Group Behavioral Therapy for Adolescents With Obsessive–Compulsive Disorder: Preliminary Outcomes

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A clinical trial was conducted to evaluate the efficacy of a 7-week group behavioral therapy program for adolescents with obsessive–compulsive disorder (OCD). Group sessions included therapist-assisted exposure and response prevention exercises, information regarding OCD, and the extensive use of behavioral homework assignments. An additional family session was conducted to educate families about OCD and to encourage participation in the group member's behavioral program. At the end of the group, all clients showed improvement on their Children's Yale–Brown Obsessive Compulsive Scale scores; 6-month follow-up revealed further improvement. Our findings provide preliminary support for the efficacy of group behavioral therapy for adolescents with OCD.

Individual behavioral exposure and response prevention for obsessive–compulsive disorder (OCD) has been established as an effective treatment for adults (Foa, Steketee, Doppelt, Turner, & Latimer, 1983; Foa, Steketee, & Ozarow, 1985; Rachman & Hodgson, 1980) and for children and adolescents (Berg, Rapoport, & Wolff, 1989; March, 1995; March, Mulle, & Herbel, 1994). Furthermore, reports have been published describing the group behavioral treatment of adults with OCD (Epsie, 1986; Fals-Stewart, Marks, & Shafer, 1993; Krone, Himle, & Nesse, 1991).

Epsie (1986) reported success with a 10-week group treatment for 5 OCD patients who had previously benefited from individual behavioral therapy and then relapsed. Significant decreases in obsession and compulsion ratings

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were found at the end of group therapy. Treatment gains were maintained at 1-year follow-up.

Krone et al. (1991) provided a preliminary report on a 7-week group behavioral therapy program for 36 patients. Treatment combined education about OCD, instruction in a behavioral approach to the self-treatment of OCD, and therapist-guided behavioral treatment. Results from that study indicated significant improvement in obsession, compulsion, and depression scores both for patients taking antiobsessional medications and for those who did not.

Fals-Stewart et al. (1993) found group exposure and response prevention to be more effective than relaxation therapy but somewhat less effective than individual behavioral treatment at reducing OCD symptoms. Treatment gains were maintained at 6-month follow-up.

Although group behavioral therapy has been shown to be an effective treatment for adults with OCD, there are no studies of the feasibility and efficacy of the group approach in treating children and adolescents with OCD. March, Leonard, and Swedo (1995) reported that clinicians often complain that their child and adolescent patients fail to comply with behavioral treatment assignments. Therefore, behavioral therapy groups may be an effective method for enhancing patient compliance by using the peer influences of the group. This study investigated the feasibility and efficacy of group behavioral therapy in the treatment of adolescents with OCD. An adolescent version of the 7-week group therapy program developed by Krone et al. (1991) is described, and preliminary outcome data are reported. Given the effectiveness of exposure and response prevention in the treatment of OCD and the efficiency of group therapy in general, this study is a timely extension of previous work.

METHOD

Clients

Fifteen adolescent outpatient clients with OCD participated in the group behavioral treatment program. They were evaluated in the child and adolescent outpatient psychiatry program at the University of Michigan Medical Center by various staff and faculty clinicians (i.e., social workers, psychologists, and psychiatrists) who were trained and experienced diagnosticians. After completing diagnostic interviews using an unstructured clinical format, all 15 clients were found to meet the criteria for OCD as set out in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–III–R* or

DSM–IV) (American Psychiatric Association, 1987, 1994). Exclusion criteria were mental retardation, autistic disorder, schizophrenia, and other psychotic disorders. The clients were not randomly assigned the OCD group intervention but were referred based on clinical judgment that group behavioral therapy may be an effective treatment. All clients agreed to participate in the group intervention.

The sample consisted of 9 boys and 6 girls between the ages of 12 and 17. The group had a mean age of 14.5 years; the mean age for boys was 13.6 years, and the mean age for girls was 15.8 years. All clients either were attending middle school or high school.

At the beginning of the group program, 10 of the 15 (67%) clients were receiving pharmacological treatment (primarily selective serotonin reuptake inhibitors) for OCD, and 3 (20%) were participating in individual behavioral or other psychosocial treatments at the time of referral to the group. No changes in medication dosage were made during the 3 weeks prior to the start of the group for the 10 clients participating in pharmacological treatment. During the course of the group treatment, medication doses were kept stable, and individual therapy was discontinued for the 3 clients involved in behavioral or psychosocial treatment. Five (33%) of the clients participating in the group had been nonresponders to previous individual behavior therapy.

Group Treatment

Clients were given a 7-week closed-ended treatment program following the format developed by Krone et al. (1991), which provided (a) education about OCD and its treatment, (b) a framework for externalizing OCD as the client's enemy to battle, (c) instruction in the behavioral approach to the self-treatment of OCD, and (d) therapist-guided behavioral treatment. The groups met weekly for 1½ hr. The first 45 min provided education about OCD and its treatment, and the second half of the group meeting offered behavioral treatment planning. The treatment program was conducted by the senior author (a social worker) and various cotherapist graduate social work interns. Workbooks that contained information about OCD, an outline of each educational topic, and a series of worksheets to document daily compliance and progress in behavior therapy were provided .

Each week, a new topic was covered in the educational component of the program. Topics included (a) the nature of OCD, (b) principles of behavior therapy, (c) causes of OCD, (d) family life and OCD, (e) specialized techniques for making the behavior therapy more effective, and (f) lifestyles and OCD. During the seventh educational session, group members developed behavioral exercises for a mock OCD client and evaluated the treatment

program. In addition to the seven educational sessions, clients and their families were invited to an optional family night. During this 1½-hr evening session, parents and other family members learned more about OCD and its treatment. Clients and their families also discussed family problems resulting from the patient's OCD and how these might be handled.

During the behavioral treatment portion of the weekly group, clients applied the principles of exposure and response prevention to design an individualized treatment program. Following an approach developed by March et al. (1994), clients were encouraged during the first session to develop a cognitive framework in which OCD was labeled as an externalized enemy for the patient to overcome. Also during the first session, clients completed an individualized behavioral analysis, and treatment goals were established. In initial sessions, the social work therapists actively suggested exercises for clients to carry out between sessions. Brief *in vivo* exposure was conducted within the group, if necessary, to get clients started. By the end of the group, clients designed their own behavioral exercises with the assistance of the therapists. The therapists explicitly adopted a role as coaches to help clients modify and refine their exercises and goals. Participants were expected to complete and record daily homework assignments that were reviewed each week.

During the first 2 weeks of the group, phone contacts were scheduled to encourage compliance, answer questions, and check progress. After this, clients were encouraged to call if they were unable to comply with their exercises. After the first 2 weeks, phone calls were infrequent.

Outcome Measures

The Children's Yale–Brown Obsessive Compulsive Scale (CY–BOCS) was used to rate the severity of obsessive–compulsive symptoms before and after the group treatment and at the 6-month follow-up (Goodman, Price, Rasmussen, Mazure, Delgado, et al., 1989; Goodman, Price, Rasmussen, Mazure, Fleischmann, et al., 1989). The CY–BOCS is a clinician-rated scale that scores the severity of 10 items, ranging from 0 (*none*) to 4 (*extreme*). The 10 items are divided into two subscales measuring obsessions and compulsions. The CY–BOCS has been shown to have good validity and interrater reliability and a high degree of internal consistency (Scahill et al., 1997). The adult version of this instrument (Y–BOCS) also has been reported to be a valid tool that is sensitive to clinical change (Goodman, Price, Rasmussen, Mazure, Delgado, et al., 1989). CY–BOCS scores generally translate into symptom severity as follows: 0 to 7, subclinical; 8 to 15, mild; 16 to 23, moderate; 24 to 31, severe; and 32 to 40, extreme. Raters (who were not

involved in providing the group treatment) trained in the administration of the CY–BOCS completed the ratings before and after the group treatment. The primary group therapist completed the 6-month follow-up ratings.

RESULTS

All 15 clients showed improvement in CY–BOCS scores from the beginning to the end of the group. Figure 1 presents mean CY–BOCS obsession, compulsion, and total scores at pregroup, postgroup, and 6-month follow-up. Paired students' *t* tests revealed significant improvement in mean CY–BOCS obsession scores from pretreatment to posttreatment, $t = 3.45$, $df = 14$, $p = .0039$ (Ms = 10.53 and 8.03, respectively; SDs = 4.37 and 3.54, respectively), significant improvement in mean CY–BOCS compulsion scores from pretreatment to posttreatment, $t = 8.04$, $df = 14$, $p = .0001$ (Ms = 11.3 and 7.2, respectively; SDs = 4.3 and 3.79, respectively), and significant improvement in mean CY–BOCS total scores from pretreatment to posttreatment, $t = 5.86$, $df = 14$, $p = .0001$ (Ms = 21.8 and 15.23, respectively; SDs = 8.38 and 7.12, respectively). In addition, paired students' *t* tests revealed significant improvement in mean CY-BOCS obsession scores from posttreatment to 6-month follow-up, $t = 2.6$, $df = 10$, $p = .0264$ (Ms = 8.03 and 5.64, respectively; SDs = 3.54 and 3.17, respectively), and CY–BOCS total scores from posttreatment to 6-month follow-up, $t = 2.47$, $df = 10$, $p = .0333$ (Ms = 15.23 and 11.54, respectively; SDs = 7.12 and 6.53, respectively). There was no significant improvement from posttreatment to 6-month follow-up in CY–BOCS compulsion scores. There were no significant differences in pre- or posttreatment CY–BOCS obsession, compulsion, or total scores between the 11 clients who provided follow-up data and the 4 who did not.

DISCUSSION AND APPLICATIONS TO SOCIAL WORK PRACTICE

This study provides preliminary evidence that weekly group behavioral therapy provided over a 7-week period can be an efficient and effective form of treatment for adolescents with OCD. Significant improvement in CY–BOCS scores were found from the beginning to the end of the group. The decrease in CY–BOCS mean scores translates into a change in clinical symptoms from high moderate severity (symptoms that cause significant interference in the client's functioning) to high mild severity (symptoms that cause mild interference in functioning). These results are consistent with

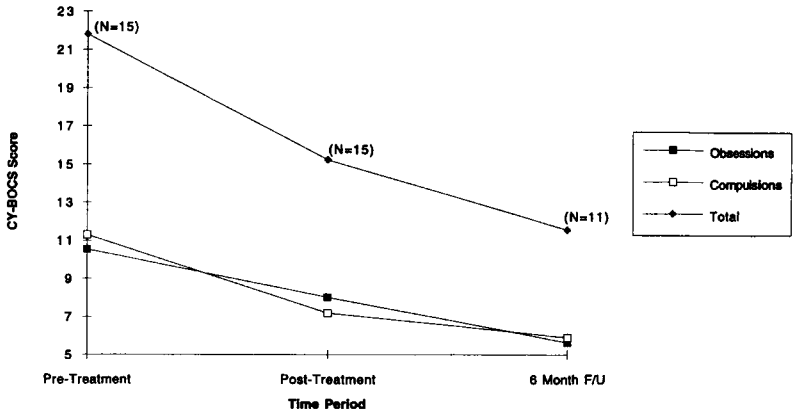

Figure 1: Mean Children's Yale–Brown Obsessive Compulsive Scale scores at pretreatment, posttreatment, and 6-month follow-up.

reports indicating the effectiveness of group treatment for adults with OCD (Epsie, 1986; Fals-Stewart et al., 1993; Krone et al., 1991).

Clinical impressions also indicated that the adolescent clients benefited from the group format, because interaction among the participants was very positive and supportive. Group members reported that meeting others with OCD helped to normalize their symptoms and made it easier for them to discuss their obsessional thoughts and ritualistic behaviors. Compliance with behavioral treatment assignments also appeared to be facilitated by the peer interaction between the group members. The clients were aware that they would be reviewing progress on daily assignments with the social work therapists and with each other. Although no formal data were collected on compliance with behavioral homework assignments, the 5 clients who previously had participated in individual behavioral therapy and were nonresponders reported better follow-through and greater degrees of compliance with homework during the group intervention. The improvement reported by these 5 clients was consistent with the improvement reported by the overall group. It was the clinical impression of the primary social work therapist that treatment compliance for the group exceeded that of other adolescents who had received only individual behavior therapy. The substantial compliance achieved by the participants in the group stands in contrast to the commonly held clinical belief that children and adolescents are noncompliant with behavioral assignments (March et al., 1995).

This study also found that clients continued to show further significant improvements in CY–BOCS obsession and total scores at the 6-month follow-up, and improvement in compulsion scores was maintained at follow-up. However, 4 of the 15 patients who participated in the group did not provide follow-up ratings, and treatment during the follow-up period was not standardized. Of the 11 clients who provided follow-up data, 3 had stopped formal treatment at the conclusion of the group, 1 continued individual behavioral treatment for another anxiety problem, 4 continued their medication treatment programs, and 3 continued to receive both medication and individual behavior therapy. Therefore, caution is advised in drawing conclusions about the long-term benefit of group behavioral therapy for adolescents with OCD.

Although the results of this study appear promising, controlled studies of group behavioral therapy using blind raters are needed to confirm the efficacy of this treatment for adolescents with OCD. The clinical effects of this treatment should be compared with established treatments such as individual behavior therapy (Berg et al., 1989; Foa et al., 1983, 1985; March, 1995; March et al., 1994; Rachman & Hodgson, 1980) and antiobsessional medication (Leonard et al., 1991; Riddle et al., 1992). It also would be useful to determine whether a combination of medication and group behavioral treatment has additional benefits over either treatment alone. Moreover, this treatment should be compared with relaxation therapy or another treatment thought to be ineffective for OCD, because treatment studies of children and adolescents with OCD using the CY–BOCS have found that the placebo response ranges from 8% (DeVeaugh-Geiss et al., 1992) to 27% (Riddle et al., 1992). Double-blind raters also are needed in future studies to reduce the possibility of rater bias. Despite these limitations, this study suggests that short-term group behavioral treatment is a feasible, efficient, and effective treatment of OCD in adolescents. The program is standardized, easily implemented, and requires less therapist time than do other behavioral programs.

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