

Development of Nursing Guidelines for Inpatients with Obsessive-Compulsive Disorder in Line with the Progress of Cognitive Behavioral Therapy: A Practical Report

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Abstract

Cognitive behavioral therapy (CBT) is widely regarded as an effective treatment for obsessive-compulsive disorder (OCD) and is usually provided on an outpatient basis. A minority of individuals need a more intensive/inpatient service, which is particularly important for patients who cannot be managed as outpatients owing to the nature or extent of their symptoms. Inpatient treatment is generally provided by a multidisciplinary team and psychiatric nurses play a specific and prominent role as they are afforded a unique assessment and intervention opportunity by virtue of their 24-hour presence on the unit. However, there are few facilities, reports of multidisciplinary approaches, or descriptions of the role of nursing staff as cotherapists for CBT-oriented treatment of inpatients with OCD. The present paper therefore reports the developed nursing guidelines for inpatients with OCD in line with the progress of CBT at Chiba University Hospital in the context of Japan being a country in which CBT is under development. In addition, availability of the guidelines, better means of managing severe OCD and key issues for dissemination of CBT in Japan are discussed.

Keywords: Obsessive-compulsive disorder; Cognitive behavioral therapy; Nursing; Inpatient

Introduction

Obsessive-compulsive disorder (OCD) is characterized by recurrent intrusive thoughts, images, or urges (i.e., obsessions) that typically cause anxiety or distress and by repetitive mental or behavioral acts (i.e., compulsions) that the individual feels driven to perform, either in response to an obsession or according to rules that he or she believes must be applied rigidly [1]. OCD has a lifetime prevalence of 2–3%, typically begins in childhood or adolescence, persists throughout a person's life and produces substantial impairment in functioning due to the severe and chronic nature of the illness [2]. Treatment with selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), clomipramine and cognitive behavioral therapy (CBT) have consistently been shown to be effective treatments for OCD in a large database of randomized controlled trials [3,4]. In particular, available evidence suggests that CBT, including exposure and response prevention (ERP), is more efficacious for OCD than pharmacotherapy [5,6].

CBT is one of the most commonly practiced forms of psychotherapy and helps patients to correct maladaptive beliefs and appraisals that lead to obsessional fear and decrease avoidance and safety-seeking behaviors (e.g., rituals) that prevent the self-correction of maladaptive beliefs. Components of CBT for OCD generally include

psychoeducation, ERP and cognitive therapy techniques (e.g., pie technique and cognitive restructuring technique) [7]. ERP is a central behavioral technique used to alleviate OCD symptoms and the resultant discomfort; treatment involves exposure to the source of the obsession (e.g., dirt, germs, or specific situations) and prevention of the patient's normal response (e.g., cleaning, washing, or checking). As patients prevent themselves from carrying out the obsessional response, they will experience high levels of anxiety and/or distress, but they will learn that this reduces over a matter of minutes. Repeated exposures generally lead to a lessening of the compulsion to carry out the obsessional response and the intensity of the exposure is carefully graduated so that the patient can build up the degree of difficulty over time.

Although a growing database of clinical trials has demonstrated the effectiveness of CBT for OCD and CBT is recommended in national guidelines such as those in the UK, USA and Canada [8-10], these results were mostly obtained on an outpatient basis. A minority of individuals need more intensive treatment and inpatient care, which is particularly important when there is a clear risk to life, extreme self-neglect, distress, or functional impairment and when psychological, pharmacological, or combined treatments over a long period of time have not been successful. In the six-stage model of stepped care for OCD proposed in the UK, inpatient care using psychological and pharmacological treatments or other intensive treatment programs is involved in the final step (Step 6), which focuses on the most severe, chronic and resistant cases [8]. Even if OCD symptoms are less severe,

some individuals cannot be managed on an outpatient basis owing to day-night reversal patterns occurring as a result of the nature or extent of their condition and inpatient care is required to assist them in regaining normal daily life. Although there is limited evidence for inpatient treatment relative to outpatient treatment, non-randomized controlled trials have shown that between 44% and 80% of OCD patients improve after receiving inpatient treatment including CBT [11-14]. However, most of these studies reported only the treatment procedure or the role of main therapist and it is unclear how other specialists (i.e., cotherapists) play a role in inpatient treatment.

Inpatient treatment for OCD is generally provided through a multidisciplinary team composed of healthcare professionals (e.g., psychiatrists, psychologists, psychiatric nurses, occupational and physical therapists, social workers and case managers); in particular, psychiatric nurses play a specific and prominent role because they are afforded unique assessment and intervention opportunities by virtue of their 24-hour presence on the unit [15]. Psychiatric nurses observe and interact with patients and significant others with the purpose of assessing behaviors, symptoms and responses to treatment and caring for patients. Because of their continuous presence, nurses have relatively frequent opportunities to recognize patterns of behavior, symptoms, deficits, thoughts and beliefs and to intervene immediately. Thus, it appears certain that efficient nursing promotes the efficacy of inpatient CBT. In contrast, ineffective nursing impedes therapeutic progress. Therefore, it is necessary to clarify the role of nursing staff as cotherapists for inpatient CBT for OCD in multidisciplinary teams.

The present article aims to describe the nursing guidelines, which were developed at Chiba University Hospital in Japan for inpatients with OCD receiving CBT-oriented treatment. In order to provide essential supporting information to promote understanding of the context of the guidelines, the paper is organized as follows. The first section describes the current status of availability of CBT in Japan. In the following section, an overview of the unit and our inpatient treatment will be explained. The final section before the discussion and the main part, reports on our nursing guidelines.

Status of Availability of CBT in Japan

To date, awareness of the effectiveness of CBT has spread, not only among professionals and academics, but also in the general public via the media (e.g., books, newspaper, TV); however, access to CBT is extremely limited in Japan. CBT was introduced into the field of psychiatry in Japan in the late 1980s and was chosen above other forms of psychotherapy as the treatment method that medical facilities would most like to provide [16]. In addition, Nakatani and colleagues demonstrated that CBT, including ERP for Japanese outpatients with OCD, is highly effective in randomized controlled trial [6]. However, many important issues need to be worked on in Japan, a country in which CBT is being developed. First, CBT for OCD is not yet covered by national health insurance and patients bear the full cost of receiving CBT. Second, although CBT for mood disorders was included in national health insurance in April 2010, it must be provided by medical doctors. Finally, there are few competent therapists providing CBT, mainly because there are few opportunities or facilities for CBT training. Against the background listed above, a survey released in 2006 revealed that only 28% of medical facilities reported being capable of conducting any form of psychotherapy in a satisfactory manner [16]. Thus, many patients suffering from OCD who would benefit from such an approach are unable to access services and

intensive/inpatient treatment providing CBT, which are much less common in Japan.

Inpatient Unit and OCD Treatment

Inpatient Psychiatric Unit

Chiba University Hospital, founded in 1874, is located in Chiba prefecture, which is adjacent to Tokyo and has a population of approximately 6 million, the 6th largest among the 47 prefectures in Japan. CBT was incorporated into our clinical practice in 2000 and its training program, transported from the UK, was set up in 2010. Named Chiba Improving Access to Psychological Therapies (Chiba-IAPT), this is the first post-qualification CBT course in Japan [17]. Similar to the requirements for high-intensity IAPT accreditation in the UK, our trainees were required to complete 200 hours of clinical practice, receive 70 hours of supervision and complete written reports for a minimum of 8 cases. The major differences between IAPT and our course pertain to the frequency with which trainees attend the course at university and the way the courses are funded. Because the trainees do not receive government funding, they are only able to attend the course once weekly for 2 years, which is funded by their employers.

Approximately 20 individuals with OCD, about 10% of all inpatients (schizophrenia 30%, mood disorder 25%, others 35%), are treated annually at the inpatient psychiatric unit. Because the unit provides unique treatment for OCD in the area (i.e., including CBT), patients are referred not only from Chiba prefecture but also from other areas. The main reasons for referral are severe and longstanding disability, day-night reversal patterns, physical complications, failure to respond to previous treatment and a lack of local CBT services. The unit has a 10-bed open ward and a 35-bed locked ward. Inpatients with OCD generally stay in 4-bed rooms in open wards, in which beds are separated by a curtain and a closet, and share a lounge, large public bath, washing machine and recreational room. Some individuals are able to stay in a private room and use a private bath because of their condition and other individuals, who require more intensive care or observation because of their severe self-care deficit or high suicide risk, stay in locked ward. Additionally, patients are encouraged to attend weekly occupational therapy sessions, which allow them to discuss their progress or problems and a recreation program to take in fresh air, exercise and interact with other inpatients. Each patient with OCD on the unit works with a multidisciplinary team comprised of a psychiatrist, registered nurse, psychologist and social worker.

Inpatient Treatment on the Unit

The mainstay of inpatient treatment on the OCD unit is individualized CBT, which may be combined with medication. The main CBT techniques are ERP and other cognitive/behavioral techniques (e.g., modeling, shaping and cognitive restructuring), similar to the techniques described by Marks IM in 1986 [18]. Inpatient CBT is mainly conducted by an attending psychiatrist as the main therapist and the format is a few hours of assessment, treatment planning and psychoeducation, followed by weekly or semiweekly treatment sessions lasting approximately 30 to 60 minutes, undertaken over 3–6 months. In order to support and assist the main therapist in reviewing and planning sessions, ongoing supervision is conducted through weekly group supervision with senior staff and other therapists and monthly group supervision with a supervisor from Chiba-IAPT. As a basic principle of the treatment, patients are taught

from the start that CBT treatment cannot be imposed upon them, that they must become their own therapists and that success depends on how hard they work in treatment. Patients keep a schedule of self-treatment tasks and are strongly encouraged to make their own suggestions for these tasks.

Upon admission to the unit, assessment, goal setting and psychoeducation are performed. Diagnostic impressions are formed on the basis of behaviors observed and initial data gathered from a significant/relevant person and the members of the multidisciplinary team. Information gathered during the assessment is then used to formulate a treatment plan in collaboration with the patient, outlining the specific exposure tasks that will be pursued in the next phase. At the same instant, each patient negotiates the goals of treatment with the therapist and progresses towards each goal, with achievement status regularly monitored throughout the admission. Before starting active treatment (ERP), the therapist educates the patient and their relatives about the conceptual model of OCD and the rationale of ERP, so that they are motivated to tolerate the distress that typically accompanies ERP-related practice.

Following the preparation phase, ERP-oriented active treatment in vivo (i.e., in the unit) is conducted. Although ERP is not suitable for a few cases, ERP-oriented treatment is described here mainly because it is the most commonly used technique in the unit. At first, an individual's fear hierarchy is established, whereby the patient and therapist work together, using the Subjective Levels of Distress Scale to rate the patient's level of distress associated with compulsions. Once a hierarchy is developed, patients are exposed in a step-wise fashion to pre-identified anxiety-provoking stimuli. Once exposure to lower-level stimuli is encountered and anxiety naturally decreases without ritual engagement or avoidance, patients are progressively exposed to more difficult stimuli. ERP progressively extends to self-ERP and concurrently reduces the extent of anxiety-reducing rituals such as hand washing. Therapist-accompanied ERP is considered to be minimal, but it is offered much more frequently than what is provided on an outpatient basis. Although patients generally try to undertake their ERP tasks in the unit during the early stages of the treatment, they are encouraged to go home at weekends if possible. In addition, family members are frequently taught to aid response prevention by withholding reassurance and refusing to participate in rituals in addition to increasing positive attention and encouragement for adaptive behavior. Additionally, behavioral experiments aimed at correcting the patient's overestimation of risk (e.g., have patient refrain from washing for a day and evaluate whether he or she was infected with a deadly virus) are sometimes incorporated into the treatment to aid in increasing the patient's sense of predictability. Furthermore, once erroneous beliefs and cognitive distortions (e.g., perfectionistic ideals, exaggerated estimates of risk, inflated sense of responsibility for intrusive thoughts) are identified, several cognitive techniques (e.g., constructive self-talk and cognitive restructuring) are taught in order to challenge these distorted thoughts and beliefs.

In the final discharge planning phase, an attempt is made to gain stability away from the hospital setting. Patients are encouraged to go home several times for increasing durations, usually over weekends, to practice the self-treatment skills acquired on the ward in their natural environment; this places the patient in stressful situations so as to force them to use more adaptive means of solving the problems they face in the outside world. Prior to discharge, patient and therapist also review overall treatment and plan some strategies for relapse prevention. Following discharge from the unit, patients are usually

followed up on an outpatient basis. In rare cases, a home-visit nurse temporarily supports the patient immediately after discharge.

Nursing Guidelines for OCD Patients

Data defined as specific to nursing for OCD patients receiving inpatient CBT were collected from nursing records and organized at each phase of treatment. The investigators (NY, YH, YY, KM, MD, MZ, KA and MY) formed a common understanding of the characteristics of this nursing by extracting, grouping and discussing each piece of data, using a bottom-up process. Discussions were repeated until all investigators had the same understanding of nursing for OCD patients receiving inpatient CBT, in order to achieve a highly reliable classification of the data. Managing physical health and medication (e.g., side effects), as basic requirements of nursing for inpatient care, are usually performed in clinical practice; however these were excluded from the data. Nursing guidelines, mainly for nurses providing patient care, were finally developed as follows:

Adaptation and Assessment Phase

Nursing Goal: Patient will be able to adapt to a hospital environment, identify a specific problem and have realistic expectations of treatment.

Nursing Care:

- Control excessive environmental stimuli for the patient.
- Coordinate the patient's daily and weekly schedule within his/her ability.
- Give accurate information to the patient and his/her family about OCD to reduce stigma.
- Express compassion for the patient's and the family's prior efforts to live with OCD.
- Help the patient to recognize things that provoke obsessive thoughts and ritualistic behaviors and the relationship between them.
- Assess and monitor the patient's level of anxiety and disability, particularly issues that the patient cannot express verbally (e.g., facial expressions, leisure activities and interaction with others).
- Discuss the patient's thoughts or feelings prior to the onset of anxiety and encourage the patient to explore possible reasons for occurrence.
- Help the patient to identify things they can control and those that are not within his/her control.
- Help the patient to identify things that can be changed and those that cannot.
- Help the patient to recognize constructive activity with which they feel comfortable and reinforce them.
- Introduce problem-solving behaviors when necessary to reduce aversive contingencies that maintain OCD.
- Help the patient to set realistic goals.
- Encourage the patient's independence and give positive reinforcement for independent, non-ritualistic behavior and use of positive coping skills.
- Allow plenty of time for rituals and do not be judgmental or verbalize disapproval of the behaviors. However, do not offer attention

during rituals and pay more attention in response to healthy behaviors.

- Allow the patient to take as much responsibility as possible for own self-care practices.
- Urge the patient to perform normal activity and self-care within his/her level of ability, but intervene when the patient is unable to do so.
- Give recognition and positive reinforcement for the patient's voluntary interactions with others.
- Promote daytime activities and discourage nighttime activities.
- If there is a risk of injury, remove sharp items from the patient's reach and prevent physical aggression and acting out behaviors by learning to recognize signs of agitation.

Intensive Treatment Phase

Nursing Goal: The patient will be able to explore more effective ways to cope with problems, increase pleasurable activities and facilitate self-care in daily life.

Nursing Care:

- Support the patient to challenge ERP assignments in vivo.
- Give the patient credit for undertaking ERP assignments in vivo.
- Educate the patient's family members about the rationale of ERP, how to aid response prevention by withholding reassurance and refusing to participate in rituals and increasing positive attention and encouragement for the patient's adaptive behaviors as needed.
- Review ERP assignments and other strategies with patient to identify which strategies worked and which did not work in vivo through homework or journals.
- Review things with the patient that can and cannot be controlled through treatment.
- Review things with the patient that can and cannot be changed.
- Help the patient to increase constructive activity with which they feel comfortable, even in vivo.
- Facilitate the patient's independence, self-care, non-ritualistic behaviors, use of positive coping skills and healthy defense mechanisms in vivo.
- Promote the patient's voluntary interactions with others in vivo.
- Review the progress of treatment goals.
- Promote daytime activities and discourage nighttime activities.
- If there is a risk of injury (life threatening behavior), remove sharp items from the patient's reach and prevent physical aggression and acting out behaviors by learning to recognize signs of agitation.

Discharge Planning Phase

Nursing Goal: Patient will be able to clarify remaining problems following discharge and establish an effective way to handle them by using supportive resources.

Nursing Care:

- Encourage the patient to challenge and review self-ERP assignments at home.
- Encourage the patient to summarize effective ways of interrupting thoughts and patterns of behavior that escalate anxiety (e.g., explain them to others).
- Encourage the patient to clarify remaining problems following discharge.
- Discuss the family's request to live with the patient with both parties as needed.
- Discuss and establish supportive resources following discharge with the patient and his/her family (e.g. home-visit nursing, outpatient care, peer-support group).
- Review the progress of treatment goals and encourage the patient to set new goals following discharge.

Discussion

This paper described our development of nursing guidelines at Chiba University Hospital, highlighting how psychiatric nurses act as cotherapists in inpatient CBT for patients with OCD as part of a multidisciplinary team. Our nursing guidelines seem to be available in clinical settings for the following reasons. Firstly, although CBT for OCD is not a commonly-used treatment in Japanese clinical settings, the inpatient treatment underlying the development of the guidelines mainly uses graduated and self-imposed ERP and is similar to inpatient treatment procedures reported in previous articles from other countries in which CBT is well established [19,20]. Second, our guidelines focus on a specific nursing intervention for OCD patients receiving inpatient CBT, but our intervention requires no special techniques in psychiatric nurses because most of them are similar to standard nursing care plans for OCD based on NANDA International (formerly the North American Nursing Diagnosis Association) processes, which generally focus on anxiety, fear, disturbed thought processes and ineffective coping [21]. However, our intervention is unique in that it additionally focuses on the problems of powerlessness, social isolation and self-care deficit because most inpatients with OCD in our unit had relatively severe and chronic illness. Finally, our nursing guidelines are unique in that the nursing intervention is separated in line with the progress of inpatient CBT, which may make it easier for nurses to understand the priority of goals and interventions at each phase of inpatient CBT; it is also a useful tool for educating novice nurses and other staff. For example, our unit holds annual workshops to allow nurses to pursue knowledge and learning about a particular feature of OCD (pathophysiology) and its treatment (medication and CBT). However, how nurses should intervene as co-therapists for OCD patients receiving CBT is unclear because our treatment is mainly provided by psychiatrists. Therefore, our unit held additional workshops based on this developed guideline this year. According to a post-hoc survey, most nurses were able to understand detailed OCD interventions in line with the progression of CBT and they reported that they could clarify which information should be shared with main therapist or other staff.

Though the present paper provided valuable information, the methodology and clinical background (i.e., immature development and dissemination of CBT in Japan) imposed the following limitations. First, our guidelines were developed based on data from a single center, which resulted in limited generalizability of the conclusions. However, it is difficult to obtain multicenter data in Japan because of

insufficient dissemination of inpatient CBT. Second, more rigorous scientific means of data collection and analysis in qualitative studies (e.g., using semi-structured interviews and the grounded theory approach) should be used to create more reproducible results. Third, our nursing interventions overlap partially with other psychosocial interventions provided by other specialists (e.g., social workers, psychiatrists as a main-therapists), it is therefore necessary to clarify the role of each specialist and to promote efficient collaboration in multidisciplinary teams. Fourth, because this paper did not examine the outcome of the guidelines, the availability of the guidelines could not be determined. Effects of the guidelines on education, nursing methods, collaboration within multidisciplinary teams and overall treatment outcomes should be examined in future studies. Finally, inpatient CBT has recently been provided by trained psychiatric nurses as main therapists in countries in which CBT is well established such as the UK and USA [11,22,23], which resulted in limited availability of our nursing guidelines for cotherapists. Over the last two decades, awareness of an important new role for nursing, in which nurses are in an ideal position to become the agents for the delivery of CBT, has spread [24,25] and further development of CBT training programs for nurses is required in countries in which CBT is being developed, as well those in which CBT is well established.

In addition, considerable means of managing severe OCD that cannot be managed on an outpatient basis are discussed. There have been various worthwhile attempts at managing severe OCD, based on the principle that CBT promotes self-management skills, such as inpatient treatment without the presence of night nurses (i.e., a free-standing hostel with a staff member on night call with a bleep) [22], partial hospitalization [26] and intensive home-based treatment [27,28]. It seems that treating patients with severe OCD in their natural environment (e.g., home-based treatment) has the following advantages over inpatient treatment: a more community-based setting, lack of stigmatization for patient, no interference from disturbed patients with other mental disorders and freedom from bureaucracy regarding hospital-based treatment. However, it is important to consider whether each form of treatment is cost effective for both patient and institution, reduce readmission and decrease subsequent utilization of health care services. For example, the Springfield Hospital tries to use home-based treatments where possible, but some patients are too severely ill to cope with therapy in the community and inpatient treatment seems more cost effective for these patients [11]. In another example, a previous report has mentioned a preference for treating patients with OCD in their natural environments as opposed to hospital, but intensive home-based treatment was used with many hours of individual therapy every week [27]. Further development of new services and evaluating existing services such as those described above in an attempt to address the needs of those who fail to respond to outpatient or traditional treatment is needed. It is also important to clarify characteristics of individuals or groups with severe OCD who benefit from services that aim to improve referral networks providing the appropriate level of treatment depending on the patient's difficulties and characteristics.

Finally, as noted in the previous section, two issues that should be addressed in order to make CBT widely available to Japanese people suffering from OCD were proposed. One is that CBT is not covered by national health insurance for the treatment of OCD. In order to obtain the required funding and organizational or national support, further research and evaluation of more research-based data are needed. The other issue hindering the dissemination of CBT in Japan is the paucity of training opportunities. Opportunities are limited for both pre- and

post-qualification training because of the scarcity of CBT experts. However, Japan is not the only place where such discussion exists because intensive training for nurses is scarce, even in countries in which CBT is well established [25]. Pre- and post-qualification training courses should be established in each area so that more health professionals can receive adequate CBT training and more patients will be able to access such services in their local areas. In addition to the need to increase training opportunities, research on efficient ways to disseminate treatment procedures, which would address the empirical question of how best to train therapists, is also required.

Conclusion

This paper discussed the development of nursing guidelines for inpatient CBT for OCD at Chiba University Hospital, highlighting the role that psychiatric nurses play as co-therapists in multidisciplinary teams. Although the methodology and clinical background underlying the report impose limited availability of the guidelines, the guidelines are unique in that the nursing intervention is separated in line with the progress of inpatient CBT, which may make it easier for nurses to understand priority goals and interventions at each phase of inpatient CBT and provide a useful tool for educating novice nurses and other staff.

With regard to managing severe OCD, it is important to continue various attempts to develop new services, evaluate existing services that address the needs of those who fail to respond to outpatient or traditional treatment and clarify characteristics of patients who benefit from each service that aims to improve referral networks providing appropriate treatment depending on the patient's difficulties and characteristics.

In addition, in order to make CBT widely available to patients with OCD, covering CBT for OCD with health insurance and increasing opportunities for CBT training in each area of Japan are required.

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