

An open trial of cognitive behavioral therapy with contingency management for hoarding disorder



Blaise L. Worden^{a,*}, William M. Bowe^{a,1}, David F. Tolin^{a,b}

^a The Institute of Living/Hartford Hospital, USA

^b Department of Psychiatry, Yale University School of Medicine, USA

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ABSTRACT

Cognitive behavioral therapy (CBT) for hoarding disorder (HD) has resulted in statistically significant improvements in hoarding symptoms, but gains have been modest and most participants continue to have clinically significant symptoms at post treatment. Contingency management, an empirically-supported intervention for substance use, may be effective in overcoming barriers to effective treatment of HD, such as fluctuating motivation and insight. The objective of the current open trial was to examine the potential effectiveness of contingency management for HD in the context of a cognitive-behavioral group therapy. Twenty-two patients completing 16-week CBT groups for HD were administered monthly contingency payments based on independent evaluator-rated reductions in overall in-home clutter. Mixed effects models suggested significant reductions in hoarding symptoms as measured by the Saving Inventory-Revised (SI-R; Frost, Steketee, & Grisham, 2004) and the Clutter Image Rating Scale (CIR; Frost, Steketee, Tolin, & Renaud, 2008), with SI-R reductions resulting in a large effect size (Cohen's $d = 2.59$) that surpassed those obtained previously in trials of CBT for HD. Mean total earning per patient was \$139, and ranged from \$0 to \$270. These preliminary results suggest that contingency management shows promise as a cost-efficient adjunctive intervention to boost gains in CBT for HD.

1. Introduction

Hoarding pathology often has been considered to be treatment-refractory. Hoarding disorder (HD) was recently differentiated from OCD in the DSM-5 (American Psychiatric Association, 2013), and this differentiation was made in part based on hoarding having a relatively poor response to gold-standard treatments for OCD, including exposure and response prevention and serotonergic medications (Abramowitz, Franklin, Furr & Schwartz, 2003; Hayashida, Kiriike, Matsunaga, Nagata, & Stein, 2010; Rufer, Fricke, Moritz, Kloss, & Hand, 2006; Steketee, Frost, & Kyrios, 2003). Given the relatively poor response of individuals with HD to traditional exposure and response prevention, several groups (e.g., Frost, Pekareva-Kochergina, & Maxner, 2011; Gilliam et al., 2011; Muroff, Steketee, Rasmussen, Gibson, Bratiotis, & Sorrentino, 2009; Steketee, Frost, Tolin, Rasmussen, & Brown, 2010; Tolin, Frost, & Steketee, 2007) have investigated adapted cognitive-behavioral therapy (CBT) for HD. These treatments tend to have a relatively reduced emphasis on habituation to feared cues via repeated exposures, and increased focus on basic skills training for cognitive deficits present in hoarding disorder (such

as difficulties organizing, problem solving, and categorizing). These protocols have included more of a focus on the development of practical skills, typically including modules surrounding methods of organization, applying problem solving models, and emotional distress tolerance skills and practice. Some of these treatments (e.g., Muroff, Steketee, Bratiotis, & Ross, 2012; Turner, Steketee, & Nauth, 2010) have utilized in-home and/or in-session de-cluttering sessions. Although most participants show reliable change over the course of CBT, the rate of clinically significant change (i.e., post-treatment scores that are more likely to come from the distribution of scores in the general population than from an HD population) is only 35%, with most patients continuing to show significant hoarding behaviors and related impairment at post-treatment (Frost, Muroff, Steketee & Tolin, 2014). While CBT for HD continues to be the most empirically-supported treatment for HD, clearly there is substantial room for improvement in these treatment protocols.

Individuals with HD present with a variety of challenges that impede successful treatment, including apparent fluctuations in insight and motivation for change (Frost, Tolin, & Maltby, 2010; Worden, DiLoreto, & Tolin, 2014), executive functioning impairments

* Correspondence to: Anxiety Disorders Center/Center for CBT, The Institute of Living 200 Retreat Avenue, Hartford, CT 06106, USA

E-mail address: blaise.worden@hhchealth.org (B.L. Worden).

¹ Dr. Bowe is now located at VA Boston Healthcare System, 150 South Huntington Avenue, Boston, MA 02130.

(Grisham, Brown, Savage, Steketee, & Barlow, 2007), and high rates of co-occurring medical and mental health comorbidities (Frost, Steketee, & Tolin, 2011; Tolin, Frost, Steketee, Gray, & Fitch, 2008). These barriers can clearly interfere with completion of necessary practice in decision making and discarding tasks. Given these barriers, contingency management (CM) may be an ideal way to boost outcomes of cognitive-behavioral treatment for HD. There are several reasons to think that CM will be an efficacious adjunct to CBT for HD: CM has historically been used in contexts in which there are high levels of ambivalence for change or motivational/insight issues, and high rates of mental/medical comorbidities. CM may be efficacious because it targets or circumvents these treatment-interfering issues.

Use of contingencies has long been a core element of several empirically supported treatments, particularly those for children and adolescents (Kanter, Manos, Bowe, Baruch, & Rusch, 2010; Marx & Gross, 1998; Walker, Greenwood, & Terry, 1994). In adults, CM has substantial empirical support for substance use disorders (SUDs; see Carroll, 2012; Petry, 2012), having some of the largest treatment effect sizes of available treatments (Petry, 2010) and often resulting in significantly better outcomes than standard care (Ledgerwood & Petry, 2006; Petry, 2006). Several smaller studies further suggest that CM may facilitate a range of behaviors such as medication adherence, treatment attendance, and health behavior maintenance (e.g., increased exercise levels, Kurti & Dallery, 2013; medication adherence, Rosen et al., 2007). Below we outline how CM may be an ideal intervention to address these unique treatment challenges that arise with HD.

CM does not rely on intrinsic motivation and good insight. Low apparent problem insight and low reported motivation for change (or high ambivalence regarding change) are commonly-cited problems in the treatment of individuals with HD (Worden et al., 2014). Individuals with HD often report low distress related to hoarding behaviors and related consequences, despite notable functional impairment (Calamari et al., 2004; Frost, Steketee, Williams, & Warren, 2000; Grisham, Brown, Liverant, & Campbell-Sills, 2005). They often have relatively low treatment compliance (e.g., Maher et al., 2012; Mataix-Cols, Marks, Greist, Kobak, & Baer, 2002), and can often appear to have strong psychological reactance or defensiveness, paired with ego-syntonic thoughts regarding the value of possessions and the consequences of discarding and wastefulness (Frost, Steketee, Tolin, Sinopoli, & Ruby, 2015; Frost et al., 2010). The presence of high levels of overvalued ideation (i.e., strong belief conviction resistant to contradictory information) surrounding possessions is likely to make individuals with HD hesitant to engage in behavioral experiments that might challenge those strong beliefs. Because CM does not rely on intrinsic motivation alone, it may help incentivize patients to complete behavioral experiments in which they are able to test out and challenge problematic beliefs and behaviors.

CM is also likely to be applicable to patients with notable medical and psychiatric comorbidities. A representative HD patient may be one with reoccurring health issues, financial problems, limited social supports, notable executive functioning deficits, and comorbid major depression. It is not hard to see why such a patient may have difficulty complying with complex interventions involving metacognitive analysis, complex therapy homework, and prioritization of distal outcomes. CM greatly simplifies the picture: it can capitalize on a drive for material acquisition while simultaneously encouraging participants to prioritize the importance of possessions and discard less prioritized ones. As mentioned above, CM has been effective with populations that have similarly high rates of concurrent medical and psychological comorbidities, suggesting that CM is likely to be a viable intervention for complex HD patients as well.

The objective of the current study was to conduct a preliminary examination of the effectiveness of contingency management (CM) in treating individuals with HD. CM incentivizing observable reductions in clutter was administered in the context of CBT for HD. It was

hypothesized that participants receiving CM would show significant pre- to post-treatment decreases in severity of hoarding symptoms and clinician-rated impairment. Exploratory benchmarking analyses were used to compare the obtained effect sizes to those of prior trials of CBT for hoarding disorder conducted within our clinic.

2. Method

2.1. Participants

Participants were recruited from an outpatient anxiety disorders/obsessive-compulsive and related disorders specialty clinic affiliated with a large nonprofit hospital. Participants were 22 consecutive voluntary enrollees in the HD treatment groups at the clinic. This group has been run at the clinic since 2008 using cohorts of 5–12 patients; the cohorts in the current group occurred during 2013. Inclusion criteria for the therapy group included a primary diagnosis of HD according to DSM-5 criteria (American Psychiatric Association, 2013) and clinical appropriateness for a group treatment format i.e., no active suicidality or aggressive behavior, psychosis, current physiological substance dependence (i.e., tolerance or withdrawal symptoms), or severe personality pathology that would be expected to substantially interfere with the group milieu (e.g., antisocial or borderline personality disorder), and primary residence within at least one hour travel time from the clinic to facilitate in-home assessments. Participants were also excluded if they had previously completed CBT for HD. Upon completion of a standard clinic intake, all individuals who were eligible and who intended to enter the HD treatment group were offered a chance to participate in the CM portion of the treatment. Informed consent was conducted by the study P.I. after the patient's clinic intake but prior to participation in group session 1. Participants were not required to participate in the experimental CM intervention in order to attend the CBT therapy group for HD.

Two participants were excluded based on non-eligibility; one due to having a primary residence greater than 1 h from the clinic, and the other due to minimal clutter (i.e., a mean household CIR rating of 1.67 at the first home visit). Three additional participants refused participation in the study; two of these participants cited distrust about confidentiality of information shared (despite being informed about confidentiality procedures) and one participant cited dislike of the participant reimbursement mechanism (a re-loadable debit card). See Fig. 1 for further information about patient eligibility and retention.

2.2. Measures

Mini-International Neuropsychiatric Interview (MINI; Sheehan et al., 1998). The MINI is a brief semi-structured diagnostic interview. The MINI was used at intake to determine comorbid Axis I diagnoses based on DSM-IV criteria for the first CM group cohort (the DIAMOND, below, was used for the second cohort). The MINI was

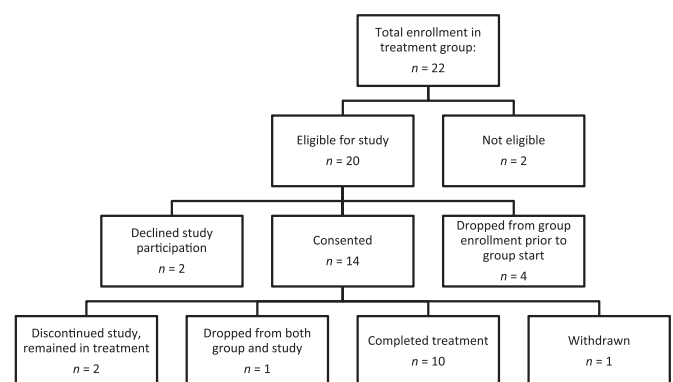


Fig. 1. Participant flow.

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