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Treatment and 12-month outcome of children and adolescents with obsessive–compulsive disorder: A naturalistic study

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ABSTRACT

Pediatric obsessive–compulsive disorder (OCD) is a disorder associated with distress and impairment in many domains. Moreover, there is a high risk of relapse and developing a chronic illness. Randomized-controlled trails (RCT), the gold-standard for evaluating treatments, show treatments to be efficacious, yet little is known about their generalizability and long-term durability in "usual-care" settings. The aim of the present study is to evaluate the feasibility and effectiveness of evidence-based pediatric OCD-treatments in regular practice. Participants were 109 children (aged 7–17 years) with a primary diagnosis of OCD, recruited from a specialized OCD-clinic in Sweden. Few exclusion criteria were applied. The youths were assessed at baseline, 6 and 12 months following the first assessment, using Children's Yale-Brown Obsessive Compulsive Scale and Children's OCD Impact Scale. They were treated with Cognitive Behavior Therapy, augmented with SSRI when indicated. The majority responded well to treatment i.e. were free from OCD or in remission at 12 month evaluation. Moreover, the participants psychosocial functioning significantly improved from baseline to evaluation at 6 and 12 months.

1. Introduction

Obsessive–compulsive disorder (OCD) causes suffering and reduces the psychosocial functioning for a substantial number of youths (Heyman et al., 2001). OCD is often associated with other psychiatric disorders as figures from 50–80% have been reported (Geller, Biederman, Griffin, Jones, & Lefkowitz, 1996; Ivarsson, Melin, & Wallin, 2008; Swedo, Rapoport, & Leonard, 1989). Furthermore, the high risk of chronic illness and of relapses (Micali et al., 2010; Stewart et al., 2004), pinpoints the need of understanding the benefits and limitations of contemporary treatment for pediatric OCD.

OCD symptoms interfere with the children's daily living at home, among peers and at school. Their everyday life may become increasingly stressful and cause difficulties with regard to concentration, school work, social activities, sleep, and fatigue (Piacentini, Bergman, Keller, & McCracken, 2003; Valderhaug & Ivarsson, 2005).

Several randomized-controlled efficacy studies have shown significant effects of Cognitive Behavior Therapy (CBT), pharmacotherapy with selective serotonin reuptake inhibitors (SSRIs), and combined treatment (CBT+SSRIs) on childhood OCD (Abramowitz, Whiteside, & Deacon, 2005; Geller et al., 2003; Watson & Rees, 2008). However, a meta-analysis comparing CBT with SSRI and combined treatment, showed that there were no significant difference between the treatments (Skarphedinsson et al., 2015). In line with this, the first line of treatment for mild to moderate pediatric OCD is CBT including exposure and response prevention (E/RP). However, a combination of CBT and SSRI may be necessary in moderate to severe cases (AACAP, 2012). However, a recent meta-analysis found no support for combined treatment from the start for moderate to severe OCD (Skarphedinsson et al., 2015). Pharmacotherapy with SSRI should be used when OCD symptoms increase during CBT, or the youth is unable or rejects to participate in CBT treatment (AACAP, 2012; Abramowitz et al., 2005; Ivarsson et al., In press).

Naturalistic outcome studies of cohorts with pediatric OCD are rare (Masi et al., 2005; Micali et al., 2010; Nakatani, Mataix-Cols, Micali, Turner, & Heyman, 2009), and there are several methodological shortcomings in the studies that have been published.

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Several factors could have confounded the results, with the foremost limitations being the lack of a structured diagnostic procedure at baseline, the use of self-assessment alone to measure the severity of OCD post treatment and/or at follow-up and the large amount of dropout to follow-up assessments. Also the studies are difficult to compare as the follow-up period after treatment the range from one to 11 years, spanning a considerable developmental period from preadolescence to adulthood (11–28 years of age) (Nakatani et al., 2009). The various time of follow-up makes it difficult to compare and interpret the results of the studies, as OCD follows a waxing and waning course. Moreover, some of the patients received other treatments during the follow-up period. The quality and extent of this treatment was not being controlled for with regard to the long-term outcome of the treatment.

Randomized controlled trails (RCT) are the gold standard for evaluating treatments for pediatric OCD. Criticisms against the efficacy studies are e.g. that RCTs are often conducted in university clinics, with highly trained therapists, and that little is known about the generalizability of the results to usual care settings (Weisz et al., 2013). According to Johansson (2009) there is need of further naturalistic studies from routine psychiatric settings complementing the randomized controlled trials.

Naturalistic studies involving patients in regular treatment conditions may supplement the efficacy studies. In studies in regular treatment clinics, treatment is evaluated using few exclusion criteria, treatment is of longer duration, and treatment delivery is usually not strictly manual based. These types of studies may increase our understanding of the "real world" effectiveness of treatment methods.

The present study includes a large cohort of youths diagnosed (5–17 years) with OCD, whose clinical symptoms and demographic data were systematically assessed at baseline using a comprehensive diagnostic work-up. Moreover, the patients were assessed at 6 and 12 months following the first assessment, using a semi-structured interview and psychometrically sound rating scales. To our knowledge, the present treatment study includes one of the largest cohorts of pediatric OCD that has been systematically studied on a long-term basis and where the treatment is systematically described.

The aim of the present study is: 1) to present the clinical features and the naturalistic course of a cohort of young patients with OCD, 2) to describe the naturalistic treatment with CBT and/or medication of OCD in this cohort of children and adolescents, and 3) to examine treatment response and functional impairment at 6 and 12 months after the first assessment.

2. Methods

2.1. Subjects

The study group was assessed and treated at a specialized pediatric outpatient OCD clinic at the Sahlgrenska University Hospital in Gothenburg, Sweden. The patients were referred consecutively from January 2001 to December 2005, half of them referred from local Child and Adolescent Psychiatric (CAP) – or pediatric outpatient clinics and half self-referred by the parents. One hundred and fifty-eight patients (47.5% boys) participated in the initial assessment, with 140 diagnosed with primary OCD according to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (American Psychiatric Association, 1994). Of those diagnosed with OCD another 26 either recovered spontaneously during the assessment or did not accept treatment although they were in need of this. One hundred and fourteen patients with OCD accepted treatment and 109 of these agreed to participate in the study (Fig. 1).

The study sample ($n=109$) consisted of 61 girls and 48 boys (mean age 12.9 years [5–17 years]), 40% children were below 12 years (girls/boys=22/22), and 60% were adolescents (girls/boys=39/26). Most (72%) lived in intact families. A majority (78%) had Swedish ethnicity, while 10% had one parent and 12% both parents of non-Swedish ethnicity. Mean socioeconomic status of the families did not differ from a Swedish general population sample (Ivarsson, Svalander, & Litlere, 2006).

2.2. Procedures

A standardized diagnostic work-up was administered at baseline. Obsessive–compulsive symptoms and comorbidity were evaluated by a child psychiatrist (the fourth author or a resident physician trained by him) using The Kiddie Schedule for Affective Disorders and Schizophrenia – Present state and Lifetime version (KSADS-PL) (Kaufman et al., 1997). The global severity of the child's disturbance was rated using the Children's Global Assessment Scale (CGAS) (Shaffer et al., 1983). OCD symptoms and severity were assessed by a therapists at the team using the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) (Goodman et al., 1989; Scahill et al., 1997), in addition the OCD severity was rated using the Clinical Global Impression (CGI) (Busner & Targum, 2007). Psychological assessments were performed by psychologists using the Wechsler Intelligence for Children (WISC III) (Wechsler, 2004). The baseline diagnostic

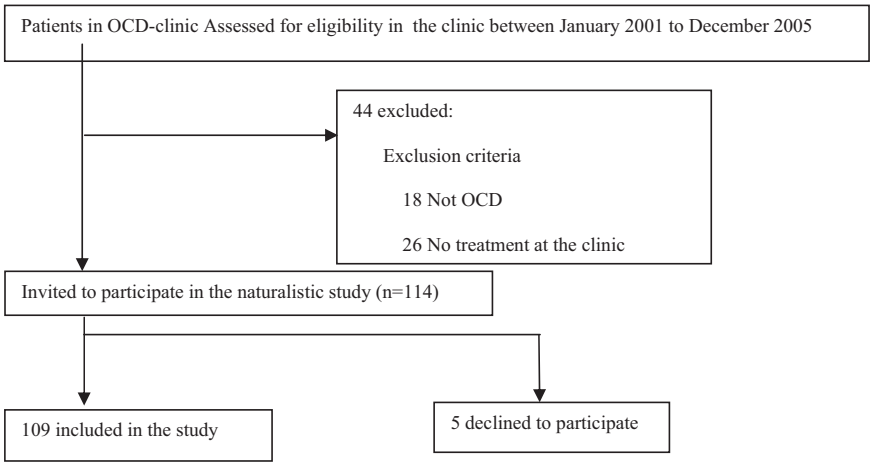

Fig. 1. Flowchart over participants in the study.