



Evaluation of cognitive behaviour therapy for paediatric obsessive-compulsive disorder in the context of tic disorders



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ABSTRACT

Background and objectives: Paediatric obsessive-compulsive disorder (OCD) and tic disorders (TD) often present together. However, there has been relatively little research on whether comorbid tic disorders influence response to cognitive behaviour therapy (CBT) for OCD. This study aimed to examine the outcomes of CBT for paediatric patients with OCD and a tic disorder compared to a matched group of children with OCD and no tics. Outcomes were compared post-treatment and at 3 or 6 month follow-up.

Methods: Participants were 29 young people with tic disorders and OCD (OCD + TD) and 29 young people with OCD without tic disorders (OCD-TD) who were matched according to age, gender and baseline OCD symptom severity. All participants received a course of CBT and outcomes were assessed using the Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS).

Results: OCD symptoms reduced over the course of CBT to an equivalent extent in the OCD + TD and OCD-TD groups. Response or remission rates did not differ significantly at either post-intervention or follow-up between those with OCD + TD and those with OCD-TD. For both groups, response rates were high - 72% of both groups were classified as responders post-intervention and, at follow-up, 81% of the OCD + TD group and 82% of the OCD no tics group responded. Those with OCD + TD responded in significantly fewer sessions than those with OCD without tics.

Limitations: A number of potential confounding factors were not assessed and therefore could not be controlled for, such as other comorbidities and stability of medication.

Conclusions: Paediatric patients with OCD and tic disorders respond equally well to standard CBT for OCD as compared to those with OCD and no tics.

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1. Introduction

1.1. Comorbidity

There has been considerable interest over the last 20 years in the causes and maintaining mechanisms of obsessive-compulsive disorder (OCD) and its association with other psychiatric disorders. There is an emerging consensus in the clinical literature that there are a range of genetic and environmental risk factors for OCD,

which may be shared with other disorders (Pauls, Abramovitch, Rauch, & Geller, 2014) and estimates suggest that over 50% of children with OCD also meet criteria for other psychiatric disorders (Geller et al., 2003). These include other anxiety disorders (55%; Franklin et al., 2011), attention deficit hyperactivity disorder (18%; Geller et al., 2003) and tic disorders (TD), including Tourette syndrome. Estimates of the prevalence of TD amongst OCD populations vary, with figures of between 9 and 59% reported in the literature (Stewart et al., 2004). Similarly, OCD is over-represented amongst children with TD, with estimates suggesting over 50% of children with TD also meet criteria for OCD (Lebowitz et al., 2012). This relationship has been well established in both the adult and child clinical literature and has recently been recognised in diagnostic classification systems, with the addition of a "tic-related" specifier to the obsessive compulsive disorders in the Diagnostic and

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Statistical Manual of Mental Disorders, 5th Edition (American Psychiatric Association, 2013).

1.2. Clinical features & phenomenology

In recent years the clinical research literature has highlighted differences in the phenotypic expression of OCD in adults with no tic history compared to those with comorbid tic disorders (OCD + TD). It is now well established that there is a greater proportion of males and earlier OCD symptom onset amongst those with a comorbid tic disorder compared to those without tics (Leckman et al., 1994). Adults with OCD + TD typically endorse higher rates of violent and sexual thoughts and imagery, counting rituals, hoarding, intrusive sounds and tic-like compulsions (Cath et al., 2001; Diniz et al., 2006). Furthermore, OCD + TD individuals are more likely to meet criteria for a range of other comorbid conditions, including other anxiety disorders, attention deficit hyperactivity disorder, trichotillomania and body dysmorphic disorder (Diniz et al., 2006).

Such questions have received far less research attention in the paediatric literature and findings are inconsistent. As in adults, some studies find a higher proportion of males with OCD + TD in comparison to OCD alone (e.g. Storch et al., 2008; Zohar et al., 1997), although some find no gender differences (Conelea et al., 2014; Hanna et al., 2002; Scahill et al., 2003). Scahill et al. (2003) found a trend towards greater levels of externalising symptoms and significantly greater levels of attention problems in those with OCD + TD. Similarly Lewin, Chang, McCracken, McQueen and Piacentini (2010) found higher rates of Oppositional Defiant Disorder and ADHD in those with OCD + TD compared to OCD alone, although no group differences in overall rates of comorbidities. Conelea et al. (2014) also found no group differences in comorbidity rates.

Most studies find no difference in overall OCD severity in those with and without TD (Conelea et al., 2014; Hanna et al., 2002; Storch et al., 2008; Zohar et al., 1997). Some studies report fewer of some types of obsessions in OCD + TD groups compared to OCD alone (overall – Lewin et al., 2010; contamination and sexual obsessions – Storch et al., 2008; religious – Conelea et al., 2014); whereas some find more (e.g. aggressive and sexual images; Zohar et al., 1997) and others find no differences (Hanna et al., 2002). Young people with OCD + TD may also be less likely to be able to identify triggers for obsessions (Leckman et al., 1994). Some studies find more compulsions in the comorbid TD groups (e.g. washing and ordering – Conelea et al., 2014; repetitive routine behaviours, ordering and arranging, unrelated to harm avoidance; Scahill et al., 2003; counting – Storch, 2008; harm-avoidance – Zohar et al., 1997) whereas others find fewer (ordering, hoarding, washing – Hanna et al., 2002; contamination, washing, reassurance seeking – Scahill et al., 2003).

1.3. Evidence for treatment of OCD

The typical natural course of tics is to peak in late childhood and enter remission during adolescence (Leckman, 2003). In contrast, OCD symptoms continue to increase in adolescence, typically peaking 2 years after the greatest severity of tics (Kichuk et al., 2013). Furthermore, OCD related difficulties are more likely to persist into adulthood (Bloch et al., 2006). Given this relationship, prioritising early treatment of OCD is particularly important in those with OCD + TD as it may prevent persistence to adulthood.

There has been a significant amount of research on the effectiveness of treatments for OCD in young people. Two treatments have been shown to be efficacious, namely cognitive behaviour therapy (CBT) incorporating exposure and response prevention

(ERP) and serotonin re-uptake inhibitor/selective serotonin re-uptake inhibitors (SRI/SSRI) medications. Two meta-analyses (Abramowitz, Whiteside, & Deacon, 2006; Watson & Rees, 2008) have demonstrated that CBT/ERP demonstrates significantly improved outcomes over pharmacotherapy, which is itself more effective than placebo. Meanwhile, other studies (Pediatric OCD Treatment Study, 2004) suggest that combined treatment modalities offer the best overall treatment response. CBT is often recommended as a first line treatment for paediatric OCD (e.g. National Institute for Clinical Excellence, 2005).

1.4. Treatment of OCD in the presence of tic disorders

Whilst there is good evidence supporting the treatment of childhood OCD, the degree to which these treatments are effective for OCD + TD groups is less clear. Whilst individuals with TD are often included in randomised controlled trials (RCTs) examining the effectiveness of CBT for paediatric OCD, their small number commonly precludes examination of any differences in their response to treatment, or differences in the treatment received. It has been suggested that young people with OCD + TD may require longer or more sessions of ERP to increase practice due to elevated 'just right' compulsions, or more home-based practice if obsessions cannot be elicited in the therapy room due to an inability to identify specific triggers (Mansueto & Keuler, 2005).

Given the high rates of comorbidity between OCD and TD, there is a relative paucity of studies examining the effectiveness of first line treatments in the OCD + TD population. A review of the literature identified only six studies examining possible moderating effects of a TD on OCD treatment (Ginsburg, Kingery, Drake, & Grados, 2008). Of these six studies, three focussed on medication, two on CBT and one a combination study. Amongst the medication studies the results were somewhat mixed, but overall suggest that comorbid tic disorders were associated with poorer SSRI treatment response. In contrast, neither of the two CBT studies found any impact of a tic disorder on the effectiveness of either individual ($n = 14$ with comorbid TD; Piacentini, Bergman, Jacobs, McCracken, & Kretschman, 2002) or group OCD treatment ($n = 8$ with comorbid TD; Himle, Fischer, Van Etten, Janeck, & Hanna, 2003). Interestingly, the final study ($n = 17$ with comorbid TD: CBT $n = 3$, CBT + medication $n = 4$, placebo $n = 5$, medication $n = 5$; March et al., 2007) examined the effectiveness of both medication and CBT on OCD treatment amongst children with OCD + TD. These results demonstrated that sertraline use was equivalent to placebo amongst individuals with comorbid tic disorders, but CBT remained effective irrespective of the presence of tics. More recently, Conelea et al. (2014) in the US similarly examined the treatment outcome of CBT for OCD alongside medication (SRI) in 124 children ($n = 66$ with comorbid tics: medication management $n = 25$, medication management plus instructions in CBT $n = 20$, medication management + CBT $n = 21$). The study found no differences in OCD severity, impairment or comorbidity, nor in treatment outcome, in the group of children with tics compared to children without. No CBT studies explicitly mention modification to the CBT intervention to account for the presence of tics and the CBT delivered was the same as that delivered to young people without comorbid tics.

Of note, the aforementioned studies are restricted by small sample sizes and they may therefore have been underpowered to detect possible effects of comorbid TD on response to CBT for OCD. They are also limited by site differences (Conelea et al., 2014; March et al., 2007). Furthermore, previous studies included different formats of intervention, including both individual and group CBT protocols, with and without medication, making comparisons between studies difficult. Finally, none of the studies focus on UK

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