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Adapting Mindfulness-based Stress Reduction for the Treatment of Obsessive-compulsive Disorder: A Case Report

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Obsessive-compulsive disorder (OCD) is an illness characterized by intrusive and distressing thoughts, images, or impulses (i.e., obsessions) and by repetitive mental or behavioral acts (i.e., compulsions) performed to prevent or reduce distress. Efficacious treatments for OCD include psychotropic medications and exposure and response prevention (EX/RP). The following case report presents an individual diagnosed with OCD who refused treatment with medication or EX/RP and was treated using an adapted Mindfulness-Based Stress Reduction (MBSR) program. After an 8-week adapted MBSR program, the endpoint evaluation revealed clinically significant reductions in symptoms of OCD as well as an increased capacity to evoke a state of mindfulness. Discussion includes generalizability of these findings, potential mechanisms of action, and the role of an adapted MBSR in the treatment of OCD.

Obsessive-compulsive disorder (OCD) is an illness characterized by intrusive and distressing thoughts, images, or impulses (i.e., obsessions) and by repetitive mental or behavioral acts (i.e., compulsions) that the person performs to prevent or reduce distress. The World Health Organization has identified OCD as one of the world's leading causes of illness-related disability (Koran, 2000; Murray and Lopez, 1996; Robins et al., 1984; Skoog and Skoog, 1999). Proven OCD treatments include pharmacotherapy with serotonin reuptake inhibitors (SRIs) and cognitive-behavioral therapy (CBT) consisting of exposure and ritual prevention (EX/RP). EX/RP is at least as efficacious as SRIs and may be more durable (Foa et al., 2005; Simpson et al., 2004). However, EX/RP treatment has limitations: some refuse it, up to 25% of patients who enter drop out (Kozak, Liebowitz, & Boa, 2000), many who complete do not fully adhere to the procedures or achieve remission (Simpson, Franklin, Cheng, Foa, & Liebowitz, 2005), and not all maintain their gains in the long term (Foa and Kozak, 1996).

Given these limitations, alternative approaches to treatment or methods to enhance effectiveness of EX/RP merit further exploration. For instance, methods that emphasize the importance of noticing and accepting rather than attempting to change internal experiences such as thoughts, feelings, and bodily sensations may be useful in bolstering the effectiveness of EX/RP. Mindfulness is one such method that promotes awareness and attention to internal experience and is characterized by an acknowledging and witnessing stance towards this experience (Kabat-Zinn, 2003). From this witnessing perspective, participants learn to notice the thoughts, emotions, and sensations that arise without evaluating their truth, importance, or value and without trying to escape, avoid, or change them. In this way, mindfulness may help people to live satisfying lives while experiencing anxiety instead of being primarily preoccupied with attempting to control emotional experiences or actively changing the content of thoughts.

Recently, behaviorally oriented theorists have advocated renewed attention to the incorporation of mindfulness into psychotherapy to increase its effectiveness (Hayes, Strosahl, & Wilson, 1999; Linehan, 1993; Orsillo, Roemer, Lerner, & Tull, 2004) and several approaches utilizing mindfulness techniques have been developed as stand-alone treatments. These include Acceptance and Commitment Therapy (ACT), ACT for OC spectrum disorders (i.e., skin picking), Dialectical Behavior Therapy (DBT), and Mindfulness-Based Cognitive Therapy (MBCT), as well as variants of mindfulness techniques such as mindful awareness and the 4 R's (Hayes et al., 1999; Linehan, 1993; Schwartz, Gulliford, Stier, & Thienemann, 2005; Segal, Williams, & Teasdale, 2002; Twohig, Hayes, & Masuda, 2006). These approaches and techniques, while incorporating a mindfulness component, do not focus on the formal practice of mindfulness meditation as an integral part of the treatment. They

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have, however, shown promise in helping individuals to cope with the symptoms associated with a variety of psychological disorders, including anxiety and depression. To date, there has not been a mindfulness meditation intervention applied to obsessive-compulsive disorder (OCD).

Mindfulness-Based Stress Reduction (MBSR) is an intensive outpatient stress-reduction program based on the formal practice of mindfulness meditation. Its primary goal is the integration of mindfulness into everyday life as a support in dealing with the individual's unique stressful life situations. Through a sustained process of daily home assignments, program participants learn and refine a range of self-regulatory skills aimed at awareness of internal experience (i.e., thoughts, emotions, sensations) and their effects on symptoms, feelings of health and well-being, stress reactivity, and overall sense of self and self-in-relationship. The practice of these mindfulness meditation techniques incorporates mental and behavioral components - for example, exposure, cognitive change, self-management, relaxation, and acceptance—that have been shown to be efficacious and necessary in the treatment of anxiety disorders (Baer, 2003). In the only study of MBSR for treatment of anxiety disorders, Kabat-Zinn and colleagues (1992) found that participation in the program led to significant reductions in symptoms of anxiety and depression in 22 medical patients with generalized anxiety disorder and panic disorder with and without agoraphobia. Additionally, there was a high rate of completion: 92% of participants completed the MBSR program and 84% of participants reported practicing MBSR techniques at least three or more times a week at 3-month follow-up (Kabat-Zinn et al., 1992). Although this was not a controlled trial, the results suggested that MBSR might be helpful in the treatment of anxiety disorders. The purpose of this report is to present the case of an individual with OCD who participated in an individual mindfulness-based treatment that was adapted from the MBSR program.

Case Report

Client Characteristics and Treatment History

Mr. X is a 25-year-old single Caucasian male, currently unemployed living with a roommate. He recently graduated from college with a bachelor's degree and was in the process of looking for work, but reported difficulty because his "intrusive thoughts took up too much time." His OCD began in college with intrusive and repetitive fears about saying something inappropriate and of harming himself or others. At that time, he began reading articles about circumcision and then developed an obsession consisting of intrusive thoughts and images about circumcision; these obsessions triggered feelings of both anxiety and anger. Mr. X expressed strong views against the practice of circumcision and, having undergone this process as an infant, now as an adult reported "feeling violated and incorrect as a male." When either thoughts or images about circumcision came to his mind, he would perform mental compulsions of reviewing the pros and cons surrounding circumcision. Mr. X also had other obsessions, such as fear of harm to others; fear of doing something embarrassing; need for symmetry; and compulsions such as checking (e.g., locks, stove), ordering, and arranging, and the urge to ask, tell, or confess. However, at presentation, his obsessions about circumcision caused him the most distress and functional impairment.

Mr. X underwent a comprehensive psychiatric evaluation for all Axis I disorders. The resulting diagnosis was OCD; no psychiatric comorbidity was found. His prior treatment history consisted of a series of adequate SRI trials (e.g. >12 weeks of different SRIs at maximum dose), which were minimally helpful with his intrusive thoughts. Given his experience, he did not want another medication trial and he refused EX/RP because the idea of calling up his obsessive thoughts on purpose was too distressing to him. At the time of presentation, he coped with his OCD by rationalizing thoughts (i.e., reviewing the pros and cons of circumcision debate) or suppressing thoughts, strategies that were minimally helpful in the short term. After he refused further medication trials and EX/RP, he was referred to the first author (SRP) for treatment of OCD using mindfulness based stress reduction.

Assessment Procedures: Treatment and Follow-up

To monitor clinical progress throughout treatment, the patient underwent independent assessments at the beginning, midpoint (Week 4), and end of treatment (Week 8). A research psychiatrist who specializes in the research and treatment of OCD conducted the independent assessments. These assessments consisted of clinician-administered and self-report measures. The primary outcome measure was the Yale-Brown Obsessive Compulsive Scale (YBOCS; Goodman et al., 1989) and the secondary process measure was the Toronto Mindfulness Scale (TMS; Bishop et al., 2006). The YBOCS is a 10-item clinician-administered instrument used to assess severity of obsessions and compulsions (range: 0 to 40); it is a standard measure of severity for OCD. A score of 16 or greater indicates at least moderate OCD. The TMS is a 10-item self-report instrument that assesses a practitioner's proficiency in the attention skills and attitudinal set that are involved in formal mindfulness meditation practice. The questions are completed in relation to the subject's experience of the immediately preceding