ROGERS
Behavioral Health

Navigating treacherous waters:

Clinical strategies to address predictors of attenuated outcome in pediatric OCD treatment

Martin E. Franklin, PhD | October 29, 2024

This webinar is based on presentations given by Dr. Franklin at an in-person continuing education seminar held in Los Angeles (April 26, 2024). Participants who attended that program will not be eligible for CE credits.

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Quick overview of logistics

- Our speaker will give a 70- to 75-minute presentation.
- Following the presentation, there will be a dedicated time to answer your questions.
- During the program, 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 speaker during the Q&A portion of the program.

2

Disclosures

Martin E. Franklin, PhD, has declared that he does not, nor does his 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 presenter has declared that he does not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships. Further, Rogers Behavioral Health does not accept commercial support for its CE programs.

3

Learning objectives

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

1. Describe the three treatment approaches with the most empirical support in the treatment of pediatric OCD.
2. Recognize the four most common predictors of attenuated outcome and the accompanying clinical strategies to mitigate their effects.

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What will be covered in this webinar

What does the extant literature tell us? Theoretical underpinnings and principles of CBT for OCD

- Efficacy of CBT, pharmacotherapy, and their combination
- Extending CBT's reach beyond the academic medical context: Effectiveness trials including NORDLOTS
- Predictors of attenuated outcome and their clinical implications

Psychiatric comorbidity: Base rates, clinical implications, and strategies to promote adherence

- Case examples with clinical strategies to mitigate potentially pernicious effects of each:
  - Low motivation for change
  - Unusual obsessional content
  - Psychiatric comorbidity
  - Family accommodation

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Presenter subjectivities

Professional identities

- Executive Clinical Director of OCD and Anxiety Services, Rogers Behavioral Health
- Associate Professor Emeritus, Penn Medicine
- PhD in Clinical Psychology, 1993, University of Rhode Island
- Clinician, Clinical Supervisor, Researcher, Educator

Personal identities

- He / Him / His
- Husband to Marlene
- Father of three young adults (Gwen, Delia, Ted)
- Possesses a disturbing amount of knowledge about baseball and its history

I acknowledge that my experience, intersectionality, privilege – and lack thereof – informs what I bring to my research, clinical practice, and teaching

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What does the extant literature tell us?

Theoretical underpinnings and principles of CBT for OCD

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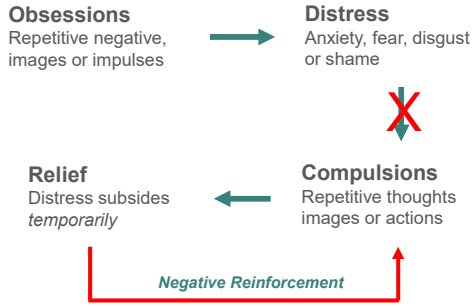
Mowrer's two factor theory:
Obsessive-compulsive cycle



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Psychological Bulletin
1986, Vol. 99, No. 1, 20-35

0033-2909/86/$00.75

Emotional Processing of Fear: Exposure to Corrective Information

Edna B. Foa and Michael J. Kozak
Temple University

In this article we propose mechanisms that govern the processing of emotional information, particularly those involved in fear reduction. Emotions are viewed as represented by information structures in memory, and anxiety is thought to occur when an information structure that serves as program to escape or avoid danger is activated. Emotional processing is defined as the modification of memory structures that underlie emotions. It is argued that some form of exposure to feared situations is common to many psychotherapies for anxiety, and that confrontation with feared objects or situations is an effective treatment. Physiological activation and habituation within and across exposure sessions are cited as indicators of emotional processing, and variables that influence activation and habituation of fear responses are examined. These variables and the indicators are analyzed to yield an account of what information must be integrated for emotional processing of a fear structure. The elements of such a structure are viewed as cognitive representations of the stimulus characteristic of the fear situation, the individual's responses in it, and aspects of its meaning for the individual. Treatment failures are interpreted with respect to the interference of cognitive defenses, autonomic arousal, mood state, and erroneous ideation with reformation of targeted fear structures. Applications of the concepts advanced here to therapeutic practice and to the broader study of psychopathology are discussed.

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Anxiety treatment: Modifying the fear structure

Foa & Kozak (1986) posited that:

- Two conditions are necessary:
  - Activation of the fear structure
  - Incorporation of ***incompatible*** information
- This process is indicated by:
  - Between-session decreases in fear
  - Change in evaluations (cognitions)

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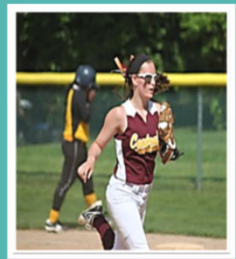
ERP principles: A more succinct explanation

Blah, blah, blah, do the thing you're afraid of,

Blah, blah, blah, the more you do it the easier it gets…

~ Gwen Franklin, age 6, to her father



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The best CBT therapists are like sherpas…

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Treatment efficacy

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(S)SRIs for Pediatric OCD: Summary

- Consistently superior to PBO in several multi-site RCTs
- Maintenance of gains with continued treatment
- Readily available, however:
  - Residual impairment is the norm
  - Some non-responders and dose-limiting side effects
  - Relapse upon SRI discontinuation
  - FDA "Black Box" warning

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CBT for pediatric OCD: Seminal studies

- Multiple meta-analyses & reviews (e.g., Farhat et al., 2022) **N = 1,234**
- Published CBT randomized trials include:

Lenhard et al. (2017): Internet-based CBT vs. WL	**N = 67**
Piacentini et al. (2011): CBT vs. REL	**N = 71**
Barrett et al. (2004): Individual and Family CBT vs. WL	**N = 77**
Bolton et al. (2011): Brief & full cognitively-oriented TX vs. WL	**N = 96**
POTS I, II, & Jr. (2004, 2011, 2014)	**Ns = 112, 124, & 127**
Storch et al (2016): DCS + CBT vs. PBO + CBT	**N = 142**
Torp et al. (2015): More CBT vs. SER for CBT partial responders	**N = 269**

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CBT for pediatric OCD: Summary

Positives:

- CBT is efficacious relative to various control conditions
- Robust symptom reduction
- Compatible with SSRIs
- COMB > CBT & SSRIs alone, but not always (POTS I Team, 2004)
- Follow-up assessments attest to the durability of treatment gains (e.g., Storch et al., 2007)

Negatives:

- Treatment refusal is an issue
- High quality CBT is difficult to find in most community settings
- TX response is neither universal nor complete: Partial and non-responders (20% – 30%, e.g., Torp et al., 2015)
- Barriers that limit access to care: Might telehealth help bridge these gaps?

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CBT implementation and managing clinical predictors of partial and non-response:

A forest-level view…

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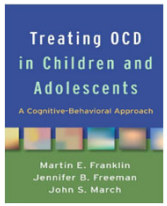
Cognitive behavioral treatment for OCD: Essential components

Exposure in vivo: Prolonged confrontation with anxiety-evoking stimuli (e.g., contact with contamination)

Imaginal exposure: Prolonged imaginal confrontation with feared images (e.g., hitting a pedestrian while driving)

Response prevention: Blocking of compulsions (e.g., leaving school without checking locker repeatedly)

Cognitive methods: Correcting erroneous cognitions (e.g., "anxiety won't ever decrease unless I ritualize;" "If I don't check someone will break in and kill my family")



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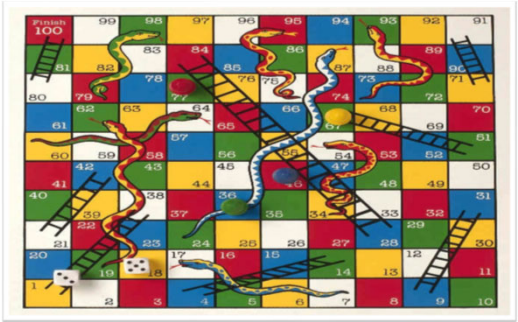
Climbing the exposure hierarchy



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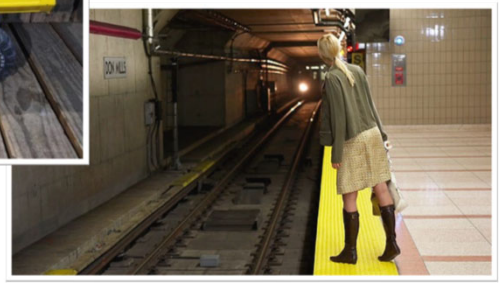

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So...
Why even use a hierarchy?

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Shaping / Successive approximations

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"Out, damned spot!"

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Principle of "The thing that touched the thing that touched the thing"

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"So, if you can't do this right now… What can you do instead?"

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Climb, but pay close attention to this:

The resistance ratio:

$$\frac{\text{\# Compulsive Urges Resisted}}{\text{Total \# of Compulsive Urges}}$$

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So, is overcorrection really necessary?

Setting the top of the stimulus hierarchy

It may well be…

at least to an extent….

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Here's another way to put it…

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But always keep in mind…

This is a treatment, not Fear Factor!

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CBT for pediatric OCD: Empirical expectations

+ Responder Rates: 60 – 80% (e.g., Franklin et al., 2024; Torp et al., 2015)
+ Remission Rates: 50 – 75% (e.g., Melin et al., 2020; Ost et al., 2016)
+ Most maintain their gains (e.g., Lenhard et al., 2017; Melin et al., 2020)
- Substantial minority of treated patients don't respond/maintain gains
- Predictor/moderator literature underdeveloped, mainly b/c of sample sizes
- Treatment modification/adjustments thus more reliant on clinical predictors

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Caveat for prediction & moderation

THE HOLY GRAIL OF PREDICTION:
"What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?"

Paul, G. (1967). Strategy of outcome research in psychotherapy. JCCP, 31(2), 109-118.

- Varied sampling frames, treatments, and methodologies contribute noise that can obscure signal, which may be why the same predictors & moderators do not emerge in each trial.
- Even w/ carefully refined methods, predictor studies can still, at best, only provide *educated guesses* about the response of an individual patient to a specific treatment in a specific context.

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Predictors & moderators of OCD TX in kids

(Franklin & Schwartz, in press)

- **Family history of OCD** (Garcia et al., 2010)
- **Presence of concomitant tics** (March et al., 2007)
- **Race/ethnicity & response to standard family TX** (Peris et al., 2020)
- Accommodation as rated by mothers (Nair et al., 2018)
- Accommodation, OCD-related impairment, depression, & externalizing disorders (Wilhelm et al., 2018)
- Project Harmony is on the horizon…

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But WHY?????

Mediators…

"Every predictor or moderator you find reflects a mediator that you have not discovered yet…"

Steve Hollon, Ph.D.

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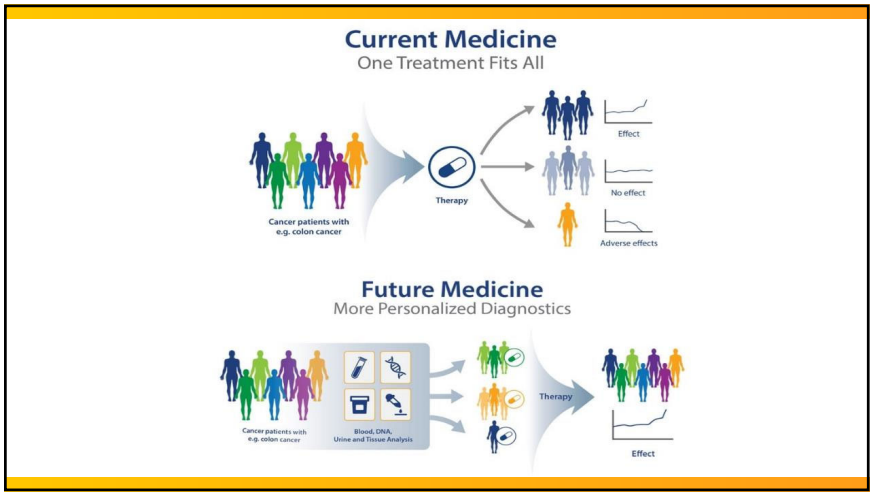

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In the meantime, which clinical predictors to discuss?

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Robust clinical predictors in pediatric OCD: What do clinicians find vexing?

1. Low motivational readiness
2. Less common obsessional presentations
3. Psychiatric comorbidity
4. Family accommodation

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Acknowledgement

Special thanks to Glen Gawarkiewicz, Ph.D., for the treacherous waters recommendations…

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A leading climate scientist known for taking his work very seriously…

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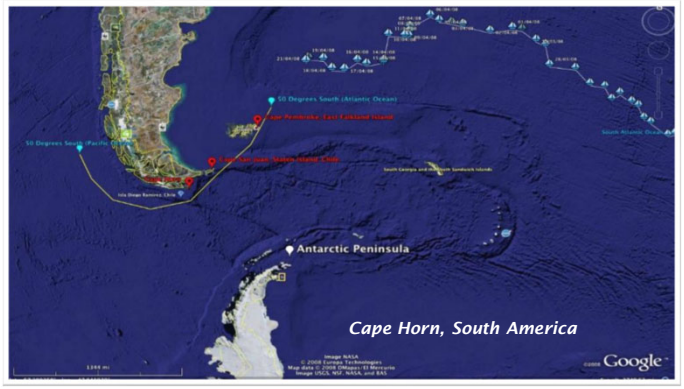
Treacherous crossing I: Low motivational readiness



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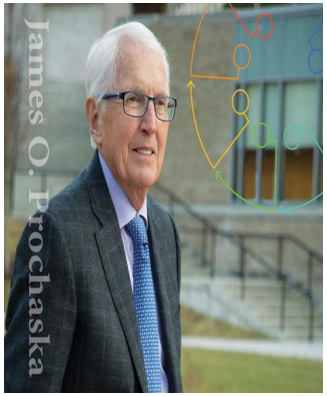

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Pre-contemplation: Its features

Pre-contemplation

- MAY NOT see their own behavior as a problem
- LESS interested in talking about the behavior w/ those who see it as problem
- Little awareness of need to modify aspects of their approach
- May have tried to change in the past and feels hopeless about being able to make the changes again or try something new

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Pre-contemplation

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Contemplation: Its features

Contemplation

- Express awareness of the benefit of changing their own behavior
- Begin to realize the problems related to their current approach
- Actively think about the pros and cons of their behavior and need for change
- Might be 'sitting on the fence'

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A laudable goal at this point…

Contemplation

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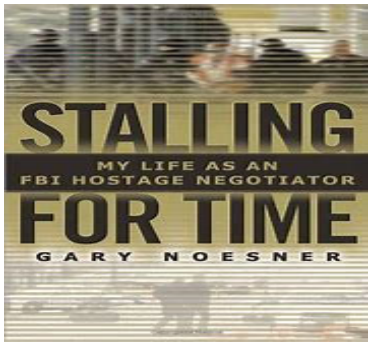
Contemplation



Clinically, it might feel a bit like this…

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Decisional balance sheet

	Short-term Good Things	Short-term Not-So-Good Things
Engaging in Treatment & Changing Parental Strategies		
Not Engaging in Treatment & Changing Parental Strategies		

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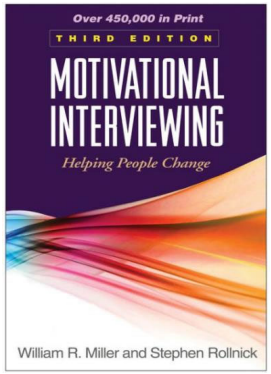
"Elicit the change language from the patient…"

Allan Zukoff, Ph.D.



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Treacherous crossing II:
Atypical obsessional content

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ERP: Gotta go where the action is,
but sometimes that's not so easy…

- Intrusive images of classmate in HS yearbook
- Fear of being trapped in someone else's dream
- Intrusive images of being buried alive
- Intrusive thoughts of stabbing others in the eye
- Fears of disrobing in public
- Images of eating human flesh

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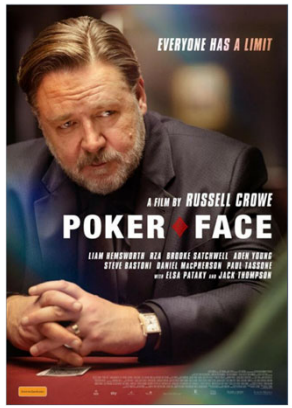

A useful clinical skill in such cases…

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You've already got a map… so USE it!

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Phenomenology that might give one pause…

"The Hand of Satan on the Sea of Darkness:" 19th Century Lithograph

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Obsessions about suicide if:

- Thoughts are experienced as intrusive
- Primary affect is anxiety
- Behaviors are intentional efforts to neutralize or reduce thoughts and the associated anxiety
- Individual does not report an intent to die
- "What if?" language is used

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Suicidal ideation if:

- Intention to die is prominent
- Direct efforts to intentionally end one's own life
- Function is to escape negative affect; negative urgency
- Perceived burdensomeness
- Thwarted belonging
- Precautions taken against being discovered

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Why is this important?

Different empirically-supported techniques for different symptom presentations

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Suicide and OCD

Storch et al. (2015):

- 36 to 63% of adults w/ OCD reported clinically significant suicidal ideation (SI) at some point
- 13% of a pediatric OCD sample reported current SI; associated with self-rated anxiety and depression as well as sexual/religious obsessions

Angelakis et al. (2015):

- Moderate to large effect links OCD and suicidality
- Associated w/ comorbidity, hopelessness, prior attempts

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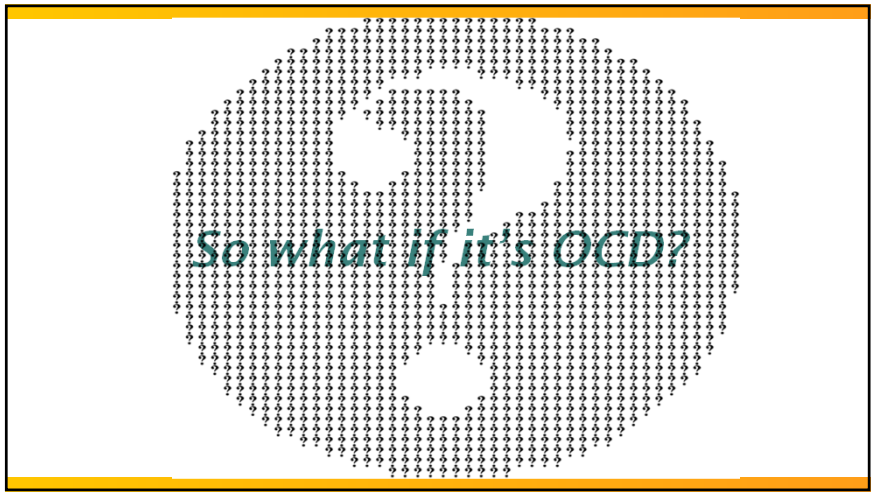

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ERP principles applied to obsessions about suicide:

Encourage approach, reduce avoidance

- What increases likelihood of intrusive thoughts?
- What does the patient avoid to prevent thoughts?
- Create a map/hierarchy
- Climb the hierarchy and reduce compulsions/avoidance
- Teach theory, modify, and expand as needed
- Define progress, reduce abstinence violation effects
- Changing relationship to ALL obsessions, including these

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So you've concluded that your patient is suffering from suicidal ideation and is considering ending their life…

Now what?

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Drs. Greg Brown & Martin Franklin

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The AIM model

Assess

Identify and assess risk

Intervene

Use evidence-based treatments that directly target suicidal behavior

Monitor

Provide continuous contact and support

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Suicide risk factors

Assess

Suicidal and injury behavior

- Suicide attempt
- Interrupted/aborted attempt
- Preparatory behavior
- Nonsuicidal self-Injury behavior

Suicidal ideation

- Wish to be dead
- Active suicidal ideation
- Suicidal ideation with general method
- Suicidal intent
- Suicidal intent with a specific plan

Activating event

- Recent loss or significant life event
- Pending incarceration or homelessness

Psychiatric treatment history

- Discharged from psychiatric inpatient care within the past few weeks, months, or year
- Hopeless, dissatisfied, non-compliant with treatment

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Suicide risk factors: recent clinical status

Assess

- Hopelessness
- Major depressive episode
- Mixed affective episode (e.g., Bipolar)
- Command hallucinations to hurt self
- Highly impulsive behavior
- Substance abuse or dependence
- Agitation or severe anxiety
- Perceived burden on family or others
- Chronic physical pain or other serious medical problem or impairment
- Social isolation
- Homicidal ideation
- Aggressive behavior towards others
- Access to lethal means when suicidal (firearms, pills, etc.)
- Sexual abuse (lifetime)
- Traumatic event (lifetime)
- Family history of suicide (lifetime)

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OCD/suicidality and race/ethnicity

Assess

National Survey of American Life (Himle et al., 2008) suggest comparable base rates across various racial and ethnic groups, yet:

- Representativeness/generalizability at issue for all races/ethnicities other than white: most published clinical trials include > 90% White patients
  - Higher risk of missed OCD diagnosis in Black Americans (Chasson et al., 2017) and in multi-ethnic urban clinics (Friedman et al., 2003)
  - Experiences of racial discrimination exacerbate obsessions and compulsions in Black Americans (Williams et al., 2017)
  - Ethnic group membership moderated relationship between obsessive beliefs and certain OC symptom dimensions (Wheaton et al., 2013)
  - Experience of racial discrimination is linked to suicidality in Black male youth, esp. when mothers also experienced such discrimination (Arshanapally et al., 2018)

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Suicide protective factors (recent)

Assess

- Identifies reasons for living
- Responsibility to family or others; living with family
- Supportive social network or family
- Fear of death or dying due to pain and suffering
- Belief that suicide is immoral, high spirituality
- Engaged in work or school

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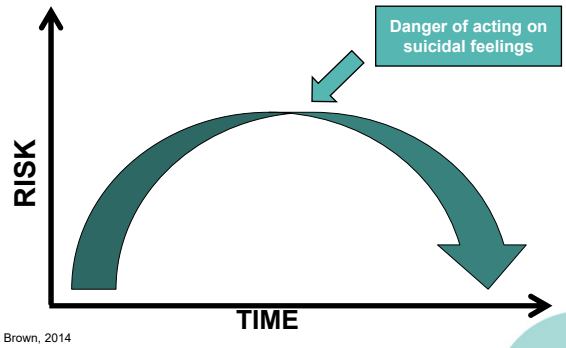
Suicide risk fluctuates over time



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Safety planning intervention (SPI)

Intervene

- Clinical intervention that results in a prioritized written list of warning signs, coping strategies and resources to use during a suicidal crisis
- Safety Plan is a brief intervention (20+ minutes)
- Safety Plan is *NOT* a "no suicide contract"


SAFETY PLAN

(Stanley & Brown, 2012)

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Focus of and in treatment is determined by:

Monitor

- Which conditions is primary?
- Regardless of that, is SI under good control? Is patient willing and able to work the Safety Plan?
- Clinical judgment of what's in patient's best interests?
- Consider concomitant treatments (e.g., meds)
- Be open about the potential need to pivot, and why

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Treacherous crossing III: Psychiatric Comorbidity

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Comorbidity across development

- Common in adults & kids, but more common in adults
- Another anxiety disorder is most common in both
- Depression more common in adults than in kids
- Externalizing disorders in kids, substance use in adults
- **Treatment selection & comorbidity: Major implications in both adults and kids**

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Differential diagnosis

- Obsessions function to increase anxiety
- Compulsions function to decrease anxiety
- Most people do not enjoy doing compulsions, but feel like they MUST complete them
- OCD is often "nonsensical"
- "JUST RIGHT" feeling can be difficult to describe – more like discomfort than anxiety

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Which do you target first?

OCD vs. Comorbidity

- Severity and associated impairment
- History of onset
- Patient preference
- Two birds with one stone?
- Can I swing the axe?

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Treacherous crossing IV: Family Accommodation

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A collaboration & friendship that goes back a ways…

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Functional impairment in the family context

- 88% of parents and 85% of children report impairment at home, in school, or socially
- 50% report significant OCD-related dysfunction in all three areas
- Parents more likely to report home/family problems, children more likely to report problems related to mental rituals
- Impairment related to level of family accommodation of symptoms – ***More accommodation leads to less impairment***

Piacentini et al., 2003

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Accommodation is not always apparent

The Iceberg of Ignorance

Anxiety interference and severity may be masked by **avoidance** (patient) or **accommodation** (family)

- *What are the patient and family doing/not doing now that would be different if patient did not have this fear?*
- *If the patient/family did NOT avoid/accommodate, what would happen?*

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Family accommodation of child OCD

	Weekly	*Daily*
Family participation in OCD		
reassure patient	97 %	56 %
participate in rituals	66 %	46 %
assist in avoidance	78 %	22 %
Consequences of not participating		
pt becomes distressed/anxious	80 %	
pt becomes angry/abusive	55 %	
rituals increase	63 %	
Modification of routine		
family routines	65 %	
work routines	43 %	
leisure routines	50 %	
assuming child's responsibilities	48 %	

N = 65
62% Male
M age = 12.3 yrs

(Peris et al., 2008)

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Family accommodation

Greater family COHESION associated with:

- Fewer negative consequences when not accommodating
- Lower levels of parental distress when accommodating

Greater family CONFLICT associated with:

- Increased distress when accommodating
- More negative child consequences when not accommodating

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Treatment implications

Setting limits in OCD youngsters with comorbid behavior problems needs to be done carefully

Treatment response may be facilitated by:

- Lessening family conflict
- Enhancing family relations
- Strengthening family organization

Parental OCD symptoms may need to be addressed:

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

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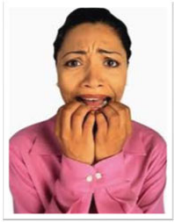
The parent overprotection trap

- Fear that something will go wrong
- Not knowing what is age appropriate
- Noncontingent reinforcement
- Negative reinforcement
- Waiting for change….*for too long*



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What is most difficult for parents?

Letting your child/teen struggle

- *"I'm damaging my child"*
- *"He's going to hate me"*
- *"Here, let me do this for you!"*

Parental "overprotection trap"

- Keeps anxiety fixed in place
- Limits progression towards next developmental stage

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Reducing parental accommodation

Impact of parental rescue:

- Child remembers situation at the height of fear
- Prevents habituation
- No mastery experience is reinforced

Impact of exposure:

- Child remembers success that allows habituation
- Learns anxiety passes on its own
- Willing to approach increasingly challenging situations
- Feeling of mastery
- Reinforcement for hanging in

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Family intervention

Goals

- 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

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UCLA Child OCD Study
Family-based Predictors of Response

Worse treatment response associated with:

- Higher parental blame, $t = 3.12$, $p < .01$
- Greater family conflict, $t = 2.44$, $p < .05$
- Lower family cohesion, $t = -4.36$, $p < .001$

(Peris et al., 2012)

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UCLA response by family risk status

Family Risk Status	Response Rate
0	92.9%
1	80.0%
2	60.0%
3	14.3%

X^2 (3, 41) = 14.33, p = .002

(Peris et al., 2012)

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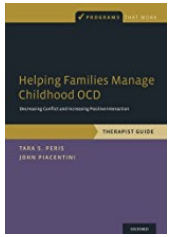
Positive Family Interaction Therapy

Six-session family adjunct to standard CBT for high-risk families

- Psychoeducation
- Self-Efficacy
- Affect Regulation
- Parenting Skills
- Family Dynamics



(Peris & Piacentini, 2016)

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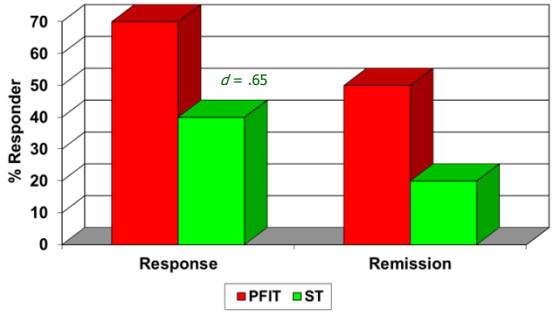
Family-enhanced vs. standard CBT for OCD youth in high-risk families



(Peris et al., 2013)

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Helpful therapist behaviors

- Collaborative approach to treatment
  - Patient should know what he/she is doing *and why*
- More time doing more extensive exposures
  - As treatment progresses, *don't be afraid to push*
- For younger patients anyway, make treatment fun!
- Balance long-term outcome with short-term anxiety
  - Too much cognitive and coping interventions may attenuate benefits of exposure

(Peris et al., 2013)

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General considerations for family intervention

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General parenting concepts

- Encourage autonomy and acknowledge when the child is facing their fears or taking steps to manage their anxiety
- Reward child's courageous behaviors
- Support the child in developing their own communication, coping, and problem-solving skills
- Control own anxiety

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Parenting pitfalls: What to avoid

- Accommodation
- (Negative) attention
- Overprotectiveness
- Intrusiveness
- Anxious interpretation of events
- Tolerance or encouragement of escape or avoidance

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Parents in the treatment process

Considerations for involvement:

- Cognitive-developmental level of child
- Degree of anxiety pathology and interference in functioning
- Comorbidity, especially with externalizing disorders
- Parental psychopathology
- Degree of family dysfunction

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How to win the avoidance battle

- Disengage/ignore at earliest possible point
- Do not engage in back-and-forth arguing
  - Extinction burst (dog at door)

- Maintain calm/non-emotional reaction
  - Avoid punishment
  - Calmest participant wins
- As soon as child calms down, even briefly, engage him/her in different activity
  - Positive reinforcement of appropriate behavior
  - This can include discussion of event

cares

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The active ingredient of parent therapy

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Case example

Roberto is a 16-year-old Hispanic cisgender male who presents to the clinic with symptoms of OCD and a prior diagnosis of depression, driven largely by the presence of what the referring clinician suggested was a history of "unusual suicidal ideation." He is a junior in a local high school but is finding it increasingly difficult to concentrate at school and to sleep at night, which has begun to affect his punctuality in the morning.

Roberto is already taking a daily dose of 75 mg of sertraline for OCD and depression but has not had CBT for either condition nor ERP for OCD. He reports several recent negative life events, including having been pulled over while driving home in his own neighborhood and subjected to interrogation about recent burglaries before being released.

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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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Key take-home messages…

1. CBT, pharmacotherapy with (S)SRIs, and combined treatments have all been found efficacious
2. Combined treatment may be preferable for more severe/more comorbid patients
3. Strategies may need to be brought to bear/modified for:
   - Low motivational readiness
   - Atypical/unusual obsessional content
   - Psychiatric comorbidity
   - Family accommodation

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Thank you

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About the presenter

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Dr. Franklin is an internationally renowned expert in the treatment of obsessive-compulsive disorder (OCD), OC-spectrum disorders, and body-focused repetitive behaviors, as well as the study and treatment of anxiety and related conditions.

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