Behaviour Research and Therapy 48 (2010) 941–948

Contents lists available at ScienceDirect

Behaviour Research and Therapy

journal homepage: www.elsevier.com/locate/brat

Challenges using motivational interviewing as an adjunct to exposure therapy for obsessive-compulsive disorder

Helen Blair Simpson [a,b,*], Allan M. Zuckoff [c,d], Michael J. Maher [a], Jessica R. Page [a], Martin E. Franklin [e], Edna B. Foa [e], Andrew B. Schmidt [a], Yuanjia Wang [f]

[a] New York State Psychiatric Institute, New York, NY, USA
[b] Department of Psychiatry, Columbia University, New York, NY, USA
[c] Department of Psychology, University of Pittsburgh, Pittsburgh, PA, USA
[d] Department of Psychiatry, University of Pittsburgh, Pittsburgh, PA, USA
[e] Department of Psychiatry, University of Pennsylvania School of Medicine, Philadelphia, PA, USA
[f] Department of Biostatistics, Mailman School of Public Health, Columbia University, New York, NY, USA

A R T I C L E I N F O

Article history:
Received 12 March 2010
Received in revised form
20 May 2010
Accepted 21 May 2010

Keywords:
Obsessive-compulsive disorder
Motivational interviewing
Exposure and response prevention
Adherence
OCD

A B S T R A C T

Exposure and response prevention (EX/RP) is an efficacious treatment for obsessive-compulsive disorder (OCD). However, patients often do not adhere fully to EX/RP procedures. Motivational interviewing (MI) has been shown to improve treatment adherence in other disorders. This pilot study used a randomized controlled design to examine whether MI can be successfully added to EX/RP and whether this intervention (EX/RP + MI) could improve patient adherence to between-session EX/RP procedures relative to EX/RP alone. Thirty adults with OCD were randomized to 18 sessions of EX/RP or EX/RP + MI. Therapists rated patient adherence at each exposure session. Independent evaluators assessed change in OCD and depressive symptoms, and patients completed self-report measures of readiness for change and quality of life. The two treatment conditions differed in degree of congruence with MI but not in conduct of EX/RP procedures. Both groups experienced clinically significant improvement in OCD symptoms, without significant group differences in patient adherence. There are several possible reasons why EX/RP + MI had no effect on patient adherence compared to standard EX/RP, each of which has important implications for the design of future MI studies in OCD. We recommend that MI be further evaluated in OCD by exploring alternative modes of delivery and by focusing on patients less ready for change than the current sample.

© 2010 Elsevier Ltd. All rights reserved.

Introduction

Cognitive-behavioral therapy consisting of exposure and response prevention (EX/RP) is a first-line treatment for obsessive-compulsive disorder (OCD), either as monotherapy or combined with pharmacotherapy (American Psychiatric Association, 2007). EX/RP requires patients to confront feared situations (exposures) and to stop ritualizing (response prevention; Kozak & Foa, 1997). When patients adhere to these procedures, EX/RP is highly efficacious (Foa et al., 2005), yet patients often fail to adhere by dropping out of treatment or by not fully implementing the procedures as recommended (Abramowitz, Franklin, Zoellner, & DiBernardo, 2002; Foa et al., 1983; Simpson, Huppert, Petkova, Foa, & Liebowitz, 2006). Reducing dropout and improving patient adherence to EX/RP procedures could potentially improve treatment outcomes substantially.

One conceptualization of why OCD patients enter but then dropout or adhere poorly to EX/RP procedures is that they are "ambivalent" or caught between mutually exclusive courses of action. Specifically, although patients may wish to improve their lives by reducing the time spent obsessing and ritualizing (leading them to seek EX/RP treatment), they may also be unwilling or unable to adhere to the EX/RP procedures designed to achieve that goal (e.g., because they find exposures too aversive or perceive some benefit to their rituals). Motivational interviewing (MI) is a client-centered, goal-oriented method designed to enhance motivation to change by helping patients explore and resolve such ambivalence (Miller, 2006; Miller & Rollnick, 2002). In MI, the therapist *expresses empathy* by evoking and reflecting patients' perceptions of their situation and the advantages and disadvantages of change. Therapists enhance motivation by eliciting and strengthening patients' articulation of their desire, ability, reasons,

* Correspondence to: Helen Blair Simpson, MD, PhD, Associate Professor of Clinical Psychiatry, Columbia University, 1051 Riverside Drive, Unit 69, New York, NY 10032, USA. Tel.: +1 212 543 6532; fax: +1 212 543 6515.
E-mail addresses: simpson@nyspi.cpmc.columbia.edu, hbs1@columbia.edu (H.B. Simpson).

0005-7967/$ – see front matter © 2010 Elsevier Ltd. All rights reserved.
doi:10.1016/j.brat.2010.05.026

need, and ultimately commitment to change and treatment ("change talk"). To accomplish this, therapists *develop discrepancy* between patients' current behavior and important values and goals and *support self-efficacy* by exploring and affirming efforts and abilities to overcome obstacles. Emphasizing collaboration, supporting patient autonomy, and avoiding confrontation and directives, therapists *roll with resistance* when it arises. The goal is to help patients talk themselves into change.

Used as a prelude or integrated with other treatments, MI has reduced dropout and enhanced treatment adherence in substance use, health behavior, and mental health contexts (Hettema, Steele, & Miller, 2005; Zweben & Zuckoff, 2002). For example, Westra, Arkowitz, and Dozois (2009) provided MI as a prelude to group CBT in patients with generalized anxiety disorder and found that these patients had better homework adherence and treatment outcome than those receiving CBT alone. Lewis-Fernandez and colleagues (in review) integrated MI into medication management for depressed Hispanics and found significantly improved retention and outcome compared to historical controls.

We wondered whether MI could improve EX/RP adherence. Thus, we created an EX/RP + MI intervention that included explicit MI strategies in the introductory sessions to enhance motivation for treatment and an MI module for use during exposure sessions if resistance to treatment emerged. Delivering this intervention to six patients in an open trial (Simpson, Zuckoff, Page, Franklin, & Foa, 2008), we found it yielded comparable outcomes to standard EX/RP. However, this study did not address whether EX/RP + MI differs in its dose of MI or improves patient adherence relative to EX/RP alone. These are key questions since there can be overlap between MI and CBT approaches (Wilson & Schlam, 2004). At the same time, adding MI to a structured, expert-driven treatment like EX/RP might dilute the integrity of MI.

Consistent with recommended stages of psychosocial treatment development (Carroll & Onken, 2005), we conducted a small randomized controlled trial to directly compare EX/RP and EX/RP + MI in adults with OCD. Our aims were to evaluate whether EX/RP + MI was more congruent with MI than standard EX/RP and to determine whether EX/RP + MI led to better patient adherence. To assess MI fidelity, we used the Motivational Interviewing Treatment Integrity scale, a measure widely used in MI clinical trials. To assess patient adherence to EX/RP procedures, we used the Patient EX/RP Adherence Scale (Simpson et al., 2010). We hypothesized: 1) EX/RP + MI would be more congruent with MI than standard EX/RP during treatment segments designed to emphasize MI elements; and 2) EX/RP + MI would lead to better patient adherence to between-session EX/RP procedures. We also explored the effects of the two treatments on OCD outcome, knowing *a priori* that the small sample had adequate power to detect only large effects.

Methods

Setting and recruitment

This study was conducted at the Anxiety Disorders Clinic (ADC), an outpatient research clinic at the New York Psychiatric Institute (NYSPI) and Columbia University. Patients were recruited (May 2007–January 2009) by advertisements and referral. The study was approved by the NYSPI institutional review board. Participants provided written informed consent.

Participants

Participants were between the ages of 18 and 70, met DSM-IV criteria for OCD for at least one year and had at least moderate symptoms on the Yale-Brown Obsessive Compulsive Scale (Y-BOCS $\geq$ 16). Patients could participate either off or on a serotonin reuptake inhibitor (SRI), and concomitant medications like benzodiazepines and antipsychotics were allowed. However, if receiving medications, patients had to be on a stable SRI dose prior to entering for at least 12 weeks (and four weeks for concomitant medications), and the dose had to remain stable during the study. Patients were excluded for lifetime mania or psychosis, current suicidal ideation or an attempt in the past 6 months, a Hamilton Depression Rating Scale (HAM-D, 17 item) score > 17, substance abuse or dependence in the past two months, an unstable medical condition, or an adequate prior trial of EX/RP ($\geq$8 sessions within two months). Other comorbid conditions were permitted only if OCD was the most severe and impairing condition. Psychotherapy outside of this study was not permitted. Eligibility was determined by a clinical interview with a senior clinician (MD or PhD). Psychiatric diagnoses were confirmed by an independent rater using the Structured Clinical Interview for DSM-IV (First, Spitzer, Gibbon, & Williams, 1996).

Procedures

Participants were randomized in blocks of four to EX/RP or EX/RP + MI. Randomization included stratification by therapist and by presence of prominent hoarding symptoms to ensure equal distribution of the two treatment conditions across these variables.

EX/RP consisted of three introductory sessions followed by 15 twice-weekly exposure sessions; all sessions lasted 90 min. Treatment followed the procedures outlined by Kozak and Foa (1997). During the introductory sessions, therapists assessed patients' OCD, presented the treatment rationale, and developed an exposure hierarchy. During exposure sessions, therapists first reviewed patients' progress with between-session EX/RP procedures, then helped patients to confront their fears for prolonged periods of time without ritualizing (i.e., *in vivo* and imaginal exposures), and ended each session by assigning specific exposures for patients to practice (at least one hour per day) before the next session. Patients were instructed to stop rituals after the first exposure session and to record any rituals that occurred. At least two exposure sessions occurred in the home environment. Between exposure sessions, therapists spoke briefly with patients by phone (for <20 min) to review progress with between-session EX/RP practice.

EX/RP + MI followed the same format: three introductory sessions and 15 exposure sessions (including at least two in the home environment); daily homework assignments; and between-session phone calls. However, MI strategies were specifically and strategically added as described in detail elsewhere (Simpson et al., 2008). In brief, although the introductory sessions accomplished the same tasks as in standard EX/RP (assessment, psychoeducation, and treatment planning), therapists used an MI-congruent approach whenever possible and introduced specific MI strategies to assess and evoke commitment to change and to treatment. During exposure sessions, standard procedures were followed (review of between-session EX/RP practice, therapist-supervised exposures, assignment of between-session EX/RP practice). However, a short (15–30 min) MI module was available for use if resistance occurred (e.g., repeated failure to do between-session EX/RP procedures, expressed reluctance to proceed with treatment). The objective of this module was to use MI strategies to assess and enhance commitment to the time-limited and intensive EX/RP used in this protocol and to reengage the patient before proceeding with in-session exposures. Therapists were trained to recognize signs of resistance using the Miller and Rollnick (2002) adaptation of a rubric developed by Chamberlain and colleagues for use in studies of resistance. Therapists were instructed to shift into the MI module if initial efforts to reengage the patient into

دریافت فوری ← متن کامل مقاله

ISIArticles
مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات