Prediction of Relapse After Cognitive-Behavioral Treatment of Gambling Disorder in Individuals With Chronic Schizophrenia: A Survival Analysis

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Gambling disorder (GD) in individuals with chronic schizophrenia is relevant because there are higher rates of GD in schizophrenic populations (10%) than in the nonschizophrenic population (1%–5%). In addition, these patients have more severe alcohol use disorder (i.e., meeting at least 6 of the DSM-5 11 criteria for diagnosis of this disorder), higher depression scores, a poor adherence to treatment, and more frequent use of outpatient mental health care. One of the main problems in GD is therapeutic failure (defined as three or more lapse episodes during treatment) or relapse (three or more lapse episodes in the follow-up period). Predicting a relapse of GD in individuals with chronic schizophrenia can be useful in targeting the patients for aftercare services. The main aim of this study was to estimate the time to a GD relapse (survival rate) and to evaluate some of the qualitative and quantitative variables related to a GD relapse by a survival analysis. The sample consisted of 35 patients with chronic schizophrenia and GD who were treated with pharmacological and cognitive-behavioral therapy. The therapeutic failure rate in the treatment period was 43%, and it was associated with the number of episodes of schizophrenia, the age of gambling onset, and the age of the patients. The relapse rate in the follow-up period was 32%, and it was associated with the patients’ age, educational level, and weekly allowance. The implications of this study for future research are discussed.

Keywords: gambling disorder; chronic schizophrenia; therapeutic failure; relapse; predictive variables

According to the data of the only cross-sectional study in an outpatient setting of individuals with schizophrenia/schizoaffective disorder and problem/disordered gambling, there are higher rates of gambling disorder (GD) in schizophrenic populations (10%) than in the nonschizophrenic population (1%–5%) (Desai & Potenza, 2009). Actually, in an Australian national survey of people with psychotic disorders, 6.4% of the people were moderate risk gamblers, and 5.8% of them were problem gamblers (Haydock, Cowlishaw, Harvey, & Castle, 2015). These patients have more severe alcohol use disorder (i.e., meeting at least 6 of 11 of the DSM-5 criteria for diagnosis of this disorder), higher depression scores, a poor adherence to GD treatment, and more frequent use of outpatient mental health care. Co-occurring GD contributes substantially to the financial costs and emotional burden of schizophrenia for patients, their families, and the mental health system (Chen, Barnett, Sempel & Timko, 2006; Green, Drake, Brunette, & Noordsy, 2007).

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There may be a bidirectional relationship between schizophrenia and GD. Individuals with schizophrenia who have positive symptoms (e.g., delusions, hallucinations, or disorganized thinking) may present an optimistic bias in the perception of risk (Ligneul, Sescousse, Barbalat, Domenech & Dreher, 2012; Yakovenko, Clark, Hodgins & Goghary, 2016). The intensity of symptomatology can affect the risk of a gambling relapse. In turn, the negative consequences of GD in these people, such as falling into debt or feeling pressure from creditors, may trigger acute psychotic episodes (Borras & Huguelet, 2007). In other cases, gambling to fill a need for activity and gambling to connect with society/world are the reasons for engaging in disordered gambling (Yakovenko et al., 2016).

The presence of GD and psychotic symptoms poses special diagnostic and treatment challenges. Mental health services, hospitals, and primary care settings are concerned with these challenges. With dual disorders, the personal, family, and social problems of these patients increase and contribute to relapses in GD (Kassani, Niazi, Hassanzadeh, & Menati, 2015; Yakovenko et al., 2016). This increases the number of hospitalizations and the cost of treatment, so there is a need for a comprehensive assessment and an integrated intervention that addresses the multiple problems associated with these co-occurring disorders (Abbou-Saleh, 2004; Potenza & Chambers, 2001; Ziedonis, Steinberg, Smelson, & Wyatt, 2009).

Among the different therapeutic approaches aiming to deal with this dual disorder, cognitive-behavioral therapy (CBT) seems to be particularly promising for the treatment of GD in individuals with schizophrenia. The utility of this approach has been tested both in case reports (Borras & Huguelet, 2007; Potenza & Chambers, 2001) and in the only controlled clinical trial until now (Echeburúa, Gómez & Freixa, 2011).

Research that evaluates program efficacy tends to emphasize the factors that predict successful treatment outcomes. Typically, clinical research in the area of GD does not include the factors associated with poor treatment outcomes. Perhaps this is because dropouts and noncompliant subjects are eliminated from the pool of treatment participants. Actually, there are no studies dealing with the prediction of therapeutic failures or relapses in individuals with schizophrenia/schizoaffective disorder and GD. There are only three specific studies that have examined the predictors of relapses in patients with GD only; however, even in these studies, the results (i.e., alcohol abuse in Echeburúa, Fernández-Montalvo & Báez, 2001; impulsivity, maladjustment in everyday life, and early age of gambling onset in González-Ortega, Echeburúa, Corral, Polo-López & Alberich, 2013; and impulsivity in Ramos-Grille, Gomà-i-Freixanet, Aragay, Valero, & Vallés, 2015) have not been conclusive because of their small sample size and because they do not take into account comorbid disorders. Therefore, the relative importance of the different predictive variables has not been definitively determined. According to this prior research, the variables tested to determine the significant variables that were included in the final model were both qualitative (gender, marital status, education, professional status, and adherence to treatment) and quantitative (age, monthly income, financial family support, alcohol/substance use, gambling episodes per week, time spent per gambling episode, amount of money spent per week, age of gambling onset, gambling severity, age of onset of the first episode of schizophrenia, number of admissions to a hospital and number of acute psychotic episodes).

Based on the literature review, our hypotheses were that an early age of onset of both the first episode of schizophrenia and the gambling behavior, a large number of admissions to a hospital, a great amount of money spent per week, a low educational level, and a poor adherence to treatment would predict a higher rate of therapeutic failure and relapse.

The survival function is the probability of survival as a function of time. A therapeutic failure during treatment is defined as patients having three or more episodes of gambling and investing more money than the weekly sum of money assigned for personal expenses in the observation period. A relapse is considered when patients have three or more lapse episodes in the follow-up period (Echeburúa et al., 2001; Echeburúa, Gómez & Freixa, 2011; Echeburúa, González-Ortega, Corral & Polo-Lopez, 2011).

Therefore, the main aim of this paper is to predict the risk of therapeutic failure or a relapse of GD in these patients with a survival analysis. To do this, we will determine the time intervals with an increased risk of therapeutic failure or a relapse and evaluate with a Cox regression model the association of all the significant variables with the failure or relapse in GD. The study is designed to identify factors associated with the treatment failures and relapses within 1 year following CBT.

Method

Participants

The sample for this study consisted of patients who were diagnosed with chronic schizophrenia and were receiving pharmacological treatment for this disorder at several mental health centers in Barcelona (Spain). The inclusion criteria for the study were as follows: (a) being in treatment for chronic schizophrenia; (b) meeting an additional diagnosis of GD according
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