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Brief Clinical Reports

TELEPHONE TREATMENT OF OBSESSIVE-COMPULSIVE DISORDER

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Abstract. Whilst there is substantial evidence of the efficacy of exposure and response prevention in Obsessive-Compulsive Disorder (OCD), little research has focused on delivering treatment in a more cost-effective way. This study investigated the use of brief treatment of a single 45-minute face-to-face treatment session, followed by eight weekly 15-minute telephone therapy sessions, and a final face-to-face session of 30 minutes. Of the four patients included in this small pilot study, of whom all completed treatment, three clients improved and one client made slight improvement. Given these promising results, further investigation of exposure and response prevention delivered in this way is warranted.

Keywords: Obsessive-Compulsive Disorder, telephone treatment, cognitive-behaviour therapy, minimal therapist contact time.

Introduction

There is substantial evidence of the efficacy of behavioural psychotherapy for Obsessive-Compulsive Disorder (OCD). Studies have found between 60–80% of people improve between 30-60% with such techniques (Roth & Fonagy, 1997). Despite therapist directed treatments for OCD, therapist time utilized is still considerable, ranging from 15 to 50 hours over 10–20 sessions in clinical trials. For treatments where clear evidence of efficacy is available, therapists should be looking more closely at maximizing the effectiveness of the delivery of therapy in terms of the use of therapist time.

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Thus it is important to determine the minimum therapist time necessary for effective outcome. Although a paucity of research exists in this area with OCD, recent work shows promise. In a small uncontrolled study, Fritzler, Hecker and Loose (1997) found that a third of people with OCD made clinically significant improvement with a self-help manual and minimal therapist contact. In a large RCT, Marks, Griest, Baer, Kobak and Hirsch (1999) compared the efficacy of treating OCD with either manual and computer-conducted phone or therapist guided treatment. Results showed that both groups improved with effect sizes comparable with meta-analysis of OCD outcome studies. Therapist guided treatment showed a slight superiority over computer treatment but on only one outcome measure.

Design and methods

All consecutive referrals of clients with OCD over a 6-week period were assessed for inclusion in the study. Inclusion criteria for the study were: 1) Primary diagnosis of OCD (DSM-IV) criteria; 2) Y-BOCS (Yale Brown Obsessive Compulsive Scale – self-report version (Steketee, Frost, & Bogart, 1996) score of >16; 3) Access to a telephone; and 4) Agreed and consented to the study. Exclusion criteria were: 1) Obsessions without compulsions; 2) Obsessional slowness; 3) Current alcohol or drug misuse; 4) Past or present psychosis or organic brain disease; 5) Current severe depression with suicidal intent.

Clients meeting inclusion criteria received a 1-hour assessment session, a 45-minute face-to-face therapist directed session, 8×15-minute weekly telephone treatment sessions, one 30-minute face-to-face discharge session and a 1-month follow-up session.

Outcome measures

Four main outcome measures were included: 1) Yale Brown Obsessive Compulsive Scale Y-BOCS – self-report version (Steketee et al., 1996) which measures severity and frequency of obsessions and compulsion range 0–40, and also rates strength of belief (0–100%). 2) Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). 3) Work and social adjustment (Marks, 1986) – a self and assessor rated 0–8 scale (0 = no impairment and 8 = extremely impaired) on each of the 5 items – work, home management, social leisure, private leisure and family relationships. 4) Target ratings (Marks, 1986) – self and assessor rated. The client describes four main targets, that he/she would like to achieve at the end of treatment e.g., ''To bath in 20 minutes 6 times a week''. Targets are rated on a 0–8 scale with 0 denoting complete success and 8 denoting no success.

Subjects

Of 5 referrals, 4 were included in the study (1 was excluded due to low Y-BOCS score of 14).

Subject 1 was a 35-year-old married male whose main fear of 3-years duration was of inadvertently causing an accident when driving. He was unable to drive alone and more recently had taken sick leave from work, thus avoiding driving altogether.

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Subject 2 was a 30-year-old mature student. Her main problem of 3-years duration was a fear of causing harm to others, particularly by fire caused by electrical appliances. This resulted in constant checking of electrical appliances and spending in excess of 5 hours daily checking and ruminating about the potential of a fire.

Subject 3 was a 35-year-old married female with three young children. Her main fear of 10-years duration was that she might cause harm to her family via certain household chemicals. She spent up to 6 hours daily in washing and checking rituals.

Subject 4 was a 40-year-old single female whose main problem of 12-years duration was a fear of imperfection. The problem occupied 3–4 hours daily and had resulted in a loss of employment 5 years previously.

Treatment

Following an assessment of the main problem, subjects were given a 45-minute face-to-face session explaining treatment (based on exposure and response prevention). A hierarchy of fears was collaboratively drawn up between client and therapist and weekly targets identified. Such targets were highly specific and focused on behavioural change. Clients were encouraged to begin with a target that they thought to be manageable, and once achieved would move onto a more difficult target. For example, the weekly target for subject 1 during the first week was "to drive with my partner for 1 hour daily on quiet roads without asking for reassurance, returning to a place where I feel I may have inadvertently caused an accident, or ring the traffic police". At week 4 the targets included "to drive alone without checking or seeking reassurance at night for 1 hour in town traffic". At week 7 "to drive alone to work using the motorway (in rush hour traffic) for 2 hours daily (round trip was 100 miles) without checking or seeking reassurance". The therapist also encouraged clients to pre-empt potential or actual problems that may occur during treatment and to use a problem solving approach to how problems could be overcome or minimized.

Telephone sessions consisted of 8 weekly, 15-minute, telephone calls. The telephone calls consisted of reviewing the previous week's homework and setting the following weekly targets. Any problems that had occurred in the previous week and any anticipated difficulties were discussed. Further, the therapist asked the client about their mental state. During the last 2 telephone sessions, the therapist also discussed issues about relapse prevention. The final session consisted of a 30-minute face-to-face session where outcome measures were repeated, and an overall review of treatment was discussed. An individualized relapse prevention plan was designed for each client.

Results

The results of the study were promising. Three of the four subjects improved and one subject made little improvement (Table 1). Y-BOCS pre- and post-treatment mean score (pre 26.3 and post 14.3) is comparable with recent studies of cognitive-behavioural interventions in OCD. Change scores were calculated on Y-BOCS and targets (Table 2) and shows the percentage of improvement the subjects made. There was also

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Table 1. Pre-, post-treatment and follow-up scores on individual subjects

Measure	Time period	Subject 1	Subject 2	Subject 3	Subject 4
Y-BOCS (0–40)	Pre	27	25	28	25
	Post	9	10	19	19
	1 mfu	6	12	18	24
Y-BOCS strength of belief 0–100%	Pre	60%	80%	90%	80%
	Post	1%	20%	20%	10%
	1 mfu	2%	20%	20%	25%
BDI	Pre	14	25	32	19
	Post	2	11	6	12
	1 mfu	2	10	4	12
Targets 0–32	Pre	26	32	32	29
	Post	2	6	19	24
	1 mfu	0	7	16	24
Work and social adjustment 0–32	Pre	10	21	16	31
	Post	1	3	14	28
	1 mfu	0	8	11	21

Table 2. Percentage change scores pre-post treatment

Measure	Subject 1	Subject 2	Subject 3	Subject 4
Y-BOCS	675	40%	32%	24%
Targets	92%	87%	40%	17%

a significant change in mood in subjects 1, 2 and 3 and some change in client 4, and only the latter remained in the depressed range at the completion of treatment.

Discussion

In this small pilot study good results were achieved with minimum therapist time. Outcome results were comparable with other larger clinical trials with CBT in OCD. The use of telephone treatment in the pilot study and routine clinical work found that most clients preferred to be contacted in the early evening. This probably reflects the fact that for those people in paid employment having access to a service after their working hours was preferable to the disruption that taking time off work causes. For others, not working, the need to disrupt domestic arrangements is no longer present. This supports the frequent pleas from user advocates for services that are more flexible in their hours of operation. Such a flexible approach to service delivery need not be a cost burden, in that the provision of early evening clinics as part of a standard working week does not incur additional staff costs. All clients reported on their satisfaction with treatment and commented on the flexibility of timing of calls.

A further advantage of this study is the reduction of therapist time and hence cost of treatment. Time spent with all individuals was a total of less than 4 hours (which

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included assessment, administration of measures, treatment and detailed and individualized relapse prevention plan). This time is often spent in assessment alone. Moreover, not one client missed a single telephone call and considering the usual number of missed appointments in routine clinical practice, this may be another interesting facet of the study.

The authors recognize the many limitations of this pilot study. However, further investigation in this small but promising study is warranted. Follow-up studies should include randomized clinical trials with large samples, random allocation, and longer follow-up.

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