Journal of Psychiatric Research 43 (2009) 1118–1123

Contents lists available at ScienceDirect

Journal of Psychiatric Research

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

Long-term outcome following Intensive Residential Treatment of Obsessive–Compulsive Disorder

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ARTICLE INFO

Article history:
Received 10 November 2008
Received in revised form 19 March 2009
Accepted 27 March 2009

Keywords:
Obsessive–Compulsive Disorder
Intensive Residential Treatment
Long-term outcome
Inpatient
Effectiveness

ABSTRACT

Background: IRT has been demonstrated as an effective treatment for severe, refractory OCD.
Methods: Consecutive IRT subjects were ascertained over a 12 month period (female $N = 26$, male $N = 35$). Psychometric measures were completed at admission and discharge from the McLean/MGH OCD Institute IRT, including the Yale-Brown Obsessive–Compulsive Scale (Y-BOCS), Beck Depression Inventory (BDI) and the Work and Social Adjustment Scale (WSA)($N = 61$). These measures were repeated at one ($N = 57$), three ($N = 42$) and six months ($N = 36$) following discharge. This study was IRB approved.
Results: OCD mean severity did not significantly worsen from discharge to the one (17.4, SD 6.5), three (16.5, SD 7.4) or six month (16.2, SD 7.3) follow-up ($p > 0.25$). Furthermore, the significant improvement from admission was maintained at each of the one (17.4, SD 6.5), three (16.5, SD 7.4) and six month (16.2, SD SD 7.3) follow-up time points ($p < 0.001$). Relapsers were significantly more likely to be living alone following discharge ($p = 0.01$), and were less likely to have comorbid illnesses ($p = 0.02$). There were no significant differences found between study dropouts and completers with regards to YBOCS scores ($P > 0.47$).
Conclusion: In the first OCD IRT long-term follow-up study to date, findings have indicated that mean treatment gains were maintained at one, three, and six months post-discharge. This finding is important as it suggests that improvements of OCD severity were subsequently retained in home and work environments. Improvement of depression severity from admission was also maintained.
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1. Introduction

Intensive Residential Treatment (IRT) has been identified as an effective treatment for severe Obsessive–Compulsive Disorder (OCD). McKenzie and Marks found that 218 patients improved by 30–50% on symptom and disability scores after undergoing IRT (McKenzie and Marks, 2003). In the largest IRT study to date for OCD, mean Yale-Brown Obsessive–Compulsive Scale (YBOCS) scores decreased 30.1% from 26.6 at admission to18.6 at discharge, demonstrating a clinically significant improvement in 403 patients (Stewart et al., 2005). Beck depression severity scores also decreased significantly, from 21.0 to 15.3 ($p < 0.001$). Within the same IRT OCD population, outcome predictors were identified to be gender, depression severity, psychosocial functioning, and the presence of comorbid tic disorders (Stewart et al., 2006). In the aforementioned studies by Stewart et al., the average duration of IRT was 66 days. What remains to be determined is whether treatment gains are retained in a naturalistic setting after discharge and maintained over time.

Hembree et al. (2003) have examined long-term outcomes of a variety of OCD treatment modalities, including SSRIs alone, exposure/ritual prevention alone (E/RP), and E/RP in combination with SSRIs ($N = 62$). At 17 months follow-up, no significant overall differences in OCD symptoms existed among the three groups. However, the E/RP groups with and without medication performed significantly better on most measures than the medication alone group. Their study suggested that E/RP leads to better long-term maintenance of improvement compared to medication alone, although analyses did not control for treatments received in the follow-up period (Hembree et al., 2003). For more severe refractory patients who do not respond to these first-time treatments, the efficacy of deep-brain stimulation in 10 refractory OCD patients has been examined, with the average improvements in YBOCS scores from 34.6 ± 0.6 (severe) to 22.3 ± 2.1 (moderate) after 36 months (Greenberg et al., 2006). Neurosurgury was also

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doi:10.1016/j.jpsychires.2009.03.012

evaluated in 17 severe treatment-refractory OCD patients, with 8 remaining as responders after 24 months (mean average YBOCS improvement 48%) (Bandelow, 2008; Jung et al., 2006). Although the long-term efficacy of DBS and cingulotomy have been tested, the long-term efficacy of the less invasive IRT has not been studied.

A limiting factor in comparing findings of these and other OCD outcome studies is the absence of a standard definition of response, remission, or relapse for the disorder. For example, when differing but commonly used definitions of relapse were applied to four different OCD studies, relapse ranged from 27% to 63% for treatment with Clomipramine (CMI), 0–50% for treatment with E/RP, and 7–67% for treatment with E/RP combined with CMI (Simpson et al., 2005). Various definitions of response and remission were also applied to the same four OCD studies and significantly more responders and remitters were found in the E/RP and the E/RP with CMI groups than the placebo group. The CMI alone group had significantly more responders and remitters than the placebo group using some, but not all definitions. In various OCD studies, the following definitions of response have been used: (1) CGI-I scores of much improved or very much improved (Foa et al., 2005; Goodman et al., 1996; Greist et al., 1995), (2) a YBOCS decrease of 25% or more (Cottraux et al., 2001; Hollander et al., 2003; Montgomery et al., 2001), (3) a YBOCS decrease of 35% or more (The Clomipramine Collaborative Study Group, 1991; Hohagen et al., 1998; Tollefson et al., 1994), and (4) a Reliable Change Index (RCI) score of greater than 1.96 (McLean et al., 2001; van Oppen et al., 2005). After reviewing the literature, Simpson et al. suggested a 25% YBOCS score decrease as a sensitive, but not necessarily specific measure of response (Simpson et al., 2006). As with response, various definitions are used for remission. YBOCS < 16, YBOCS < 12, and YBOCS < 8 have all been used in the literature. Simpson et al. Simpson et al. (2006) and Frank and colleagues (Frank et al., 1991), recommend using YBOCS total score of $\leqslant 12$ for at least one week as a standard definition of remission.

In light of the fact that the long-term effectiveness for first line DBS and surgical treatment of OCD have been investigated, the current study examines the long-term benefits of IRT for OCD. Based on the previously reported significant YBOCS scores decrease between IRT admission and discharge, combined with the fact that both CBT and medications are central components of the IRT program, we hypothesized that treatment gains will be maintained at one, three, and six months following IRT discharge.

2. Methods

2.1. Subjects

The study population was comprised of 61 subjects (female $N = 26$, male $N = 35$) who received treatment at the McLean Hospital's OCD Institute IRT program. The diagnosis of OCD was based upon diagnostic instruments used at admission, as well as clinical assessments by psychiatrists and psychologists with expertise in the treatment of OCD. Threshold criteria for admission to the OCDI include the presence of OCD-related severe life impairment and inadequate prior treatment response. These criteria are determined via admission package information, YBOCS scores, and collateral information from family members and treating clinicians, and are confirmed by OCDI psychiatrist assessments.

Consecutive subjects were ascertained over a 12 month period, and were assessed at admission and discharge, and following discharge via telephone interviews at one ($N = 57$) (mean number of days: 37.5, SD 9.3), three ($N = 42$) (97.2, SD 10.4), and six months ($N = 36$) (195.3, SD 15.4). This study was given ethical approval by the Institutional Review Board (IRB) at McLean Hospital.

2.2. Assessments

Several psychometric measures were used in this study, as follows. The Yale-Brown Obsessive–Compulsive Scale (YBOCS) is a 10-item measure rating each item between 0 (lowest severity) and 4 (highest severity). It has high convergent validity with the NIMH-Obsessive–Compulsive Scale ($r = 0.67$) Goodman et al., 1989. The YBOCS symptom checklist measures the current and past presence of 15 categories of obsessions and compulsions. The Beck Depression Inventory (BDI) is a 21-item depression severity scale, with a split-half reliability (Pearson's r) of 0.86, a construct validity correlation with the Symptom checklist 90-Revised of 0.76, sensitivity of 100% and specificity of 89% with a cutoff score of 16 (Beck et al., 1961; Burt and Ishak, 2002). The Work and Social Adjustment Scale (WSA) is a 5-item measure that assesses functional impairment and quality of life, with a test–retest reliability of 0.73, a convergent validity with clinician interviews of 0.81–0.86, and increasing scores that reflect worse functional impairment (Mundt et al., 2002). In addition, a semi-structured interview was created, screened, and adjusted to capture information on treatment, occupation, social, and other factors that may influence long-term outcome.

2.3. Statistical analyses

Data was coded from original intake, discharge, and follow-up measures, double-entered into the OCDI database, and verified. The primary outcome measure was the OCD severity change between discharge and follow-up assessments one, three, and six month follow-up time points, as measured by YBOCS scores. Secondary outcomes of interest included changes in comorbid depression severity, as measured by the BDI, and psychosocial functioning changes, as measured by the WSA.

Descriptive and comparative analyses were conducted to determine relapse rates of subjects across follow-up time points. As contrasted with the approach of Romano et al, treatment relapse was conservatively defined by the presence of a higher OCD YBOCS severity score in more than one half of the follow-up assessments compared to discharge. Rather than using Romano et al's cross-sectional definition, our definition utilizes multiple time-points to capture a longitudinal perspective of relapse/remission (Romano et al., 2001). Characteristics of subject relapsers vs. non-relapsers and of study dropouts vs. completers were statistically compared using χ^2 and Fisher's exact tests for categorical data and t-tests for continuous data. SPSS 15.0 (Statistical Package for Social Sciences) software was used in statistical analyses and statistical significance was defined at $p < 0.05$ (SPSS, 2006).

3. Results

The intent-to-treat population included 61 first-time participants of the OCDI who voluntarily consented to provide post-discharge outcome data. Among those who dropped out, the most common reason for study incompletion was due to subject relocation or lost contact. Study dropouts and completers were statistically compared with respect to gender and OCD admission and discharge severity and social functioning (the previously identified outcome predictors (Stewart et al., 2006). Between discharge and one month, there were four (6.6%) subjects lost to follow-up, between one and three months, there were fifteen (24.6%) subjects lost to follow-up, and between three and six months, there were 6 (9.8%) subjects lost to follow-up. No significant differences were identified between completers and dropouts ($p = 0.15$) with respect to gender (50% vs. 61.5% male, respectively), YBOCS severity at admission (YBOCS = 24.9 vs. 24.5) or discharge (YBOCS = 16.6 vs.

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