

Initial Focus on OCD May Ease Defiant Disorder

Results show patients must be open to engaging in exposure therapy for treatment to be effective.

BY DAMIAN McNAMARA
Miami Bureau

MIAMI — Children with comorbid oppositional-defiant and obsessive-compulsive disorders may be more likely to engage in and benefit from cognitive-behavioral therapy if the oppositional defiant disorder is treated first, according to preliminary findings from an ongoing study.

Such comorbid children are at increased risk for early, more severe obsessive-compulsive disorder (OCD).

"Children with oppositional defiant behavior tend to develop OCD more rapidly," Jennifer Adkins, Ph.D., said at the annual conference of the Anxiety Disorders Association of America.

"They engage in rituals more than other children might be able to, and that allows OCD symptoms to get more severe more rapidly," she noted. "There is a strong importance to this work in children—80% of adults with OCD exhibited the disorder in childhood," said Dr. Adkins, of the department of psychiatry at the University of Florida, Gainesville.

Dr. Adkins and her associates studied 40 pediatric patients at the University of Florida in Tallahassee. The goal was to determine whether oppositional defiant disorder and/or family accommodation alter cognitive-behavioral therapy (CBT) outcomes immediately after treatment and/or at follow-up.

All participants actively sought treatment for OCD. An independent evaluator performed a preassessment.

Patients had 15 CBT sessions. Those sessions were followed by an assessment immediately after treatment and at 3 months' follow-up.

Clinicians assessed the participants with a diagnostic clinical interview and the Children's Yale-Brown Obsessive-Compulsive Scale.

Parents provided input using the Child Behavior Checklist and the Family Accommodation Scale.

"We don't expect full clinical remission; we expect alleviation of symptoms," Dr. Adkins said.

The investigators defined a treatment responder as someone who experienced a 70% or more reduction in total score on

the obsessive-compulsive scale, "so we set a higher standard for clinical response than most researchers," Dr. Adkins said.

Mean age was 13 years (range 8-18 years), most patients were white, and annual family income ranged from \$30,000 to \$350,000.

Twenty-five of the patients were taking concurrent selective serotonin reuptake inhibitors.

The CBT protocol included exposure and response prevention, psychoeducation, and attempted cognitive restructuring. There is active family involvement, "so parents become the treatment after we are done," Dr. Adkins said.

Age and onset severity were not predictive of treatment outcome. The presence of oppositional defiant disorder, however, significantly predicted poorer outcome immediately after treatment but not at follow-up.

The disorder correctly predicted outcomes in 58% of the patients. There was excellent specificity with no false positives, although "the false negatives

brought down" the accuracy, according to Dr. Adkins.

"Treatment may be more effective if oppositional defiant disorder is addressed before starting CBT for OCD, especially if they are extremely oppositional," Dr. Adkins said.

"Patients must be agreeable to engage in exposure therapy for it to be effective."

Dr. Adkins and her colleagues also examined the effect of family accommodation on treatment outcomes.

"Interestingly, family accommodation did not predict outcome at this immediate time measurement," Dr. Adkins said. At the 3-month

follow-up, though, family accommodation proved to be 70% predictive.

Parents may be less stringent about adhering to no-accommodation rules following the end of active treatment, she proposed.

"This is an early study. We only have 40 participants so far," Dr. Adkins said. "More significant predictors of outcome may be identified as we recruit and assess more patients." ■

Children with oppositional defiant behavior engage in rituals more than others might be able to, which allows OCD symptoms to get more severe faster.

Survey: Teens Use Inhalants More, Worry About Risks Less

BY SHARON WORCESTER
Southeast Bureau

Inhalant abuse, known as "sniffing" or "huffing," appears to be increasing among teens, and shifting attitudes about the practice are cause for alarm, according to the Partnership for a Drug-Free America.

In a new survey of 7,200 7th-12th graders, about 23% reported abusing inhalants. That's up about 2% since 2001, according to the Partnership, which conducts such surveys annually. The most recent survey—the 2005 Partnership Attitude Tracking Study—was conducted from March through June 2005 and has a margin of error of +/- 1.5%.

Of particular concern is that the percentage of teens reporting that they "strongly agree" that inhalant abuse can be deadly declined 19% since 2001, with only 64% of respondents in the 2005 survey agreeing that inhalants can kill.

"What stands out is the teens' decreasing perception of risk because that often correlates with increases in use. We clearly need to address underlying attitudes and help teens understand the dangers associated with this

form of substance abuse," Steve Pasierb, president and chief executive officer of the Partnership, said in a written statement.

Earlier this year, a report by the National Survey on Drug Use and Health called "Characteristics of Recent Adolescent Inhalant Initiates" found that recent inhalant initiates were significantly more likely to be white, compared with the general population (70% vs. 62%), and significantly more likely to be 14-15 years old, compared with the general population (39% vs. 34%).

Among adolescents, substances commonly used for huffing include spray paint, glue, computer duster, cooking spray, and correction fluid. Sniffing highly concentrated amounts of vapors from some products can cause a syndrome known as "sudden sniffing death," which can result after even a single session of inhalant use.

The most common causes of death as a result of inhalant use are sudden cardiac death and suffocation or asphyxiation. Chronic exposure to inhalants can also cause damage to the brain, heart, lungs, liver, and kidneys.

Educational campaigns about the dangers of inhalant abuse also must target parents, who according to the Partnership report are either not aware or are in denial about the prevalence of inhalant abuse among teens.

Of 1,200 parents of teens who were also surveyed, only 5% believe their child ever abused inhalants; teens are four times more likely to report inhalant abuse than parents expect.

Although about 75% of parents reported discussing cigarettes "a lot" with their children, only 50% reported spending the same amount of time discussing the risks of inhalant abuse.

A new educational cam-



KATHRYN DALES

campaign from the Partnership and the Alliance for Consumer Education will seek to educate parents and teens through a mass media campaign and via outreach to school counselors and nurses.

Similar campaigns in the 1990s were effective for reducing inhalant abuse; between 1995 and 2001, data suggested these programs led to an increase from 64% to 79% in the proportion of teens who perceived inhalant abuse as risky, and inhalant abuse declined significantly during that period, from 23% to 18%.

However, today's middle school kids weren't exposed to those educational campaigns, and the result is "generational forgetting" and a new generation of kids that clearly need to be educated, Mr. Pasierb said.

Another dangerous aspect of inhalant abuse is that inhalants may serve as a starter. The National Survey on Drug Use and Health data showed that 23% of recent inhalant initiates had not used cigarettes, alcohol, or marijuana prior to their first use of inhalants. ■

Senior writer Heidi Splete contributed to this report.

Signs and Symptoms of Inhalant Abuse

Someone who is abusing inhalants may exhibit one or all of the following symptoms:

- ▶ Burning sensation on the tongue.
- ▶ Dazed, dizzy, or drunken-seeming appearance.
- ▶ Nausea and/or loss of appetite.
- ▶ Neurologic problems including peripheral neuropathy, loss of vision, severe cognitive impairment, and seizures.
- ▶ Red or runny eyes and/or nose.

- ▶ Signs of paint, correction fluid, or other chemical products in unusual places, such as the face or fingers.
- ▶ Slurred or disoriented speech.
- ▶ Unusual behaviors such as anxiety, irritability, anger, excitability, or restlessness with no discernable cause.
- ▶ Unusual odor on the breath or chemical odor on clothing.

Sources: U.S. Consumer Product Safety Commission and the National Inhalant Prevention Coalition