



The effect of adding Coping Power Program-Sweden to Parent Management Training-effects and moderators in a randomized controlled trial



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ABSTRACT

For children with oppositional defiant disorder (ODD), Parent Management Training (PMT) is a recommended treatment in addition to child Cognitive Behavioral Therapy (child-CBT). There is however a lack of studies investigating the additive effect of group-based child-CBT to PMT for children between 8 and 12 years. The current study investigated the incremental effect of group-based child-CBT, based on the Coping Power Program, when added to the Swedish group-based PMT program KOMET. Outcomes were child behavior problems, child prosocial behavior, parenting skills and the moderating effect of child characteristics. One hundred and twenty children 8–12 years with ODD or Disruptive Behavioral Disorder NOS and their parents were randomized either to combined child-CBT and PMT ($n = 63$) or to PMT only ($n = 57$) in Swedish Child- and Adolescent Psychiatric settings. Participants were assessed pre- and post-treatment using semi-structured interviews and child- and parent ratings. After treatment, behavior problems were reduced in both groups. Prosocial behavior were significantly more improved in the combined treatment. Parenting skills were improved in both groups. In moderator analyses, behavior problems and prosocial behavior improved significantly more in the combined treatment compared to PMT only in the group of children with high levels of ODD symptoms.

1. Introduction

Effective treatments for children with oppositional defiant disorder (ODD¹) Diagnostic and Statistical Manual of Mental Disorders, DSM-5, (American Psychiatric Association, APA 2013) are important to halt a development into more severe disorders such as conduct disorder (CD) or antisocial personality disorder (APA, 2013) during adolescence and early adulthood. Children at high risk for antisocial development constitute a subgroup where treatment success is especially needed. Research indicates that a larger number of risk factors is related to a higher likelihood that a child with conduct problems will continue exhibiting antisocial behaviors in adolescence and adulthood (e.g. Burke, Loeber, & Birmaher, 2002). There is not a single risk factor that leads to the development of antisocial development, but rather combinations and interactions of individual characteristics, family relations and stressors and environmental factors (Dodge & Pettit, 2003; Loeber & Farrington, 1998). Example of risk factors are genetics, child temperament, behavior impulsivity/inhibition difficulties, low verbal

intelligence, deficiencies in social cognition, parenting strategies, deviant peers as well as low SES and disadvantaged neighborhoods (Burke et al., 2002). A common comorbid diagnosis among children with ODD is Attention Deficit Hyperactivity Disorder (ADHD). About 50% of children with ADHD also fulfill an ODD diagnosis (Loeber, Burke, & Pardini, 2009). Children with co-occurring ADHD and ODD/CD have a more severe prognosis than children with only ADHD or only ODD/CD (Angold, Costello, & Erkanli, 1999).

Treatments are not only important for reducing risk for severe future antisocial behavior, but also to reduce individual suffering and societal costs associated with an antisocial development (Christenson, Crane, Malloy, & Parker, 2016). Numerous studies have shown that Parent Management Training (PMT) is an effective treatment for ODD and CD in reducing child behavior problems (e.g. Furlong et al., 2013). While PMT targets many of the risk factors involved in antisocial development such as authoritarian or passive parenting, coercive patterns between parent and child, and parental stress, there are some risk factors, in particular related to the child, that remain untreated.

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¹ Abbreviations: ODD = Oppositional defiant disorder; DBD NOS = Disruptive behavior disorder not otherwise specified; CD = Conduct disorder; ADHD = Attention deficit hyperactivity disorder; PMT = Parent Management Training; child CBT = child focused Cognitive behavior therapy.

Examples of these are child tendency to attribute hostile intentions to others, inadequate problem-solving skills and inability to handle anger due to affect regulatory deficiencies. These risk factors may be targeted in child Cognitive Behavior Therapy (child-CBT) where children are trained in affect regulation, perspective taking, problem-solving strategies, prosocial behavior and in handling peer pressure (Kazdin, Esveldt-Dawson, French, & Unis, 1987; Lochman & Wells, 2002a,b). Meta analyses suggest that studies combining PMT and child-CBT show larger effect sizes than studies with PMT only (Fossum, Handegard, Adolfsen, Vis, & Wynn, 2016; McCart, Priester, Davies, & Azen, 2006). However, several of these meta analyses compare treatment effects of PMT or PMT in combination with child CBT to an untreated control only (e. g Furlong et al., 2013; Michelson, Davenport, Dretzke, Barlow, & Day, 2013) or compares the effect of child CBT and PMT together with other parent directed psycho-social treatments (e.g. Fossum et al., 2016) or includes other conditions such as ADHD (e.g. Battagliese et al., 2015), which makes it harder to know whether PMT only is better than combining PMT with another intervention for children with disruptive behavior. A few studies have directly, within the same study, compared whether a combination of child-CBT and PMT improves treatment effects and compared this to PMT. Webster-Stratton and colleagues (1997) as well as and Drugli, Larsson, and Clifford (2007) have evaluated the Incredible Years for young children (4–8 year old) in USA and Norway respectively. Both studies showed increased post-treatment effects in child social problem-solving and conflict management skills when child-CBT was added to PMT and compared to PMT only. Behavior problems were reduced in both treatment groups but no significant difference was seen between the two conditions. In the one-year follow-up, however, behavior problems decreased significantly in the PMT and child CBT condition compared to the PMT only condition in the US study while this was not found in the Norwegian study (Larsson et al., 2009). Studies examining the additive effect of child-CBT to PMT for older children aged 8–12 years with behavioral problems are scarcer. When individually delivered child-CBT and PMT for children 8–12 years of age has been compared to individual PMT, the combined treatment was more successful in improving behavior problems, reducing parental stress and depression and increasing child prosocial behavior than PMT or child CBT alone at one year follow up (Kazdin, Siegel, Bass, 1992).

The Coping Power Program is a group-delivered CBT-program for children 8–12 years, which has been investigated within the school setting, both as stand-alone intervention and in combination with PMT (Lochman & Wells, 2002a,b). The results showed that the combination of child-CBT and PMT yielded larger effects in terms of reduced covert delinquency and improved teacher-rated behavioral outcomes compared to child-CBT only (Lochman & Wells, 2004). The Coping Power Program child component in addition to PMT has also been evaluated in child and adolescent psychiatric settings, where it was compared to treatment as usual (van de Wiel et al., 2007). The Coping Power Program showed medium to large between-group effect-sizes on reduction of behavior problems when compared to family therapy, but only small between-group effect-sizes when compared to behavioral therapy. In summary, there is as far as we are aware, limited knowledge of the effects of the combination of group-delivered child-CBT and PMT when compared to group delivered PMT only, for children 8–12 years with clinical levels of behavior problems.

Knowledge about how child and/or family characteristics might influence treatment outcome is essential for good treatment planning in clinical practices. A clinician needs to know for which client a certain intervention may be more effective. In the context of PMT, it is important to know for which families that PMT only is effective and when the addition of child-CBT to PMT yields more effective outcomes. Numerous studies have investigated predictors and moderators for PMT. For instance, two meta analyses showed that maternal mental health, such as depression and stress, and low family income predicted lower treatment effects (Lundahl, Risser, & Lovejoy, 2006; Reyno &

McGrath, 2006).

There are few studies evaluating moderators of treatment effects for the combination of child-CBT and PMT compared to PMT only. Severity of child behavior problems before treatment has been associated with a smaller treatment effect in PMT in some meta-analyses (Reyno & McGrath, 2006), other studies have shown that PMT was more effective for children with a clinical level of problem behavior compared to a sub clinical level (Deković et al., 2011). A high number of ODD symptoms has been associated with increasingly poor functioning in relationships with peers, partners and parents in adult life (Burke, Rowe, & Boylan, 2014). Further, children with Callous/Unemotional traits (CU Traits), i.e., lack of empathy, deficient guilt/remorse, and shallow affect, constitute a more severe subgroup of children with conduct problems (Hawes, Dadds, Brennan, Rhodes, & Cauchi, 2013; Kahn, Byrd, & Pardini, 2013). A recent meta-analysis concluded that it is difficult to draw firm conclusions about treatment effects for children with high CU traits due to the mixed results (Wilkinson, Waller, & Viding, 2016). In some of the studies, CU traits predicted a negative treatment response while others did not show this prediction. Some studies has shown a reduction in both CU traits and antisocial behavior after participating in different types of interventions, such as PMT, child-CBT and multi-systemic treatments, but that these children begin with a poorer pre-morbid functioning, which might explain the earlier described reduced treatment effects for children with CU traits. There is a need to further investigate treatment outcomes for this group, especially within a larger-sample RTC-design and long-term follow-up (Wilkinson et al., 2016).

The overall aim of the present study was to investigate to what extent child-CBT in combination with PMT has an additive effect in reducing child behavior problems and increasing prosocial behavior, as well as improving parenting behaviors, when compared to PMT only for children aged 8–12 years with behavior problems, examined in a randomized controlled trial conducted in child- and adolescent psychiatry outpatient clinics.

Three specific questions were formulated:

1. How effective is the combination of group based PMT and child-CBT in a Swedish child and adolescent psychiatry setting in reducing child behavior problems and improving child prosocial, problem-solving and emotional skills, compared to PMT only?
2. How effective is the combination of PMT and child-CBT treatment in enhancing functional parental strategies, parental sense of competence and reducing parental stress as compared to PMT only?
3. How does severity of disruptive behavior, presence of CU traits, comorbid ADHD, and risk level for antisocial development moderate child behavior outcomes in child-CBT combined with PMT compared to PMT only?

We hypothesized that the combined treatment would lead to more prosocial behavior and more effective problem-solving skills, compared to the PMT only group. We expected a significant behavior problem reduction and increased parental strategies in both groups since all participants were receiving PMT.

2. Method

2.1. Trial design

The study used a randomized controlled design with pre- and post measurements, completed by parent and child. Children and their families were randomized to either (a) Parent Management Training, KOMET or (b) Parent Management Training, KOMET and child-CBT training, the Coping Power Program. The study was conducted within a child- and adolescent psychiatric outpatient setting. Baseline and post treatment data were collected through pen and paper questionnaires, interviews and assessments were conducted at the outpatient clinics as

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