Evaluating Group Cognitive Behavior Therapy for Obsessive-Compulsive Disorder in a University OCD Clinic

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In obsessive-compulsive disorder, obsessions are repetitive, unwanted and intrusive thoughts, images or urges…w*as the stove really off? Am I really straight? Did I hit someone while driving?* OCD is sometimes called the "doubting disease" (Singer, 2013) because its sufferers tend to doubt the truth or definitiveness of their obsession. These obsessions cause distress and anxiety in the individual who may attempt to suppress the obsession or reassure himself using another thought or action which then becomes compulsive (APA, 2013). Because it is impossible to have certainty all of the time, OCD sufferers are stuck in a cycle of obsessions and doubt, compulsions and further doubt.

Resources invested in OCD treatment benefit people from diverse cultures and socioeconomic backgrounds. An epidemiological study by Ruscio, Stein, Chiu and Kessler (2008) found a lifetime prevalence of OCD of 2.3% and a 12-month prevalence of 1.2%. OCD is present in cultures and societies the world over. More males than females are affected in childhood, and more females are affected in adulthood. There are similarities across cultures in the age of onset and gender distribution (APA, 2013). OCD is sufficiently prevalent to warrant attention and resources.

OCD can be disabling for individuals, and public health implications for society. If untreated, the course of OCD is often chronic with waxing and waning of symptoms (APA, 2013, p. 238). In one study, 47% of OCD patients experienced work interference and 40% were unable to work for an average of two years. This results in an estimated lifetime indirect cost of $40 billion due to lost wages (Hollander et al., 1996). Treatment is important to the economic well-being of individuals and communities because of lost wages due to absence from work or failure of an individual to achieve his or her full potential.

Selective serotonin reuptake inhibitors (SSRIs) and cognitive behavior therapy (CBT) are the first-line treatments recommended for OCD (APA, 2007). The American Psychiatric Association (APA, 2007) as well as the National Institute for Health and Care Excellence (NICE, 2005) in the United Kingdom recommend CBT, especially a type of CBT called exposure and response prevention (ERP), as a first-line treatment alone or in combination with medication for mild to moderate OCD. Despite this, one study in the U.S. showed that 65% of adult patients treated for OCD were treated with an SSRI, while only 7.5% received CBT (Blanco et al., 2006). In other words, only 7.5% of patients received evidence-based, first-line treatment for a relatively common, debilitating disorder.

The OCD clinic is a "clinic-within-a-clinic" of an adult outpatient psychiatric clinic (OPC) in a university setting. Its goal is to provide high-quality, evidence-based care to clients with a *primary* diagnosis of OCD and related disorders such as trichotillomania, body dysmorphic disorder and hoarding disorder. Despite this goal, when this project was initiated, there were no therapists who practiced CBT/ERP for OCD located within the OCD clinic. But based on clinical guidelines, comprehensive treatment for OCD must offer CBT/ERP in addition to medication. The following literature review will evaluate the evidence for the claim that provision of appropriate psychotherapy is a worthwhile goal of the OCD clinic.

Review of Literature

The literature search was conducted using Ovid and included the databases Medline without revisions, PsychINFO, and Cochrane Database of Systematic Reviews (CDSR). The keyword "obsessive-compulsive disorder" was searched in Medline and limited to evidence-based medicine (EBM) reviews available in English language. In PsychINFO and CDSR "obsessive-compulsive disorder" *and* "evidence-based treatments" was searched. In order to

gather evidence for practice recommendations based on the highest levels of evidence, only systematic reviews or meta-analysis of OCD treatments were included. Systematic reviews were excluded that were limited to pharmacologic interventions or pediatric populations as this was not the intended focus. Review of treatments for disorders under the umbrella of "anxiety" were also excluded in order to preserve the specific population focus. The website *ScienceDirect* suggested two systematic reviews which were included. In total, the final review included 13 articles (Appendix A).

Differences in therapy types. The definitions and procedures of CBT, cognitive therapy (CT), and ERP can overlap and have slightly different meanings depending on the source. ERP is *exposure* to an anxiety-provoking stimulus with subsequent resistance of performing the compulsion that relieves the anxiety (*response prevention*). Through this method the participant can unlearn associations and reduce anxiety in future exposures (Fisher & Wells, 2005, p. 1544; Gava et al., 2009). Behavior therapy in the context of OCD is generally synonymous with ERP (Gava et al., 2009). CT involves cognitive restructuring and changing maladaptive beliefs (Gava et al., 2009). In CBT, the cognitive methods are the same as CT and the behavioral component is exposure with the intent to disprove false beliefs rather than to habituate to the anxiety (Fisher & Wells, 2005; Romanelli, Frances, Gamba, Mojtabai & Segal; 2014). In practice and research it can be difficult to distinguish between the nuances of cognitive, behavioral and cognitive-behavioral treatments (Gava et al., 2009, p.3). In this review, it was understood that therapies are described as ERP or CBT but that there is often overlap in techniques and implementation between these two therapies.

CBT and ERP are effective for OCD. From these articles, eleven authors (Abramowitz, 1997; Abramowitz, 1998; Eddy et al., 2004; Fisher & Wells, 2005; Gava et al., 2009; Houghton,

2013; Kobak et al., 1998; Podea, 2009; Romanelli et al., 2014; Rosa-Alcazar et al., 2008; Williams, 2014) provide evidence that CBT and ERP are effective for OCD. Fisher & Wells (2005) found ERP more effective than CBT and Eddy et al. (2004) found ERP may be superior to CBT. Houghton (2010) concluded that CBT is effective in general outpatient settings with typical populations in addition to research trials. In research trials, subjects are often "ideal" and do not represent a realistic patient population. While ERP may have greater evidentiary support, CBT is also efficacious in research and in practice. This literature review supports the assertion that CBT and ERP are at least as efficacious as medication (Kobak et al., 1998; Podea, 2009; Romannelli et al., 2014) and concludes the combination of ERP and SRI (SSRI and clomipramine) medication is likely the most effective treatment for decreasing OCD symptoms (APA, 2007; Eddy et al., 2004).

Group modality. This review addresses, to a lesser extent, the effectiveness of modality of therapy delivery: individual vs. group. The limited discussion of modality is due to the fewer number of studies in the literature review that address this variable. Group therapy is an effective modality for ERP and CBT in general (Gava et al., 2007; Jonsson & Hougaard, 2009; Jonsson & Hougaard, 2011, Rosa-Alcazar et al., 2008) based on a reduction in OCD symptoms. The evidence is conflicting as to how dropout rates in CBT group therapy compare to individual therapy. There is less research on group ERP compared to individual treatment, and more RCTs are needed to make a definitive statement on the superiority of one modality. When weighing group ERP vs. CBT, only Fisher & Wells (2005) found a difference between group ERP and CBT, in which group ERP is effective but group CBT is not. With all of the evidence taken together, one can be reasonably certain that group CBT or ERP are evidence-based practices in the treatment of OCD.

In order to meet the goal of the OCD clinic - to provide high-quality, evidence-based care to clients with OCD - ERP must become an available service. This review of literature incorporates findings from 13 systematic reviews with years of publication ranging from 1997 to 2014 and provides strong evidence that ERP or CBT with exposure components is an effective treatment for OCD. In addition to being an evidence-based treatment modality, it provides an important treatment option for individuals suffering from OCD who prefer not to or are unable to take medications, or are non-responders to pharmacotherapy.

Approach to the Conduct of the Project

This project's aim was to provide comprehensive, evidence-based care to patients of the OCD clinic. This project included an implementation plan and summative evaluation (Mateo & Foreman, 2014, p. 291) of an evidence-based practice; specifically ERP/CBT for patients with OCD at the clinical site - a university-based OCD clinic. The therapy was delivered through a group therapy modality. The implementation plan included the rationale for the program (literature review), the group protocols used, administrative/financial considerations, outcomes measurement, facilitators and barriers. The summative evaluation included measures of clinical symptoms, revenue, patient satisfaction, other mental health provider perspective, and group leader observations and recommendations.

In addition to providing evidence-based care for patients at the clinic, offering ERP/CBT to the clinic improved access to this service for the local community. Experienced ERP/CBT therapists are limited in the Portland-Metro area. Almost all of the providers listed on the International OCD Foundation website are in private practice and are on limited private insurance panels (IOCDF, 2015). Providing EPR/CBT at the OCD clinic increased availability in the Portland-area because the OPC contracts with more insurance companies than many other

ERP/CBT therapists in private practice.

Access to evidence-based mental health care is an ethical issue. Although access for more clients with private insurance is an improvement, ERP/CBT should be available to anyone with OCD in need of treatment. Group therapy is more cost effective than individual therapy due to the greater number of patients treated (Fisher & Wells, 2005; Jonsson & Hougaard, 2009; Rosa-Alcazar et al., 2008) and is an intriguing option to increase access to this therapy for low-resource individuals or those without private insurance. Group ERP/CBT was chosen based on this benefit. The plan was to include enough patients in the group with private insurance to subsidize the enrollment of a few patients on public-payor insurance plans such as Medicare or Oregon Health Plan (OHP) - Oregon's Medicaid program.

The Setting

The OCD clinic provides niche services to patients who often have not been successfully treated elsewhere. The purpose of the OCD clinic is to serve clients with a *primary* diagnosis of obsessive-compulsive disorder and related disorders such as trichotillomania, body dysmorphic disorder and hoarding disorder. The clinic consists of a psychiatrist and psychiatric-mental health nurse practitioner (PMHNP). According to the psychiatrist, an estimated 80% of patients treated there necessitate psychiatric care that could not be managed by a primary care provider. Some of the patients have not had success with treatment by another psychiatric provider.

Implementation of the Project

Group protocol. The group followed a combination of two protocols: an established 12-week protocol written by Sochting, Whittle and McLean (1997) and a 16-week protocol written by Dr. Zuercher-White (used with permission). Sochting's book "Cognitive Behavior Group Therapy" (2014) was consulted as well as material from "The OCD Workbook" (Hyman

& Pedrick, 2010) and "Brain Lock" (Schwartz, 1996). The PMHNP implemented the project and served as the ERP/CBT group leader. The PMHNP attended an OCD CBT group held at another clinic through the duration of her group in order to learn additional therapy skills for this specific modality.

Time and Location. Tuesdays from 6:00pm to 8:00pm was selected in order to allow participants enough time to travel to the group after work, but not end too late into the evening. Support staff that would normally check-in patients in the electronic medical record (EMR) were not available after 5:00pm. Attendance was reported to the support staff the following morning, and patients were checked-in at that time by the support staff. This after-the-fact check-in did not negatively alter workflow and prevented extending support staff work hours.

Financial considerations. Each participant was billed for a group session with Current Procedure Terminology (CPT) code 90853 with a work-relative value unit (wRVU) of 0.59. As a point of reference, 45 minutes of individual psychotherapy (90834) carries an RVU of 2.4 (New York State Psychiatric Association, n.d.). The billed rate for the group was $85 per person, per session. The cost for the PMHNP to conduct one group session is about $165; calculated in the following manner:

PMHNP salary = $70,000
Benefits = 30% of salary = $21,000 (0.3 x 70,000)
Overhead cost per provider = $10,000 (per administration)
70,000 + 21,000 + 10,000 = $101,000

FTE = 0.6 or 1224 hours/year
$101,000/1224 = $82.52/hour
Group session is 2 hours = **$165.00** (82.50 x 2) = cost per group
$165.00 x 12 sessions = $1,980 total cost

The cost of the group was the basic benchmark against which financial viability was measured. The department administration set a goal of 5% profit margin which they wanted to see met in order to consider the group financially successful. The reimbursement rate for the group from insurance companies is fixed, so the number of participants was the variable that can be manipulated to meet the financial goal. Calculations to determine target number of participants in group is as follows:

5% margin = $180 in reimbursement per group session (165 x 1.05)
Private insurance companies reimburse estimated average of $37/session for 90853*
(Range from $32-$44)
OHP not contracted with clinic & Medicare does not reimburse 90853
= No reimbursement from patients with OHP or Medicare

7 private insurance members x ~$37/session = $259
3 governmental payers = $0 reimbursement
Build in no show rate of 30% = $181 (259 x 0.7) per session
Goal of 10 participants: 7 private insurance and 3 governmental payers
$181 x 12 sessions = $2,175 = cost + 5% margin
*Current Procedural Terminology (CPT) code for group psychotherapy

In accordance with OHSU policy at the time, patients were unable to opt out of having insurance billed and pay a sliding scale fee. This has since changed so that patients with OHP may pay out-of-pocket for the cash price of the service with a 35% discount. OHP was billed for those members who carried that insurance. The payment was denied by OHP and then written off by the clinic so that the patient was not charged for the service.

Documentation. An individual progress note was written for each participant and the encounter was billed with the associated note. A note template was built to meet billing criteria for each participant. A therapist at a different clinic, who had led group therapy in the past, was contacted. She graciously shared her group template which had been built with the help of a medical coding specialist. After the template was adapted, it was reviewed by a department EMR specialist as well as a billing specialist.

Participants. Referrals from the OPC were solicited during a clinic meeting in July 2015 and again in December 2015. The group drew eight of 10 referrals from four providers at the OPC including two patients of the PMHNP (also the group leader). Solicitations for referrals were sent to two private practice settings that focus on anxiety disorders. No referrals came from these sources, likely because the patients at these clinics were already engaged in ERP/CBT.

In order to recruit patients with OHP, information was sent to a contact at a Medicaid primary care clinic who distributed it to providers there. An e-mail "blast" was also sent throughout the university's psychiatry department. Many faculty of the department have professional relationships with outside organizations and this was helpful for the dissemination of the group information. Two participants with OHP were referred from a community mental health organization by a PMHNP who was told about the group from a faculty member who received the e-mail "blast."

In order to qualify for participation in the group, participants must have had a psychiatric or psychologic diagnostic evaluation by a clinician at one of the referral sites and an established diagnosis of OCD. The referring provider must have determined ERP to be an appropriate treatment modality for the patient. The conditions leading to this determination were willingness to engage in exposure to feared stimuli and lack of contraindication such as a medical condition

in which increasing anxiety could be pose risk. The participant must have been agreeable to a group therapy modality as well as able to understand and sign an informed consent. Participants were at least 18 years of age, as this is the official minimum age of the clinic site.

This project used purposive sampling because the referring practitioner choose who was appropriate for the ERP group with final determination by the PMHNP. Some participants were called by the PMHNP for further assessment after the referral was made, to assess risks such as history of self-harm or multiple co-morbid diagnoses that could interfere with treatment. After further discussion with those participants they were vetted for participation. The sample used is unlikely to be generalizable to other settings due to small sample size and sampling method (Mateo & Foreman, 2014, p. 195). As the aim of the project is not to conduct research, these limitations do not impede the goals of the project.

Institutional Review Board approval. The plan for the evaluation of the group was submitted to the Institutional Review Board at the university for a request for determination in October 2015. It was determined to be research of minimal risk. A minimal risk protocol was submitted in November 2015 and approved in December 2015. All group participants signed the university's Terms & Conditions of Service form. As required due to the designation of minimal risk research, a consent information sheet was written and given to all participants of the project receiving a questionnaire. This included group participants and their other mental health providers such as psychiatrists, nurse practitioners and counselors.

Outcomes Measures

The OPC clinic, of which the OCD clinic is a part, is guided by the six aims laid out in the Institute of Medicine report Crossing the Quality Chasm (2001): Safety, timeliness, patient-

centeredness, effectiveness, efficiency and quality. These aims served as guides for the outcome measures:

Y-BOCS. Pre-group and post-group Yale-Brown Obsessive Compulsive Scale (Y-BOCS) scores of the group were used to inform the participants of their individual progress *(Effectiveness)*. The Y-BOCS is a long-established psychometric, and has been tested several times for reliability and validity. One of the more recent studies (1995) found internal consistency of alpha = 0.69 (acceptable). Inter-rater reliability was excellent. Test-retest reliability is generally high but was not in this study due to varied methods i.e. longer time between testing. The convergent validity with other OCD scales is moderate or "good" (Woody, Steketee, & Chambless, 1995).

Revenue. Total amount billed, insurance claim reimbursement and self-payments of the group were collected and compared to the cost of the group (page 9) in order to determine whether the group met its financial benchmarks and therefore is financially sustainable. But the care is also *efficient* if it can serve multiple patients with improvement in symptoms at a low cost relative to other modalities such as individual therapy

Patient satisfaction. This was assessed using qualitative pre and post-group individual questionnaires with open-ended questions (Appendix B). The pre-group questionnaire included the following questions: How long have you been seeking treatment for OCD? (*Timeliness*) What barriers did you encounter to enrolling in the group or coming to the group? (*Patient-centered*) What do you hope to get out of the group? What are your goals for treatment? What would you describe as "success" in treating your OCD symptoms? (*Effectiveness*) The final post-group questionnaire asked: Did you experience any untoward effects or bad outcomes or side effects as a result of the group? (*Safety*) How did the group help you meet your goals? Did the

group help you meet your original definition of success? (*Effectiveness*) What changes would you make to the group? (*Patient-centered, quality*) What were barriers to attending the group? (*Patient-centered*) How could we make it easier for you to attend? (*Timeliness*).

Perspective of other mental health providers. If the clients were seeing another provider for OCD treatment, his or her perspective on the group was sought. A provider questionnaire was developed (Appendix C). Drafts of the letter and questionnaire were sent to two psychiatrists and a psychologist for feedback and revisions were made accordingly. Group participants signed an ROI during the first group session for their other mental health providers. A copy of the ROI, consent information sheet and a letter were sent to other providers after the first group. The letter informed the provider of the patient's enrollment in the group and that he or she would receive a questionnaire at its conclusion.

After the last group, questionnaires were sent to the providers of the remaining participants with an explanatory letter, copy of ROI, consent information sheet and return envelope. Providers were asked not to identify themselves or patients on the questionnaire. The questionnaire included the following questions: Had this patient had any previous treatment with CBT/ERP therapy provided by you? If no, what were the barriers to providing it or why did you choose not to? If yes, describe what benefits or limitations of treatment that you noted. Have you noticed any improvement in patient's functioning or progress toward goals as a result of participation in the group? If no, why do you think that patient did not benefit? If yes, what progress did the client make toward treatment goals? Would you refer another client to the group? Why or why not? Any other suggestions for improvement.

Themes or “codes” were gleaned from questionnaire responses from both participants and providers in order to summarize trends. Summary of feedback from the questionnaire is described based on these responses.

Facilitators and Barriers

The OCD clinic was in a prime moment for change due to a multitude of factors. It recently expanded by hiring the aforementioned PMHNP. The idea of implementing a ERP/CBT group for OCD at the clinic was well received at clinic meetings. One psychologist voiced the desire to provide more psychotherapy within the OPC rather than having to refer the clients to outside therapists. This sentiment was congruent with the overall theme of this project - to increase the availability of psychotherapy services within the clinic.

Anticipated barriers to change included scheduling and payment. Payment was an issue because the clinic does not accept OHP and Medicare does not reimburse for group therapy visits. Because of this, the number of OHP or Medicare-only clients in the group was limited to three (two enrolled). It was anticipated that meeting financial goals would be challenging. A psychologist working in another department wrote in an e-mail:

> I have not run a group for several years, mainly because it has been difficult to put together a sufficiently large group to make it viable, given that patient referral come in individually and by the time 8 people have been assigned (a good number for my purposes) a couple of months can go by, and the first few people assigned are no longer interested or have moved on in some other way.

An unanticipated barrier was recruiting a group co-leader. Using an unpaid intern or resident as a co-leader was the goal in order to keep the cost of the group low. The role of the co-leader was to help monitor group safety and process as well as take notes and assist in

distributing and collecting paperwork. Finding a co-leader who had the additional time and interest for the group proved challenging. No psychology interns or psychiatry residents volunteered. Eventually, a PMHNP student was recruited by the project's chair. The student proved to be an asset to the group as she had group therapy experience as a licensed professional counselor (LPC).

Space to hold the group sessions proved to be an unexpected hurdle. The plan was to use the conference room at the OPC. As it turned out, it was unavailable for group use during this time and many other evening times during the week. By sending out e-mails to other clinic managers, support staff helped to locate an available conference room located in the Sleep Disorders Clinic. This clinic is within the psychiatry department, so sharing this space with an OPC group did not cause conflicts with shared overhead costs.

Summative Evaluation

Outcomes Measures

Y-BOCS scores. Ten participants started in the group. The average Y-BOCS score of the ten participants was of 27.5 with a severity category of 24-31 being "severe." Five of the 10 participants did not remain enrolled in the group for the full 12 weeks and were deemed "non-completers" for evaluation purposes. Of the non-completers, two participants attended one session, one participant attended three sessions, one attended four sessions and one attended nine sessions. The average starting Y-BOCS score of the five non-completers was 25.8.

The average Y-BOCS score of the five that completed the group, or "completers" was 29.7. The average Y-BOCS score at the end of the 12 weeks for the completers was 26.1 - an improvement (decrease) of 3.6 points from the beginning to end of the 12-week group. All five

completers had a decrease in their Y-BOCS score from the first to the last group; however, they all began the group in the YBOCS severe category and ended in the severe category.

Revenue. The wRVU for CPT 90853 is 0.59. There were 70 visits charged, with a total wRVU of 41.3. In general, each participant was charged after each group visit with CPT code 90853 at a rate of $85. One participant was charged a self-pay discounted fee of $49.60 for two visits during a lapse in insurance. Both participants with OHP insurance were non-completers and had a combined total of 10 visits. OHP rejected the claims and the charge was waived by the department as previously arranged as a means to extend care to this population. The goal was to have the revenue from those with private insurance subsidize the cost of the participants with OHP.

The total number of claims reimbursed by insurance companies was 45 as of May 19, 2016, with four claims pending. One participant had claims billed through Medicare but with supplemental insurance. The reimbursement from those claims was $12. The estimated average reimbursement by insurance companies for a claim for 90853 was $37. Actual average reimbursement was $46, with reimbursements ranging from $12 - $66. The total amount billed for the group was $5,681. The total amount reimbursed or paid as of May 19, 2016 was $2,082 with $172 pending reimbursement. This met the goal of $2,175 to cover cost (including overhead) plus a 5% profit margin. One participant had not met his deductible, and therefore was responsible for the insurance adjusted rate of his 10 visits at $66 each. He has not paid for any of those visits, and likely will not as his account was in collections; so this could not realistically be counted toward the revenue.

Overhead of $10,000 per practitioner was included in the cost of the group, but the conference room used to hold the group session would have been unused during the group

sessions. So for practical purposes there was no additional cost to the clinic to hold the group in that space. If the group cost were to be re-calculated without overhead cost of $10,000, then the cost to the clinic was about $74/hour or $149 per group session, with a total cost of $1,784. Including a 5% profit margin, the goal for total revenue would be $1,874. The group met this goal by $380. Using either goal, the group was a cost-effective modality to offer CBT/ERP.

Some of the participants may have pursued individual therapy had they not participated in group therapy. 45 or 60 minutes of individual therapy is reimbursed at a higher rate than group therapy. So there may have been lost profits due to decreased opportunity for individual therapy. But having the group available in the evening made therapy available to some who may not have otherwise been able to attend individual therapy during the day. The group modality also made it available to two participants with OHP which would not have been possible with individual therapy.

During the course of the 12 weeks, one participant had a gap in his insurance coverage for two weeks. He was able to continue treatment because of the self-pay discounted group fee rate of $49.60. This was available only to those without insurance and paying out-of-pocket. Because of the group, he was able to continue making progress in his treatment during those three weeks rather than not being able to afford therapy for three weeks. This highlighted the group's purpose of meeting the needs of the greater community and fostering equity of available services across socio-economic levels.

Patient satisfaction. These five completers were able to give completed data sets including pre and post Y-BOCS scores and pre and post participant surveys. These materials were collected together, but without patient identifiers on them. The answers to each question were transcribed, and themes were extracted from the qualitative data. These themes included

cost, time, travel, medication, peers, family, identifying thoughts or behaviors as OCD, increased anxiety/OCD symptoms, decreased anxiety/OCD symptoms, tools/techniques to manage OCD, and accountability.

The average amount of time that the completers had spent looking for CBT for OCD was 2.2 years. Non-completers in general had not been looking for CBT - they had already received some CBT or it was suggested to them to join the group by a provider. This could indicate a difference that contributed to these participants not completing the group, as they were not actively searching for the therapy to begin with. Themes of barriers to enrolling in the group included increased anxiety about participating in a group, fears of speaking in front of others, threatened confidentiality in a group setting or fear of symptom exacerbation from focusing on their OCD. Issues of time and travel to the group were also noted.

Barriers to attendance given only by the completers included time, travel in traffic, and scheduling as well as increased anxiety by participating in exposure therapy. Suggestions on how to make it easier to attend included later start time, moving the group to a Friday, or offering the group through web-based options. The question asking participants what they hoped to get out of the group could have been combined with the goals for treatment as the answers were similar. The primary goals were to: decrease OCD and anxiety symptoms, improve recognition of OCD thoughts, learn new tools and techniques to manage OCD and anxiety, find peer support and decrease reliance on medication.

For the completers, the group helped them meet their goals by providing a supportive peer environment and providing accountability for follow-through with exposure “homework.” On the pre-group questionnaire, themes for success in the group were simple: a decrease in OCD symptoms and better coping with those symptoms. Four of the five completers stated that the

group helped them partially achieve their original definition of success. It helped them make progress toward their self-defined success but they did not achieve it completely. Suggestions for improvement included longer time - both longer group sessions and longer duration. One participant gave the suggestion to include family or loved ones, possibly in a separate group, so they could learn more about OCD, how to support their loved ones, and get support from each other.

Untoward effects of the group included an increase in obsessive thoughts and anxiety or feeling overwhelmed. This confirms the notion that in CBT/ERP for OCD, symptoms often worsen initially because time is spent tracking symptoms which increases focus on them, and then anxiety increases when exposures are started because an exposure is purposefully engaging in a behavior or activity that makes the person anxious. The benefit from the exposures are long-term, and it is helpful if the participant can view it as an initial investment for a long-term gain.

Three of the non-completers gave reasons to the group leader for dropping out. One non-completer noted that she had difficulty relating to others in the group. A common fear in the group was of contamination. This individual reported that she did not have a fear of germs or contaminants and felt that the group was less relevant for her. She also cited difficulty with committing time to the group in addition to her work and challenges with arriving by 6:00pm. Another non-completer chose not to continue with the group after 4 sessions because she knew most of the material that had been presented. She had already used many of the exposure and cognitive techniques that were being discussed. One of the participants missed three of the first four groups and therefore decided she may be too far behind to continue.

Two participants cited fear of “catching” the compulsions of other group members - that by hearing the things that other group members were obsessed/worried about, they may also start

to worry about those things and begin engaging in those compulsions themselves. Experienced therapists report that although this is often a fear of group participants, it generally doesn't occur. OCD ideas are often illogical, and are only compelling for the individual who has them. None of the completers started new obsessions and compulsions based on those in the group; the opposite was true - members often tried to help each other see the irrationality of their fears.

In retrospect it would have been helpful to have a questionnaire to mail to participants who chose not to complete the group. This was a missed opportunity for structured feedback that could have informed some of the barriers of attending the group, which were probably a bigger issue for the non-completers than for those that continued. Of course, it is uncertain whether these participants would have returned a voluntary questionnaire or whether they would have been completely forthcoming about their reasons for leaving. All of the reasons those individuals chose not to continue is unknowable.

Perspective of other mental health providers. ROIs were obtained for other mental-health providers of group participants such as psychiatrists and individual therapists. Six post-group questionnaires were sent to five other providers (one provider had two patients involved in the group). Four questionnaires based on four participants were returned from three providers. One of four indicated that they had attempted CBT/ERP with his/her patient before the group. Barriers to providing ERP or CBT were lack of confidence in delivering that therapy, limited availability for therapy in their schedule as well as initial focus on supportive therapy.

All four questionnaires noted an improvement in patient function or progress toward treatment goals as a result of the group. Progress included improved insight, active engagement in treatment, improved understanding of OCD and better distress and anxiety tolerance. Three of four questionnaires indicated they would refer to the group again; the fourth was left blank. No

suggestions for improvement were given. The group provided a treatment for the group members that overall could not be provided by other members of the patient's mental healthcare team. All providers saw this group to be useful and saw improvements in their patients in their OCD.

Group leader observations and recommendations

There were some challenges to group facilitation. For example, two of the five completers were engaged in individual ERP/CBT with the group leader before the group started. This added a layer of complexity to facilitating the group because something that was discussed individually could not be brought up unless or until the participant brought it up, as this would have been a violation of confidentiality. For example, if a participant made a remark about substance use as a way to cope with anxiety, it was difficult for the group leader to address the remark in an unbiased way, given the private information known about the person's substance use problem. In light of this challenge, it was helpful to have a co-leader that had not met any of the participants previously. She was able to address concerns that arose in the group in a neutral way. Based on this experience, it is recommended to have a co-leader that does not have any individual involvement in participant's treatment.

The participants voiced an appreciation for the mutual understanding they received from each other. They noted how they could share their particular obsession and compulsions with the group, and even if the other members didn't share the same fear, and could see it was irrational, they still "got it." This understanding was not available from friends or family without OCD.

The mutual understanding, on some occasions, contributed to a unproductive group trend to re-affirm each other's compulsions or fears as reasonable. There was one group member in particular who encouraged this. This response had to be closely monitored and moderated by the group leader to shift focus back to how the behavior negatively impacted functioning.

There were times when participants argued the irrationality of each other's obsessions and fears. But in addition to arguing the irrationality, the participants often encouraged each other to engage in exposure and face their fears, which ultimately proved to be helpful for each other. One particular benefit of group therapy for ERP is that when other group members achieve success they can share it with the group. The participants who had never engaged in any exposure therapy were skeptical of the counter-intuitive idea that *doing the thing that makes you anxious* is a good way to treat OCD. To address the incredulousness, including participants at varying stages in treatment is advantageous because it carries much more weight when someone with OCD can attest that they did an exposure and it helped them improve their function; as opposed to this being endorsed by the group leader who may not fully understand the difficulty of what she has proposed. This recommendation should be taken with consideration that one of the participants dropped out because she felt she had nothing new to learn from the group. If someone has experience with ERP/CBT, it is important to assess if the group can offer them anything new while also serving the needs of those new to ERP/CBT.

Sochting (2014) advises eight participants as an ideal number for group CBT. The group was planned with a target number of 10, with the expectation of absenteeism. An absentee or "no-show" rate of 30% was built into the financial plan. A final attrition rate of 50% was higher than expected. In order to prevent the financial losses brought on by attrition, the group could be run as an open group rather than closed and on a fixed time-course. This structure has many advantages. It allows for new members to join as they are ready and current members remain in the group until they achieved their goals. It provides for the advantage of participants at varying stages of treatment, and it address the suggestion for improvement to lengthen the group.

Challenges with individual participants added complexity to the group. Self-harm was evident in a participant. It was clear to the group leader through private communication and non-verbal communication that it was disturbing to the group. The patient was contacted about the self-harm privately, and care was coordinated with the participant's individual therapist. But because the conversations were private and confidential, this information was not privy to the group to reassure them and left the group with unresolved concerns. A phone screening with the participant about this issue was done before the group and the individual was prepared to share this issue in group, but ultimately chose not to which left it as an unaddressed area of concern.

After a few group sessions, it became increasingly clear that one of the participants did not have primary symptoms appropriate for ERP/CBT. Because of a multitude of mental health diagnosis, this individual was screened on the phone prior to being admitted to the group. But this screening proved insufficient to detect the interference that other symptoms other than those of OCD would cause with this person's participation in the group. These instances provide evidence for the recommendation that all potential participants for a group meet with the group leader individually for at least two therapy sessions in order to properly assess appropriateness of symptoms and function for an ERP/CBT group.

Conclusion

During the final group session, some of the participants requested that the group continue. They appreciated aspects of group therapy that cannot be replicated in individual therapy. Most importantly, they felt understood by other members of the group. They felt free to discuss their obsessions and compulsions without having to explain *why*, as they would to someone without OCD. Many of the obsessions and compulsions in OCD are highly irrational - but the participants understood how it can still be compelling. As one participant remarked, "If

you get it, you've got it." The empathy was perceived as more genuine than from a therapist who "doesn't understand" what it's like.

The group gave encouragement and celebrated each other's successes. It provided an extra level of accountability - if someone didn't complete their homework he had to report that to the group, as opposed to an individual therapist. If someone thought about not attending the session, he knew an entire group was expecting him. The group offered benefit of shared learning. The participants gained insights through hearing the experiences of others - what worked and what didn't. Those who didn't believe exposure therapy could work were encouraged by those who reported individual success with it.

All of these group modality advantages add value to ERP/CBT, but these advantages aren't valued by the greater system in which the care is provided. The wRVU and reimbursement for each participant is low compared to that of an individual therapy session, and even lower compared to visits where medications are prescribed. Centers for Medicare and Medicaid Services (CMS) - a major driver of healthcare insurance industry standards for the entire country - does not reimburse for group therapy visits. This implies that group therapy has no proven value.

Despite the added value of group therapy for the patients, there is an element of risk involved for the practitioner because a certain number of clients are necessary to cover the cost of the group and make a profit. If several of the clients cannot, or do not, attend a group, it still must be offered for those that do attend - even if that comes at an overall loss to the provider or clinic. Also, as previously mentioned, at least some of patients attending group therapy attended it instead of individual therapy appointments. Reimbursement would have been higher overall seeing those clients individually.

All of the post-group questionnaires filled out by participants and providers had positive feedback regarding the benefits of the group. Each of the five participants that ended the group had a reduction in their YBOCS score. The group had added benefit not available in individual therapy, and was regarded as an effective and quality intervention. And yet there is little incentive to the provider and the OCD clinic to continue offering the group. The reimbursement is too low, and the financial risk is too high if the number of participants can't be maintained above a certain threshold at each group - which is unpredictable and difficult to manage. The fact that the group was able to provide a type of therapy to clients with OHP who would otherwise be unable to attain it has value from an ethical perspective, but no value for the clinic in any other incentivizing way.

At this point in time, psychiatry is reimbursed completely by fee-for-service, and although the Affordable Care Act promises to tie reimbursement to outcomes, that is still in the distant future for psychiatry. Current policy is such that clinics that are not participants in an accountable care organization or managed care system have little-to-no incentive to provide ERP/CBT group therapy although it is evidence-based, low-cost and effective. The fact that CMS does not reimburse for the visits but will reimburse for individual therapy proves this point. If this country hopes to offer mental health care to growing numbers of people at low cost, it would be prudent to implement policy that encourages providers and clinics to offer low-cost but effective services and treatments.

Summary

OCD is a chronic, disabling disorder that warrants attention and resources. Serotonin-based antidepressant medications and CBT are first line treatments recommended for OCD (APA, 2007), but only 7.5% of adults with OCD received CBT (Blanco et al., 2006). The goal of

the OCD clinic is to provide high-quality, evidence-based care to clients with a primary diagnosis of OCD. A review of literature provides evidence that CBT and ERP are indeed effective for OCD, at least as effective as medications. The literature also supports the effectiveness of group CBT or ERP therapy for the treatment of OCD in adults. This project's aim was to provide comprehensive, evidence-based care to the patients of the OCD clinic which includes ERP/CBT. The project consisted of an implementation plan and summative evaluation of an ERP/CBT group.

The implementation plan included rationale, group protocols used, administrative and financial considerations including cost and revenue goals, outcomes measurement, and facilitators and barriers. The group therapy was delivered in two hour sessions over 12 weeks. The summative evolution included measures of clinical symptoms using the YBOCS, revenue, patient satisfaction, other mental health provider perspective and group leader observations and recommendations. The group met its target enrollment of 10 participants, with a 50% attrition rate by the end of the 12 weeks. The average decrease in YBOCS scores was 3.6. The financial goal was cost of the group with 5% profit margin. The total revenue met this goal by $79. Participants were generally satisfied with the group. Benefits of the group format included a supportive peer environment and accountability. Other mental health providers of the participants gave positive feedback and stated that their patients gained greater awareness and engagement. They would refer to the group again. Suggestions for a future group include individual assessments with each participant before enrollment in the group to ensure appropriateness and fit for group therapy. An open group format where enrollment time is flexible and participant numbers can be continuously renewed would be helpful.

Overall the group was effective, satisfied patient and providers and met minimal financial goals. Despite this, revenue for the clinic would be higher if each of these participants was seen in individual therapy. The added value of group therapy is not recognized in terms of reimbursement. Group therapy is actually de-valued by such standard-makers as CMS. The fact that this is a highly efficient and cost-effective way to deliver care disincentivizes the clinic from offering it. Outside of a managed-care setting our healthcare rewards high-cost, inefficient care. This will have to change if our country aims to provide quality, evidence-based and cost-effective care with increased access - a goal that group therapy is well situated to meet.

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Appendix A

Articles Included in the Review of Literature

CBT and ERP are effective for OCD

Author	Description	Result
Romanelli et al. (2104)	Meta- analysis - 15 trials, 106 treatment conditions (some child studies)	ERP plus SRI superior to SRI alone but not ERP alone
Williams (2014)	Meta-analysis on impact of symptom dimensions on outcome for ERP therapy in OCD	ERP was effective for all symptom dimensions, however it was less effective for unacceptable/taboo thoughts and hoarding
Houghton (2010)	Practice-based prospective study compared against systematic review to determine effectiveness of routinely delivered CBT for OCD	CBT is effective in general outpatient settings with "typical" populations and providers
Podea (2009)	Systematic lit review of the latest research of effective psychological treatments for OCD	CBT is an effective treatment, at least as effective as medication
Rosa-Alcazar et al. (2008)	Meta-analysis -19 controlled studies, 24 comparisons of CBT, ERP and combination	ERP, CBT and combo are all effective, none are superior
Gava et al. (2007)	Meta-analysis - 7 randomized studies, 10 comparisons of psychological treatment vs. Treatment as usual	CBT, CT, ERP significantly fewer symptoms post-treatment vs Treatment as usual (waitlist control)
Fisher & Wells (2005)	Meta-analysis. 5 randomized studies with control group or two or more treatment groups. Tested clinical significance analysis of psychological treatments.	ERP and CBT both produce improvement, ERP is superior

CBT and ERP are effective for OCD

Eddy et al. (2004)	Meta-analysis of pharmacotherapy - 15 trials, 33 treatment conditions. Psychotherapy - 32 trials, 68 treatment conditions. Both - 3 trials	ERP, CBT, CT were equally effective, ERP was possibly more effective (non-significant). Combo psychological and pharmacological therapy is the most efficacious
Abramowitz (1998)	Meta-analysis to determine clinical significance ERP in the treatment of OCD	ERP was effective in a clinically significant way and results lasted up to 5 months
Kobak et al. (1998)	Meta-analysis - 77 studies, 106 treatment conditions	Clomipramine, fluoxetine and fluvoxamine are equally effective as is ERP
Abramowitz (1997)	Quantitative review - 32 studies, 37 controlled (or multiple treatment groups) comparisons on efficacy of treatments for OCD	ERP and CBT are both effective, with no superiority between the two.

Evidence for group ERP

Author	Design	Result
Jonsson & Hougaard (2011)	Randomized comparative study of group vs individual CBT for OCD	OCD can be treated effectively with a group format of CBT
Jonsson & Hougaard (2009)	Meta-analysis -13 studies, 15 comparisons of group CBT and ERP. Controlled, randomized and open trials	Group CBT and ERP are effective but not superior to individual. Group therapy drop out was higher than other treatment or wait-list controls (13.5%)

Evidence for group ERP		
Rosa-Alcazar et al. (2008)	Meta-analysis -19 controlled studies, 24 comparisons of CBT, ERP and combination	Group treatment achieved similar results to individual therapy
Gava et al. (2007)	Meta-analysis - 7 randomized studies, 10 comparisons of psychological treatment vs. Treatment as usual	No difference in efficacy of group, higher dropout rate in individual
Fisher & Wells (2005)	Meta-analysis - 5 randomized studies with control group or two or more treatment groups. Tested clinical significance analysis of psychological treatments.	Group ERP is effective, group CBT is not. Dropout rate of group ERP 20%
Eddy et al. (2004)	Meta-analysis of pharmacotherapy - 15 trials, 33 treatment conditions. Psychotherapy - 32 trials, 68 treatment conditions. Both - 3 trials	Individual therapy is likely more effective than group

Appendix B

Participant Group Questionnaires

Participant Pre-Group Questionnaire

Pre-group Y-BOCS score:

How long have you been seeking CBT for OCD?

What barriers did you encounter to enrolling in the group or coming to the group?

What do you hope to get out of the group?

What are your goals for treatment?

1)

2)

3)

What would you describe as “success” in treating your OCD symptoms?

Participant Post-Group Questionnaire

Post-group YBOCS score:

Did you experience any untoward effects or bad outcomes or side effects as a result of this group?

How did the group help you meet your goals?

Did the group help you achieve your original definition of success?

What changes would you make to the group?

What were barriers to your attendance in the group?

How could we make it easier for you to attend?

Appendix C

Provider Post-Group Questionnaire

Please do not identify yourself or your client on this questionnaire.

Had this patient had any previous treatment with cognitive behavior therapy/exposure and response prevention therapy provided by you?

Yes / No

If *no*, what were the barriers to providing it or why did you choose not to?

If *yes*, describe what benefits or limitation of treatment that you noted.

Have you noticed any improvement in patient's functioning or progress toward goals as a result of participation in the group?

Yes / No

If *no*, why do you think the patient did not benefit?

If *yes*, what progress did the client make toward treatment goals?

Would you refer another client to the group? Why or why not?

Any other suggestions for improvement.