CASE REPORT

Occupational Therapy and Obsessive-Compulsive Disorder

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This case report describes an occupational therapy treatment program for a patient diagnosed with obsessive-compulsive disorder, based on the Model of Human Occupation (Barris & Kielhofner, 1985).

Background

John was a 24-year-old man who was admitted to an inpatient psychiatric ward following a suicide attempt. He was in the military at the time of his hospitalization, training to be an electrical systems specialist. His work history included a short enlistment in the Air Force as a supply clerk, a job as a prison guard, and his position in the Army.

John described his wife, daughter, parents, and three siblings as a close and supportive family. His parents considered him a model student; he earned good grades in school and never had any problems while he was growing up. A maternal uncle had been hospitalized for paranoid schizophrenia.

John's symptoms first occurred while he was attending the Army’s 6-week basic training course. He experienced difficulty remembering details and needed to constantly check his wall locker and wallet. This preoccupation with checking details made him feel helpless and frustrated. After graduation from basic training, he returned home for the Christmas holiday. He continued to experience a need to recheck details while at home. Because of his intense frustration, he attempted suicide by hanging. He did not tell anyone about this attempt.

After basic training, he attended advanced individual training, where he again experienced the need to constantly check and recheck minute details. He was unable to mail a letter, for example, because he was not sure that he had addressed the envelope correctly. He would check the letter repeatedly to make sure it was correct, but was still unable to mail it. He again attempted suicide by hanging, but this time a friend stopped him and referred him to the mental health center on the Army post. He was admitted to an inpatient psychiatric ward where he was evaluated and diagnosed with obsessive-compulsive disorder.

Summary of Diagnosis

According to the Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev.), obsessive-compulsive disorder is characterized by "recurrent obsessions or compulsions sufficiently severe to cause marked distress, be time consuming, or significantly interfere with a person's normal routine, occupational functioning, or usual social activities or relationships with others" (American Psychiatric Association, 1987, p. 245). The etiology of the disorder is uncertain. Onset generally occurs during adolescence and young adulthood. Obsessive-compulsive

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disorder is usually chronic, with waxing and waning of symptoms (Kaplan & Sadock, 1985).

The management and treatment of obsessive-compulsive disorder has been addressed in the occupational therapy literature by Lake (1964). She explained that “by combining the principles of psychotherapy and creativity, the occupational therapist uses his [or her] ‘self’ and activities to encourage the patient’s expression of and/or sublimation of needs” (p. 149). She recommended that the therapist create a nonthreatening environment in which patients feel free to discover repressed parts of themselves.

Barris and Kielhofner (1985) outlined the occupational therapist’s role in treating depression and anxiety, symptoms that often contribute to and are complications of obsessive-compulsive disorder. Depressed patients often struggle with feelings of incompetence and fear of failure. They frequently identify few interests, although they may have had many in the past. Occupational therapy for depressed patients targets their premorbid functioning and incorporates interests and activities compatible with their previous occupational roles. The goal for hospitalization is to reestablish occupational routines.

**Occupational Therapy Evaluation**

As John’s occupational therapist, I used the Model of Human Occupation to structure his assessment and treatment plan, because it is the primary frame of reference used in this inpatient psychiatry setting. The model examines three primary subsystems: volition, habituation, and performance (Barris & Kielhofner, 1985).

**Volition.** John perceived himself as helpless and expressed feelings of inefficacy and incompetence. This negative self-evaluation contributed to his expectation that he would fail at whatever he did. Volition was primarily evaluated through clinical observation and the Internal/External Scale (Rotter, 1966). The patient identified two valued goals: being free of his compulsions and being able to support his family. He explained that he expected to fail at any job he undertook, so that he would not be able to earn a living and provide for them. On the Interest Check List (Matsutsuyu, 1969), the patient showed a limited range of interests, and most of the interests he did have involved solitary and sedentary activity. In high school, he had been active in team sports and social events; he recognized that many of his activities had been discontinued when he joined the Army.

**Habituation.** The Role Checklist (Oakley, 1982) was used to evaluate habituation. It became clear that John had experienced several disruptions in his roles as worker, family member, and caregiver, roles that he valued highly. He thought that he could no longer be an effective worker in the Army, and this, in turn, affected his role as a family member. He thought he could no longer support his family. His role as a friend was also compromised because of his depression and withdrawal, and he had limited his participation in hobbies and sports during his military training. His normal routines were interrupted by his compulsions (e.g., checking his wall locker continuously). He was embarrassed about this and hid his frustration from his family and friends.

**Performance.** The area of performance was assessed through clinical observation and the Occupational Performance Screen (Harlan, McDonald, & Sinnott, 1986). John exhibited no skill deficits in the occupational therapy clinic. He could complete complex tasks using written instructions and with minimal assistance. Clinic activities, such as structured crafts, seemed to have a calming and relaxing effect on him. Outside the clinic, however, his compulsions affected certain acts. When he had to complete a task associated with pressure (e.g., mailing a letter to his family), the compulsions would reappear.

**Environment.** In addition to the three primary subsystems, environment was evaluated through an interview with the patient and a review of the results of other assessments. The military environment was very demanding and stressful to the patient, and it separated him from his supportive family. His entrance into the military and inability to cope with the highly structured life-style appeared to be the precipitating cause of his symptoms. His inability to cope with these stressors decreased his ability to perform effectively in occupational roles.

While hospitalized, John received treatment from health-care-team members from various disciplines. The psychologist administered several tests to provide a definitive diagnosis of obsessive-compulsive disorder. The social worker led a discharge planning group who helped the patient formulate his plans. The patient’s goals in art therapy were to symbolize things about himself through his artwork, represent changes he could make, and formulate and clarify his personal goals. His work was used to assess his degree of depression and his suicidal ideation. In therapeutic recreation, he was placed in a socialization group to facilitate his ability to engage in conversation and to help him identify his personal needs. He was also placed in an exercise group to increase his self-esteem through participation in physical exercise. He was treated by a psychiatrist with 40 mg Prozac (a bicyclic antidepressant) daily.

The health care team held an initial meeting during the treatment planning conference to establish the patient’s treatment plan. Thereafter, the team met daily to discuss the patient’s progress.

**Occupational Therapy Intervention**

An occupational therapy treatment plan was formulated in collaboration with the patient, following the results from the assessment.

To address John’s problem of feeling incompetent and expecting failure, we had to have him recognize his
personal strengths and his ability to perform tasks successfully. This was accomplished by having him complete multiple tasks in the occupational therapy clinic, examine the result, and judge whether or not he had been successful. The tasks were graded in difficulty to instill confidence in his ability to succeed and ranged from simple painting to a complex woodworking project.

Together we explored various behavioral techniques to address the patient’s frustration and the way he was functionally impaired by his obsessions and compulsions. These included reality orientation and desensitization. The goal was to reduce, or compensate for, the stress of the compulsions.

To help solve the problem of his disrupted worker role, John participated in a work therapy program. This occurred at about the time he was becoming more confident in his own abilities. He requested a data-entry position, because this was a field of interest for him and a possible area for a future job application. In this assignment in a structured environment, he experienced success again in the worker role. He incorporated the confidence he had established in the clinic with learned behavioral techniques to help him function under pressure.

Group and individual sessions were used to address the problem of decreased ability to handle occupational stress and frustration. I taught the patient various stress management techniques (e.g., leisure skills, progressive relaxation, and time management). He experimented with the ideas presented and incorporated them into his normal routines and habits. In addition, I identified a support group for people with obsessive-compulsive disorder near the patient’s home. John attended one meeting when he went home for a visit.

Discharge Planning

In general, John was very receptive to the occupational therapy treatment plan. After 1 month, he went home to his family for 1 week, where he received a great deal of support from his wife and parents. He returned to the inpatient unit more self-assured and more confident that he had a future. He was transferred to a transition unit, where he began the process of medical discharge from the military. On this unit, a certified occupational therapy assistant helped him with prevocational training, which included writing résumés and practicing interviewing skills. He was also referred to the educational center to explore possible future vocations.

John was discharged from the military. He intended to continue outpatient therapy through the Veterans Administration hospital near his home and to attend the obsessive-compulsive disorder support group weekly.

Summary

The Model of Human Occupation, used as a frame of reference in the assessment and treatment of obsessive-compulsive disorder, helped identify how major disruptions in habituation and volition can affect a person’s ability to perform and adapt in his or her environment. Careful application of this model promoted a more holistic view of John’s life-style and guided me, as his occupational therapist, in creating a purposeful and meaningful treatment plan.

References


Harlan, B. A., McDonald, P., & Sinnott, M. (1986). The Occupational Performance Screen. (Available from Walter Reed Army Medical Center, Occupational Therapy Department, Washington, DC 20307)


Editor’s Note. To continue the Case Report department, we need and welcome reports that document the practice of occupational therapy for specific clinical situations. Guidelines for writing case reports are available from the Editor.