours of treatment to the patient, while team members were able to maintain their regular clinical responsibilities. This arrangement also provided enhanced coordination between psychotherapy and medication management providers.

Second, the current program utilized an individualized treatment approach tailored specifically to the idiosyncratic nature of the patient's presenting symptoms. This feature was important given the multifaceted nature of OCD, with potential for symptoms across a variety of obsessive and compulsive domains. During each session, at least one clinician provided one-on-one treatment to the patient. Such close supervision of the patient facilitated detailed and ongoing individualized assessment and treatment of obsessional thoughts, rituals, avoidant behaviors, and potential safety and neutralizing behaviors. Further, the team approach allowed for ongoing collaboration between the mental health providers in fine-tuning the treatment plan.

Third, the flexible nature of the current program permitted the patient to return home during the weekend so that she had opportunities for ERP practice in her most challenging environment and could generalize treatment gains. Fourth, the brevity of the current program contrasted the average treatment length in many existing IOPs (4 weeks or longer) and residential programs (8 weeks or greater; International OCD Foundation, 2012). Specifically, the program's aim was to support the patient in conducting exposures at the top of her hierarchy within 2 weeks. The highly accelerated nature of the program allowed the patient to return to her daily life with relatively little disruption and was a cost-effective alternative in comparison to existing residential treatment programs.

Case Description

The patient was a 42 year-old, married woman with two children who self-referred to the Outpatient Psychiatry Department at University of Chicago Hospital for treatment of OCD. She was not able to locate any ERP treatment providers near her hometown, and traveled approximately 350 miles to the hospital. The patient reported symptom onset at age 27. Her obsessions were specific to contamination fears, with an emphasis on bowel movements, which caused a disgust response. Subsequently, she had many compulsions in the form of extensive bathroom and washing rituals in attempt to reduce or neutralize the disgust response. Her symptoms were most severe in her home, although she experienced obsessions and compulsions outside of the home as well. At pretreatment, her obsessions and compulsions occupied at least 7 hours per day, but were described by the patient to be present almost constantly. She reported that she attended a 2-month residential program approximately 5 years prior and experienced significant symptom reduction; however, she discontinued medication and ERP practice upon completion of the program. Although the patient reported a previous history of depressive symptoms, a comorbid diagnosis of major depressive disorder was not warranted as her mood was reportedly always closely linked to her OCD severity. The patient had been prescribed escitalopram (20 mg) by a previous mental health provider but did not consistently take it.

At the initial assessment (4 months prior to starting ERP), the psychiatrist discontinued escitalopram and prescribed fluoxetine (20 mg, increased gradually to 80 mg) and risperidone (0.5 mg). The psychiatrist and patient discussed her returning to the residential program that she previously attended for further ERP treatment; however, the patient was unwilling to be away from her children again for an extended period. The psychiatrist continued to provide medication management to the

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