

***Response to Commentaries on Story of “Hope”: Successful Treatment
of Obsessive Compulsive Disorder***

Evidence-Based Practice in the Treatment of OCD

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^c I want to thank Daniel Fishman, the editor of this *PCSP* journal, for inviting me to write a case study like the “Story of ‘Hope’ ” (Clement, 2007), as well as for his long list of questions and suggestions following the submission of the first draft. His editorial help improved the article substantially.

ABSTRACT

Kazdin (2007) and Barlow (2007) elucidated the components of evidence-based practice and affirmed the Story of Hope (Clement, 2007) as an illustration of how such practice can be accomplished within a full-time private practice. These three psychologists agreed on a number of points. Evidence-based practice includes (a) systematic evaluation of individual patients with repeated administration of brief, objective measures before, during, and following treatment, (b) accurate diagnosis in order to select the most appropriate treatment(s) for the patient in question, (c) whenever possible using an empirically supported treatment (EST), (d) relating research findings to clinical practice and outcomes from psychotherapy back to research, (e) adapting treatment components to the particular patient and their specific circumstances, (f) continually analyzing progress, and (g) accumulating treatment outcomes across cases into a database. Finally, regarding the case of Hope herself, although there had been a drop in her level of functioning at a 21-month, post-treatment follow-up, Hope’s treatment effect size was still very large (2.57).

Key words: obsessive compulsive disorder (OCD); evidence-based practice; empirically supported treatment; treatment effect size

I was very pleased when I learned that two preeminent clinical psychologists – Alan E. Kazdin and David H. Barlow -- had been invited to write commentaries on my case study of Hope. Their comments are both affirming and thought provoking. I will reply only to a few of the ideas each discussed.

RESPONSE TO KAZDIN’S COMMENTS

Dr. Kazdin (2007) affirmed a treatment approach that weaves together systematically the activities of evaluating the individual patient to determine treatment effects over time; quantifying change so that the amount of change in a given patient may be compared to similar cases; moving back and forth between research findings and routine clinical practice; employing

standardized metrics (effect sizes) to express the magnitude of change during and following treatment; and accumulating outcomes across cases over time in a database. He summarized well what I have been trying to do in my private practice.

His commentary emphasized the importance of systematic evaluation as essential for an empirical approach to psychotherapy in routine clinical practice. He made clear that he believes that using objective measures to evaluate outcomes in routine psychotherapy can greatly help to bridge the gap between research and practice, but training programs in clinical psychology and other mental health disciplines have not trained their students how to do so. Similarly, the recently published “Practice Guideline for the Treatment of Patients with Obsessive-Compulsive Disorder” (American Psychiatric Association, 2007) fails to call for such systematic evaluation. In fairness to the document, however, it does recommend the use of rating scales such as the Yale-Brown Obsessive Compulsive Scale. And when it comes to choosing a specific form of psychotherapy, the guideline concluded, “CBT [cognitive-behavior therapy] that relies primarily on behavioral techniques such as exposure and response prevention (ERP) is recommended because it has the best evidentiary support” (p. 9).

Dr. Kazdin made clear that the traditional battery of psychological tests is not appropriate for the kind of “ongoing assessment and monitoring of individual patients ... to chart progress and make decisions about treatment” that he recommends. He emphasized the value of brief assessment instruments such as (a) the Outcome Questionnaire 45 (OQ-45) (Lambert, Hansen, Umphress, Lunnen, Okiishi, Burlingame, Heufner, & Reisinger, 1996); (b) Integra’s COMPASS Outpatient Tracking Assessment System (Howard, Brill, Lueger, O’Mahoney, & Grisson, 1995; Howard, Maras, Brill, Martinovich, & Lutz, 1996), which has evolved into the “Polaris-MH Outcomes Management System” (Grissom & Lyons, 2007); and (c) Goal Attainment Scaling (Kiresuk, T.J., & Sherman, R.E., 1968).

I did not use any of these instruments in my work with Hope. Although I have read through the OQ-45 and descriptions of its use, I have never employed it in my own practice. I have field tested the COMPASS instrument with several patients but have not used it routinely. I learned about Goal Attainment Scaling shortly after its introduction in the late 1960s and have used it with many cases. Its major advantage is that the therapist and patient can tailor-make scales to match their goals for therapy. The major disadvantage is the amount of time required from the patient and therapist to create such scales. During my career I have written over 100 distinctive scales in the Goal Attainment Scaling format, but even with the help of a resource such as *550 Indicators for Use in Setting Goals* (Garwick & Brintnall, 1977), the task is labor-intensive. I no longer do Goal Attainment Scaling.

There is another instrument that can be used for rapid and repeated assessment before, during, and following treatment. Leonard Derogatis and his collaborators have developed a 90-item scale (the SCL-90-R), a 53-item scale (the Brief Symptom Inventory (BSI)), and an 18-item scale (the BSI-18) (Derogatis & Fitzpatrick, 2004; Derogatis & Melisaratos, 1983). I used the BSI with many patients a few years ago when a particular managed care company was asking all of its patients to complete the instrument at intake and at termination or prior to the company’s approving additional treatment sessions. Currently I do not currently utilize any of the Derogatis scales in my practice, but I view his scales as well as the OQ-45 and the COMPASS/Polaris-MH

instruments as viable assessment tools for routine clinical practice. The system that I have developed and that I use in my own practice provides another alternative (Clement, 1996, 1999).

In closing my response to Dr. Kazdin's comments, I want to emphasize my agreement with him that routine, repeated, rapid assessment using objective measures that can be expressed in a standard metric is essential to answer his question: "How can we provide the best care available to this patient in front of us right now?"

RESPONSE TO BARLOW'S COMMENTS

Although Dr. Barlow (2007) said, "[I]t is only in the past 10 years that EBP [evidence-based practice] has been formally identified as a systematic method of delivering clinical care," he, Dr. Kazdin, many others, and I have spent our careers trying to promote evidence-based practice one way or another. In the 1960s, when the three of us went through our own doctoral training, I believe we all recognized that at least three problems existed. First, the evidence of what treatments worked best for what clinical problems was meager. Second, the diagnostic systems (DSM-I and DSM-II) were grossly inadequate and theoretically biased rather than being empirically grounded. Third, many of our professors, clinical supervisors, and later our professional colleagues seemed to be more influenced by theoretical systems (e.g., psychoanalysis) than empirical evidence. The good news is that the situation has been changing across these 40-plus years so that an increasing number of professionals and policy makers are seeing the value of what Dr. Barlow listed as (1) empirically supported treatments (ESTs), (2) clinical practice guidelines, and (3) evidence-based practice. I appreciated his application of these three concepts as a template for evaluating my treatment of Hope.

Clearly Dr. Barlow has been a leader in establishing, identifying, and disseminating ESTs (e.g., Barlow, 2001). As mentioned in the preceding paragraph, however, several decades ago there were frequently no ESTs available to use with a particular patient. For example, a mother brought her young son to me for treatment of a recurring nightmare and sleep walking. I couldn't remember having learned anything during graduate school about how to treat these problems, so I did a literature search. Although I found theorizing about what may cause these problems, I was not successful in finding any guidance in how to treat them. In the absence of such help, I developed a treatment plan based on Guthrie's (1938) theory of learning, had the mother implement the plan at home, and had her gather data before, during, and following the intervention (Clement, 1970). The treatment was a success.

As mentioned in the Story of Hope, during the past many years I have attended many symposia on ESTs and evidence-based practices at the annual meetings of the American Psychological Association. Oftentimes these have been in a debate-like format. In contrast, Dr. Barlow provided a very balanced analysis of what we know at present regarding the treatment of OCD and of other disorders in adults. His summary indicates that for OCD, specific treatment procedures account for the biggest part of the variance in treatment outcome, patient and other factors come in second, and therapist factors, third. He also outlined five steps to follow in doing evidence-based practice: (1) ongoing monitoring, (2) diagnosis and case formulation, (3) choose the treatment(s) (ESTs if possible), (4) adapt the treatment to the specific circumstances, and (5) continually analyze progress.

The last step relates to what seemed to be his only criticism of my managing Hope's case. He pointed out that during the course of her treatment I only repeated the objective measures at the 14th, 69th, and 103rd sessions, and he concluded, "[This] is probably not adequate to pick up various ups and downs in patient progress." I agree. Although it is very unlikely that I would have asked Hope to re-evaluate herself session-by-session (in addition to listening to her oral accounts of how she was doing), I could easily have asked her to complete the Adult Problems Checklist following every 5th or 10th session. She probably would have only needed a couple of minutes per occasion to do so.

Even though it did not seem to be a criticism, Dr. Barlow noted that I had not indicated how fees were handled for Hope's 103 sessions. All sessions were covered by insurance, but her coverage changed two or three times based on her husband's changing employers. Each of her insurance plans paid for the majority of the fee. She had a modest co-payment for each session.

Finally, in his commentary Dr. Barlow made a case for distinguishing between "psychological treatments" and "psychotherapy." Using these two categories, saying that I used both psychological treatments and psychotherapy is fair, but he did not provide clear criteria for defining the boundary between psychological treatments and psychotherapy. Implied in his comments is the idea that psychological treatments would be shorter than psychotherapy. In this regard, for the record it seems important to note that in the Story of Hope, I pointed out that the mean number of sessions per case of OCD that I treated during the first 40 years of private practice was 31 and the range was 4 to 252, but I failed to mention that the median was 22. The corresponding data for all treatment cases was a mean of 17 sessions, a median of 10, and a range of 1 to 357.

EPILOGUE

The recently released "Practice Guideline for the Treatment of Patients with OCD" (American Psychiatric Association, 2007) warned, "OCD seen in clinical practice is usually a chronic illness with a waxing and waning course" (p. 12). In light of that warning, Hope's email to me in mid June 2007 should not be a total surprise:

I am writing to you to ask for advice and help. I am not doing very well. Meaning I still have a hard time being on my own without having the urge of tidying up. Currently, [my husband] is in Europe for eleven days. . . . I cannot say that I am very successful at the changing and delaying strategy that you taught me. I feel extremely lonely and responsible for the well being of the people I love, mainly for [my husband]. I am kind of embarrassed. It is not easy for me to admit that I still have trouble with anxiety after all you taught me and after all I tried so hard to accomplish. [My husband] has been on different business trips since we moved to [our present location] and I have stopped seeing you. Although I have been more successful at dealing with my fears on those occasions I am still struggling, and this time I am really struggling. Last year when I went to Europe to defend my thesis I had a really hard time coping with stress and with separation from [him] and right now I find myself in the same situation.

Also, I have noticed that from time to time I will obsess about something, such as disease or the idea of having hit somebody while driving and having hurt the person without noticing.

I would appreciate it if you could give your opinion on this matter. I am thinking that it would be best for me to start seeing a therapist again. I trust you Paul. I often think of you and wish I could just come by your office and talk to you every week.

A few days following the receipt of the preceding email, Hope and I had a conversation on the telephone. She confessed that she still had many rituals built into her daily life and magical thinking was still a big problem. In our conversation I made a few recommendations, and she agreed to get a list of providers in her insurance plan who claimed expertise in OCD. Within a few days she sent me a list of four names. I researched each clinician and gave Hope my recommendations. Toward the end of July she was able to see the therapist who seemed the most qualified. Unfortunately, that psychologist had recently withdrawn as a provider under Hope's insurance; nevertheless, Hope scheduled a second appointment and intended to negotiate a financial agreement that would work for both Hope and the clinician.

On the morning of August 7, 2007, I sent Hope an email asking her to evaluate herself once again using the Scale of Functioning (Clement, 1999) to rate how she was doing on her original eight problems. She provided her scores that same evening:

Anxious, Tense, Worried	=	7
Bad Dreams or Nightmares	=	7
Bothered by Recurring Thoughts	=	6
Fears or Phobias (flying)	=	7
Feeling Detached from Myself	=	7
Job/Work Performance	=	9
Panic	=	6
Performing Unusual Habits or Rituals	=	7

These scores were for 21 months following the end of treatment. The mean of these eight scores was 7.00 (SD = 0.93). The mean of her scores at intake had been 4.62 (SD = 0.92) Based on these numbers, her treatment effect size at almost two years post-treatment was 2.57. In spite of her psychic distress, struggles, and slippage, Hope continued to manifest much of what she had gained.

In addition to her quantitative self-evaluation, Hope provided a narrative analysis of herself:

It took me about two weeks to get my anxiety back in check after [my husband] came back from his trip to Europe. The fact that my reproductive system is not functioning as it should is still a cause of great concern for me. However, I find that I have been very pro-active and I have tried, as you have taught me, to stay focused on what I like to do and what makes me happy even in the face of fear.... I have tried to stay as focused on my daily tasks as I possibly can at work and to make time to enjoy those little things that make life worth living: significant others, breakfast early in the morning, British mysteries, bike rides, music, arts, people you love.

I have been thinking a lot about what I learned from my 12 days as a single woman [when her husband was in Europe], and I have concluded that despite anxiety I have managed on my own. I have cooked for myself, taken care of my cat, exercised, gone to work everyday, spent time with friends, and reached out for help when I needed to.

So that is an update on the Story of Hope. In reflecting on our relatively long history of working together and in writing the present response to Drs. Kazdin and Barlow, I have two regrets. First, I don't think that I gave Hope any specific warnings about the chronic nature of OCD and the likelihood that her symptoms would ebb and flow across time. Second, I regret that I did not set up an explicit relapse prevention program (cf. Hiss, Foa, & Kozak, 1994) as we moved toward terminating treatment in the fall of 2005. Also, I want to confess that when she recently told me that she wanted to see a therapist in her new location, there was a part of me that wanted her to live *happily ever after* based on our previous work together. In contrast, I am a long-term believer in the value of booster treatments to stabilize and maintain former treatment gains, but Hope's traveling half way across the country to get booster sessions with me would not have made any sense.

Meanwhile, I am grateful for having had the privilege of serving as Hope's therapist for two and a half years, of writing the Story of Hope for the readers of *Pragmatic Case Studies in Psychotherapy*, and of preparing this response to the commentaries of Drs. Kazdin and Barlow.

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