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SUCCESSFUL OUTCOME OF EXPOSURE AND RESPONSE PREVENTION IN THE TREATMENT OF OBSESSIVE COMPULSIVE DISORDER IN A PATIENT WITH SCHIZOPHRENIA

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Abstract. We present the case of a 31-year-old man with comorbid schizophrenia and obsessive compulsive disorder (OCD) distinct from delusional beliefs. The OCD was successfully treated to 6-month follow-up with Exposure and Response Prevention (ERP) without leading to significant deterioration of psychotic phenomena. Considerations for clinicians are discussed.

Keywords: Psychosis, obsessive compulsive disorder, cognitive behaviour therapy.

Introduction

The prevalence of obsessive compulsive disorder (OCD) in schizophrenia appears to be relatively common (Poyurovsky et al., 2001) with OCD distinct from delusional presentations in 7.8% of cases. It is associated with a poorer prognosis and impaired social functioning (Poyurovsky et al., 2001). Commonly, treatment in such patients has been pharmacological, usually involving a combination of antipsychotic drugs, as well as serotonin reuptake inhibitors (Reznik & Sirota, 2000). There is paucity, however. of reliable evidence available to inform practitioners of further management options, both pharmacological and psychological (Hwang & Olper, 2000). This is in contrast to patients who suffer only from obsessive compulsive disorder in whom both psychological treatments and pharmacological treatments have been shown to be effective (Abramowitz, 1997). This may reflect concerns that increased stress of exposure-based interventions may increase vulnerability to psychotic relapse. However, literature reviews aimed at exploring this issue provided the authors with no empirical evidence to guide them. Therefore we present a case report of a man with both schizophrenia and obsessive-compulsive disorder whose OCD symptoms improved considerably with exposure

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and response prevention whilst showing no deterioration in psychotic symptoms. Implications are discussed.

Case report

The subject was referred urgently by his general practitioner in 1996 with increasing psychotic experiences. Symptoms had been present for almost one year. As a result of subsequent distress he had cut himself with broken crockery. He reported hallucinations involving a crowd of people talking to him as well as delusions of thought broadcasting, believing others and in particular his mother and his sister were able to hear his thoughts. He also experienced fear that people were talking about him in the street and kept looking at him from behind curtains when he was outside. He became increasingly socially withdrawn and had left his latest employment shortly before referral due to his psychological difficulties.

The care package instigated consisted of regular outpatient clinic attendance to see a consultant psychiatrist, weekly contact with a community mental health nurse and Quetiapine 500-mg daily. Over a 2-year period symptoms slowly settled. During this period of stability of his psychosis he became more concerned about his obsessive-compulsive symptoms. He had experienced OCD since age 16; onset linked to checking his appearance and performance for school, with the aim of reducing the vulnerability to bullying he had been subject to. It was unclear from review of his medical notes whether his OCD symptoms had actually worsened because of successful treatment of his psychosis with atypical antipsychotic or whether the improvement in schizophrenic symptoms allowed him to be more concerned and forthcoming about OCD symptoms. The main obsession at assessment was fear of making mistakes whilst carrying out daily activities, resulting in the possibility of a range of consequences from people being upset with him, disasters such as the house burning down, or death to himself/others. This led to marked autonomic arousal and an urge to ritualize. He performed numerous overt checking rituals, particularly of items such as cookers, kettles and gas fires. He also engaged in extensive cognitive rituals consisting of keeping lists, which were repeated and attached to most daily tasks. At assessment his rituals took over 8 hours daily and caused extreme discomfort when interrupted.

Treatment

Treatment consisted of graded exposure and response prevention (ERP). The treatment and its rationale were carefully shared with him, along with a discussion of potential relapse warning signs of his psychosis. During initial treatment sessions his community mental health nurse was involved in treatment to assist in the collaborative monitoring of psychotic symptoms and an action plan was established should these become apparent. He received 20 hours of therapist time focused upon exposure to distressing obsessions and ritual prevention. Exposure targets were carried out at home independently and monitored by the subject using dairies. These consisted of holding the distressing thought and resisting the use of both cognitive and physical compulsions whilst engaging in anxiety provoking activities (i.e. turning off gas fire and leaving room). Modelling of targets took place in session with the therapist if needed. The pace of therapy was carefully considered to prevent undue arousal, and initially this was slower than routinely delivered. This subject, however, readily accepted the treatment rationale and soon was able to set his own targets and progressed substantially between sessions. Treatment

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Table 1. YBOCS score

Outcome measure (score ranges)		Pre treatment	Mid treatment	Discharge	3-month follow-up	6-month follow-up
YBOCS	Obsessions (0–20)	14	9	8	5	4
	Compulsion (0–20)	17	11	9	6	5

in the end did not take longer than routine ERP for a subject with this level of OCD symptoms. Follow-up sessions at 1, 3 and 6-months post-treatment reinforced the therapeutic strategies used and relapse prevention. Further details of treatment and presentation are included in the full report available from the author. Medication remained unchanged throughout the delivery of ERP and to the 6-month follow-up reported in this paper.

Outcome

Outcomes were measured using the Yale-Brown Obsessive Compulsive Scale (YBOCS) (Steketee, Frost, & Bogart, 1996) used to measure OCD severity. Scores range from 0–40 (0–7 very mild, 8–15 mild, 16–23 moderate, 24–31 marked, 32–40 severe). Results (Table 1) show a significant reduction in OCD symptoms maintained to 6-month follow-up. Other measures of problem and goal ratings and impact on daily functioning were also used and reflect this improvement. General mood/anxiety ratings were used to monitor for increased anxiety or depression during the intervention; scoring reflected a low level of symptoms maintained throughout. Details of other measures are included in the full report. Psychotic symptoms were for the most part stable and were assessed by regular outpatient appointments with the subjects' consultant psychiatrist.

Discussion

We report the successful treatment of OCD by exposure and response prevention in a man with schizophrenia. During treatment, and subsequent to treatment, his psychotic symptoms remained stable. In this case a reasonably brief intervention has resulted in a marked reduction in severity, distress and impact of long-term symptoms. He no longer requires case management from a community psychiatric nurse as he feels competent to plan his own treatment. His psychiatrist via outpatient appointments now manages his care package. There is a dearth of reports of psychological interventions in these cases (O'Dwyer & Marks, 2000), with most discussing single cases where obsession and delusion overlap. Given the lack of controlled studies, it is difficult to suggest which patients may benefit from this intervention, given the potential risk of the worsening of psychotic symptoms that this treatment may cause. Considering this case, where OCD symptoms were quite separate from psychotic experience, it would seem relevant to consider CBT in individuals whose psychosis is stable. It would seem particularly appropriate, as in this case, with those who are well engaged in treatment, who are compliant with antipsychotic treatment and who are able to gain an understanding of therapy and its rationale. A regular review of mental state and a more graded approach than might be used for patients with OCD alone is suggested. Further case studies are recommended and would benefit from a comparison baseline period and formal measurement of psychotic

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symptoms, which was not possible in this case. Ideally, controlled trials will provide an indication of the generalizability of the approach outlined in this paper.

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