



Differences between early and late drop-outs from treatment for obsessive–compulsive disorder

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ABSTRACT

To examine characteristics of drop-outs from treatment for obsessive–compulsive disorder (OCD), we studied 121 participants who underwent exposure or cognitive treatment, either alone or with fluvoxamine. OCD symptoms were assessed at pre-treatment, post-treatment, and at every session. No differences in attrition were found between treatment conditions. Drop-outs from treatment ($n=31$) were divided into early (before session 6) and late (session 6 or after) drop-outs. We found that early drop-outs had more severe OCD symptoms at termination compared to completers, whereas late drop-outs did not differ from treatment completers. Higher levels of depressive symptoms were associated with early drop-outs, and lower levels with completers. These findings suggest that individuals with high levels of pretreatment depression are at risk for early drop-out with elevated OCD symptoms. Conversely, late drop-outs may be treatment responders who drop out after experiencing substantial improvement. Implications for allocation of resources for attrition prevention are discussed.

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1. Introduction

Obsessive–compulsive disorder (OCD) is a common and debilitating psychological disorder experienced by 1.5–3% of the population (Bebbington, 1998; Stein, Forde, Anderson, & Walker, 1997). Individuals with OCD experience impairments in general functioning and poor quality of life (Koran, 2000; Norberg, Calamari, Cohen, & Riemann, 2008) as well as interpersonal problems and marital distress (Emmelkamp, de Haan, & Hoogduin, 1990; Riggs, Hiss, & Foa, 1992). Effective treatments for OCD include cognitive-behavior treatment (CBT) or pharmacotherapy (Eddy, Dutra, Bradley, & Westen, 2004; Fineberg & Gale, 2005; Kobak, Greist, Jefferson, Katzelnick, & Henk, 1998; Rosa-Alcázar, Sánchez-Meca, Gómez-Conesa, & Marín-Martínez, 2008), with both treatments being equally effective (Kobak et al., 1998; Rosa-Alcázar et al., 2008).

As is the case with other anxiety disorders, many individuals drop out prematurely from treatments for OCD. Individuals who drop out of treatment usually do so unilaterally, without agree-

ment of the clinician, by not arriving at scheduled sessions (Pekarik, 1985). Moreover, some individuals do not even begin treatment and drop out before its inception (Hofmann et al., 1998). Mean attrition rates for cognitive-behavior therapy (CBT) of OCD are 13–27% (Abramowitz, 1997; Foa et al., 2005; Kobak et al., 1998; Taylor et al., 2003), and pharmacological treatments report comparable attrition rates (19–25%; Abramowitz, 1997; Kobak et al., 1998). Thus, attrition is a common and substantial phenomenon in CBT and pharmacotherapy for OCD.

Attrition can have many adverse effects (Ogrodniczuk, Joyce, & Piper, 2005). It can lead to reduced treatment efficacy (Clarkin & Levy, 2004), and loss of therapist hours (Pekarik, 1985), both of which have a negative effect on overall cost-effectiveness (April & Nicholas, 1996). Attrition can also affect the treating clinician, leading to feelings of failure which reduce clinician self-confidence and effectiveness (Ogrodniczuk et al., 2005). Finally, it can complicate the interpretation of results from treatment studies, as treatment completers may not be representative of treatment seekers (Westen, Novotny, & Thompson-Brenner, 2004), especially if drop-outs systematically differ from completers on clinically relevant variables (Little & Rubin, 1989). Due to these pernicious effects, many strategies for reducing and minimizing attrition have been suggested (see Ogrodniczuk et al., 2005 for a review).

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Recent studies have examined differences between drop-outs and completers in treatments for anxiety disorders. For instance, Hofmann and Suvak (2006) followed individuals receiving CBT for social anxiety disorder and compared drop-outs ($n=34$) with treatment completers ($n=99$). No differences were found on demographic characteristics, clinical measures, or AXIS-I and II symptomatology. The only difference found was that drop-outs rated the treatment rationale as less logical than completers, and this difference was no longer significant after adjusting for multiple group comparisons. Similarly, Keijsers, Kampman, and Hoogduin (2001) compared drop-outs and completers in CBT for panic disorder and found differences only in education level and motivation. However, differences were very small in magnitude and the authors concluded they could not reliably differentiate completers and drop-outs.

Only a single study focused on attrition in the treatment of OCD (Hansen, Hoogduin, Schaap, & de Haan, 1992). In this study, the authors contacted 25 drop-outs, 2–7 years after treatment. Results could be obtained from 15 of the drop-outs (60%) who were matched with a group of 15 completers. The authors found that drop-outs had fewer OCD symptoms at intake, and experienced less anxiety during exposures, compared to treatment completers. However, it is difficult to interpret the results of this study due to the small sample size, high refusal rate (40%), and retrospective assessment (2–7 years after treatment). It is important to note that the majority of recent treatment studies in OCD report no differences between completers and drop-outs on pre-treatment measures (e.g., Foa et al., 2005; Taylor et al., 2003). To our knowledge, differences on OCD symptoms at the time of treatment termination between drop-outs and completers have not been investigated.

Although attrition has generally been regarded as a negative phenomenon, there is some evidence that certain drop-outs experience significant improvement before dropping out (April & Nicholas, 1996; Manthei, 1995; Pekarik, 1983b). Along these lines, Pekarik (1992) found that individuals who dropped-out late in the course of treatment improved considerably and were highly similar to completers whereas individuals who dropped-out early experienced aggravation or improved to a lesser extent. Thus, the timing of attrition may be related to different trajectories of change within treatment.

In the present study we examined whether time of dropout (i.e., early vs. late in treatment) was associated with OCD symptomatology. Based on Pekarik (1992) we hypothesized that early drop-outs will have elevated OCD symptoms compared to late drop-outs and to completers at the time of treatment termination. We also wanted to explore whether pre-treatment measures could predict early and late drop-out.

2. Methods

2.1. Participants

The study was approved by the VU-University, Medical Centre's Ethical Review Committee (Amsterdam, The Netherlands). The sample for the present study included participants from two 2-sited randomized controlled trials (RCTs) in the Netherlands, which were originally set up to compare the effectiveness of cognitive therapy (CT) and exposure therapy (ET) with and without Fluvoxamine for the treatment of OCD (van Balkom et al., 1998; van Oppen, van Balkom, Spinhoven, Hoogduin, & van Dyck, 1995). We combined data from these RCTs as the inclusion criteria, recruitment process, assessments methods, measures, measurement intervals, and treatment protocols were all identical. Moreover, all patients were treated at the same outpatient clinics in the Netherlands (in Delft and Amsterdam) by the same therapists during the same period.

Participants were excluded from the present study if they (a) solely reported obsessions (b) had suicidal tendencies (c) had organic brain disease (d) had past or present psychosis (e) had psychoactive substance use disorder (f) had a severe medical disorder (g) were receiving psychological treatment elsewhere and (h) had been treated with either behavior or cognitive therapy in the 6 months preceding baseline.

The sample included 121 participants (71 females; 58.7%), with an average age of 35.1 ($SD=10.7$). All participants were diagnosed with primary OCD according to DSM-IIIIR criteria using the Anxiety Disorder Interview Schedule-Revised (Di Nardo, O'Brien, Barlow, Waddell, & Blanchard, 1983). Many participants had an additional AXIS-I disorder (44.6%) and most (67.8%) had received treatment in the past for OCD. Table 1 presents demographic and pre-treatment clinical measures for all participants.

Drop-outs were defined as individuals who either (a) did not attend the final treatment session and did not have a post-treatment score, and/or (b) did not attend 7 sessions or more during the treatment. This is consistent with previous definitions of drop-out in the OCD treatment outcome literature (e.g., McLean et al., 2001). Of the total sample, 31 individuals (25.6%) dropped-out and 90 individuals (74.4%) completed treatment. Treatment completers attended significantly more sessions ($M=13.9$; $SD=0.7$) compared to drop-outs ($M=5.0$; $SD=4.3$; $F_{(1,119)}=366.2$, $p<0.001$). No differences in attrition were detected between the four treatment conditions ($\chi^2_{(3)}=3.61$, $p=0.31$, *n.s.*). Thus, we analyzed drop-outs from all treatment conditions together.

2.2. Treatments

The present study included 4 treatment conditions: cognitive therapy (CT), exposure therapy (ET), CT plus Fluvoxamine, and ET plus Fluvoxamine. All treatments were 16 weeks long. Therapists in psychological treatments were clinical psychologists who had ample experience in the use of cognitive and behavioral techniques and psychiatrists or psychiatry residents administered Fluvoxamine. Fluvoxamine dosage started at 50 mg per day, and in the absence of disturbing side effects, was increased to a maximum of 300 mg per day after 3 weeks of treatment. After 8 weeks Fluvoxamine remained at a constant level and no changes in dosage were made. Further details regarding pharmacotherapy can be found elsewhere (van Balkom et al., 1998).

CT for OCD was based on cognitive therapy for depression and anxiety disorders (Beck, 1976; Beck, Emery, & Greenberg, 1985; Salkovskis, 1985; Van Oppen & Arntz, 1994). During the treatment, therapists helped participants to identify distressing thoughts (i.e., negative automatic thoughts) as well as dysfunctional core assumptions and subsequently challenge them. This was done both during the sessions and as homework assignments using thought diaries. Behavioral experiments to test beliefs were conducted from session 6 and onward.

ET for OCD was based on treatment protocols by Emmelkamp (1982). During treatment, a hierarchy of stressful situations was constructed and gradual exposure to these situations was given as homework. Each session started with a discussion about the performance of the previous homework tasks and new homework tasks were discussed at length. Further details of psychological treatments can be found elsewhere (Oppen, van Balkom, de Haan, & van Dyck, 2005; van Oppen, van Balkom, Spinhoven, et al., 1995).

2.3. Procedure

Participants who sought treatment at one of the clinics were screened by an experienced psychiatrist or clinical psychologist using a Dutch version of the standardized Anxiety Disorder Inter-

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