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Pilot trial of cognitive and behavioral treatment for hoarding disorder delivered via webcam: Feasibility and preliminary outcomes

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ABSTRACT

Individual office-based cognitive behavioral treatment (CBT) for hoarding disorder (HD) has demonstrated clear improvement in symptoms, although the extent of gains, length of treatment and lack of trained clinicians remain problematic. The current pilot study examined the feasibility and effectiveness of a home-based CBT delivered individually via webcam (CBT-W) technology for seven adults with HD. Three clients received weekly CBT-W over an average of 35 weeks and four received more intensive treatment that averaged 23 weeks. Standard measures of hoarding severity were collected at baseline, post-treatment, and 3-month follow-up. Acceptability and feasibility of treatment were demonstrated in client interest to enter CBT-W, good attendance at scheduled therapy sessions, high completion rates of assessments and treatment, strong therapeutic alliance ratings, and reported comfort with the use of technology during the therapy sessions. Most clients showed gains immediately following CBT-W, and two were clinically significantly improved. Self-reported follow-up assessments showed generally stable outcomes. Webcam and internet technology may increase access to empirically supported treatment for hoarding and reduce clinician time and costs of CBT through in-home delivery. Research on larger samples is needed to determine overall efficacy and durability of CBT-W and to examine factors that affect outcomes.

1. Introduction

Hoarding disorder (HD) includes symptoms of difficulty discarding ordinary items, substantial clutter that impairs daily functioning, and often excessive acquiring that contributes to clutter (American Psychiatric Association, 2013; Frost & Hartl, 1996). Research indicates that hoarding is a serious psychiatric problem with profound public health consequences that include health, housing and family problems (e.g., Drury, Ajmi, Fernandez de la Cruz, Nordsletten, & Mataix-Cols, 2014; Tolin, Frost, Steketee, Fitch, 2008; Tolin, Frost, Steketee, Gray, & Fitch, 2008). The prevalence rate has been estimated to range from 2% to 5% (e.g., Iervolino et al., 2009; Samuels et al., 2008).

In recent pilot studies and controlled trials, individually delivered cognitive behavioral treatment (CBT) designed specifically for hoarding symptoms showed promising results. Twenty-six sessions scheduled approximately weekly plus monthly clinician home visits produced 30–40% reductions in hoarding symptoms (Steketee, Frost, Tolin, Rasmussen, & Brown, 2010). However, motivation problems interfered with regular attendance and homework completion, and the lengthy treatment period averaging 49 weeks raised concerns about overall therapy cost versus benefit. A recent meta-analysis of individual and group treatments confirmed the benefit of CBT for HD with a large effect size (Tolin, Frost, Steketee, & Muroff, 2015), although only 24–43% of clients showed clinically significant change. Better clinical outcomes were associated with more CBT sessions and home visits. The authors concluded that CBT was promising, but there remained significant room for improvement. This may be especially true for reducing clutter which showed somewhat lower effect sizes in group treatments that used fewer home visits compared to groups with more home visits (Muroff, Steketee, Bratiotis, & Ross, 2012). These findings, combined with the lack of trained providers suggests that both treatment methods and access can be improved.

A technology-based distance treatment model may be especially useful in addressing treatment concerns about dissemination, adherence, and duration, with the added benefit of in-home treatment delivery for this fundamentally home-based problem. Findings from the few studies that have applied internet/technology treatments to hoarding and related obsessive-compulsive disorder (OCD) symptoms are promising. A self-help CBT-based internet group for hoarding yielded modest benefits, especially for those engaged for longer periods (Muroff, Steketee, Himle, & Frost, 2010). A pilot study of CBT delivered via videoconferencing showed good outcomes for OCD patients and

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included one person with clinical hoarding whose symptoms improved (Himle et al., 2006). Likewise, videoconferencing and internet treatments have proved effective for disorders that are often co-morbid with HD, such as social anxiety and depression (for reviews see Andersson, Carlbring, Ljótsson, & Hedman, 2013; Hedman, Botella, & Berger, 2016). Additionally, video-delivered CBT for anxiety disorders appears to be as effective as face-to-face CBT (Bouchard et al., 2004; Griffiths, Blignault, & Yellowlees, 2006; Stubbings, Rees, Roberts, & Kane, 2013) with very good therapeutic alliance (Bouchard et al., 2004; Manchanda & McLaren, 1998).

Evidence suggests that home-based CBT is effective for treating treatment refractory OCD clients (e.g., Rosqvist et al., 2001, 2002), but this has not been tested yet with hoarding clients where it seems especially relevant. Conducting hoarding treatment in the home might eliminate the need for office practice sessions, maximize the transfer of treatment skills to the natural setting, and reduce barriers due to physical disabilities evident in some hoarding clients. At the same time, home visits that are not feasible for many clinicians can be replaced with inexpensive technology to deliver home-based CBT to clients who need only basic computer and internet skills. Thus, home-based CBT delivered via webcam (CBT-W) seems an especially appropriate strategy for treating hoarding. The present pilot study of 7 clients examined the feasibility, acceptability, and effectiveness of using a webcam and computer delivery method via the internet (CBT-W) to treat adults with HD.

2. Methods

2.1. Participants

Pilot study participants were recruited from two sources: clients with limited improvement after group CBT for HD and treatment seekers from a hoarding research project. Inclusion criteria were age 18 or older; primary diagnosis of hoarding disorder based on Hoarding Rating Scale (see below) with at least moderate severity (4 or higher) on acquiring, difficulty discarding, and clutter; and no psychotropic medications or medication stability for at least 2 months and expected to remain so for 6 months. Participants were also required to have access to a working computer and high-speed internet in their home. Clients were excluded if their hoarding symptoms were due to OCD (e.g., contamination fears, checking rituals) and/or if a higher level of care was deemed necessary due to current psychosis, bipolar symptoms, serious cognitive impairment, or substance use disorders within the past 6 months. Of seven participating clients, clients 1–3 had received prior CBT (treatment refractory) and clients 4–7 reported no history of prior treatment for HD. Table 1 displays clients' demographic characteristics and comorbid mental health conditions. The sample included 5 women and 2 men who ranged in age from 53 to 69. All were at least college educated; six were White and one was Asian.

2.2. Measures

The Anxiety Disorders Interview Schedule (ADIS-IV; DiNardo, Brown, Barlow, 1994) was used at baseline to determine co-morbid diagnoses (e.g., anxiety, mood, somatoform, substance use disorders) and screen for other conditions (e.g., psychosis).

The Hoarding Rating Scale-Interview (HRS-I; Tolin, Frost, & Steketee, 2010) is a 5-item semi-structured interview that assesses difficulty discarding, clutter, acquisition, distress, and impairment on scales from 0 (no problem) to 8 (severe problem). This measure has demonstrated excellent reliability (test-retest, inter-rater, home versus office, internal consistency) and validity (concurrent, discriminant). HRS symptom ratings were used in conjunction with the ADIS-IV-L to determine the diagnosis of HD.

The Saving Inventory-Revised (SI-R; Frost, Steketee, & Grisham, 2004) contains 23 items that measure acquisition, difficulty discarding, and excessive clutter; items are scored from 0 (no problem) to 4 (very severe, extreme). The SI-R showed good internal consistency, test–retest reliability, known groups validity, and concurrent and divergent validity in clinical and nonclinical samples.

The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) was given to clients to assess the therapeutic alliance on 36 items rated from 1 ("never") to 7 ("always"), for a maximum score of 252. This measure showed adequate reliability and concurrent validity in relation to other relationship indicators (Tracey & Kokotovic, 1989).

Reliability of measures for the current sample is not reported due to the small sample size.

2.3. Procedures

The study was approved by the Institutional Review Board. Individuals who expressed interest were screened by phone to determine initial eligibility. After signing an informed consent form, all participants were assessed for psychiatric diagnoses using the ADIS which was administered by a trained clinician. A supplement was added to permit diagnosis of hoarding disorder as a standardized instrument had not yet been developed. Clients completed the self-report SI-R at baseline, post-treatment and 3-month follow-up. The clinician completed the HRS-I at baseline and immediately after treatment. Working alliance was assessed after 4 weeks and at the end of treatment.

Prior to the start of treatment, clinicians visited the home to finalize eligibility, complete the consent process, and complete the HRS-I assessment. Clinicians requested permission to walk through the home and invited clients to share their thoughts and feelings about their space and possessions, focus areas for treatment, and how it felt to have the clinician in their home. The first author accompanied the clinician to the initial home visit to assist with the set-up and testing of the webcamera and videoconferencing software and provide a trouble-shooting guide for use during treatment. The clinician visited the home again at the end of treatment to complete a final assessment and collect the wide

Table 1
Biographical information for treatment refractory clients 1–3 treated weekly and untreated clients 4–7 treated intensively.

Participant	Sex	Age	Race/ ethnicity*	Marital status	Education	Comorbid mental health conditions	Weeks of treatment
26 Weekly Sessions							
Client 1	M	56	White	Widowed	College	GAD, OCD	30
Client 2	F	54	Asian	Married	Master's	MDD, SocPh	38
Client 3	F	60	White	Single	Master's	MDD, SocPh PTSD, ADD	36
26 Intensive Sessions							
Client 4	F	54	White	Single	Master's	MDD	23
Client 5	M	69	White	Married	College	NA*	22
Client 6	F	53	White	Living with partner	College	OCD, GAD	23
Client 7	F	66	White	Married	Master's	SpecificPh	23

GAD = Generalized Anxiety Disorder; OCD = Obsessive-Compulsive Disorder; MDD = Major Depressive Disorder; SocPh = Social Phobia, PTSD = Post-Traumatic Stress Disorder; ADD = Attention Deficit Disorder; SpecificPh = Specific Phobia; NA = Not available (*due to corrupted data file).

* All White participants were non-Hispanic.

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