Evidence-Based Treatment for
Obsessive-Compulsive Disorder in Youth

Day One

What is OCD?
What causes OCD?
What does CBT for OCD entail?
How well does CBT for OCD work?

Major Changes in the DSM-5

- The fifth edition of the DSM included a new chapter titled "Obsessive-Compulsive and Related Disorders"

- Pulled together both diagnoses from multiple previous categories and new diagnoses

Obsessive-Compulsive Disorder	
• Formerly in Anxiety Disorders	
Body Dysmorphic Disorder	
• Formerly in Somatoform Disorders	
Hoarding Disorder	
Excoriation (skin-picking)	
• New disorders	
Trichotillomania (Hair-pulling)	
○ Formerly in Impulse Control Disorders	

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OC&R Disorders

- Somewhat controversial, but reorganized for two primary reasons
    1) to reflect the increasing evidence of these disorders' relatedness to one another and distinction from other anxiety disorders
    2) to help clinicians better identify and treat individuals suffering from these disorders

- Chapter is placed next to Anxiety Disorders to reflect similarities and overlap between these

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OC&R Disorders

- All have features in common such as an obsessive preoccupation and repetitive behaviors

- They have enough similarities to group them together in the same diagnostic classification

- But also, have enough important differences between them to exist as distinct disorders

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What is Obsessive-Compulsive Disorder?

Operational Definition

A. Presence of obsessions, compulsions, or both:

• Obsessions as defined by (1) and (2):
1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted and that in most individuals cause marked anxiety or distress
2. The person attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion)

Common Obsessions

• Unwanted thoughts of harming loved ones

• Persistent doubts that one has not locked doors or switched off electrical appliances

• Intrusive thoughts of being contaminated

• Morally or sexually repugnant thoughts

Operational Definition

- Compulsions as defined by (1) and (2):
    1. Repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
    2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive

Common Compulsions

- Hand washing

- Ordering

- Checking

- Praying

- Counting

- Thinking good thoughts to undo bad ones

Operational Definition

B. The O/C are time consuming (for example, take more than 1 hour a day) or cause clinically significant distress or impairment in functioning.

C. The O/C symptoms are not due to the direct physiological effects of a substance or a GMC

D. The content of the obsessions or compulsions is not restricted to the symptoms of another mental disorder

OCD Specifiers

- *Good or fair insight*: Recognizes that OCD beliefs are definitely or probably not true, or that they may or may not be true

- *Poor insight*: Thinks OCD beliefs are probably true

- *Absent insight/delusional beliefs*: Completely convinced OCD beliefs are true

- *Tic-related OCD*: The individual has a lifetime history of a chronic tic disorder

OCD Symptom Dimensions

4-factor	5-factor
• Hoarding • Contamination/cleaning • Symmetry/ordering • Forbidden thoughts	• Hoarding • Contamination/ cleaning • Symmetry/ordering • Forbidden thoughts • Over-responsibility

OCD Prevalence

- Around 1% in pediatric population

- Between 2-3% in the adult population
  - Large number of "sub-clinical" cases (5%)

- 96%+ of patients have both O and C

Abramowitz et al. (2009); Leckman et al. (2010)

OCD Course

- Usually gradual onset

- Chronic, unremitting course if untreated

- Symptoms can change across time, but will rarely disappear

Abramowitz et al. (2009);

Gender Differences

- Many more male youth are diagnosed, but no sex differences in adults

- Among men, hoarding associated with GAD and tic disorders, but in women with SAD, PTSD, BDD, nail biting, and skin picking

Vesaga-Lopez et al. (2008)

Comorbidity

- Up to 75% present with comorbid disorders

- Most common in pediatrics are ADHD, DBDs, depression, and other anxiety disorders

- Presence of comorbids predict QoL, more so than OCD severity

Lack et al. (2009)

Impact of OCD

- Almost *all* children with OCD report obsessions causing significant distress

- Pervasive decrease in QoL compared to controls

- Youth show problematic peer relations, academic difficulties, and participate in fewer recreational activities

Lack et al. (2009); Fontenelle et al. (2010)

Etiology

- Modestly heritable for adult onset (27-47%)

- Higher heritability for child onset (45-65%)

- Environment is very important contributor to OCD, and a cognitive-behavioral model is most well-supported
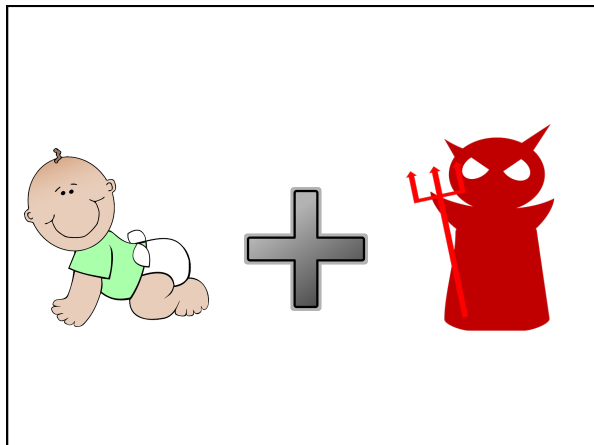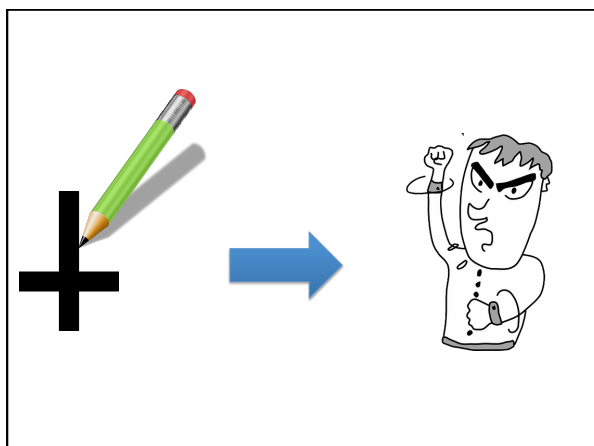
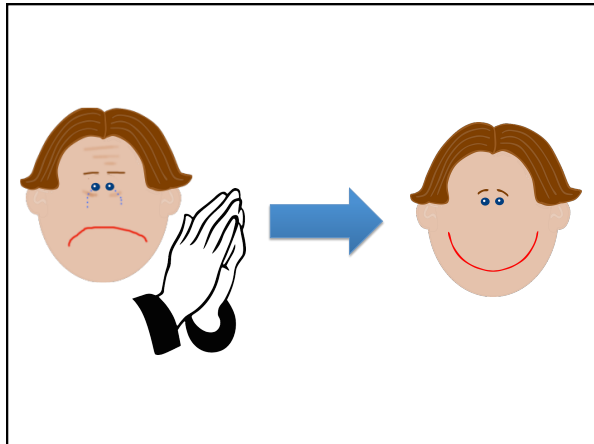Abramowitz et al. (2009)

Cognitive-Behavioral

- Focuses on a bi-directional view of behavior and cognitions, both of which influence emotion

- Obsessions initially arise from dysfunctional beliefs that someone has

- Causes unwanted intrusive thoughts (which are normal) to be appraised as threatening or unacceptable, causing distress
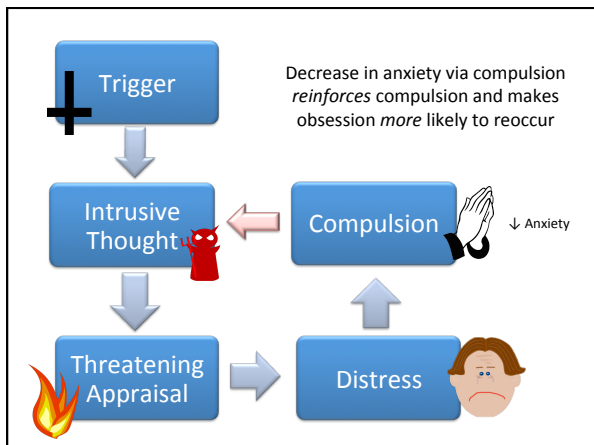
Cognitive-Behavioral

- Distress causes one to try and reduce it via some type of escape or avoidance behavior

- This in turn reinforces those maladaptive beliefs, perpetuating the cycle

Trigger

Decrease in anxiety via compulsion *reinforces* compulsion and makes obsession *more* likely to reoccur

Intrusive Thought

Compulsion

↓ Anxiety

Threatening Appraisal

Distress

CBT for OCD

- The treatment of choice, for both adult and child OCD; superior to meds alone

- Primarily focuses on EX/RP, which has shown effect sizes of 1.16-1.72 (88-95% improve)

- Low (12%) relapse rate, but up to 25% will drop out prior to completion of treatment

CBT Outcomes

- Those with hoarding symptoms appear to respond less well to treatment

- May need to add motivational enhancement techniques for those who are reluctant to engage in exposures

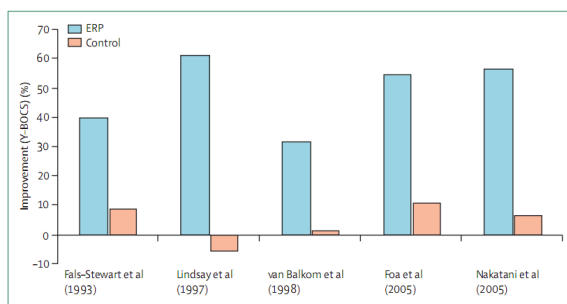- Group therapy is as effective as individual

Abramowitz et al. (2009)

CBT Outcomes

- Those with comorbidity present higher severity, but respond equally well to EX/RP

- Comorbid anxiety or depressive symptoms tend to show improvements as well, even if not specifically targeted

Storch et al. (2010)

CBT Outcomes

Cognitive-Behavioral Therapy for Obsessive-Compulsive Disorder

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Outline of CBT Treatment

- Typically between 10-16 sessions

- Includes parent and child in all aspects of treatment
  - May need to include other family/support persons

- Three primary components
  - Psychoeducation, parent education, EX/RP with cognitive strategies

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Psychoeducation
- Provide OCD information
- Correct misattributions
- Differentiate between OCD and non-OCD
- Describe treatment program

Parent Tools
- Differential attention
- Modeling
- Scaffolding

Child Tools
- Learn to externalize OCD
- Learn how to rate anxiety levels

Considerations

- Keep information and activities developmentally appropriate
  - For young children (under 8), they may not need/benefit from the education portion
  - Older children and adolescents, however, should be included

- Deliver treatment "with the child" and not "to the child"

Day Two

Treatment Components & Demonstrations

Session Sequence

- An initial assessment should be conducted prior to therapy starting

- Complete a clinical interview (KSADS, ADIS-C) and symptom measures (CY-BOCS, FAIS-C)

- Helps determine differential or comorbid diagnoses and impact of OCD symptoms on functioning

Session 1

- Results of assessment

- Provide education on
  - Etiology and course of OCD – Cormorbidity
  - OCD vs non-OCD behaviors

- Give overview of treatment program

- Homework – daily record of OCD symptoms

Instructions: Please keep a *daily* record of **TWO** of your child's OCD symptoms. In the space provided below (feel free to use additional space if necessary) record the date, the specific symptom, the amount of time your child spent engaging in that symptom, how much disturbance it causes in the family, and how the parents are involved in the symptom.

| Date	OCD symptom	Time spent	Family disturbance	Parent's involvement
T 3/17	At dinner, looked at roll for mold	5 min	Made us run late for basketball	Answered many questions
W 3/18	Refused to eat muffin for breakfast	10 min	Fought on way to school	Yelled at her
W 3/18	Asked if she would get sick from Lysol	1 min	None	Told her not to worry (2x)
Th 3/19	Looked at bagel for mold	4 min	None	Answered many questions
F 3/20	Asked about bottle of Windex	1 min	None	Told her not to worry (2x)
Sa 3/21	Looked at dinner roll for mold	1 min	She cried	Answered many questions
Su 3/22	Asked if she would get sick from Windex	1 min	None	Told her not to worry
M 3/23	Refused to eat toast	5 min	Late to school b/c made eggs	Answered many questions

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Session 2

- Review past session

- Start development of hierarchy

- Give overview of parent and child tools

- Introduce differential attention and reward plan

- Homework – Track two O/C symptoms, prepare rewards and rewards chart

Ranking	Description of Symptom	Label (O, C, ?)	Notes
1.	Worries about household cleaners	O	
2.	Avoiding eating off recently cleaned surfaces	C	
3.	Questioning parents about use of household cleaners	C	
4.	Worries about mold on food	O	
5.	Examination of food for mold	C	
6.	Worries about whether she had swallowed objects (e.g., paper clip)	O	
7.	Avoiding eating certain foods	?	Need more info

Session 3

- Review last week

- Introduce child to reward program

- Review OCD symptoms with child

- Introduce feeling thermometer/symptom tracking (child tools)
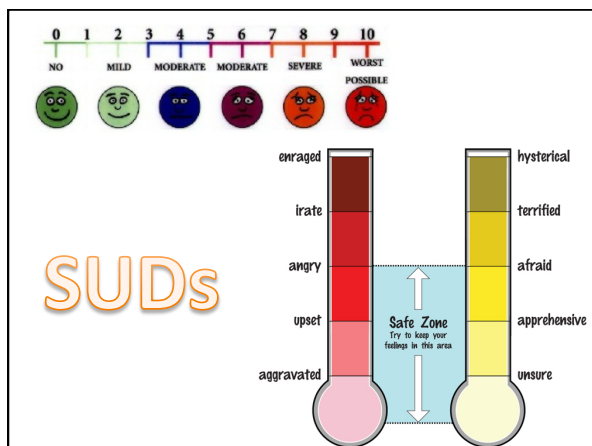
Session 3

- Discuss praise & encouragement

- Review level of family involvement in and accommodation of OCD symptoms

- Homework – Monitor symptoms, start reward chart for doing so

- New hierarchy (by therapist between sessions)

Exposure Techniques

- The common thread in effective anxiety treatments is hierarchy-based exposure tasks

- Controversy over exactly *why* exposure therapy works so well for anxiety

- Does *not* require extensive preparation to be effective and long-lasting

Rosqvist (2005)

Exposure Techniques

- Begin by constructing a fear hierarchy
  1. Generate specific feared situations
  2. Rate them using Subjective Units of Distress

- Continue by actually doing the exposures, working from lower to higher SUDs situations

Sample Fear Hierarchy

Situation	Fear Rating
Driving over the Steel Bridge at rush hour	100
Driving on the highway at rush hour, at dusk, and in poor weather	90
Driving on the highway at rush hour, in good weather	80
Being a passenger on the highway during rush hour	75
Driving on the highway in the middle of the day, in good weather	65
Driving on a city street at midday, when it is raining	65
Driving on a city street at midday, when the sky is clear	50
Turning onto a city street during traffic hours	45
Driving in a busy parking lot during business hours	35
Driving in an empty parking lot during "off" hours	25

Exercise!

- You will now create your own fear hierarchies

- Should include a wide range of fears and/or situations that are distressing

- Use SUDs rating to distinguish and order the hierarchy

Trigger	Obsession	Compulsion	Rating
Smelling cleaner, seeing the bottle, or seeing shiny or wet surfaces in the kitchen	Worries about being poisoned by household cleaners	Avoiding eating off recently cleaned surfaces	
Smelling cleaner, seeing the bottle, or seeing shiny or wet surfaces in the kitchen	Worries about being poisoned by household cleaners	Repeated questioning parents about use of cleaners (verbal checking)	
	Worries about mold on food	Examination of food for mold (self)	
	Worries about mold on food	Asking family member to examine food for mold	
	Worries about mold on food	Avoiding eating food that is likely to be moldy (e.g., bread, muffins)	
	Worries about whether he had swallowed objects (e.g., paper clip)		
	Worries about touching dirt on the floor		

Session 4

- Review last week

- Problem solve homework or reward program

- Continue hierarchy development

- Introduce arguing with OCD

- Conduct in-session exposure

Exposure Types

- Imaginal exposure tasks
  – Often used in the beginning, or when the child has abstract worries / fears
  – Allows for practicing coping skills before confronting the real situation

- In vivo exposure tasks
  – Often follow imaginal exposures, use a "live and in person" version of the feared situation

Exposures

- Exposure occur both in and out of session

- Requires cooperation of parents to facilitate successful homework exposures

- Should be similar to what is being done in session, using a hierarchy and SUDs ratings

- Internal and external rewards for successful exposure completion should be discussed beforehand

Exposures

- Ideal exposures are prolonged, repeated, and prevent the use of distraction behaviors

- SUDs decrease of at least 50%, with more being better

- May require shaping up to the more difficult situations, in terms of both time and use of distractors
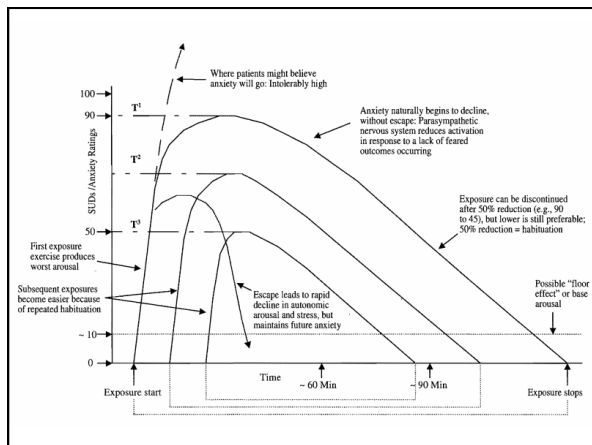
Therapist Tasks

- Realize long-term benefits outweigh short-term distress, and communicate this effective to the family

- Work collaboratively with the child and family to plan and execute the exposures

- Maintain rapport during exposures by building upon pre-established rapport

Therapist Tasks

- Do not allow avoidance or distracter behaviors during the exposure

- Modeling how to conduct exposures for the parents, so that they can perform them at home

- Be flexible and creative when dealing with less than optimal exposures and resistance

Obstacles for the Therapist

- I'm making my client more upset / anxious

- It's difficult to see people in distress

- Can be emotionally draining for some therapists

- May have to do exposures that you are not comfortable with

Exercise!

- Now for an in vivo demonstration of EX/RP

Session 4

- Discuss differential attention again – especially ignoring

- Review family involvement in OCD symptoms

- Problem solve homework compliance obstacles

- Homework – EX/RP task completion, parents use positive attention and ignoring

Session 5

- Review last week

- Problem solve homework tasks

- Revise hierarchy of symptoms

- Review arguing with OCD

- Conduct in-session exposure

Session 5

- Discuss modeling

- Homework
  - Parental modeling, use of differential attention
  - Child completes EX/RP task(s) each day

Session 6

- Review last week

- Problem solve homework tasks

- Review disengagement efforts

- Revise hierarchy of symptoms & arguing

- Introduce scaffolding/coaching

Scaffolding

- Step 1 – Find out how child feels and empathize with the child

- Step 2 – Brainstorm with child how to approach the situation

- Step 3 – Choose option from Step 2 and act on it

- Step 4 – Evaluate and reward

Session 6

- Conduct in-session exposure

- Review scaffolding/coaching steps

- Homework
  - Parents use modeling, DA, scaffolding, continue disengagement, reward task completion
  - Child completes ERP task(s) each day

Session 7

- Review past week

- Problem solve homework

- Review disengagement

- Revise hierarchy of symptoms & check arguing

- Conduct in-session exposure to check parental scaffolding

Session 7

- Expand use of scaffolding outside of EX/RP practice tasks

- Homework
  - Encourage use of all parental tools
  - Have parents apply scaffolding outside planned practice times
  - Child complete ERP task(s) each day

Sessions 8-10

- Review past week

- Problem solve homework

- Review disengagement

- Revise hierarchy of symptoms & arguing

- Conduct in-session exposures

- Homework assignments

Further Sessions

- Take place two weeks after previous sessions

- Similar to sessions 8-10

- Focus on how to handle OCD future problems
  – Relapse prevention strategies
  – Dealing with symptom reappearance

Ending Therapy

- Sessions should be spaced further apart

- Some families may need more booster sessions than others

- Plan on having long-term follow-up visits to check progress and troubleshoot