



The impact of symptom dimensions on outcome for exposure and ritual prevention therapy in obsessive-compulsive disorder



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ABSTRACT

Objective: Obsessive-compulsive disorder (OCD) is a severe condition with varied symptom presentations. The behavioral treatment with the most empirical support is exposure and ritual prevention (EX/RP). This study examined the impact of symptom dimensions on EX/RP outcomes in OCD patients.

Method: The Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) was used to determine primary symptoms for each participant. An exploratory factor analysis (EFA) of 238 patients identified five dimensions: contamination/cleaning, doubts about harm/checking, hoarding, symmetry/ordering, and unacceptable/taboo thoughts (including religious/moral and somatic obsessions among others). A linear regression was conducted on those who had received EX/RP ($n = 87$) to examine whether scores on the five symptom dimensions predicted post-treatment Y-BOCS scores, accounting for pre-treatment Y-BOCS scores.

Results: The average reduction in Y-BOCS score was 43.0%, however the regression indicated that unacceptable/taboo thoughts ($\beta = .27, p = .02$) and hoarding dimensions ($\beta = .23, p = .04$) were associated with significantly poorer EX/RP treatment outcomes. Specifically, patients endorsing religious/moral obsessions, somatic concerns, and hoarding obsessions showed significantly smaller reductions in Y-BOCS severity scores.

Conclusions: EX/RP was effective for all symptom dimensions, however it was less effective for unacceptable/taboo thoughts and hoarding than for other dimensions. Clinical implications and directions for research are discussed.

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1. Introduction

Obsessive-compulsive disorder (OCD) is a severe disorder involving distressing, intrusive obsessions and repetitive compulsions. Lifetime prevalence rates are estimated at 1.6–2.3% with nearly two-thirds of those afflicted reporting severe role impairment (Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Ruscio, Stein, Chiu, & Kessler, 2010). Cognitive behavioral therapy (CBT) consisting of exposure and ritual prevention (EX/RP) is the

psychotherapeutic treatment of choice because of its efficacy and high empirical support (Foa et al., 2005; Frances, Docherty, & Kahn, 1997; Greist et al., 2003; Koran, Hanna, Hollander, Nestadt, & Simpson, 2007; NICE, 2005; Simpson et al., 2008). However, due to the wide range of varied symptom profiles, it is not clear if EX/RP is equally effective for all types of OCD symptoms (i.e., different symptom dimensions or profiles; Williams, Mugno, Franklin, & Faber, 2013).

OCD symptom dimensions have often been identified based on factor analytic studies of the Yale-Brown Obsessive-Compulsive Scale checklist (Y-BOCS; Goodman et al., 1989), using either the symptom categories (e.g., Abramowitz, Franklin, Schwartz, & Furr, 2003; Baer, 1994; Leckman et al., 1997; Williams et al., 2011) or individual items (e.g., Feinstein, Fallon, Petkova, & Liebowitz, 2003; Pinto et al., 2008). Similar results have been found with both approaches, and recent studies have generally yielded five symptom dimensions: contamination/cleaning, symmetry/ordering, doubts about harm/checking, hoarding, and

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unacceptable/taboo thoughts, which has been linked to reassurance, mental rituals, and somatic concerns (Pinto et al., 2008; Williams et al., 2011), although some studies have found variations in this pattern (e.g., Katerberg et al., 2010; Whittal, McLean, Woody, Rachman, & Robichaud, 2010).

Data suggest these symptom dimensions are associated with differential response to EX/RP treatment (e.g., Leckman et al., 2010), but findings vary due to methodological differences and other factors. For example, although patients with contamination/cleaning or doubts about harm/checking symptoms appear to respond well to EX/RP (De Araujo, Ito, Marks, & Deale, 1995; Foa & Goldstein, 1978; Foa, Kozak, Steketee, & McCarthy, 1992), one study of group treatment for OCD found those high on the dimension of contamination/cleaning were more resistant to treatment (McLean et al., 2001), possibly due to disgust as a factor in obsessional distress (Feinstein et al., 2003; McKay, 2006). In contrast, Abramowitz, Foa, and Franklin found that the symmetry/ordering dimension predicted a poorer response to EX/RP than other dimensions. Other studies have found that unacceptable/taboo thoughts (i.e., sexual, aggressive, and religious concerns) take longer to treat, possibly due to more obsessions and fewer observable compulsions and more mental rituals (Alonso et al., 2010; Grant et al., 2006; Rufer, Fricke, Moritz, Kloss, & Hand, 2006; Williams et al., 2011). Finally, hoarding symptoms seem to be the most resistant to CBT treatment for OCD (Abramowitz, Franklin, et al., 2003; Mataix-Cols, Marks, Greist, Kobak, & Baer, 2002; Rufer et al., 2006; Saxena et al., 2002).

It is difficult to arrive at clear conclusions regarding the effectiveness of EX/RP for different symptom dimensions because prior studies have each had limitations that may contribute to divergent findings. Such limitations include: small sample size (e.g., Alonso et al., 2010), inclusion of only some symptom dimensions in the analyses (e.g., De Araujo et al., 1995; Grant et al., 2006; Saxena et al., 2002), data from open treatment outpatient records (e.g., Abramowitz, Franklin, et al., 2003; Storch et al., 2008), alternative format for EX/RP (e.g., McLean et al., 2001; Mataix-Cols et al., 2002), and/or treatment included additional psychosocial interventions (e.g., Rufer et al., 2006; Saxena et al., 2002).

To address this gap in the literature, we combined samples from two previous randomized controlled trials of EX/RP to examine treatment outcomes by OCD symptom dimension in a well-characterized sample. In these studies, EX/RP treatment was conducted in a standardized manner across both samples, and the assessment of outcome was conducted by trained evaluators who were blind to whether or not the patient was receiving EX/RP. Findings related to the phenomenology of OCD symptom dimensions in this combined sample were reported previously (Williams et al., 2011), and we now aim to extend this project by examining a subset of those participants who received EX/RP ($n = 87$).

Given that patients with cleaning and checking compulsions have been consistently well-represented in research and clinical practice (Williams, Mugno, et al., 2013), our hypothesis was that these two dimensions (i.e., contamination/cleaning and doubts about harm/checking) would predict the best response to EX/RP, whereas the hoarding dimension would predict the poorest EX/RP outcomes (e.g., Abramowitz, Franklin, et al., 2003; Rufer et al., 2006; Saxena et al., 2002).

2. Methods

2.1. Participants

Data from two OCD treatment outcomes studies were pooled ($n = 238$). Both studies recruited adults ages 18–65 with a primary diagnosis of OCD. Briefly, the first study investigated the efficacy of EX/RP, clomipramine (or placebo), and their combination; the

second study compared the efficacy of adding CBT (EX/RP or Stress Management Training) to serotonin reuptake inhibitor (SRI) medication. All participants received informed consent, and both these studies were approved by their respective institutional review boards (IRBs). Full study descriptions are available elsewhere (Foa et al., 2005; Simpson et al., 2008). Participants of interest were those randomly assigned to receive EX/RP as a part of treatment ($n = 117$). From this sample, 30 participants were not included in the treatment outcome analyses because of missing Y-BOCS pre- or post-treatment data, leaving a final sample of 87 adults (61.0% male; $M_{age} = 36.4$, $SD = 12.3$; 83.3% non-Hispanic White).

2.2. Measures

All participants were administered a battery of assessments before and after treatment by a trained independent evaluator who was blinded to treatment condition.

The Y-BOCS (Goodman et al., 1989) is considered a gold-standard, clinician-administered measure that consists of a symptom checklist and severity scale. The symptom checklist consists of more than 60 specific symptoms (“symptom items”) that are grouped into discrete clusters of obsessions or compulsions (“symptom categories,” $n = 17$). The version of the Y-BOCS checklist used in this study included 5 additional items that expanded upon the original item about mental compulsions (Foa et al., 1995); this expanded version has been widely used to ensure that mental compulsions are adequately captured (e.g., Foa et al., 2005; Simpson et al., 2008, 2013; Williams, Elstein, et al., 2012). Each checklist item is rated as having never been a problem, occurring in the past, or currently presenting (past week). The three most interfering, or distressing obsessions and compulsions are then identified and ranked as “target symptoms.”

The 10-item severity scale is divided into an obsessions subscale and a compulsions subscale (5 questions each). Each question is scored on a 0–4 scale, with total scores ranging from 0 (*non-clinical*) to 40 (*extreme*). Scores greater than or equal to 16 were required for study entry, which indicates clinically significant OCD symptoms. The Y-BOCS severity scale has excellent psychometric properties, including reliability and construct validity (Goodman & Price, 1992; Goodman et al., 1989; Williams, Wetterneck, Thibodeau, & Duque, 2013; Woody, Steketee, & Chambless, 1995).

2.3. Treatment

All participants in the current sample completed EX/RP as part of their treatment through the randomized trial. The majority (79.5%) were also receiving an SRI. Specifically, 19 of 36 participants from the first study were receiving clomipramine that was started at the same time as the EX/RP treatment; the remaining 17 received EX/RP alone. All 47 participants from the second study were taking an SRI (clomipramine, fluoxetine, paroxetine, sertraline, fluvoxamine, citalopram, or escitalopram) for at least 12 weeks at a stable dose prior to starting EX/RP treatment.

Outpatient EX/RP treatment was conducted each weekday over a 4-week period in the first study and twice-weekly over an 8-week period in the second study. Previous research has shown that these two scheduling strategies produce similar results, and therefore the outcome data were collapsed across studies. Treatment consisted of two information-gathering sessions, followed by fifteen 90-min exposure sessions, which includes imaginal and in vivo exercises. Details of the EX/RP treatment procedure are described elsewhere (Kozak & Foa, 1997; Foa, Yadin, & Lichner, 2012).

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