Evidence-based psychosocial treatments for child and adolescent obsessive-compulsive disorder

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CRD summary
This review evaluated psychosocial treatments for child and adolescent obsessive-compulsive disorder. The authors concluded that there was strong support for individual cognitive behavioural therapy (CBT) as a first-line intervention in outpatient/day treatment settings, and that individual CBT with structured family intervention and/or group CBT were viable alternatives. The lack of good quality evidence suggested that the authors' conclusions may not be reliable.

Authors' objectives
To evaluate the evidence base of psychosocial treatments for child and adolescent obsessive-compulsive disorder (OCD).

Searching
MEDLINE and PsycINFO were searched and search terms reported (search dates were not reported). Review articles and treatment studies were searched and investigators working in the area contacted. Studies published since 1994 and written in English were considered.

Study selection
Studies classified as Type 1 (methodologically strong randomised, controlled trials, RCTs), Type 2 (weaker RCTs and non-randomised trials) or Type 3 (uncontrolled studies) by Nathan and Gorman (2002) criteria were eligible for inclusion. Psychosocial treatment studies of children or adolescents with OCD with more than one participant were eligible for inclusion. Most of the included studies were Type 3 and were conducted in an outpatient setting. The included participants ranged from seven to 18 years old. Most studies included those with primary OCD. The included studies investigated a number of interventions including individual or group cognitive behavioural therapy (ICBT or GCBT) with and without family involvement, Anxiety Management Component (AMC) and therapist interventions. The interventions varied in duration and frequency. In the included studies treatment gains were assessed through a variety of tools (for example, Global Scale (CY-BOCS), Clinical Global Impressions Improvement (CGI-I) and Children's Depression Inventory (CDI)).

The authors stated neither how the papers were selected for the review nor how many reviewers performed the selection.

Assessment of study quality
Studies were assessed in terms of randomisation, prospective data collection, comparison groups, blinding, inclusion/exclusion criteria, diagnostic methods, sample size and reporting of statistical methods and classified as Type 1 (most rigorous), Type 2 (some Type 1 requirements missing) and Type 3 (generally open trials aimed at obtaining pilot data).

Validity was assessed by one author and checked by the remaining authors. Decisions were reached by consensus.

Data extraction
Within-group and between-group effect sizes (standardised mean difference, Cohen's d) were calculated for each study where data allowed. The authors stated neither how the data were extracted for the review nor how many reviewers performed the data extraction.

Methods of synthesis
The studies were combined narratively and were synthesised by type of study design and type of treatment (group or individual). Tables of individual study details were also presented.
Results of the review
Sixteen studies were included in the review (n=478): two Type 1 (n=189); four Type 2 (n=116); and 10 Type 3 (n=173). Study size ranged from seven to 112 participants.

Exposure-based CBT produced remission rates of OCD ranging from 40 per cent to 85 per cent (four studies: two Type 1 and two Type 3).

CBT was associated with between-group effect sizes on the CY-BOCS from 0.99 to 2.84 for the Type 1 studies and within-group effect sizes on the CY-BOCS from 1.57 to 4.32 (ICBT) and 0.82 to 1.15 (GCBT) for Types 2 and 3.

Authors’ conclusions
This review suggested there was strong support for the use of individual CBT as a first-line intervention for children and adolescents with OCD seen in out patient or day treatment settings. It also suggested that individual CBT accompanied by a structured family intervention and/or delivered in group format were reasonably viable therapeutic alternatives.

CRD commentary
The research question was broad, but had inclusion criteria for study design, participants and a wide criteria for intervention. There were no inclusion criteria for outcomes, which may have led to subjective decisions during study selection. It appeared there were limited attempts to find unpublished data. Inclusion was limited to studies in English, which may have introduced language bias into the review. Validity of the primary studies was assessed and taken into consideration by the authors. Multiple reviewers were involved in this, reducing the possibility of error and bias. The process of study selection and data extraction were not described, so it was not known whether similar steps were taken. Narrative synthesis appeared to be appropriate given the diversity of interventions described. The included studies were mostly uncontrolled studies. Controlled studies mainly compared different types or intensities of intervention. The outcome measures and their clinical significance were not well described. Due to poor reporting of the review process and lack of good-quality studies in this review the authors’ conclusions may not be reliable.

Implications of the review for practice and research
Practice: The authors did not state any implications for practice.

Research: The authors stated that replication studies that focus on evaluation of relative effectiveness of group and individual treatments and durability beyond 18 months post-treatment were needed. Studies with designs that can be used to develop specific treatment guidelines for specific clinical presentations and a more thorough examination of family involvement were also required. Controlled research into the central components of CBT and evaluation of CBT interventions in real world settings (such as hospitals, community centres and schools) were also needed.

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