

Cognitive Therapy Lite

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It is a situation commonly described when beginning therapists discuss their approach to learning the cognitive therapy model: "I just finished an intake [evaluation] and thought that this patient would be a good candidate for cognitive therapy," the trainee said. "So, first, I drew a diagram and explained the model. Then I drew the triple columns and explained the concept of recording situations, thoughts, and feelings. Then I told the patient that we would meet once a week and to expect to complete homework assignments between sessions." This rather structured rendering of cognitive therapy is appropriate for some patients and some problems. For others, the structure serves as a disincentive for the patient to do the work of psychotherapy. These patients are often engaged more readily by a conversational, even informal, approach: no triple columns, no homework, limited explanation, and perhaps even less frequent appointments. Instead, the patient talks and the therapist confines his or her remarks to posing questions, asking about meanings, and occasionally telling a story to illustrate a point. The model of understanding the patient and the problem is still cognitive therapy. In searching for a phrase to capture this particular style, we decided on "cognitive therapy lite."

Obsessive-compulsive disorder (OCD) is a common and potentially disabling illness. It is thought to be the fourth most common psychiatric diagnosis after specific phobias, substance-related disorders, and major depression. There is increasing evidence that OCD has a strong biological component, and the treatment of this disease has been revolutionized by the development of the selective serotonin reuptake inhibitors (SSRIs). These medications have been proved to be quite effective in multiple double-blind, placebo-controlled trials, and their use is now considered a standard of care in the management of this disease. There are some cases in which the response to medication is inadequate and the clinician is called on to supplement pharmacotherapy with other, complementary modes of treatment.

PRESENTATION OF THE PROBLEM

Robert is a 55-year-old divorced white man who was diagnosed with OCD 17 months ago when he first pre-

sented to our psychiatric outpatient clinic. At the time of his initial presentation, he reported persistent and intrusive thoughts about harming other people. Specifically, he described having thoughts about placing sharp objects in others' food. He stated that if he saw any food that was unattended, he would immediately have the thought that he may have placed something dangerous in the food. He recognized these thoughts as strange and often absurd, yet he could not rid himself of the thoughts and would often spend hours agonizing over whether he should act on his impulses to throw the food in the garbage disposal or trash can. He lived with his elderly and sick father, and he would often have thoughts that he was somehow responsible for his father's illness, that he had harmed him with some food that contained sharp or other harmful objects. A large proportion of the patient's time was spent at home with his father as he closely monitored, and often discarded, food that may have been "contaminated."

Robert grew up as the middle of 3 children in a suburban home outside Washington, D.C. He described his early childhood as "unremarkable," and he graduated from high school near the top of his class. His mother stayed at home to raise Robert and his 2 brothers, and his father worked in a factory. Robert was unaware of any family members with psychiatric illnesses or problems with drug or alcohol use. He was married at age 21, and he and his wife had 2 children. He worked as a salesman for several different companies over the course of almost 30 years. Robert and his wife divorced 13 years ago, after their youngest son had moved out of their home. At the time of his presentation in the clinic, he was living with his father and reported using alcohol only on rare occasions, and he denied the use of tobacco or illicit drugs.

Reviewing the patient's history further revealed that he had been having intrusive thoughts since his early twenties. The thoughts had grown more persistent and bothersome over time, although the patient had never sought treatment in the past, not knowing that what he was experiencing was a treatable illness. Five years ago, his father had been diagnosed with colon cancer, and this seemed to trigger a worsening of his obsessions and resulted in ruminative worrying and some compulsive behavior, such as

throwing away food and inspecting and washing the cups, plates, and bowls around the house. Two years ago, Robert was diagnosed with prostate cancer. This further heightened his symptoms, as he grew increasingly concerned about his health. Even though he felt that these intrusive thoughts were absurd, he could not rid himself of them. His rumination, checking, washing, and discarding increased to the point that he was unable to do much else. He eventually reported these problems to his urologist, who made the referral to the psychiatric clinic.

The symptoms described by the patient were consistent with a DSM-IV diagnosis of obsessive-compulsive disorder. His thoughts were recurrent, obtrusive, and viewed by the patient himself as “out of character” or ego-dystonic. The obsessive thoughts led to a great deal of anxiety, and he began to feel “trapped” and “overrun” by the thoughts. His compulsions consisted mainly of repetitive mental exercises of reviewing his actions to be certain that he had not placed objects in food. He did have other compulsions, such as inspecting and washing food containers, as well as discarding food, although these behaviors were initially less prominent and time consuming. It is important to note that a person need only have obsessions or compulsions to meet DSM-IV criteria for this disorder, although in a vast majority of patients both are present.

Robert was initially started on paroxetine, which was subsequently discontinued due to side effects. Fluoxetine was then prescribed, and the dosage was increased to 60 mg/day. He reported some benefit at the higher dose, but again developed side effects that were troublesome to him, and he agreed to a trial of citalopram. After several months, the dosage of citalopram had been increased to 80 mg/day, and the patient reported a modest improvement in his symptoms. He noted that the thoughts did not seem to occur quite as frequently. He did, however, point out that when the obsessions did occur they were just as intrusive, troublesome, and difficult to ignore. In addition, his worrying and rumination continued to consume vast amounts of time, and his washing and discarding had both continued to the point where he was spending inordinate amounts of money on food and cleaning supplies. After almost a year in our clinic, he had achieved only a mild improvement in his OCD symptoms through the use of high-dose SSRI therapy.

Prior to my (J.S.C.) first appointment with him, Robert had been coming to the clinic once a month for 30-minute medication management appointments. During our first meeting together, I suggested to him that we meet more frequently to initiate a course of brief cognitive therapy, explaining that this might help to augment the effects of his

medication. I explained the principles of cognitive therapy in general, and he seemed very interested. However, due to transportation problems, he stated that he would be able to come to the clinic only once a month. He did offer to come for hour-long appointments once a month, and we contracted for extended once-monthly sessions, which were to consist of medication management and brief, intermittent cognitive therapy.

PSYCHOTHERAPY

We started the first hour-long session by reviewing the obsessions that were becoming more intrusive to Robert. He explained that the thoughts about placing objects in people’s food, specifically his father’s, were becoming more and more prominent and troublesome. He described spending many hours in the kitchen ruminating over these thoughts and wondering what he should or could do about them. We discussed the origin of these obsessive thoughts, and Robert clearly stated that he felt as though these thoughts came from his own mind. He went on to say that even though he believed these thoughts were “strange and absurd,” he felt that he had to “do something” when he had them. In other words, he felt the need to act on them, because he would be responsible if something bad did happen and he could have stopped it. I provided some education on OCD and attempted to normalize some of his experiences. I explained that many people had impulses to do things that may be out of character for them, but their brains did not allow them to dwell on the thought, so that a fleeting thought or strange idea came and went without a second thought. He laughed at this and explained that it was not the “second thought” that he was worried about, but rather the third, and fourth, and fifth, and sixth, and so on.

We then went on to discuss the concept of “automatic thoughts” in the context of what he was experiencing. I defined an automatic thought for him and explained that, with OCD, there are essentially 2 types of automatic thoughts. The first is the obsession, and the second is the thought that one has after the obsession has intruded. The obsession itself is difficult to control, as by definition it enters awareness without much prompting or warning. We began to focus on the “second automatic thought,” which in Robert’s case included thoughts such as, “What if I did put something in his food? . . . He may get even sicker, or I may cause him to die.” Identifying these thoughts was easy for him to do, and he went on with other examples, such as “What can I do about it? What can I do to be certain that I haven’t put anything in there?” He explained that these thoughts would

scroll through his head for hours at times, until he absolutely had to do something about it or was forced to move onto something else. I went on to explain that these thoughts were the cause of his problems, more so than the obsession itself. I asked what would happen if he was able to keep from thinking in the manner that he had just described. He thought for a moment and said, "Honestly, I have no idea."

I began the second session by describing an example of an old and long-abandoned treatment for OCD. A patient with OCD would sit in a chair in an otherwise empty room, with the therapist standing behind him or her. The patient was instructed to let the therapist know as soon as an unwanted thought entered into the patient's awareness, at which point the therapist would hurl a fragile plate or glass against the wall behind the patient with a resounding crash. Invariably, the patient would jump out of his or her chair and ask what was happening, concerned more about the noise and perhaps their safety than the thought that had just crossed his or her mind. I explained that this was a method of interrupting the thought process that led to excessive rumination and sometimes compulsions that were time consuming and often debilitating. "It gives you something else to think about," Robert interjected. "It gives you time to think about something else," I offered. We went on to discuss the idea of creating a window of opportunity after the obsession, so that he could dispute and interrupt the self-talk that would follow. We then looked at the probability of his having actually placed something in his father's food, and he was readily able to determine that there was very little likelihood that this would ever actually happen.

Robert began the third session by describing an incident in which he had gone to a neighbor's party and thrown away the birthday cake after having thoughts that he may have placed something harmful in it. "And I was really upset with myself for giving in like that," he said. We talked about "giving in" and what he could do to give himself a choice in the future. We created a list of options of what he could do when placed in a similar situation in the future. He then went on to report that he was able to "interrupt" and even "avoid" the repetitive thoughts on several occasions over the past month. He offered multiple examples, and it became clear that the birthday cake was the exception to the rule over the past month, as he had averted many potentially similar results. We looked at these successes and

examined what he was able to do to avoid the repetitive self-talk, and he began to see more clearly that he was starting to "break some dishes" on his own.

Our fourth session began with another example from Robert. This time he was having guests, and one family member placed an almost-full plate of food next to him and asked him to "keep an eye on it" until he got back from the bathroom. The thought appeared almost immediately: "Did I put something in the food?" Robert reported that his immediate next thought was, "Of course I didn't; Uncle Joey just put it down there, and there was no time for me to do anything." This dispute kept the other thoughts at bay, but not completely out of the picture, as he still contemplated throwing away the food. Uncle Joey returned and walked away with his plate of food. Robert told himself that everything would be fine and walked the other way. "And then what?" I asked. "Nothing happened," he responded with a smile, "Everything was fine."

We met again several weeks ago, at which point Robert informed me that he was doing "very well" and that "those stupid thoughts still come and go all the time, but at least I can get them to go now." He talked about his increasingly effective disputing of the previously destructive self-talk, and he offered numerous examples of successfully avoiding the ruminations and compulsions. He reported that he had only one more problem that he wanted help with. "And what's that?" I asked. "What do I do with all of this time that I have on my hands?" he replied.

Throughout the 5 sessions described above, we continued to discuss Robert's medication and its effectiveness and side effects, and we also reviewed his other medications and the status of his cancer. The extended "medication management" sessions gave us time to work on cognitive therapy techniques that he was able to readily understand and apply. No medication changes were made during the 5 months. Robert was able to apply the principles of cognitive therapy and "try them on" for himself in the intervening weeks, and this resulted in a marked reduction in his symptoms over the course of 5 sessions. We plan to continue once-a-month follow-up for medication management and meet for "refresher" courses of cognitive therapy when needed. In the meantime, it is likely that Robert will be trying to find ways to fill the time that was once occupied by his ruminations and anxiety.

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