Hypnotically Facilitated Treatment of Obsessive-Compulsive Disorder: Can it Be Evidence-Based?

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Published online: 29 Oct 2010.

To cite this article: Claire Frederick (2007) Hypnotically Facilitated Treatment of Obsessive-Compulsive Disorder: Can it Be Evidence-Based? , International Journal of Clinical and Experimental Hypnosis, 55:2, 189-206, DOI: 10.1080/00207140601177913

To link to this article: http://dx.doi.org/10.1080/00207140601177913

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HYPNOTICALLY FACILITATED TREATMENT OF OBSESSIVE-COMPULSIVE DISORDER: Can it Be Evidence-Based?

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Abstract: There are extensive evidence-based guidelines for the treatment of Obsessive-Compulsive Disorder (OCD) with medication, behavior therapy, and cognitive therapy. Nevertheless, there remain a significant percentage of patients whose symptoms are more or less refractory to standardized treatments. This situation could be rooted in the phenotypic heterogeneity of the disorder as well as in its high rates of comorbid psychopathology. Studies have also found OCD to be associated with higher levels of dissociation. This paper examines what may be needed to establish evidence-based hypnotically facilitated therapies for treatment-resistant OCD. It provides an introduction to the complexity of the treatment issues surrounding OCD and considers both possibilities for and obstacles to setting up an evidence-base for using hypnotically facilitated psychotherapies for its treatment.

Although there are some concerns about the adequacy of substantiation for the efficacy of hypnotically facilitated psychotherapy (Schoenberger, 2000), there is growing empirical evidence that hypnotically facilitated cognitive-behavioral therapy is more efficacious in the treatment of a number of psychiatric/psychological disorders than cognitive-behavioral therapy (CBT) alone (Alladin, 2003, 2006a; Kirsch, Montgomery, & Sapirstein, 1995). Alladin (2003, 2006a, 2006b, 2007) has established evidence-based hypnotically facilitated CBT for nonendogenous depression. Similarly, hypnotically facilitated therapy has been shown to be efficacious for certain physical illnesses that have psychological components, such as irritable bowel syndrome (IBS) (Palsson, 2006) and headaches and pediatric recurrent headaches (Holden, Deichmann, & Levy, 1999), as well as complex conditions such as nicotine dependence (Green & Lynn, 2000) and nocturnal enuresis (Mellon & McGrath, 2000).

Unfortunately, there are no efficacy studies for hypnotic facilitation of psychotherapies such as CBT, exposure response prevention (ERP),

Manuscript submitted January 14, 2006; Final revision July 17, 2006.

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ego-enhancement, hypnoanalytic psychotherapy, and so forth with OCD. What the hypnosis literature does contain are descriptions of clinical work with small numbers of patients and reports of single-case successes, usually unaccompanied by measurable data. One reason for the dearth of relevant research is the sheer complexity of OCD. There has been insufficient attention to its multiple phenotypic presentations as well as to the intricate mix of factors that enter into the production of this disorder.

OCD is a significantly disabling, chronic disorder that often impedes adequate social functioning. Once considered relatively rare, it has a 2 to 3% incidence in cultures of diversity (Rasmussen & Eisen, 1992; Steketee, Pigott, & Schemmel, 2003) and has been called “a hidden epidemic” (Steketee et al., p. 1). The individual who suffers with OCD (American Psychiatric Association, 1994) is gripped by unbidden thoughts and/or compulsory physical activities that are invariably experienced as ego-dystonic. It is characteristic of the disorder that the there is no sense of internal control over the symptoms (Salzman & Thaler, 1981). Persons with OCD may wait an average of 7 years before seeking treatment (Riggs & Foa, 1993). Several syndromes such as trichotillomania, eating disorders, pica, and Tourette’s disorder bear some superficial resemblance to OCD. They have been grouped by some investigators into an Obsessive-Compulsive Spectrum Disorder (McElroy, Phillips, & Keck, 1994; Rapoport, 1990; Stein, 2000), and evidence for some neurobiological overlap is beginning to emerge (Rapoport; Stein).

Comorbidities

Comorbidity with numerous conditions may exist (Steketee et al., 2003). For example, Angst et al. (2005) found comorbidity of OCD and Obsessive-Compulsive Spectrum Disorder (OCS) with bipolar and bipolar spectrum disorders, as well as anxiety disorders to be common. There is also significant comorbidity with dissociative difficulties (Grabe et al., 1999; Kluft, 1993b; Watson, Wu, & Cutshall, 2004).

THE ETIOLOGY OF OCD

OCD has never wanted for explanations as to its origins. Over the millennia, it has been associated with such things as demon possession, melancholia, scrupulosity (Ellenberger, 1970), and, eventually, neurasthenia (Ellenberger; Janet, 1903). Janet (1903, 1909, 1920/1965) rescued the disorder from the nosological wastebasket of “neurasthenia” by defining it with careful clinical descriptions that continue to be reflected in the current Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV; American Psychiatric Association, 1994), and...
by offering a scientific theory concerning its genesis. Freud (1909/1961, 1925/1961) further contributed to its rescue by perceiving the disorder to be the result of psychological defenses that protected against unconscious anxiety. Subsequently, others perceived the condition to proceed (at least in part) from faulty or incorrect beliefs woven into patterns of thought and behavior (Steketee & Frost, 1998). More recently, dissociative pathology has been identified again as a causal factor in certain patients (Erickson & Kubie, 1939/1980; Frederick, 1990, 2002; Ross & Anderson, 1988).

Psychological models of OCD have been radically challenged by the relatively recent emergence of evidence for a biological basis for the disorder. Genetic research demonstrates the significant role of heredity (Hettema, Neale, & Kendler, 2001; Jonnal, Gardner, Prescott, & Kendler, 2000). Neuroimaging revealed neural pathway disturbances in the basal ganglia, subcortical areas of the brain, and the orbito-frontal cortex (Cottraux & Gerald, 1998; Friedlander & Derocher, 2005; Van der Wee et al., 2004). Both dopamine and serotonin disturbances underpin the pathophysiology of OCD (Steketee et al., 2003; Van der Wee et al., p. 2205). There are a noteworthy number of medical conditions, such as traumata, endocrine problems, neoplasms (Steketee et al., 2003), and toxin exposures that may produce the symptoms of OCD (Cottraux & Gerald, 1998). A notable example of this is pediatric autoimmune neuropsychiatric disorder (PANDAS), a streptococcal infection in very young children (Leonard & Swedo, 2001).

OCD is extremely complex in terms of its causative factors. There appears to be a combination of genetic and socio-psychological factors. Identifying the elements of the disorder is often confounded by the presence of comorbidities, external environmental influences, and the presence of significant dissociation. The role of diatheses (constitutional factors that predispose the body to certain illnesses or conditions) in OCD is inescapable. Frederick (1990, 2002) proposed that the etiology of OCD could be viewed best from the framework of a stress-diathesis model. This integrative model encompasses biological and socio-psychological factors (Alexopoulos, 2004). Frederick (1990, 2002) thought that OCD should be thought of as a spectrum of manifestations that extends from the most biologically determined to the most psychologically determined.

THE TREATMENT OF OCD

Socio-Psychological Treatments

There are many socio-psychological treatment approaches to OCD. These have ranged from exorcism (Ellenberger, 1970) to psychoanalysis (Freud, 1909/1961, 1925/1961). On the main, however, behavioral and cognitive therapies are currently considered the psychotherapies
of choice (W. Greist, 1992; J. Greist et al., 2002; March, Frances, Carpender, & Keck, 1997; Steketee et al., 2003). Among these are exposure response prevention (ERP), the “psychosocial treatment of choice” (Van Noppen & Steketee, 2001, p. 133). In a 2-year follow-up, ERP was shown to be helpful to 75% of patients treated by Marks, Hodgson, and Rachman (1975). Similarly, Foa and Kozak (1996) found strong evidence that ERP was efficacious in the treatment of OCD. However, Abramowitz, Taylor, and McKay (2005) noted that ERP is not completely effective for many patients. Some patients refuse to engage in it, and some neither benefit from nor tolerate it. They note increasing interest in cognitive interventions as adjuncts or alternatives to exposure-based treatments.

Abramowitz et al. (2005), like Van Noppen and Steketee (2001) and Steketee et al. (2003), report that over the years CBT has demonstrated greater efficacy for OCD than no treatment at all. Patients have a lower incidence of dropout than ERP. Additional psychosocial approaches that are buttressed by research studies establishing evidence for their helpfulness have included psychoeducational groups, group and computer-assisted ERP, and family therapy (Steketee et al., 2003).

The success of CBT is most striking with children. The Pediatric OCD Treatment Study (POTS) Team (2004) revealed the greatest improvement in children who combined CBT and medication.

Somatic Treatments

The introduction of clomipramine (Anafranil) was a breakthrough in OCD treatment. It produced marked improvement in symptoms in 35 to 42% of the cases treated (Pato & Zohar, 2001; Steketee et al., 2003; Thoren, Asberg, & Bertilsson, 1988). Even greater success followed with certain serotonin reuptake inhibitors such as fluvoxamine, fluoxetine, sertraline, and paroxetine (Goodman, McDougle, & Price, 1992). These medication discoveries, the existing emphasis on the constitutional aspects of OCD, and the current weight placed on short-term treatments have led to an almost routine use of psychopharmacologic treatment for OCD. Medication is commonly used in combination with behavioral or cognitive-behavioral therapies (Pato & Zohar, 2001; Steketee et al., 2003) but may be offered at times as the sole treatment (Goodman et al.; Pato & Zohar; Steketee et al.).

Hypnosis in the Treatment of OCD

Brown and Fromm (1986) cautioned against the use of formal hypnosis with patients with obsessive compulsive personality disorder, an Axis II disorder characterized by a pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control at the expense flexibility, openness, and efficiency (American Psychiatric Association, 1994). They noted that unless the OCD symptoms are
fairly circumscribed hypnosis “has a poor success rate” (p. 245). In contrast, there have been reports of a number of successful hypnotically facilitated interventions with the Axis I OCD, the major subject of consideration here.

Hypno-Imagery

Several types of hypno-imagery interventions were described as useful by Kroger and Fezler (1976). They recommended the routine use of hypnosis for deep relaxation, and they also facilitated behavioral programs with hypno-imagery protocols. However, like Brown and Fromm (1986), they cautioned therapists that there were problems inherent in such programs where no identifying or triggering situation or stimulus can be found.

Hypno-imagery has also been used for ego-enhancement with mastery techniques and ego-enhancing hypnotic age progressions that can produce robust and enduring relief of symptoms (Johnson & Hallenbeck, 1985). Frederick and McNeal (1999) recommend the use of a wide variety of ego-strengthening techniques with OCD patients.

Hypnoanalysis

Another hypnotically facilitated approach attempts to resolve underlying psychopathology. This category of techniques deals with the ideology, symbolism, and psychodynamics of the symptoms (Brown & Fromm, 1986). Milton Erickson successfully utilized hypnoanalytic techniques in his treatment of an “obsessional neurosis” (Erickson & Kubie, 1980).

Frederick (1990) reported the rapid treatment of severe, long-standing OCD with ego state therapy (Watkins & Watkins, 1979). This patient had remained free of his obsessions and compulsive rituals when seen in a 7-year follow-up (Frederick, 2002).

Refractories to Treatment

Despite the availability of both somatic and psychological evidence-based modalities for its treatment, OCD can be difficult to manage in some patients for whom the symptoms cling with amazing stubbornness (Pato & Zohar, 2001; Schruers, Koning, Luermans, Haack, & Griez, 2005; Steketee et al., 2003). Schruers et al. reported a 30% rate of refractoriness, while Pallanti et al. (2002), in collaboration with the International Treatment Refractory OCD Consortium, reported that 40 to 60% of patients fail to improve sufficiently. Some patients refuse medication, while others (25%) will not engage in behavioral programs (J. Greist et al., 2002). Certain patients cooperate fully but fail to respond to any of the treatments in which they engage. Refractoriness to treatment has led to an incredible assortment of
“next step” and “last-ditch” treatments, including medication augmentation (Pato & Zohar), antipsychotic and novel medications (Denys, van Megen, & Westenberg, 2002), electroconvulsive and insulin therapies (Schruers et al.), deep cranial stimulation (Nuttin, Cosyns, Demeulemeester, Gymbel, & Myerson, 1999), intensive residential treatment (Steketee et al.), and even the extreme recourse of psychosurgery (Aquizate et al., 2004; Baer et al., 1995; Schruers et al.; Tan, Marks, & Marsep, 1971).

Pallanti et al. (2002), in collaboration with the International Treatment Refractory OCD Consortium, believe that it is difficult to cluster this refractory group of patients because of (a) ambiguities in diagnostic criteria, (b) the possibility that subtypes may exist, and (c) the high degree of comorbidity:

Moreover, the findings of current studies of so-called “non-responsive” cases are currently non-generalizable because of the lack of an operational definition of non-response. The result had been that a cumulative body of data on a reasonably homogeneous sample of non-responders had not been developed. (Pallanti et al., 2002, p. 181)

Moreover, the stages of response have not been defined nor have levels of nonresponse. Indeed, there is currently no systematic nosology for OCD. Attempts to create such a nosology (Grabe et al., 1999; Lasalle-Ricci et al., 2005; Lochner et al., 2004; Watson et al., 2004) are insufficient in number at this time and require replication. There is no measurable, in-depth profile of the “refractory patient” that goes beyond symptom severity and persistence.

Another significant issue in understanding refractoriness is the heterogeneity of the condition (Mataix-Cols, Conceição do Rosario-Campos, & Leckman, 2005). Its heterogeneity has the potential for reducing the reliability and power of many “findings from natural history studies to genome scans, neuroimaging, and clinical trials” (Mataix-Cols et al., p. 228).

Finally, comorbidity looms as a factor that must be taken into account: “Comorbid OCD/OCS was associated with significantly higher levels of treatment-seeking, impairment, distress and suicidality” (compared with pure OCD/OCS). Comorbidity with bipolar disorders significantly increased the risk for alcohol abuse/dependence” (Angst et al., 2005, p. 65).

**OCD and Dissociation**

Janet was aware of constitutional factors in OCD. He also believed that dissociation was significant in its genesis (Janet, 1909, 1920/1965, 1976). In his classic work, *Les Obsessions et la Psychasthénie* [Obsessions and Psychasthenia], Janet (1903) considered OCD to be the result of a
special mental state in which there was inadequate contact with reality and low psychological tension. According to Janet, certain conditions such as an intercurrent physical illness could make an individual more susceptible to utilizing dissociation as a way of dealing with trauma; at that time a shift toward lowered energy would take place in the mind. Janet’s system is complex (van der Hart & Friedman, 1989) and involves multifarious psychological and physical mechanisms, including heredity, dissociation, and mind-body correlations (Janet 1907, 1909, 1920/1965, 1976).

One of the most interesting and classic clinical case reports in the hypnosis literature is that of Milton Erickson’s treatment of an “obsessional neurosis” (Erickson & Kubie, 1980) in a young woman. A second personality (of whom the hypnotic subject had had no conscious or previous awareness) helped the presenting personality by eventually guiding her to the “cause” of her difficulty and the resolution of her obsessionalism. Erickson’s treatment permanently cured her of her obsessions and compulsions. The similarity between certain aspects of dissociative identity disorder (DID) symptoms to the symptoms of OCD was also noted by Beahrs (1982).

Shusta (1999) successfully treated a “treatment-resistant” patient who had comorbid DID. He had been refractory to a multitude of medications, electric-shock treatments, and psychotherapies as well as an inpatient hospitalization. Shusta taught the patient to work with the parts of his personality in an adaptive manner (Kluft, 1993a) that allowed a more mature part of himself to be aware of the fears of child alters. The patient relapsed when he failed to carry out this internal self-care, and he regained freedom from his symptoms when he resumed it.

In addition to the somewhat isolated clinical case reports that have followed Janet’s work (Erickson & Kubie, 1980; Frederick, 1990; Shusta, 1999), there are some investigations that demonstrate links between dissociation and some forms of OCD. Ross and Anderson (1988) found that test scores of a number of their OCD patients resembled DID (formerly known as multiple personality disorder) patients’ scores. They noted that a minority of these patients appeared to be free of dissociative pathology and have a freestanding disorder. They compared the obsessions and compulsions found in DID patients with Schneiderian symptoms and suggested that therapists should always be ready to explore their genesis. They recommended that OCD be included in a new diagnostic category of “trauma disorders” for patients with both OCD and posttraumatic symptoms.

In Kluft’s (1993b) examination of epidemiological studies, there were indications that as many as one third of DID patients experienced obsessions and compulsions. Grabe et al. (1999) evaluated a cohort of 70 patients for phenomenological association of OCD and dissociative symptomatology using the Dissociative Experiences Scale (Bernstein &
Correlation and discriminant analyses revealed that symptoms of “checking” and “symmetry and ordering” were significantly related to dissociative symptoms, while there was no association with “washing and cleaning,” “counting and touching,” and “aggressive impulses and fantasies.”

Their findings were reaffirmed by Watson, Wu, and Cutshall (2004), who reported three studies designed to determine the connection between OCD and dissociation as to the type of symptom. Their third study was done with a psychiatric outpatient population, and it suggested clinical generalizability. They concluded that a strong link exists between OCD and dissociation and that assessment for the type of OCD symptoms is an important part of the diagnostic workup.

Lochner et al. (2004) demonstrated a link between childhood trauma and dissociative experiences in patients with both OCD and trichotillomania. They believe that many dissociative symptoms may be present in a substantial proportion of patients diagnosed with these disorders. High dissociators can also be differentiated from low dissociators via some demographic features (e.g., lower age) and comorbidity profile (e.g., increased incidence of impulse dyscontrol disorders).

McNevin and Rivera (2001) presented three cases in which dissociation was linked with the pathology of OCD. These patients did not respond adequately to CBT with adjunctive medication. However, their obsessions and compulsions improved when the dissociation was worked with psychodynamically. They recommended “psychodynamic understanding . . . within a cognitive-behavioral context” (McNevin & Rivera, p. 129). Frederick (2002) presented clinical descriptions of 5 patients with OCD, 4 of whom displayed initially or at a later time severe dissociative symptoms and responded positively to treatment.

**HOW TO OBTAIN AN EFFICACY BASE FOR HYPNOTICALLY FACILITATED THERAPY FOR OCD**

The subtypes of OCD and their natural history have not been identified adequately. Studies have demonstrated the roles of constitution, behavior patterns, comorbidities, and dissociation in the genesis of OCD. Yet, there has been no sorting out of conditions that are primarily biologically driven and those that may be more psychologically determined. Nor has the effect of comorbidities on treatment resistance been clarified. The role of dissociation in some cases of treatment-refractory OCD has not made its way into mainstream contemporary consensus literature and is sparsely represented in the hypnosis literature. The Consensus Committee’s (March et al., 1997) presentation of a standard treatment for OCD does not reflect robust studies that indicate a clear
connection between a great deal of OCD and dissociation (Grabe et al., 1999; Lochner et al., 2004; Watson et al., 2004).

Good evidence bases begin with good clinical practice. An integrative, phase-oriented treatment model may serve to offer patients with the disorder a greater opportunity to obtain relief and to give clinicians who seek treatment standards a path for discovering them. Ginandes’s (2002) strategic and integrative model for the therapy of mind/body problems begins with an initial stage in which various hypnotic and nonhypnotic techniques are utilized to help the patient with his or her symptoms. This could include such interventions as hypnotically facilitated cognitive and behavioral therapies, ego-enhancement, direct and indirect suggestion, and so forth and could include the use of appropriate medication. This first stage is somewhat similar to Stage I (safety and stability) of the SARI model (SARI is an acronym for the stages of the model), which was created for hypnotically facilitated therapy with posttraumatic and dissociative patients (Phillips & Frederick, 1995). As with Ginandes’s (2002) model, Stage I SARI model work integrates various elements: the establishment of an active therapeutic alliance, hypnosis and self-hypnosis for self-soothing, hypnotic imagery and hypnotic suggestion for symptom control, cognitive-behavioral interventions, group and/or family therapy (when indicated), appropriate medication, and so forth.

There are many investigative tools that could enable investigators to evaluate various hypnotically facilitated therapies for efficacy work with OCD. For many patients the work of the first stage will probably be at least as efficacious as the nonhypnotically facilitated therapy interventions. Future studies can either confirm or deny this.

The next stage in Ginandes’s (2002) model is a shift to deeper, hypnoanalytic work should the first-stage work fail to produce adequate relief. Within treatment considerations for OCD, a failure of the first stage to produce relief should signal an examination for any complicating factors such as comorbidities, dissociatively driven symptoms, secondary relationship and other social gain, and recondite physical problems. There are always reasons for refractoriness. For example, a patient with strong biological components and little or no dissociative pathology may not be responding to medication adequately and may need medication change or augmentation (Denys et al., 2002; Pato & Zohar, 2001) more than psychological therapy.

Shusta’s (1999) recommendation that all refractory OCD patients be screened for dissociation is well advised. In view of both clinical and research studies about dissociation in patients with OCD, it is recommended that every patient who presents with an OCD spectrum disorder be screened for dissociation. Should that have been omitted in the workup, it must certainly be done when unexplained refractoriness emerges. Suggestions for the screening are the Dissociative Experiences
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Scales (DES) (Bernstein & Putnam, 1986), the Somataform Diagnostic Questionnaire-20 (SDQ-20; Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, 1996), and the Somataform Diagnostic Questionnaire-5 (SDQ-5; Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, 1997). The most useful instrument (and the most time consuming) is the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D; Steinberg, 1993, 1994).

McNevin and Rivera’s (2001) study of three cases is illustrative of what happens with such “refractory” patients whose OCD is driven by dissociation when they receive appropriate treatment. Four of Frederick’s (2002) five reported cases all screened positively for dissociation. Efficacy research can be directed at discovering whether resolution of dissociative issues connected with the symptoms will relieve or eliminate them. There are always limitations to psychodynamic and hypnoanalytic approaches, and these appear in treating patients whose OCD is heavily driven by inborn or genetic components; has been brought about by infection, neoplasm, or toxins; and/or whose characterological structure, family dynamics, and need for secondary gain are embedded within the meaning and utility of their symptoms. A strategic, integrated treatment model for OCD allows for both single-case studies (Borckardt & Nash, 2002; Fonagy & Moran, 1993) and clinical studies with robust populations; it permits comparisons of hypnotically facilitated treatments with those that do not involve hypnosis.

Obstacles to Evidence-Based Therapy

Of course, we are a long way from establishing evidence-based, manualized hypnotically facilitated psychotherapies for OCD. The illness is extremely complex, and its taxonomy is poorly understood. It may be useful to question whether or to what extent efficacy-based research is applicable to complex, uncovering applications of clinical hypnosis (Amundson, Alladin, & Gill, 2003), especially those that involve deep, unconscious, and unmeasurable intersubjectivity (Frederick, 2005). Frederick (2003, 2005) expressed concerns about the relative relevance of efficacy studies. Among them are problems with design and population selection (Gabbard, 2001), the issue of comorbidities, the introduction of unrecorded effectiveness factors, and the “difficulties inherent in making measurements in complex systems” (Frederick, 2005). Despite their possible shortcomings, efficacy studies have a great potential for usefulness in the service of good therapy if they are not concretized and given greater importance than the need for individualization of treatment and the promotion of effectiveness factors in treatment (Amundson et al.; Frederick, 2005; Oster, 2003).

The following case material is descriptive of the application of such a model with a treatment-resistant patient. Although it emphasizes transtheoretical effectiveness factors in treatment (Amundson et al.,
EVIDENCE-BASED TREATMENT OF OCD

(2003), it may provide information for the structuring of a broadly defined efficacy base study.

**CLINICAL CASE REPORT: JACK**

Jack is a 30-year-old dentist who encountered difficulties because of his obsessional fear of contamination while performing procedures. He had 2 years of CBT combined with clomipramine. However, he obtained no relief, and indeed, his symptoms worsened. He did not feel he had an adequate affective connection with the therapist. Jack’s dental partner was concerned that Jack’s compulsive behaviors (triple face masks and goggles, multiple layers of gloves, checking practices, excessive rumination about doing certain procedures, spacey appearance) would be damaging to their dental practice. He insisted that Jack get more help.

When I began his treatment, Jack produced normal DES, SDQ-20, and SDQ-5 scores in his initial diagnostic interviews. Over a period of months, however, he subsequently endorsed many amnesia items and significant depersonalization and derealization items of the SCID-D. He also described somatosensory flashbacks of “something” in his eye and “blood in the mouth.”

Jack came from a family in which chaos and rage had been prominent features. A grandmother was a notable “worrier,” and his mother had rituals. He reported significant sexual trauma in college but still had no feeling about it. “I can talk about it, but I feel totally nothing when I do.” Jack was placed on fluoxetine, and an emphasis was placed on developing a therapeutic alliance, the introduction of the expectation that he could recover, self-hypnosis, hypnotic ego-strengthening, and cognitive-behavioral interventions such as thought stopping. Once Jack began to experience a small degree of mastery over his response to treatment and to have the expectation that he could recover, ego state exploration was begun. After a year of weekly therapy, his symptoms abated, he became more assertive, and he was able to relax and to enjoy both work and recreation. He achieved certification in his dental specialty, and he left the partnership to establish a solo practice in his subspecialty.

Jack’s wife then left him, and he was able to cope with this appropriately. During the second year of his treatment, his symptoms and flashbacks gradually vanished, and Jack became completely free of ruminations and compulsive behaviors. He then saw me twice a year for “checkups.” Three years later, he remains symptom free. Because of the strong familial element to Jack’s symptoms, we decided that he should remain on fluoxetine.

Jack’s treatment was geared to improving his response to therapeutic interventions. Although he had received treatments shown to be efficacious in his previous therapy (clomipramine and CBT), they had not helped him. Luborsky, McLelen, Diguer, Woody, and Seligman
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(1997) in comparisons of 22 therapists across 7 patient samples found that identical manualized and strictly controlled treatment applications yielded results that varied strongly. To this end, effectiveness factors such as working to create a therapeutic partnership and offering Jack hope that he could recover may have been vital to his improvement. Another deficiency in his previous therapy was the failure to try other, more efficacious medications or medication combinations (Pato & Zohar, 2001).

The Stage I work (Ginandes, 2002; Phillips & Frederick, 1995) also included efficacy-based interventions (medication and CBT). The stabilization and symptom improvement gave Jack hope that his treatment was working. The Stage II (Ginandes) work introduced hypnoanalysis and expanded into resolution of Jack's dissociative symptoms. Psychotherapy and maintenance medication (directed at genetic factors) have produced enduring relief from the symptoms of OCD.

There is no need for efficacy and effectiveness to be exclusive of one another. It is recommended that research be conducted into their respective roles in the treatment of the extremely complex clinical syndrome known as OCD. It is possible that, especially with refractory cases, efficacious treatments are not able to work with certain patients when effectiveness factors are absent. The path to the discovery of efficacy-based treatments for OCD stretches into the future as a long and complicated one.

REFERENCES


Hypnotisch unterstützte Behandlung der Zwangsstörung: Ist Evidenzbasierung möglich?

Claire Frederick

Artikel beleuchtet die notwendigen Schritte für die Etablierung evidenzbasierter hypnosetherapeutisch unterstützter Therapieformen für behandlungsresistente Zwangsstörungen. Er liefert eine Einleitung zur Komplexität der Probleme bei der Behandlung von Zwangsstörungen und begutachtet sowohl Chancen als auch Schwierigkeiten für die Erstellung einer Evidenzgrundlage für hypnosetherapeutisch unterstützte Therapieansätze.

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Le traitement des troubles obsessionnels-compulsifs facilité par l'hypnose - Peut-il être fondé sur l'expérience clinique?

Claire Frederick

Résumé: Il ne manque pas de directives fondées sur l’expérience clinique pour traiter les troubles obsessionnels-compulsifs (TOC) à l’aide de médicaments, de thérapies comportementales ou de thérapies cognitives. Pourtant, il reste encore un pourcentage élevé de patients dont les symptômes demeurent plus ou moins réfractaires aux traitements standardisés. Cette situation pourrait trouver son origine dans l’hétérogénéité phénotypique de ces troubles ainsi que dans leur forte comorbidité psychopathologique. Des études ont également démontré que les TOC sont associés à un haut degré de dissociation. Cet article examine ce qu’exigerait l’élaboration de thérapies facilitées par l’hypnose et fondées sur l’expérience clinique pour traiter les TOC résistants aux traitements. Il fournit une introduction à la complexité des questions relatives au traitement des TOC et examine tant les avantages que les inconvénients d’une méthode fondée sur l’expérience clinique, dans le traitement faisant appel à des psychothérapies facilitées par l’hypnose.

JOHANNE REYNAULT
C. Tr. (STIBC)

Tratamiento del trastorno obsesivo-compulsivo facilitado por hipnosis: ¿Puede basarse en la evidencia?

Claire Frederick

Resumen: Hay directivas extensas basadas en la evidencia para el tratamiento del trastorno obsesivo compulsivo (OCD) mediante medicamentos, terapia de comportamiento, y terapia cognitiva. Empero, existe un porcentaje importante de pacientes cuyos síntomas son más o menos refractarios a los tratamientos convencionales. Esta situación puede deberse a la heterogeneidad fenotípica del desorden así como también a su alta comorbilidad psicopatológica. Algunos estudios también han mostrado que el OCD está asociado a niveles altos de disociación. Este trabajo examina qué se necesita hacer para establecer
terapias facilitadas por hipnosis para el OCD resistente a tratamiento, basadas en la evidencia. Proveo una introducción a la complejidad de los puntos de tratamiento en relación al OCD y considero tanto las potencialidades como los obstáculos para forjar psicoterapias facilitadas por hipnosis para el tratamiento del OCD basadas en la evidencia.

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