The Society for Clinical Child and Adolescent Psychology (SCCAP): Initiative for Dissemination of Evidence-based Treatments for Childhood and Adolescent Mental Health Problems

With additional support from Florida International University and The Children's Trust.

SOCIETY OF CLINICAL CHILD & ADOLESCENT PSYCHOLOGY

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Keynote

Evidence-based Treatment of Obsessive Compulsive Disorder in Children and Adolescents

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Disclosure

Royalties for Treatment
Manual and Child Workbook
from Oxford University Press

OCD Diagnostic Criteria

OBSESSIONS

- Unwanted, repetitive, intrusive thoughts, impulses, images
- Cause marked distress
- Not simply excess worries about everyday topics
- Individual attempts to ignore, neutralize or suppress
- Usually recognized as product of one's own mind

Obsessions – Adult

I just know I left the oven on.

Obsessions – Child

I just know I left the computer on.

OCD Diagnostic Criteria

COMPULSIONS

- Repetitive behaviors or mental acts conducted in response to obsession
- Typically performed in stereotypic or rule-bound fashion
- Behavior logically unrelated to obsessive fear or else completed in manner out of proportion to fear
- Aimed at reducing stress or preventing dreaded event

OCD Diagnostic Criteria
Features in Childhood

Obsessions

- May be less well-formed in children than adults
- “Bizarre” easily misdiagnosed

Accompanying Feelings

- Fear/Anxiety, Doubt, Disgust, Unacceptable urges, Sensory Incompleteness

Checking Compulsions

OCD Diagnostic Criteria

Children and adolescents do not need to recognize that symptoms are excessive or unrealistic

Symptoms must be:

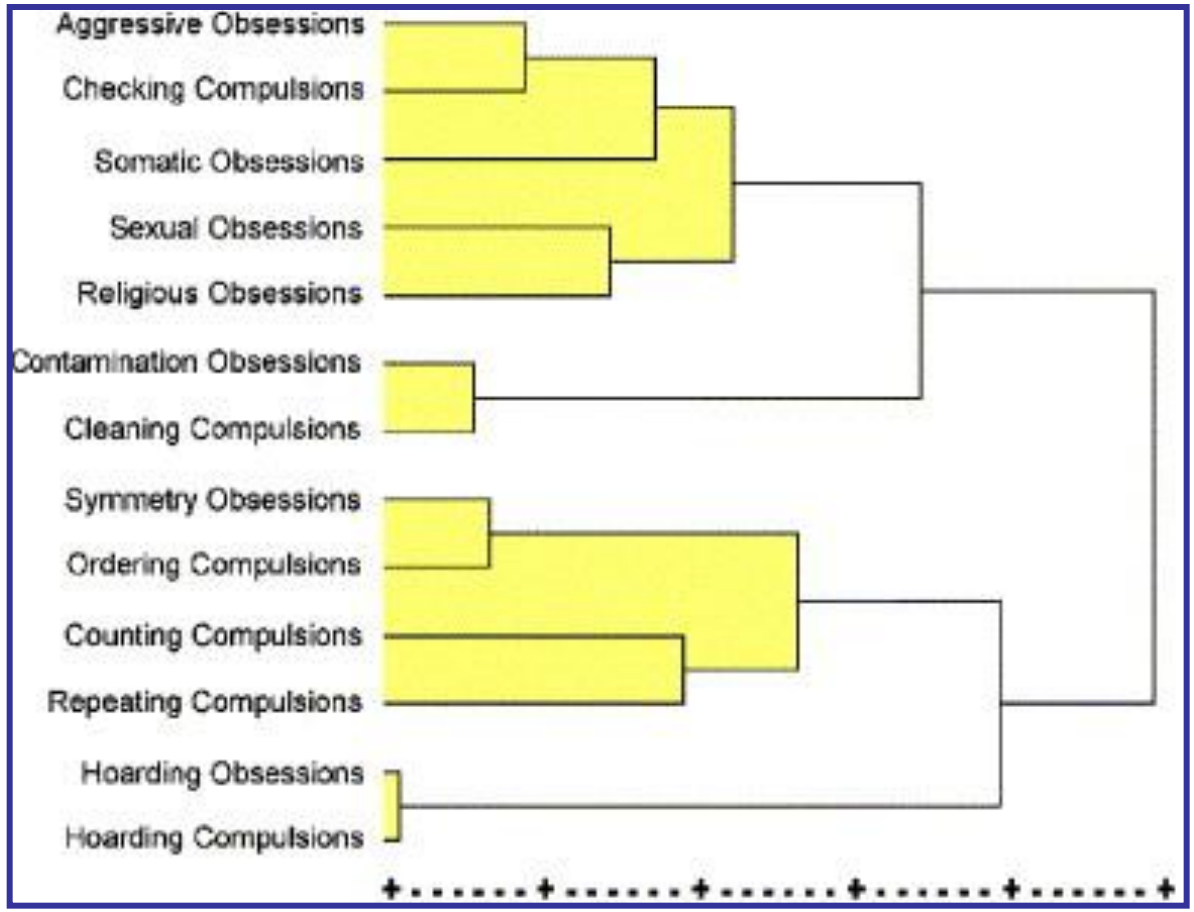
- Distressing,
- Interfering, or
- Time consuming

Not due to another Axis I disorder or general medical condition

Obsessions and Compulsions

OBSESSION	COMPULSION
• Contamination	Washing / Cleaning
• Concern about Harm	Checking / Others
• Need for Symmetry	Arranging / Tapping
• Fear of losing things	Hoarding
• Fear of embarrassment	Avoidance
• “Just Right” Phenomenon	Repeating
• Moral obsessions	Confessing / Telling

Clustering of Symptoms



Hasler et al. (2007)

Major Symptom Factors of OCD

- Aggressive / harm obsessions & checking compulsions
- Contamination obsessions & cleaning compulsions
- Symmetry / order obsessions & arranging / precision compulsions
- Saving / collecting obsessions & hoarding / saving compulsions
- Sexual/religious obsessions & mental compulsions

(Leckman et al, 1997; Summerfeldt et al, 1999; Calamari et al, 1999)

Childhood OCD

- 1-3% prevalence
- More common in boys prepubertally
- Onset may be abrupt or gradual
- Onset or exacerbation may be related to psychosocial trauma or stress in some cases
- Symptoms may wax and wane or be chronic and progressive
- Child may be able to ignore/resist symptoms at times (e.g., with friends, at school)
- Symptoms worse when child sick, stressed, or tired
- Variable course: 41% full-OCD after 1-15yr FU; 60% at least some symptoms (Stewart et al., 2004)

OCD-Related Functional Impairment

- One of 10 most disabling medical conditions worldwide (Murray and Lopez, 1996)
- 151 OCD youngsters and their parents completed parallel self-report rating scale (COIS) assessing OCD-related dysfunction in three areas: home/family, school, and social
- 88% of parents and 85% of children reported at least one area of significant OCD-related dysfunction.
- Half of sample reported significant OCD-related dysfunction at home, in school, and socially.
- Parents more likely to report home/family problems, children more likely to report problems related to mental rituals.

Piacentini et al., 2003

Most Common Problems

Parent Report

Concentrating on school work	72 %
Doing homework	68
Doing assigned chores at home	67
Getting ready for bed at night	66
Getting along with parents	66
Bathing / grooming in the morning	62
Getting dressed in the morning	60
Getting to school on time	59
Taking tests	59
Completing in-class work	57
Sleeping at night	56
Getting along with sibs	55

Piacentini et al., 2003

Most Common Problems
Child Report

Concentrating on school work	64	%
Letting others touch / use things	62	
Doing homework	60	
Being with a group of strangers	56	
Completing in-class work	55	
Getting ready for bed at night	54	
Bathing/grooming in morning	52	
Doing assigned chores at home	52	
Sleeping at night	49	
Getting along with parents	49	
Getting to school on time	48	
Writing in class	48	
Taking tests	46	

Piacentini et al., 2003

OCD-Related Impairment

Parent-Child Differences

	Child-Report			Parent-Report			
	No Problem	Slight Problem	Significant Problem	No Problem	Slight Problem	Significant Problem	Parent-Child Diff
	%	%	%	%	%	%	*t (P>C)*
GLOBAL PROBLEM RATINGS							
Problems at School	20	36	44	20	33	47	1.52
Problems socially with friends	46	35	19	24	42	33	4.33***
Prevented from going places	48	32	20	43	32	25	1.50
Problems at home/with family	23	29	48	8	27	66	4.28***

*** p < .001

Piacentini et al., 2003

Comorbidity in Childhood OCD

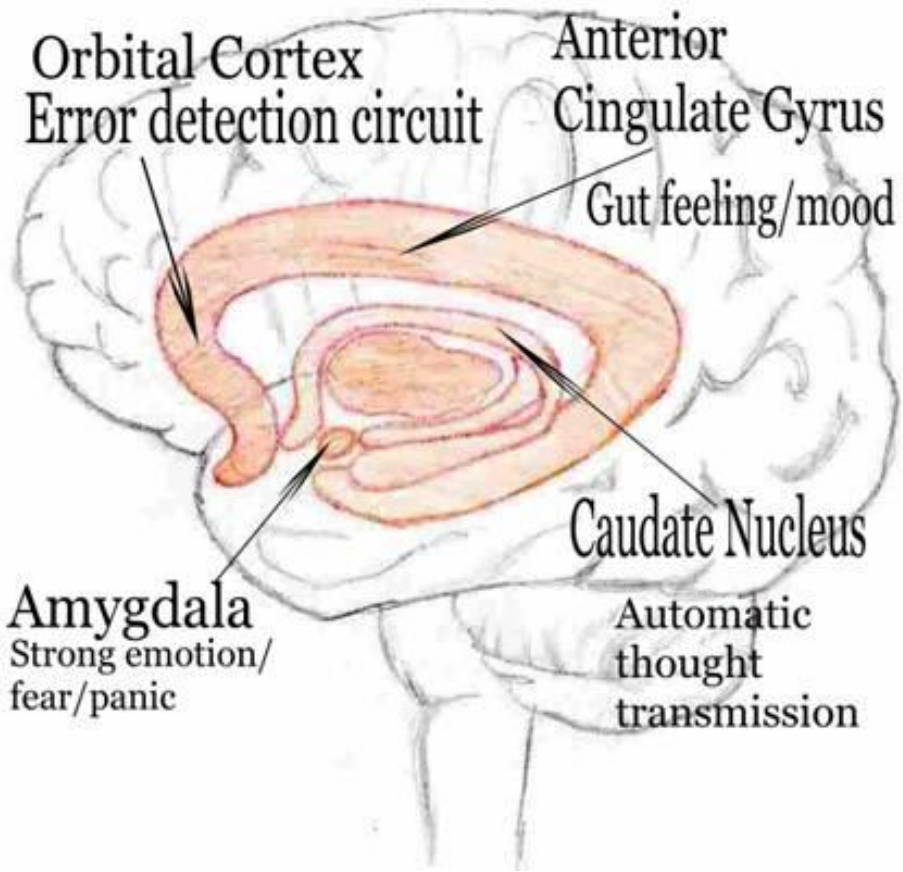
	N	%
Other Anxiety Disorders	47	42.0
ADHD	22	19.6
ODD/CD	10	8.9
Tic Disorders	12	10.7
MDE/Dysthymia	12	10.7
One Comorbid Disorder	82	73.2
Multiple Comorbid	35	31.3

(N=112) UCLA Child OCD Program

OCD Neurobiology

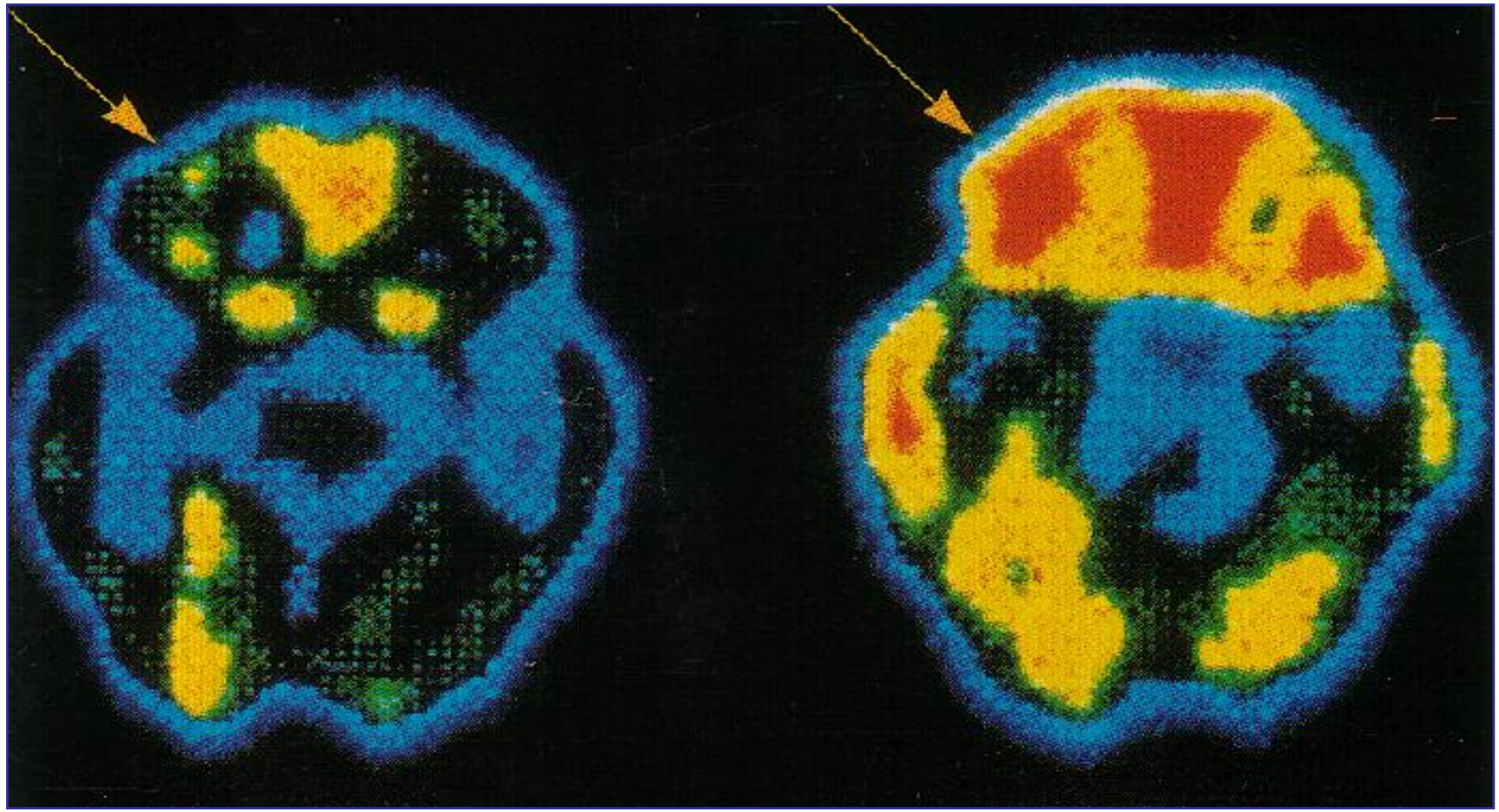
- Serotonin Hypothesis: SSRI efficacy, but 5-HT and metabolites not found to consistently differ between OCD and normals in CSF or peripherally
- 5-HT binding studies suggest impaired 5-HT binding may play a role in OCD pathogenesis
- Mixed evidence for dopaminergic involvement. Increased dopamine transmission in basal ganglia may relate to hyperactivity of cortico-striato-thalamo-cortico circuit.

Cortico-Striatal-Thalamic Model



- Circuit possibly involved in regulation of repetitive thoughts and behaviors: underactive caudate nuclei so that thoughts, actions generated by orbitofrontal cortex are not suppressed

Baseline Glucose Metabolism in OCD

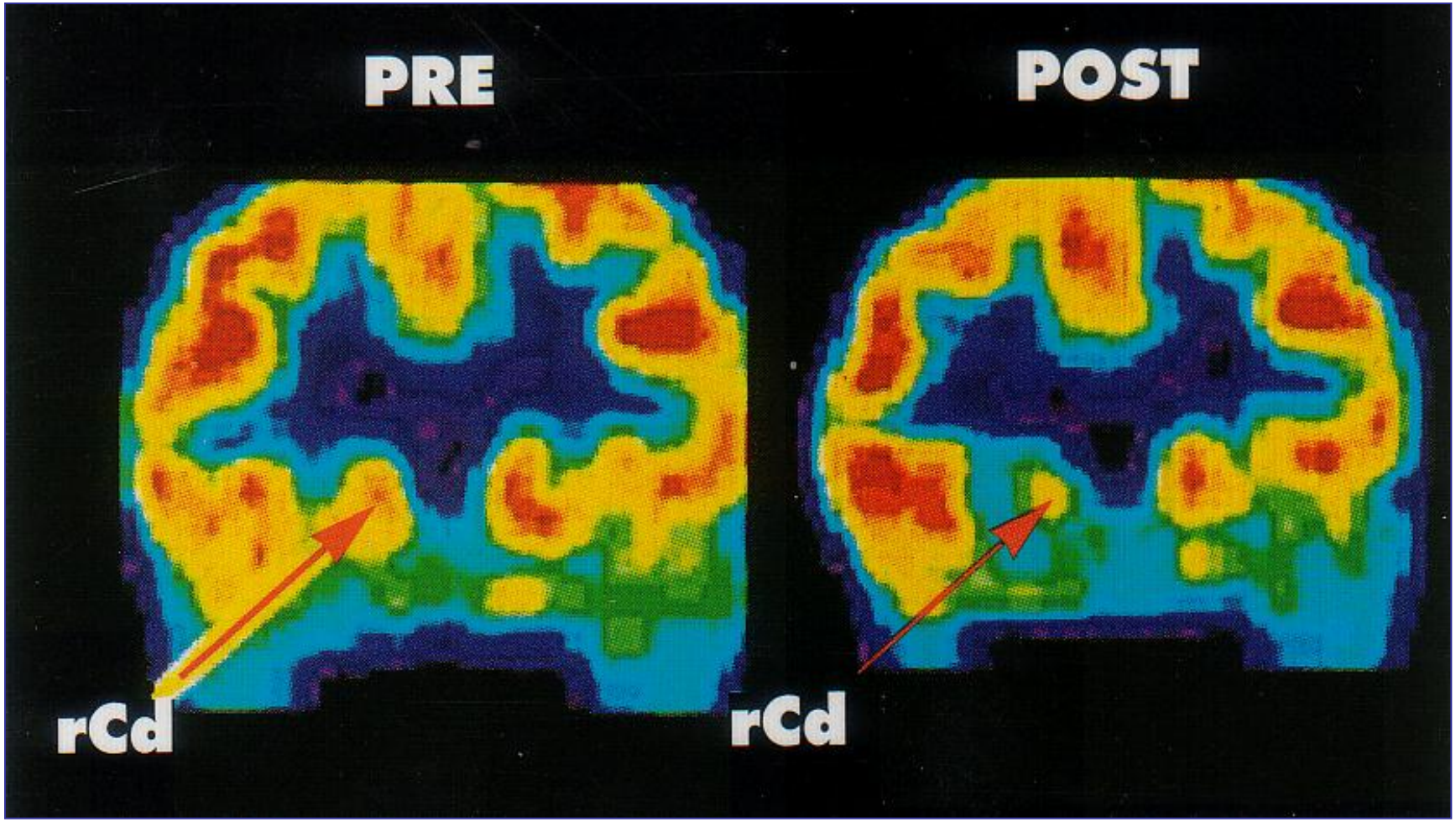


NORMAL **OCD** Schwartz, 1996

OCD Neuroanatomy

- Increased glucose metabolism or other indices of activation in the orbitofrontal cortex and caudate nuclei
- Normalizes with behavioral and pharmacological treatment (Schwartz et al., 1996)
- Part of a circuit possibly involved in regulation of repetitive thoughts and behaviors: underactive caudate nuclei so that thoughts, actions generated by orbitofrontal cortex are not suppressed

Change in Glucose Metabolism Pre/Post CBT



Schwartz, 1996

OCD Neuropsychology

- Deficits in systems subserved by dorsal and ventral corticostriatal circuitry
- Executive function: set-shifting, spatial working memory (DLPFC); alternation tasks, decision-making (OFC)
- Cognitive flexibility, reversal learning ?
- Methodologic problems (small N, heterogeneous samples) limit conclusions that can be drawn

OCD Genetics

- Family studies show rates of OCD significantly greater in relatives of probands vs. controls (12% vs 2%) (Pauls et al., 1995)
  - Familiality increases with increased homogeneity of proband symptom type (e.g., cleaning, hoarding, etc.)
  - GAD and agoraphobia show strong association to OCD phenotype (family rates remain elevated when dx controlled for in probands)
  - Major depression elevated in relatives but likely secondary to OCD
  - Perhaps predisposition for anxiety, not specific dx, is inherited
  - Tics and earlier onset age associated with higher rates (esp in combination)

Nicolini et al (2009)

OCD Genetics

- Segregation analyses suggest evidence for both single and polygenic inheritence
  - Ordering and symmetry, OCD with eating disorder, early onset age – Autosomal Dominant
- Candidate gene studies:
  - COMT, MAO-A, Dopamine transporters and receptors – studies typically small with mixed results.
  - More evidence for SERT (serotonin transporter) and 5-HT receptor genes
  - Glutamate transporter SLC1A1 has been associated with OCD in multiple studies

Nicolini et al (2009)

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Strep

PANDAS Diagnostic criteria

- Presence of obsessive-compulsive disorder and/or a tic disorder
- Pediatric onset of symptoms (age 3 years to puberty)
- Episodic course of symptom severity
- Association with group A Beta-hemolytic streptococcal infection (a positive throat culture for strep or history of Scarlet Fever)
- Association with neurological abnormalities (motoric hyperactivity, or adventitious movements, such as choreiform movements)

http://www.nimh.nih.gov

Strep + OCD = PANDAS ?

- **NO**
- Almost all school aged children get strep throat at some point in their lives.
- The average child has 2-3 strep throat infections each year.
- PANDAS is considered only when there is a very close relationship between the abrupt onset or worsening or OCD and/or tics, and a preceding strep infection.
- If strep is found in conjunction with two or three episodes of OCD/tics, then it may be that the child has PANDAS.

- **PANDAS IS NOT A VALIDATED DISORDER**

http://www.nimh.nih.gov

What to do for PANDAS

OCD

- Treat the OCD symptoms according to best practice standards

Strep infection

- Treat the strep infection according to best practice standards

What not to do for PANDAS

- Steroids
- Plasmapheresis
- Intravenous immunoglobulin
- Antibiotic prophylaxis

Cognitive Aspects

of OCD

Intrusive Mental Processes

- 80-90% community experience occasional intrusive thoughts
- Similar in content to obsessions from patient samples (e.g., Rachman & de Silva, 1978)
- Exacerbated by stress but subside

Cognitive Biases in Adult OCD

Thought-Action Fusion

Individuals with TAF:

- Experience thoughts and actions about harm as equivalent (thinking it is same as doing it)
- Believe that having an intrusive negative thought is as wrong as acting it out (thinking it is as bad as doing it)

Exaggerated Responsibility

- Failing to prevent or trying to prevent harm to others is the same as having caused harm
- Responsibility is not attenuated by low probability of occurrence

(Rachman, 1993)

Cognitive Processses in Child OCD

Barrett & Healy, 2002

- OCD children report higher levels of responsibility, probability of harm and severity, thought action fusion, and less cognitive control compared to nonclinic comparison children.
- OCD children only reported less cognitive control than anxious comparison children.
- Specificity of cognitive biases to OCD is questionable in children. May be developmental phenomenon

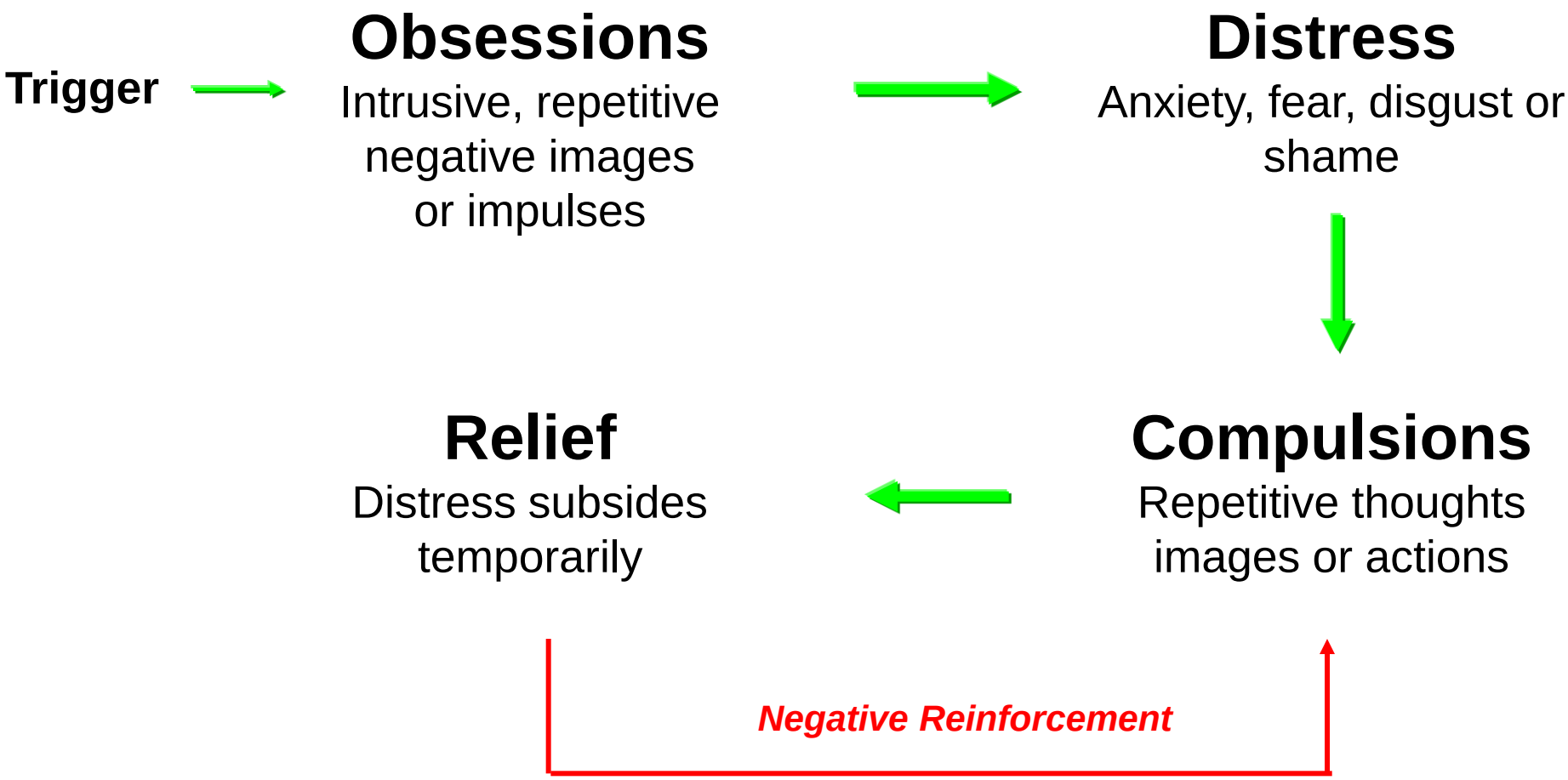
Cognitive Processses in Child OCD

Barrett & Healy, 2004

- Experimental manipulation of responsibility during BAT.
  - Manipulation inflated perceived responsibility for harm in OCD children
  - However, this did not lead to increases in estimated probability or severity of harm or distress.
- CBT led to significant decreases in perceived responsibility for harm, probability and severity of harm, and distress.
- Although CBT effective in addressing responsibility, this bias may not be as important in child OCD versus adult disorder.

Obsessive Compulsive Cycle

Obsessive Compulsive Cycle



Assessment of Childhood OCD

Accurate Diagnosis of OCD in Youth

- Young children tend to think in the moment and hence misrepresent symptoms or severity
- Adolescents may under-report symptoms (especially boys)
- The nature of certain symptoms (otherwise normative behaviors) leads to misdiagnosis or being missed completely
- Accurate diagnosis in youth is dependent upon both child/adolescent AND parent report (DiBartolo, Albano, Barlow & Heimberg, 1998)

Assessment of Childhood OCD

GOALS

- Determine baseline severity
- Identify comorbidities and other complicating factors
- Monitor response to treatment

CONSIDERATIONS

- Secretive nature of symptoms
- Multiple informants
- Developmental issues
- Family assessment

Assessment of OCD

Diagnostic Interview Schedules

- Provides reliable differential diagnoses

Behavioral Assessment Techniques

- Fear and Avoidance Hierarchies
- Behavioral Avoidance Tasks

Questionnaires

- Self-Report; Parent-Report; Teacher Ratings

Differential Diagnosis

Other Anxiety Disorders

GAD, SAD, Panic

Pervasive Developmental Disorders

Asperger's Syndrome

Tic Disorders

Compulsion vs. Complex Motor Tic

Other Disorders

Children's Yale-Brown Obsessive Compulsive Scale (CYBOCS)

10 Items

- 5 items on Obsessions Subscale
- 5 items on Compulsions Subscale

Each item scored 0 - 4

- 20 Point Maximum for Obsessions
- 20 Point Maximum for Compulsions

Total Score ranges from 0-40

CYBOCS ge 15 → clinically significant OCD

CY-BOCS: Checklist Categories

- Washing/Cleaning
- Checking
- Repeating
- Counting
- Ordering/Arranging
- Hoarding/Saving
- Excessive Games/Superstitious Behaviors
- Rituals Involving other persons
- Sexual Obsessions
- Somatic obsessions
- Aggressive Obsessions
- Miscellaneous

Child OC Impairment Scale (COIS-R)

- Measure of OCD-specific impairment
- Parallel Child/Adult Versions
- Covers School, Social, Home
- Good psychometrics
- Useful in helping break down child resistance to treatment

Piacentini et al., 2007

Summary of Child Assessment

Multi-informant:

- child, parent, teacher

Multi-method:

- Self-report, clinician driven, behavioral, observational

Developmentally sensitive

Ongoing through treatment

OCD Treatment Planning

Assessment

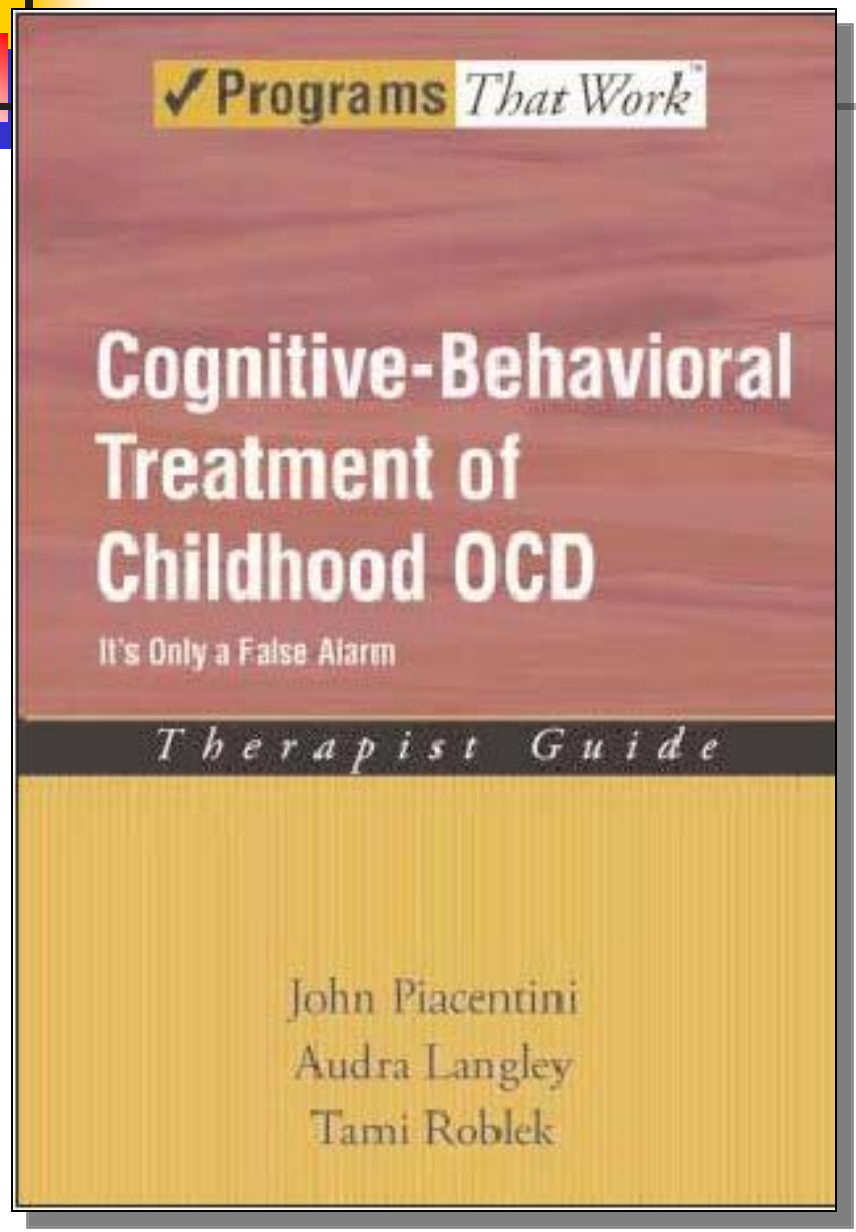
1. OCD Symptoms, Severity, Impairment
2. Comorbid Disorders

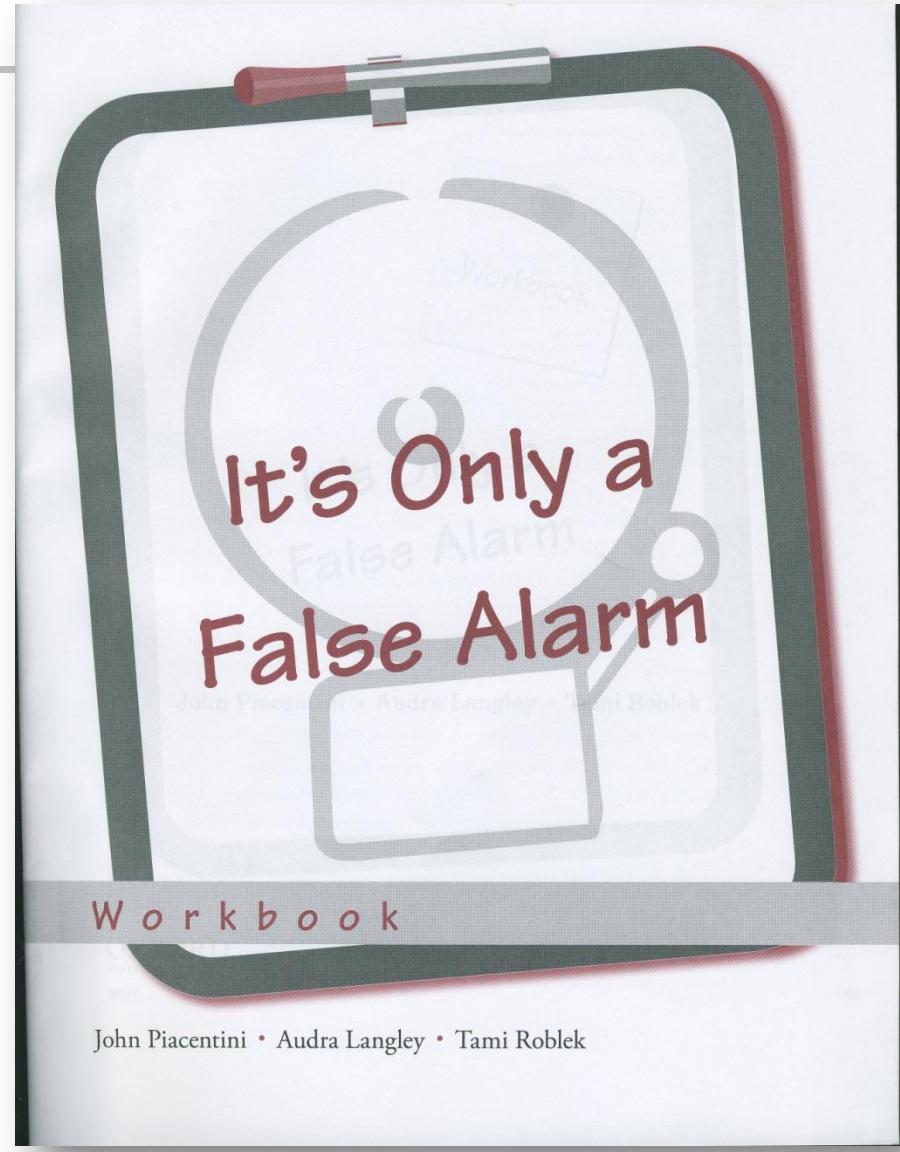
Treatment Planning

1. Effective vs. ineffective treatments
2. Assess insight and motivation
3. Determine most appropriate treatment setting
4. Assess need for combined medication and CBT
5. Prioritze treatment of comorbid disorders
6. Address family and environmental factors

Education: patient, family, etc.

Cognitive Behavioral Treatment of Childhood OCD


✓Programs That Work
Cognitive-Behavioral Treatment of Childhood OCD
It's Only a False Alarm
Therapist Guide
John Piacentini
Audra Langley
Tami Roblek


It's Only a False Alarm
Workbook
John Piacentini • Audra Langley • Tami Roblek

CBT Program for Childhood OCD

- **Psychoeducation** - to reduce blame, stigma, anxiety
- **Assessment** - “Fear Thermometer” to create sx hierarchy
- **Graded Exposure**
- **Response Prevention**

} **to address “core” OCD symptoms**

- **Use of Graphics** - visual record of progress
- **Reward Program** - motivation and address comorbidity
- **Cognitive Restructuring** - to manage anxiety and obsessions
- **Homework** - to foster generalization
- **Family Work** - to foster maintenance of tx gains

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Psychoeducation

GOALS: Reduce stigma, blame, and anxiety

Prevalence

- Common Disorder (0.5 - 2%)

Neurobiological Framework

- “Asthma” analogy

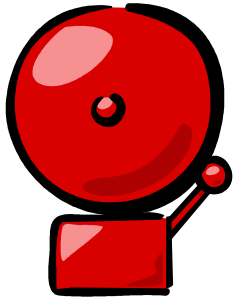
Ethological Perspective

- Anxiety as “False Alarm”

Ethological Perspective

Anxiety has been conserved as an evolutionary trait across species because it serves a protective function

OCD as a False Alarm



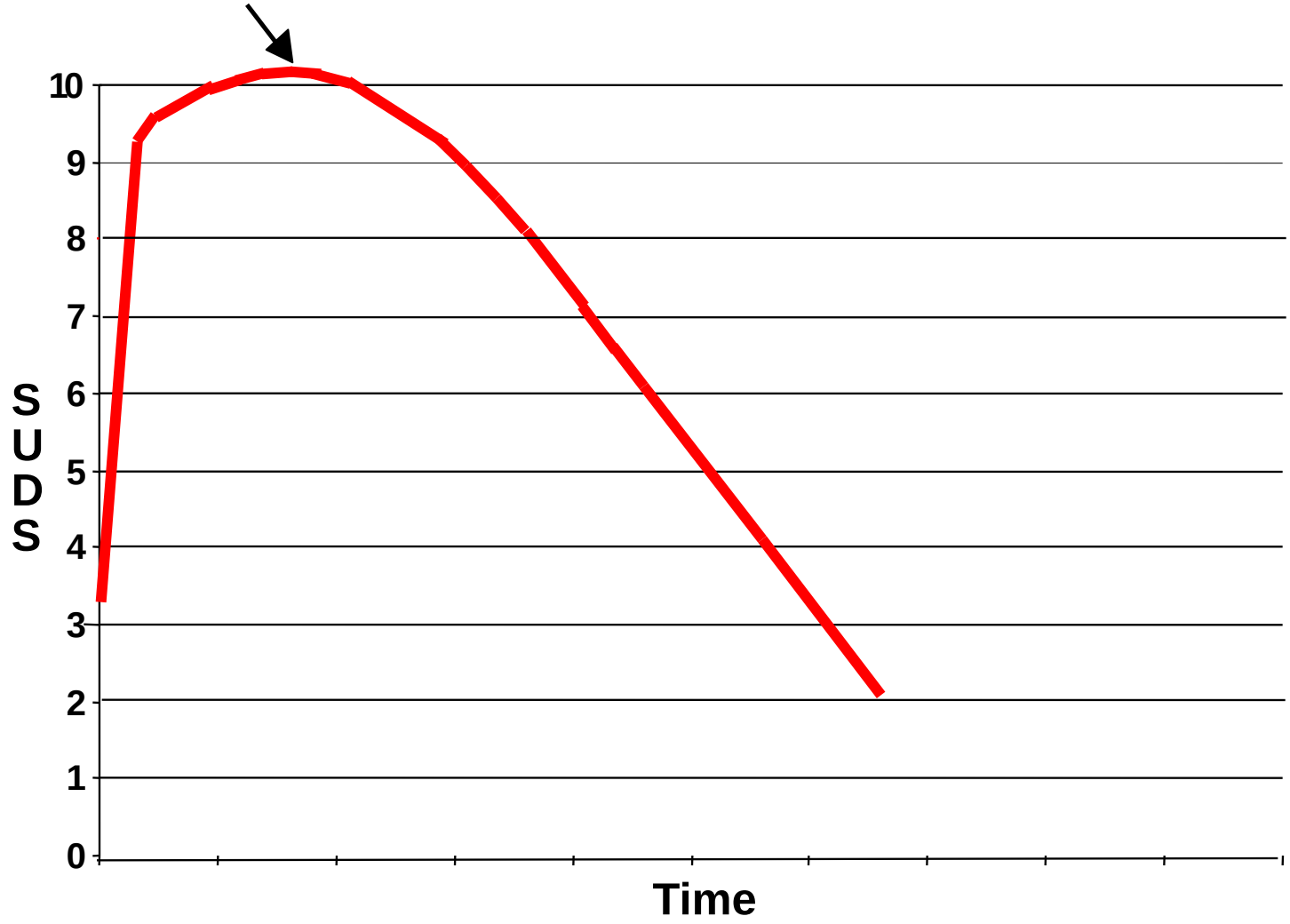
Fire Drill Analogy

The fire alarm is scary sounding to get your attention and make you leave the school building in case there's a fire.

But sometimes the alarm goes off when there's no fire (a false alarm). It still sounds scary, even though there's no real danger.

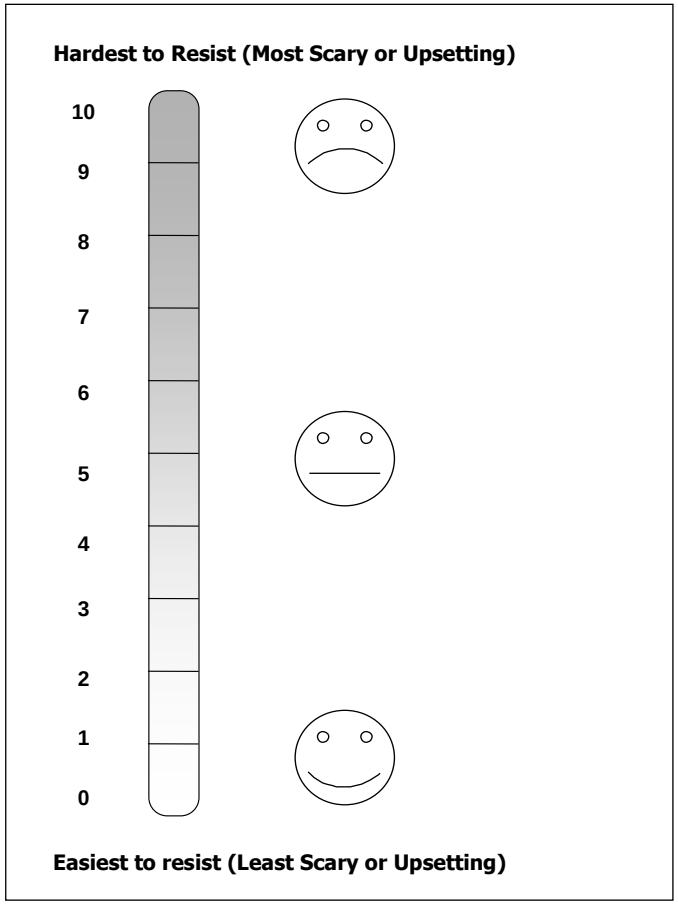
OCD is like a false fire alarm. It makes you scared even when there's no real danger. In treatment you will learn how to ignore your OCD false alarm so it doesn't bother you anymore

OCD Habituation - 1



OCD Symptom Hierarchy

Fear Thermometer (SUDS)



OCD Symptom Hierarchy

Situation	SUDS
Walking through kitchen door	10
Checking locks at night	9
Turning TV on and off (3 times)	6
Flipping lightswitch (3 times)	6
Erasing/Rewriting Homework	4
Brushing teeth	3
Throwing away old homework	2

Negative Reinforcement Cycle

Obsessions
Repetitive negative, images or impulses

Distress
Anxiety, fear, disgust or shame

Compulsions
Repetitive thoughts images or actions

Relief
Distress subsides temporarily

Negative Reinforcement

Exposure Plus Response Prevention (ERP)

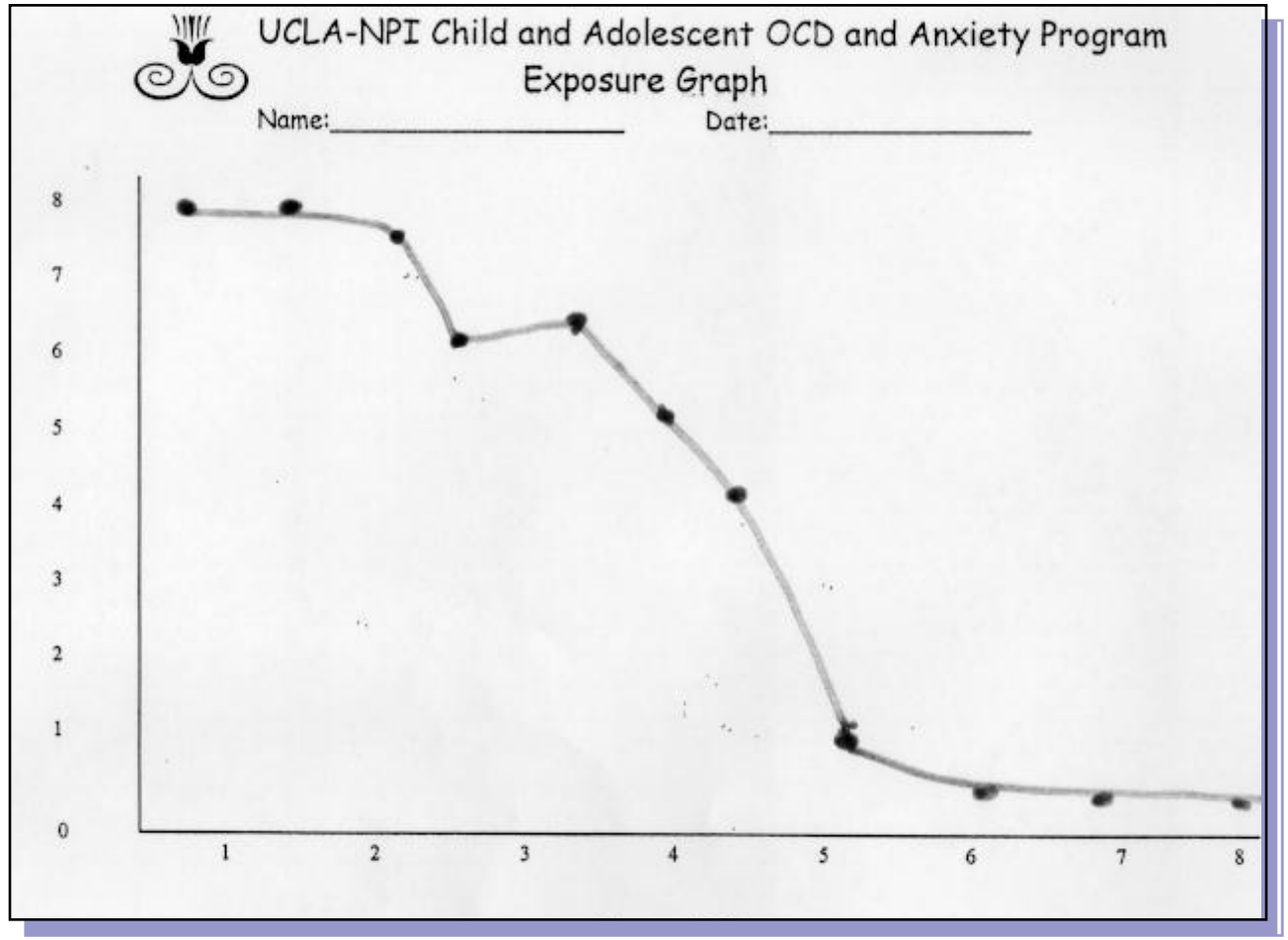
EXPOSURE

- Begin with item low on Symptom Hierarchy
- Therapist models behavior first

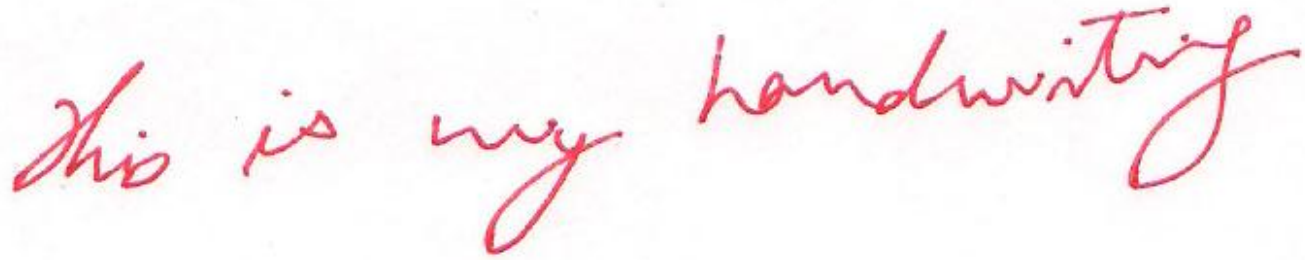
RESPONSE PREVENTION

- Individual encouraged to resist ritualizing
- Assess SUDS (anxiety) level at frequent intervals
- Continue exposure until anxiety decreases > 50% from peak
- Repeat exercise as often as possible in session

Exposure Graph



Writing Crooked



Optimizing Exposure Efficacy

Craske et al., 2008; BRAT

Within and between session habituation does not predict anxiety reduction over time in adults

Length of fear expression predicts extinction learning

Treatment Implications

- Exposure goal - sustained fear tolerance not fear reduction
- Patient expectations about exposure
- Unpredictability of exposure (e.g., symptom grab bag)
- Sustained exposure
- Developmental considerations

Unclear if this applies to younger children

Cognitive Restructuring

Externalize: Recognize and Relabel Fears as OCD

- *“I won’t get sick if I touch this, its just my OCD talking”*

Reality Testing

- *Challenge irrational beliefs*

Mindfulness-based Approaches

- *Neutral, non-affective reaction to symptoms and fear*

Learn to Tolerate Uncertainty

- *Bad things do happen, just not very often*

Exposing Obsessive Thoughts

Write the OCD thought you are going to work on here:

_____

The following list contains a number of different ways you can expose this thought. There are a few blank spaces at the bottom in case you and your therapist come up with some additional ideas. Now rank the exposures in order from easiest to hardest, starting with the number 1.

Rank (1 is easiest)	Exposure List
_____	Imagine the thought
_____	Write the thought
_____	Draw a picture of the thought
_____	Say the thought out loud
_____	Tell the thought to my therapist
_____	Show my therapist a picture of the thought
_____	Have my therapist read my description of the thought
_____	Sing the thought
_____	Record the thought and listen to it
_____	_____
_____	_____

Homework

How Often

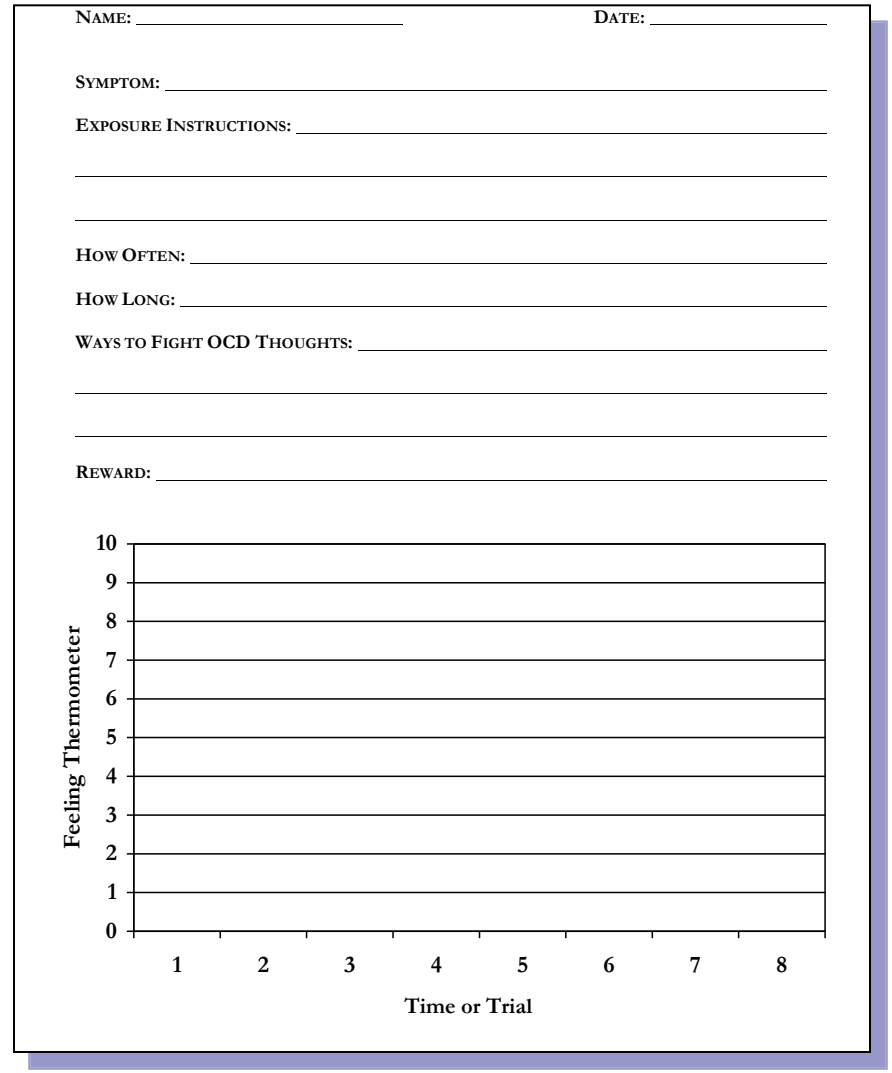
- Daily for 30-45 minutes or until anxiety disappears

What is Practiced

- Situations covered in session
- Situations unable to be covered in session

Reviewed in Session

Covered by Reward Program



Reward Program

How Often

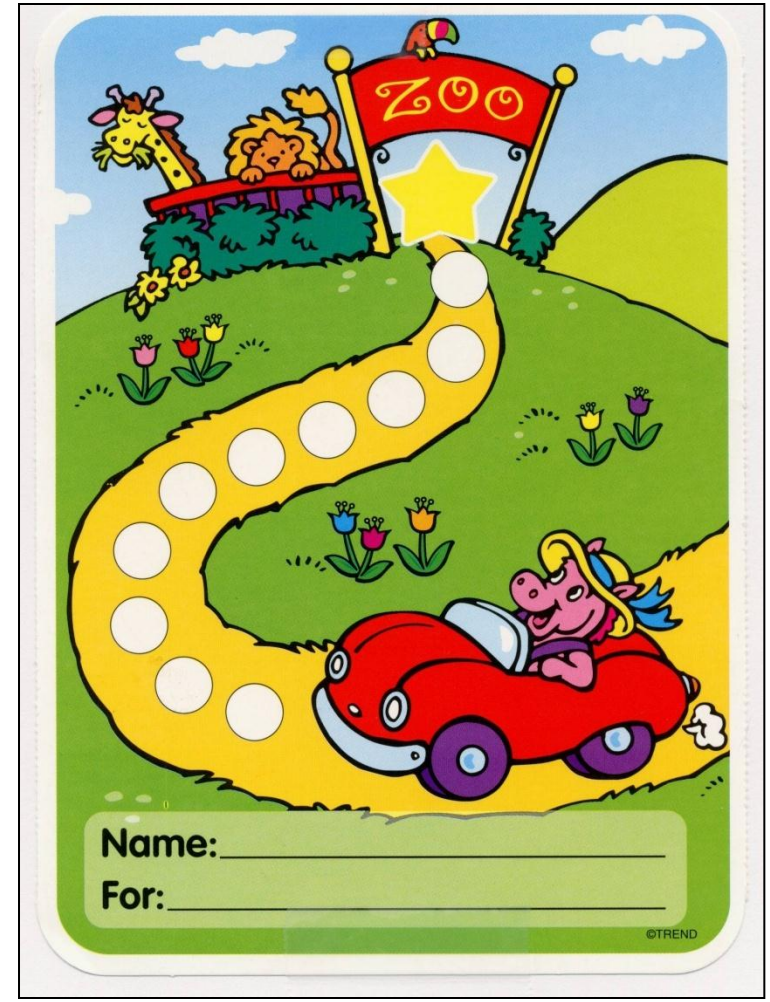
- Younger children or more difficult tasks require more frequent rewards

What Gets Rewarded

- Effort not results
- Clearly defined behaviors

Selecting a Reward

- Desired, strong, realistic

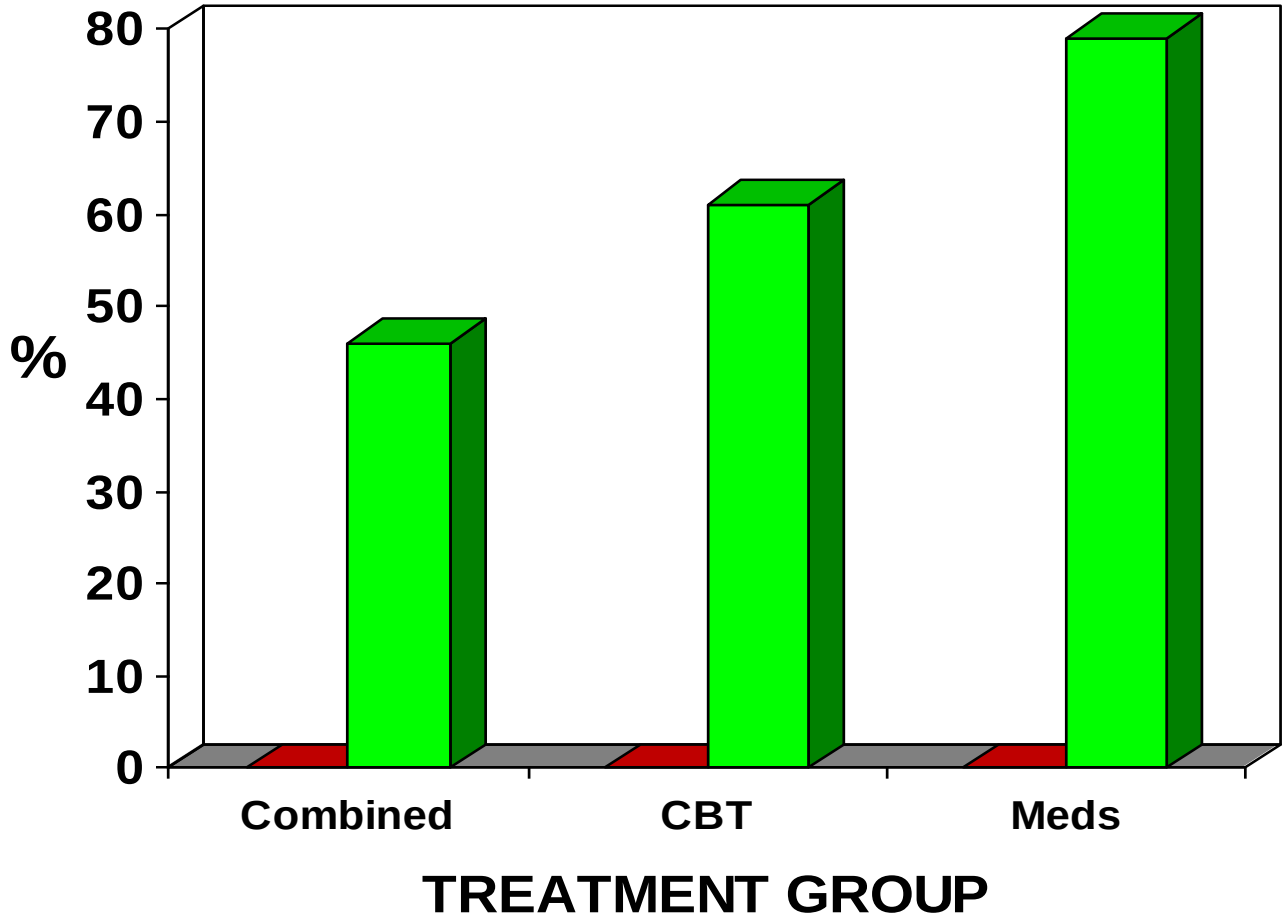


Family Factors in Childhood OCD

Treatments for child OCD typically do not lead to symptom remission

POTS I: Symptomatic at Post-Tx

(CYBOCS > 10)



Combo	46%
CBT	61%
SSRI	79%

POTS Team, 2004

Predictors of Worse CBT Response

Adult Studies

- Comorbidity
- Motivation
- Fixity of Beliefs
- Family Factors
  - Expressed Emotion
  - Patient expectation of criticism

Abramowitz et al. (2000); Chambless et al. (1999); Foa et al. (1997)

Predictors of Worse CBT Response

Child/Adolescent Studies

- More severe OCD
- Poorer psychosocial functioning
- Family history of OCD
- Family factors
  - Overall family dysfunction
  - Parental blame/criticism
  - Poorer family cohesion
  - Higher family conflict

Barrett et al. (2005); Piacentini et al. (2002); Peris et al. (submitted); Mars Garcia et al. (2010)

Family environment may be an important intervention target

Family Factors in Child OCD

- Family Distress/Dysfunction (66 – 90%)
- Elevated rates of parental OCD (20 – 50%)
- Elevated rates of Parental Blame
- Elevated rates of Expressed Emotion
- Family Accommodation (62 – 100%)
- Actual participation in OCD rituals (50 – 75%)

Allsopp & Verduyn, 1990; Apter et al., 1984; Bolton et al., 1983; Cooper et al. 1996; Peris et al., 2008; Piacentini et al. 2003; Storch et al., 2007; Van Noppen et al., 1991

Family Accommodation

Family accommodation is thought to be a barrier to treatment inasmuch as it reinforces avoidance behaviors and undermines exposure-based exercises

Family Accommodation

Calvocoressi et al. (1995; 1999)

- High rates of family accommodation
- Associated with increased family distress

Amir et al. (2000)

- Modification of family routine linked with depression
- Refusal to accommodate linked to anxiety
- Accommodation not linked to severity of child's OCD

Storch et al. (2007)

- Family accommodation may mediate the relationship between
- OCD symptom severity and associated functional impairment

Family Accommodation

	Less than 1x/month	Weekly	Daily
Participation in OCD			
reassure patient	14%	**30%**	**56%**
participate in rituals	41	**14**	**45**
Consequences of not participating			
pt becomes distressed/anxious	19	**47**	**34**
pt becomes angry/abusive	48	**29**	**22**

	None	Mild Moderate	Severe
Modification of family routine			
modified family routine	33	**55**	**13**
Distress			
when OCD not accomodated	27	**60**	**13**

Peris et al., 2008

Family Context of Childhood OCD

- FAMILY ACCOMMODATION very common
- 60-90% report participating in child's OCD via reassurance or worse
- 50-80% report child reacts negatively when accommodation is resisted
  - positively correlated with OCD severity and presence of comorbid externalizing symptoms
- 75% of parents report distress when giving in to their child's OCD
  - given parental resistance is key part of CBT, this needs to be addressed in treatment

Peris et al., 2008

Parental OCD and Family Context

	Parent YBOCS > 15		
	YES	NO	
FES Organization	3.2	5.4	**
FA Distress	2.1	1.1	**
FA Consequences	5.8	3.6	*

* p < .05, ** p < .01, *** p < .001

Parental OCD

- Associated with less family organization
- More negative consequences of OCD limit setting
- Greater distress when limit setting

Peris et al., 2008

Family Accommodation

- Higher child CYBOCS scores associated with greater family participation in child rituals, greater modification of family routine, and more negative child response to OCD-related limit setting
- Higher family conflict associated with more negative child response to limit setting and greater parental distress when accommodating child symptoms
- Higher family cohesion associated with opposite pattern

Family Context of Childhood OCD

Asking families of OCD children – especially distressed families - to resist accommodating child symptoms likely to lead to:

- Emotional distress on part of family
- Negative reaction on part of child

Individual vs. Family CBT ??

FCBT: Individual child+family interventions which specify structured weekly intervention sessions focused on changing family dynamics

ICBT: Primarily individual child treatments which include family members in a less-structured or less-frequent manner, often as a brief check-in at the end of individual sessions

Barrett, Farrell, Pina, Peris, & Piacentini, 2008

Family Intervention

Goals of Family Intervention

- Reduce level of conflict and feelings of anger, blame, guilt
- Enhance family problem solving
- Facilitate disengagement from child's OCD symptoms
- Rebuild normal (OCD-free) family interaction patterns
- Foster environment conducive to maintaining treatment gains

Evidence-base For Treatment Of Childhood OCD

Controlled Medication Trials

- **Clomipramine** - DeVeaugh-Geiss et al., 1992
- **Fluoxetine** - Riddle et al., 1992; Geller, 2001; Liebowitz, 2003
- **Fluvoxamine** - Riddle et al., 2001
- **Sertraline** - March et al., 1998
- **Paroxetine** – Geller et al., 2004

Meta-Analysis of SRIs for OCD

Geller et al. (2003)

Methods

- All published placebo-controlled medication trials
- Twelve studies with 1,044 total participants
- Four outcome measures: CYBOCS, LOI, NIMH, CGI
- CMI, PAR, FLUV, FLX, SER

Findings

- Mean **ES = 0.46** (95% CI = 0.37 - 0.55) ($p<.001$)
- Overall ES is modest
- CMI > PAR=FLUV=FLX=SER
- No relationship between ES and publication date

Psychosocial Treatment Of Childhood OCD

Psychosocial Tx of Child OCD

# of Studies	Design	Description
2	Type 1	Rigorously designed RCTs
4	Type 2	One or more design limitations
10	Type 3	Open trials

Barrett, Farrell, Pina, Peris, & Piacentini, 2008
JCCAP Special issue on EBTs for Childhood Disorders

Controlled Efficacy Trials for Child OCD

	N	Outcome
De Haan (1998)	22	CBT > CMI
Barrett et al. (2004)	77	Ind-CBT = Group-CBT > WL
POTS I (POTS Team, 2004)	112	COMBO >? CBT >= SER > PBO

Barrett, Farrell, Pina, Peris, & Piacentini, 2008
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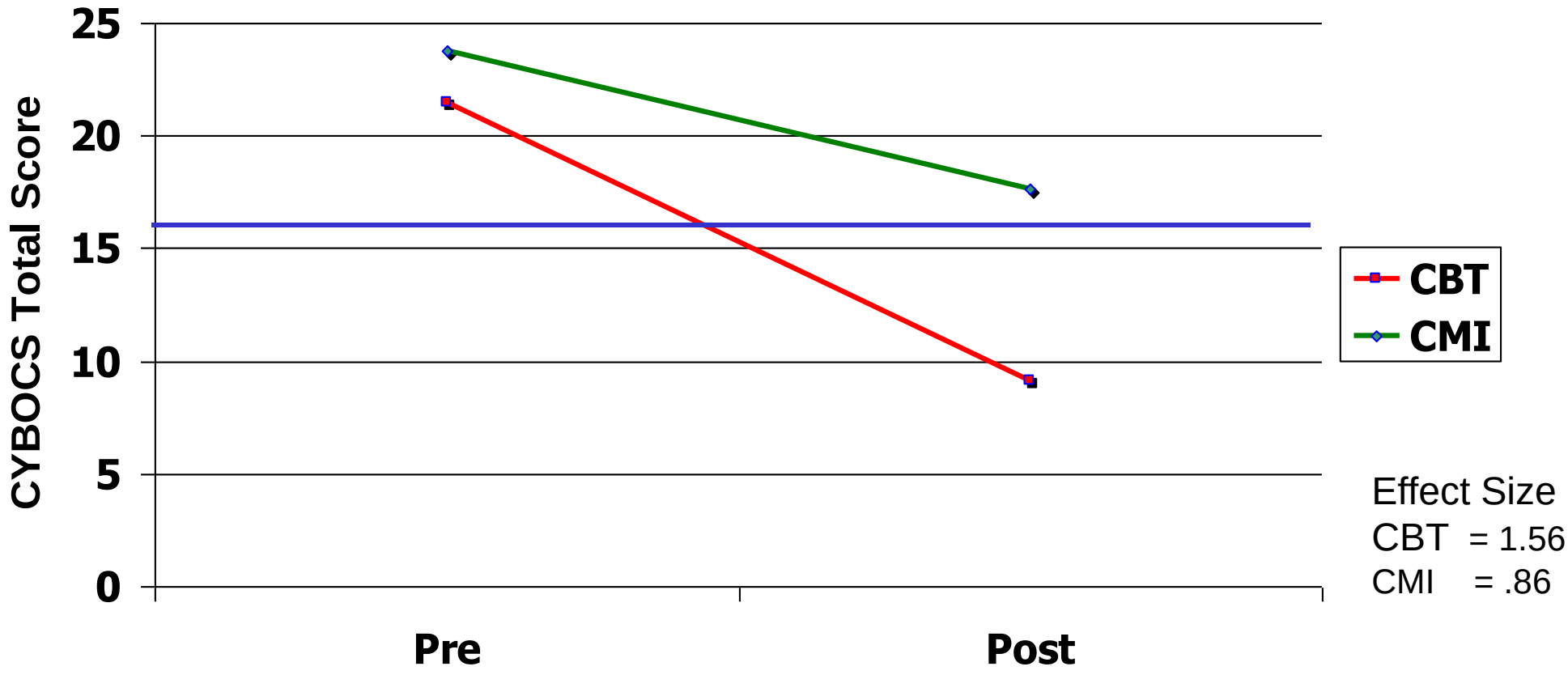
POTS (March et al, 2004)	112	COMBO >? CBT >= SER > PBO
POTS II (March et al, under review)	124	MM+Full CBT > MM+CBT-lite > MM
UCLA (Piacentini et al, under review)	71	CBT > PsychoEd/Relax Training

Comparison across trials complicated by methodological differences

Comparison of CBT and CMI

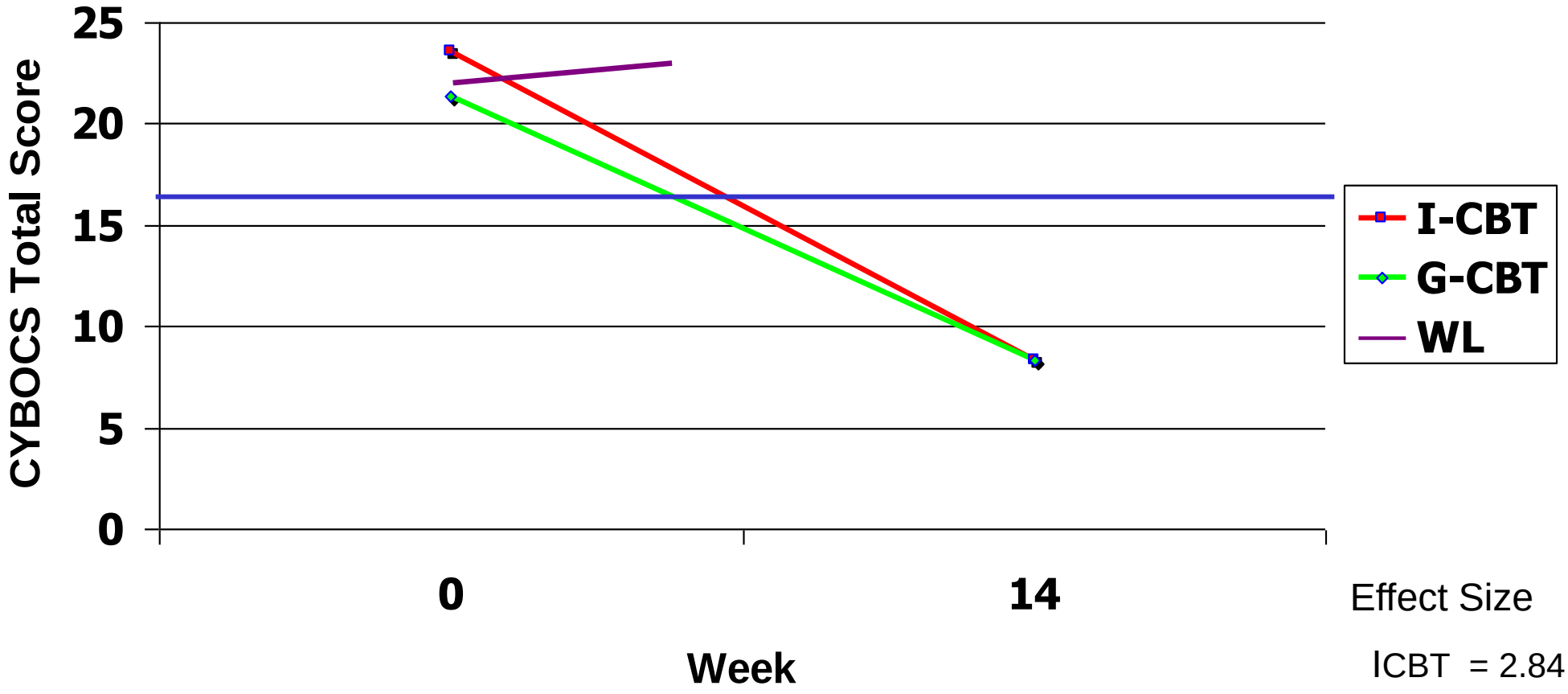
DeHaan et al. (1998)



Comparison of Individual & Group CBT

Barrett et al. (2004)

I-CBT = G-CBT > WL



Effect Size

ICBT = 2.84

GCBT = 2.63

Pediatric OCD Treatment Study (POTS)

Duke (J. March), Penn (E. Foa, M. Franklin), Brown (H. Leonard)

128 OCD youngsters randomized to:

- CBT - SER - COMBO - Pill PBO

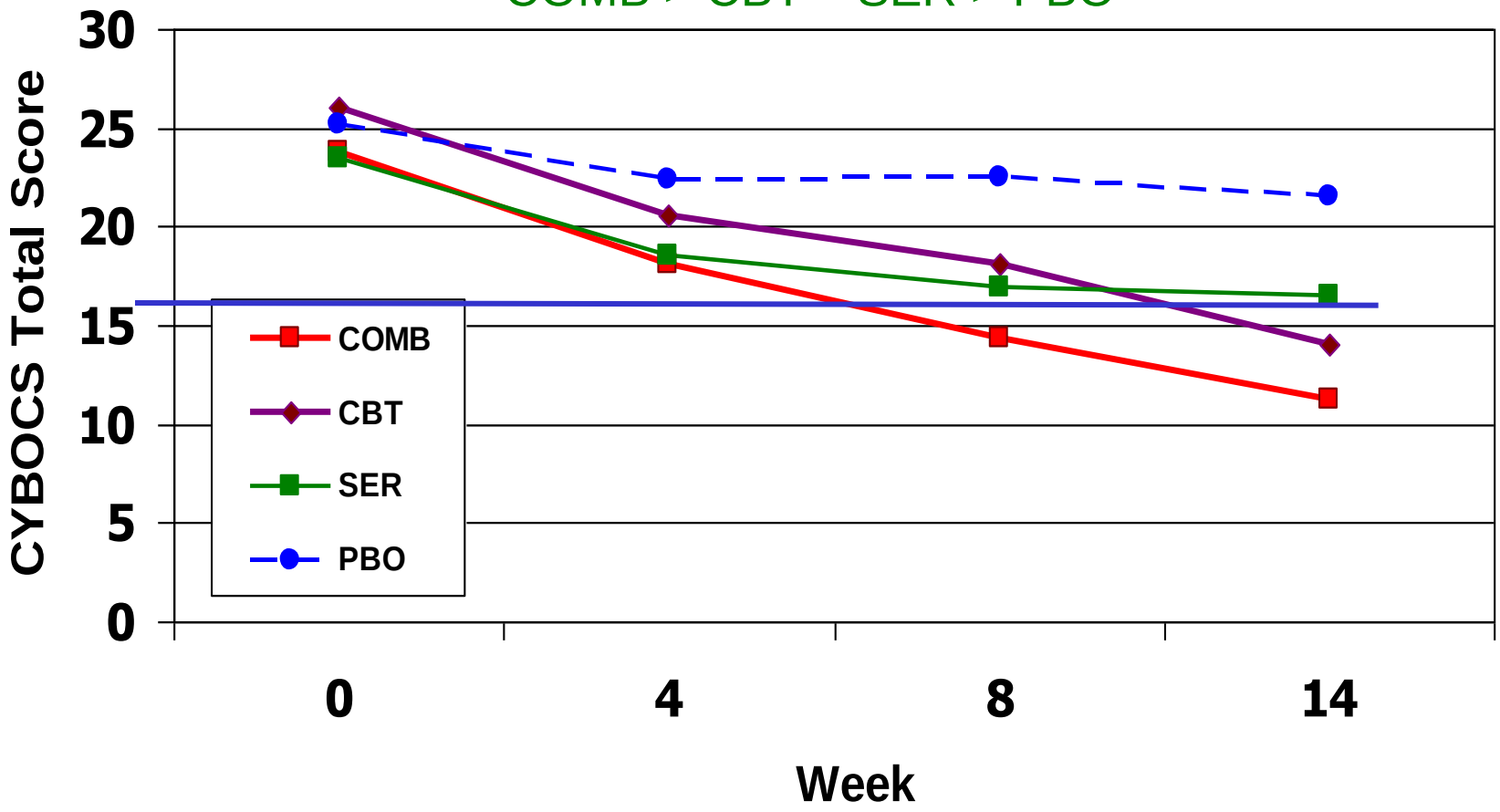
SAMPLE CHARACTERISTICS

Gender (female):	50%
Mean age:	11.7 *(2.7)*
Age range:	7-17
Ethnicity (Caucasian):	93%
Any Comorbid Disorder	80%
• Internalizing Disorder	63%
• Externalizing Disorder	27%
- ADD/ADHD and on Psychostimulant	10%

Change in CYBOCS Total Score

POTS STUDY

COMB > CBT = SER > PBO

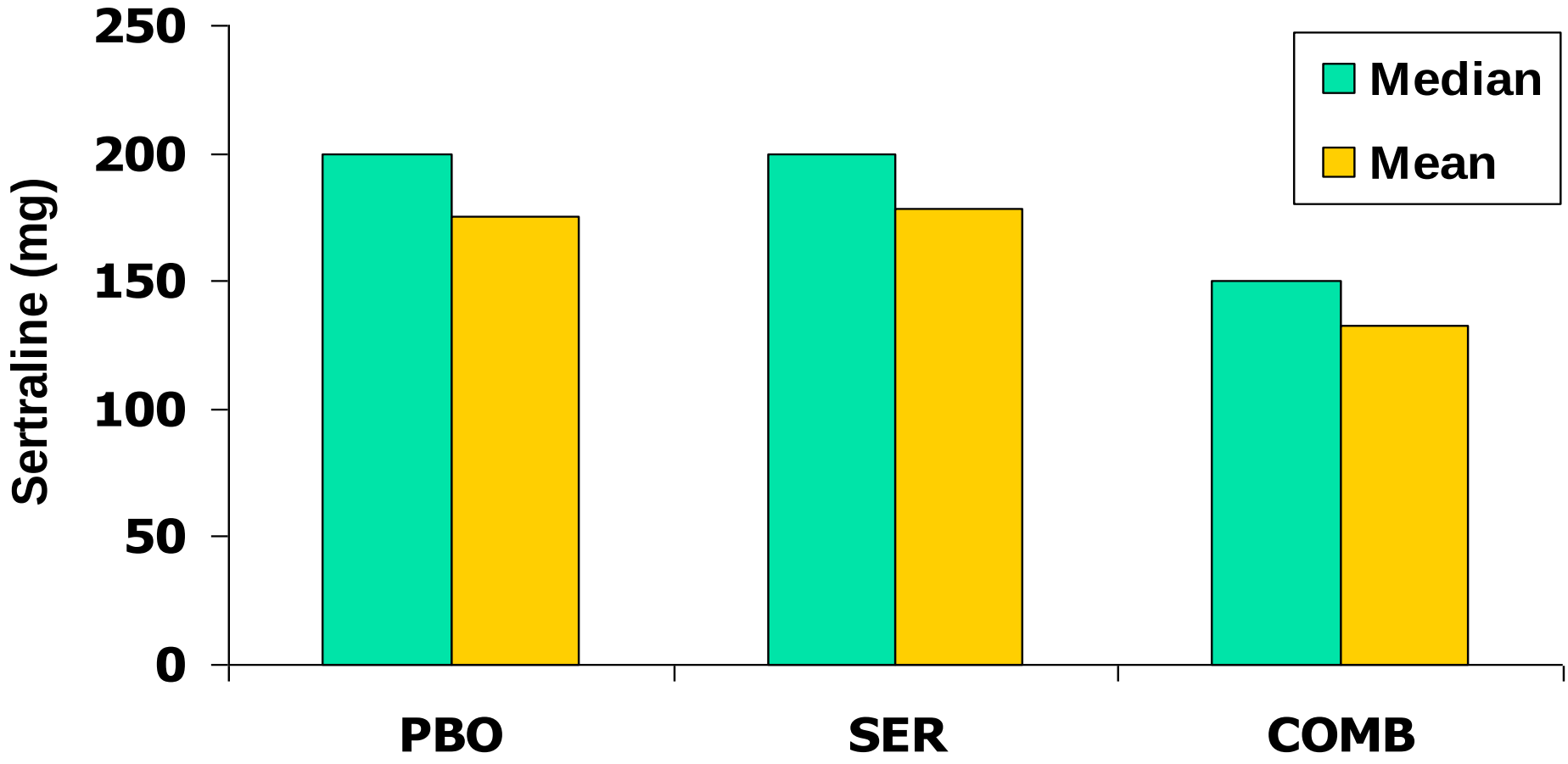


Effect Size

CBT = .98
Comb = 1.46

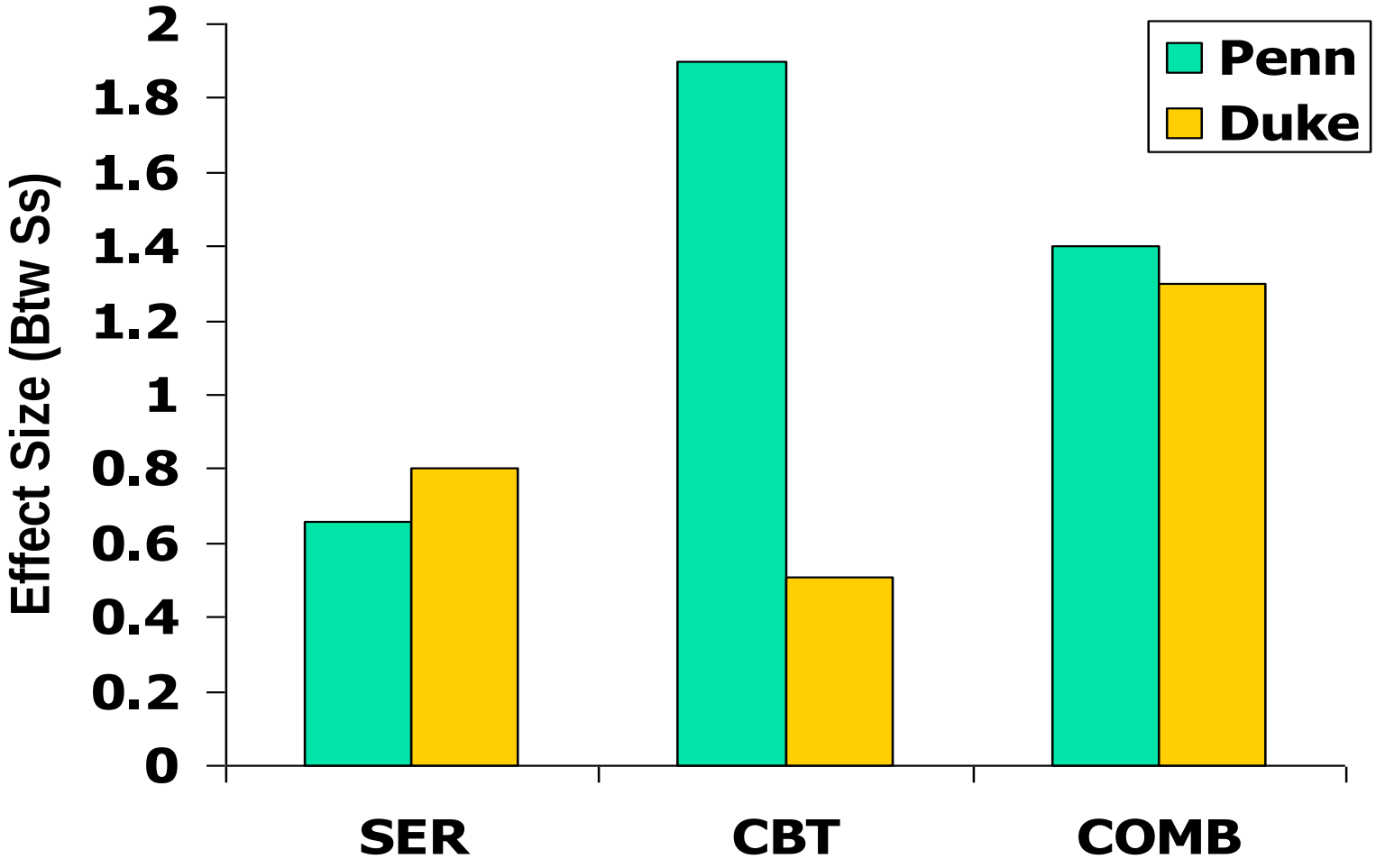
Lower Med Doses in Combo Group

POTS STUDY



Treatment x Site Interaction

DUKE-PENN (POTS) STUDY



UCLA CBT for Child OCD Study

Randomized Controlled Trial comparing:

- **F/CBT** – CBT **(ERP+Cog Restructuring)** plus a structured family component
- **P/RT** – Psychoeducation plus Relaxation Training

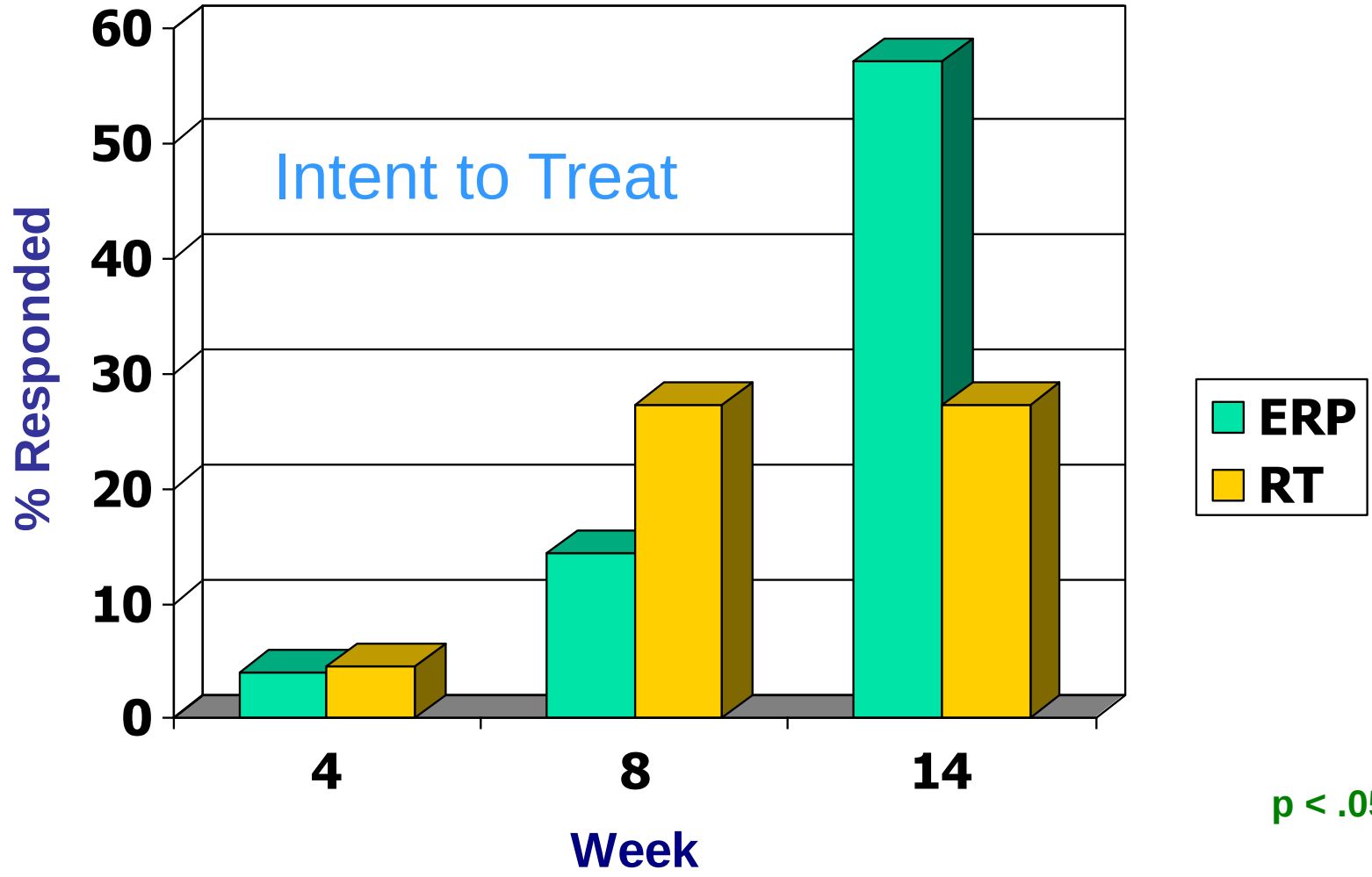
F/CBT included weekly manualized family CBT component

Twelve sessions therapy delivered over 14 weeks

Piacentini et al. (under review)
Supported by NIMH R01 MH58549

Treatment Response Rate

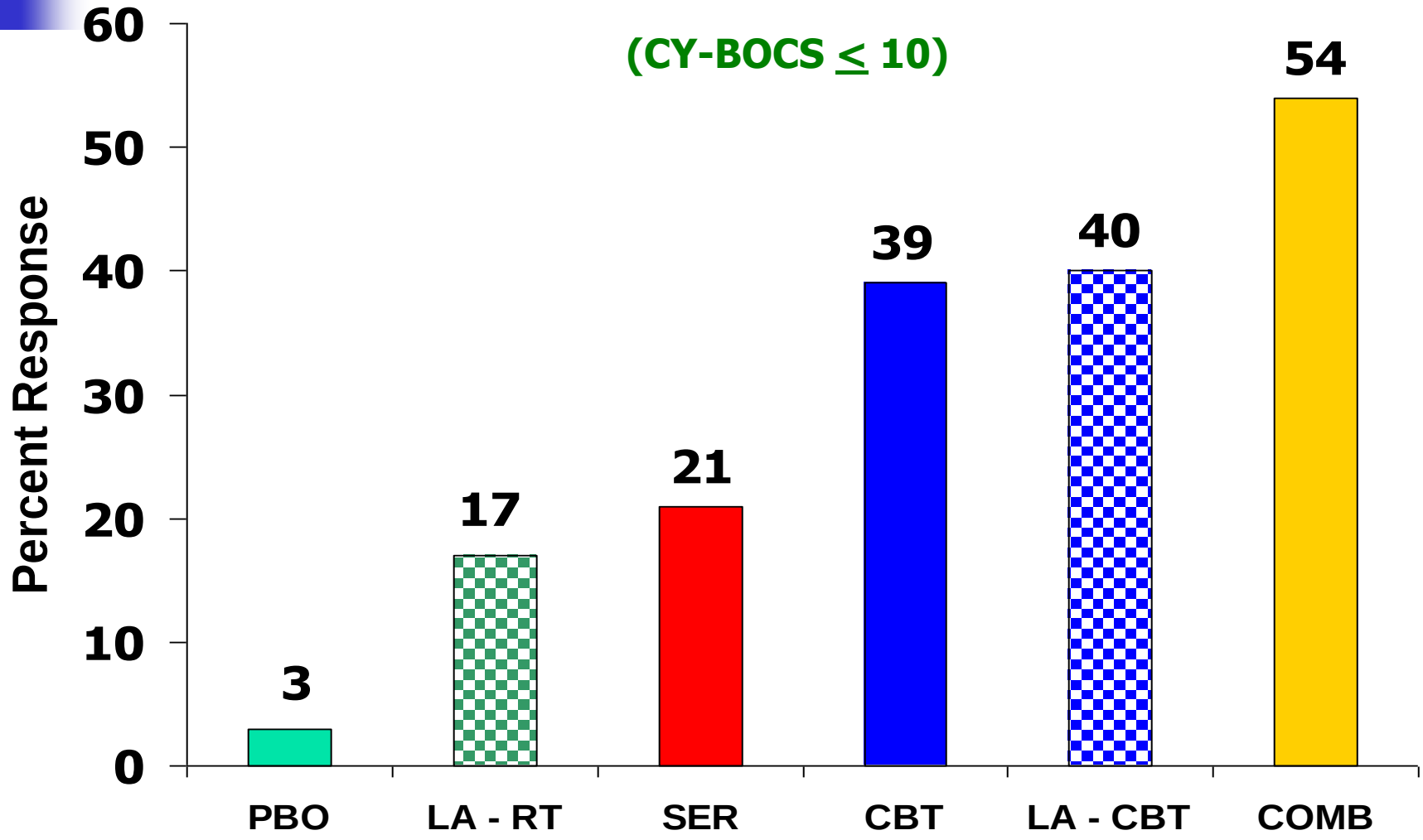
UCLA STUDY



$p < .05$

Excellent Responder

POTS and UCLA Studies



Family Accommodation as Outcome Mediator

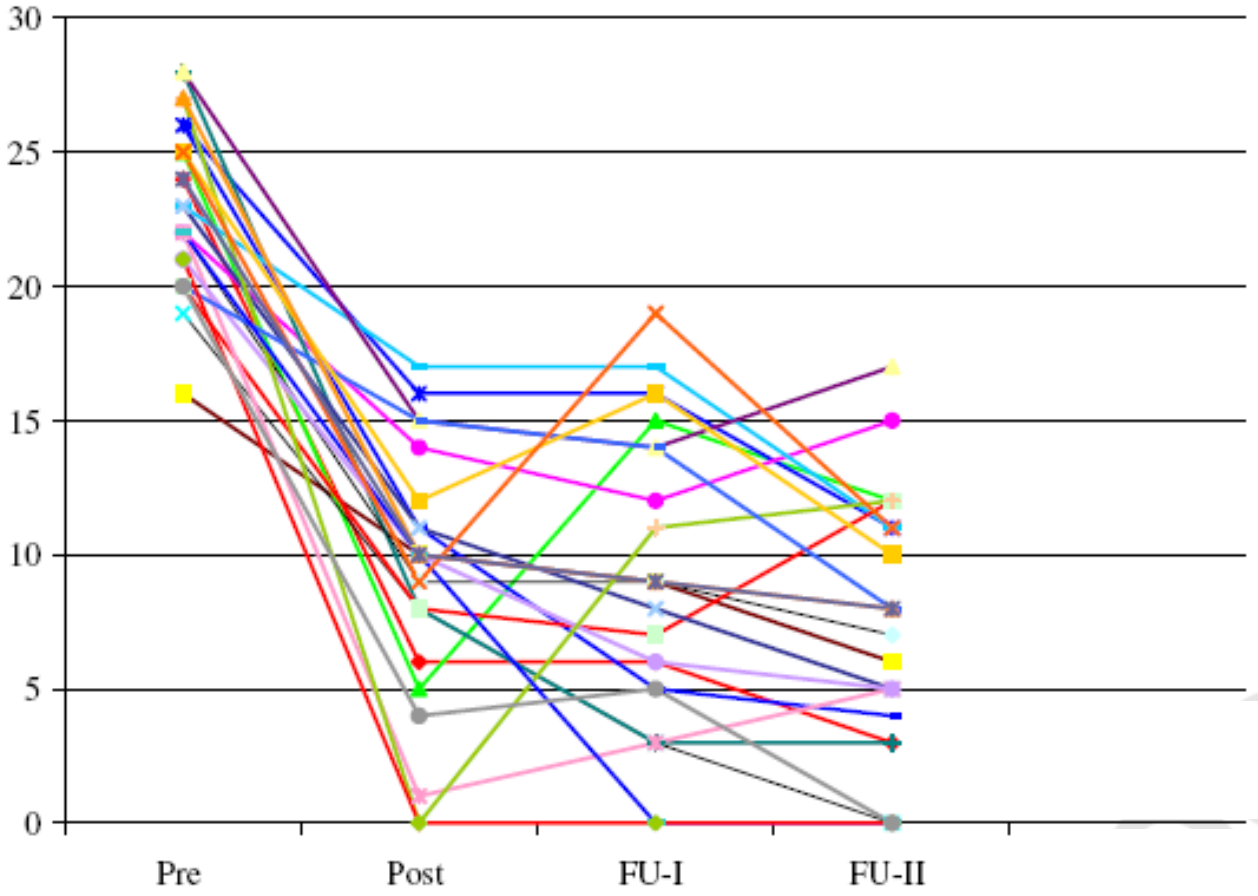
Storch et al. (2007): Families receiving intensive FCBT showed greater reduction in family accommodation compared to those receiving weekly treatment.

Merlo et al. (2009): In a partially-overlapping sample of children receiving FCBT through one of two separate open-label studies, decreases in family accommodation over the course of treatment predicted reduced symptom severity and OCD-related impairment post-treatment.

Piacentini et al. (under review): FCBT was associated with a marginally greater reduction in parent-reported accommodation of OCD symptoms ($p=.05$). Reduction in family accommodation temporally preceded improvement in OCD severity across treatment groups and child functional status for FCBT only

Effectiveness of CBT for Child OCD

Valderhaug, Larsson, Gotestam, & Piacentini, 2006



28 Norwegian youth treated in community clinics by community practitioners.

60.6% response rate post-tx

68.8% response rate at 6 mo FU

Intensive CBT for Child OCD

Franklin al. (1998)

14 Ss age 10-17 nonrandom assignment to outpatient (16wks) or intensive (18 days) CBT. Groups didn't differ post-tx

Storch et al. (2006)

40 Ss age 7-17 randomized to 14 sessions outpatient (14 wks) or intensive (3wks) CBT c/ family component. Intensive > outpatient post-tx but not at 3 mo FU

Excellent response rates to intensive CBT, but differences in baseline severity differences (sicker kids in intensive tx) complicate comparison with outpatient samples.

Diversity in Child OCD Treatment Research

Limited available data suggests treatment outcome not related to gender or ethnicity, but this has not been systematically evaluated in controlled trials.

Classification of Psychosocial Treatments for OCD in Children and Adolescents

Treatment	Citation
Well-Established Treatments	
None	—
Probably Efficacious Treatments	
Individual CBT	POTS (2004)
Individual CBT + sertraline	POTS (2004)
Possibly Efficacious Treatments	
Family-Focused Individual CBT	Barrett et al. (2004)
Family-Focused Group CBT	Barrett et al. (2004)
Experimental Treatments	
Group CBT	Multiple authors

Barrett et al., JCCAP, 2008

For more information, please go to the main website and browse for workshops on this topic or check out our additional resources.

Additional Resources

Online resources:

1. National Institute of Mental Health: http://nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd/index.shtml
2. Society of Clinical Child and Adolescent Psychology website: http://effective childtherapy.com

Books:

1. Albano, A. M., March, J.S., Piacentini, J. (1999). Obsessive-compulsive disorder. In in R. T., Ammerman, M. Hersen, & C. G. Last (Eds.), *Handbook of prescriptive treatments for children and adolescents* (pp. 193-213). Needham Heights: Allyn & Bacon.
2. Franklin, M.E., Freeman, J., & March, J.S. (2010). Treating pediatric obsessive-compulsive disorder. In J.R. Weisz & A.E. Kazdin. (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 80-92). New York: Guilford Press.

Peer-reviewed Journal Articles:

1.Barrett, P.M., Farrell, L., Pina, A.A., Peris, T.S. & Piacentini, J. (2008). Evidence-based psychosocial treatments for child and adolescent obsessive–compulsive disorder. *Journal of Clinical Child & Adolescent Psychology, 37 (1),* 131-155.
2. Garcia, A.M., Sapyta , J.J., Moore, P.S. Freeman, J.B., Franklin, M.E., March, J.S., Foa, E.B. (2010). Predictors and moderators of treatment outcome in the pediatric obsessive compulsive treatment study (POTS I). *Journal of the American Academy of Child & Adolescent Psychiatry 49 (10),* 1024-1033.
3. Geller, D.A., Biederman, J., Stewart, S.E., Mullin, B., Martin, A., Spencer, T. & Faraone, S.V. (2003). Which SSRI? A meta-analysis of pharmacotherapy trials in pediatric obsessive-compulsive disorder. *American Journal of Psychiatry, 160*, 1919-1928.
4. Peris, T.S., Bergman, R.L., Langley, A., Chang, S., McCracken, J.T., & Piacentini, J. (2008). Correlates of accommodation of pediatric obsessive-compulsive disorder: Parent, child, and family characteristics. *Journal of the American Academy of Child and Adolescent Psychiatry. 47 (10),* 1173-1181
5. Piacentini J., Bergman L., Keller M., & McCracken J. (2003). Functional impairment in children and adolescents with obsessive-compulsive disorder. *Journal of Child and Adolescent Psychopharmacology, 13,* S61–S69.

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