Cognitive-Behavioral Therapy Effective for OCD

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Toronto — Childhood obsessive-compulsive disorder often resists very well to an intense course of cognitive-behavioral therapy with an emphasis on exposure and response prevention. Unfortunately, up to 5 million children in the United States and Canada are not receiving complete treatment for their OCD, because few clinicians are trained in this kind of therapeutic approach, Eric A. Storch, Ph.D., said at the joint annual meeting of the American Academy of Child and Adolescent Psychiatry and the Canadian Academy of Child and Adolescent Psychiatry.

“There’s definitely a lack of training in this area,” said Dr. Storch of the University of Florida, Gainesville. “Some therapists are too reluctant to even try it. But to the question, ‘Does CBT work for OCD?’ the answer is a resounding yes.”

Three randomized controlled trials have shown the effectiveness of exposure and response prevention (CBT) techniques, he said. A 1998 trial included 22 children aged 8-18 years who were randomly assigned to ERP or clomipramine for 12 weeks. Those on ERP showed an average improvement of almost 60%, compared with a 33% improvement for those in the medication arm (J. Am. Acad. Child Adolesc. Psychiatry 1998;37:1022-8).

One of the three studies included 77 children aged 7-17 years to individual or group cognitive-behavioral family-based therapy or a 4-6 week wait list. The children in both therapy groups improved similarly, with symptom reductions of more than 60%, while symptoms increased slightly in the wait-list group (J. Am. Acad. Child Adolesc. Psychiatry 2004;43:46-62). A study of 48 patients aged 8-18 years old by several of the same researchers found that treatment gains were maintained, 70% of subjects in individual therapy and 84% in group therapy were diagnosed free at a follow-up of 12-18 months (J. Am. Acad. Child Adolesc. Psychiatry 2005;44:1005-14).

The Pediatric OCD Treatment Study, also published in 2004, randomized 112 children aged 7-17 years to CBT alone, sertraline alone, combined CBT and sertraline, or placebo for 12 weeks. Rates of remission were 54% in the combined intervention group, 39% in the CBT group, and 21% in the sertraline-only group (JAMDA 2004;292:1969-76). Dr. Storch is now conducting his own trial. It includes 31 children aged 7-17 years, who were randomized to intensive CBT (14 sessions in 3 weeks) or 14 week CBT sessions. Preliminary findings indicate a greater improvement in the intensive CBT group (94%) than in the weekly group (67%).

Up to 80% of OCD has a childhood onset, Dr. Storch said. Without treatment, these children face a life of disruptive behaviors—to help them identify the driving thoughts and behaviors. “It doesn’t result in school performance. Some children with PANDAS may not have a positive stress threshold, however. In these cases, strep titer rises may give evidence of a subclinical infection. If strep is present, children should take a full course of antibiotics and return for a repeat culture shortly after the antibiotic is completed.

PANDAS appears to be at the center of a convergence of three factors, Dr. Murphy said: a group A strep infection, genetic predisposition (familial OCD, Tourette syndrome), and an environmental stress factor such as a central nervous system injury or infection. The incidence peaks at ages 5-12 years—the same ages in which strep infections peak.

Dr. Murphy presented the results of a prospective study of 25 children, aged 7-17 years, with typical OCD and tics. The children were assessed every 6 weeks and had at least 6 consecutive assessments; strep titers were taken at each visit. Fifteen children exhibited an episodic or sawtooth disease course. Almost 60% of the episodic group had elevated group A strep titers on all of their visits, while 60% of the stable disease course group had no elevated titers at any time, suggesting that those with a PANDAS-like course have had more frequent undetected strep infections or prolonged immune reaction to past strep infections.

Those with episodic disease were also more likely to have exacerbations in the fall and winter, concurrent with the seasonal rise in strep infections. The children in the episodic group were more likely to be male (67% vs. 30%) and have attention-deficit hyperactivity disorder (73% vs. 40%), compared with those in the steady course group. “Unlike its namesake, however, PANDAS isn’t all black and white,” Dr. Murphy said. There have been few reports that antibiotics for children suspected of having the disorder improved their OCD or tic symptoms. Definitive studies still need to be conducted to clarify the impact of antibiotic treatment on symptoms.

In a 2005 study, 23 children with PANDAS received either systemic or prophylactic antibiotics. The drugs decreased additional strep infections and neuropsychiatric symptom exacerbations (Biol. Psychiatry 2005;57:778-92).


An early clinical trial involving the use of prophylactic penicillin for PANDAS revealed no conclusive evidence that the antibiotic reduced clinical exacerbation. However, the sample size was small (37 subjects), the treatment arm was brief, and the lack of efficacy may have been attributable to cognitive restructuring and another innate streptococcal colonization in the patients enrolled in the study, Dr. Murphy said. Since then, investigators have reported improvement in neuropsychiatric symptoms with antibiotic treatment in patients with PANDAS. Difficulties with study design and the small sample size of these early antibiotic trials limit the clinical influence of their findings.