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Cognitive and Behavioral Practice xx (2017) xxx-xxx

**Cognitive and
Behavioral
Practice**
www.elsevier.com/locate/cabp

Intensive Outpatient Comprehensive Behavioral Intervention for Tics: A Clinical Replication Series

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Comprehensive Behavioral Intervention for Tics (CBIT) is an efficacious behavioral treatment for Tourette's disorder. In its standard format, CBIT is completed in 8 sessions over a 10-week period. Unfortunately, significant obstacles (e.g., not having a provider nearby; inability to attend weekly sessions) prevent many individuals from participating in standard outpatient CBIT. An intensive outpatient program that compresses CBIT into a week may help overcome many of these barriers. The present clinical replication series examines treatment outcomes in 5 individuals with Tourette's disorder. Importantly, 4 out of the 5 participants reported clinically meaningful tic reductions on the Yale Global Tic Severity Scale (YGTSS) at the posttreatment assessment, with an average decrease of 11.5 points across those 4 participants. This represents a 28% decrease in the average posttreatment YGTSS score from the average baseline YGTSS score. Of the 3 participants who completed the 1-month follow-up assessment, 2 participants continued to endorse reductions in their baseline tic severity on the YGTSS and were rated as having a positive response on the Clinician Global Impressions–Improvement subscale. Clinical implications are discussed.

PERSISTENT tic disorders, such as Tourette's disorder (TD), are characterized by motor and/or vocal tics that occur regularly and persist for at least a year (American Psychiatric Association, 2013). Tics often occur in bouts and can wax and wane over the periods of hours, days, weeks, or months. While clinical presentation varies greatly, persistent tic disorders are generally associated with increased functional impairment, interpersonal distress, and lower quality of life (Conelea et al., 2011; Conelea et al., 2013; McGuire, Hanks, Lewin, Storch, & Murphy, 2013; Specht et al., 2011; Zinner, Conelea, Glew, Woods, & Budman, 2012). Moreover, there are high comorbidity rates between persistent tics and psychological disorders, including attention-deficit/hyperactivity disorder (ADHD), obsessive-compulsive disorder (OCD), anxiety, depression, and disruptive behaviors (Hirschtritt et al., 2015; Rizzo, Gulisano, Cali, & Curatolo, 2012). Given the potential disruption and distress caused by persistent tics, the need for safe, effective, and accessible treatment is clear.

Pharmacotherapy is the most common intervention for treating persistent tic disorders in children and adults (Woods, Conelea, & Himle, 2010). However, due to

concerns about serious side effects and potential long-term consequences of prolonged use, medications are often only prescribed when tics are causing physical pain or impairment and are frequently discontinued by patients (Peterson & Azrin, 1993; Peterson, Campise, & Azrin, 1994; Scahill et al., 2006). In light of these concerns, behavioral therapies have been developed to promote tic management skills (for review, see Peterson, 2007). Habit reversal training (HRT) is the behavioral approach with the most empirical support (for review, see Verdellen, Griendt, Hartmann, & Murphy, 2011). HRT is a multi-component behavioral treatment that incorporates awareness training for tics and their corresponding premonitory urges, contingency management, social support, relaxation training, and competing response training (Azrin & Nunn, 1973). HRT provides the foundation for Comprehensive Behavioral Intervention for Tics (CBIT; Woods et al., 2008), a time-limited behavioral therapy that also includes functional assessments and function-based interventions. Two multisite randomized clinical trials have demonstrated the efficacy of CBIT for children (Piacentini et al., 2010) and adults (Wilhelm et al., 2012). These studies found CBIT to be superior to supportive counseling in reducing tics. More specifically, 52% of children and 38.1% of adults in the CBIT condition were rated as *very much improved* or *much improved* on the Clinician Global Impressions–Improvement (CGI-I) scale at posttreatment compared to 18.5%

Keywords: CBIT; Tourette's disorder; tics; intensive outpatient

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of children and 6.4% of adults in the supportive counseling condition. In both studies, participants who received CBIT maintained their treatment gains and reported decreased psychological symptoms at the 6-month follow-up. Taken together, these studies indicate that CBIT is a safe and effective therapy that can produce benefits that surpass the period of active treatment. CBIT is now recommended in clinical practice guidelines as a first-line treatment for persistent tic disorders in the United States, Canada, and Europe (Murphy, Lewin, Storch, & Stock, 2013; Steeves et al., 2012; Verdellen et al., 2011).

Unfortunately, despite its demonstrated efficacy, utilization rates for CBIT remain low. For example, Woods et al. (2010) studied treatment utilization rates for children ($N = 740$ parents) and adults ($N = 672$) with chronic tics and found that while two thirds of their respondents had received treatment for their tics, less than 7% had received HRT or CBIT. In comparison, 93% of adults and 83% of children have used medications to help manage their tics. Participants who had sought any tic-related treatment were asked to identify treatment barriers they had encountered. Not having a specialist nearby to provide treatment for tics was reported by 33% of parents and 17% of adults. Likewise, over 40% of parents and 30% of adults had difficulties finding a treatment provider who understood tics. When treatment-seeking participants were asked the reasons they have not received *behavioral* therapy, almost 30% of parents and 20% of adults reported that they did not know where to go to receive this type of care. Other obstacles that interfered with seeking behavioral treatments included not having a provider nearby, difficulty traveling the distance needed to obtain services, and/or not having the time to attend weekly therapy sessions.

The standard CBIT protocol includes eight treatment sessions over a 10-week period. This format markedly decreases the feasibility of treatment for patients who have to travel considerable distances to receive care. For these individuals, attending weekly 60-minute sessions for 2 months may increase the logistical difficulties and the indirect costs associated with receiving behavioral therapy for their tics (i.e., travel expenses for eight trips). The standard outpatient CBIT protocol may also contribute to greater academic or occupational disruptions than alternative treatment formats (e.g., missing 8 days of work). Compressing the standard outpatient CBIT protocol into a 4-day intensive outpatient program (IOP) may help overcome many of these barriers. If associated with positive outcomes, IOP CBIT could extend treatment catchment areas to include individuals for whom specialty services would otherwise be geographically inaccessible (Blount, Lockhart, Garcia, Raj, & Peterson, 2014).

Intensive treatment formats have been adopted for other behavioral treatments such as specific phobias (Davis, Ollendick, & Öst, 2009) and obsessive-compulsive disorder (Whiteside, Brown, & Abramowitz, 2008). Additionally, treatment outcomes from clinical case studies on intensive outpatient behavioral therapies for tics are promising. For example, Flanckbaum, Rockmore, and Franklin (2011) documented significant tic reduction in a 25-year-old male following a course of intensive outpatient HRT. The patient, who met diagnostic criteria for TD on the Yale Global Tic Severity Scale (YGTSS Total Tic Score: 43/50) at baseline, completed seven sessions (60–75 minute duration) over 2 weeks. Treatment, which targeted two tics, was divided into seven phases that covered psychoeducation (Phase 1); identifying target tics (Phase 2); habit reversal (Phase 3); function-based assessment and intervention (Phase 4); relaxation (Phase 5); skill generalization and relapse prevention (Phase 6); and follow-up booster sessions (Phase 7). By the end of treatment, the patient reported a notable decrease in frequency and subjective distress for his most problematic tic. The low frequency of his second tic remained stable throughout treatment. Unfortunately, due to time constraints, he did not complete a posttreatment YGTSS.

More recently, Blount et al. (2014) published a case series that included two male youths who participated in a 4-day intensive outpatient CBIT protocol similar to that presented in this study. Addressing one of the limitations of Flanckbaum et al. (2011), both boys completed structured posttreatment and follow-up assessments. Patient A's baseline YGTSS Total Tic score decreased by 40% at posttreatment, 60% at the 1-month follow-up, and 67% at the 7-month follow-up. Patient B's posttreatment and 6-month-follow-up YGTSS Total Tic score were 30% lower than his baseline score. Overall, despite marked differences in clinical presentation, both patients experienced notable treatment gains. Building on these case studies, the present clinical replication series reports the treatment outcomes of an IOP CBIT treatment protocol in a small sample of children and adults with TD. It was hypothesized that the participants would experience a significant reduction in their tics following completion of the IOP CBIT and that treatment benefits would persist during the 1-month follow-up period.

Methods

The present study uses a pretest-posttest quasi-experimental design, also referred to as a clinical replication series, to examine treatment outcomes following participation in IOP CBIT. This study was conducted in compliance with the University of Texas Health Science Center at San Antonio's Institutional Review Board.

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