Cognitive-Behavioral Therapy for Obsessive-Compulsive Disorder in Children and Adolescents

Katharina Kircanski, MA, CPhil*, Tara S. Peris, PhD,
John C. Piacentini, PhD, ABPP

KEYWORDS

• Obsessive-compulsive disorder • Cognitive-behavior therapy
• Exposure • Response prevention • Children/adolescents

Obsessive-compulsive disorder (OCD) is relatively common in children and adolescents, with a prevalence rate of 0.5% to 2% in community samples.[1–4] As defined by the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revised (DSM-IV), OCD is characterized by obsessions and/or compulsions that are distressing, time-consuming (take more than 1 hour per day), or cause clinically significant impairment.[5] Obsessions are recurrent, persistent, and distressing thoughts, images, or impulses. Compulsions are repetitive behaviors or mental acts performed in response to obsessions in order to reduce distress or avoid perceived harm.

A growing body of research has demonstrated the efficacy of cognitive-behavioral therapy (CBT) for childhood OCD, both as a monotherapy and when combined with psychopharmacological interventions.[6–8] Based on a review of the literature and expert consensus, CBT is regarded as the initial treatment of choice for OCD in children and adolescents in terms of efficacy, safety, and durability of response.[9,10] This article reviews the clinical presentation and assessment of childhood OCD, cognitive-behavioral conceptualization of OCD, implementation of CBT for childhood OCD, and the body of evidence supporting this treatment approach.

Disclosures: See last page of article.

Division of Child and Adolescent Psychiatry, UCLA-Semel Institute for Neuroscience and Human Behavior, University of California-Los Angeles, 760 Westwood Plaza, Los Angeles, CA 90024, USA

* Corresponding author. Division of Child and Adolescent Psychiatry, UCLA-NPI, Room 68–218A, 760 Westwood Plaza, Los Angeles, CA 90024.

E-mail address: kkircanski@mednet.ucla.edu

Child Adolesc Psychiatric Clin N Am 20 (2011) 239–254
doi:10.1016/j.chc.2011.01.014 **childpsych.theclinics.com**
1056-4993/11/$ – see front matter

CLINICAL PRESENTATION OF CHILDHOOD OCD

Most youth with OCD experience both obsessions and compulsions. Common obsessions involve excessive concern about germs, contamination, and illness, fear of harm to self or others, preoccupations with symmetry, moral and religious obsessions, intrusive sexual thoughts, and superstitious obsessions.[2,11,12] Common compulsions involve excessive and/or ritualized washing, checking, counting, touching, ordering, arranging, confessing, seeking reassurance, and mental rituals such as praying,[5,12] Compulsions may be performed to alleviate anxiety, discomfort, disgust, or the sense that something is "not right."[13]

Typical age of onset is from 8 to 11 years, although onset can occur as young as 2 to 3 years with emerging interest in early-onset childhood OCD.[14–17] Gender distribution tends to follow a 3:2 male to female ratio until adolescence, when this distribution evens out.[12] OCD in youth may be associated with significant functional impairment in home, daily living, school, and social domains.[18–23] Psychiatric comorbidities are highly common and include other anxiety disorders, mood disorders, attention-deficit hyperactivity disorder (ADHD), and tic disorders.[6,23–26] Of interest, comorbidity has been linked to greater OCD symptom severity and poorer response to CBT.[26–28] Pediatric OCD is a typically chronic condition, with 40% of youth meeting diagnostic criteria up to 15 years after initial identification and 20% exhibiting subclinical symptoms.[29,30] When untreated or inadequately treated, associated impairment tends to increase over time.[31]

ASSESSMENT OF CHILDHOOD OCD

A comprehensive diagnostic assessment is recommended for youth presenting with OCD. Initial evaluation should include assessment of current and past OCD symptoms, current symptom severity, associated functional impairment, and psychiatric comorbidity.[32] Evaluation should include information from multiple informants, as parent-child symptom agreement has been shown to be low.[33] In addition, one must distinguish OCD from normative ritualistic behavior in early childhood, and understand that youth may not recognize their symptoms as inappropriate or impairing or may be guarded about their symptoms because of fear of punishment or embarrassment.[2,11,34,35]

Several standardized measures exist for the assessment of childhood OCD, with the most commonly used presented here. The Anxiety Disorders Interview Schedule for DSM-IV—Parent and Child Version (ADIS-IV: PC) is a semi-structured clinician-administered diagnostic interview that is most commonly used in treatment studies to establish an OCD diagnosis, rule out phenomenologically similar conditions, and identify comorbidities.[36,37] The Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) is a clinician-administered rating scale used to rate the severity of OCD symptoms.[37] The Children's Florida Obsessive-Compulsive Inventory (C-FOCI) is a brief screening instrument for pediatric OCD, and the Obsessive-Compulsive Inventory—Revised (OCI-R) measures distress associated with obsessions and compulsions.[38,39] The Child OCD Impact Scale-Revised (COIS-R) assesses OCD-related functional impairment via both parent and child self-report versions.[40] More detailed reviews of assessment strategies and instruments are provided by Merlo and colleagues[41] and Lewin and Piacentini.[37]

COGNITIVE AND BEHAVIORAL CONCEPTUALIZATIONS OF CHILDHOOD OCD

Behavioral Conceptualization

The behavioral model of OCD conceptualizes obsessions as intrusive and unwanted thoughts, images, or impulses that generate a significant and rapid increase in anxiety,