



## Concentrated exposure and response prevention for adolescents with obsessive-compulsive disorder: A replication study



Eili N. Riise<sup>a,b,\*</sup>, Gerd Kvale<sup>a,b</sup>, Lars-Göran Öst<sup>b,d,e</sup>, Solvei Harila Skjold<sup>b,c</sup>, Bjarne Hansen<sup>a,b</sup>

<sup>a</sup> Department of Clinical Psychology, University of Bergen, Norway

<sup>b</sup> Haukeland University Hospital, OCD-team, Bergen, Norway

<sup>c</sup> Øyane Outpatient Clinic for Child and Adolescent Psychiatry, Haukeland University Hospital, Bergen, Norway

<sup>d</sup> Department of Clinical Neuroscience, The Karolinska Institute, Stockholm, Sweden

<sup>e</sup> Department of Psychology, Stockholm University, Sweden

### ARTICLE INFO

#### Keywords:

Adolescents  
OCD  
ERP  
CBT  
Replication

### ABSTRACT

A previous effectiveness study (Riise et al., 2016) demonstrated promising findings from a 4-day concentrated exposure and response prevention (ERP) treatment, the Bergen 4-day treatment (B4DT), for adolescents with obsessive-compulsive disorder (OCD). The present study investigated whether the results reported in the original study were replicated in a new sample of adolescents. Forty-one referred patients aged 11–18 underwent treatment at an outpatient clinic, as part of public health care. Treatment was delivered to 2–4 patients and their parents simultaneously, during four consecutive days, followed by a three-week period of self-administered ERP. Obsessive-compulsive symptoms were assessed at pre-treatment, post-treatment, 3- and 6-month follow-up. The results demonstrated significant reductions in OCD-symptoms. Remission was achieved by 33 patients (80%) at post-treatment, and 30 (73%) at follow-up. At post-treatment or follow-up there were no significant differences between the present sample and the sample in Riise et al. (2016) on OCD-severity or on rates of response or remission. The results demonstrate that the treatment was successfully replicated in a new sample and adds further support to the efficacy of the B4DT. Findings suggest that a concentrated treatment format with prolonged sessions might be a viable option to improve treatment outcomes of ERP.

### 1. Introduction

Obsessive-compulsive disorder (OCD) is characterized by recurrent obsessions and compulsions and affects about 1–2% of children and adolescents (Canals, Hernández-Martínez, Cosi, & Voltas, 2012; Zohar, 1999). Cognitive behavioral therapy (CBT) with exposure and response prevention (ERP) is recommended as first line treatment for pediatric OCD (Geller & March, 2012). Exposure and response prevention has been found effective across various ways of delivery; in inpatient (Björgvinsson et al., 2008; Leonard et al., 2016) and outpatient settings (Pediatric OCD Treatment Study Team, 2004), delivered over the internet (Lenhard et al., 2017) and over telephone (Turner et al., 2014). It has also been found effective delivered individually, to groups and to families (Öst, Riise, Wergeland, Hansen, & Kvale, 2016).

Although ERP is documented effective, about 30% of patients do not respond to treatment (McGuire et al., 2015; Öst et al., 2016). Typically, the treatment is delivered in weekly sessions distributed over 2–3 months, which might seem both long-lasting and practically inconvenient for many patients. In the context of these challenges an

increasing number of studies have investigated whether ERP treatment can be delivered to youths within a shorter time span. A meta-analysis on brief, intensive and concentrated CBT for anxiety disorders in children found that these treatment formats yield lower attrition rates than standard CBT (Öst & Ollendick, 2017). If impairing OCD-symptoms can be treated within a shorter time frame and with less drop-out, this might be more cost-effective in the long run compared to standard ERP treatment. Evidence suggests favorable outcomes of treatment delivered over three weeks (14 daily 90-min sessions; Storch et al., 2007) and five days (two 50-min sessions a day; Whiteside et al., 2014). Furthermore, Farrell et al. (2016) found that ERP could be successfully delivered in two weekly sessions of 3.5 h followed by 4 one-hour sessions of e-therapy. The use of extended sessions facilitates therapist-assisted exposure in a number of OCD-relevant contexts (i.e. home, school, public places) which might improve the effect of treatment (Abramowitz, 1996; Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014).

In order to obtain reliable knowledge from research, replications are considered to be of critical importance. Nevertheless, replications are

\* Corresponding author at: Department of Clinical Psychology, University of Bergen, Norway.

rarely conducted in psychology (Makel, Plucker, & Hegarty, 2012). The lack of replications has been a substance for debate primarily in the area of cognitive and social psychology (Open Science Collaboration, 2015). However, recent evidence suggests low rates of replication in psychotherapy studies as well. Tajika, Ogawa, Takeshima, Hayasaka, and Furukawa (2015) investigated replication rates in highly cited psychotherapy and pharmacotherapy studies and found that more than half of the studies had not been subject to an attempt of replication. Considering the fact that clinical trials form the basis of treatment recommendations, the findings are especially worrying. Furthermore, in the field of pediatric psychology, replications might be of particular importance, since published studies tend to have small sample sizes with greater risk of sampling error (Drotar, 2010).

Our research group has previously demonstrated highly encouraging results from the Bergen Four Day Treatment (B4DT) developed by GK and BH (Havnen, Hansen, Öst, & Kvale, 2014, 2017). Riise et al. (2016) investigated the effect of the B4DT when delivered to a sample of 22 adolescents. Results revealed large effect sizes and post-treatment response and remission rates of 91% and 73%, respectively. The findings from the adult sample were replicated in a recent study (Havnen et al., 2017) and the purpose of the present study is to investigate whether the treatment effects reported in Riise et al. (2016) are replicated in a new sample of adolescents. The treatment is delivered during four consecutive days to 2–4 patients and their parents simultaneously, with a patient-therapist ratio of 1:1. The first day has a thorough psychoeducation session (3 h) followed by two whole days (6–8 h) of therapist-assisted ERP. The fourth day contains a three-hour long group session focusing on how to maintain treatment gains and a plan for future self-administered exposures is completed. Our aim is to perform a systematic replication (Barlow, Nock, & Hersen, 2009) of the original study in which disorder, treatment and setting remains the same, but therapists vary. Based on the replicated findings for adults (Havnen et al., 2017) we predict that the treatment effects of the present study will be on a par with those of the original study (Riise et al., 2016).

## 2. Method

### 2.1. Participants

The study is based on data from standard assessment procedures at a specialized child and adolescent OCD unit, at Haukeland University Hospital, Bergen, Norway, which is part of the public child and adolescent mental health care. The OCD unit is required to offer treatment to children and adolescents up to 18 years of age consecutively referred from local psychiatric outpatient clinics for children and adolescents. All patients fulfilling diagnostic OCD-criteria according to DSM-IV/DSM-5 were offered treatment, except for patients who were psychotic, suicidal or in active substance abuse. Patients who were younger than 11 years of age, hospitalized, diagnosed with mental retardation or pervasive developmental disorder were not included in the B4DT, but offered individual treatment.

During the period October 2015 to June 2017 a total of 116 patients were referred. Of these, 38 did not have OCD, 16 were offered individual weekly treatment [outside age range ( $n = 8$ ), autism ( $n = 6$ ), mental retardation ( $n = 1$ ), hospitalized ( $n = 1$ )] and 1 was referred to a psychosis unit. Sixty-one patients fulfilled diagnostic criteria and were offered B4DT. Of these, 13 patients declined any kind of treatment, 6 patients (10%) declined B4DT but accepted individual weekly CBT (did not want group treatment), and 1 patient postponed treatment. No patients declined due to the concentration of sessions. A total of 41 patients received the B4DT.

The mean age of the sample was 15.0 ( $SD = 1.8$ ; range 11–18) and 71% ( $n = 29$ ) were females. Twenty adolescents lived with both parents, 20 lived with one of their parents part or full-time and one lived in a foster family. Most of the patients were Caucasian ( $n = 38$ ).

Fourteen of the patients (34%) had moderate OCD (16–23), 25 (61%) had severe OCD (24–31), and 2 (5%) were classified with extreme OCD (32–40). The mean duration of OCD symptoms was 3.5 years ( $SD = 3.26$ ). Twenty-five patients (61%) had previously received psychological treatment, seven of which had received ERP and 18 patients had undergone other forms of psychotherapy.

Twenty-six patients (63%) had comorbid disorders; 18 patients had one comorbid disorder, 8 had two or more comorbid disorders. Comorbid disorders included depression ( $n = 13$ ), other anxiety disorders [specific phobia ( $n = 4$ ), social phobia ( $n = 4$ ), agoraphobia ( $n = 1$ ), panic disorder ( $n = 1$ ), generalized anxiety disorder ( $n = 1$ ), unspecified anxiety disorder ( $n = 1$ ), separation anxiety disorder ( $n = 1$ )], post-traumatic stress disorder ( $n = 1$ ), adjustment disorder ( $n = 1$ ), anorexia nervosa ( $n = 1$ ), unspecified eating disorder ( $n = 1$ ), Tourette's syndrome ( $n = 1$ ), Attention-Deficit/Hyperactivity Disorder ( $n = 3$ ) persistent tic disorder ( $n = 1$ ) and enuresis ( $n = 1$ ). Seven patients (17%) currently received pharmacological treatment [SSRI ( $n = 3$ ), antipsychotics ( $n = 1$ ), stimulants ( $n = 2$ ), tricyclic antidepressant ( $n = 1$ )].

## 3. Measures

### 3.1. Schedule for Affective Disorders and Schizophrenia for School-Age Children – Present and Lifetime Version (K-SADS-PL; Kaufman et al., 1997)

The K-SADS-PL is a clinician-administered semi-structured diagnostic interview which has demonstrated good psychometric properties. It has shown an interrater reliability of 98% agreement, and test-retest reliability for anxiety disorders with a kappa coefficient of 0.80. The K-SADS-PL was used for diagnostic assessment and all interviews were administered by one of the therapists at the OCD-unit. Adolescents and parents were interviewed separately. If there were disagreements between the informants regarding subjective phenomena (e.g. intrusive thoughts or mental rituals) information provided by the adolescent was weighted highest. If the discrepancies were related to observable behavior, such as overt rituals, the clinicians discussed the disagreements with the informants. Ultimately, the interviewer made a clinical judgment based on the overall information from both informants to determine diagnoses.

### 3.2. Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS; Scahill et al., 1997)

The CY-BOCS is a semi-structured clinician-administered interview used to evaluate the severity of OCD-symptoms on five dimensions (time occupied by symptoms, interference, distress, resistance and degree of control over symptom). It has a total severity score with a range of 0–40. The CY-BOCS has demonstrated good internal consistency (Cronbach's  $\alpha = 0.90$ ), test-retest reliability (intra class correlation = 0.79) (Storch et al., 2004), and inter-rater reliability (intra class correlation = 0.84) (Scahill et al., 1997). The internal consistency in the present sample was 0.83.

### 3.3. Children's Depression Inventory (CDI; Kovacs, 1992)

The CDI is a questionnaire assessing depressive symptoms. It has 27 items and each item has three statements. The participant indicates the statement that fits best with their own thoughts or feelings (e.g. I am sometimes sad / I am often sad / I am always sad) with each statement corresponding to a score of 0–2. The CDI has a total severity score of 0–54 and higher scores indicate more severe depressive symptoms. The questionnaire has acceptable test-retest reliability and internal consistency (Kovacs, 1992; Smucker, Craighead, Craighead, & Green, 1986). A high level of internal consistency was found in the present sample (Cronbach's  $\alpha = 0.90$ ).

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