Treatment considerations for complex OCD in children and adolescents

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ROGERS Behavioral Health

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Quick overview of logistics

Our speakers will give a 75-minute presentation.

Following the presentation, there will be a dedicated time to answer your questions.

- Please use the **Q&A feature**, located in the toolbar at the bottom of your screen, to send your question to the moderator.
- The moderator will review all questions submitted and select the most appropriate ones to ask the presenter.

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Disclosures

Jennifer Park, PhD, and Cuong Tieu, MD, have each declared that they do not, nor does their family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation.

The presenters have each declared that they do not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships.

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Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Describe two patient-specific factors that may contribute to attenuated response to weekly CBT
2. Identify three specific variables that contribute to clinical decision making regarding higher levels of care for pediatric OCD patients

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What we'll cover in this webinar

Brief overview of pediatric OCD and effective treatments
- Evidence based treatments for pediatric OCD
- Overview of intensive ERP treatment

Enhancing implementation of intensive CBT for children and adolescents
- Nonspecific factors interfering with treatment
- Complex comorbidities
- Managing family accommodation

Intensive treatment services delivered at a higher level of care
- Identifying appropriate level of care for complex cases
- Treatment services

Moderated Q&A

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Brief overview of pediatric OCD and effective treatments

Please use the Q&A feature to send your questions to the moderator.

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Prevalence and impairment

- Prevalence rates in childhood of 1-2%
- At least half of adults report that their symptoms of OCD began in childhood (Janowitz et al, 2009)
- Mean age of onset for pediatric OCD between 9 and 11 years in boys and 11 and 13 years in girls (Kessler et al., 2005; Stewart et al, 2007)
- Significant functional and psychosocial impairment across domains (Piacentini and Langley, 2004)
- Poorer long-term outcomes (Stewart et al., 2004)

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Evidenced-based treatments for pediatric OCD

- Cognitive behavioral therapy (CBT) with exposure and response prevention (E/RP) (McGuire et al., 2015)
- SSRIs (McGuire et al., 2015, Sijeric et al., 2020)
- Effect sizes: 1.21 (CBT) and 0.5 (SSRIs) (McGuire et al., 2015)
- AACAP practice parameters
  - Mild to moderate OCD: CBT only
  - Moderate to severe OCD: CBT + Pharmacotherapy

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Diversity in treatment for pediatric OCD

- Adults with OCD
  - Prevalence similar between African American and general population (Williams et al., 2016)
  - Prevalence consistent across ethnic groups in the US (Himle et al., 2008) and across different countries (Weismann et al., 1994)
- Peris et al (2020), *N* = 62, 8-17 yo
  - 34% non-white
  - Standard therapy (ST) vs enhanced family therapy (ET)
  - Minority status did not moderate treatment outcome
  - Race/ethnicity did moderate outcome in ET

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Treatment delivery

- Standard weekly CBT
  - Once per week for 50 minutes each session
- Intensive CBT
  - Time limited, concentrated
  - Variations in delivery
    - Setting: Residential vs outpatient
    - Duration: 90-minute session vs several hour sessions
    - Frequency: Daily vs 3-4 times per week
    - Modality: Group vs individual

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Intensive CBT: Research evidence

- Intensive outpatient meta-analysis and systematic review (Jonsson et al., 2015):
  - Adults, adolescents and children with OCD (N = 646)
  - 17 studies from the past 10 years (since publication)
  - Very strong pre-post effect sizes: 1.31 - 5.29
- Intensive residential treatment (IRT)
  - Intensive CBT with emphasis on E/RP robust treatment method for OCD (Højgard et al., 2018; Leonard et al., 2015)

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Who would benefit from intensive CBT / higher LOC

- Increased severity and impairment
  - Rapid symptom improvement
- Circumvent hospitalization
- Enhanced family motivation and engagement
- Treatment access
- Need for increased support
  - Increased time for therapist-assisted exposures and support for trouble shooting
  - Ability to practice in session exposures in different locations
  - Massed exposures (e.g., 4 exposures within same day)

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Limitations of outpatient CBT

- Treatment refusal
- Treatment attrition
- Partial responders
- Treatment non-responders

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Enhancing implementation of intensive CBT for children and adolescents

Please use the Q&A feature to send your questions to the moderator.

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Case example

Diana is a 16 yo cisgender, Caucasian female with perfectionism OCD related to performance in school and rowing. She will spend hours reviewing, re-reading and re-writing her homework assignments and will forgo sleep in order to engage in her compulsions. When it is rowing season, her OCD symptoms increase significantly as she engages in over-exercising and rigidity related to which foods she believes she can or can not eat.

Diana seeks reassurance from her parents, demanding that they review her homework and her rowing tapes to ensure that she is performing well. She also has her parents email her teachers and rowing coaches to check to see if she is excelling in her performance.

Generally, Diana's parents accommodate by doing exactly what Diana requests them to do. Diana's mother reacts anxiously to Diana's distress and provides reassurance and accommodation readily. Diana's father also accommodates, but in addition will try to set limits when frustrated by family impairment (e.g., late at night and he wants to sleep, running late to work) – and then he becomes very angry and critical.

At times when Diana's OCD is not accommodated, Diana has had rage attacks and will kick and throw furniture towards her parents while screaming and yelling. These moments appear unpredictable for Diana's parents as at times she can manage the lack of accommodation better than others – but the fear of physical aggression occurring has led Diana's parents to be inconsistent on how they respond to Diana's requests for accommodation.

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Case example

Diana also has worsening depressive symptoms – she reports that she does not enjoy doing anything anymore and while her anxiety drives her to engage in her OCD compulsions, she does not feel that she has the energy to do anything else. As Diana only spoke with her friends about school or rowing, they have started to distance themselves from Diana, leading to Diana feeling isolated and alone. She often berates herself and says that she's "not good enough to do anything right". Diana has started to self harm frequently, particularly in moments when she feels overwhelmed and hopeless. Diana has also reported that late at night she has started to have increased thoughts of wanting to die and thinking of specific ways to overdose and die if "things become too much".

Diana tried E/RP in the past but stopped treatment due to lack of willingness to engage in treatment. She noted that doing well in school and rowing was really important for her future, so it was necessary for her to do what she needed to do in order to achieve her goals, even if her OCD made her feel miserable.

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Enhancing implementation of intensive CBT

- Complex clinical presentations require multifaceted approach
- Pull from various types of treatment modalities to enhance E/RP
- Address barriers to engagement with E/RP first
  - Increase patients' ability to access E/RP

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Nonspecific factors interfering with treatment

- Treatment readiness
  - Associated with treatment adherence (Dowling et al., 2016)
    - Readiness to stop rituals and compulsions
    - Readiness to stop avoiding situations that trigger obsessions or compulsions
    - Readiness to participate in ERP
  - Motivation and treatment engagement
  - Self efficacy, self-criticism

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Values-based behaviors

- Cultivating intrinsic vs extrinsic motivation
- Values-based work to increase willingness and readiness
  - How is OCD getting in the way of living a life you want?
  - Engage in values based behavioral commitments
    - Purpose of E/RP is to live a more valued and fulfilling life = *Is this the type of person I want to be?*
    - Transdiagnostic
  - Identify and discuss values
  - Rate how you feel you are meeting your values
  - Which behaviors are driven by values vs driven by anxiety/OCD?

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Parent-child collaboration is key

- Parents support values driven behaviors
  - Values defined collaboratively
  - Normal for parents and child to not 100% agree
    - Consider and compromise
  - Discuss how to support child in moments of high distress, focusing on values and what they are working towards

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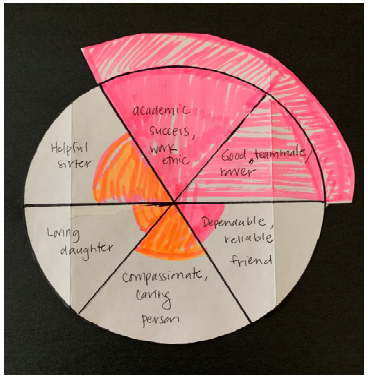
Values assessment

- Are there certain values that are out of balance? – If yes, what is contributing to it?
- Operationalize the values – what does it mean to you to be a "dependable friend"? What does that look like?
- Identify specific behavioral commitments



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Self-compassion

- Ability to self-validate, self-soothe, and compassionately comfort oneself when experiencing distress
  - Self-kindness over self-criticism
  - Experience as shared humanity rather than isolating experiences
  - Mindfulness rather than over identification with painful thoughts and feelings

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Steps for self-compassion

- Identify the statement
- Label the emotion
- Identify the goal or desire
- Validate
- Compassionate reframe

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Steps for self-compassion

- **Statement**
  - *"I can't do anything right, there is no point in trying because I'm terrible at everything anyway"*
- **Label the emotion**
  - *Hopelessness, anger, sadness*
- **Identify the goal or desire**
  - *"Find a way out", escape painful feeling*

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Steps for self-compassion

- **Validate the experience of the emotion**
  - *"This is a moment of suffering"*
  - *"It makes sense that…*
  - *"Others in my shoes would feel this way in this situation too"*

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Steps for self-compassion

- **Compassionate reframe**
  - *"I am feeling angry and hopeless because I feel that I am not doing as well I should in school and that whatever I attempt I fail at."*
  - *"I know that there are others at my school who also work hard and have also felt this way."*
  - *"I am doing the best that I can given the circumstances and I am going to continue to try to what I can with what I have"*

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Complex comorbidities

- Comorbidity is more often the norm than the exception
- Identify comorbidities that need to be addressed prior to engaging in E/RP vs those that can be addressed conjunctively
  - What must be stabilized in order to access E/RP?
  - Medication management
    - ADHD, Psychosis

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Complex comorbidities

- Suicidality and/or self-harm
  - DBT skills work to stabilize, then pivot to ERP
    - Distress tolerance, TIPP
    - Behavior chain analysis
  - Starting E/RP work
    - Differentiate between dysregulation vs high anxiety
      - Ensure default is not always DBT

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Complex comorbidities

- Depression
  - Behavioral activation
  - Self-compassion
  - Values-based behavioral commitments

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Managing family accommodation

- Parents struggle to reduce accommodations
  - High levels of child distress, aggression, rage attacks, oppositional behaviors
- Parental fear, reluctance or guilt
- Highly critical parents can damage rapport and child engagement
- Many families engage in dual responses
  - Parent A → Antagonistic
  - Parent B → Accommodating

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Managing family accommodation

- Parental validation and acknowledgement
  - Create goals that are feasible and within skillset of parents
- Ensure safety
  - Create behavioral crisis plan
- Plan created collaboratively with parent and child
  - If child is unwilling, plan clearly communicated to child in advance
- Parental emotional response
  - Managing parental distress
  - Ability to tolerate child's anxiety/distress

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Managing family accommodation

- Parental behavioral response
  - Focus on gradual shaping behaviors
  - Follow through with differential reinforcement
    - Providing praise/rewards
    - Allow natural/logical consequences to occur

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Intensive treatment services delivered at a higher level of care

Residential treatment

Q&A Please use the Q&A feature to send your questions to the moderator.

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The clinical relationship between fearfulness and tyranny in children is explored. A characteristic pattern of family interaction emerges that underlies the dynamics of tyranny and fears. Ignoring this interaction and treating fear alone was not helpful; introducing changes in family interaction that lead to the control of tyranny affected both fears and tyranny.

(Barcai, A., & Rosenthal, M. K. 1974)

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Case example

- Billy is a 13-year-old male presents with a two-year history of contamination OCD and is status post 10 weeks of PHP treatment
- CY-BOCS score upon admission was rated as moderate severity
- Sertraline was optimized to 250 mg daily with unclear effect on both depression and anxiety
- Family history suggest both maternal and paternal side anxiety and depression; Medical history was unremarkable; Social history lives with both parents and an older sister who he considers contaminated
- Billy confesses he would neutralize or “decontaminate” after PHP programming by hand washing, using barriers in the bathroom and showering in the middle of the night when his family was asleep

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Treatment in higher level of care

- Residential care at Rogers combines the intensity of inpatient psychiatric care with a comprehensive range of therapies and strong parent/family education and involvement
  - Less restrictive environment than acute inpatient hospitalization
  - More clinically intensive than a wilderness program or alternative/therapeutic school experiences
  - For children’s center, typical stay ranges from 75 to 80 days

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Treatment in higher level of care

- CY-BOCS scores
- Moderate to Severe on admission
- 2022 1st quarter: effect size is >2

(Farhat et al, 2022)

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Treatment in higher level of care

- Functional impairment (i.e., ADLs, academics, social settings)
- Severe mood dysregulation [1]
- Refractory patients
- Complex cases with co-morbidities [2]
- No access to consistent in-person ERP treatment
- Family accommodation [3]
- Polypharmacy

[1] (Chua et al, 2021) [2] (Storch et al, 2015) [3] (Lebowitz et al, 2020)

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Treatment in higher level of care

- Intensive CBT/ERP
- Medication management
- Therapeutic milieu
- Structured environment
- Group and individual programming (art, experiential, nutrition and pet therapy)

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Case example

- Billy was admitted for residential treatment where there was 24/7 staffing support to monitor ”after hours” decontamination rituals
- He worked through his hierarchy with high fidelity, meeting with the team on a daily basis, doing ERP for two- hour blocks in the morning and afternoon
- A contamination rag was incorporated into therapy as he tended to handwash excessively during the day and not respond to first prompts to stop hand washing or he would spend excessive time in the bathroom
- Habituation occurred with exposure work, but he struggled to generalize his coping skills when on pass with his family

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Time for questions and answers…

- Please use the Q&A button – not the chat – to submit your question
- If we don't get to your question, please feel free to send an email to webinars@rogersbh.org and we will follow-up with you

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Where to get additional information…

International OCD Foundation

https://iocdf.org

ADAA ANXIETY AND DEPRESSION ASSOCIATION OF AMERICA

https://adaa.org/

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About the presenters….

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