



Intensive residential treatment for severe obsessive-compulsive disorder: Characterizing treatment course and predictors of response



Brian P. Brennan^{a, b, f, *}, Catherine Lee^c, Jason A. Elias^{b, f}, Jesse M. Crosby^b,
Brittany M. Mathes^b, Marie-Christine Andre^{b, e}, Christina M. Gironde^b,
Harrison G. Pope Jr.^{a, f}, Michael A. Jenike^{b, f}, Garrett M. Fitzmaurice^{c, d}, James I. Hudson^{a, f}

^a Biological Psychiatry Laboratory, McLean Hospital, Belmont, MA, USA

^b Obsessive-Compulsive Disorder Institute, McLean Hospital, Belmont, MA, USA

^c Department of Biostatistics, Harvard School of Public Health, Boston, MA, USA

^d Laboratory for Psychiatric Biostatistics, McLean Hospital, Belmont, MA, USA

^e Psychology Department, Suffolk University, Boston, MA, USA

^f Department of Psychiatry, Harvard Medical School, Boston, MA, USA

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ABSTRACT

Background: Intensive residential treatment (IRT) is effective for severe, treatment-resistant obsessive-compulsive disorder (OCD). We sought to characterize predictors and course of response to IRT.

Methods: Admission, monthly, and discharge data were collected on individuals receiving IRT. We examined the association between baseline characteristics and percent change in OCD symptoms as measured by the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) using linear regression. We compared baseline characteristics of IRT responders ($\geq 35\%$ reduction in Y-BOCS) versus non-responders, and of patients who did versus those who did not achieve wellness (Y-BOCS ≤ 12) using non-parametric tests. To examine the course of OCD severity over time, we used linear mixed-effects models with randomly varying intercepts and slopes.

Results: We evaluated 281 individuals admitted to an IRT program. Greater baseline Y-BOCS scores were associated with a significantly greater percent reduction in Y-BOCS scores ($\beta = -1.49$ [95% confidence interval: -2.06 to -0.93]; $P < .001$). IRT responders showed significantly greater baseline Y-BOCS scores than non-responders (mean (SD) 28 (5.2) vs. 25.6 (5.8); $P = .003$) and lower past-year alcohol use scores than non-responders (1.4 (1.9) vs. 2.1 (2.2); $P = .01$). Participants who achieved wellness displayed lower hoarding factor scores than those who did not (5 (4.6) vs. 9.53 (6.3); $P = .03$). OCD symptoms declined rapidly over the first month but more slowly over the remaining two months.

Conclusions: Higher baseline OCD severity, lower past-year alcohol use, and fewer hoarding symptoms predicted better response to IRT. IRT yielded an initial rapid reduction in OCD symptoms, followed by a slower decline after the first month.

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1. Background

Obsessive-compulsive disorder (OCD) is a chronic and often debilitating psychiatric illness, affecting between 2% and 3% of the United States population at some time in their lives (Karno et al., 1988). The current first-line treatments for OCD include both pharmacologic approaches such as the selective serotonin reuptake inhibitors and behavioral treatment such as exposure response

prevention therapy. For most OCD patients, these treatments alone or in combination produce at least moderate symptom reduction (Jenike, 2004). However, a subset of OCD patients derives little or no relief from these therapies and requires more intensive treatment approaches. This severe, treatment-refractory subset of cases accounts for nearly all of the OCD-related psychiatric hospitalizations in the United States, as well as the vast majority of social and functional impairment (Ruscio et al., 2010). Thus, it is important to develop specialized treatment approaches targeting this unique and challenging patient population.

One such approach is intensive residential treatment (IRT). IRT utilizes a multidimensional treatment strategy incorporating

* Corresponding author. McLean Hospital, 115 Mill Street, Belmont, MA 02478, USA. Tel.: +1 617 855 2911; fax: +1 617 855 3585.

E-mail address: bbrennan@partners.org (B.P. Brennan).

intensive behavioral, medication, and milieu treatment administered in a residential setting. To date, several studies of IRT have demonstrated a significant reduction in OCD symptoms (Bjorgvinsson et al., 2013, 2008; Boschen et al., 2008; Drummond, 1993; Stewart et al., 2005) that persists post-discharge (Stewart et al., 2009), suggesting that this approach is a viable treatment option for OCD patients with severe and refractory illness. However, given the significant personal and financial investment required for IRT, it is important to seek predictors of response to this treatment. Currently, three studies of IRT have examined outcome predictors for patients with OCD (Bjorgvinsson et al., 2013, 2008; Stewart et al., 2006), but two of these (Bjorgvinsson et al., 2013, 2008) employed modest sample sizes ($N < 50$) and one (Bjorgvinsson et al., 2008) examined only adolescents with OCD. Moreover, none of these studies examined the longitudinal course of treatment response. Such studies are critical for refining and optimizing the IRT approach.

The Obsessive-Compulsive Disorder Institute at McLean Hospital (OCDI), a representative IRT program, utilizes a multidisciplinary staff to provide intensive behavioral, pharmacologic, and group treatment at both residential and partial hospital levels of care. On average, IRT involves about 2–4 h of daily exposure response prevention therapy, weekly meetings with psychiatrists who specialize in the pharmacologic management of OCD, and case management with a social worker to address family dynamics and aftercare planning. The average length of stay in the OCIDI is approximately 45 days, and about 25% of patients stay at least 3 months.

In a previous study of OCIDI patients, our group found that lower initial OCD severity, female sex, and better baseline psychosocial functioning predicted less severe OCD at discharge (Stewart et al., 2006). However, this study did not examine the trajectory of OCD severity over the course of IRT – data that could guide decisions on optimal treatment approaches and length of stay. Therefore, the aims of this study were 1) to replicate and expand upon our previous findings of baseline predictors of response to IRT and 2) to characterize the course of OCD severity over time during IRT treatment. Based on our previous study, we hypothesized that female patients with less severe OCD, better baseline psychosocial functioning, and fewer baseline depressive symptoms would respond best to IRT. We also hypothesized that patients with primary contamination/washing symptoms would respond better to IRT than other patients, since in our experience, contamination/washing symptoms generally appear more amenable to the exposure response prevention approach. Additionally, based on anecdotal experience, we hypothesized that patients receiving IRT improve rapidly over the first month, but more gradually thereafter.

2. Materials and methods

2.1. Study population

Study participants were first time-admissions to the OCIDI between May 2011 and May 2013 who gave written informed consent to participate in a research database study approved by the McLean Hospital Institutional Review Board. Each participant met admission criteria to the OCIDI, which included having severe OCD symptoms, significantly compromised social and occupational functioning, and evidence of treatment resistance to previous medication trials or outpatient behavioral therapies. In addition, each patient had a confirmed diagnosis of OCD based on admission assessments by both a behavioral therapist and a psychiatrist with expertise in OCD.

2.2. Clinical assessments

Each study participant was administered a battery of self-report clinical rating scales upon admission, detailed below, which were

repeated monthly and at discharge. Participants also completed an admission demographic questionnaire covering age of onset of OCD symptoms, family history of OCD, marital status, educational background, employment status, and prior diagnosis of post-traumatic stress disorder.

The Yale-Brown Obsessive Compulsive Scale (Y-BOCS), our primary measure of OCD severity, is a 10-item scale with demonstrated reliability used to assess the severity of both obsessions and compulsions, with each item rated on a scale between 0 (lowest severity) and 4 (highest severity) (Goodman et al., 1989). The self-report version of the Y-BOCS has been shown to correlate highly with the clinician-administered version (Federici et al., 2010). The Obsessive Compulsive Symptoms Rating Scale (OCSRS) is a self-report measure that assesses the presence of 67 specific OCD and obsessive-compulsive spectrum symptoms grouped into 22 categories including obsessions (e.g., aggression, contamination, sexual, hoarding, religious, symmetry, somatic), compulsions (e.g., cleaning, checking, repeating, counting, ordering, hoarding), and several miscellaneous categories (Wilhelm and Steketee, 2006). Individuals then rate the severity of each category on a scale from 0 (no problem) to 10 (very severe). These category scores have been shown to be reliable and valid with good internal consistency (Yovel et al., 2012). The Quick Inventory of Depressive Symptomatology – Self Report Version (QIDS-SR₁₆), a widely used 16-item self-report scale with demonstrated high internal consistency and validity (Rush et al., 2003), assesses the severity of depressive symptoms. The Work and Social Adjustment Scale (WSA), a 5-item self-report measure of functional impairment, demonstrates good reliability and validity (Mundt et al., 2002). Each item is rated on a scale from 0 (not at all) to 8 (very severe). The 10-item Schwartz Outcome Scale (SOS-10) is a reliable and internally consistent (Blais et al., 1999) quality-of-life measure with higher scores indicating better functioning. The Alcohol Use Disorders Identification Test – Consumption Questions (AUDIT-C), and the Drug Abuse Screening Test (DAST-10) are brief screening questionnaires with demonstrated reliability and face validity (Bush et al., 1998; Skinner, 1982) assessing past-year alcohol and drug use, respectively, with higher scores indicating greater evidence of abuse or dependence.

Using established criteria (Farris et al., 2013), we defined “response” as a decrease in Y-BOCS score of $\geq 35\%$ from admission to discharge and “wellness” as a Y-BOCS score of ≤ 12 at last assessment. For participants discharged before discharge measures could be obtained, we used the final completed assessment in a last-observation-carried-forward (LOCF) approach.

2.3. Statistical analyses

2.3.1. Univariate predictors of response and wellness

We examined the association between baseline characteristics and percent change in total Y-BOCS scores between admission and discharge assessments using linear regression. Additionally, we compared the baseline characteristics of responders versus non-responders, and of patients who did and did not achieve wellness, using the Wilcoxon rank-sum test for continuous data and Fisher's exact test for categorical data. All baseline characteristics of interest were chosen prior to conducting any analyses and all results (both significant and non-significant) are reported in this manuscript.

We also assessed OCD symptom dimension ratings, obtained at admission, as predictors of response. Using the widely accepted four-factor solution for OCD symptoms, which includes: 1) forbidden thoughts (aggressive, sexual, and religious obsessions) and checking compulsions; 2) symmetry obsessions and ordering compulsions; 3) contamination obsessions and washing compulsions; and 4) hoarding obsessions and compulsions, (Bloch et al., 2008) we calculated factor scores for each of the four factor

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