



## Clinical Report

## Delivering exposure and ritual prevention for obsessive-compulsive disorder via videoconference: Clinical considerations and recommendations

Elizabeth M. Goetter<sup>a,b,\*</sup>, James D. Herbert<sup>b</sup>, Evan M. Forman<sup>b</sup>, Erica K. Yuen<sup>c,d</sup>, Marina Gershkovich<sup>b</sup>, Lisa H. Glassman<sup>b</sup>, Stephanie J. Rabin<sup>b,e</sup>, Stephanie P. Goldstein<sup>b</sup>

<sup>a</sup> Massachusetts General Hospital, One Bowdoin Square, 6th Floor, Boston, MA 02114, USA

<sup>b</sup> Drexel University, 3141 Chestnut Street, Philadelphia, PA 19104, USA

<sup>c</sup> Medical University of South Carolina, 67 President Street, Charleston, SC 29425, USA

<sup>d</sup> Ralph H. Johnson Veterans Administration Medical Center, 109 Bee St., Charleston, SC 29401, USA

<sup>e</sup> Minneapolis VA Health Care System, 1 Veterans Drive, Minneapolis, MN 55417, USA

## ARTICLE INFO

## Article history:

Received 5 November 2012

Received in revised form

2 January 2013

Accepted 9 January 2013

Available online 20 January 2013

## Keywords:

Obsessive-compulsive disorder

Exposure and ritual prevention

Telehealth

Videoconference-mediated

exposure therapy

## ABSTRACT

Exposure and ritual prevention (ERP) has been shown to be effective for treating obsessive-compulsive disorder (OCD), but many people with OCD are not able to access this specialized, evidence-based mental health treatment. Internet-mediated technologies, e.g., videoconferencing, represent a way to increase the availability of evidence-based treatments such as ERP, but given that OCD is a complex disorder requiring a nuanced treatment approach, clinicians attempting to implement ERP remotely should appreciate not only the advantages but also the challenges associated with treating OCD from a distance. Using a case example, we describe this treatment method and discuss relevant clinical considerations.

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## 1. Introduction

Obsessive compulsive disorder (OCD) is a relatively common and highly debilitating anxiety disorder that affects approximately 1% of individuals in the US in any given year (Kessler et al., 2005). Characterized by distressing, repetitive thoughts and/or impulses (obsessions) and recurrent efforts to neutralize or reduce the obsessional anxiety (compulsions), OCD follows a chronic waxing and waning course that is unlikely to remit without treatment (Franklin & Foa, 2008). Fortunately, with the development of behavior therapy the prognosis of OCD has improved.

Exposure and ritual prevention (ERP), a two-pronged approach that involves exposure to the anxiety provoking content of the obsessions while simultaneously refraining from performing anxiety-reducing compulsions, is currently considered the only empirically supported behavioral intervention for OCD (Abramowitz, 2006). Its efficacy has been established from robust outcome findings across a variety of both randomized and uncontrolled studies (Abramowitz, 1997; Franklin, Abramowitz, Kozak, Levitt, & Foa, 2000). For example, ERP has been shown to be superior to progressive muscle relaxation (Fals-Stewart, Marks, & Schafer,

1993), general anxiety management techniques (Lindsay, Crino, & Andrews, 1997), pill placebo (Foa et al. 2005), and inactive control conditions (McLean et al. 2001; van Balkom et al. 1998). When compared to pharmacological interventions, ERP is superior to medication alone and adding medication to ERP confers no benefit (Foa et al., 2005). However, despite its established efficacy, only a very small percentage of individuals with OCD will receive ERP.

The National Institute of Mental Health (NIMH, 2000) estimates that approximately 3.3 million Americans suffer from OCD. Yet only a fraction of these individuals will receive treatment from a therapist who specializes in ERP for OCD. Among the barriers to successful implementation of ERP are insufficient training at the trainee level (Crits-Christoph, Frank, Chambless, Brody, & Karp, 1995), therapist underutilization of and adverse reactions to the approach (Olatunji, Deacon, & Abramowitz, 2009), inadequate dissemination efforts (Gunter & Whittal, 2010), and a maldistribution of specialist providers that places individuals in rural areas at a disadvantage. For instance, a review of the therapists listed in the International Obsessive Compulsive Foundation directory reveals that 91% of these OCD specialists practice in metropolitan areas (International OCD Foundation. Treatment providers list., 2010). Yet, over 50 million people live in non-metropolitan areas of the United States (US Census Bureau, 2000). Considering that 1% of Americans will have OCD in a given year, over 500,000 individuals with OCD will not have access to a trained therapist solely because of where they live. It is important to address the barriers to receiving quality,

\* Corresponding author at: Massachusetts General Hospital, Center for Anxiety and Traumatic Stress Disorders, One Bowdoin Square, 6th Floor, Boston, MA 02114, USA. Tel.: +1 617 643 8981; fax: +1 617 643 9715.

E-mail addresses: [egoetter@partners.org](mailto:egoetter@partners.org), [egoetter@gmail.com](mailto:egoetter@gmail.com) (E.M. Goetter).

evidence-based treatment because OCD is a debilitating disorder with significant public health implications including substantial occupational and social impairments, significant family burdens, as well as increased utilization of medical and mental health services and enormous economic costs (DuPont, Rice, Shiraki, & Rowland, 1995; Horwath & Weissman, 2000).

## 2. Technology as a means to deliver evidence-based interventions

As the use of and accessibility to technology increases, telehealth applications (e.g., interactions between health care professionals and their patients that occur remotely) are emerging as viable avenues through which to disseminate evidence-based interventions like ERP (American Psychological Association Practice Organization, 2010). Although still not ubiquitous, mental health providers' use of videoconference-mediated interventions has increased noticeably in recent years (DeAngelis, 2012). Videoconferencing interventions have a key advantage over other computerized interventions (e.g., self-help websites) and telephone-based treatments in that they incorporate the face-to-face element of therapy. Videoconferencing is an interactive way of communicating that allows real-time, simultaneous transmission of audio and video content. To date, videoconferencing-based treatments have been applied to social anxiety disorder (Yuen et al., 2010), panic disorder with agoraphobia (Bouchard et al., 2004), posttraumatic stress disorder (Deutsch, Frueh, & Santos, 2000; Germain, Marchand, Bouchard, Drouin & Guay, 2009), obsessive compulsive disorder (Himle et al., 2006) pediatric tic disorders (Himle, Olufs, Himle, Tucker, & Woods, 2010), pediatric depression (Nelson, Barnard, & Cain, 2003), mixed anxiety and depression (Manchanda & McLaren, 1998; Simpson, Deans, & Brebner, 2001), and bulimia nervosa (Mitchell et al., 2004; Mitchell, Myers, Swan-Kremeier, & Wonderlich, 2003). The initial research on the acceptability of these approaches is favorable (Simpson, 2009; Yuen, Goetter, Herbert, & Forman, 2012).

To date, only two published studies have examined videoconference-based treatment for adults with OCD (Himle et al., 2006; Vogel et al. 2012), though others are underway (Goetter, unpublished dissertation). The first, a small pilot study, found that among three participants, treatment was acceptable and resulted in clinically significant gains. A second study piloted the effectiveness of a total of 15 sessions of ERP delivered through a combination of modalities: six sessions via videoconference and nine sessions via cell phone (Vogel et al., 2012). All six participants had 50% or larger reductions in measures of OCD, depression, and general anxiety with gains at follow-up only slightly reduced. Treatment acceptability and therapeutic alliance were also rated highly by all participants. Like many of the existing studies examining the feasibility and effectiveness of videoconference-based treatments, the small sample sizes and lack of control conditions preclude firm conclusions, and replication is warranted. Nonetheless, providers have been encouraged by the preliminary findings supporting the effectiveness and acceptability of these methods.

OCD is widely recognized as an especially difficult disorder to treat, which may pose additional challenges to the remote therapist. OCD is associated with high rates of disability (Huppert, Simpson, Nissenson, Liebowitz, & Foa, 2009; Mancebo et al., 2008; Ruscio, Stein, Chiu, & Kessler, 2010) and is frequently associated with complex, comorbid conditions (Angst et al., 2005; Mancebo, Grant, Pinto, Eisen, & Rasmussen, 2009; Torres et al., 2006). Many individuals will prematurely end treatment (Stanley & Turner, 1995), and among treatment completers, many continue to exhibit residual symptoms (Whittal & McLean, 1999) with as many as 10% showing no improvement (Foa, Steketee, & Ozarow, 1985). In one study of ERP,

between 10% and 18% of individuals sought additional behavioral treatment for OCD following the acute treatment phase of the study (O'Sullivan & Marks, 1991). Taken together, these findings suggest that OCD is a chronic and particularly difficult disorder to treat.

Clinically, the delivery of ERP presents challenges to even the most experienced therapists. First, OCD is a heterogeneous disorder, meaning that the content of obsessions and manifestation of compulsions are unique across individuals. Additionally, in any given individual with OCD, it is not uncommon for him/her to experience obsessions and compulsions that vary in content across time. Second, OCD is a complex disorder typically accompanied by subtle safety and avoidance behaviors. Relatedly, OCD behaviors are often covert in nature, with compulsions frequently taking the form of mental behaviors that are not apparent to the therapist. Moreover, when compulsions take a mental form it can be difficult for the therapist to discriminate between obsessional thoughts and neutralizing (i.e., compulsive) thoughts. Finally, given that therapist-assisted exposure is more effective than patient-directed exposure (Abramowitz, 1996) the ERP therapist is required to take an active and creative approach in treatment to ensure effective exposure exercises. In doing so, it is not uncommon for the therapist to question the safety or ethics of certain exposures (Olatunji et al., 2009). In summary, the ERP therapist must be skilled in actively assessing OCD behaviors, monitoring the conceptualization of the patient's behaviors, and taking a dynamic and participatory role in the treatment. Thus, despite the promising findings from early videoconference-mediated ERP trials, it is not immediately obvious how ERP might be delivered most effectively using a remote method.

Given that remote, Internet-based interventions are becoming increasingly popular, early findings from videoconference-mediated ERP are promising, and delivering ERP (even face-to-face) presents a challenge for many clinicians, it is important to discuss the clinical application of videoconference-mediated ERP for the treatment of OCD. We delivered a pilot test of ERP via videoconference and present a case example with the purpose of (1) demonstrating the effectiveness of this method, (2) illustrating the advantages and disadvantages of remote delivery of ERP, and (3) highlighting relevant considerations for therapists who provide exposure for OCD through videoconference.

## 3. Case introduction

Mrs. A was a 42-year-old, Caucasian woman who lived with her husband and three children in a small suburban town in North America.<sup>1</sup> She worked full-time as a hospital administrator and spent the majority of her free time with her family. She was referred for treatment for OCD by her primary care physician.

Mrs. A had experienced symptoms of OCD off and on since the age of 18. Her OCD had typically concerned a fear that she would inadvertently cause harm to those around her. At the time she was evaluated, her obsessions concerned harm to various others, and specifically to her children: fears of becoming contaminated and spreading contaminants to her children, fears of becoming contaminated at work and spreading it to pediatric patients as well as coworkers and others who might have contact with children, fears that she would hit children with her car when driving, and a fear that she herself had undiagnosed HIV/AIDS and was inadvertently spreading it to others. Her compulsions included excessive hand washing, elaborate cleaning routines in her home (e.g., bathroom and toilet cleaning, excessive laundry washing, cleaning her children's beds, washing off grocery items), and at work

<sup>1</sup> Details of this case have been altered to protect the patient's identity.

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