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Just Say No

Sequential Parent Management Training and Cognitive-Behavioral Therapy for a Child With Comorbid Disruptive Behavior and Obsessive Compulsive Disorder

Heather D. Lehmkuhl
Nationwide Children's Hospital, Columbus, Ohio
Eric A. Storch
Omar Rahman
University of South Florida, St. Petersburg
Jennifer Freeman
Brown Medical School, Providence, Rhode Island
Gary R. Geffken
University of Florida, Gainesville
Tanya K. Murphy
University of South Florida, St. Petersburg

Psychiatric comorbidity is common in pediatric patients with obsessive-compulsive disorder (OCD) and may negatively affect treatment outcome. In particular, comorbid disruptive behavior disorders have been associated with attenuated treatment response in youth undergoing cognitive-behavioral therapy (CBT) for OCD. This article presents the case of a 10-year-old female with a primary diagnosis of OCD and secondary diagnosis of oppositional defiant disorder who was successfully treated with parent management training (PMT) prior to initiation of CBT. PMT was effective in reducing oppositional behaviors and resulted in improved adherence to the treatment protocol. The current report provides preliminary evidence for the effectiveness of PMT in youth with OCD and comorbid disruptive behavior. Clinical recommendations are provided to foster improved outcomes in this population.

Keywords: *obsessive-compulsive disorder; disruptive behavior disorder; patent management training; cognitive-behavioral therapy*

1 Theoretical and Research Basis

Psychiatric comorbidity is a common occurrence among pediatric patients with obsessive-compulsive disorder (OCD). Estimates suggest that as many as 74% of youth with OCD

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have a comorbid condition (Geller et al., 2001; Storch et al., 2008), with the most common including depression, anxiety, disruptive behavior disorders (DBDs; e.g., oppositional defiant disorder [ODD], conduct disorder, disruptive behavior disorder NOS), and attention-deficit/hyperactivity disorder (Geller, Biederman, Griffin, Jones, & Lefkowitz, 1996; Geller et al., 2001; Swedo, Rapoport, Leonard, Lenane, & Cheslow, 1989). Comorbidity has a significant impact on presentation as, relative to those without a comorbid disorder, presence of a comorbid condition is linked to significantly greater psychosocial impairment (Sukhodolsky et al., 2005).

In addition, to increased impairment, presence of a comorbid condition is associated with significantly attenuated treatment response to the two demonstrated effective therapeutic modalities: namely, pharmacotherapy with serotonin reuptake inhibitors and cognitive-behavioral therapy (CBT) with exposure and response prevention (ERP; Abramowitz, Whiteside, & Deacon, 2005). Among the varied comorbidities, comorbid DBDs have emerged as being particularly detrimental to treatment outcome. Outside of the context of OCD, DBDs in children represent a serious, highly prevalent, and costly public health problem (Klein & Mannuzza, 1991) that, left untreated, can escalate into more serious delinquent and antisocial behavior (Loeber, Burke, Lahey, Winters, & Zera, 2000). Disruptive behavior in conjunction with OCD has an interactive effect that contributes to considerable functional impairment beyond what would be expected with OCD or disruptive behavior alone. In general, comorbid conditions may affect CBT response by forcing the clinician to divide his or her attention between these secondary concerns and the primary concern of OCD (Storch et al., 2008). Moreover, DBDs interfere with the therapeutic process via increased resistance to engage in exposures, higher overall levels of family conflict, and secondary gains from symptoms (e.g., reduced role expectations), which serve to maintain the OCD symptoms. In addition, parents of children with both OCD and DBDs often respond very differently when the child's behaviors are perceived to be anxiety related versus a "behavior problem" leading to inconsistencies in parenting and treatment implementation.

Available data suggest that youth with OCD and a comorbid DBD exhibit an attenuated treatment response. In the most rigorous study to date, of 96 youth receiving family-based CBT for OCD, Storch and colleagues (2008) found that those with a comorbid DBD had both significantly poorer treatment response and remission rates. Only 57% of those with a comorbid DBD were treatment responders (vs. 75% of the overall sample) and only 24% achieved OCD symptom remission (vs. 59% of the overall sample). Geller and colleagues (2003) examined influence of comorbidity on treatment response in 193 youth treated with paroxetine and had similar findings. In the overall sample 71% were responders; in participants without any comorbidity, 75% were responders. In contrast, only 39% of youth with ODD responded to paroxetine.

Given that impairment associated with pediatric OCD is likely compounded in the presence of a comorbid disorder (Sukhodolsky et al., 2005) and treatment response likely attenuated (Geller et al., 2003; Storch et al., 2008), an investigation of alternative strategies for treatment is clearly warranted. To date, there has been no empirical work has been conducted tailoring interventions to address co-occurring disruptive behavior problems in youth with OCD. Given this, we report on the case of a 10-year-old girl with OCD and comorbid ODD treated with parent management training (PMT) prior to a course of CBT.

2 Case Presentation

Jessica (a pseudonym), a 10-year-old Hispanic female, was referred by her child psychiatrist for treatment of OCD. Prior to presentation, Jessica had been prescribed Lexapro (10 mg) and omega 3 fatty acids but had not experienced clinically meaningful symptom relief per self- and parent reports. She was experiencing significant distress related to her OCD symptoms, particularly at home, but was able to function reasonably well in school. Notably, Jessica's family members reported considerable impairment in the domains of completing tasks in a timely manner, dressing, eating, and participating in other activities efficiently because of her need for things to feel "just right." Her family members also reported experiencing significant family discord because of having to accommodate OCD symptoms.

3 Presenting Complaints

At the initial assessment, Jessica presented with significant obsessive-compulsive symptoms. Specifically, she was engaging in numerous rituals related to getting dressed, taking medication, and eating in the morning. These rituals consisted of elaborate routines involving her parents (e.g., placing food on her plate in a certain order, repeatedly arranging her medication). Jessica described wanting things to feel "just right" and being unable to cease a task until she achieved this feeling. In addition, Jessica engaged in continuous reassurance seeking from family members (predominately her mother) to convince herself that nothing bad would happen once a task was completed. Finally, Jessica hoarded multiple items in her room, including food and trash, to such an extent that the family's home was infested with insects. Jessica's family accommodated the majority of her rituals and completed tasks for her in an effort to prevent escalations in disruptive behavior. Jessica endorsed mild depressive symptoms that were related to having OCD and a desire to stop engaging in her rituals.

In addition to OCD, Jessica displayed considerable disruptive behaviors that compounded overall impairment and made it difficult for her parents to encourage participation in therapeutic tasks. For example, Jessica did not complete assigned chores when asked to do so (even when these were unrelated to her OCD symptoms), refused to comply with other requests, argued with and talked back to her parents, physically fought and verbally argued with her sisters and friends, and had temper tantrums when denied her wishes. Jessica's parents frequently reinforced her behavior by completing tasks for her or reassigning tasks to her sisters, which led to many family disagreements. Her parents reported that these disruptive behaviors were as impairing as her OCD symptoms, as they limited the family members' ability to interact positively with one another. In contrast, these disruptive behaviors did not appear in school, perhaps because of the firm behavioral contingencies imposed by school personnel.

Jessica's parents sought treatment for her primarily to address obsessive-compulsive symptoms. However, CBT for OCD relies extensively on the patients' ability to perform exposures in session as well as complete out of session practice as appropriate. At intake, Jessica was not complying with her parents' requests, and they acknowledged feeling ill

equipped to respond to disruptive and noncompliant behavior, particularly with confronting anxiety-provoking situations. Given this, we believed it to be unlikely that Jessica would participate in exposure tasks unless the parents' behavioral management competencies were significantly improved. Thus, we began treatment with PMT to improve compliance with commands as well as parental consistency. It was our belief that improved behavioral management would result in improved participation in exposure tasks, thereby allowing Jessica to maximally benefit from treatment.

4 History

Jessica was the third of three children and lived with her biological parents and sisters. Overall, the family reported a stable home life and generally good sibling relationships in spite of Jessica's disruptive behavior. She was actively involved in dancing and participated in several competitions per year. She did not have any social impairment on the basis of self- or parent reports. Results of intelligence and achievement testing suggested that Jessica was of high average intelligence (Wechsler Intelligence Scales for Children–IV Full Scale IQ = 110; Wechsler, 2004) and performing at or above her abilities in academic abilities (Woodcock Johnson–III total achievement = 120).

Jessica was prescribed Lexapro (10 mg) by a local child psychiatrist 10 weeks prior to entering treatment. She had not participated in psychotherapy previously. Past occupational therapy for sensory defensiveness had resulted in limited success, and Jessica's mother now believed that the sensory complaints were OCD related (i.e., needing to feel "just right").

5 Assessment

Jessica and her biological mother participated in a 90-min intake interview with a licensed psychologist experienced with pediatric OCD. Because of the nature of her OCD symptoms and the distance that she lived from the clinic, Jessica was enrolled in the intensive CBT program. Given family concerns and Jessica's disobedience, it was decided that she and her mother would participate in four to six 1-hr PMT sessions prior to beginning the intensive treatment program. Such duration was based on our assessment of the parents' baseline skills and their overall motivation to change maladaptive patterns of behavior.

Jessica and her mother participated in three assessments during the course of treatment: baseline, pre-CBT, and post-CBT. The baseline assessment was conducted following the intake interview. A pre-CBT assessment was conducted after the last parent training session and before Jessica entered CBT. Finally, Jessica completed an assessment following conclusion of CBT.

A multi-informant procedure was used to assess Jessica's symptomatology including the Children's Yale-Brown Obsessive-Compulsive Scale (OCD symptom severity; CY-BOCS; Scahill et al., 1997), Multidimensional Anxiety Scale for Children (MASC; general anxiety symptoms; March, Parker, Sullivan, Stallings, & Conners, 1997), Conners' Parent Rating Scale (CPRS; externalizing behaviors; Conners, 1989), Child Obsessive Compulsive Impact Scale (COIS; impact of obsessive-compulsive symptoms; Piacentini, Bergman, Keller, & McCracken, 2003), and Family Accommodation Scale (FAS; Calvocoressi et al., 1999). Diagnostic

Table 1
Baseline, Pre-CBT, and Post-CBT Scores

Measure	Baseline	Pre-CBT	Post-CBT
CY-BOCS Total	31	25	8
CY-BOCS Obsession	14	12	4
CY-BOCS Compulsions	17	13	4
MASC	28	—	13
CPRS Oppositional	57	46	46
CPRS Hyperactive	90	82	61
CPRS Perfectionism	72	56	48
CPRS Psychosomatic	90	87	56
CPRS Restless-Impulsive	90	84	68
COIS School	19	—	18
COIS Social	0	—	0
COIS Home	36	—	13
COIS Global	7	—	1
COIS Total	62	—	32

Note: CBT = cognitive-behavioral therapy; CY-BOCS = Children's Yale-Brown Obsessive-Compulsive Scale; MASC = Multidimensional Anxiety Scale for Children; CPRS = Conners' Parent Rating Scale; COIS = Child Obsessive Compulsive Impact Scale. The MASC and COIS were not provided at the pre-CBT session to minimize participant burden. Only subscales deemed pertinent to the present study were included in the table.

impressions made during the clinical interview were confirmed using the Anxiety Disorders Interview Schedule for Children–Parent Version (Silverman & Nelles, 1988). Finally, an independent assessor provided ratings of the clinical severity and improvement (at posttreatment and follow-up assessments only) using the Clinical Global Impression of Severity (National Institute of Mental Health, 1985) and Improvement scales (Guy, 1976).

Table 1 presents scores for measures across assessments. At the baseline assessment, Jessica's CY-BOCS total score corresponded with severe OCD symptom severity. Results of the diagnostic interview using the ADIS confirmed the diagnoses of OCD and ODD. Jessica did not report clinical levels of anxiety on the MASC. On the FAS, Jessica's mother endorsed very high levels of accommodation. On the CPRS, Jessica's profile was consistent with a child disruptive and hyperactive behavior. Scores on the COIS revealed that she was experiencing modest school impairment (primarily on home-based tasks such as homework) but significant home and overall impairment as a result of her OCD symptoms. Based on the above information, the independent evaluator rated Jessica's symptom presentation on the Clinical Global Impression as "severely ill."

6 Case Conceptualization

Jessica's clinical presentation was complicated by her disruptive behavior. She was frequently noncompliant with parental requests and often behaved aggressively when denied her wishes. Her disruptive behavior resulted in significant family discord and conflict between Jessica and her siblings (e.g., Jessica becoming upset with her sisters for completing tasks "incorrectly"), her siblings and her parents (e.g., siblings angry about differential expectations for Jessica), and between her parents (e.g., how best to respond to her

symptoms). Many of Jessica's OCD symptoms were motivated by a "just right" feeling. For example, Jessica was unable to complete a task or had to repeat the task until she felt that it was "just right." She did not have the ability to cope effectively with her anxiety and thus relied on her parents to provide reassurance and assist her with rituals. Jessica's parents also significantly reduced their expectations for her participation in routine family activities, which provided secondary reinforcement for disruptive behavior.

The existing literature identifies CBT with ERP as one of the gold standards for treatment; however, youth who exhibit disruptive behaviors have poorer treatment outcomes than those who do not (Storch et al., 2008). Thus, we conceptualized Jessica as having two primary sets of symptoms, which, though they interacted, could be addressed separately in a sequential fashion. First, her disruptive behavior would be addressed through a brief course of evidence-based PMT (Kazdin, 1997) focused on reducing negative parent–child interactions and increasing compliance. Although up to six PMT sessions were planned, this phase of treatment lasted only four sessions because of her mother's rapid acquisition of skills. Through PMT, Jessica's mother learned to delineate between disruptive and OCD-related behaviors and to respond appropriately to disruptive behavior. Subsequently, Jessica participated in 11 daily exposure-based CBT sessions to address her OCD symptoms. These sessions primarily included ERP exercises, which are considered the primary therapeutic modality in OCD treatment (Abramowitz et al., 2005).

7 Course of Treatment and Assessment of Progress

Jessica's mother initially participated alone in three weekly 1-hr sessions of PMT; they attended the fourth session together to practice skills that had been learned. Session 1 began with psychoeducation about the nature and course of both OCD and DBD symptoms. This session also focused on educating Jessica's mother about differential attention to positive and disruptive behaviors. For example, she was encouraged to ignore acting out behaviors and was instructed to praise her when engaged in appropriate behavior. Jessica's mother identified at least two disruptive behaviors that she would ignore between sessions (i.e., crying when taking medication, messy eating habits). The mother was encouraged to attend to instances, no matter how brief, that Jessica was not engaged in either of the identified disruptive behaviors and to provide labeled praise (e.g., "I appreciate it when you take your medication without crying").

The second PMT session began with a review of between-session homework. Following additional practice in attending to positive behavior and ignoring negative behavior, the remainder of the session focused on strategies to improve compliance to commands. Providing effective commands and ensuring understanding were discussed. Jessica's mother and the therapist role-played providing commands and responding to successful (or not) compliance. Providing praise for compliance or warnings and specific consequences for noncompliance was addressed. For homework, the mother chose three tasks for Jessica to complete and was encouraged to use the strategies discussed in sessions to achieve compliance.

The third PMT session addressed the implementation of a token economy for specific behaviors. For example, Jessica's mother identified as a target behavior taking medicine the

first time without having to repeat the instruction. Her mother initially raised some concerns that using tokens could be interpreted as "bribing" her daughter. This notion was reframed as being a method of encouraging Jessica to engage in more socially appropriate behaviors. Jessica's mother chose three behaviors to target over the coming week. A chart was developed during the session to record the frequency of desired behaviors (i.e., which days Jessica took her medication after the first request). The mother completed the rewards list with her daughter at home to ensure that the rewards were motivating for Jessica. Consequences for negative behaviors and noncompliance were reviewed prior to the end of the session; they consisted primarily of removing privileges, such as no TV after dinner.

Jessica and her mother attended the final PMT session together. Initially, Jessica's mother and the therapist met alone to review strategies she had learned and discuss any areas of concern. Jessica was present for the middle portion of the session so that the therapist could evaluate the parent–child interaction in completing a task. Feedback was given to Jessica's mother following the interaction. The therapist spoke with her alone to identify strategies that worked (e.g., providing "good" commands) and to make suggestions for improvement (e.g., increasing statements of praise for appropriate behaviors). This was followed by a discussion about generalizing these strategies to other situations, particularly to the upcoming CBT course.

Jessica and her mother completed an assessment before beginning CBT to monitor treatment progress. Jessica's CY-BOCS score was reduced to 25 (from 31 at baseline), suggesting that although she still was experiencing clinically significant symptoms, some of the symptoms and impairment were related to her disruptive behavior rather than to OCD. Examination of the pattern of responses on the CPRS also indicated improvement as Jessica's scores on the Oppositional, Hyperactivity, Perfectionism, Psychosomatic, and Restless Impulsive scales declined.

Following conclusion of PMT, Jessica and her mother participated in 11 sessions of exposure-based CBT spanning 3 weeks. Under supervision of the second author, Jessica was seen by the first author and an advanced clinical psychology intern, with approximately half of the sessions seen by each. The initial CBT session involved constructing a hierarchy of Jessica's obsessions and compulsions that was based on child and parent reports of symptoms. Principles of cognitive therapy were also introduced. Specifically, the therapist provided the rationale for including cognitive components (i.e., cognitive restructuring, thought records) with ERP. Jessica completed an initial thought record in session with the therapist to ensure that she understood it. In the second CBT session, the therapist reviewed the rationale for ERP and conducted a relatively easy exposure.

Sessions 3 through 10 followed a similar pattern. At the beginning of each session, homework from the previous session was reviewed, and any problems were addressed. Cognitive strategies, including restructuring of maladaptive thoughts (e.g., if it doesn't feel right when I swallow the pill, something bad will happen), were then practiced. Following this, exposures were conducted. Examples of exposures for Jessica included throwing things away after having worked on them (e.g., a drawing), not asking for reassurance, taking medication by varying the order and swallowing it immediately, and altering tooth brushing and other grooming routines. Per practice guidelines, Jessica's anxiety was monitored throughout each exposure, and exposures were continued until her anxiety had

dropped in intensity by at least 50%. At various points throughout treatment, the therapists met alone with Jessica's mother to reinforce the behavioral strategies learned during the PMT phase of treatment. She maintained the skills that she acquired during PMT. The mother reported that she felt more confident with PMT skills and that she had generalized use of them to her other children.

The final session was devoted to relapse prevention. During this session, Jessica completed several exposures that she had been working on over the course of therapy, as she wanted to demonstrate hat she had made significant progress in symptom control. Generalization of skills to the home environment was addressed by discussing ways to conduct exposures at home and independently practice cognitive skills. As Jessica and her mother did not live near the clinic, this was particularly important. A follow-up session was scheduled for approximately 6 weeks later, so that progress might be assessed and to provide any additional support needed at that time.

Relative to baseline, Jessica's post-CBT assessment revealed significant improvement in her OCD and disruptive behavior. Her post-CBT CY-BOCS score of 8 (as compared to a baseline score of 31 and a pre-CBT score of 25) was consistent with subclinical symptom levels. On the MASC, Jessica reported reduced anxiety symptoms that were again well below the clinical range. According to the mother's report, family accommodation had decreased minimally since the first visit, which was reflected in only a 4-point decrease on the FAS. This is in contrast to her verbal report and clinician observations, which indicated that family accommodation was much improved and she and Jessica's father were not engaged in accommodation. Results of CPRS indicated continued improvement on indices of hyperactivity, perfectionism, psychosomatic complaints, and impulsive tendencies. These improvements may have been related to continued practice of behavioral management skills coupled with the skills acquired during CBT. On the COIS, the impact of Jessica's OCD symptoms had reduced at home and overall by more than 50%. Finally, based on all the available information and meeting with the family, the independent evaluator reported that Jessica was considered "very much improved." Anecdotally, the mother reported feeling more competent in providing discipline and helping her to combat OCD symptoms (which the clinical team agreed with) and also noted improved family harmony.

8 Complicating Factors

The most salient complicating factor was Jessica's disruptive behavior, which empirically has been linked to attenuated CBT and pharmacological response in pediatric OCD patients (Geller et al., 2003; Storch et al., 2008). Disruptive behavior was a specific focus of the PMT phase to minimize the impact such behaviors would have on CBT engagement. Jessica's mother responded well to PMT and engaged in the requisite behavioral tasks. Increasing her effectiveness as a parent and decreasing the child's disruptive behavior were critical to ensuring her CBT success. Throughout the CBT phase, Jessica's disruptive behavior was continually monitored, and "booster" PMT sessions were scheduled as needed.

Another complicating factor in this case was geography. Jessica and her mother lived 3 hours from the clinic and did not have access to a provider trained in evidence-based psychological care for OCD. During the PMT phase, it was difficult for the mother to attend appointments and/or arrange for child care for such a long duration.

Being far from home during treatment may affect conducting exposures as some of the feared stimuli may be specific to the patient's home environment; thus, exposures conducted in session were at times less "real" than they would have been at home. However, it may be that being in a novel situation allows for enhanced skill acquisition (Storch et al., 2007) and sufficiently prepares the patient to return to the home environment where anxiety may be greater. To address the distance barrier, Jessica and her mother stayed in a hotel during intensive treatment, which reduced their travel time to the clinic and allowed for additional flexibility if sessions ran long. Jessica and her mother returned home for the weekends. This fostered generalizability by allowing Jessica to complete therapeutic tasks in her home environment.

9 Follow-Up

One follow-up session was scheduled 6 weeks after the last intensive CBT session. This session was designed to assess Jessica's progress since ending treatment and to bolster any of her (or her mother's) CBT skills that had been waning. Jessica and her mother attended the session together, and her functioning since leaving treatment was reviewed. Both reported that the child's behavior had significantly improved and that they were both enjoying a more harmonious relationship. Jessica noted that the majority of her OCD symptoms had significantly reduced, although she continued to have modest difficulty with hoarding. Ways of handling residual hoarding symptoms were reviewed, with Jessica and her mother negotiating "rules" as to what Jessica would be allowed to keep in the home. At the end of the follow-up session, Jessica's mother and therapist discussed long-term follow-up. A phone session was conducted 1 month later, and, given sustained gains, treatment was concluded.

10 Treatment Implications of the Case

The purpose of this case was to investigate whether a brief course of PMT would improve outcomes for a youngster with OCD and comorbid DBD. The present case study provides initial support for this treatment strategy. Results of Jessica's case indicate that a brief course of PMT was associated with decreases in disruptive behavior, increased compliance, and improvements in parental effectiveness. Given the child's pattern of symptoms, unwillingness to follow directives, and intolerance for wish denial, it is unlikely that she would have responded positively to CBT without sequential PMT. As noted earlier, CBT relies on the patient's engagement in exposures and participation in other therapy related activities (e.g., cognitive restructuring). If Jessica and her parents had not had an opportunity to learn more effective behavioral management strategies, she likely would not have participated in sessions and completed between-session exposures, both of which are necessary therapeutic mechanisms. At the end of treatment, Jessica's OCD symptoms were in the subclinical range, and she was experiencing a more harmonious relationship with her family members. Finally, though not specifically studied here, this case provides additional evidence that family involvement in treatment is important, particularly with youth. Jessica's mother was actively involved in sessions that may have improved outcomes by

enhancing her acquisition of both PMT and CBT skills and making it possible for the therapist to observe and correct maladaptive parental behaviors.

11 Recommendations to Clinicians and Students

Based on the present case and relevant literature (e.g., Sukhodolsky et al., 2005), two recommendations are made to clinicians and students working with pediatric OCD and comorbid DBDs. First, a thorough assessment of the nature and severity of any DBDs should be included in the initial assessment. Given the negative impact of DBDs on OCD treatment, assessing the extent to which the child engages in disruptive behavior, as well as the family's ability to cope with it, is essential in designing an effective intervention. Second, providing treatment for DBDs and maladaptive familial patterns prior to beginning CBT may improve outcomes. A short course of focused treatment may improve efficacy by instructing parents in behavioral management techniques in terms of giving good commands, encouraging compliance through praise and reward, and learning effective punishment strategies. One important component is ensuring that parents feel competent and confident in their new abilities, have the time to practice them between sessions, and have an opportunity to receive feedback. PMT and the resulting increased compliance can be beneficial later when parents must help their child engage in anxiety-provoking exposures and refrain from engaging in rituals.

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Heather D. Lehmkuhl, PhD, is a pediatric psychologist at Nationwide Children's Hospital in Columbus, Ohio.

Eric A. Storch, PhD, is an associate professor in the Departments of Pediatrics and Psychiatry at the University of South Florida in St. Petersburg.

Omar Rahman, MA, is a research associate in the Department of Pediatrics at the University of South Florida in St. Petersburg.

Jennifer Freeman, PhD, is a research assistant professor at Brown University in Providence, Rhode Island.

Gary R. Geffken, PhD, is an associate professor in the Department of Psychiatry at the University of Florida in Gainesville.

Tanya K. Murphy, MD, is the Maurice A. and Thelma P. Rothman Chair of Developmental Pediatrics and professor in the Departments of Pediatrics and Psychiatry at the University of South Florida in St. Petersburg.