Psychosocial Treatment of the Affective and Behavioral Dimensions of ODD and the Potential Moderating Role of Anxiety on Treatment Outcomes

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DSM-5 Criteria for ODD

- 1. Often loses temper**
- 2. Often argues with adults
- 3. Often actively defies or refuses adult requests or rules
- 4. Often deliberately does things that annoy other people
- 5. Often blames others for his/her own mistakes or misbehavior
- 6. Is often touchy or easily annoyed by others**
- 7. Is often angry or resentful**
- 8. Is often spiteful or vindictive

** Affective/Irritable Dimension

Comorbid conditions

- Dysthymia/MDD (20 - 30%)
- Anxiety Disorders, including PTSD (25 – 50%)
- Learning disabilities (25-50%)
- ADHD (40-80%)
- School under-performance (60-90%)

NOTE: Sometimes oppositional and defiant behaviors are not ODD!

Psychosocial Treatments for ODD in Youth (Murrihy, Kidman, & Ollendick, 2010; AHRQ, 2014)

- Well-established

  Parent Management Training (PMT)*; Problem Solving Skills Training + PMT; Multi-Systemic Therapy (MST); Positive Parenting Program (Triple P); Parent-Child Interaction Therapy (PCIT); The Incredible Years (ICY)

- Probably Efficacious

  Group Social Skills Training (SST); Group Assertiveness Training; Individual/Group Anger Control Training; Individual Collaborative & Proactive Solutions (CPS)*

Psychosocial Treatment of ODD and its Comorbidities (NIMH: 1 R01 MH76141)

- Compare Parent Management Training (PMT) to Collaborative & Proactive Solutions (CPS) and Wait-List Control (WLC) in the treatment of children and adolescents with ODD
- Study conducted in Virginia with 134 families (11 in waitlist – re-randomized to PMT and CPS; resulting in 67 in each treatment condition)
- **Examine anxiety disorders as a moderator of Tx outcomes**

Causes of Defiance and Oppositional Behaviors from PMT Perspective

- Negative Child Temperament
- Negative Parent Temperament
- Parent, Child, and Family stress
- Ineffective Child Management by Parent
  - Highly inconsistent/permissive parenting
  - Use of harsh, extreme punishment
  - Absence of authoritative parenting

ODD is not solely in the child; it is a family affair!

Goals of the PMT Program

- Increase parental knowledge about ODD and its origins within the family
- Be more consistent, contingent, & predictable
- Use more approval, recognition, & rewards
- Switch to mild punishment (response cost/timeout) but only if necessary
- Increase child compliance
- Improve parent-child-family relationships
- Improve child's developmental prognosis

Parent Management Training (PMT)

- Empirically supported and well established treatment (Barkley, 1997; Brestan & Eyberg, 1998; Murrihy, Kidman, & Ollendick, 2010; Ollendick & King, 2012; AHRQ, 2014)

- Manualized (12 sessions) with specified content – individual session with parent and child present (Ollendick [2008] a modification of Barkley, 1997)

Collaborative & Proactive Solutions (CPS)

- Not yet empirically supported although initial results are highly promising --- one small RCT + large RCT completed by us in the United States. Large RCT currently underway in Australia and reported upon in this symposium!
- Focuses primarily on lagging skills in the child and unsolved problems in the family – manualized (12 sessions)
- Goal: Diminish negative behaviors/increase positive behaviors through collaboration and proactive solutions to unsolved problems

What Lagging Skills Have Been Identified in Youth with ODD?

- Executive Functioning Skills
- Language Processing/Communication Skills
- Emotion Regulation Skills
- Cognitive Flexibility Skills
- Social Skills
- Among several others!

Options for Addressing Unsolved Problems

- Plan A: Solve the problem unilaterally
- Plan B*: Solve the problem collaboratively
- Plan C: Set the problem aside for now

NOTE: Significant differences in therapeutic approach between CPS and PMT

Sequence in Each Session for BOTH PMT and CPS

- Review homework
- Introduce new skills & rationale
- Review parental handout
- Model the skill for the parent
- Have parent rehearse with child
- Discuss parental comfort & issues
- Assign homework

Inclusion/Exclusion Criteria

Inclusion Criteria

- Diagnosis of ODD according to DSM-IV
- Severity of ODD of at least 4 on a 0-8 scale (ADIS C/P)
- Age 7-14 years
- Duration of ODD at least 6 months
- Accept random assignment to study conditions

- Exclusion Criteria
  - Primary major depression, but only if currently suicidal
  - Drug or alcohol abuse, chronic
  - Childhood schizophrenia/BPD/ASD
  - Intellectual Impairment

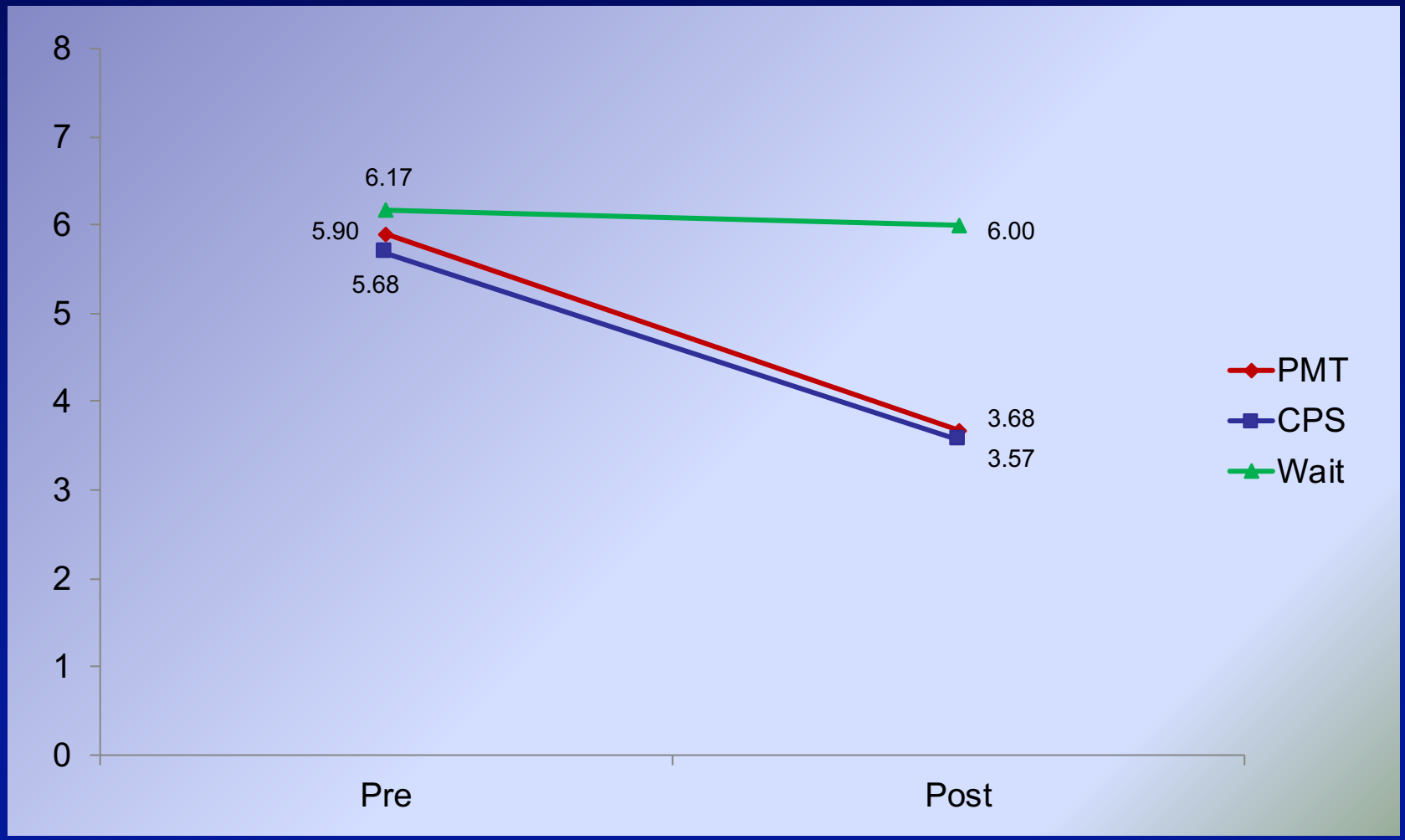
Project Enrollment

- 134 families; principal reason for referral = ODD; 64% primary, 36% secondary
- 94% comorbid with at least one other disorder: 55% comorbid with ADHD and 45% with an Anxiety Disorder
- 83 boys, 51 girls; average age = 9.58 years
- 81 of 134 (60.4%) families from two-parent families; income highly variable
- 111 Caucasian, 12 African American, 7 Hispanic/Latino, 3 Asian American, 1 other

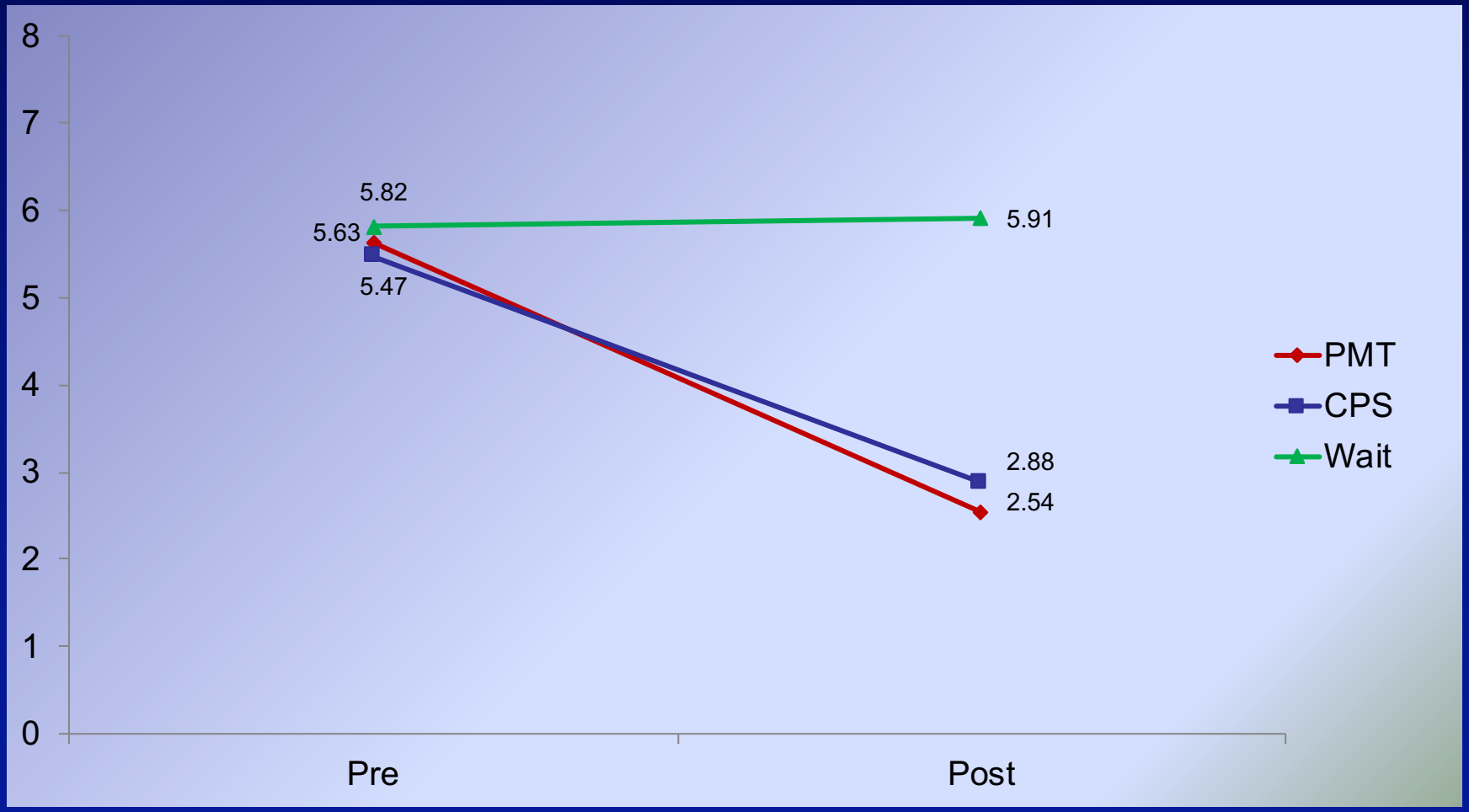
Assessments

- Diagnostic Screening Interview
  - Anxiety Disorders Interview Schedule (ADIS C/P)
  - Diagnostic Interview Schedule for Children (DISC)
- Independent Assessor Rating
  - Severity of ODD and other disorders
  - Children's Global Assessment Scale
  - Clinical Global Impressions – Severity/Improvement
- Self-Report: Beck Youth Inventory, Behavior Rating Inventory of Executive Functioning, Emotion Regulation Checklist, Disruptive Behavior Disorders Rating Scale, BASC (parent, teacher, self)
- Laboratory-Based Measures: Problem Solving Task, Tangram Task, Emotional Stroop, Emotion Coaching Task

Outcomes: ODD Clinician Severity Ratings



Outcomes: DBDRS ODD Symptom Totals (Parent Report)



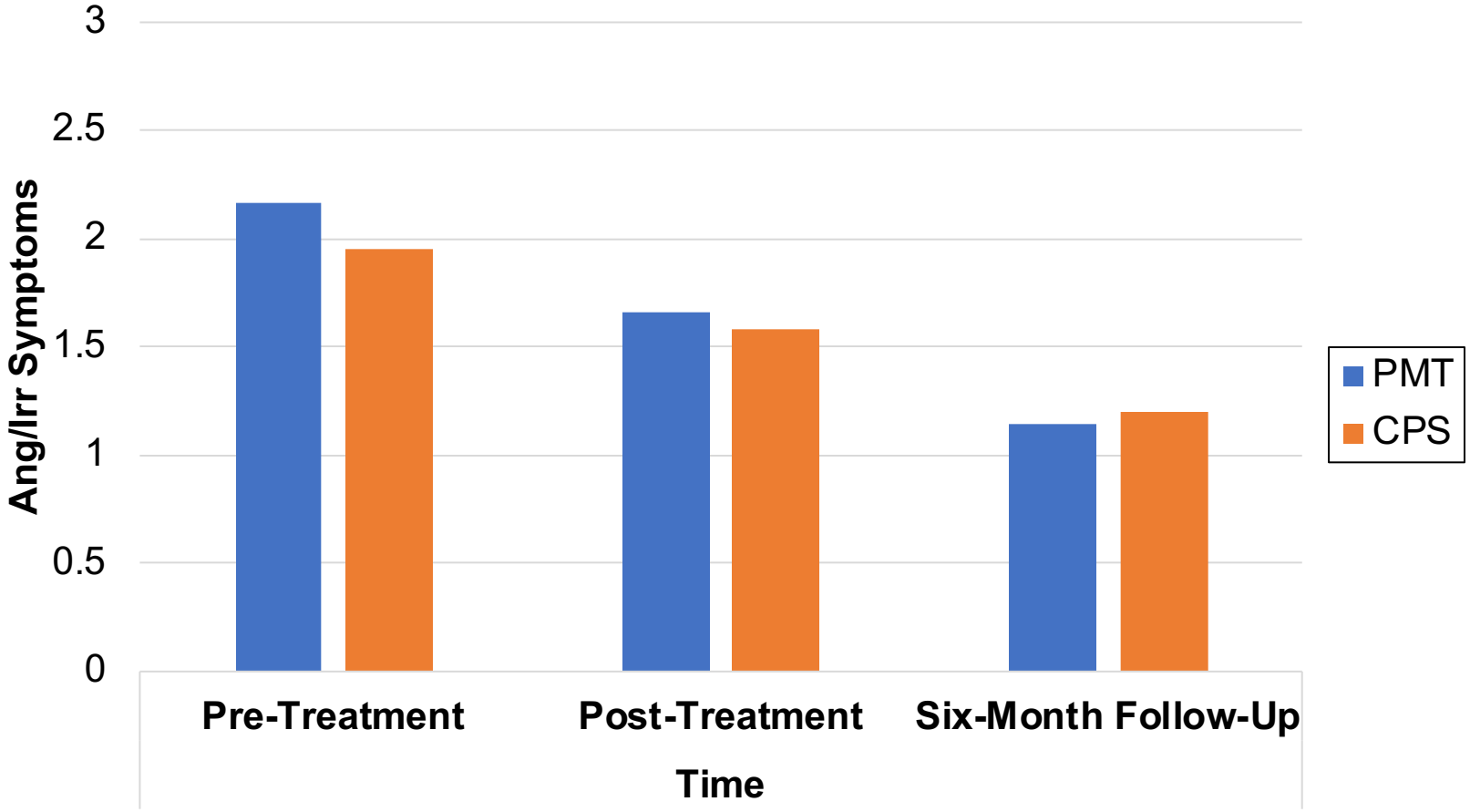
Dimensions of ODD (Stringaris & Goodman; Leibenluft, Pine, Brotman and colleagues)

- Affective/Irritable Dimension
  - Often loses temper
  - Is often touchy or easily annoyed
  - Is often angry or resentful
- Behavioral/Headstrong Dimension
  - Often argues with adults
  - Actively defies or refuses adult requests or rules
  - Deliberately does things that annoy other people
  - Blames others for own mistakes or misbehavior
- Hurtful/Vindictive Dimension
  - Is often spiteful or vindictive

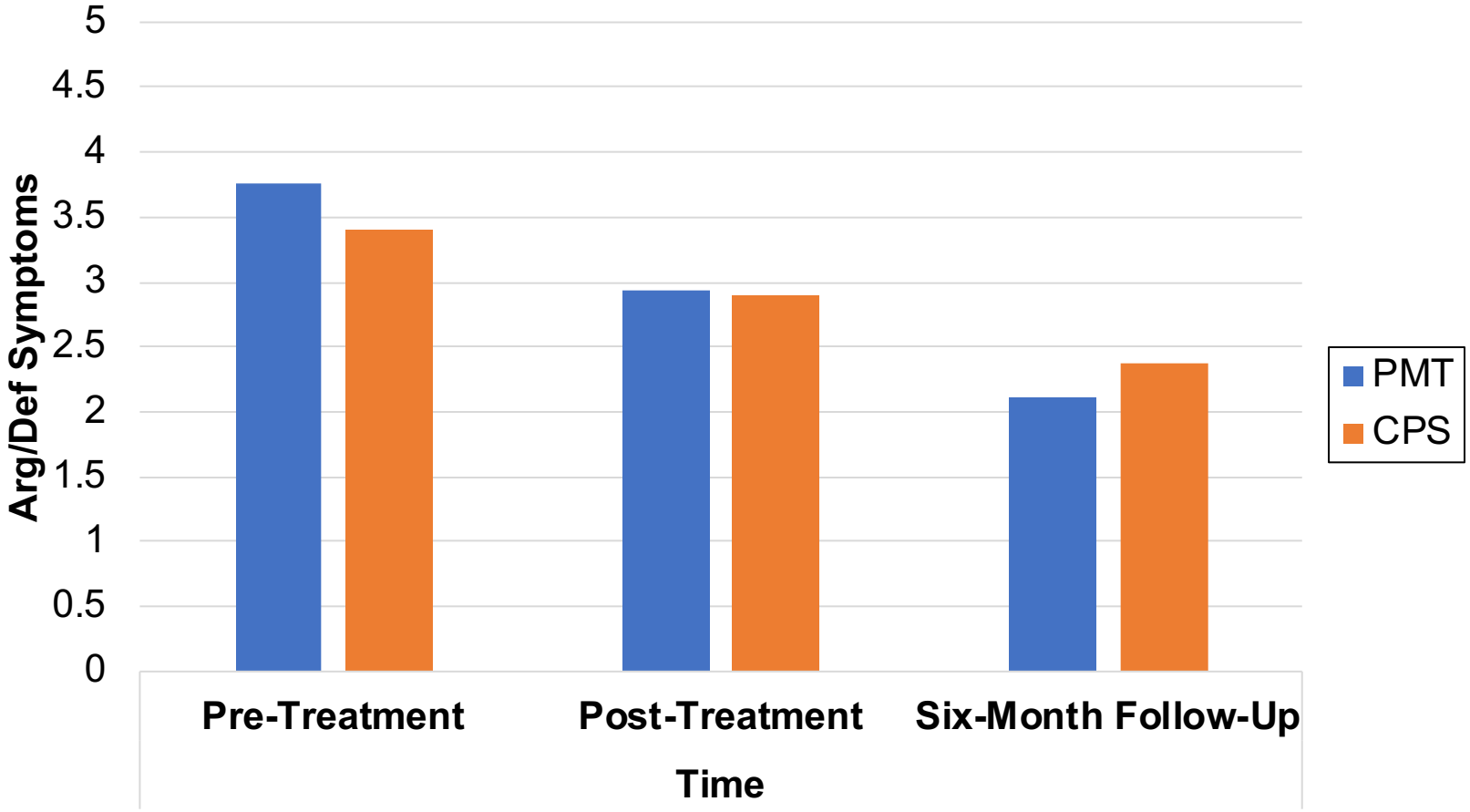
Percent of Youth Meeting each ODD Symptom on ADIS/P in our sample

- Affective/Irritable Dimension
  - Often loses temper 95%
  - Is often touchy or easily annoyed 74%
  - Is often angry or resentful 46%
- Behavioral/Headstrong Dimension
  - Often argues with adults 93%
  - Actively defies or refuses adult requests 90%
  - Deliberately does things to annoy other people 70%
  - Blames others for own mistakes or misbehavior 81%
- Hurtful/Vindictive Dimension
  - Is often spiteful or vindictive 37%

Affective Symptoms Decreased Significantly and at a Similar Rate between Treatments Across Time



Behavioral Symptoms Decreased Significantly and at a Similar Rate between Treatments Across Time



Moderators and Predictors of Treatment Outcome

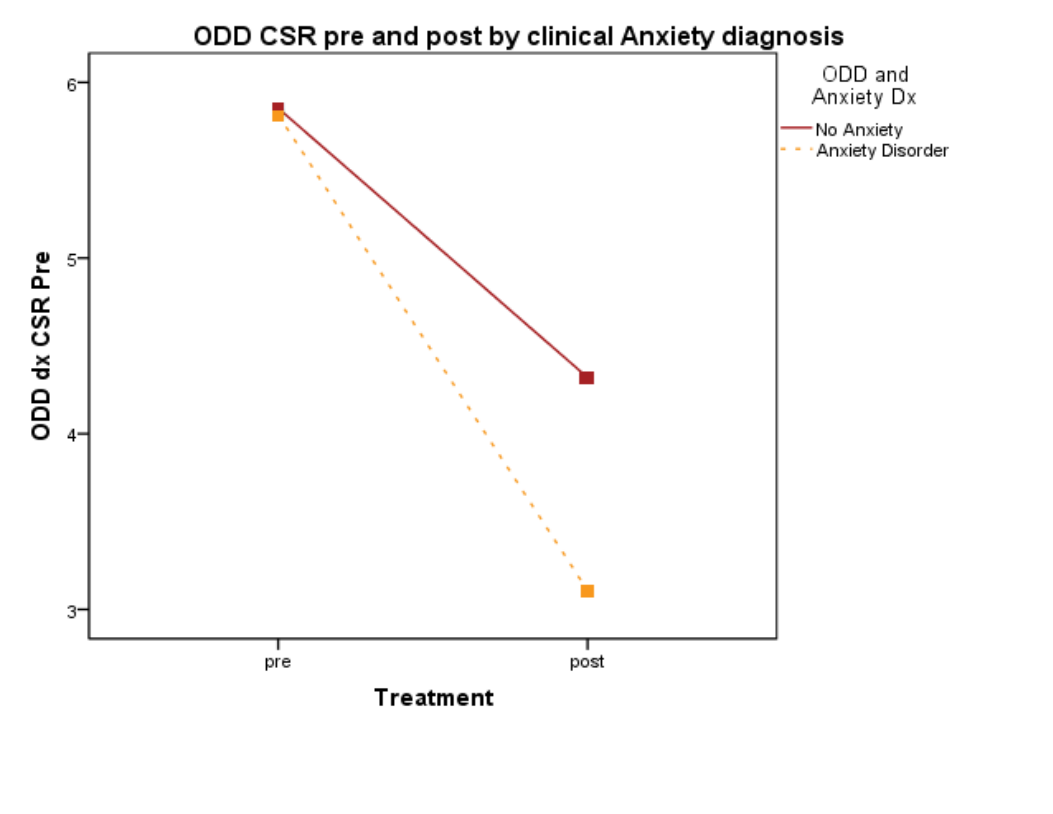
- Moderators of Treatment Outcome: A variable that is measured prior to the treatment assignment and implementation of the treatment that *differentially* predicts treatment outcomes. Moderator variables can identify subgroups of individuals *for whom* a specific treatment is more or less effective.

- Predictors of Treatment Outcome: A variable measured prior to treatment assignment that is associated with treatment outcome *regardless* of treatment assignment. They too tell us *for whom* treatments are effective.

Does Presence of Anxiety Predict/Moderate the Primary Outcome?

- Yes, anxiety predicted treatment outcome for ODD CSR ($p<.015$); however, anxiety did not moderate CSR treatment outcome

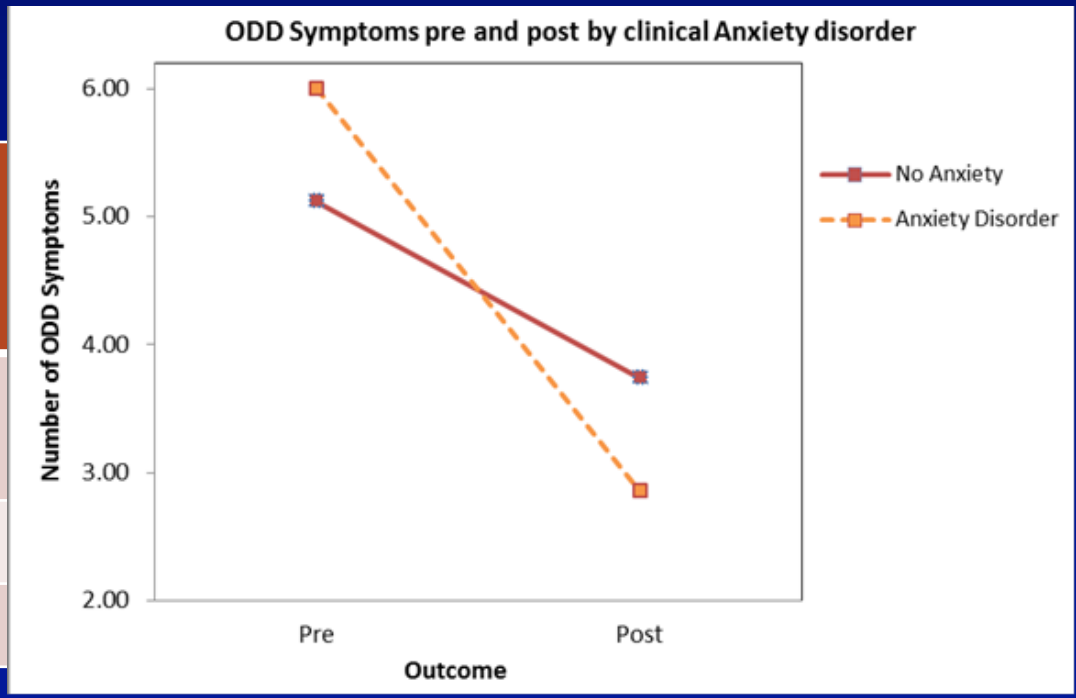
	ODD CSR Pre	ODD CSR Post
No Anxiety	5.86	4.31
Anxiety	5.81	3.12
Overall	5.84	3.67



Was Anxiety related to Maternal Report of Outcomes?

- Yes, anxiety predicted treatment outcome for mother report on the DBDRS ($p < .05$); however, it did not moderate treatment outcome

	ODD Symptoms Pre	ODD Symptoms Post
No Anxiety	5.12	3.74
Anxiety	6.00	2.85
Overall	5.56	3.24



What can We Conclude?

- Tentatively, anxiety serves to mitigate the effects of ODD and to be associated with better treatment outcomes – see Pine et al. (2000) and Drabick, Bubier, & Ollendick (2010) for hypothesized protective effects
- However anxiety does not moderate treatment outcomes; both treatments lead to significant reductions in anxiety but not differentially so – both for affective and behavioral symptoms
- Replication and examination of other internalizing comorbidities (e.g., depression) are needed

Implications and Summary

- Numerous evidence-based, efficacious programs are available – still they are effective only for 50% – 66% of youth and their families
- Most of these programs are embedded in Behavioral, Cognitive-Behavioral, and Family Systems Orientations
- There is a striking absence of evidence for humanistic, Gestalt, psychodynamic, and play therapy approaches
- Some treatments appear to work better than others; however, the absence of evidence is not evidence of ineffectiveness; we desperately need trials comparing these other approaches since they are practiced routinely