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Parent-based treatment for childhood and adolescent OCD

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ABSTRACT

Despite the efficacy of E/RP and pharmacotherapy for OCD, many children do not respond adequately to therapy. Furthermore, many children exhibit low motivation or ability to actively participate in therapy, a requirement of E/RP. Research has underscored the importance of family accommodation for the clinical course and treatment outcomes of childhood OCD. Recent studies highlighted the potential of family involvement in treatment to enhance outcomes for challenging cases. These interventions however still require child participation. The goal of this clinical report is to describe an exclusively parent-based intervention and present preliminary indications of its acceptability, feasibility and potential efficacy. The Supportive Parenting for Anxious Childhood Emotions (SPACE) Program is a manualized treatment focused on reducing accommodation and coping supportively with the child's responses to the process. The theoretical foundation of the intervention is presented and its practical implementation is illustrated, with excerpts from the treatment manual and a clinical vignette. Preliminary results from the parents of 6 children, who refused individual therapy, are presented. Parents participated in 10 weekly sessions and reported high satisfaction and reduced child symptoms. Research is required to investigate the potential of SPACE as a complement or alternative to other evidence based interventions for childhood OCD.

1. The need for better outcomes in childhood OCD

Despite significant evidence for the effectiveness of exposure and response prevention (E/RP) as a treatment for pediatric OCD, many children and adolescents[1] do not adequately respond to treatment (Barrett, Farrell, Pina, Peris, & Piacentini, 2008; Ginsburg, Kingery, Newman, Kelly, & Grados, 2008; Krebs and Heyman, 2010). As many as half of all patients continue to report having OCD symptoms after treatment and many still meet diagnostic criteria for the disorder. Pharmacotherapy, particularly with SRIs, has also been shown to be effective in treating childhood OCD (Geller and March, 2012). However, combining E/RP with psychopharmacological treatment improves outcomes only modestly and many youth remain non-or-partial responders (Abramowitz, Whiteside, & Deacon, 2005; Pediatric OCD Treatment Study Team, 2004). Furthermore, even after successful treatment, rates of relapse in pediatric OCD are considerable (Leonard et al., 1989).

2. Family accommodation and treatment response

Several clinical features have been associated with poor treatment outcomes for childhood OCD including severity of symptoms, comorbid conditions, and poor insight (Storch et al., 2008). Family factors have also been found to influence treatment outcome (Merlo, Lehmkuhl, Geffken, & Storch, 2009; Peris and Piacentini, 2013; Piacentini et al., 2011). Family accommodation, in particular, has been associated with poor response to treatment and refractory OCD (Garcia et al., 2010; Lebowitz, Panza, Su, & Bloch, 2012). Family accommodation is common across the childhood anxiety disorders (Lebowitz et al., 2013) and particularly prevalent in childhood OCD. Accommodation to OCD (Calvocoressi et al., 1995) includes active participation in symptom-driven behaviors (e.g., parents wash their hands because of a child's contamination fear) as well as modifications to parent and family routines (e.g., refraining from inviting guests into the home or driving special routes). Although family accommodation is usually intended to reduce the child's discomfort and to help them escape the distress caused by the disorder, higher levels of accommodation have consistently been found to predict greater symptom severity and impairment as well as poorer response to treatment (Lebowitz et al., 2012; Storch et al., 2007). E/RP encourages independent coping and confrontation of avoided triggers. Accommodation is contrary to these goals by enabling avoidance and providing reassurance. It is also plausible that parental participation in symptoms of OCD could be interpreted by the child as confirmation of the obsessive beliefs, potentially reducing insight (Adelman and Lebowitz, 2012). In most cases children actively attempt to engage their parents in accommodation, often exhibiting high levels of aggression and distress when parents are not compliant (Lebowitz, Omer, & Leckman, 2011; Lebowitz, Vitulano, Mataix-Cols, & Leckman, 2011; Stewart, 2012).

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[1] Throughout this paper we will use the term 'child' inclusively, to refer to children and adolescents for the sake of brevity.

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3. Child participation and collaboration in treatment

E/RP relies on active participation by the patient in the psychotherapeutic process, and places high demands and expectations on the patient, relative to many forms of psychotherapy. Like in other therapies the patient is expected to arrive for sessions and speak with the therapist. However, in E/RP the child is also expected to engage in active tasks and exercises, both during sessions and between them. And these tasks, by definition, involve exposure to stimuli and to situations that evoke anxiety and trigger distress. Not surprisingly, children exhibit different degrees of motivation and capacity to engage in this challenging process. A child who is ashamed of the content of the obsessive thoughts may be reluctant to disclose them, a child with poor insight can be particularly fearful of engaging in exposures and a child who has come to rely heavily on family accommodation might not wish to engage in a process that could lead to diminished accommodation.

In addition to impacting treatment outcomes, these factors may also prevent some children from ever beginning treatment in the first place. Unfortunately, estimating the number of children who are not willing to engage in treatment and therefore do not participate in clinical research is very difficult. Among adults, it has been estimated that approximately 25% of patients with OCD refuse to participate in E/RP (Franklin and Foa, 2002). There is very little data on treatment refusal in children with OCD, however clinical experience points to the existence of many children who similarly refuse to engage in treatment or do not fully participate in the therapy despite physically attending sessions (Abramowitz, Franklin, Zoellner, & DiBernardo, 2002).

4. Family involvement in individual child therapy for OCD

The evidence for parental influences on maintenance of childhood OCD and on treatment outcomes has led several research groups to explore the benefit of family-based treatment. These efforts have focused on enhancing the effects of individual E/RP by adding or incorporating family therapy into the therapeutic process (Barrett, Healy-Farrell, & March, 2004; Piacentini et al., 2011; Storch et al., 2007). Results of these studies generally supported the efficacy of the interventions, but have not demonstrated clear superiority over individual E/RP without the family components. In the case of very early onset OCD, family based behavioral therapy was shown to be a potentially effective alternative to individual therapy, which may be untenable because of developmental considerations (Freeman et al., 2007, 2008).

In a more recent study, Peris and Piacentini (2013) randomly assigned complex pediatric OCD patients at elevated risk of failing treatment, to either individual treatment or to individual treatment enhanced with family treatment sessions. They found that patients in the augmented condition were significantly more likely to respond to treatment than patient who received individual child treatment only. This encouraging result, along with similar advances in adult treatment (Abramowitz et al., 2013), bolsters the hope that increasingly focusing on the intra-family dynamics such as family accommodation may enhance outcomes for childhood OCD. However, important questions remain. Firstly, family-augmented interventions still require active child participation and do not provide a viable solution for children who decline to participate in treatment. Secondly, it is unclear which family element led to the change in child symptoms. Studies have typically attempted to modify multiple family dynamics including family accommodation, cohesion, conflict and communication. The current clinical report describes an exclusively parent based intervention that focuses on supportively reducing family accommodation in parents of children with OCD.

5. Parent based treatment—the SPACE Program

We developed and manualized a parent-only intervention aimed at reducing family accommodation, and in turn bringing about reduction in child symptoms, named the Supportive Parenting for Anxious Childhood Emotions (SPACE) Program (Lebowitz and Omer, 2013) which has shown potential for improving anxiety symptoms in children with anxiety disorders. Parents participate in 10 weekly hour-long sessions. SPACE first educates parents on the difference between protective behavior, which focuses on short-term prevention or alleviation of the child's distress, and supportive behavior, which focuses on promoting the child's ability to tolerate anxiety and self-regulate negative effect. Over the course of SPACE, family accommodation is systematically charted and monitored and parents are guided in reducing the accommodating behavior. Because some children respond initially to parents' reduced accommodation with elevated distress or aggression, the treatment includes a set of tools for problem-solving these situations supportively.

SPACE is not the only treatment program for pediatric OCD to involve parents or to address the issue of family accommodation (March, 1998; Pediatric OCD Treatment Study Team, 2004). However, SPACE is unique in (a) making the reduction of family accommodation the main objective of treatment as a means of improving child functioning and potentially increasing motivation for individual treatment; (b) working exclusively with parents on family accommodating thus allowing for treatment of children who do not themselves participate in therapy; and (c) providing a cohesive set of tools for the systematic monitoring and reduction of family accommodation and for dealing with the ensuing difficult child responses.

One conceptual framework uniquely suited to coping with children's dysregulated reactions without ‘fanning the fire’ and escalating the conflict is that of non-violent resistance (NVR). NVR is best known in the political and broader societal context, having been pioneered as an instrument for achieving social change by Gandhi and Kumarappa (1951), Martin Luther King Jr. (King Jr., 2003) and others. The underlying principle of NVR is the individual's choice to accept the limits of their ability to make another person change, and instead to focus on changing one's own behavior so that it is better aligned with their beliefs and values. This acceptance of the other and emphasis on self-change is appropriate for a parent-based intervention as it focuses attention on changes parents can make to their own behavior rather than on attempts to directly change the child. When a child responds negatively to the parental steps, parents can simply persist, neither abandoning their goals nor engaging in argument. Translations of NVR have already been applied to other family problems such as parent training for aggressive and explosive behavior(Weinblatt and Omer, 2008; Omer, Steinmetz, Carthy, & von Schlippe, 2013), as well as parent training for highly dependent young adults (Lebowitz, Dolberger, Nortov, & Omer, 2012). The NVR approach provides parents in these situations with practical alternatives to becoming drawn into the patterns of coercion and interaction that can create an unhelpful quagmire (Patterson and Reid, 1970). Like other approaches that emphasize diverting attention from negative behavior (Peed, Roberts, & Forehand, 1977), NVR emphasized modifying parental toward more adaptive patterns. NVR also adds to these approaches a toolbox of positive parental behaviors that better reflect their aims and goals. SPACE draws on NVR principle to help parents cope with disruptive or distressing child reactions to reduced accommodation. The NVR approach suits the treatment children with OCD whose behavior, though disruptive, is driven by anxiety and distress. NVR does not cast the child in the role of ‘misbehaver’ but emphasizes the need to modify parental responses. Additional components of the treatment focus on increasing the ability of both parents to work collaboratively and on engaging the help of other supporters from the broader family