



Exposure and response prevention with or without parent management training for children with obsessive-compulsive disorder complicated by disruptive behavior: A multiple-baseline across-responses design study



Denis G. Sukhodolsky^{a,*}, Bernard S. Gorman^b, Lawrence Scahill^a,
Diane Findley^a, Joseph McGuire^a

^a Yale University School of Medicine, Child Study Center, 230 S. Frontage Rd., New Haven, CT 06520, USA

^b Nassau Community College, Psychology Department, Education Drive, Garden City, NY 11530, USA

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ABSTRACT

Comorbidity with disruptive behavior disorders may have important implications for exposure-based cognitive behavioral treatments of children with OCD. Child noncompliance and parent-child conflict may interfere with performance of exposure activities and completion of therapeutic homework assignments, thus diminishing response to treatment. We investigated whether response to exposure and response prevention (ERP) can be enhanced if disruptive behavior is treated first with parent management training (PMT). A multiple-baseline across-responses design was used to investigate the effects of ERP with or without PMT in six children (age range 9–14 years) with OCD and disruptive behavior. Weekly ratings of OCD were conducted for four weeks to establish baseline. After that, children were randomly assigned to receive six weekly sessions of PMT and then twelve weekly sessions of ERP (ERP-plus-PMT condition) or to receive ERP after a six week waiting period (ERP-only condition). The outcome assessments were conducted weekly using the Child Yale-Brown Obsessive Compulsive Scale (CY-BOCS) administered by an experienced clinician, who was blind to treatment assignment. Three subjects in the ERP-plus-PMT condition evidenced a 39 percent reduction in the CY-BOCS score versus a 10 percent reduction in three subjects in the ERP-only condition. The results of our single-subject study suggest the feasibility and positive effects of combining ERP with PMT for children with OCD complicated by disruptive behavior.

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1. Introduction

Obsessive-compulsive disorder (OCD) is present in 1–4 percent of children under the age of 18 years (Costello et al., 1996; Rapoport et al., 2000) and it frequently co-occurs with other psychiatric conditions. In clinical samples, the high lifetime rates of comorbid depression, anxiety, and tic disorders have been well documented and estimated to be as high as 80, 70 and 60 percent, respectively (Flament et al., 1990; Geller, Biederman, Jones, Lefkowitz, & Griffin, 1996; Leonard et al., 1993). Clinical series have also documented the rate of co-occurrence of OCD with disruptive behavior disorders and ADHD to be from 10 to 50 percent (Geller et al., 2002; Hanna, 1995; Sukhodolsky et al., 2005). In one population-based study, 11 of 25 (44 percent) children with OCD were found to have a disruptive behavior disorder (Heyman et al., 2001). Comorbidity with

disruptive behavior disorders may contribute to functional impairment (Piacentini, Bergman, Keller, & McCracken, 2003) and have important implications for the treatment of OCD (Storch, Lewin, Geffken, Morgan, & Murphy, 2010).

To date, evidence has emerged to support the efficacy of both exposure-based cognitive-behavioral therapy and pharmacological intervention with the selective serotonin reuptake inhibitors (SSRIs) for pediatric OCD (Franklin et al., 2011; Kircanski, Peris, & Piacentini, 2011; The Pediatric OCD Treatment Study (POTS) Team, 2004). However, not all youth with OCD are willing to participate or show beneficial response to these efficacious treatments. In one study, the response rate to paroxetine in children with OCD and disruptive behavior disorder was lower than in children with OCD alone (Geller et al., 2003). The number of co-occurring externalizing symptoms was also negatively associated with treatment response across treatment conditions in the POTS study (Garcia et al., 2010). Implementation of psychosocial interventions for OCD such as exposure and response prevention (ERP) may be hindered by the child's behavioral problems and family

* Corresponding author. Tel.: +1 2037856446.

E-mail address: denis.sukhodolsky@yale.edu (D.G. Sukhodolsky).

dysfunction associated with disruptive behavior disorders (March, Franklin, Nelson, & Foa, 2001; Scahill, Vitulano, Brenner, Lynch, & King, 1996; Storch et al., 2008). For example, child noncompliance and parent–child conflict may interfere with participation in treatment, performance of the in-session activities, and completion of homework assignments. Several studies evaluated the effects of child-focused behavior therapy for OCD where parents also receive psychoeducation and training in the administration of home-based ERP (Barrett, Healy-Farrell, & March, 2004; Piacentini et al., 2011). However, to our knowledge, there were no systematic evaluations of ERP and treatments specifically targeting noncompliance in children with both OCD and disruptive behavior disorders.

We reasoned that parent management training (PMT) may be a useful approach for children with OCD and co-occurring disruptive behavior. PMT is among one of the best-studied interventions for children with disruptive behavior disorders varying in age from preschool to early adolescence (Drugli, Larsson, Fossum, & Mørch, 2010; Eyberg, Nelson, & Boggs, 2008; Kazdin, 2005). It has been also evaluated for reducing noncompliance and behavioral problems in children with neuropsychiatric disorders such as Tourette syndrome (Scahill et al., 2006) and autism (Aman et al., 2009). PMT is rooted in a considerable body of research indicating that disruptive behavior in children may be maintained by maladaptive parent–child interaction (Patterson, 1982). For example, to avoid conflict with their children, parents may fail to limit unacceptable behavior. At other times, the application of parental authority may be overly harsh, which may promote anger and defiance in the child. Perhaps because of an accumulation of tension and hostility, parents may fail to acknowledge positive behavior in some situations. In PMT, parents are taught specific methods of behavior modification such as providing contingent positive reinforcement and setting clear expectations and limits, aimed at reducing the child's noncompliance and promoting positive behavior.

The primary aim of this study was to examine the effects of a 12-session ERP intervention augmented by a 6-session parent management training (PMT) in children with OCD and disruptive behavior. It was hypothesized that children who receive PMT before ERP will show faster rates of reduction in obsessive compulsive symptoms and lower levels of symptom severity at the end of the treatment than children who receive ERP-only. The secondary aim was to explore the effects of PMT on irritable and oppositional behavior in children with OCD with comorbid disruptive behavior disorder.

2. Methods

2.1. Participants

Participants were recruited from the OCD Specialty Clinic at the Yale University Child Study Center. Boys and girls between the ages of 8 and 14 years were eligible for the study (PMT has been best studied in this age group). Other inclusion criteria were a principal DSM-IV diagnosis of OCD, a CY-BOCS score > 16 (clinically significant range), a secondary DSM-IV diagnosis of oppositional defiant or conduct disorder, and a score of at least 12 (1.5 standard deviation units above the age norms) on the Disruptive Behavior Rating Scale. Children on currently stable medication for OCD or allowed psychiatric disorders were able to participate in the study. Co-occurring attention-deficit/hyperactivity disorder, other anxiety disorders or depressive disorders were allowed unless the disorder required immediate treatment or change in current treatment. Stable medication was defined as no new medication or medication discontinuation for six weeks prior to randomization; no dose increases of ongoing medication for three

weeks prior to randomization; and no planned changes in medication for the duration of the study. The study was approved by the Yale School of Medicine institutional review board. All children provided assent and parents provided consent prior to randomization. Families were paid \$20 for each assessment or treatment visit.

2.2. Design

The study used a *multiple-baseline design* across responses to investigate the effects of ERP with or without PMT in children with OCD and disruptive behavior. The two categories of responses of interest were severity of OCD symptoms and disruptive behavior. Weekly ratings of OCD symptom severity were collected for four weeks to confirm a stable baseline level of OCD symptoms. After that, children were randomly assigned to receive six weekly sessions of PMT and then twelve weekly sessions of ERP (PMT-plus-ERP condition) or to continue for six weeks of waiting while receiving weekly assessments and then twelve sessions of ERP (ERP-only condition). The outcome assessments were conducted weekly using the CY-BOCS administered by an independent evaluator and the Disruptive Behavior Rating Scale (DBRS) completed by the parents.

2.3. Diagnostic assessment procedures

DSM-IV diagnoses were established based on a comprehensive evaluation by an experienced clinician which included a semi-structured psychiatric interview, the *Schedule for Affective Disorders and Schizophrenia for School-Age Children Present and Lifetime Version (K-SADS-PL)* (Kaufman et al., 1997) and the *Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS)* (Scahill et al., 1997). Intelligence was evaluated with the *Kaufman Brief Intelligence Test (K-BIT)* (Kaufman & Kaufman, 1990). Severity of disruptive behavior was evaluated by the *Disruptive Behavior Rating Scale (DBRS)* (Barkley, 1997).

2.4. Outcome assessments

The outcome assessments of OCD symptom severity were conducted weekly using the CY-BOCS administered by an independent evaluator, who was blind to treatment assignment. The CY-BOCS is a 10-item clinician-rated instrument for measuring the severity of obsessive-compulsive symptoms during the past week that is conducted with the parent and child. Symptoms are rated in terms of time, interference, distress, resistance, and control on a scale from 0 = not present to 4 = extreme. The scale yields three summary scores for current symptoms: an obsession score (range = 0–20), a compulsion score (range = 0–20), and a total score (range = 0–40), with increasing scores suggesting greater severity. Internal consistency of the 10-item scale is 0.87 (Scahill et al., 1997). The independent evaluator was trained to reliability by an expert clinician (LS) and had extensive experience in administering the CY-BOCS in research studies (Rosario-Campos et al., 2005, 2006).

Disruptive behavior was evaluated by the *Disruptive Behavior Rating Scale (DBRS)*, an 8-item scale keyed to the DSM-IV criteria for oppositional defiant disorder (ODD), which was filled out by the parents on a weekly basis. Examples of relevant items on this scale include: loses temper, argues with adults, actively defies adult requests, touchy or easily annoyed, and is angry and resentful. The parent is asked to rate each item on a 4-point scale where 0 = never or rarely, 1 = sometimes, 2 = often, and 3 = very often. The internal consistency of the scale ranges from 0.86 to 0.93 (Gomez, Burns, & Walsh, 2008), and scores of 12 and higher are considered clinically significant (Barkley, Edwards, Laneri, Fletcher, & Metevia, 2001). It has been sensitive to change in other clinical studies of disruptive

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