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

Pre: 6.17 PMT, 5.90 CPS, 5.68 Wait
Post: 6.00 PMT, 3.68 CPS, 3.57 Wait
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

<table>
<thead>
<tr>
<th>Time</th>
<th>Ang/Irr Symptoms</th>
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<tbody>
<tr>
<td>Pre-Treatment</td>
<td>PMT: 2.1, CPS: 2</td>
</tr>
<tr>
<td>Post-Treatment</td>
<td>PMT: 1.5, CPS: 1.9</td>
</tr>
<tr>
<td>Six-Month Follow-Up</td>
<td>PMT: 1, CPS: 1.1</td>
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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.
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

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<tr>
<th></th>
<th>ODD Symptoms Pre</th>
<th>ODD Symptoms Post</th>
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<tbody>
<tr>
<td>No Anxiety</td>
<td>5.12</td>
<td>3.74</td>
</tr>
<tr>
<td>Anxiety</td>
<td>6.00</td>
<td>2.85</td>
</tr>
<tr>
<td>Overall</td>
<td>5.56</td>
<td>3.24</td>
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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