Journal of Obsessive-Compulsive and Related Disorders 14 (2017) 59–64

Contents lists available at ScienceDirect

Journal of Obsessive-Compulsive and Related Disorders

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

Short communication

A long-term follow-up of group behavioral therapy for obsessive-compulsive disorder in a general outpatient clinic in Norway

Tor Sunde[a,*], Liv Tveit Walseth[a], Joseph A. Himle[a,b], Patrick A. Vogel[c], Gunvor Launes[a], Vegard Øksendal Haaland[a,d], Asle Hoffart[e,f], Sverre Urnes Johnson[e,f], Åshild Tellefsen Haaland[a]

[a] ABUP, Sørlandet Hospital, SSHF, Seviceboks 416, 4604 Kristiansand, Norway
[b] School of Social Work and School of Medicine-Psychiatry, University of Michigan, 1080 South University Ave., Ann Arbor, MI 48109, USA
[c] Norwegian University of Science and Technology, Department of Psychology, NTNU, 7491 Trondheim, Norway
[d] Clinical Neuroscience Research Group, Department of Psychology, Postboks 1094, Blindern, 0317 Oslo, Norway
[e] Research Institute, Modum Bad Psychiatric Center, 3370 Vikersund, Norway
[f] Department of Psychology, University of Oslo, Postboks 1094, Blindern, 0317 Oslo, Norway

ARTICLE INFO

Keywords:
Obsessive-compulsive disorder
Cognitive behavioral group therapy
ERP
Follow-up

ABSTRACT

There is a lack of knowledge regarding the long-term effect of evidence-based CBT/ ERP treatment for OCD that is delivered in routine clinical care. The aim of this study was to examine the long-term effectiveness of behavioral treatment for OCD in a Norwegian general outpatient clinic. In the current study, 62% (N = 40) of the original patients treated in a previously published study of group ERP for OCD were re-evaluated an average of eight years after completing the original treatment. This is the longest follow-up study that has been conducted for OCD patients treated with group ERP. There was a significant reduction in symptoms from pre- to post-treatment measured with the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), the Spielberger State Anxiety Inventory (STAI-S) and the Beck Depression Inventory (BDI). The gains were in average maintained from post-treatment through extended long-term follow-up. Fifty percent of the participants experienced either a clinically significant improvement (10%) or recovery (40%) in OCD symptoms at extended long-term follow-up. This suggests that many patients receiving general outpatient mental health clinic based group ERP for OCD maintain gains over the long-term.

1. Introduction

Cognitive behavior therapy (CBT) that includes exposure and response prevention (ERP) is established as a treatment of choice for obsessive-compulsive disorder (OCD) (McKay et al., 2015). A recent meta-analysis of CBT for OCD that included ERP indicated that more than 60 percent of patients achieved a clinically significant change from pre- to post- treatment in randomized clinical trials (Ost, Havnen, Hansen, & Kvale, 2015). Meta-analyses have also revealed large mean effect sizes and no significant differences between individual and group CBT after acute treatment (Jonsson & Hougaard, 2009; Ost et al., 2015). The strong empirical support for the short-term benefit of CBT notwithstanding, knowledge about the long-term maintenance of gains after CBT is limited.

One meta-analysis on the long-term follow-up of adult OCD patients exists (Sharma, Thennarasu, & Reddy, 2014). This meta-analysis found that more than 50% of the patients remain improved from pre-treatment to follow-up (ranging from 1 to 15 years). However, the interventions in included studies varied considerably (e.g., medication, CBT or both) making it difficult to determine how effective CBT alone is in the long run.

Of the existing group CBT studies, gains in treatment are maintained after two years (Braga, Manfro, Niederauer, & Cordioli, 2010; Jakubovski et al., 2013; Van Noppen, Pato, Marsland, & Rasmussen, 1998; Whittal, Robichaud, Thordarson, & McLean, 2008), four years (Himle et al., 2001) and five years (Borges et al., 2011). However, the studies are often encumbered with small samples (range from 21 to 46) and high attrition rates (from 4.8% to 77%).

The majority of the studies mentioned above involve treatments provided by experienced CBT providers working in specialized OCD/ anxiety clinics. A few studies of *individual* CBT and one study of *group* CBT delivered in typical outpatient clinics have shown promising

* Corresponding author.
E-mail addresses: tor.sunde@sshf.no (T. Sunde), liv.tveit.walseth@sshf.no (L.T. Walseth), himlej@med.umich.edu (J.A. Himle), patrickv@svt.ntnu.no (P.A. Vogel), gunvor.launes@sshf.no (G. Launes), vegard.oksendal.haaland@sshf.no (V.Ø. Haaland), asle.hoffart@modum-bad.no (A. Hoffart), sverreurnesjohnson@gmail.com (S.U. Johnson), aashild.haaland@sshf.no (Å.T. Haaland).

http://dx.doi.org/10.1016/j.jocrd.2017.06.002
Received 3 March 2017; Received in revised form 7 June 2017; Accepted 7 June 2017
Available online 09 June 2017

results with pre- to post-treatment effect sizes similar to those found in specialty OCD/anxiety clinics (Haaland et al., 2010; Houghton, Saxon, Bradburn, Ricketts, & Hardy, 2010; Rothbaum & Shahar, 2000; Warren & Thomas, 2001). Only one study has reported long-term follow-up 1–10 years) data on individual ERP for adult OCD provided in a general outpatient clinic, and they found outcomes similar to those observed in long-term studies from specialized clinics (Olsen, Mais, Bilet, & Martinsen, 2008). As far as we know, no studies of *group*-based CBT for OCD delivered in a general outpatient clinic have been published with follow-ups beyond one year. Research on both short and long-term outcomes of OCD treatment delivered in ordinary outpatient settings is critical given that community-based practitioners will play an important role in addressing the well-established gap between the availability of CBT for OCD and the patients who need it (Shafran et al., 2009).

This study presents follow-up data from a subsample of the patients described in our previous paper involving group-based ERP for OCD (Haaland et al., 2010) and some additional patients treated and evaluated in the same way. As far as we know, this is the first long-term follow-up study of group ERP for OCD delivered in a general outpatient clinic by therapists with limited training in ERP. To our knowledge, this is also the longest follow-up of group ERP for OCD delivered in any setting that has been presented in the literature.

2. Method

2.1. Participants

Between 2003 and 2009, a total of 65 patients completed 12 weekly sessions of group ERP in a general outpatient clinic in Norway. They were then assessed pre- and post-treatment and at a 3-month and 12-month follow-up. The scientific methods, treatment description and the response to acute treatment has been described in detail by Haaland et al. (2010). Fifty of the 65 patients involved in the present study were included in this previous report (Haaland et al., 2010), and fifteen more patients were invited later and underwent the same treatment and procedures. Of the 65 patients contacted to participate in the present study, 40 (62%) agreed to participate. The participants had received group ERP 5–11 years (M = 8.23, SD = 1.86) before participating in the present follow-up study (here after referred to as the extended long-term follow-up). Table 1 presents the demographic characteristics of the participants measured at extended long-term follow-up.

Table 1
Descriptive information for the extended long-term follow-up sample (N = 40).

Variable	Mean /% (n)
Age at follow-up	43.6
Female gender	77.5% (31)
Marital status[a]	
Single	28.9% (11)
Married	42.1% (16)
Divorced	2.6% (1)
Separated	2.6% (1)
Cohabiting	23.7% (9)
Employment status[b]	
Employed	48.6% (18)
Unemployed	13.5% (5)
Student	8.1% (3)
Homemaker	5.4% (2)
Disabled	13.5% (5)
Sick leave	8.1% (3)
Retired	2.7% (1)

Note: The demographic characteristics are measured at mean eight years follow-up.
[a] n = 38 due to missing data.
[b] n = 37 due to missing data.

2.2. Procedure

All the 65 eligible patients were initially sent a letter inviting them to participate in the present study. The letter informed that we were seeking to reassess persons who participated in our treatment in order to learn more about OCD and how to improve our ERP treatment. Those who did not reply to the letter were contacted by phone two weeks later. Of those invited, 24 refused, and 1 could not be traced (n = 25). The forty that agreed to participate provided written informed consent. Data collection was conducted from December 2013 to June 2014. The Y-BOCS was administered face-to-face with all participants (N = 40). Participants also completed a series of questionnaires and rating scales relevant to OCD and other psychiatric symptoms. In addition, some of the participants were involved in a qualitative portion of the study that is reported elsewhere (Walseth, Haaland, Launes, Himle, & Haaland, 2017; Walseth, Walseth, Launes, Haaland, & Haaland,). Two evaluators, one PhD/ MD (L.T.W.) and one psychologist, that had not been involved in the original outcome study, administered the Y-BOCS to assess the level of OCD symptoms. Each evaluator discussed the Y-BOCS scores with V.Ø.H. and Å.T.H. until a consensus was determined. To determine the inter-rater reliability of the Y-BOCS, a subsample of audiotapes from 8 (20%) randomly selected patients was analyzed by an independent rater located in another Norwegian clinic. The inter-rater agreement was high, 0.99 ($p < 0.001$, 2-tailed), using the Pearson's r statistic for total Y-BOCS scores at follow-up. The study was approved by the Regional Committee for Medical and Health Research Ethics.[1]

2.3. Measures

2.3.1. Yale-Brown Obsessive Compulsive Scale interview (Y-BOCS: Goodman et al., 1989)

The Y-BOCS includes 10 questions focused on obsessions and compulsions rated over the past two weeks yeilding a total score ranging from 0 to 40. A Y-BOCS score of 0–7 is sub-clinical, 8–15 is categorized as “mild”, 16–23 is “moderate”, 24–31 is “severe” and 32–40 is “extreme” levels of OCD symptoms. The Y-BOCS has been evaluated and has good psychometric properties (Taylor, 1995).

2.3.2. Beck Depression Inventory (BDI: Beck & Steer, 1987)

The BDI consists of 21 items and is a self-report inventory for depressive symptoms over the past week. The BDI has shown excellent validity and reliability scores, high internal consistency and has been widely used (Beck, Steer, & Garbin, 1988).

2.3.3. Spielberger State-Trait Anxiety Inventory-S Anxiety scale (STAI-S: Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983)

The STAI-S consists of 20 items and is a self-report inventory for current anxiety symptoms. It is a commonly used outcome measure in treatment studies and has been found to be highly reliable and valid (Metzger, 1976).

2.4. Therapist training

Two therapists, one psychiatrist G.L. and one psychologist Å.T.H., conducted the initial group ERP. They had limited clinical experience in treating OCD and had treated 2–4 patients each prior to conducting the group ERP treatment. Before providing the group treatment in the study, they attended a course focusing on ERP for OCD. The course lasted for six months and consisted of two days of training in OCD diagnosis and treatment, five supervised group sessions of two and a half hours each, and, finally, a one-day seminar. In addition, they had a five-day training course on the OCD group manual by the manual developer

[1] REC number; 2013/ 1210 sør-øst.