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Case report

The efficacy of brief strategic therapy in treating obsessive-compulsive disorder: a case series

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Abstract. *Background and aim:* International guidelines indicate pharmacological therapy and cognitive-behavioral therapy (CBT) as gold standard treatments for obsessive-compulsive disorder (OCD). However, up to 40% patients do not fully respond to CBT, thus manifesting persistent symptomatology. Empirical research reported brief strategic therapy (BST) as a potential treatment for OCD. The aim of the present study is to evaluate the efficacy of BST in treating OCD and to identify the clinical characteristics associated to treatment-response. *Methods:* a BST protocol was administered to patients with OCD. During a 24-weeks observational period, the following scales have been administered at the baseline and every 4 weeks: Yale Brown Obsessive-Compulsive scale (Y-BOCS), Clinical Global Impression (CGI), Global Assessment of Functioning (GAF), Quality of Life Index (QL-I), Medical Outcomes Study Short Form 12-item, Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM), Generalized Anxiety Disorder Scale (GAD-7), Patient Health Questionnaire - 9 (PHQ-9) and Somatic Symptom Scale-8 (SSS-8). *Results:* eight patients completed the treatment and a subgroup of five patients obtained clinical remission, defined as Y-BOCS total score < 25. The repeated measures ANOVA showed a significant decreased of the Y-BOCS total scores ($p<.001$). Comparisons between the two subgroups (remitters *vs.* non-remitters) highlighted some potential baseline characteristics associated with remission: i.e., a higher mean level of anxiety, quality of life, physical health, and a lower mean level of somatic symptoms, as well as alower prevalence of personality disorders comorbidity. *Conclusions*: BST could be a useful therapeutic strategy in treating OCD patients. Further studies with larger samples and with long-term follow-up are needed to assess the post-treatment maintenance of clinical effects. (www.actabiomedica.it)

Key words: brief strategic therapy, obsessive-compulsive disorder, treatment, psychotherapy, remission

Introduction

Obsessive-compulsive disorder (OCD) is a relatively rare and chronic disorder characterized by uncontrollable, intrusive, unwanted, persistent and recurrent thoughts (defined as obsessions), followed by finalistic and voluntary behaviors or mental acts (defined as compulsions), that the patient feels compelled to perform (1). OCD can be considered one of the most debilitating psychiatric illnesses, with a lifetime prevalence of approximately 2-3% in the general population (2). Furthermore, OCD is often in comorbidity with other psychiatric disorders (especially with bipolar disorder) (3,4) and medical illnesses (5,6).

Anincreased suicidal risk is also reported for OCD patients (7,8).

To date, available treatments for adult patients with OCD include cognitive-behavioral therapy with exposition and response prevention (CBT-ERP) and pharmacotherapy (selective serotonin reuptake inhibitors - SSRIs and clomipramine) (9,10).

OCD showed a reduced rate of clinical response to placebo (and antidepressant) compared to other anxiety disorders (11). At the same time, the efficacy of CBT-ERP has been widely demonstrated in long-term relapse prevention, being also in several cases more effective than pharmacotherapy (12,13). Despite this slight superiority of non-pharmacological treatment, patients with OCD often remain symptomatic in the long-term (14-17), especially when the maintenance of exposure training is not assured (16). However, CBT-ERP efficacy resulted lower than pharmacotherapy in the case of a more severe obsessive-compulsive symptomatology, characterized by pathological doubts or repetitive mental compulsions as core manifestations , as well as in patients with depressive comorbidity (12,13,17).

Furthermore, it is well known that less than 40% of clinically evaluated patients receive a specific OCD-pharmacological treatment, while less than 10% of them obtain evidence-based therapeutic strategies (17,18). About 30% and 25% of patients with OCD prematurely interrupt both pharmacological treatments and CBT-ERP respectively, due to an inadequate clinical response (10,13,20,21),.

Currently, no treatment has been demonstrated to be enough effective to always achieve full remission in OCD. As a matter of fact, most of the interventions can be expected to reduce symptoms intensity by 50-80%, but the illness is constitutively cyclic, and patients often get worse under stress (22). In addition, because of its own nature, CBT-ERP provokes subjective anxiety, and about 25% of patients drop out before the end of treatment or refuse it. Therefore, more innovative and effective pharmacological treatments, as well as different augmentation strategies and novel psychological approaches are required, hoping to obtain full symptomatic remission.

Brief strategic therapy (BST) has empirically shown promising results for OCD treatment (23,24), due to several similarities shared with the CBT-ERP approach. Specifically, these common aspects include: structured sessions focused on the present moment and the need of patient's collaboration and active participation, within a good patient-therapist relationship. Furthermore, BST is based on the modern constructivist epistemology that conceives the subject as the active builder of its own reality, rather than a mere victim of it. The patient works both during the therapeutic sessions, together with the professional, and alone, between sessions. Given the critical issue of individuating evidence-based gold standard treatments for OCD, as well as the therapeutic goal of obtaining full symptomatic remission, the effectiveness of BST deserves to be studied.

The aims of the present case series were to evaluate the efficacy of BST in treating OCD and to determine potential clinical characteristics associated with post-intervention clinical remission.

Material and methods

Sample

Eight patients with a primary diagnosis of OCD were consecutively recruited from the outpatient psychiatric unit of the IRCCS Ospedale Policlinico San Martino, Department of Neuroscience, Rehabilitation, Ophthalmology, Genetics, Maternal and Child Health, University of Genoa, (Italy) from September 2019 to September 2020.

The following inclusion criteria were considered: a) OCD diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), criteria (1); b) age > 18 years; c) a Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) total score > 16; d) willing to voluntarily participate in the study expressed through a written informed consent; e) if taking drugs, no changes in pharmacological therapy in the 16 weeks before. Exclusion criteria included a primary diagnosis of schizophrenia, schizoaffective disorder, delusional disorder, bipolar disorder; a current primary alcohol and/or substance use disorder; pregnancy or postpartum; positive history of

acute neurological injury, a loss of consciousness related to the presence of severe medical or neurological conditions; refusal or inability to give consent prior to participate. To maintain the clinical setting close to real world conditions, the presence of personality disorders or secondary current or lifetime substance use disorders (drugs or medications) were not considered as exclusion criteria.

The study design was conducted in accordance with the guidelines provided in the current version of the Declaration of Helsinki and it was approved by the local Ethical Review Board (591/2020).

Procedures

Clinical evaluations were carried out by two expert clinicians with more than ten years of BST experience in outpatient daily clinical practice.

Psychotherapy was administered following the protocols of BST for obsessive-compulsive symptoms (23-25); the sessions had a mean duration between 45 and 60 minutes and were carried out every two weeks, until the remission of symptoms, for a maximum of eight visits. Once clinical remission was achieved, follow-up visits were performed monthly to conclude the observational period (24-weeks) andto check the maintenance of the remission state.

Measures

A semi-structured interview was used to collect sociodemographic (i.e., age, gender, marital and occupational status, education level) and clinical (i.e., pharmacological treatment, duration of illness, age at onset, medical and psychiatric comorbidities) characteristics at the baseline.

The following evaluation scales were administered: Y-BOCS including Symptoms Check-list (Y-BOCS SC), Global Assessment of Functioning, Clinical Global Impression (CGI), Quality of Life Index (QL-I), 12-item Short Form Health Survey (SF-12), Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM), Generalized Anxiety Disorder Scale (GAD-7), Patient Health Questionnaire - 9 (PHQ-9), Somatic Symptom Scale-8 (SSS-8). This structured assessment was performed at the baseline (T0) and every 4 weeks until the end of the study (16 weeks of intervention and 8 weeks of follow-up) (T6). Response was defined as a decrease of the Y-BOCS total score $\geq$ 25% with respect to baseline assessment and remission as a Y-BOCS decrease $\geq$ 25% and Y-BOCS $<$ 16 at post-treatment score (26,27).

Statistical analysis

All statistical analyses were performed using the SPSS version 25.0 (IBM Corp., Armonk, NY, USA) and the value of statistical significance was set at $p < .05$ (two tailed).

The sociodemographic and clinical characteristics of the subjects were represented as mean and standard deviation (SD) for continuous variables and in terms of frequency and percentage regarding categorical variables.

To evaluate the efficacy of BST, the Friedman test was performed on Y-BOCS total scores (considering also the obsessive and compulsive subscales) at baseline (T0) and every 4 weeks until at the end of the study (T6). Results were correctedfor age and gender.

Furthermore, variables associated with the percentage of Y-BOCS reduction at T6 were examined with Mann-Whitney U test for continuous variables and Spearman correlation for dichotomous variables.

Results

A total of eight patients met the inclusion criteria and were enrolled in the present study. The mean (±SD) age of the patients was 39.8 ± 19.3 years; half of them was female and in an active working status. The mean educational level was 12.1 ± 2.9 years, while mean age of onset and mean duration of illness were 21.5 ± 5.6 and 18.2 ± 14.3 years, respectively. Four patients (50.0%) showed an Axis II personality disorder comorbidity.

Regarding the response to pharmacological treatment prior BST, three patients reported a partial response to at least 16 weeks of anti-obsessive medications (SSRIs or clomipramine) as recommended by guidelines: i.e., $\geq$ 250 mg/day of venlafaxine,

≥ 200 mg/day of fluvoxamine and sertraline, ≥ 100 mg/day of clomipramine, ≥ 40 mg/ day of citalopram, fluoxetine, and paroxetine, ≥ 20 mg/day of escitalopram and vortioxetine. Other four patients did not achieve the adequate dosage of anti-obsessive medications due to the occurrence of significant side effects. Only one patient was not taking any pharmacological treatment prior the beginning of BST protocol.

Figure 1 reports that the clinical efficacy of BST, based on Y-BOCS total score changes, was significantly different between remitters and no-remitters after 8 weeks (T2).

Table 1 shows the efficacy of BST on the total scores of the Y-BOCS (p<.001), including obsession (p=.001) and compulsion (p<.001) subscale. The decrease of mean total score Y-BOCS between pre- and post- treatment was of 43%.

When comparisons among the two subgroups (remitters *vs.* non-remitters) were made, remitters OCD patients at baseline showed higher mean total score GAD-7 (17.0 ± 3.7 *vs.* 11.0 ± 1.7, p=.043), QL-I (5.6 ± 1.3 *vs.* 2.7 ± 1.5, p=.029), Physical Component Summary-12 (52.8 ± 4.4 *vs.* 42.6 ± 6.4, p=.033) and lower mean total score SSS-8 (9.4 ± 3.4 *vs.* 17.3 ± 2.5, p=.014) at baseline visit. On the contrary, no-remitters OCD patients reported higher prevalence of Axis II personality disorder comorbidity (100% *vs.* 20%, p=.018) (Table 2).

Discussion

These case series show preliminary evidence of the efficacy of BST for the treatment of obsessive-compulsive symptomatology in real world setting. The reduction of the average Y-BOCS total score by 43% is comparable to the literature evidence for CBT (28,29) and to the studies conducted on patients with resistant-OCD (26,30-35), even if other studies reported a higher prevalence (54-63.8%) (36-38). This slight discrepancy could be explained by the presence in our sample of patients with a positive history for appropriate treatment resistance, as well as expressing different duration of illness. It could be also related tothe small sample size and the presence of personality disorders comorbidity (Table 3).

The response rate (62.5%) of our sample is similar to that reported for CBT-ERP, described by several reviews (58-74%) (13,20,21,39), while the remission rate (62.5%) is higher than that observed in other studies (14,15,40). Our patients showed the same rates of response and remission, according to the basic assumptions of BST: the goal of OCD treatment should not be the reduction of obsessive-compulsive symptoms, but the remission of the disorder. BST intervention is aimed at remission, also because it is believed that patients who do not gain remission tend to fall back in the short-term (23-25).

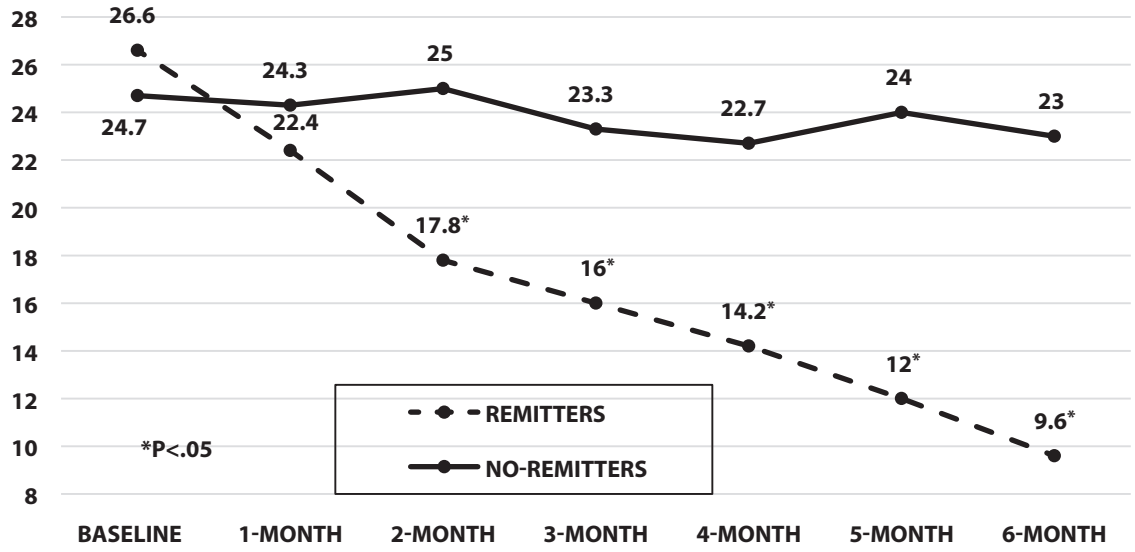

Figure 1. statistical difference on total score Y-BOCS between remitters and no-remitters

Table 1. Outcome measures for Intent-to-Treat sample (N = 8)

Mean ± SD	T0	T1	T2	T3	T4	T5	T6	F	p
Y-BOCS total score	25.9 ± 1.7	23.1 ± 3.0	20.5 ± 4.1	18.8 ± 4.3	17.4 ± 4.8	16.5 ± 6.6	14.6 ± 7.1	14.283	<.001
Y-BOCS Obsessions	13.0 ± 2.0	12.3 ± 2.7	11.8 ± 3.4	11.1 ± 3.2	10.8 ± 3.7	10.1 ± 4.9	8.9 ± 5.1	4.923	.001
Y-BOCS Compulsions	12.9 ± 2.8	10.9 ± 2.4	8.8 ± 2.7	7.6 ± 2.7	6.6 ± 2.1	6.4 ± 2.3	5.8 ± 2.6	16.883	<.001

Table 2. Difference in clinical assessment between remitters and no-remitters OCD patients.

Mean ± SD	Remitters (N=5)	No-Remitters (N=3)	p
Generalized Anxiety Disorder-7	17.0 ± 3.7	11.0 ± 1.7	.043
Patient Health Questionnaire-9	18.2 ± 9.8	18.0 ± 7.4	.977
Somatic Symptom Scale-8	9.4 ± 3.4	17.3 ± 2.5	.014
Clinical Outcomes in Routine Evaluation-Outcome Measure	2.6 ± 1.1	2.2 ± 0.7	.577
Global Assessment of Functioning	53.6 ± 11.8	55.0 ± 17.3	.895
Clinical Global Impression	5.0 ± 1.4	4.3 ± 1.5	.553
Quality of Life-Index	5.6 ± 1.3	2.7 ± 1.5	.029
Physical Component Summary	52.8 ± 4.4	42.6 ± 6.4	.033
Mental Component Summary	22.8 ± 10.8	23.7 ± 14.3	.922
Personality Disorder comorbidity, N (%)	1 (20%)	3 (100%)	.018

Table 3. Potential advantages of BST compared to CBT

Severe OCD: Bypass resistance through the prescription of the symptom
Direct intervention on caregiver' behaviors
< Number of visits to obtain clinical response (empirical)
Ad-hoc strategies for different symptom dimensions (i.e., obsessions without compulsions, magic thinking, pathological doubt, obsessions, washing clusters.
No worsening of OCD symptomatology in the early stage of treatment
(Possible) decrease of OC symptomatology from first visit
Aiming at full remission of OCD

A significant clinical response was observed after 4 weeks of treatment in two patients (25%), while all remitters responded after eight weeks. A possible explanation could be related to the different durations of illness. As for other disorders, a shorter duration of illness could predict at least the short-term efficacy of therapeutic strategies. However, further studies are needed to confirm this hypothesis. Finally, the average response time was 6.4 weeks, for an average of 4.2 sessions per patient, testifying a slightly faster response than that produced by SSRIs (9,10,13) and CBT-ERP (26,30,34). The timing of our response rates (8 weeks) is like that showed in the study conducted by Simpson and colleagues, who have nevertheless proposed a more intensive treatment protocol with 17 bi-weekly sessions of 90-120 minutes, bi-weekly phone calls and home sessions (41). Furthermore, intensive protocols are also difficult to conduct in daily clinical practice.

The 'non-remitters' OCD patients were characterized by the presence of personality disorder comorbidity, as described in several reviews about this topic (13,20,21) and consistently with the functioning of the BST protocol for the OCD treatment (23). In fact, this non-pharmacological intervention works on the perception of control, not being focused on inner conflicts, object relations or on other typical traits of

personality disorders. In particular, when personality disorder is comorbid, obsessive-compulsive symptomatology might constitute a sort of superficial "shell", covering a deeper affective or psychotic core, thus being equally less susceptible to clinical remission.

The subgroups of 'remitters' OCD patients showed at the baseline significantly higher mean score of anxiety and quality of life, particularly physical health, and lower levels of somatic symptoms. Patients with classical presentation of OCD have increased anxiety symptomatology due to pathological mechanism involved, while patients with more primitive personological defenses could experience OC symptomatology more frequently associated with somatization and, thus, also with an overall influence on the perceived quality of physical health. BST is highly effective on anxiety (23-25), while it may be less effective in patients with alexithymia and somatic symptomatology. Our findings are consistent with data literature, where lower quality of life and the presence of comorbidity were identified as predictors of no-response (10,12,13,20).

Lastly, BST is usually a well-tolerated intervention and in the present case series no drop-out was reported. This could be probably also due to the small sample size. However, the BST principal aim (i.e., engaging the patient), the absence of exhibiting tasks and the constructive use of the patient' resistance rather than its "opposition", are all factors that could lead to lower drop-out rates than those observed in CBT 8-30% (23).

Before concluding, it is necessary to underline several existing methodological differences between CBT-ERP and BST (23,24), for which it is possible to conceive BST as an innovative and alternative approach to treat OCD patients. First, while the CBT therapist guides the patient through a process of learning, awareness and voluntary effort, the BST therapist adopts targeted strategies in order to facilitate the patient's corrective emotional experiences, from the perceptual to the cognitive level through the behavioral one, being a solution-focused rather than a problem-focused approach. Furthermore, CBT methodology works for a progressive acquisition of knowledge while BST methodology aims at the effects of discovery and subsequent acquisitions, looking at relapses as opportunities to revise ongoing strategies. CBT is traditionally characterized by a logical-rational communication while BST uses an approach based on perceptual-emotional restructuring, with specific counter-rituals in order to change the patient's perception. This allows BST to focus on symptom prescription bypassing the rational pathological OC mechanism and, thus, getting around the patient's resistance to change. Therefore, the BST, not requiring exposition (13,20,23), may provide the following advantages over CBT: a) faster response to treatment and symptoms remission without any increase of anxiety; b) greater adherence with lower drop-out rates; c) chances of administration also in the case of severe OC symptoms (23).

The BST model already demonstrates its maximum effectiveness in the first 4-5 sessions and the beneficial effect can last up to three hours. Improvements in obsessive-compulsive symptoms have also been reported after the first session (23,24). These characteristics would make BST more feasible in real world clinical settings (25). In contrast, intensive CBT programs, which reached short-time clinical responses, tend to be difficult to apply in common clinical practice. Finally, it is likely that the presence of personality disorder comorbidity could limit the effectiveness of BST for the OCD treatment, as well as of CBT-ERP.

The major limitation of the study was the small sample size which limits the generalization of the results; furthermore, differences in terms of symptomatic clusters or drug-resistance were not evaluated. Secondly, the long-term effects of BST cannot be demonstrated as patient prospective evaluation continued only in the two months, following the end of treatment.

Conclusion

To the best of our knowledge, these case series are the first reporting efficacy of BST for the OCD treatment with faster response rates and a smaller number of short sessions (25). The BST model could be a very suitable treatment to be administered in daily clinical practice and could represent an innovative and additional non-pharmacological approach for patients with OCD.

The presence of personality disorders and higher levels of somatic symptoms were associated with no-response and no-remission; therefore, these patients should be treated with different therapeutic strategies. Similarly, the absence of clinical response after two months could indicate the ineffectiveness of BST.

Further long-term studies are needed to evaluate the efficacy of BST in larger samples, in severe and resistant-OCD samples and to establish the effectiveness in the long-term.

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