Intensive Outpatient Treatment for Obsessive-Compulsive Spectrum Disorders

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Abstract: Exposure and response prevention (ERP) is the most effective treatment for obsessive-compulsive disorder (OCD), yet the intensive treatment schedule often described and recommended is not readily accessible to many populations. In the present article, the authors describe a time-limited, outpatient, intensive treatment for Obsessive Compulsive Spectrum Disorders in Israel. Working in the client's natural environment and making use of technology are particularly highlighted.

Introduction

Exposure and response (ritual) prevention has proven to be a highly effective form of intervention for obsessive-compulsive disorder (1) and is considered the psychosocial treatment of choice for this disorder (2). The majority of treatment studies have described an intensive ERP regimen involving 15 outpatient treatment sessions over three weeks (e.g., 3) or intensive inpatient treatment programs (e.g., 4, 5). Although these schedules are well suited for research or specialty clinics, time and financial constraints limit their transportability and accessibility. Thus the best OCD treatment is often the most difficult to find and access (6).

As such, others have looked at the efficacy of a less intensive version of ERP. Abramowitz et al. (7) reported clinical effectiveness of a twice-weekly ERP program (15 sessions over 8 weeks) and Emmelkamp et al. (8) found no difference between massed and spaced ERP sessions.

The question of which patients benefit from which degree of treatment intensity is still debated, with little to no empirical data to guide the decision. Thus, clinicians are left with only clinical impressions and anecdotal data when determining treatment intensity. The commonly held view is that less frequent sessions may suffice for patients whose OCD symptoms are mild or moderate in severity, who readily understand the importance of daily exposure homework, and who adhere strictly to ritual abstinence instructions. More frequent, and therefore intensive, ERP is recommended when patients have high emotional reactivity, poor insight, or difficulty comprehending the rationale for the treatment procedures. Indicators that an intensive regimen should be considered include: missed sessions, excessive bargaining over exposure instructions, difficulty refraining from ritualizing, and involvement of family members in avoidance and rituals (7).

In addition to frequency of sessions, the setting in which they occur has also been studied. While the majority of treatments occur in the hospital or clinic setting, there is some evidence to suggest that treating patients in the natural environment can be as, if not more, efficacious than synthetic environments (9). While natural settings have the clear advantage of being the least restrictive, they also have the added advantage of maximizing the effects of in vivo ERP. In more artificial settings, patients and clinicians struggle to duplicate the feared stimuli and patients frequently complain that the treatment they are receiving at the clinic or hospital is not generalizable to their real lives. The obvious benefits to working in a natural setting are that (a) the patients’ symptoms occur in such settings (i.e., compulsive hoarding) and thus don’t need to be duplicated, (b) the problem of generalization from office or hospital settings can be diminished, and (c) there is increased access to in-
individuals in the client's environment who affect symptom maintenance. As a result, the direct utility to the consumer of this treatment approach vis-à-vis more conventional methods may be higher, as they will not be faced with having to generalize treatment gains to the practical aspects of their non-patient lives. For the OCD patient, implications for welfare and functioning post-treatment are important when this approach is adopted. Although response rates to behavior therapy are high for many OCD sufferers, the long-term maintenance of gains is less stable. Naturally based therapy may be indicated in reducing relapse, and may be a factor in aiding the OCD patient to better cope with the clinical and subclinical symptoms that may remain even after significant improvement.

However, it is important to note that in a recent study by Rowa et al. (10) the authors found that home-based ERP was no more effective than standard office-based ERP and that significant improvements were noted in both groups. Although they note that home-based ERP may be more useful for certain individuals (e.g., those with particular symptom presentations, such as hoarding, which cannot be replicated in the doctor’s office), it is clear that more work needs to be done in this area.

We present here a description of an Israeli, community-based outpatient program housed in a naturalistic setting, with an innovative outreach program. It provides the intensity often sought in hospitalization or in more time-intensive outpatient programs, while allowing the individual to live and work at home and to continue to participate as much as possible in daily routine activities. Such services address the necessity for aftercare programs to prevent relapse while also addressing the need for social and occupational rehabilitation.

**Treatment Rationale**

The Israeli Center for the Treatment of Obsessive-Compulsive Spectrum Disorders (The Center) is unique in that it offers a robust treatment approach for refractory OCD patients in an outpatient and time-limited manner. The program runs for three days per week, for approximately six hours per day, and over a span of three months on average.

The principle rationale for this program is the potential to introduce treatment that will be more easily accessed by the targeted population. In addition to access, we believe that even with severe forms of OCD, keeping the patients in their natural environment leads to more rapid recovery and longer-term maintenance of treatment gains.

Research suggests that following a combination of self-directed *in vivo* ERP and therapist-controlled ERP, 75% to 85% of patients have fewer symptoms of OCD and their gains are maintained over time (11, 12). A well thought-out, outpatient protocol is of equal therapeutic efficacy to intensive inpatient treatment of OCD (13). Similarly, some authors feel that self-directed *in vivo* ERP is just as effective clinically as therapist-controlled *in vivo* ERP, and it is more cost effective (14).

However, a meta-analysis found that therapist-supervised ERP is more effective than self-controlled exposure, and that complete exposure paired with response prevention is more effective than partial or no response prevention (15). For the majority of persons who suffer from OCD, self-guided exposure is the treatment of choice. However, for those with refractory OCD, coaching can add to the effectiveness of these techniques (see “Coaching” below).

When patients engage in exposure and response prevention mostly in natural settings, it emerges that they have less difficulty generalizing typical symptom reduction from the treatment site to their lives that occur in natural situations (11). In fact, effectiveness of this behavioral approach for treating OCD appears to be intensified when it is adapted to the natural settings in which the feared condition occurs (16).

**Case 1**

A 24-year-old religious woman presented with religious obsessions, concerns about morality, fear of violating rules, scrupulosity, and a co-morbid affective disorder. At the time of intake, the patient was participating minimally in daily activities. Most notable was the fact that the patient had not showered in two and one-half months. Her initial ERP sessions were focused on showering at the Center. Through coaching (through the bathroom door), using exposures and response prevention (i.e., hanging papers on the bathroom walls stating her fear, using different methods to decrease her concentration in checking
rituals, and contracting with the patient), she was able to increase the frequency of her showering to twice per week and to reduce the duration of her showering to 25 minutes. Despite these gains, the patient felt frustrated that she was unable to maintain them at home. Subsequently, we implemented an at-home ERP with coaching program. Following the same protocol as at the Center, the patient was able to transfer her learning to her home environment.

During the course of our home-based work with this patient, we discovered that she had hoarding compulsions. Specifically, this patient would hoard plastic bags in which she would then separate objects into contaminated and non-contaminated categories. She would also refrain from opening gifts from her past four birthdays. Had we not entered her home, we would likely have remained unaware of this behavior, which suggests another benefit of working in a client’s natural environment.

**Treatment Approach**

The Center provides a comprehensive program that integrates somatic, behavioral and milieu treatments to serve treatment refractory OCD and its most common co-morbid conditions.

**Setting & Milieu**

Housed in a private home on a rural “moshav” (village) in Israel, the Center offers an extremely naturalistic outpatient treatment setting. Patients participate in exposures that emulate those they face at home. Examples of this include, but are not limited to, preparing meals in our kitchen, washing dishes after meals, taking out the trash, taking showers, and so forth. In this way, patients are exposed to their naturally occurring feared stimuli. This is augmented by Center staff visits to the home and exposures designed in the actual setting where the fear occurs (see “Behavioral Treatment” below). Further, given the somewhat rural geographic location of the Center, patients must travel a lengthy and sometimes complicated route (if using public transportation) to access our facility. This ensures a degree of motivation for those who actively choose to participate in the program. Patients are discouraged from receiving transport from family members, and instead are encouraged to get to the Center on their own.

In addition to the therapeutic milieu that hosts the program, the Center has three satellite apartments that are scattered throughout the “moshav.” These apartments, which house two patients each, are used for overseas patients who are in Israel only to pursue this treatment, and for others from within Israel whose homes are too far away from the Center to travel to it each day. Used both during active treatment, and oftentimes as a component of aftercare, the goal with these satellite apartments is to replicate a naturalistic setting where treatment can be generalized and controlled. Patients are encouraged to create their environment in a way that is similar to how they really live at home. Much like a regular home visit, the satellite apartments afford the opportunity for staff to monitor and to assess improvement. However, given the apartments’ proximity to the Center, an additional benefit is that the coaches can have regular access to and involvement with the patients during the four non-treatment days per week.

Both the milieu and the satellite apartments are constructed to stress proactive involvement of the patient in the treatment. This involvement is achieved by viewing the patient as a colleague in the process, rather than a passive recipient of it. Decisions regarding treatment as well as policies are made through collaboration between staff and patients.

**Therapeutic Contracts: Self-Directed Treatment Plans**

Each patient, based on feedback from staff and other patients, completes a weekly therapeutic contract detailing his treatment plan for the upcoming week. Patients are instructed to define the problem or problems that they are addressing that week, the solution to the problem, short-term objectives that break the problem into smaller components, action steps necessary to accomplish their objectives, and obstacles that may decrease the likelihood to achieve the goals. Patients are encouraged to delineate these steps for both time spent at the Center and at home. At the end of the week, the patient receives feedback once again from staff and other patients on the progress and effort he has made.

Treatment plans are broken into smaller daily contracts that the patients complete at the start of each day. In these planning sessions, individual ap-
pointments, exposures, groups, chores, and other events are placed on a daily activity schedule. Patients also outline specific goals for the day and rate their anxiety using objective measures. Work on the daily contracts is geared towards learning time management skills and daily planning. In addition, the emphasis is on the patient taking responsibility for the treatment and its progress.

Medical Treatment
Patients meet with a psychiatrist and the program director at the Center bi-weekly. In this way, the medical treatment is integrated into the overall program. In addition to these sessions, patients can access the medical staff on an as-needed basis. Pharmacologic treatments are tailored for patients with treatment resistant OCD and play an integral role in the program (17).

Behavioral Therapy: ERP
Behavioral therapy utilizing exposure and response prevention (ERP) is considered the psychosocial treatment of choice for obsessive-compulsive disorder (OCD). Individual ERP treatment is the most common therapy format, and much of the empirical support for ERP is based upon studies of OCD subjects treated individually. However, there are numerous advantages of delivering this effective intervention in a group format, including cost savings to patients and time-efficiency for ERP therapists (18). Ninety-minute individual treatment sessions at least three times a week over an average of four to eight weeks is considered acceptable for producing adequate results (19–22).

In our treatment model, patients complete regular objective measures of improvement and attend two hours of ERP therapy in a group setting three times per week. During these groups, ERP tasks are designed to trigger clients’ obsessional processes, while respecting clients’ privacy, spiritual and cultural belief, and gender identity. The decision as to frequency and duration of treatment is largely based upon the clients’ current level of functioning and tolerability to anxiety eliciting stimuli. During therapy sessions, patients are exposed to items that are listed on their hierarchies and prevented from engaging in compulsive behaviors. Patients have the option to be assisted by peers in designing their exposures, as long as it is clear that the helper is clinically benefiting from such involvement. Most, if not all, of the ERP sessions are done with the aid of staff supervision, unless the involvement of a staff member is contraindicated (i.e., passive reassurance). Patients monitor their Subjective Units of Discomfort (SUDS) levels during exposures, unless monitoring the SUDS level interferes with the designed exposures. In such cases, coaches monitor SUDS levels. At the end of the ERP session, patients reconvene to debrief the exposure. During this meeting they recount what they did, their maximum SUD, their current SUD, and what they feel accounted for any change that occurred.

Coaching
Coaching is another main component of the program and is designed to facilitate the realization of treatment goals. Coaches are highly skilled mental health counselors who receive weekly supervision from the Center’s psychological staff. While the milieu setting, in a private home, allows for many *in vivo* exposures, such as using the bathroom, preparing food, encountering contaminated items, and so forth, for many, the most anxiety provoking areas remain outside the Center.

Patients are encouraged to incorporate these home-based problems into their daily and weekly treatment planning and to use self-exposure to address them. For many of our patients who experience refractory OCD, coaching can add to the effectiveness of these interventions.

Coaching is used during the daily ERP session, and during the nights and weekends when the patient is away from the Center. During the treatment day, coaches accompany patients to their homes, to the satellite apartments, or to carefully designed exposures in the community. During non-treatment hours, patients use phone calls and Short Message Service (SMS) with center staff. The following is an example of a home-based treatment utilizing coaching.

Case 2
A 32-year-old married woman with refractory OCD presented with a fear of contamination, excessive hand-washing compulsions, and a host of avoidance behaviors. This patient initially reported that she was
spending approximately 10 hours per day in the bathroom, approximately two hours each time she went to the bathroom. Using phone coaching during ERP sessions, we were able to reduce the number, frequency, and duration of bathroom rituals so that eventually she was able to enter and exit the bathroom in six-minutes. From the beginning, we were conscious of the generalizability of this treatment to other settings. As such, rather that coach her through the door, we relied on telephones (the patient using her cellular phone on speaker from inside the bathroom). Once we had achieved this significant treatment gain at the Center, the patient was ready to implement it at her home during non-treatment days. We standardized the protocol among all of our coaches and assigned each one a different day of treatment. The patient called the designated person on the designated day at each bathroom occurrence. The patient was able to quickly transfer her Center gains to her home and maintain the six-minute time frame.

**Group Therapies**

Patients attend four to five groups per day. The group therapy program provides a forum for therapies targeting motivation, compliance, decreasing behavioral symptoms, increasing adaptive family communication, increasing work and social functioning, presenting education and support, and offering additional vehicles for cognitive and behavioral therapies. See Table 1 for an illustration of these groups in the treatment program.

**Table 1. Illustration of Daily Schedule**

<table>
<thead>
<tr>
<th>Time</th>
<th>Group Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00</td>
<td><strong>Contract</strong></td>
</tr>
<tr>
<td>11:00–12:30</td>
<td><strong>Exposure and Response Prevention (ERP)</strong></td>
</tr>
<tr>
<td>12:30</td>
<td><strong>Lunch</strong></td>
</tr>
<tr>
<td>14:00–15:30</td>
<td><strong>Life Skills</strong></td>
</tr>
<tr>
<td>15:30–16:00</td>
<td><strong>Relaxation</strong></td>
</tr>
<tr>
<td>16:00</td>
<td><strong>Self ERP</strong></td>
</tr>
<tr>
<td>17:00</td>
<td><strong>Sports</strong></td>
</tr>
<tr>
<td>17:30</td>
<td><strong>Self Assessment</strong></td>
</tr>
</tbody>
</table>

**Individual Therapy**

Patients participate in weekly individual therapy with Center psychologists. The focus of these sessions is to address issues that are not covered by the ERP group. Typical components of the individual sessions include but are not limited to, barriers to treatment, trouble-shooting self-exposures at home, negotiating family and social relations, occupational related problems, and motivation. Individual therapists and the ERP group leaders have regular contact to address obstacles and special challenges.

**Family Involvement**

Obsessive-compulsive disorder can have an adverse effect on family members’ quality of life and interactions. Many families become dysfunctional as a result of a member’s OCD and the family’s involvement in his symptoms. Calvocoressi and colleagues (23) surveyed 34 family members of patients with OCD. Nearly one-third of these family members reassured the patient three or more times per week and participated in compulsion-related behaviors or avoidance by taking over the patient’s responsibilities.

Several authors have reported on the efficacy of family involvement in treatment through support groups that include psycho-education and social support for family members (e.g., 24–26).

We hold bi-weekly family groups at the Center. These groups focus on strategies for managing difficult problem behaviors, such as reassurance seeking and requests that often result in maintaining obsessive-compulsive behaviors. In addition, families are offered education about general topics of OCD such as theories of development, treatment options, medications, complications, motivation, and relapse prevention.

**Aftercare**

After completion of the intensive therapy phase, individuals with OCD may meet weekly with a behavior therapist for at least six months (20). Patients are encouraged to maintain treatment gains and develop their own exposure assignments. During times of stress, it is expected that old symptoms may recur. Booster sessions, when necessary, may be provided for further support and relapse prevention (27).
At the Center, patients continue weekly individual therapy with a staff psychologist for a duration of four months. Further, they are invited to the bi-weekly family group where they are encouraged to share their experiences during and after treatment. This offers them an opportunity to review their progress and to serve as a role-model to those in earlier stages of treatment. Often, participation in these meetings helps post-treatment patients to view objectively their progress by listening to patients who are in earlier stages of recovery and to benefit from this reflection.

A very important component of our aftercare program is the utilization of satellite apartments, which are made available to patients whose home environment may decrease the likelihood of maintaining treatment gains. The main purpose of these apartments is to give patients the opportunity to test their newly-acquired skills and to increase their independence and degree of responsibility. Center coaches are in contact with the patients during the week, helping patients to implement new skills and to continue with daily ERP, decreasing the likelihood of potential relapse.

Technology
There have been several studies exploring the use of automated devices in helping patients to monitor their behavior (28–30). Most of these have reviewed symptom monitoring and the gathering of self-report data. For instance, Taylor and colleagues (28) replaced the standard self-monitoring alternative of paper and pencil diaries with a Personal Digital Assistant (PDA). The computer provides real-time acquisition and storage and easy data transfer to the analysis program. Others have attempted to use computer-based devices in reducing OCD symptoms and improving compliance with ERP. Baer and colleagues (30) implemented a system called OC-Check to use on a portable hand-held and a desktop computer with a checking ritual patient. Whenever the patient had an urge to check, she was asked to consult OC-Check and wait three minutes, while watching the time tick away on the computer and being told that nothing bad would follow. Although the patient was reluctant to use the handheld computer in public, she observed that the rituals increased when she stopped using the system outside of her home. The authors report that using this program helped the patient reduce her checking rituals markedly for up to one year.

At the Center, we are making use of similar technologies. Through cellular phone technology, and specifically the use of SMS, patients communicate with staff throughout the day and night about their symptom frequency and duration. For the patient, the act of sending the message is efficacious. Further, in doing so, they are generating a digital log of these behaviors which are then uploaded to a database on our computer system. This increases accuracy of reporting and enables greater ease and efficiency with tracking symptom change.

We are also using a proprietary device in the reduction of frequent hand-washing behavior. The device is designed to assess and intervene in hand-washing behavior. It is used to monitor, record and store water use information. The device is safe to use and it produces reliable and objective measures of tasks involved in water use in a standard bathroom. Further, it can automatically regulate the frequency and duration of water flow from the tap. By simply entering an identification number, the computer can direct the patient to use the faucet in three levels of interventions:

1. Leave me alone — the computer only records the water use and time spent on the task.
2. Show the progress — using two visual bars, the patient can monitor the use of water and time spent on the task. The computer records the information and saves it in a database.
3. Intervene when necessary — The computer, using its electronic faucet, can stop water flow after a certain period of time and amount of water being used based on the treatment agreement.

The patient and the clinician view the saved information once per week to identify problematic episodes and to adjust the restrictions of the program according to the client’s progress.

Case 3
The same 32-year-old woman presented earlier has benefited from the use of various technologies at the Center. Foremost is the use of text messaging (SMS). As a transition from phone-coaching to more self-
directed coaching, we implemented a system of SMS check-ins with Center staff at each bathroom occurrence. The patient would send a brief message stating “I’m entering the bathroom now” upon entering and a corollary one of “I’m exiting the bathroom now” upon exiting. The patient had these set as templates in her cellular phone so that in literally one second she could send the message. We were then able to show her and discuss with her the recorded data and use it as a more accurate tool to track her progress over time.

Given that this patient responded so well to external limiting cues, we decided to try utilizing the computerized water-flow device. This device regulates the use and frequency of water flowing from her tap, thereby limiting her hand-washing behavior. We have contracted with the patient and her family around the use of this device and its implementation in her home and are in the final stages of setting it up.

Conclusion

The proposed treatment model addresses the heterogeneous needs of patients with obsessive-compulsive spectrum disorders, and, at the same time, allows them to stay in the community. It offers the intensity provided by hospitalization and other more time-intensive outpatient programs, while avoiding many of the costs and risks associated with these treatments. Specifically, it enables patients to stay in the community, to practice normalization, and to sustain or improve their daily functioning within a continuum of care that extends beyond the treatment setting to the home and work environments.

It will be important to study the efficacy of this treatment model as compared to other treatments for OCD spectrum disorders. In particular, questions about the use of external devices and their efficacy promoting self-help programs should be further explored, as well as home-based versus office or hospital-based programs.

References


