


Intensive CBT Telehealth for Pediatric OCD during COVID-19: Comparison with a Matched Sample Treated In-Person

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Based on: Grand Rounds Lecture, Child & Adol Psychiatry, UCLA (March 10, 2022) and recently presented at Rogers in-person seminar held in Miami (September 9, 2022)




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.

- 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.



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.

Learning objectives

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

1. Describe the four essential components of cognitive behavioral treatment for OCD.
2. Recognize the potential value of telehealth treatments in mitigating at least two crucial barriers to care.

What we'll cover in this webinar

- Telehealth: Rationale and efficacy**
 - Review of evidence
 - COVID-19 clinical implications
 - Rationale for current study
- Current study**
 - Participant characteristics
 - Measures
 - Multi-modal treatment and level of care
 - Efficacy and treatment trajectories
 - Predictors and moderators
 - Study limitations
- Clinical implications and what's next?**
 - Case example
 - Other project-related studies and publication plans going forward
- Moderated Q&A**

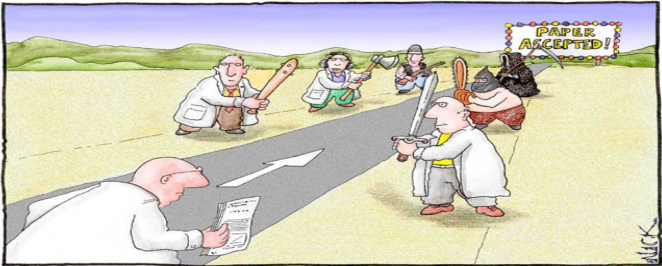
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Telehealth: Rationale and efficacy

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

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Looking Forward to Word from the Editor...



Most scientists regarded the new streamlined peer-review process as 'quite an improvement.'

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Telehealth (TH) in Psychology/Psychiatry: What Does the Evidence Tell Us?

- Non-OCD ([depression](#): Morland et al., 2010; [substance abuse](#): Jiang et al., 2017; [PTSD](#): Germain et al., 2009; Morland et al., 2020)
- OCD in Adults (e.g., Andersson et al., 2012; Mahoney et al., 2014; Wootton et al., 2013)
- OCD in Kids/Teens (e.g., Comer et al., 2014; 2017; Lenhard et al., 2017; Storch et al., 2011)

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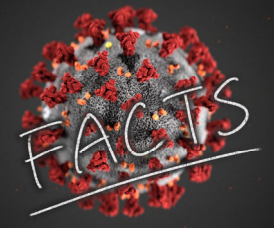
***TH in Psychology/Psychiatry:
An Alternative/Equivalent Platform?***

- A potential avenue for care when access to care is limited by distance/travel, time/expense, & therapist availability
- For whom does it work?
- For whom does it **NOT** work?
- **Some interest in the topic for a decade, but then the world changed...**

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***COVID-19:
Clinical Implications***


- Rising tide raises all boats
- OCD is a particularly relevant boat
- Therapist unavailability
- Patient reluctance
- **Immediate need to shift to Virtual platforms to continue to provide care**



CDC Website, 2020

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Things that grew during the pandemic:



- Rates of anxiety and depressive symptoms in the population (according to CDC data)
- Demand for mental health services across the developmental spectrum
- Need to study delivery methods to determine their long-term viability as a method to bridge the mental health treatment access gap

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Debate at home about the striking resemblance...



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Rationale for Current Study

- COVID necessitated the pivot to TH, which provided opportunity to explore outcomes on a large scale
- Large samples available at Rogers afford chance to examine treatment response, predictors, and moderators
- Large patient database allowed for matching procedure to control for variables that differentially influence treatment outcome
- Practical, real-world implications for those being treated at a higher level of care


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CBT for Pediatric OCD: Seminal Studies

- Multiple meta-analyses & reviews (e.g., Farhat et al., in press) **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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Current study



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

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Participants

- Matching variables included age & LOC
- 643 patients received TH after June 2020
(67% female; 69% Caucasian, 20% did not disclose race/ethnicity)
- 643 matched controls received In-Person (IP) care after 9/15
(55% female, 80% Caucasian, 9% did not disclose race/ethnicity)
- **Total sample size = 1,286 youth w/ OCD!!!**
- Mean age for both groups = 14.1, range 7 – 17 inclusive

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Measures & Criteria

- **CY-BOCS (Scahill et al., 1997)**
 - ✓ Primary outcome measure in clinical trials; range 0 - 40
 - ✓ Self-report comparable to clinician-rated (Conelea et al., 2012)
- **CY-BOCS Criteria (from Farhat et al., JAACAP, in press)**
 - ✓ Responder Criteria: $\geq 35\%$ CY-BOCS reduction
 - ✓ Remission: Post-TX CY-BOCS ≤ 12
- **PQ-LES-Q (Endicott et al., 2006)**
 - ✓ 14 item scale
 - ✓ Scores range from 14 to 70 and are expressed as % (0 – 100)

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Predictors

- Primary:
 - Remote Treatment
- Covariates:
 - Treatment setting: PHP & IOP, Age, Length of stay, Sex (assigned at birth), Race (White/non-White) and Ethnicity (Hispanic/non-Hispanic), Insurance Payer-type, Number of Diagnoses
- Models were trimmed to exclude non-significant predictors

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Multi-modal Treatment & Levels of Care

The diagram illustrates a multi-modal treatment approach using a staircase metaphor. It shows four steps. On the left side, red arrows point downwards from the top step, and the word 'DOWN' is written in green on the second and third steps. On the right side, blue arrows point upwards from the bottom step, and the word 'UP' is written in green on the second and third steps. This represents different levels of care and treatment modalities.

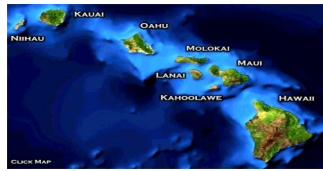
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Cognitive behavioral treatment for OCD: Essential components

- Exposure in vivo:** Prolonged confrontation with anxiety-evoking stimuli (e.g., contact with contamination)
- Imaginal exposure:** Prolonged imaginal confrontation with feared images (e.g., buried alive, hitting a pedestrian while driving)
- Response prevention:** Blocking of compulsions (e.g., leaving the kitchen without checking the stove)
- Cognitive methods:** Correcting erroneous cognitions (e.g., "anxiety won't decrease unless I ritualize;" "If I don't check someone will break in and kill my family")

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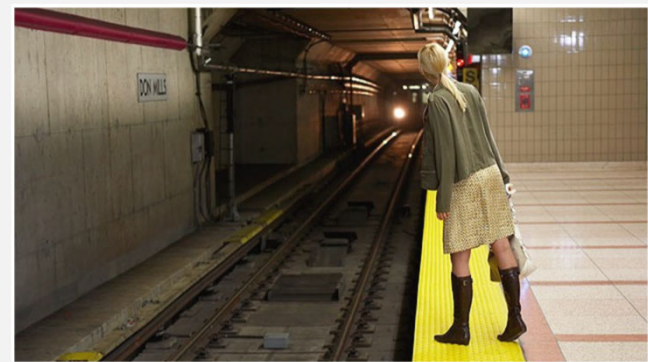
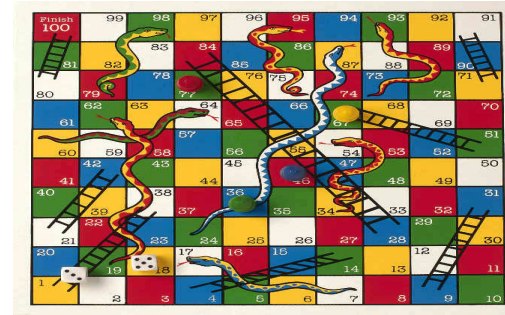
Treatment Hierarchies: Mapping OCD



Goal: to map the person's experience with OCD

- Generate fear estimates: low, medium, or high?
- Identify triggers, obsessions, compulsions, avoidance behaviors, & feared consequences
- Allows therapist & patient to create a hierarchy to guide treatment

Climbing the Exposure Hierarchy



Rasmussen & Eisen (Brown University): OCD “Flavors”

Incompleteness

Harm Avoidance

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Habituation & the “NJRE”/Disgust Presentations?

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Levels of care

Partial Hospitalization:

- 6 hours of programming per day
- Typical stay of 4 – 6 weeks
- 3 hours of individual CBT blocks
- Also group, education, & Parent University

Intensive Outpatient:

- 3 hours of programming per day
- Typical stay of 2 – 4 weeks
- Includes group & education

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Concomitant Pharmacotherapy

Majority receiving concomitant pharmacotherapy, usually SSRI

Will examine:

- ✓ Optimized meds (minimum therapeutic dose, criteria from POTS II, Franklin et al., 2011)
- ✓ Suboptimized meds
- ✓ No meds
- ✓ Suboptimized but had med adjustment during their stay

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Results

Length of Stay (PHP vs. IOP)

	In-Person	Telehealth	Total	Difference IP v. TH
PHP	31.09 (13.26)	32.08 (13.88)	31.58 (13.57)	
IOP	23.47 (12.48)	24.81 (12.56)	24.14 (12.52)	
Total	28.32 (13.48)	29.43 (13.85)		d = 0.08, p = 0.14
Difference IOP v. PHP			d = 0.57, p < 0.001	

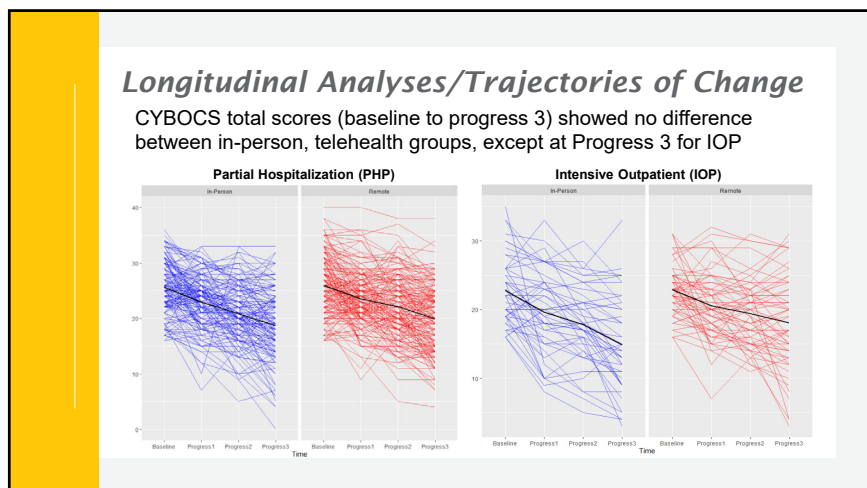
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Results

CY-BOCS & PQ-LES-Q Continuous Data

	In-Person (n = 643)			Telehealth (n = 643)		
	Admission M (SD)	Discharge M (SD)	Effect (d)	Admission M (SD)	Discharge M (SD)	Effect (d)
PHP (n = 409)						
CYBOCS	25.0 (5.3)	15.5 (7.5)	1.5	25.2 (5.3)	16.7 (7.0)	1.4
PQ-LES-Q	44.7 (9.1)	51.6 (9.9)	0.7	45.1 (9.2)	51.3 (9.0)	0.7
IOP (n = 234)						
CYBOCS	22.6 (4.7)	14.8 (7.3)	1.3	21.7 (4.0)	16.5 (6.2)	1.0
PQ-LES-Q	48.2 (8.5)	52.5 (9.4)	0.5	48.3 (7.9)	51.7 (8.9)	0.4

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- ### Summary of Regression Analyses
- Four variables predicted CY-BOCS scores at discharge:
 - TH, age, diagnosis count, length of stay
 - Of these, only length of stay was negatively associated with CY-BOCS at discharge
 - Age and DX count also predicted PQ-LES-Q, both negatively
 - **On average, TH patients discharged with CY-BOCS scores 1.25 points higher than IP patients**
 - **≤ 3 point Y-BOCS difference not considered clinically meaningful (e.g., Foa et al., 2022, JAMA Psychiatry)**

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Moderators

- Setting, age, diagnosis count, race (White/non-White), ethnicity (Hispanic/non-Hispanic), and sex all assessed
- **None** moderated either CY-BOCS at discharge or PQ-LES-Q at discharge
 - Except a trending ($p < 0.1$) effect suggesting that TH may have been more beneficial for girls than for boys

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Study Limitations

Sampling frame:

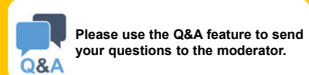
- ✓ Limited SES, racial, & ethnic diversity
- ✓ Truncated age range

Design issues:

- ✓ Lack of randomization
- ✓ Clinical diagnostic assessment procedure
- ✓ Self-report primary outcome measure (CY-BOCS)
- ✓ Concomitant & diverse pharmacotherapy regimens
- ✓ Lack of follow-up assessments

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Clinical implications and what's next?



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Clinical Implications

- TH offers a feasible and efficacious alternative to IP
- TH predicts slightly higher discharge CY-BOCS
 - Especially at IOP
 - More work is needed to consider additional variables
- TX response was robust across variables
- Large-scale test and robust response to TH supports its continued use
- Offers a viable choice when travel/distance and paucity of local expertise limits access to this EST

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Case example

Ghosts in the Basement...



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So Now for a Major Potential Confound...



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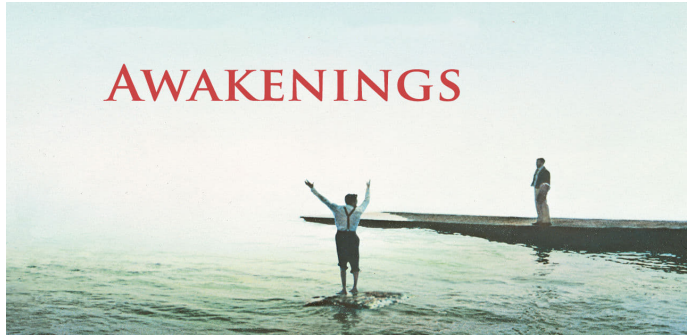
What's Next?

- Expand TH evaluation to other program lines @ Rogers
- Examination of TX outcomes x concomitant med status
- Machine learning approaches to outcome prediction/moderation
- Examination of TX outcome x SES, race, & ethnicity
- Discussion of implications of our sampling frame for generalizability of findings
- Broader discussion of improving inclusiveness & access to care

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Don't Let the Telehealth Light Go Out...

AWAKENINGS

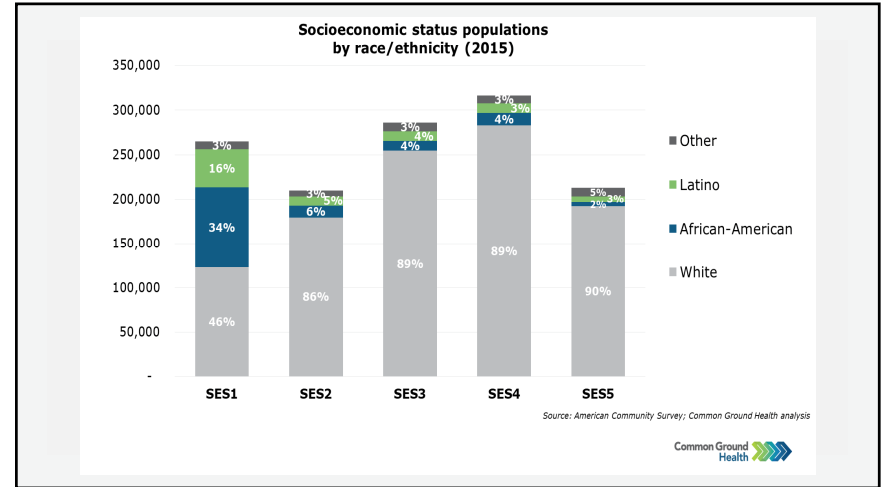


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*In the End...
What Kind of World Are We Trying to Build?*





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*My Apologies for the Rant,
But Something HAS to Be Done!!!*



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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

- CBT involving exposure plus response prevention (ERP) is an efficacious treatment for OCD across the developmental spectrum
- ERP can be delivered effectively via telehealth, across multiple levels of care (PHP, IOP, OP)
- There are some clinical circumstances where TH may be preferable
- TH may offer an opportunity to bridge the access to care gap

About the presenter....



Martin E. Franklin, PhD

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Dr. Franklin is an internationally renowned expert on OCD, OC-spectrum disorders, and body-focused repetitive behaviors, as well as the study and treatment of anxiety and related conditions. In addition to serving as the clinical director of Rogers' Philadelphia location, Dr. Franklin is an associate professor emeritus of clinical psychology in psychiatry at the University of Pennsylvania Perelman School of Medicine.

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