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Appendix A. Methods

A.1 Details of Study Selection

A.1.1 Search Strategy (Details)

We searched for studies and existing systematic reviews in MEDLINE (via PubMed), the Cochrane Register of Clinical Trials, the Cochrane Database of Systematic Reviews, Embase, CINAHL and PsycINFO and Education Resources Information Center (ERIC) databases on July 6, 2023. We searched using index terms, along with free-text words, for concepts related to OCD and pediatric and adolescent populations. Duplicate citations were removed prior to screening. We did not apply language, date, or country restrictions. Search strategies included filters to remove nonhuman studies and articles that are not primary studies or systematic reviews. The full search strategies for all databases are detailed below.

Additional searches were conducted on September 1, 2023 in the ClinicalTrials.gov registry for ongoing and unpublished studies with study results. The reference lists of relevant existing systematic reviews were screened for additional eligible studies. A Supplemental Evidence And Data for Systematic review (SEADS) portal and Federal Register Notice was e available for this review. Additional articles suggested to us from any source, including through the SEADS portal, were screened with the same eligibility criteria as the studies identified in the database searches.

Per our EPC's standard processes, we took advantage of the machine learning capacities of Abstrackr (http://abstrackr.cebm.brown.edu/) to limit resources spent on abstract screening. We trained the machine learning algorithm as follows: (1) We reviewed the reference lists from known existing systematic reviews and clinical practice guidelines to identify potentially relevant studies for each KQ. (2) We confirmed this set of potentially relevant citations was successfully captured by our database searched. (3) Based on recently published work by Sampson et. al.,[1] we selected the top 500 articles from our search using PubMed's best-match algorithm. (4) The articles from steps (1) and (3) were entered into Abstrackr and screened by all team members, with resolution of all conflicts in conference. (5) Subsequently, citations found by the full literature searches were added to the already-screened citations in Abstrackr, and abstract screening continued in duplicate, with conflicts adjudicated in conference or by a third screener. (6) We stopped double screening when the predicted likelihood of the remaining unscreened papers was below 0.40 (this threshold is based on experience with several dozen screening projects and an analysis in preparation for publication) and we had rejected at least 400 consecutive citations.

Potentially relevant citations were retrieved in full text. Non-English language articles were screened, and data extracted from full text, either by readers of the relevant languages or after translation via Google Translate (https://translate.google.com/), if possible. The search strategies for all databases were peer reviewed by another experienced systematic review librarian. Searches will be updated during the draft report's public posting period.

A.1.1.1 PubMed Search

(("Obsessive-Compulsive Disorder"[Mesh] OR (Obsessive Compulsive AND (Disorder* OR Neuros*)) OR Anankastic Personalit*[tiab] OR "OCD"[tiab]) AND ("child"[Mesh] OR

"adolescent"[Mesh] OR toddler*[tiab] OR nursery[tiab] OR preschool[tiab] OR pre-school[tiab] OR child*[tiab] OR childhood[tiab] OR children[tiab] OR girl[tiab] OR girls[tiab] OR boy[tiab] OR boys[tiab] OR pediatri*[tiab] OR paediatri*[tiab] OR adolesc*[tiab] OR pubescen*[tiab] OR school-age*[tiab] OR student*[tiab] OR preteen*[tiab] OR pre-teen*[tiab] OR teen*[tiab] OR juvenile[tiab] OR juveniles[tiab] OR young* adult*[tiab] OR youth[tiab] OR youths[tiab] OR minors[tiab] OR college[tiab] OR university[tiab] OR student[tiab]) AND ("Cohort Studies"[Mesh] OR cohort OR "Clinical Trial"[Publication Type] OR follow-up OR followup OR "different models" OR longitudinal OR "Placebos"[Mesh] OR placebo* OR "Research Design"[Mesh] OR "Evaluation Study" [Publication Type] OR "Comparative Study"[Publication Type] OR ((comparative OR Intervention) AND study) OR pretest* OR posttest* OR prepost* OR "before and after" OR interrupted time* OR time serie* OR intervention* OR ((quasi-experiment* OR quasiexperiment* OR quasi OR experimental) AND (method OR study OR trial OR design*)) OR "real world" OR "real-world" OR "Case-Control Studies"[Mesh] OR case control OR "Random Allocation"[Mesh] OR "Clinical Trial"[Publication Type] OR "Double-Blind Method"[Mesh] OR "Single-Blind Method"[Mesh] OR random* OR "Placebos"[Mesh] OR placebo OR ((clinical OR controlled) AND trial*) OR ((singl* OR doubl* OR trebl* OR tripl*) AND (blind* OR mask*)) OR crossover OR cross-over OR cross-over OR "treatment switching" OR "Treatment Switching"[Mesh] OR RCT OR "Randomized Controlled Trial"[Publication Type] OR systematic[sb] OR reliability OR validity OR sensitivity OR specificity OR area under the curve OR AUC)) NOT ("addresses" OR "autobiography"[pt] OR "bibliography"[pt] OR "biography"[pt] OR "case reports" OR "comment"[pt] OR "congresses" OR "dictionary"[pt] OR "directory"[pt] OR "festschrift"[pt] OR "government publications" OR "historical article"[pt] OR "interview"[pt] OR "lectures" OR "legal cases" OR "legislation"[pt] OR "news"[pt] OR "newspaper article"[pt] OR "patient education handout"[pt] OR "periodical index"[pt] OR "comment on" OR ("Animals"[Mesh] NOT "Humans"[Mesh]) OR rats[tw] OR cow[tw] OR cows[tw] OR chicken*[tw] OR horse[tw] OR horses[tw] OR mice[tw] OR mouse[tw] OR bovine[tw] OR sheep OR ovine OR murinae OR "animal model")

A.1.1.2 Embase Search

No. Query
#15 #13 NOT #14
#14 #10 AND #11 AND ([article]/lim OR [article in press]/lim OR [erratum]/lim OR [letter]/lim) AND [medline]/lim
#13 #10 AND #11 AND ([article]/lim OR [article in press]/lim OR [erratum]/lim OR [letter]/lim)
#11 'cohort studies'/exp OR longitudinal OR ((comparative OR intervention) AND study) OR prepost* OR 'before and after' OR 'interrupted time*' OR 'time serie*' OR intervention* OR (('quasi experiment*' OR quasiexperiment* OR quasi OR experimental) AND (method OR study OR trial OR design*)) OR 'real world' OR 'random allocation'/exp OR 'double-blind method'/exp OR 'single-blind method'/exp OR random* OR ((clinical OR controlled) AND trial*)
#10 #3 AND #9
#9 #4 OR #5 OR #6 OR #7 OR #8
#8 toddler* OR nursery OR preschool OR 'pre school' OR child* OR childhood OR children OR girl OR girls OR boy OR boys OR pediatri* OR paediatri* OR adolesc* OR pubescen* OR 'school age*' OR student* OR preteen* OR 'pre teen*' OR teen* OR juvenile OR juveniles OR youth OR youths OR minors OR college OR university OR student

#7 'adolescent'/exp OR 'adolescent'
#6 'young adult'/exp OR 'young adult'
#5 'juvenile'/exp OR 'juvenile'
#4 'child'/exp OR 'child'
#3 #1 OR #2
#2 'ocd'
#1 'obsessive compulsive disorder'/exp OR 'obsessive compulsive disorder'

A.1.1.3 Cochrane Search

ID	Search	Hits
#1	MeSH descriptor: [Obsessive-Compulsive Disorder] explode all trees	1291
#2	Obsessive Compulsive or Obsessive-Compulsive	3773
#3	Disorder* OR Neuros*	225566
#4	#2 AND #3	3599
#5	"OCD"	1973
#6	#1 OR #4 OR #5	3910
#7	MeSH descriptor: [Child] explode all trees	77901
#8	MeSH descriptor: [Adolescent] explode all trees	125416
#9	toddler* OR nursery OR preschool OR pre-school OR child* OR childhood OR childrenOR girl OR girls OR boy OR boys OR pediatri* OR paediatri* OR adolesc* OR pubescen* OR school-age* OR student* OR preteen* OR pre-teen* OR teen* OR juvenile OR juveniles OR young* adult* OR youth OR youths OR minors OR college OR university OR student	812843
#10	#7 OR #8 OR #9	812843
#11	#6 AND #10	2228

A.1.1.4 CINAHL Search

(obsessive compulsive disorder or obsessive-compulsive disorder or ocd)
AND
Limits
Source Types
- Academic Journals

Age
- young adulthood (18-29 yr...
- adolescence (13-17 yrs)
- childhood (birth-12 yrs)
- school age (6-12 yrs)
- adolescent: 13-18 years
- child: 6-12 years
- preschool age (2-5 yrs)
- child, preschool: 2-5 yea...

Methodology
- empirical study
- quantitative study
- longitudinal study

- followup study
- clinical trial
- treatment outcome
- prospective study
- retrospective study
- meta analysis
- systematic review

A.1.1.5 ClinicalTrials.gov Search

Condition
Obsessive Compulsive Disorder OR OCD OR Anankastic Personality

Other terms
Pediatric OR child OR children OR adolescent OR teen OR college OR university OR kid

A.1.2 Inclusion and Exclusion Criteria (Details)

The specific eligibility criteria provided below have been refined based on discussions with a panel of Key Informants (KIs) and a Technical Expert Panel (TEP). These stakeholders included perspectives from clinicians and researchers in child and adolescent psychiatry, child psychology, research funding, patient, and family advocacy.

	Key Question 1 (Diagnosis of OCD)	**Key Question 2 (Treatment of OCD)**
Population	Children and adolescents (<21 years) • in whom there is clinical consideration of OCD • diagnosed with OCD and/or other conditions which may be either be comorbid with OCD or may present with similar symptoms *Include*: • Studies evaluating only children and adolescents with OCD (to estimate test sensitivity alone) *Exclude*: • Studies that include both adults and children that do not explicitly report a pediatric or adolescent subgroup in the abstract • Studies that perform population-based screening (among individuals without a clinical concern for OCD)	Children and adolescents (<21 years) with diagnosed OCD, including those with: • possible PANS/PANDAS (with OCD) • other comorbid conditions (e.g., autism) *Exclude:* • Children and adolescents diagnosed with other OCD-spectrum conditions (e.g., body dysmorphic disorder, body focused repetitive behaviors) without an OCD diagnosis • Subclinical OCD or obsessive or compulsive symptoms without an OCD diagnosis • Studies that include both adults and children that do not explicitly report a subgroup by age in the abstract

Interventions	Index Test(s)
	• Tools to diagnose OCD in symptomatic patients. For example,
	  ○ Obsessive Compulsive Inventory-Child Version (OCI-CV-R)
	  ○ Toronto Obsessive-Compulsive Scale (TOCS)
	  ○ Short Obsessive-Compulsive Screener (SOCS)
	• Diagnostic prediction models
	• Must report use of specific cut-point(s) to classify an individual as having OCD or a
		Psychological interventions for OCD, alone or in combination with pharmacological and/or other interventions, including:
		• Cognitive behavioral therapy (CBT)
		  ○ Exposure and response prevention (ERP)
		  ○ Psychoeducation
		  ○ Coping skills
		  ○ Cognitive therapy
		• Acceptance and commitment therapy (ACT)
		• Targeted family interventions
		• Other psychological interventions
		• Delivery method

	Key Question 1 (Diagnosis of OCD)	Key Question 2 (Treatment of OCD)
	prediction algorithm or model to predict the probability of OCD • Alternative administration (e.g., child versus parent versus teacher report, in-person versus telehealth) *Exclude*: • Specific individual symptoms, behaviors, or characteristics • Genetic studies • Biomarker studies	○ Therapist led, e.g., scheduled, in-person, or via telephone, video conference ○ Self-guided, e.g., asynchronous, therapist serves as supportive coach Pharmacological interventions, alone or in combination with psychological interventions • Selective serotonin reuptake inhibitors (SSRIs) • Tricyclic antidepressants (TCA), including clomipramine • Serotonin and norepinephrine reuptake inhibitors (SNRIs) • Medication augmentation strategies ○ SSRI augmentation with clomipramine, and other medications, including neuroleptics, nonsteroidal anti-inflammatory drugs (NSAIDs) ○ Glutamate modulating agents (e.g., D—cycloserine, riluzole) • Other pharmacologic interventions, alone or in combination with psychological and/or other interventions, including dose escalation, longer treatment duration Neuromodulation interventions: • Transcranial magnetic stimulation (TMS), • Transcranial direct current stimulation (tDCS), • Transcranial alternating current stimulation (tACS), • Deep brain stimulation (DBS) Complementary/integrative therapies: • Naturopathic interventions • Mind-body practices (e.g., mindfulness, meditation, yoga) • Sensory integration (e.g., deep pressure) *Exclude*: • Specific treatments for PANS/PANDAS (e.g., antibiotics, immunomodulation, intravenous immunoglobulin)
Comparators	Reference standard(s) • Clinical interview • Validated diagnostic assessment instruments (others may be included) ○ Anxiety Disorders Interview Schedule for DSM-5 child version ○ (ADIS-C) ○ Kiddie Schedule for Affective Disorders and Schizophrenia, Present and Lifetime version (K-SADS-PL) for DSM-5 ○ Mini-International Neuropsychiatric Interview for Children and Adolescents (MINI-KID) ○ Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS)	• No treatment (e.g., waitlist control) • Pill placebo or sham control • Another active intervention or co-intervention (e.g., relaxation therapy) • Alternative delivery methods

	Key Question 1 (Diagnosis of OCD)	Key Question 2 (Treatment of OCD)
	○ Children's Yale-Brown Obsessive-Compulsive Scale Second Edition (CY-BOCS-II) • Different index tests (if also compared with reference standard) • Different reference standards (i.e., comparison of reference standards) • Different respondents (e.g., clinician, self, parent, educator) • Different methods to give test (e.g., in person vs. via tele-health) • Different populations (see effect modifiers below)	
Outcomes (prioritized outcomes have an asterisk and are in bold font)	OCD diagnosis • **Sensitivity/Specificity*** • Positive and negative likelihood ratios • Accuracy • Area under the Receiver Operator Characteristic Curve (AUC ROC) • Predicted probability of OCD (model calibration/discrimination) • Time to initiation of treatment (cohort studies) *Exclude*: • Studies not reporting predictive validity that report other psychometric properties of scales: for example, reliability or validity (content, construct, convergent, discriminant, divergent, face)	OCD symptom severity • **Children's Yale-Brown Obsessive Compulsive Scale Total (CY-BOCS)*** • **Clinical Global Impression–Severity (CGI–S)*** Treatment response and remission • **Clinical remission (posttreatment CY-BOCS total score ≤ 12 as defined by Farhat et. al.[2], or as reported)*** • **Clinical Global Impression–Improvement (CGI–I)*** Functional impairment in school, social, and home/family domains • **The Child Obsessive Compulsive Impact Scale— Revised (COIS-R)*** ○ Raters: child (COIS-C), parent (COIS-P) Family accommodation • **Family Accommodation Scale (FAS)*** Family functioning • OCD Family Functioning Scale • Family Environment Scale (FES) • Parental Attitudes and Behaviors Scale (PABS) Patient/parent reported experience measures (PREMs) Patient reported outcome measure (PROMs) • Top Problems assessment (TPA) **Quality of Life (QoL) General and Health Related (HRQoL) (validated scales only)*** • Quality of Life Enjoyment and Satisfaction Questionnaire-Short Form (QLESQ) **Acceptability of treatment*** • Parental satisfaction with services • Withdrawals/discontinuation Sleep-related problems Suicidal thoughts and behavior

	Key Question 1 (Diagnosis of OCD)	Key Question 2 (Treatment of OCD)
		• Columbia Suicide Severity Rating Scale Recent Self-Report Screener (C-SSRS) Anxiety and depression **Adverse events related to treatment*** <u>*Exclude:*</u> • Neuroimaging (e.g., functional MRI)
Potential Effect Modifiers/Subgroups of interest	• Patient, family, social, and other characteristics, including: ○ Race/Ethnicity (racial and ethnic discrimination is the effect modifier of interest but many/most studies will not contain that so we will use race/ethnicity as a marker for likelihood of experience with discrimination and would explicitly discuss this in the review) ○ Identity and Culture (e.g., spiritual and religious beliefs and practices, native language, gender identity, sexual orientation, physical/mental disability status) ○ Age ○ Age at symptom onset ○ Social determinants of health, including education level, socioeconomic status, immigration status, refugee status, and geography (e.g., urban vs. rural) ○ Diagnosis of PANS/PANDAS ○ OCD in first degree relatives ○ Level of family accommodation ○ Co-occurring disorders (e.g., major depressive disorder, anxiety disorders, attention-deficit hyperactivity disorder, conduct disorders, autism spectrum disorder, and Tourette syndrome, other tic disorders) ○ Diagnosis during COVID-19 pandemic (as defined by study authors) ○ Primary versus specialist care • Respondent type <u>*Exclude*</u>*:* • Neuroimaging, e.g., functional MRI	• Patient, family, social, and other characteristics, including: ○ Race/Ethnicity (racial and ethnic discrimination is the effect modifier of interest but many/most studies will not contain that so we will use race/ethnicity as a marker for likelihood of experience with discrimination and would explicitly discuss this in the review) ○ Identity and culture (e.g., spiritual, and religious beliefs and practices, native language, gender identity, sexual orientation, physical/mental disability status) ○ Age ○ Age at symptom onset ○ Social determinants of health, including education level, socioeconomic status, immigration status, refugee status, and geography (e.g., urban vs. rural) ○ Diagnosis of PANS/PANDAS ○ OCD in first degree relatives ○ Level of family accommodation ○ Co-occurring disorders (e.g., major depressive disorder, anxiety disorders, attention-deficit hyperactivity disorder, conduct disorders, autism spectrum disorder, and Tourette syndrome, other tic disorders) ○ Diagnosis during COVID-19 pandemic (as defined by study authors) ○ Duration of symptoms prior to treatment ○ Symptom severity ○ In-session exposure and response prevention ○ Medication dose ○ Care settings and care intensities ▪ Traditional outpatient ▪ Intensive outpatient • Day programs (e.g., partial hospitalization) • Residential ▪ Inpatient ▪ Other care settings, including school-based settings ▪ Telehealth (vs. in-person) ▪ Primary versus specialist care
Design	Cohort or cross-sectional studies • comparing an index test(s) to a reference standard	Comparative trials • Randomized controlled trials • Nonrandomized comparative studies

	Key Question 1 (Diagnosis of OCD)	Key Question 2 (Treatment of OCD)
	• comparing an index test(s) in two or more subgroups of interest • comparing two or more diagnostic strategies Randomized controlled trials Nonrandomized comparative studies • prospective or retrospective with appropriate adjustment for confounding Systematic reviews (for reference lists only) *Exclude:* • Prevalence studies • Qualitative studies • Case reports and case series, • Unpublished studies, including conference abstracts (but include studies with reported results in the ClinicalTrials.gov database)	○ prospective or retrospective with appropriate adjustment for confounding Single arm studies, N ≥50 • with multivariable analyses of potential effect modifiers/subgroups of interest Systematic reviews (for reference lists only) *Exclude:* • Cross-sectional studies (no longitudinal follow-up) • Qualitative studies • Case reports and case series, • Unpublished studies, including conference abstracts (but include studies with reported results in the ClinicalTrials.gov database)
Timing	Any	Any
Setting	Any, including administration of test(s) in-person or via tele-health	Any

Abbreviations:

* Prioritized outcome

A.2 Data Extraction and Data Management (Details)

We extracted data from eligible primary studies into the Systematic Review Data Repository-Plus (https://srdrplus.ahrq.gov) and GSheets as appropriate. Data extracted in GSheets were imported into SRDR+ at the end of the project. For each study, one researcher extracted and entered data, which were confirmed by a second, independent researcher. In the instance where two studies, or separate subgroups were reported within a single article, outcomes for each study or relevant subgroup were extracted separately.

For each study, we extracted article-identifying information, study design features, funding source, population characteristics and sample sizes, intervention and comparator names and descriptions, and relevant outcomes and their definitions.

For priority outcomes, we extracted the number of participants, mean and standard deviation (SD), standard error (SE) or confidence interval (CI) for both arms at baseline and end-of-treatment. When available, we extracted mean, SD, SE, or CI for within group change from baseline. When the within group correlation was not reported, we imputed a correlation of 0.5 as described in an AHRQ Methods Research Report.{Balk EM, 2012 #293} When necessary, we extracted data from figures using the Plot Digitizer program.{Huwaldt, 2020 #294}

A.3 Assessing Applicability

For each KQ, we assessed the applicability of the included studies primarily based on the studies' eligibility criteria and their included participants, specifically related to such factors as age, race/ethnicity, and comorbidities.

A.4 Peer Review and Public Commentary

Experts in OCD, including clinicians and researchers in child and adolescent psychiatry and child psychology are being invited to provide external peer review of this SR. The Agency for Healthcare Research and Quality (AHRQ) and an Associate Editor from a fellow Evidence-based Practice Center also provide comments. The draft report will be posted on the AHRQ Website to elicit public comment for a period of 45 days. All reviewer and public comments will be addressed, revising the text as appropriate. A summary of peer review comments and a disposition of public comments table will be posted on the Effective Health Care website (https://effectivehealthcare.ahrq.gov).

A.5 Abbreviations and Acronyms

AACAP	American Academy of Child and Adolescent Psychiatry
ACT	Acceptance and commitment therapy
ADIS-C	Anxiety Disorders Interview Scale-Child Version
AHRQ	Agency for Healthcare Research and Quality
ANOVA	analysis of variance
ASD	Autism spectrum disorder
AUC ROC	Area Under the receiver operating characteristics curve
briefERP	Brief duration exposure and response therapy
CBCL-OCS	Child Behavior Checklist-Obsessive Compulsive subscale
CBT	Cognitive Behavioral Therapy
CD-POC	Coercive Disruptive Behavior Scale
CFB	Change from baseline
C-FOCI	Children's Florida Obsessive Compulsive Inventory
CGI-S	Clinical Global Impressions-Severity Severity
CHOCI	Obsessional Compulsive Inventory-Child
CMB-I	Cognitive bias modification-interpretation
COIS, COIS-R	Child Obsessive Compulsive Impact Scale-Revised
CY-BOCS	Children’s Yale-Brown Obsessive Compulsive Scale
CI	confidence interval
CINAHL	Cumulative Index to Nursing and Allied Health Literature
Cohen’s d	a standardized effect size
COI	conflicts of interest
COIS	Child Obsessive Compulsive Impact Scale
DABWA	The Development and Well-Being Assessment
DISC-2.1	Sensitivity of the Diagnostic Interview Schedule for Children, 2nd edition
DSM	Diagnostic and Statistical Manual of Mental Disorders
DCS	D-cycloserine
EPC	Evidence-based Practice Center

ERP	Cognitive behavioral therapy with exposure and response prevention
FAS	Family Accommodation Scale
FI	Family Intervention
GRADE	Grading of Recommendations, Assessment, Development, and Evaluations
I^2	Perecnet of total variability that is due to between-study variability
intensiveERP	Intensive delivery of exposure and response prevention
IPTW	Inverse probability of treatment weighting
K-SADS-PL	Kiddie Schedule for Affective Disorders and Schizophrenia, Present and Lifetime version
KI	Key Informant
KQ	Key Question
LEAD	Longitudinal Expert All Data
LOI-CV	Leyton Obsessional Inventory – Child Version
MD	mean difference
MINI-KID	Mini International Neuropsychiatric Interview for Children and Adolescents
N, n	number of (studies, participants)
MA	meta-analysis
N/A	not applicable
NMA	network meta-analysis
NMD	Net Mean Difference
NordLOTS	Nordic long-term OCD treatment study
NR	not reported
NRCS	nonrandomized comparative study
NS	not significant, defined as $P < 0.05$
OCI-CV	Obsessive Compulsive Inventory – Child Version
OCD	Obsessive-Compulsive Disorder
OFF	OCD Family Functioning Scale
OR	odds ratio
aOR	adjusted odds ratio
PANDAS	Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal infections
PANS	Pediatric Acute-onset Neuropsychiatric Syndrome
PCORI	Patient-Centered Outcomes Research Institute
PFIT	Positive Family Interaction Therapy
PMT	Parent Management Training
PQ-LES-Q	Pediatric Quality of Life Enjoyment and Satisfaction Questionnaire
PROSPERO	International Prospective register of systematic reviews

pwMA	pairwise meta-analysis
QoL	Quality of Life
QUADAS-2	Quality Assessment of Diagnostic Accuracy Studies 2
RCT	randomized controlled trial
RD	risk difference
REML	restricted maximum likelihood
RoB	risk of bias
ROBINS-I	Risk of Bias in Nonrandomized Studies of Interventions
RR	relative risk
aRR	adjusted relative risk
remoteERP	Remotely delivered ERP
rTMS	repetitive transcranial magnetic stimulation
SD	sample standard deviation
SoE	strength of evidence
SCAS-OCD	Spence Children's Anxiety Scale – OCD subscale
SOCS	Short Obsessive-Compulsive Disorder Screener
SPE	Strength of evidence for association
SR	systematic review
SROC	Summary receiver operating characteristics
SRDR+	Systematic Review Data Repository Plus
SSRI	Selective Serotonin Reuptake Inhibitor
TAU	Treatment As Usual
TCA	Tricyclic antidepressant
TEP	Technical Expert Panel
TOCS	Toronto Obsessive–Compulsive Scale
TOO	Task Order Officer
U.S.	United States
U.K.	United Kingdom
vs	versus
Y-BOCS	Yale-Brown Obsessive Compulsive Scale
CY-BOCS-SR	Children’s Yale-Brown Obsessive Compulsive Scale -Self Report
YSR OCD	Youth Self-Report OCD subscale

Appendix B. List of Excluded Studies

The 275 excluded articles and records, along with reasons for exclusion, are summarized in Appendix Table B–1. Details on exclusion reasons and numbers are given in Figure C–1, Flow diagram for studies.

Table B–1. Excluded articles and records with reasons for exclusion

No.	First Author	Year	PMID or (other) ID	Title	Journal	Reason for Exclusion
1	Adam	2019	31244891	Psychometric evaluation of a parent-rating and self-rating inventory for pediatric obsessive-compulsive disorder: German OCD Inventory for Children and Adolescents (OCD-CA)	*Child Adolesc Psychiatry Ment Health*	I: Index test not used for diagnosis
2	Adam	2022	36494821	Extended treatment of multimodal cognitive behavioral therapy in children and adolescents with obsessive‚Äìcompulsive disorder improves symptom reduction: A within-subject design	*Child and Adolescent Psychiatry and Mental Health*	D: Single-arm study N≥50, unadjusted
3	Albert	2012	23023076	[Combined treatments in obsessive-compulsive disorder: current knowledge and future prospects]	*Riv Psichiatr*	D: Not a primary study
4	Alderman	2006	16553533	Drug concentration monitoring with tolerability and efficacy assessments during open-label, long-term sertraline treatment of children and adolescents	*J Child Adolesc Psychopharmacol*	D: Single-arm study N≥50, unadjusted
5	Anderson	2007	16540080	Group versus individual cognitive-behavioural treatment for obsessive-compulsive disorder: a controlled trial	*Behav Res Ther*	P: Not a population <21 years with OCD
6	Arnold	2014	2014-49981-008(PsycINFO)	Does cognitive-behavioral therapy response in youth with obsessive-compulsive disorder differ if treatment ends during summer?	*Annals of Clinical Psychiatry*	D: Single-arm study N≥50, unadjusted
7	Aspvall	2018	29971153	Internet-delivered cognitive behavioural therapy for young children with obsessive-compulsive disorder: development and initial evaluation of the BIP OCD Junior programme	*BJPsych Open*	D: Single-arm study N≥50, unadjusted
8	Aspvall	2020	32013900	Validity and clinical utility of the obsessive compulsive inventory - child version: further evaluation in clinical samples	*BMC Psychiatry*	I: Index test not used for diagnosis
9	Aspvall	2020	32082991	Implementation of internet-delivered cognitive behaviour therapy for pediatric obsessive-compulsive disorder: Lessons from clinics in Sweden, United Kingdom and Australia	*Internet Interv*	D: Single-arm study N≥50, unadjusted

No.	First Author	Year	PMID or (other) ID	Title	Journal	Reason for Exclusion
10	Aspvall	2021	2021-34763-236(PsycINFO)	Novel treatment approaches for children and adolescents with obsessive-compulsive disorder		D: Not a primary study
11	Ayres	2000	2000-95024-249(PsycINFO)	Obsessive Compulsive Disorder in children and adolescents: A longitudinal study		D: Not a peer-reviewed publication
12	Babiano-Espinosa	2022	35460057	eCBT Versus Standard Individual CBT for Paediatric Obsessive-Compulsive Disorder	*Child Psychiatry Hum Dev*	D: KQ2: not an RCT or adjusted NRCS
13	Bakhshaie	2020	32822898	Temporal precedence of the change in obsessive-compulsive symptoms and change in depressive symptoms during exposure and response prevention for pediatric obsessive-compulsive disorders	*Behav Res Ther*	D: Single-arm study of pooled treatments
14	Bastiani	1996	9162209	Comparison of obsessions and compulsions in patients with anorexia nervosa and obsessive compulsive disorder	*Biol Psychiatry*	P: Not a population <21 years with OCD
15	Baving	2000	10746297	[Obsessive-compulsive disorder, frontostriatal system and the effect of the serotonergic system]	*Z Kinder Jugendpsychiatr Psychother*	D: KQ2: not an RCT or adjusted NRCS
16	Beig	2017	27058836	[Effectiveness of cognitive-behavioral therapy in children and adolescents with obsessive-compulsive disorders treated in an outpatient clinic]	*Z Kinder Jugendpsychiatr Psychother*	D: Single-arm study N≥50, unadjusted
17	Benazon	2002	12038645	Cognitive behavior therapy in treatment-naive children and adolescents with obsessive-compulsive disorder: an open trial	*Behav Res Ther*	D: Single-arm study N≥50, unadjusted
18	Benazon	2003	14566164	Neurochemical analyses in pediatric obsessive-compulsive disorder in patients treated with cognitive-behavioral therapy	*J Am Acad Child Adolesc Psychiatry*	D: Single-arm study N≥50, unadjusted
19	Benito	2018	29939055	Measuring fear change within exposures: Functionally-defined habituation predicts outcome in three randomized controlled trials for pediatric OCD	*J Consult Clin Psychol*	D: Single-arm study N≥50, unadjusted
20	Benito	2020	33990231	Therapist Behavior During Exposure Tasks Predicts Habituation and Clinical Outcome in Three Randomized Controlled Trials for Pediatric OCD	*Behavior therapy*	D: Single-arm study N≥50, unadjusted
21	Bennett	2015	25843610	Evaluation of cognitive behaviour therapy for paediatric obsessive-compulsive disorder in the context of tic disorders	*J Behav Ther Exp Psychiatry*	D: Single-arm study N≥50, unadjusted

No.	First Author	Year	PMID or (other) ID	Title	Journal	Reason for Exclusion
22	Berg	1986	1987-02850-001(PsycINFO)	The Leyton Obsessional Inventory,ÄîChild Version	*Journal of the American Academy of Child Psychiatry*	O: No extractable or new outcomes of interest
23	Bernstein	2017	27830935	Use of Computer Vision Tools to Identify Behavioral Markers of Pediatric Obsessive-Compulsive Disorder: A Pilot Study	*J Child Adolesc Psychopharmacol*	I: Index test not used for diagnosis
24	Bettess	2023	35303769	Clinical characteristics of transformation obsessions in obsessive-compulsive disorder: A psychopathological study	*Aust N Z J Psychiatry*	P: Not a population <21 years with OCD
25	Björgvinsson	2008	18520782	Treatment outcome for adolescent obsessive-compulsive disorder in a specialized hospital setting	*J Psychiatr Pract*	D: Single-arm study N≥50, unadjusted
26	Bloch	2016	27027204	N-Acetylcysteine in the Treatment of Pediatric Tourette Syndrome: Randomized, Double-Blind, Placebo-Controlled Add-On Trial	*J Child Adolesc Psychopharmacol*	P: Not a population <21 years with OCD
27	Borda	2017	2017-34965-012(PsycINFO)	Overvalued ideation in adolescents with obsessive-compulsive disorder	*Psychiatry Research*	D: Single-arm study N≥50, unadjusted
28	Bortoncello	2012	22306130	Psychometric properties of the Brazilian version of the Obsessive Beliefs Questionnaire (OBQ-44)	*J Anxiety Disord*	P: Not a population <21 years with OCD
29	Bose	2022	2022-17115-001(PsycINFO)	Therapeutic alliance in psychosocial interventions for youth internalizing disorders: A systematic review and preliminary meta-analysis	*Clinical Psychology: Science and Practice*	P: Not a population <21 years with OCD
30	Brown	2017	28714753	Pediatric Acute-Onset Neuropsychiatric Syndrome Response to Oral Corticosteroid Bursts: An Observational Study of Patients in an Academic Community-Based PANS Clinic	*J Child Adolesc Psychopharmacol*	I: Not an intervention/index test of interest
31	Brown	2017	28696786	Effect of Early and Prophylactic Nonsteroidal Anti-Inflammatory Drugs on Flare Duration in Pediatric Acute-Onset Neuropsychiatric Syndrome: An Observational Study of Patients Followed by an Academic Community-Based Pediatric Acute-Onset Neuropsychiatric Syndrome Clinic	*J Child Adolesc Psychopharmacol*	P: Not a population <21 years with OCD
32	Canavera	2022	CN-02399450(Cochrane)	A Five-Day Intensive Treatment for Pediatric Obsessive-Compulsive Disorder: a Multiple Baseline Design Pilot Study	*Evidence-based practice in child and adolescent mental health*	D: Single-arm study N≥50, unadjusted

No.	First Author	Year	PMID or (other) ID	Title	Journal	Reason for Exclusion
33	Cervin	2019	30481695	Validation of an interview-only version of the Dimensional Yale-Brown Obsessive-Compulsive Scale (DY-BOCS) in treatment-seeking youth with obsessive-compulsive disorder	*Psychiatry Res*	O: No extractable or new outcomes of interest
34	Cervin	2021	33483124	Incompleteness and Disgust Predict Treatment Outcome in Pediatric Obsessive-Compulsive Disorder	*Behav Ther*	D: Single-arm study of pooled treatments
35	Cervin	2023	34978642	Symptom dimension breakpoints for the Obsessive-Compulsive Inventory-Child Version (OCI-CV)	*Child Psychiatry and Human Development*	I: Index test not used for diagnosis
36	Chai	2013	2014-08162-007(PsycINFO)	Validity of the children's Yale-Brown obsessive compulsive scale in Singaporean children	*Advances in Mental Health*	O: No extractable or new outcomes of interest
37	Ching	2018	28681684	Association splitting of the sexual orientation-OCD-relevant semantic network	*Cogn Behav Ther*	P: Not a population <21 years with OCD
38	Chu	2015	25892174	Mediators of exposure therapy for youth obsessive-compulsive disorder: specificity and temporal sequence of client and treatment factors	*Behav Ther*	D: Single-arm study N≥50, unadjusted
39	Coles	2010	20577988	Development and initial validation of the obsessive belief questionnaire-child version (OBQ-CV)	*Depress Anxiety*	I: Index test not used for diagnosis
40	Cook	2001	11589530	Long-term sertraline treatment of children and adolescents with obsessive-compulsive disorder	*J Am Acad Child Adolesc Psychiatry*	O: No extractable or new outcomes of interest
41	De Caluwé	2014	2013-45490-001(PsycINFO)	Development and validation of the Youth Obsessive‚ÄìCompulsive Symptoms Scale (YOCSS)	*Child Psychiatry and Human Development*	P: Not a population <21 years with OCD
42	De Nadai	2015	26003507	Contemporary models of pediatric obsessive-compulsive disorder: An evaluation with a large clinical sample	*Psychiatry Res*	I: Index test not used for diagnosis
43	DeVeaugh-Geiss	1991	1993-97959-005(PsycINFO)	Clomipramine hydrochloride (Anafranil) in the treatment of obsessive-compulsive disorder: Results from three multicentre trials	*Understanding obsessive-compulsive disorder (OCD).*	D: Not a peer-reviewed publication
44	Duholm	2022	36510026	Specific Contamination Symptoms are Associated with Experiencing a Limited Response of Cognitive-Behavioral Therapy in Pediatric Patients with OCD	*Child Psychiatry Hum Dev*	D: Single-arm study N≥50, unadjusted

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45	Efe	2022	35905054	Impact of Attention-Deficit/Hyperactivity Disorder Comorbidity on Phenomenology and Treatment Outcomes of Pediatric Obsessive-Compulsive Disorder	*J Child Adolesc Psychopharmacol*	I: Not an intervention/index test of interest
46	Elsner	2022	35086513	Mechanisms of exposure and response prevention in obsessive-compulsive disorder: effects of habituation and expectancy violation on short-term outcome in cognitive behavioral therapy	*BMC Psychiatry*	P: Not a population <21 years with OCD
47	Farrell	2010	20181328	Cognitive-behavioral treatment of childhood obsessive-compulsive disorder in community-based clinical practice: clinical significance and benchmarking against efficacy	*Behav Res Ther*	D: Single-arm study N≥50, unadjusted
48	Farrell	2012	22633155	Comorbidity and treatment response in pediatric obsessive-compulsive disorder: a pilot study of group cognitive-behavioral treatment	*Psychiatry Res*	D: Single-arm study N≥50, unadjusted
49	Farrell	2016	27395805	Brief intensive CBT for pediatric OCD with E-therapy maintenance	*J Anxiety Disord*	D: Single-arm study N≥50, unadjusted
50	Farrell	2022	36591101	FAST CBT for pediatric OCD: A multiple-baseline controlled pilot trial of parent training in exposure and response prevention delivered via telehealth	*Front Psychol*	D: Single-arm study N≥50, unadjusted
51	Fernández de la Cruz	2015	2016-01377-007(PsycINFO)	Phenomenology and treatment outcomes in children and adolescents from ethnic minorities with obsessive,Äìcompulsive disorder	*Journal of Obsessive-Compulsive and Related Disorders*	D: Single-arm study N≥50, unadjusted
52	Fernández de la Cruz		L601056186(Embase)	Phenomenology and treatment outcomes in children and adolescents from ethnic minorities with obsessive-compulsive disorder	*Journal of Obsessive-Compulsive and Related Disorders*	D: Single-arm study N≥50, unadjusted
53	Fischer	1998	NA(From SRs)	Group behavioral therapy for adolescents with obsessive-compulsive disorder: Preliminary outcomes.	*Research on Social Work Practice*	D: Single-arm study N≥50, unadjusted
54	Flament	1985	3885292	A controlled trial of clomipramine in childhood obsessive compulsive disorder	*Psychopharmacol Bull*	O: No extractable or new outcomes of interest
55	Flament	1987	3548637	Biochemical changes during clomipramine treatment of childhood obsessive-compulsive disorder	*Arch Gen Psychiatry*	D: Single-arm study N≥50, unadjusted

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56	Flessner	2010	19842168	The impact of neuropsychological functioning on treatment outcome in pediatric obsessive-compulsive disorder	*Depress Anxiety*	O: No extractable or new outcomes of interest
57	Flessner	2011	CN-00795157(Cochrane)	Predictors of Parental Accommodation in Pediatric Obsessive-Compulsive Disorder: findings from the Pediatric Obsessive-Compulsive Disorder Treatment Study (POTS) Trial	*Journal of the American Academy of Child and Adolescent Psychiatry*	O: No extractable or new outcomes of interest
58	Foa	2010	20171333	Development and validation of a child version of the obsessive compulsive inventory	*Behav Ther*	I: Index test not used for diagnosis
59	Franklin	1998	9549962	Cognitive-behavioral treatment of pediatric obsessive-compulsive disorder: an open clinical trial	*J Am Acad Child Adolesc Psychiatry*	D: KQ2: not an RCT or adjusted NRCS
60	Franklin	2012	CN-01017907(Cochrane)	Cognitive behavior therapy augmentation of pharmacotherapy in pediatric obsessive-compulsive disorder: the pediatric OCD treatment study II (POTS II) randomized controlled trial (JAMA - Journal of the American Medical Association (2011) 306, 11, (1224-1232))	*JAMA*	O: No extractable or new outcomes of interest
61	Franklin	2015	25771752	Cognitive-behavioral therapy for pediatric obsessive-compulsive disorder: Empirical review and clinical recommendations	*Psychiatry Res*	D: Not a primary study
62	Freeman	2011	21340599	The Children's Yale-Brown Obsessive Compulsive Scale: reliability and validity for use among 5 to 8 year olds with obsessive-compulsive disorder	*J Abnorm Child Psychol*	I: Index test not used for diagnosis
63	Gallant	2008	18329843	Convergent and discriminant validity of the Children's Yale-Brown Obsessive Compulsive Scale-Symptom Checklist	*J Anxiety Disord*	I: Index test not used for diagnosis
64	Geller	2004	15103533	Re-examining comorbidity of Obsessive Compulsive and Attention-Deficit Hyperactivity Disorder using an empirically derived taxonomy	*Eur Child Adolesc Psychiatry*	I: Index test not used for diagnosis
65	Geller	2019	30852257	Fear extinction learning as a predictor of response to cognitive behavioral therapy for pediatric obsessive compulsive disorder	*J Anxiety Disord*	D: Single-arm study of pooled treatments
66	Gittins Stone	2023	36749490	Examining the Effectiveness of an Intensive Telemental Health Treatment for Pediatric Anxiety and OCD During the COVID-19 Pandemic and Pediatric Mental Health Crisis.	*Child psychiatry and human development*	P: Not a population <21 years with OCD

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67	Godoy	2011	21504689	[Factor structure and reliability of the Spanish adaptation of the Children's Yale-Brown Obsessive-Compulsive Scale--Self Report (CY-BOCS-SR)]	*Psicothema*	P: Not a population <21 years with OCD
68	Goodman	1997	9184625	Fluvoxamine in the treatment of obsessive-compulsive disorder and related conditions	*J Clin Psychiatry*	D: Not a primary study
69	Gordon	1992	1536276	Differential response of seven subjects with autistic disorder to clomipramine and desipramine	*Am J Psychiatry*	P: Not a population <21 years with OCD
70	Gorrell	2019	30734406	Rituals and preoccupations associated with bulimia nervosa in adolescents: Does motivation to change matter?	*Eur Eat Disord Rev*	P: Not a population <21 years with OCD
71	Gregory	2020	31864218	Cost-Effectiveness of Treatment Alternatives for Treatment-Refractory Pediatric Obsessive-Compulsive Disorder	*J Anxiety Disord*	O: No extractable or new outcomes of interest
72	Guggisberg	2005	2005-99016-280(PsycINFO)	Methodological review and meta-analysis of treatments for child and adolescent obsessive-compulsive disorder		D: Not a peer-reviewed publication
73	Guzick	2017	28966908	The link between ADHD-like inattention and obsessions and compulsions during treatment of youth with OCD	*J Obsessive Compuls Relat Disord*	D: Single-arm study N≥50, unadjusted
74	Guzick	2021	34134828	Irritability in Children and Adolescents With OCD	*Behav Ther*	D: Single-arm study of pooled treatments
75	Guzick	2023	36908861	Development and pilot testing of internet-delivered, family-based cognitive behavioral therapy for anxiety and obsessive-compulsive disorders in autistic youth	*J Obsessive Compuls Relat Disord*	P: Not a population <21 years with OCD
76	Harris	2010	2010-19252-014(PsycINFO)	Disinhibition as a side effect of treatment with fluvoxamine in pediatric patients with obsessive-compulsive disorder	*Journal of Child and Adolescent Psychopharmacology*	D: Single-arm study N≥50, unadjusted
77	Henin	2017	CN-01439319(Cochrane)	Long-term efficacy of cognitive-behavioral therapy for pediatric OCD with and without d-cycloserine augmentation	*Neuropsychopharmacology*	D: Not a peer-reviewed publication
78	Himle	2003	12621595	Group behavioral therapy for adolescents with tic-related and non-tic-related obsessive-compulsive disorder	*Depress Anxiety*	D: Single-arm study N≥50, unadjusted

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79	Holmgren Melin	2015	CN-01070018(Cochrane)	Treatment and 12-month outcome of children and adolescents with obsessive-compulsive disorder: a naturalistic study	*Journal of obsessive-compulsive and related disorders*	D: Single-arm study N≥50, unadjusted
80	Hudson	2015	NA(From SRs)	Comparing outcomes for children with different anxiety disorders following cognitive behavioural therapy.	*Behaviour Research and Therapy*	P: Not a population <21 years with OCD
81	Højgaard	2017	29096776	One-Year Outcome for Responders of Cognitive-Behavioral Therapy for Pediatric Obsessive-Compulsive Disorder	*J Am Acad Child Adolesc Psychiatry*	D: Single-arm study N≥50, unadjusted
82	Højgaard	2017	28032202	Pediatric obsessive-compulsive disorder with tic symptoms: Clinical presentation and treatment outcome	*European Child & Adolescent Psychiatry*	D: Single-arm study N≥50, unadjusted
83	Iniesta-Sepúlveda	2018	28389841	An Initial Case Series of Intensive Cognitive-Behavioral Therapy for Obsessive-Compulsive Disorder in Adolescents with Autism Spectrum Disorder	*Child Psychiatry Hum Dev*	D: Single-arm study N≥50, unadjusted
84	Ivarsson	2015	25591044	Sleep problems and cognitive behavior therapy in pediatric obsessive-compulsive disorder have bidirectional effects	*J Anxiety Disord*	D: Single-arm study N≥50, unadjusted
85	Ivarsson	2016	CN-01304673(Cochrane)	The Nordic long-term obsessive compulsive disorder treatment study: effectiveness of a stepped-care treatment	*Journal of the American Academy of Child and Adolescent Psychiatry*	D: Not a peer-reviewed publication
86	Jacoby	2021	34428688	Longitudinal trajectory and predictors of change in family accommodation during exposure therapy for pediatric OCD	*J Anxiety Disord*	D: Single-arm study of pooled treatments
87	Jalenques	2018	29392455	The MOVES (Motor tic, Obsessions and compulsions, Vocal tic Evaluation Survey): cross-cultural evaluation of the French version and additional psychometric assessment	*J Neurol*	P: Not a population <21 years with OCD
88	Janzen	2001	2001-95020-060(PsycINFO)	Assessment of obsessive-compulsive disorder in youth using parent and youth rating scales		D: Not a peer-reviewed publication
89	Jaspers-Fayer	2017	28121463	Prevalence of Acute-Onset Subtypes in Pediatric Obsessive-Compulsive Disorder	*J Child Adolesc Psychopharmacol*	D: Single-arm study N≥50, unadjusted
90	Jassi	2020	32006302	The Work and Social Adjustment Scale, Youth and Parent Versions: Psychometric Evaluation of a Brief Measure of Functional Impairment in Young People	*Child Psychiatry Hum Dev*	I: Index test not used for diagnosis

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91	Jensen	2020	2022-97309-001(PsycINFO)	The Children's Yale-Brown Obsessive-Compulsive Scale's auxiliary items: Long-term outcome	*Journal of Obsessive-Compulsive and Related Disorders*	O: No extractable or new outcomes of interest
92	Jensen	2020	31736082	Distinct trajectories of long-term symptom severity in pediatric obsessive-compulsive disorder during and after stepped-care treatment	*Journal of Child Psychology and Psychiatry*	D: Single-arm study of pooled treatments
93	Jensen	2022	36265194	Long- term remission status in pediatric obsessive-compulsive disorder: Evaluating the predictive value of symptom severity after treatment	*Psychiatry Res*	O: No extractable or new outcomes of interest
94	Jensen	2022	33881628	Quality of life in pediatric patients with obsessive-compulsive disorder during and 3¬†years after stepped-care treatment	*European Child & Adolescent Psychiatry*	D: Single-arm study of pooled treatments
95	Jones	2013	109867399(CINAHL)	Psychometric properties of the obsessive compulsive inventory: child version in children and adolescents with obsessive-compulsive disorder	*Child Psychiatry & Human Development*	O: No extractable or new outcomes of interest
96	Joseph	2011	CN-01020479(Cochrane)	A placebo-controlled trial of riluzole for treatment of childhood-onset obsessive compulsive disorder	*Neuropsychopharmacology*	D: Not a peer-reviewed publication
97	Kano	2013	24228477	[Treatment-refractory OCD from the viewpoint of obsessive-compulsive spectrum disorders: impact of comorbid child and adolescent psychiatric disorders]	*Seishin Shinkeigaku Zasshi*	D: Not a primary study
98	Kay	2016	27638964	Outcome of multidisciplinary, CBT-focused treatment for pediatric OCD	*Gen Hosp Psychiatry*	D: Single-arm study N≥50, unadjusted
99	Keeley	2011	2011-17425-001(PsycINFO)	The therapeutic alliance in the cognitive behavioral treatment of pediatric obsessive-compulsive disorder	*Journal of Anxiety Disorders*	D: Single-arm study N≥50, unadjusted
100	Kim	2020	CN-02141314(Cochrane)	Understanding Anxiety and Symptom Impact as Mediators Explaining Cognitive-Behavior Therapy and Pharmacotherapy Response in Childhood Obsessive-Compulsive Disorder	*Journal of psychopathology and behavioral assessment*	O: No extractable or new outcomes of interest
101	Kircanski	2011	21440853	Cognitive-behavioral therapy for obsessive-compulsive disorder in children and adolescents	*Child Adolesc Psychiatr Clin N Am*	D: Not a primary study

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102	Kircanski	2014	23774008	Reduction of subjective distress in CBT for childhood OCD: nature of change, predictors, and relation to treatment outcome	*J Anxiety Disord*	O: No extractable or new outcomes of interest
103	Kircanski	2015	25052626	Exposure and response prevention process predicts treatment outcome in youth with OCD	*J Abnorm Child Psychol*	D: Single-arm study N≥50, unadjusted
104	Krebs	2013	22957831	Temper outbursts in paediatric obsessive-compulsive disorder and their association with depressed mood and treatment outcome	*Journal of Child Psychology and Psychiatry*	D: Single-arm study N≥50, unadjusted
105	Krebs	2015	25130442	How resistant is 'treatment-resistant' obsessive-compulsive disorder in youth?	*Br J Clin Psychol*	D: KQ2: not an RCT or adjusted NRCS
106	Krulewicz	2006	16601647	Analysis of electrocardiographic data following use of paroxetine in pediatric depression and obsessive-compulsive disorder	*J Am Acad Child Adolesc Psychiatry*	O: No extractable or new outcomes of interest
107	Kurlan	1993	8477412	A pilot controlled study of fluoxetine for obsessive-compulsive symptoms in children with Tourette's syndrome	*Clin Neuropharmacol*	P: Not a population <21 years with OCD
108	Lavell	2016	27544784	Predictors of treatment response to group cognitive behavioural therapy for pediatric obsessive-compulsive disorder	*Psychiatry Research*	D: Single-arm study N≥50, unadjusted
109	Lee	2005	32806851	Broad Outcome Measures May Underestimate Effectiveness: An Instrument Comparison Study	*Child Adolesc Ment Health*	I: Index test not used for diagnosis
110	Lei	1986	3556093	[A cross-over treatment of obsessive-compulsive neurosis with imipramine and chlorimipramine]	*Zhonghua Shen Jing Jing Shen Ke Za Zhi*	P: Not a population <21 years with OCD
111	Lenhard	2014	24949622	Internet-delivered cognitive behavior therapy for adolescents with obsessive-compulsive disorder: an open trial	*PLoS One*	D: Single-arm study N≥50, unadjusted
112	Lenhard	2016	CN-01304706(Cochrane)	Cost-effectiveness of internet delivered cognitive-behavior therapy for obsessive-compulsive disorder: results from a randomized controlled trial	*Journal of the American Academy of Child and Adolescent Psychiatry*	D: Not a study design of interest
113	Lenhard	2017	28637745	Corrections: Cost-effectiveness of therapist-guided internet-delivered cognitive behaviour therapy for paediatric obsessive-compulsive disorder: results from a randomised controlled trial	*BMJ Open*	O: No extractable or new outcomes of interest

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114	Lenhard	2018	28752937	Prediction of outcome in internet-delivered cognitive behaviour therapy for paediatric obsessive-compulsive disorder: A machine learning approach	*Int J Methods Psychiatr Res*	O: No extractable or new outcomes of interest
115	Lenhard	2020	33043148	Long-term outcomes of therapist-guided Internet-delivered cognitive behavior therapy for pediatric obsessive-compulsive disorder	*NPJ Digit Med*	O: No extractable or new outcomes of interest
116	Lenhard	2022	2022-34077-293(PsycINFO)	Internet-delivered cognitive behavior therapy for adolescents with obsessive-compulsive disorder		D: Not a peer-reviewed publication
117	Leon	2018	29119300	Longitudinal outcomes of children with pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections (PANDAS)	*Eur Child Adolesc Psychiatry*	P: Not a population <21 years with OCD
118	Leonard	1988	3290954	Treatment of childhood obsessive compulsive disorder with clomipramine and desmethylimipramine: a double-blind crossover comparison	*Psychopharmacol Bull*	D: KQ2: not an RCT or adjusted NRCS
119	Leonard	1993	8498877	A 2- to 7-year follow-up study of 54 obsessive-compulsive children and adolescents	*Arch Gen Psychiatry*	D: Single-arm study of pooled treatments
120	Leonard	1995	1996-23910-001(PsycINFO)	Electrocardiographic changes during desipramine and clomipramine treatment in children and adolescents	*Journal of the American Academy of Child & Adolescent Psychiatry*	P: Not a population <21 years with OCD
121	Leonard	2014	2014-33301-005(PsycINFO)	The effect of depression symptom severity on OCD treatment outcome in an adolescent residential sample	*Journal of Obsessive-Compulsive and Related Disorders*	O: No extractable or new outcomes of interest
122	Leonard	2016	26308588	Residential treatment outcomes for adolescents with obsessive-compulsive disorder	*Psychother Res*	D: Single-arm study N≥50, unadjusted
123	Lewin	2012	22963592	Agreement between therapists, parents, patients, and independent evaluators on clinical improvement in pediatric obsessive-compulsive disorder	*J Consult Clin Psychol*	O: No extractable or new outcomes of interest
124	Liebowitz	1990	2309962	Fluoxetine for adolescents with obsessive-compulsive disorder	*Am J Psychiatry*	D: Not a primary study

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125	Liu	2011	NA(From SRs)	Fluvoxamine combined with cognitive behavioral therapy in child and adolescent obsessive neurosis	*J Clin Psychosom Dis*	Unable to retrieve full text
126	Lopez	2012	2012-99020-383(PsycINFO)	Effect of exposure-based parent-child interaction therapy on early childhood compulsive behaviors		D: Not a primary study
127	López-Pina	2015	25010899	Reliability generalization study of the Yale-Brown Obsessive-Compulsive Scale for children and adolescents	*J Pers Assess*	I: Index test not used for diagnosis
128	Mancebo	2014	24952937	Long-term course of pediatric obsessive-compulsive disorder: 3 years of prospective follow-up	*Compr Psychiatry*	I: Not an intervention/index test of interest
129	Martin	2005	16049647	Group cognitive-behavior therapy with family involvement for middle-school-age children with obsessive-compulsive disorder: a pilot study	*Child Psychiatry Hum Dev*	D: Single-arm study N≥50, unadjusted
130	Martin	2020	32008168	Co-occurring obsessive-compulsive disorder and autism spectrum disorder in young people: prevalence, clinical characteristics and outcomes	*Eur Child Adolesc Psychiatry*	D: Not a study design of interest
131	Masi	2007	17822342	Bipolar co-morbidity in pediatric obsessive-compulsive disorder: clinical and treatment implications	*J Child Adolesc Psychopharmacol*	D: Single-arm study of pooled treatments
132	Masi	2009	19320532	Pharmacotherapy in paediatric obsessive-compulsive disorder: a naturalistic, retrospective study	*CNS Drugs*	D: Single-arm study N≥50, unadjusted
133	Masi	2013	23664673	Antipsychotic augmentation of selective serotonin reuptake inhibitors in resistant tic-related obsessive-compulsive disorder in children and adolescents: a naturalistic comparative study	*J Psychiatr Res*	D: KQ2: not an RCT or adjusted NRCS
134	McBride	2020	32026260	The Impact of Comorbidity on Cognitive-Behavioral Therapy Response in Youth with Anxiety and Autism Spectrum Disorder	*Child Psychiatry Hum Dev*	P: Not a population <21 years with OCD
135	McGuire	2019	30824248	Defining Treatment Outcomes in Pediatric Obsessive-Compulsive Disorder Using a Self-Report Scale	*Behav Ther*	I: Index test not used for diagnosis
136	McGuire	2019	30644767	Symptom Dimension Response in Children and Adolescents with Obsessive-Compulsive Disorder	*J Clin Child Adolesc Psychol*	O: No extractable or new outcomes of interest

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137	McKay	2003	14692851	The Children's Yale-Brown Obsessive-Compulsive Scale: item structure in an outpatient setting	*Psychol Assess*	I: Index test not used for diagnosis
138	McKenzie	2020	2020-47546-001(PsycINFO)	Variability in emotion regulation in paediatric obsessive-compulsive disorder: Associations with symptom presentation and response to treatment	*Journal of Obsessive-Compulsive and Related Disorders*	D: Single-arm study N≥50, unadjusted
139	McNamara	2014	103982872(CINAHL)	Self-Regulation and Other Executive Functions Relationship to Pediatric OCD Severity and Treatment Outcome	*Journal of Psychopathology & Behavioral Assessment*	D: Not a primary study
140	Melin	2018	29502315	A solid majority remit following evidence-based OCD treatments: a 3-year naturalistic outcome study in pediatric OCD	*Eur Child Adolesc Psychiatry*	D: Single-arm study N≥50, unadjusted
141	Melin	2020	30768383	Treatment Gains Are Sustainable in Pediatric Obsessive-Compulsive Disorder: Three-Year Follow-Up From the NordLOTS	*J Am Acad Child Adolesc Psychiatry*	D: Single-arm study N≥50, unadjusted
142	Meyer	2014	23756717	Prospective relationship between obsessive-compulsive and depressive symptoms during multimodal treatment in pediatric obsessive-compulsive disorder	*Child Psychiatry Hum Dev*	D: Single-arm study of pooled treatments
143	Monzani	2015	25753746	Transformation obsessions in paediatric obsessive-compulsive disorder: Clinical characteristics and treatment response to cognitive behaviour therapy	*J Behav Ther Exp Psychiatry*	D: Single-arm study N≥50, unadjusted
144	Moritz	1998	1998-95014-194(PsycINFO)	Behavior therapy in game format for the treatment of childhood obsessive compulsive disorder		D: Not a peer-reviewed publication
145	Murphy	2017	28358599	A Double-Blind Randomized Placebo-Controlled Pilot Study of Azithromycin in Youth with Acute-Onset Obsessive-Compulsive Disorder	*J Child Adolesc Psychopharmacol*	I: Not an intervention/index test of interest
146	Murray	2015	2015-19893-001(PsycINFO)	Outcomes of cognitive behaviour therapy for obsessive-compulsive disorder in young people with and without autism spectrum disorders: A case controlled study	*Psychiatry Research*	D: Single-arm study N≥50, unadjusted
147	Muñoz-Solomando	2008	18520736	Cognitive behavioural therapy for children and adolescents	*Curr Opin Psychiatry*	D: Not a primary study

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148	Nadeau	2015	25978743	A pilot trial of cognitive-behavioral therapy augmentation of antibiotic treatment in youth with pediatric acute-onset neuropsychiatric syndrome-related obsessive-compulsive disorder	*J Child Adolesc Psychopharmacol*	D: Single-arm study N≥50, unadjusted
149	Nadeau	2017	27215910	Further Psychometric Evaluation of the Child Disgust Scale	*Child Psychiatry Hum Dev*	I: Index test not used for diagnosis
150	Nakatani	2009	105418794(CINAHL)	Outcomes of cognitive behaviour therapy for obsessive compulsive disorder in a clinical setting: a 10-year experience from a specialist OCD service for children and adolescents	*Child & Adolescent Mental Health*	D: Single-arm study N≥50, unadjusted
151	Nevell	2021	2020-97492-083(PsycINFO)	Outcomes and predictors of treatment in an intensive outpatient program for pediatric obsessive-compulsive disorder		D: Not a peer-reviewed publication
152	Niemeyer	2022	36092975	Memantine as treatment for compulsivity in child and adolescent psychiatry: Descriptive findings from an incompleted randomized, double-blind, placebo-controlled trial	*Contemp Clin Trials Commun*	P: Not a population <21 years with OCD
153	Nissen	2017	28928194	Diagnostic validity of early-onset obsessive-compulsive disorder in the Danish Psychiatric Central Register: findings from a cohort sample	*BMJ Open*	I: Not an intervention/index test of interest
154	Nissen	2018	29993297	The importance of insight, avoidance behavior, not-just-right perception and personality traits in pediatric obsessive-compulsive disorder (OCD): a naturalistic clinical study	*Nord J Psychiatry*	O: No extractable or new outcomes of interest
155	Nogueira Arjona	2012	23079369	[Psychometric properties of the Spanish version of the Obsessive Belief Questionnaire-Children's Version in a non-clinical sample]	*Psicothema*	P: Not a population <21 years with OCD
156	Ogle	2021	2021-27921-238(PsycINFO)	Executive function, self-efficacy, and school engagement among youth in clinical treatment for anxiety and obsessive-compulsive disorder		D: Not a peer-reviewed publication
157	Olatunji	2013	22999486	Cognitive-behavioral therapy for obsessive-compulsive disorder: a meta-analysis of treatment outcome and moderators	*J Psychiatr Res*	D: Not a primary study
158	Olatunji	2022	2022-25278-011(PsycINFO)	Decoupling of obsessions and compulsions during cognitive behavioral therapy for youths with obsessive compulsive disorder	*Clinical Psychological Science*	D: Single-arm study of pooled treatments

No.	First Author	Year	PMID or (other) ID	Title	Journal	Reason for Exclusion
159	Olino	2011	21456041	Evidence for successful implementation of exposure and response prevention in a naturalistic group format for pediatric OCD	*Depress Anxiety*	D: Single-arm study N≥50, unadjusted
160	Park	2014	24999301	Does d-Cycloserine Augmentation of CBT Improve Therapeutic Homework Compliance for Pediatric Obsessive-Compulsive Disorder?	*J Child Fam Stud*	O: No extractable or new outcomes of interest
161	Peris	2012	22309471	Family factors predict treatment outcome for pediatric obsessive-compulsive disorder	*J Consult Clin Psychol*	O: No extractable or new outcomes of interest
162	Perlmutter	1999	10513708	Therapeutic plasma exchange and intravenous immunoglobulin for obsessive-compulsive disorder and tic disorders in childhood	*Lancet*	I: Not an intervention/index test of interest
163	Petersen	2022	2022-18280-001(PsycINFO)	Intensive outpatient acceptance and commitment therapy with exposure and response prevention for adolescents	*Journal of Contextual Behavioral Science*	D: Single-arm study N≥50, unadjusted
164	Pedapati	2015	26228567	Neural correlates associated with symptom provocation in pediatric obsessive compulsive disorder after a single session of sham-controlled repetitive transcranial magnetic stimulation	*Psychiatry Res*	I: Not an intervention/index test of interest
165	Piacentini	2002	12194545	Open trial of cognitive behavior therapy for childhood obsessive-compulsive disorder	*J Anxiety Disord*	D: Single-arm study N≥50, unadjusted
166	Piacentini	2007	18088221	Functional impairment in childhood OCD: development and psychometrics properties of the Child Obsessive-Compulsive Impact Scale-Revised (COIS-R)	*J Clin Child Adolesc Psychol*	I: Index test not used for diagnosis
167	Piacentini	2016	CN-01304680(Cochrane)	Neural correlates of cognitive behavioral therapy-related changes in pediatric obsessive-compulsive disorder symptom dimensions	*Journal of the American Academy of Child and Adolescent Psychiatry*	D: Not a peer-reviewed publication
168	Przeworski	2012	22090186	Maternal and child expressed emotion as predictors of treatment response in pediatric obsessive-compulsive disorder	*Child Psychiatry and Human Development*	C: Not a comparison of interest
169	Rapoport	1980	6996027	Clinical controlled trial of chlorimipramine in adolescents with obsessive-compulsive disorder	*Psychopharmacol Bull*	D: KQ2: not an RCT or adjusted NRCS

No.	First Author	Year	PMID or (other) ID	Title	Journal	Reason for Exclusion
170	Rech	2020	35990243	Symptom Trajectories of Early Responders and Remitters among Youth with OCD	*J Obsessive Compuls Relat Disord*	D: Single-arm study of pooled treatments
171	Reddihough	2019	31638682	Effect of Fluoxetine on Obsessive-Compulsive Behaviors in Children and Adolescents With Autism Spectrum Disorders: A Randomized Clinical Trial	*Jama*	P: Not a population <21 years with OCD
172	Reddy	2003	12752023	A follow-up study of juvenile obsessive-compulsive disorder from India	*Acta Psychiatr Scand*	D: Single-arm study of pooled treatments
173	Rees	2016	27381977	Online Obsessive-Compulsive Disorder Treatment: Preliminary Results of the 'OCD? Not Me!' Self-Guided Internet-Based Cognitive Behavioral Therapy Program for Young People	*JMIR Ment Health*	D: Single-arm study N≥50, unadjusted
174	Rodríguez-Jiménez	2016	2016-44724-002(PsycINFO)	Metric invariance, reliability, and validity of the Child Version of the Obsessive Compulsive Inventory (OCI-CV) in community and clinical samples	*Journal of Obsessive-Compulsive and Related Disorders*	O: No extractable or new outcomes of interest
174	Rodríguez-Jiménez	2017	2015-29405-001(PsycINFO)	Factor structure and measurement invariance of the Obsessive-Compulsive Inventory-Child Version (OCI-CV) in general population	*European Journal of Psychological Assessment*	P: Not a population <21 years with OCD
175	Rosa-Alcázar	2017	27792972	A preliminary study of cognitive-behavioral family-based treatment versus parent training for young children with obsessive-compulsive disorder	*J Affect Disord*	D: Not an RCT or adjusted NRCS
176	Rosa-Alcázar	2021	34867529	Predictors of Parental Accommodation and Response Treatment in Young Children With Obsessive-Compulsive Disorder	*Front Psychiatry*	D: Single-arm study N≥50, unadjusted
177	Rozenman	2017	27225633	Distinguishing Fear Versus Distress Symptomatology in Pediatric OCD	*Child Psychiatry Hum Dev*	I: Not an intervention/index test of interest
178	Rozenman	2019	31075706	Improvement in anxiety and depression symptoms following cognitive behavior therapy for pediatric obsessive compulsive disorder	*Psychiatry Res*	D: Single-arm study N≥50, unadjusted
179	Rueda-Jaimes	2007	17306168	Validación del Inventario de Obsesiones de Leyton, versión corta, en niños y adolescentes de Bucaramanga (Colombia).	*Aten Primaria*	P: Not a population <21 years with OCD

No.	First Author	Year	PMID or (other) ID	Title	Journal	Reason for Exclusion
180	Russman Block	2023	36475374	Resting-State Connectivity and Response to Psychotherapy Treatment in Adolescents and Adults With OCD: A Randomized Clinical Trial	*Am J Psychiatry*	C: Not a comparison of interest
181	Ruta	2010	19557496	Obsessive-compulsive traits in children and adolescents with Asperger syndrome	*Eur Child Adolesc Psychiatry*	I: Not an intervention/index test of interest
182	Sandoval-Lentisco	2023	35849418	Florida Obsessive-Compulsive Inventory¬†and Children's Florida Obsessive Compulsive Inventory: A reliability generalization meta-analysis	*J Clin Psychol*	I: Index test not used for diagnosis
183	Saxena	2002	11838621	Obsessive-compulsive hoarding: symptom severity and response to multimodal treatment	*J Clin Psychiatry*	P: Not a population <21 years with OCD
184	Scahill	1997	9183141	Children's Yale-Brown Obsessive Compulsive Scale: reliability and validity	*J Am Acad Child Adolesc Psychiatry*	I: Index test not used for diagnosis
185	Scahill	2016	25882391	Sensitivity of the modified Children's Yale-Brown Obsessive Compulsive Scale to detect change: Results from two multi-site trials	*Autism*	P: Not a population <21 years with OCD
186	Schultz	2018	30383480	Psychometric validation of a Danish version of the Obsessive Beliefs Questionnaire - Child Version (OBQ-CV)	*Nord J Psychiatry*	I: Index test not used for diagnosis
187	Schwarzlose	2022	35238927	Picky Eating in Childhood: Associations With Obsessive-Compulsive Symptoms	*J Pediatr Psychol*	P: Not a population <21 years with OCD
188	Scully	2012	2012-99200-025(PsycINFO)	Child and family predictors of treatment response in childhood obsessive compulsive disorder		D: Not a peer-reviewed publication
189	Selles	2020	2022-97307-001(PsycINFO)	Family profiles in pediatric obsessive-compulsive disorder	*Journal of Obsessive-Compulsive and Related Disorders*	D: Single-arm study N≥50, unadjusted
190	Sen	2016	28269076	Classification of obsessive-compulsive disorder from resting-state fMRI	*Annu Int Conf IEEE Eng Med Biol Soc*	D: Not a study design of interest
191	Seol	2013	23482407	Korean self-report version of the yale-brown obsessive-compulsive scale: factor structure, reliability, and validity	*Psychiatry Investig*	P: Not a population <21 years with OCD

No.	First Author	Year	PMID or (other) ID	Title	Journal	Reason for Exclusion
192	Sevilla-Cermeño	2019	2019-27571-020(PsycINFO)	Insomnia in pediatric obsessive-compulsive disorder: Prevalence and association with multimodal treatment outcomes in a naturalistic clinical setting	*Sleep Medicine*	D: Single-arm study N≥50, unadjusted
193	Shahni Fayz	2023	NA(ad hoc)	Effectiveness of mindfulness-based stress reduction program on emotion regulation and obsessive-compulsive symptoms of child	*Journal of Applied Family Therapy*	D: KQ2: not an RCT or adjusted NRCS
194	Shalev	2009	19542825	Long-term durability of cognitive behavioral therapy gains for pediatric obsessive-compulsive disorder	*J Am Acad Child Adolesc Psychiatry*	D: Single-arm study N≥50, unadjusted
195	Shavitt	2016	CN-01304664(Cochrane)	Adaptive treatment strategies for children and adolescents with obsessive compulsive disorder	*Journal of the American Academy of Child and Adolescent Psychiatry*	D: Not a peer-reviewed publication
196	Simons	2006	16785776	Metacognitive therapy versus exposure and response prevention for pediatric obsessive-compulsive disorder. A case series with randomized allocation	*Psychother Psychosom*	O: No extractable or new outcomes of interest
197	Skarphedinsson	2015	CN-01471427(Cochrane)	Continued cognitive-behavior therapy versus sertraline for children and adolescents with obsessive-compulsive disorder that were non-responders to cognitive behavior therapy: treatment outcome and moderator analysis	*European child & adolescent psychiatry*	D: Not a peer-reviewed publication
198	Skarphedinsson	2015	26348088	Sertraline Treatment of Nonresponders to Extended Cognitive-Behavior Therapy in Pediatric Obsessive-Compulsive Disorder	*J Child Adolesc Psychopharmacol*	D: Single-arm study N≥50, unadjusted
199	Skarphedinsson	2016	CN-01304688(Cochrane)	Long-term effectiveness of treatments for cognitive-behavioral therapy resistant youth with obsessive-compulsive disorder initially randomized to continued cognitive-behavioral therapy or sertraline	*Journal of the American Academy of Child and Adolescent Psychiatry*	D: Not a peer-reviewed publication
200	Skarphedinsson	2017	27209422	Defining cognitive-behavior therapy response and remission in pediatric OCD: A signal detection analysis of the Children-Yale-Brown Obsessive Compulsive Scale	*European Child & Adolescent Psychiatry*	D: Single-arm study N≥50, unadjusted
201	Smárason	2022	35282768	Age differences in children with obsessive-compulsive disorder: symptoms, comorbidity, severity and impairment	*Nord J Psychiatry*	D: Not a peer-reviewed publication
202	Smárason	2023	37119789	Long-term functional impairment in pediatric OCD after and during treatment: An analysis of distinct trajectories	*Psychiatry Res*	D: Single-arm study of pooled treatments

No.	First Author	Year	PMID or (other) ID	Title	Journal	Reason for Exclusion
203	Snider	2005	15820236	Antibiotic prophylaxis with azithromycin or penicillin for childhood-onset neuropsychiatric disorders	*Biol Psychiatry*	P: Not a population <21 years with OCD
204	Solmi	2020	32394557	Safety of 80 antidepressants, antipsychotics, anti-attention-deficit/hyperactivity medications and mood stabilizers in children and adolescents with psychiatric disorders: a large scale systematic meta-review of 78 adverse effects	*World Psychiatry*	P: Not a population <21 years with OCD
205	Sperling	2020	139885178(CINAHL)	The impact of intensive treatment for pediatric anxiety and obsessive-compulsive disorder on daily functioning	*Clinical Child Psychology & Psychiatry*	P: Not a population <21 years with OCD
206	Sperling	2021	34165353	Associations between parental distress and pediatric anxiety and obsessive-compulsive disorder treatment outcomes	*Clin Child Psychol Psychiatry*	D: Single-arm study N≥50, unadjusted
207	Steinberger	2002	12121206	Classification of obsessive-compulsive disorder in childhood and adolescence	*Acta Psychiatr Scand*	O: No extractable or new outcomes of interest
208	Steinhausen	2009	18723315	Performance of the adolescent obsessive-compulsive scale in a community survey	*J Anxiety Disord*	P: Not a population <21 years with OCD
209	Stewart	2004	15180774	Long-term outcome of pediatric obsessive-compulsive disorder: a meta-analysis and qualitative review of the literature	*Acta Psychiatr Scand*	O: No extractable or new outcomes of interest
210	Storch	2004	15572188	Psychometric evaluation of the Children's Yale-Brown Obsessive-Compulsive Scale	*Psychiatry Res*	I: Index test not used for diagnosis
211	Storch	2007	17044015	Sequential cognitive-behavioral therapy for children with obsessive-compulsive disorder with an inadequate medication response: a case series of five patients	*Depress Anxiety*	I: Index test not used for diagnosis
212	Storch	2008	18356759	Impact of comorbidity on cognitive-behavioral therapy response in pediatric obsessive-compulsive disorder	*J Am Acad Child Adolesc Psychiatry*	D: Single-arm study N≥50, unadjusted
213	Storch	2008	2008-15242-004(PsycINFO)	Somatic symptoms in children and adolescents with obsessive-compulsive disorder: Associations with clinical characteristics and cognitive-behavioral therapy response	*Behavioural and Cognitive Psychotherapy*	O: No extractable or new outcomes of interest

No.	First Author	Year	PMID or (other) ID	Title	Journal	Reason for Exclusion
214	Storch	2008	105800628(CINAHL)	Comorbidity of pediatric obsessive-compulsive disorder and anxiety disorders: impact on symptom severity and impairment	*Journal of Psychopathology & Behavioral Assessment*	D: Single-arm study N≥50, unadjusted
215	Storch	2009	2009-08447-010(PsycINFO)	Children's Florida Obsessive Compulsive Inventory: Psychometric properties and feasibility of a self-report measure of obsessive=compulsive symptoms in youth	*Child Psychiatry and Human Development*	I: Index test not used for diagnosis
216	Storch	2010	20610140	Defining treatment response and remission in obsessive-compulsive disorder: a signal detection analysis of the Children's Yale-Brown Obsessive Compulsive Scale	*J Am Acad Child Adolesc Psychiatry*	I: Index test not used for diagnosis
217	Storch	2010	CN-01032125(Cochrane)	D-cycloserine augmentation of cognitive-behavioral therapy in pediatric obsessive-compulsive disorder: a preliminary study	*Neuropsychopharmacology*	D: Not a peer-reviewed publication
218	Storch	2010	20390817	An open trial of intensive family based cognitive-behavioral therapy in youth with obsessive-compulsive disorder who are medication partial responders or nonresponders	*J Clin Child Adolesc Psychol*	D: Not a peer-reviewed publication
219	Storch	2011	20886284	Development and preliminary psychometric evaluation of the Children's Saving Inventory	*Child Psychiatry Hum Dev*	I: Index test not used for diagnosis
220	Storch	2016	CN-01304668(Cochrane)	Augmentation of cognitive behavioral therapy with d-cycloserine in pediatric obsessive-compulsive disorder: a randomized controlled trial	*Journal of the American Academy of Child and Adolescent Psychiatry*	D: Not a peer-reviewed publication
221	Storch	2018	28910139	Quality of Life in Children and Youth with Obsessive-Compulsive Disorder	*J Child Adolesc Psychopharmacol*	D: Single-arm study of pooled treatments
222	Storch	2019	30577944	Development and Psychometric Evaluation of the Children's Yale-Brown Obsessive-Compulsive Scale Second Edition	*J Am Acad Child Adolesc Psychiatry*	I: Index test not used for diagnosis
223	Storch	2019	30877851	Sudden gains in cognitive behavioral therapy among children and adolescents with obsessive compulsive disorder	*Journal of behavior therapy and experimental psychiatry*	D: Single-arm study N≥50, unadjusted
224	Stárková	2002	2002-04255-003(PsycINFO)	Fluvoxamin v pedopsychiatrick√© praxi (retrospektivn√≠ studie) = Fluvoxamine in child and adolescent psychiatry (retrospective study)	*Česká a Slovenská Psychiatrie*	P: Not a population <21 years with OCD
225	Sukhodolsky	2013	23602943	Exposure and response prevention with or without parent management training for children with obsessive-compulsive	*J Anxiety Disord*	D: Single-arm study N≥50, unadjusted

No.	First Author	Year	PMID or (other) ID	Title	Journal	Reason for Exclusion
				disorder complicated by disruptive behavior: a multiple-baseline across-responses design study		
226	Sullivan	2018	2018-13260-042(PsycINFO)	A meta-analysis of the effectiveness and efficiency of d-cycloserine-augmented exposure therapy with treatment resistant pediatric OCD patients		D: Not a peer-reviewed publication
227	Tan	2005	NA(From SRs)	A comparative study of clomipramine and paroxetine in the treatment of adolescents with obsessive-compulsive disorder	*Journal of Binzhou Medical College*	Unable to retrieve full text
228	Thamrin	2017	CN-01452332(Cochrane)	Reducing different types of family accommodation for families of youth with obsessive-compulsive disorder: comparison of two family intervention approaches	*Journal of the American Academy of Child and Adolescent Psychiatry*	D: Not a peer-reviewed publication
229	Thienemann	2001	11699798	Manual-Driven group cognitive-behavioral therapy for adolescents with obsessive-compulsive disorder: a pilot study	*J Am Acad Child Adolesc Psychiatry*	D: Single-arm study N≥50, unadjusted
230	Thierfelder	2022	36085677	Multimodal Sensor-Based Identification of Stress and Compulsive Actions in Children with Obsessive-Compulsive Disorder for Telemedical Treatment	*Annu Int Conf IEEE Eng Med Biol Soc*	D: Single-arm study N≥50, unadjusted
231	Tini	2022	35248877	Therapeutic drug monitoring of sertraline in children and adolescents: A naturalistic study with insights into the clinical response and treatment of obsessive-compulsive disorder	*Compr Psychiatry*	D: Single-arm study N≥50, unadjusted
232	Tollefson	1994	7961535	Continuation treatment of OCD: double-blind and open-label experience with fluoxetine	*J Clin Psychiatry*	P: Not a population <21 years with OCD
233	Torp	2015	25463245	Effectiveness of cognitive behavior treatment for pediatric obsessive-compulsive disorder: acute outcomes from the Nordic Long-term OCD Treatment Study (NordLOTS)	*Behav Res Ther*	O: No extractable or new outcomes of interest
234	Torp	2017	2017-47863-013(PsycINFO)	Early responders and remitters to exposure-based CBT for pediatric OCD	*Journal of Obsessive-Compulsive and Related Disorders*	D: Single-arm study N≥50, unadjusted
235	Turner	2009	19545482	A pilot study of telephone cognitive-behavioural therapy for obsessive-compulsive disorder in young people	*Behav Cogn Psychother*	D: Single-arm study N≥50, unadjusted
236	Uher	2008	18023139	Self-, parent-report and interview measures of obsessive-compulsive disorder in children and adolescents	*J Anxiety Disord*	I: Index test not used for diagnosis

No.	First Author	Year	PMID or (other) ID	Title	Journal	Reason for Exclusion
237	Ulloa	2004	2004-18723-003(PsycINFO)	Estudio de validez y confiabilidad de la versi√≥n en espa√±ol de la escala Yale-Brown del trastorno obsesivo-compulsivo para ni√±os y adolescentes = Validity and reliability of the Spanish version of Yale-Brown rating scale for children and adolescents	*Actas Espa√±olas de Psiquiatr√≠a*	I: Index test not used for diagnosis
238	Valderhaug	2007	16836977	An open clinical trial of cognitive-behaviour therapy in children and adolescents with obsessive-compulsive disorder administered in regular outpatient clinics	*Behav Res Ther*	D: Single-arm study N≥50, unadjusted
239	Vattimo	2016	CN-01304623(Cochrane)	Predicting obsessive-compulsive disorder treatment response in pediatric patients using structural neuroimaging correlates: a comparison between simple linear regression and support vector regression	*Journal of the American Academy of Child and Adolescent Psychiatry*	D: Not a peer-reviewed publication
240	Vattimo	2017	CN-01439240(Cochrane)	Treatment response prediction in pediatric patients with OCD using structural neuroimaging correlates: simple linear regression versus support vector regression	*Neuropsychopharmacology*	D: Not a peer-reviewed publication
241	Vattimo	2019	30972581	Caudate volume differences among treatment responders, non-responders and controls in children with obsessive‚Äìcompulsive disorder	*European Child & Adolescent Psychiatry*	C: Not a comparison of interest
242	Vause	2017	CN-01714036(Cochrane)	Preliminary Randomized Trial of Function-Based Cognitive-Behavioral Therapy to Treat Obsessive Compulsive Behavior in Children with Autism Spectrum Disorder	*Focus on autism and other developmental disabilities*	P: Not a population <21 years with OCD
243	Vause	2020	30293128	Functional Behavior-Based Cognitive-Behavioral Therapy for Obsessive Compulsive Behavior in Children with Autism Spectrum Disorder: A Randomized Controlled Trial	*J Autism Dev Disord*	P: Not a population <21 years with OCD
244	Vulink	2009	19497245	Quetiapine augments the effect of citalopram in non-refractory obsessive-compulsive disorder: a randomized, double-blind, placebo-controlled study of 76 patients	*J Clin Psychiatry*	P: Not a population <21 years with OCD
245	Wagner	2003	12880500	Remission status after long-term sertraline treatment of pediatric obsessive-compulsive disorder	*J Child Adolesc Psychopharmacol*	O: No extractable or new outcomes of interest

No.	First Author	Year	PMID or (other) ID	Title	Journal	Reason for Exclusion
246	Walitza	2008	18200431	Children and adolescents with obsessive-compulsive disorder and comorbid attention-deficit/hyperactivity disorder: preliminary results of a prospective follow-up study	*J Neural Transm (Vienna)*	D: Single-arm study N≥50, unadjusted
247	Walkup	1999	CN-00319964(Cochrane)	Fluvoxamine in childhood OCD: long-term treatment	*Journal of the european college of neuropsychopharmacology*	D: Not a peer-reviewed publication
248	Wei	2020	2020-48460-005(PsycINFO)	Emotion regulation strategy use and symptom change during intensive treatment of transitional age youth patients with obsessive compulsive disorder	*Journal of Behavioral and Cognitive Therapy*	P: Not a population <21 years with OCD
249	Weir	2000	10920742	Treating obsessive-compulsive and tic disorders	*Cmaj*	P: Not a population <21 years with OCD
250	Wever	1997	9088493	Juvenile obsessive-compulsive disorder	*Aust N Z J Psychiatry*	D: Single-arm study N≥50, unadjusted
251	Whiteside	2010	20569789	An uncontrolled examination of a 5-day intensive treatment for pediatric OCD	*Behav Ther*	D: Single-arm study N≥50, unadjusted
252	Whiteside	2018	28918645	Increasing Availability of Exposure Therapy Through Intensive Group Treatment for Childhood Anxiety and OCD	*Behav Modif*	D: Single-arm study N≥50, unadjusted
253	Wilens	1999	10230189	Absence of cardiovascular adverse effects of sertraline in children and adolescents	*J Am Acad Child Adolesc Psychiatry*	O: No extractable or new outcomes of interest
254	Wolters	2011	21497051	Psychometric properties of a Dutch version of the Obsessive Beliefs Questionnaire--Child Version (OBQ-CV)	*J Anxiety Disord*	I: Index test not used for diagnosis
255	Wolters	2012	22197341	Psychometric properties of the Dutch version of the Meta-Cognitions Questionnaire-Adolescent Version (MCQ-A) in non-clinical adolescents and adolescents with obsessive-compulsive disorder	*J Anxiety Disord*	I: Index test not used for diagnosis
256	Wolters	2015	CN-01098688(Cochrane)	Improving treatment: supplementing cognitive behavioral therapy with a cognitive bias modification training for children and adolescents with OCD	*European child & adolescent psychiatry*	D: Not a peer-reviewed publication

No.	First Author	Year	PMID or (other) ID	Title	Journal	Reason for Exclusion
257	Wolters	2019	30032391	Mediating Mechanisms in Cognitive Behavioral Therapy for Childhood OCD: The Role of Dysfunctional Beliefs	*Child Psychiatry Hum Dev*	O: No extractable or new outcomes of interest
258	Wong	2020	32361667	Manipulating visual perspective for obsessional imagery and its impact on obsessive-compulsive symptoms in an analogue sample	*J Anxiety Disord*	P: Not a population <21 years with OCD
259	Wu	2009	19345557	Inferential confusion, obsessive beliefs, and obsessive-compulsive symptoms: a replication and extension	*J Anxiety Disord*	P: Not a population <21 years with OCD
260	Xia	2012	2012-02515-010(PsycINFO)	Revision of the Children's Florida Obsessive Compulsive Inventory	*Chinese Mental Health Journal*	P: Not a population <21 years with OCD
261	Yamamuro	2016	27552672	A longitudinal event-related potential study of selective serotonin reuptake inhibitor therapy in treatment-na√Øve pediatric obsessive compulsive disorder patients	*Psychiatry Res*	D: Not a study design of interest
262	Yaryura-Tobias	2000	10870874	Parental obsessive,Äìcompulsive disorder as a prognostic factor in a year long fluvoxamine treatment in childhood and adolescent obsessive,Äìcompulsive disorder	*International Clinical Psychopharmacology*	D: Single-arm study N≥50, unadjusted
263	Yucelen	2006	16324902	Interrater reliability and clinical efficacy of Children's Yale-Brown Obsessive-Compulsive Scale in an outpatient setting	*Compr Psychiatry*	I: Index test not used for diagnosis
264	Zheng	2020	32364596	Association of Pediatric Acute-Onset Neuropsychiatric Syndrome With Microstructural Differences in Brain Regions Detected via Diffusion-Weighted Magnetic Resonance Imaging	*JAMA Netw Open*	D: Not a study design of interest
265	Ólafsdóttir	2023	35013848	Body Dysmorphic Symptoms in Youth with Obsessive-compulsive Disorder: Prevalence, Clinical Correlates, and Cognitive Behavioral Therapy Outcome	*Child Psychiatry Hum Dev*	D: Single-arm study N≥50, unadjusted
266	Şimşek	2022	35330724	Developing and Examining the Effectiveness of a Cognitive Behavioral Therapy-Based Psychoeducation Practice for Reducing Obsessive-Compulsive Symptoms in Adolescents: A Mixed-Methods Study With a Turkish Sample	*Front Psychol*	P: Not a population <21 years with OCD
267		2020	L2006956099(Embase)	The effect of transdiagnostic emotion-focused treatment on obsessive-compulsive symptoms in children and adolescents	*Journal of Obsessive-Compulsive and Related Disorders*	P: Not a population <21 years with OCD

No.	First Author	Year	PMID or (other) ID	Title	Journal	Reason for Exclusion
268			L2015668905(Embase)	The Role of Intolerance of Uncertainty in Treatment for Pediatric Anxiety Disorders and Obsessive-Compulsive Disorder	*Evidence-Based Practice in Child and Adolescent Mental Health*	D: Single-arm study N≥50, unadjusted
269			NCT01302080(CT.gov)	Sertraline Pediatric Registry for the Evaluation of Safety (SPRITES)	*CT.gov*	P: Not a population <21 years with OCD
270			NCT01281969(CT.gov)	Intravenous Immunoglobulin for PANDAS	*CT.gov*	I: Not an intervention/index test of interest
271			NCT01617083(CT.gov)	Antibiotic Treatment Trial for the PANDAS/PANS Phenotype	*CT.gov*	I: Not an intervention/index test of interest
272			NCT02421315(CT.gov)	Overlapping Neural Circuits in Pediatric OCD	*CT.gov*	I: Not an intervention/index test of interest
273			NCT01018056(CT.gov)	Developing New Treatments for Tourette Syndrome: Therapeutic Trials With Modulators of Glutamatergic Neurotransmission	*CT.gov*	P: Not a population <21 years with OCD
274			NCT00592852(CT.gov)	Fluoxetine for Obsessive-Compulsive Disorder in Children and Adolescents With Bipolar Disorder	*CT.gov*	D: Single-arm study N≥50, unadjusted
275			NCT01172873(CT.gov)	D-Cycloserine Augmentation to CBT With Exposure and Response Prevention in Adults and Adolescents With OCD	*CT.gov*	D: Single-arm study N≥50, unadjusted
276			NCT02797808(CT.gov)	Effects of Sertraline on Brain Connectivity in Adolescents With OCD	*CT.gov*	D: Single-arm study N≥50, unadjusted

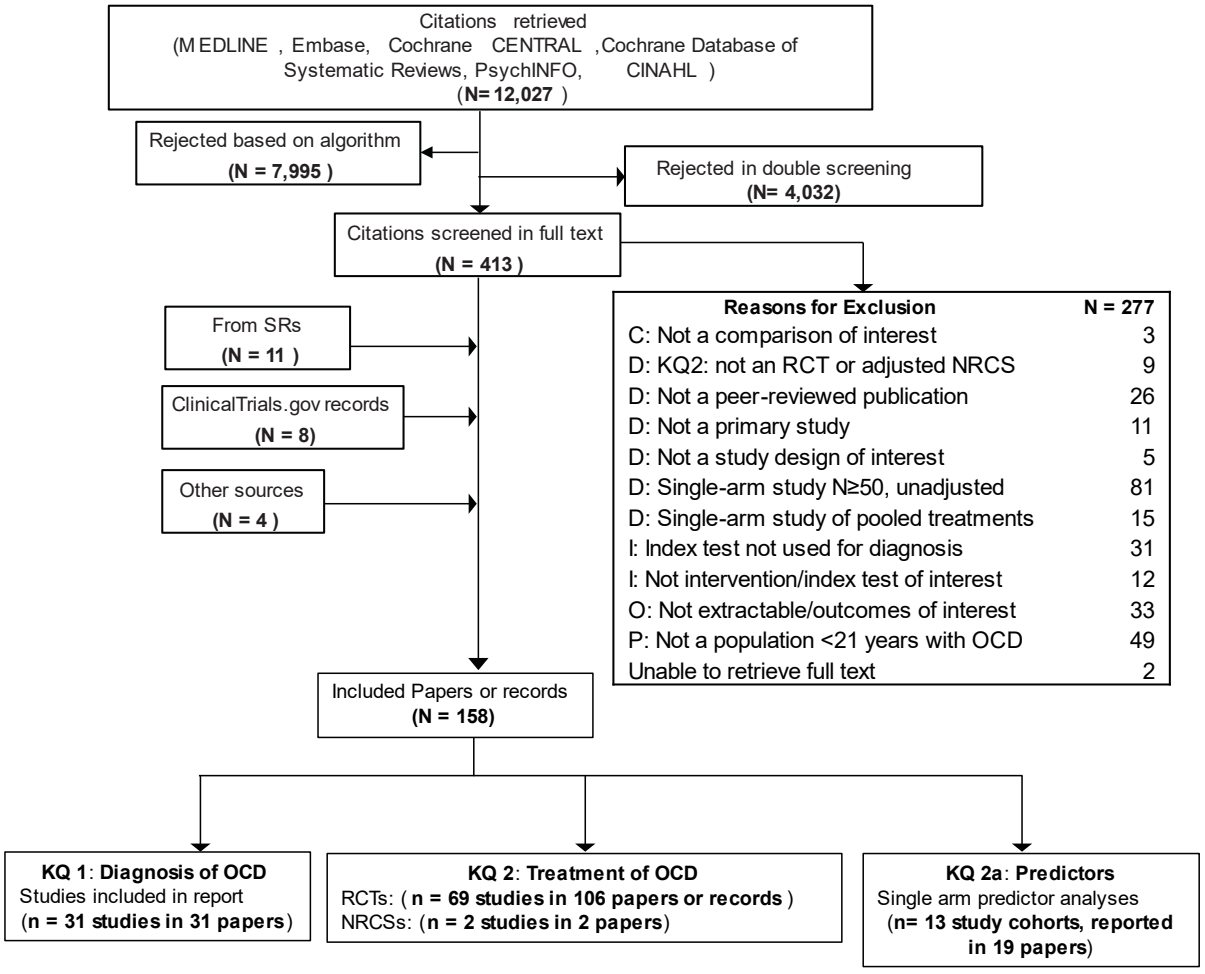
Abbreviations: ad hoc = not found in a search; Cochrane = Cochrane Register of Clinical Trials; CT.gov = clinicaltrials.gov; N = number of participants enrolled; NA = not applicable; No. = number; OCD = obsessive compulsive disorder; PMID = PubMed identifier;

Appendix C. Results: Design, Arm, and Sample Details

C.1 Results of Literature Searches

As illustrated by Figure C–1, our citation search retrieved a combined 12,207 citations. Of these, 436 were deemed potentially relevant and retrieved in full text. After full-text screening, our review includes 31 eligible studies for KQ1, 73 studies in 109 papers or records for KQ2 and 20 papers reporting predictor analyses from 13 single arm studies (reported in 20 papers).

Figure C–1. Flow diagram for studies



Abbreviations: CINAHL = Cumulative Index of the Nursing and Allied Health Literature, KQ = key question; N = number; NRCS = nonrandomized comparative study; OCD = obsessive compulsive disorder; RCT = randomized controlled trial; SR = systematic review

C.2 Description of Included Studies

C.2.1 Overall Summary of Study and Patient Characteristics

Appendix Tables C-1.1 to C–2.3.2 summarize the design, arm, and patient characteristics in separate tables for each KQ.

Table C–1.1. Key Question 1: Baseline Data for Brief Assessment Tools, Part 1

Author, year, PMID Country Years	OCD Group Source	Comparison Group Source	Diagnosis Criteria	Diagnosis: Specific Method/Evaluator
Abramovitch, 2022 35091252 US/Canada/Australia	Outpatient psychiatric clinic	Outpatient psychiatric clinic	DSM-IV	Structured Interview + Clinical Diagnosis MD/PhD
Abramovitch, 2022, 35697331 US/Canada/Australia	Outpatient psychiatric clinic	Outpatient psychiatric clinic	DSM-IV	Structured Interview + Clinical Diagnosis MD/PhD
Andersen, 2012, 23171745 Denmark 2000-2005	Child Psychiatric Outpatient Clinic	Child Psychiatric Outpatient Clinic	ICD-10/CBCL	Structured Interview Both
Bamber, 2002, 12364847 UK	Clinical services and depression research study	Secondary schools	DSM-IV (KSADS-PL)	Structured interview NR
Battle, 2013, 2013-15434-007 Spain	Clinical services receiving medical care in a child hospital	Primary health care child assistance units	DSM-IV-TR	NR
Hudziak, 2006, 16423147 US	Outpatient psychiatric clinic	Outpatient psychiatric clinic	DSM-III-R	Clinical Diagnosis MD/PhD
Ivarsson, 2008, 18280696 Sweden	Outpatient psychiatric clinic	Outpatient psychiatric clinic	DSM-IV	Structured Interview + Clinical Diagnosis MD/PhD
Lambe, 2021, 37431399 Canada	Outpatient psychiatric clinic	Tertiary care clinics	DSM-IV or DSM-V	Structured Interview + Clinical Diagnosis MD/PhD
Piqueras, 2015, 27703719 Spain	Outpatient psychiatric clinic	NR	NR	NR
Piqueras, 2017, 27283942 Spain	Child and adolescent psychiatry unit	Students in school	DSM-IV-TR (K-SADS-PL)	Structured Interview + Clinical Diagnosis MD/PhD
Rough, 2020, 32030629 US	Psychiatry clinic	NR	DSM-V, K-SADS-PL, SOCOBS, CY-BOCS	Structured Interview NR
Saad, 2017, 28151703 Brazil	Cohort Study for Psychiatric Disorders	Cohort Study for Psychiatric Disorders	DAWBA DSM-IV	Structured Interview + Clinical Diagnosis MD/PhD
Sattler, 2018, 2019-05127-008 US	Outpatient child and adolescent anxiety center at Mayo Clinic	Outpatient child and adolescent anxiety center at Mayo Clinic	DSM-IV TR	Structured Interview + Clinical Diagnosis MD/PhD
Shafran, 2003, 12550826 UK/Canada	Specialist OCD Clinic	Psychiatric clinics	DSM-IV	Structured Interview + Clinical Diagnosis MD/PhD
Skarphedinsson, 2021, 34293000 Sweden	Outpatient child and adolescent psychiatry (CAP) clinic	Outpatient child and adolescent psychiatry (CAP) clinic	DSM-IV	Structured Interview + Clinical Diagnosis MD/PhD
Stewart, 2005, 16379516 US	Clinical treatment program	NA	DSM-IV (K-SADS-E)	Structured Interview + Clinical Diagnosis MD/PhD

Author, year, PMID Country Years	OCD Group Source	Comparison Group Source	Diagnosis Criteria	Diagnosis: Specific Method/Evaluator
Storch, 2006, 16046257 US 1998-2004	Outpatient psychiatric clinic	Patients undergoing psychodiagnostic testing	NR	Clinical Diagnosis MD/PhD
Storch, 2011, 21353458 US	Unclear	NA	DSM-IV-TR (ADIS-IV-P)	Structured Interview + Clinical Diagnosis MD/PhD
Uher, 2007, 17906247 UK	Clinic for Obsessive–Compulsive and Related Disorders	Clinic for Obsessive–Compulsive and Related Disorders	ICD-10	Structured Interview + Clinical Diagnosis MD/PhD
Whiteside, 2012, 22078243 US	Outpatient clinic for concerns regarding anxiety	Outpatient clinic for concerns regarding anxiety	DSM-IV	Structured Interview + Clinical Diagnosis Research Associate
Zemestani, 2021, 2021-61128-001 Iran	Psychiatric outpatient clinic	Schools	DSM-V (SCID-5-CV)	Structured Interview + Clinical Diagnosis MD/PhD
Zemestani, 2022, 33409771 Iran	psychiatric outpatient clinic	Elementary and high schools	DSM-5 (SCID-5-CV)	Structured interview MD/PhD

Abbreviations: ADIS-IV-P = ADIS-IV-P, based on the DSM-IV, parent report; CBCL = Child Behavior Checklist; CY-BOCS = Children's Yale-Brown Obsessive Compulsive Scale; DAWBA = Development and Well-Being Assessment; DSM = Diagnostic and Statistical Manual of Mental Disorders; ICD = International Classification of Diseases; K-SADS-E = Schedule for Affective Disorders and Schizophrenia for School-Age Children-Epidemiological samples; K-SADS-PL = Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime version; MD = Doctor of medicine; NR = Not reported; OCD = Obsessive Compulsive Disorder; PhD = Doctor of philosophy; PMID = PubMed Identifier; SCID-5-CV = Structured Clinical Interview for DSM-5 Disorders—Clinician Version; SOCOBS = Schedule for Obsessive-Compulsive and Other Behavioral Syndromes; TR = Text revision; UK = United Kingdom; US = United States.

Table C–1.2. Key Question 1: Baseline Data for Brief Assessment Tools, Part 2

Author, year, PMID Country Years	Age, Mean (SD) [Range] Male, N (%)	Race, N% Ethnicity, N%	Comorbidities; N%
Abramovitch, 2022 35091252 US/Canada/Australia	12.6 (2.9) Male, 380 (48.3)	White 666 (84.6) Black/African American 6 (0.8) Asian 16 (2) Hispanic 25 (3.2)	NR
Abramovitch, 2022, 35697331 US/Canada/Australia	12.6 (2.9) Male, 380 (48.3)	White 666 (84.6) Black/African American 6 (0.8) Asian 16 (2) Hispanic 25 (3.2)	NR
Andersen, 2012, 23171745 Denmark 2000-2005	11.7 (2.9) [4-17] Male, 78 (46.4)	NR	NR
Bamber, 2002, 12364847 UK	13.32 (0.95) Male, 4 (44)	NR	Depression 14 (60.9)

Author, year, PMID Country Years	Age, Mean (SD) [Range] Male, N (%)	Race, N% Ethnicity, N%	Comorbidities; N%
Battle, 2013, 2013-15434-007 Spain	13.2 (2.6) [8-17] Male, 54 (69.23)	NR	NR
Hudziak, 2006, 16423147 US	NR	NR	Anxiety 31 (25); Depression 26 affective disorder 26% vs. 40% in clinical controls; Conduct disorder 32%; disruptive disorders 32% in clinical controls; ADHD 21% in OCD group vs. 47% in clinical controls;
Ivarsson, 2008, 18280696 Sweden	NR [4-17] Male, 190 (52.5)	NR	NR
Lambe, 2021, 37431399 Canada	11.71 (3.58) [6-21] Male, 32.4%	NR	NR
Piqueras, 2015, 27703719 Spain	14.62 (2.65) [9-19] Male, 46 (49)	NR	Anxiety 15 (16); Depression 2 (2.1); Tics/Tourette's 4 (4.3)
Piqueras, 2017, 27283942 Spain	14.62 (2.65) [8-19] Male, 46 (48.9)	NR	Anxiety 20 (21.3); Depression 7 (7.4); Bipolar spectrum disorders 2 (2.1); Tics/Tourette's 8 (8.5); ADHD 7 (7.4); ODD 3 (3.2)
Rough, 2020, 32030629 US	14.19 (3.30) [7-18] Male, 324 (71.4)	White 672 (89) Black/African American 1 (0.1) Asian 4 (0.8) American Indian 15 (3.4) Other 2 (0.4) Hispanic 35 (4.6)	Anxiety 164 (36.1); Depression 65 (14.3); Tics/Tourette's 34 (7.49); ADHD 115 (25.3)
Saad, 2017, 28151703 Brazil	8.86 (1.84) [6-12] Male, 1382 (55)	NR	Anxiety 74 (30.33); Depression 36 (14.75); Tics/Tourette's 8 (3.28); Conduct disorder 13 (5.33); ADHD 56 (22.95); ODD 27 (11.07)
Sattler, 2018, 2019-05127-008 US	12.2 (2.9) [5-18] Male, 501 (45.8)	White 951 (86.9)	NR
Shabani, 2019, 2019-80248-001 Iran	14.7 (1.8) [10-18] Male, 68 (53.1)	NR	NR
Shafran, 2003, 12550826 UK/Canada	11.9 (2.3) [7-17] Male, 38 (43)	NR	NR
Skarphedinsson, 2021, 34293000 Sweden 2010-2013	12.1 (3.2) [6.1-17.8] Male, 78 (56.2)	NR	Comorbidities: anxiety 50 (36), depression 41 (30), bipolar disorder 63 (45.5), conduct disorder 6 (4.5), ADHD 74 (53.2), Oppositional defiant disorder 32 (23.2)

Author, year, PMID Country Years	Age, Mean (SD) [Range] Male, N (%)	Race, N% Ethnicity, N%	Comorbidities; N%
Stewart, 2005, 16379516 US	11.5 (3.1) Male, NR	NR	NR
Storch, 2006, 16046257 US 1998-2004	10.5 (3.3) [4-18] Male, 135 (71.0)	White 163 (86) Black/African American 15 (8.0) Other 8 (4) Hispanic 4 (2)	NR
Storch, 2011, 21353458 US	11.48 (2.76) [7-18] Male, 31 (62)	White 41 (82) Black 1 (2) Asian 2 (4) Other 4 (8) Hispanic 2 (4)	Comorbidities: Psychotic disorder, Bipolar disorder, ASD/PDD excluded
Uher, 2007, 17906247 UK	NR [11-15] NR	NR	NR
Whiteside, 2012, 22078243 US	12.81 (3.1) [7-18] Male, 83 (52)	White 154 (96.7)	NR
Zemestani, 2021, 2021-61128-001 Iran	15.82 (1.70) Male, 20 (32.3)	NR	Anxiety 30 (48.3); Depression 12 (19.4); ADHD 17 (27.6)
Zemestani, 2022, 33409771 Iran	15.82 (1.70) [7-17] Male, 20 (32.3)	NR	Anxiety 30 (48); Depression 30 (19.4); ADHD 17 (27.6)

Abbreviation: ADHD = Attention Deficit Hyperactivity Disorder; ASD = Autism Spectrum Disorder; NR = Not reported; OCD = Obsessive Compulsive Disorder; ODD = Oppositional Defiant Disorder; PDD = Pervasive Developmental Disorder; PMID = PubMed Identifier; PTSD = post-traumatic stress disorder; SD = Standard deviation; TS = Tourette Syndrome; UK = United Kingdom; US = United States, vs = versus.

Table C–2.1.1 Key Question 2: design details RCTs

Author, year, PMID Study Name Country Years Registry number	Industry Funding	Diagnostic method, Evaluator CY-BOCS cutoff	Excluded comorbidities	Exclusion criteria regarding previous treatment	Previous medication status
Alaghband-Rad, 2009, 19190958 Iran 1999-2002	NR	DSM-IV: Clinical diagnosis MD/PhD	.	.	.

Author, year, PMID Study Name Country Years Registry number	Industry Funding	Diagnostic method, Evaluator CY-BOCS cutoff	Excluded comorbidities	Exclusion criteria regarding previous treatment	Previous medication status
Asbahr, 2005, 16239861 Brazil 2000-2002	No	DSM-IV: Structured interview	ADHD; ASD/PDD; Tics/Tourette's; Psychotic disorders; Depressive disorders; Trauma/stressor related disorders; Bipolar spectrum disorders; BPD; any organic brain disorder.	Subjects with previous or current treatment were excluded.	.
Aspvall, 2021, 33974020 Sweden 2017-2020; NCT03263546	No	DSM-V: Clinical diagnosis MD/PhD ≥16	ASD/PDD; Psychotic disorders; Intellectual impairment Explicitly excluded	Course of CBT for OCD in the past 12 months or change in any psychotropic medication in the 6 weeks before the pretreatment assessment.	Dose optimized/stabilized
Barrett, 2003, 12647571 US <2003	NR	DSM-IV OCD: Structured interview MD/PhD	Tics/Tourette's; Psychotic disorders; other anxiety disorders, Depressive disorders Explicitly excluded	.	.
Barrett, 2004, 14691360 Australia	No	DSM-IV: Structured interview Research associate or similar	ADHD; ASD/PDD; Tics/Tourette's; Conduct Disorder; Psychotic disorders; other anxiety disorders; Depressive disorders; Intellectual impairment; ODD	Subjects receiving concurrent psychotherapy were excluded	Dose optimized/stabilized
Bolton, 2008, 17207457 UK 2008	No	DSM-IV: Clinical diagnosis		Concurrent medication treatment for OCD	.
Bolton, 2011, 21644984 UK 2011	No	DSM-IV	ASD/PDD; Psychotic disorders	.	Dose optimized/stabilized
Comer, 2017, 27869451 US 2012-2016	No	NR	PANS/PANDAS; ADHD; ASD/PDD; Tics/Tourette's; Conduct Disorder; Psychotic disorders; other anxiety disorders; Depressive disorders; Intellectual impairment; Trauma/stressor related disorders; ODD; Bipolar spectrum disorders	Child receiving medication or psychotherapy to manage emotional or behavioral problems	.

Author, year, PMID Study Name Country Years Registry number	Industry Funding	Diagnostic method, Evaluator CY-BOCS cutoff	Excluded comorbidities	Exclusion criteria regarding previous treatment	Previous medication status
de Haan, 1998, 9785713 The Netherlands	NR	DSM-III-R: Clinical diagnosis + Structured interview MD/PhD	ASD/PDD; Tics/Tourette's; Psychotic disorders; Depressive disorders; Intellectual impairment	Treatment with behavior therapy or serotonergic antidepressants in the 6 months	.
DeVeaugh-Geiss, 1992, 1537780 US 1986-1988	Yes	DSM-III	ADHD; ASD/PDD; Tics/Tourette's; Psychotic disorders; Depressive disorders; Intellectual impairment; Bipolar spectrum disorders	Concomitant behavioral therapy.	.
Farrell, 2013, 23722990 Australia 2009-2010	No	≥19	.	.	.
Farrell, 2022, 35084071 Australia 2015-2019	No	ADIS-P CSR: Structured interview MD/PhD ≥16	ASD/PDD; Psychotic disorders; Bipolar spectrum disorders	Receiving concurrent psychological treatment.	Dose optimized/stabilized
Fatori, 2018, 30025255 Brazil 2018	No	DSM-IV MD/PhD ≥16	.	.	.
Flament, 1985, 3899048 US	NR	DSM-III: Clinical diagnosis MD/PhD	Tics/Tourette's; Psychotic disorders; Depressive disorders; Intellectual impairment	No response to previous therapy	.
Franklin, 2011, 21934055 POTS II United States 2004-2009 NCT00074815	No	NR: Clinical diagnosis MD/PhD ≥16	PANS/PANDAS; ADHD; ASD/PDD; Tics/Tourette's; Conduct Disorder; Psychotic disorders; other anxiety disorders; Depressive disorders; Intellectual impairment; Trauma/stressor related disorders; ODD; Bipolar spectrum disorders	Having failed an adequate CBT trial (>10 sessions)	Dose optimized/stabilized
Freeman, 2008, 18356758 US ~2008	No	DSM-IV MD/PhD ≥11	PANS/PANDAS; ADHD; ASD/PDD; Tics/Tourette's Conduct Disorder; other anxiety disorders; Depressive disorders; Intellectual impairment; Trauma/stressor related disorders; ODD; Bipolar spectrum disorders	No response to 10 sessions of E/RP; or 6 weeks of medication	Dose optimized/stabilized

Author, year, PMID Study Name Country Years Registry number	Industry Funding	Diagnostic method, Evaluator CY-BOCS cutoff	Excluded comorbidities	Exclusion criteria regarding previous treatment	Previous medication status
Freeman, 2014, 24759852 POTS Jr US 2006-2011 NCT00533806	No	NR: Clinical diagnosis MD/PhD ≥16	PANS/PANDAS; ASD/PDD	.	.
Geller, 2001, 11437015 US 2001	Yes	DSM-IV: Clinical diagnosis ≥16	ADHD; Tics/Tourette's; Psychotic disorders; Depressive disorders; Bipolar spectrum disorders	Ongoing therapy for OCD or depression other than supportive psychotherapy.	.
Geller, 2003, 12880497 US 1997-1998	Yes	DSM-IV: Structured interview MD/PhD ≥16	ADHD; Psychotic disorders; Intellectual impairment	No medication ≤ 30 days; no previous psychological treatment	Dose optimized/stabilized
Geller, 2004, 15502598 US, Canada 2000-2001	Yes	DSM-IV: Structured interview MD/PhD ≥17	ASD/PDD; Tics/Tourette's; Psychotic disorders; Depressive disorders; Intellectual impairment; Bipolar spectrum disorders	Previous nonresponse to SSRIs; concurrent treatment.	.
Ghanizadeh, 2017, 28659986 Iran 2011-2012	No	DSM-IV-TR: Structured interview	ADHD; Psychotic disorders	.	.
Grant, 2014, 24356715 US 2011-2012 NCT00251303	No	DSM-IV: Structured interview MD/PhD ≥20	ASD/PDD; Psychotic disorders; other anxiety disorders	.	.
Guo, 2008; China 2001-2005	NR	CCMD-3 ≥16	Conduct Disorder	.	.
He, 2007; China; 2005-2006	NR	CCMD ≥16	Conduct Disorder	.	.
Hollmann, 2022, 36329915 Germany 2019-2022 NCT05037344	No	DSM-V: Clinical diagnosis MD/PhD ≥16	Psychotic disorders; Intellectual impairment	.	.

Author, year, PMID Study Name Country Years Registry number	Industry Funding	Diagnostic method, Evaluator CY-BOCS cutoff	Excluded comorbidities	Exclusion criteria regarding previous treatment	Previous medication status
Lenhard, 2017, 27993223 BiPOCD Sweden 2014-2015 NCT02191631	No	DSM-V: Clinical diagnosis + Structured interview MD/PhD ≥16	ASD/PDD; Psychotic disorders; Bipolar spectrum disorders	Completed CBT for OCD within the past 12 months, ongoing psychological treatment of OCD.	Dose optimized/stabilized
Leonard, 1989, 2686576, US	No	DSM 3: Structured interview + Clinical diagnosis MD/PhD	Tics/Tourette's; Psychotic disorders; Intellectual impairment	.	.
Lewin, 2014, 24657310 US 2011-2013 NCT01447966	No	DSM-IV: Clinical diagnosis MD/PhD ≥16	ADHD; ASD/PDD; Psychotic disorders; Intellectual impairment	Recent change in psychotropic medication, concurrent psychotherapy or behavioral intervention.	.
Li, 2020, 31800306 US 2012-2020 NCT01172275	Yes	Clinical diagnosis MD/PhD ≥16	Tics/Tourette's; Psychotic disorders; Intellectual impairment; Bipolar spectrum disorders	.	.
Liebowitz, 2002, 12447029 US 1991-1998	No	DSM-III-R or DSM-IV ≥16	Psychotic disorders	Previous fluoxetine treatment at 40 mg/day or more for at least 4 weeks	.
Liu, 2012 China 2010-2011	No	ICD-10 ≥16	Depressive disorders	.	.
Ma, 2014 China 2007-2013	NR	≥17	.	.	.
March, 1990, 19630661 US ~1990	Yes	DSM-III: Clinical diagnosis MD/PhD	ASD/PDD; Tics/Tourette's; Psychotic disorders; other anxiety disorders; Depressive disorders; Intellectual impairment; Trauma/stressor related disorders; Bipolar spectrum disorders	.	.
March, 1998, 9842950 US	Yes	DSM-III-R: Clinical diagnosis + Structured interview ≥16	ASD/PDD; Conduct Disorder; Intellectual impairment	Participated in a previous sertraline study or be treated with sertraline.	Dose optimized/stabilized

Author, year, PMID Study Name Country Years Registry number	Industry Funding	Diagnostic method, Evaluator CY-BOCS cutoff	Excluded comorbidities	Exclusion criteria regarding previous treatment	Previous medication status
Mataix-Cols, 2014, 24262813 UK ISRCTN70977225	No	DSM-IV ≥17	ASD/PDD; Psychotic disorders; Bipolar spectrum disorders	.	Dose optimized/stabilized
Merlo, 2010, 19675960 US 2019	NR	NR: Structured interview ≥16	ASD/PDD; Psychotic disorders	.	.
Nai, 2009; China; 2005-2008	NR	CCMD-3 ≥16	Conduct Disorder	.	.
Nasiry, 2020 Cognitive Bias Modification of Interpretation (CBMI) Iran ~2020	No	DSM-V: Clinical diagnosis MD/PhD ≥15	ADHD; ASD/PDD; Tics/Tourette's; Conduct Disorder; Psychotic disorders; other anxiety disorders; Depressive disorders; Intellectual impairment; Trauma/stressor related disorders; ODD; Bipolar spectrum disorders	.	.
NCT01933919 Japan 2013-2015	NR	NR ≥16	ADHD; Tics/Tourette's; Psychotic disorders; Depressive disorders; Intellectual impairment; Bipolar spectrum disorders	Fluvoxamine ≤ 2 months	.
Neziroglu, 2000, 11191690 US 2000	No	DSM-IV MD/PhD	.	.	.
Noras, 2022, 35748547 Iran 2020-2021 IRCT20191127045521N1	No	DSM-V: Clinical diagnosis MD/PhD	Psychotic disorders	Exclude: Phenobarbital, Oxazepam, Sedative drug consumption	.
Peris, 2013, 22548378; US	No	DSM-IV-TR: Structured interview Research associate or similar ≥15	Conduct Disorder; Psychotic disorders	Failed CBT trials for anxiety or OCD within the last two years	Dose optimized/stabilized

Author, year, PMID Study Name Country Years Registry number	Industry Funding	Diagnostic method, Evaluator CY-BOCS cutoff	Excluded comorbidities	Exclusion criteria regarding previous treatment	Previous medication status
Peris, 2017, 29173737 US 2008-20016 NCT01409642	No	DSM-IV ≥15	Psychotic disorders	Prior history of receiving CBT for OCD	Dose optimized/stabilized
Piacentini, 2011, 22024003 US 1998-2003 NCT 00000386	No	DSM-IV MD/PhD ≥16	ASD/PDD; Psychotic disorders; Bipolar spectrum disorders	Concurrent psychotropic medication for OCD at study entry	.
POTS Team, 2004, 15507582 POTS US 1997-2022	No	DSM-IV: Clinical diagnosis + Structured interview ≥17	Psychotic disorders; Depressive disorders; Intellectual impairment; Bipolar spectrum disorders	Concurrent psychotropic treatment; no response to 2 previous SRI trials or a CBT trial for OCD.	Dose optimized/stabilized
Rempel, 2023, 37048570 Germany 2019-2022 EK18012019	No	ICD-10: Clinical diagnosis MD/PhD ≥8	ASD/PDD; Psychotic disorders; Depressive disorders; Intellectual impairment	Treatment naïve	Dose optimized/stabilized
Reynolds, 2013, 24060194 UK 2013	No	DSM-IV	Psychotic disorders; Bipolar spectrum disorders	.	.
Rezvan, 2013, 23413047 Iran ~2013	No	DSM-IV: Clinical diagnosis + Structured interview MD/PhD	.	Previously treated with either pharmacotherapy or psychotherapy continuing medication during the study	.
Riddle, 1992, 1429406 US 1988-1990	No	DSM-III-R MD/PhD	Tics/Tourette's; Psychotic disorders; Depressive disorders; Intellectual impairment	Previous fluoxetine treatment	.
Riddle, 2001, 11211371; US 1991-1994	Yes	DSM-III-R ≥16	Tics/Tourette's; Psychotic disorders; Depressive disorders	Treatment with fluoxetine ≤ 30 days, a monoamine oxidase inhibitor ≤ 14 days, or tricyclic antidepressant or other psychotropic drug ≤ 7 days	Dose optimized/stabilized

Author, year, PMID Study Name Country Years Registry number	Industry Funding	Diagnostic method, Evaluator CY-BOCS cutoff	Excluded comorbidities	Exclusion criteria regarding previous treatment	Previous medication status
Rosa-Alcázar, 2019, 31516500 Spain 2012-2018	No	DSM-IV-TR, DSM-V: Clinical diagnosis, MD/PhD, ≥16	ADHD; ASD/PDD; Psychotic disorders; Intellectual impairment	Medications not stable for > 8 weeks.	.
Salemink, 2015, 25724385 The Netherlands <2015	NR	DSM-IV ≥8	Psychotic disorders	.	.
Selles, 2021, 34079488 Canada 2018-2021 NCT03672565	No	NR: Clinical diagnosis MD/PhD ≥16	Explicitly included	Treatment naïve	.
Shabani, 2019 Iran IRCT20170326331 44N1	No	DSM-V: Clinical diagnosis MD/PhD ≥16	ADHD; ASD/PDD; Psychotic disorders; Depressive disorders; Intellectual impairment	Participants have not received a psychological intervention in the past year. SSRI (≥3 months)	Dose optimized/stabilized
Shen, 2020 China 2017-2018	NR	CCMD ≥16	.	.	.
Simons, 2006, 16785776 Germany 2006	NR	DSM-IV: Structured interview	ASD/PDD; Psychotic disorders; Intellectual impairment	Concomitant medications for OCD	.
Skarphedinsson, 2015, 25239489 NordLOTS Sweden, Denmark, Norway 2008-2012 ISRCTN66385119	No	DSM-IV ≥16	ASD/PDD; Psychotic disorders; Depressive disorders; Intellectual impairment	No response to CBT in step 1; no medications 6 months before step 1	.
Storch, 2007, 17420681 US	NR	DSM-IV-TR: Clinical diagnosis MD/PhD ≥16	Psychotic disorders; other anxiety disorders; Intellectual impairment; Bipolar spectrum disorders	.	Dose optimized/stabilized

Author, year, PMID Study Name Country Years Registry number	Industry Funding	Diagnostic method, Evaluator CY-BOCS cutoff	Excluded comorbidities	Exclusion criteria regarding previous treatment	Previous medication status
Storch, 2010, 20817153 US 2007-2009 NCT00864123	No	DSM-IV: Clinical diagnosis MD/PhD ≥16	ASD/PDD; Psychotic disorders; Bipolar spectrum disorders	Received at least one DCS dose.	Dose optimized/stabilized
Storch, 2011, 21684018 US	No	DSM-IV-TR: Clinical diagnosis, MD/PhD ≥16	ASD/PDD; Conduct Disorder; Psychotic disorders; Bipolar spectrum disorders	Change in any psychotropic medications for at least 8 weeks	Dose optimized/stabilized
Storch, 2013, 24184429 US 2009-2011 NCT00382291	Yes	Current DSM-IV-TR: Clinical diagnosis ≥17	PANS/PANDAS; ASD/PDD; Psychotic disorders; Bipolar spectrum disorders	Concomitant psychotropic medications other than medication for ADHD or PRN sedative/hypnotics for insomnia. Prior adequate trial of (AACAP, 2012) or allergy to sertraline.	.
Storch, 2016, 27367832 US 2011-2015 NCT 00864123	No	DSM-IV-TR: Clinical diagnosis ≥16	ASD/PDD; Psychotic disorders; other anxiety disorders; Bipolar spectrum disorders	.	Dose optimized/stabilized
Tuerk, 2023 OC-Go US	NR	DSM-V: Structured interview	.	.	.
Turner, 2014, 25457928 UK 2008-2011 ISRCTN27070832	No	DSM-IV: Structured interview MD/PHD ≥16	ASD/PDD; Psychotic disorders; Intellectual impairment	Concurrent medication	Dose optimized/stabilized
Williams, 2010, 19921305 UK 2010	No	ADIS-C: Structured interview	ASD/PDD; Psychotic disorders	.	.
Wolters, 2016, The Netherlands 2007-2010 ISRCTN07851536	NR	DSM-IV: Structured interview ≥16	Psychotic disorders	Medication for OCD, CBT for OCD ≤ 6 months	.

Author, year, PMID Study Name Country Years Registry number	Industry Funding	Diagnostic method, Evaluator CY-BOCS cutoff	Excluded comorbidities	Exclusion criteria regarding previous treatment	Previous medication status
Wolters, 2021, The Netherlands 2013-2016 NTR4275	No	DSM-IV ≥16	Psychotic disorders	No stable dosage of medication for at least 12 weeks (SSRI, TCA, or antipsychotic medication) or four weeks (methylphenidate, Risperidone), CBT ≤ 3 months	Dose optimized/stabilized
Xie, 2020, China 2016-2017	NR	CCMD-3 ≥16	.	.	.
Zhang, 2014, China 2008-2012	NR	ICD-10 ≥16	.	.	.
Zhu, 2008, China 2005-2007	NR	CCMD-3 ≥16	Conduct Disorder	.	.

Abbreviations: ADHD = Attention Deficit Hyperactivity Disorder; ADIS-C = Anxiety Disorders Interview Schedule-Child version for DSM-IV; ADISP = Anxiety Disorders Interview Schedule–Parent, based on the DSM-IV; ASD = Autism Spectrum Disorder; CBT= Cognitive Behavioral Therapy; BPD = Borderline Personality Disorder CCMD-3 = Chinese Classification and Diagnostic Criteria for Mental Disorder, 3rd edition, CY-BOCS = Children's Yale-Brown Obsessive Compulsive Scale; DCS = D-cycloserine; DSM = Diagnostic and Statistical Manual of Mental Disorders; ICD = International Classification of Diseases; MD = Doctor of medicine; NR = Not reported; OCD = Obsessive Compulsive Disorder; ODD = Oppositional Defiant Disorder; PANDAS = Pediatric Autoimmune Neuropsychiatric Disorders Associated with Strep Infection; PANS = Pediatric Acute-onset Neuropsychiatric Syndrome; PDD = Pervasive Developmental Disorder; PhD = Doctor of philosophy; PMID = PubMed Identifier; POTS = Pediatric OCD Treatment Study; PRN = As needed (from Latin phrase: pro re nata); RCTs = Randomized Controlled Trials; SSRI = Selective Serotonin Reuptake Inhibitor; TR = Text revision UK = United Kingdom; US = United States.

Table C–2.1.2. Key Question 2: design details NRCSs

Author, year, PMID Study Name Country Years Analysis Method	Industry Funding	Diagnostic method, Evaluator CY-BOCS cutoff	Excluded comorbidities
Franklin, 2023 United States 2015-2022 propensity score analysis	No	DSM V: Clinical diagnosis MD/PhD ≥16	.
Schuberth, 2023; Canada 2011-2017 propensity score analysis	No	DSM-IV/5: Clinical diagnosis ≥16	Conduct Disorder; Depressive disorders

Abbreviations: CY-BOCS = Children's Yale-Brown Obsessive Compulsive Scale; DSM = Diagnostic and Statistical Manual of Mental Disorders; MD = Doctor of medicine; NRCS = Non Randomized Comparative Study; PhD = Doctor of philosophy; PMID= PubMed Identifier

Table C-2.1.3 Key Question 2: Design Details of Planned or Ongoing Trials Registered in ClinicalTrials.gov

NCT Number	Study Title	Study URL	Study Acronym	Goal Enrollment	Start Date
NCT03595098	Treatment Effects of Family Based Cognitive Therapy in Children and Adolescents With Obsessive Compulsive Disorder	https://clinicaltrials.gov/study/NCT03595098	TECTO	128	8/28/2018
NCT03528109	Improving Access to Child Anxiety Treatment	https://clinicaltrials.gov/study/NCT03528109	IMPACT	379	7/1/2018
NCT04548609	Transcranial Direct Current Stimulation (tDCS) in Pediatric Obsessive Compulsive Disorder (OCD)	https://clinicaltrials.gov/study/NCT04548609		36	1/25/2021
NCT05104697	TMS for Improving Response Inhibition in Adolescents With OCD	https://clinicaltrials.gov/study/NCT05104697		25	4/1/2022
NCT05931913	TMS + Exposure Therapy for Pediatric OCD	https://clinicaltrials.gov/study/NCT05931913	NExT	60	10/1/2023
NCT04673578	Adjunctive Celecoxib in Childhood-onset OCD Study	https://clinicaltrials.gov/study/NCT04673578	ACE-OCD	80	6/1/2021
NCT04963257	Sertraline Combined With Fluvoxamine in the Treatment of Refractory Obsessive-compulsive Disorder	https://clinicaltrials.gov/study/NCT04963257		400	1/1/2020
NCT05609916	CBT Augmentation to Promote Medication Discontinuation in Pediatric OCD	https://clinicaltrials.gov/study/NCT05609916		200	11/30/2022

Table C–2.2. KQ 2 Arm details

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Alaghband-Rad 2009 19190958	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Fluoxetine	.	.	.	Fluoxetine, 20mg daily, 6 weeks	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Alaghband-Rad 2009 19190958	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Citalopram	.	.	.	Citalopram, 20mg daily, 6 weeks	.	.
Asbahr 2005 16239861	Psychological/behavioral intervention	GCBT	Psychoeducation, Cognitive restructuring, ERP/Exposure, ACT/Acceptance and commitment	Twelve 90-minute sessions over 12 weeks	In person/clinic, MD/PhD Group family-focused	.	.	.
Asbahr 2005 16239861	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Sertraline	.	.	NR, MD Individual	Sertraline (SSRI), 25mg for the first week then gradually titrated (every 4 days) to a maximum daily dose of 200 mg, as much as could be tolerated, once/d, 12 weeks	.	.
Aspvall 2021 33974020	Psychological/behavioral intervention	iCBT implemented in a stepped-care model	Psychoeducation, ERP/Exposure	Fourteen sessions over 16 weeks	Virtual/home asynchronous, MD/PhD Individual family-focused	.	.	.
Aspvall 2021 33974020	Psychological/behavioral intervention	In-person CBT	Psychoeducation, ERP/Exposure	Fourteen 45–60-minute sessions over 16 weeks	In person/clinic, MD/PhD Individual	.	.	.
Barrett 2003 12647571	Psychological/behavioral intervention	CBT	General CBT/not specified	Fourteen 90-minute sessions over 14 weeks	Virtual/home synchronous, MD Individual family-focused	.	.	.
Barrett 2003 12647571	Placebo/no treatment	Waitlist	.	.	.	.	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Barrett 2004 14691360	Psychological/behavioral intervention	CBFT (individual)	Psychoeducation, Cognitive restructuring, ERP/Exposure, manual: Freedom From Obsessions and Compulsions Using Cognitive-Behavioral Strategies (FOCUS)	Sixteen 90-minute sessions over 14 weeks	In person/clinic; NR Individual family-focused	.	.	.
Barrett 2004 14691360	Psychological/behavioral intervention	CBFT (group)	Psychoeducation, Cognitive restructuring, ERP/Exposure, manual: Freedom from Obsessions and Compulsions Using Cognitive-Behavioral Strategies (FOCUS)	Sixteen 90-minute sessions over 14 weeks	In person/clinic, NR Group family-focused	.	.	.
Barrett 2004 14691360	Placebo/no treatment	Waitlist	.	.	.	.	.	.
Bolton 2008 17207457	Psychological/behavioral intervention	E-RP	ERP/Exposure	NR	In person/clinic, MD/PhD Individual	.	.	.
Bolton 2008 17207457	Placebo/no treatment	.	.	.	.	.	.	.
Bolton 2011 21644984	Psychological/behavioral intervention	Full CBT	General CBT/not specified	Twelve sessions over 12 weeks	In person/clinic, NR Individual	.	.	.
Bolton 2011 21644984	Psychological/behavioral intervention	Brief CBT	General CBT/not specified	Five sessions over 12 weeks	NR, MD/PhD Individual	.	.	.
Bolton 2011 21644984	Placebo/no treatment	.	.	.	.	.	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Comer 2017 27869451	Psychological/behavioral intervention	Computer-delivered family-based CBT	ERP/Exposure	Fourteen sessions over 14 weeks	Virtual/home synchronous, MD/PhD Individual family-focused	.	.	.
Comer 2017 27869451	Psychological/behavioral intervention	Clinic-based CBT	ERP/Exposure	Fourteen sessions over 14 weeks	In person/clinic, MD/PhD Individual family-focused	.	.	.
de Haan 1998 9785713	Psychological/behavioral intervention	ERP	Psychoeducation, ERP/Exposure	twelve sessions over 12 weeks	In person/clinic, MD/PhD Individual	.	.	.
de Haan 1998 9785713	Pharmacological intervention: Tricyclic antidepressants (TCA)	Clomipramine	.	.	.	Clomipramine, mean 2.5 (0.63) mg/kg/day (range = 1.4-3.3 mg/kg/day), 25-mg/day for the first week, titrated (every 4 days) to a maximum daily dosage of 3 mg/kg/day, with a maximum of 200 mg/day, daily, 12 weeks	.	.
DeVeaugh-Geiss 1992 1537780	Pharmacological intervention: Tricyclic antidepressants (TCA)	Clomipramine Hydrochloride	.	.	.	Clomipramine, 75-200mg, depending on BW, 25mg for the first 4 days, daily, 8 weeks	.	.
DeVeaugh-Geiss 1992 1537780	Placebo/no treatment	.	.	.	.	.	.	.
Farrell 2013 23722990	Psychological/behavioral intervention + Pharmacological intervention	D-cycloserine + ERP	.	Nine 90-minutes sessions 9 weeks.	In person Trained therapist Individual	D-cycloserine, 25-50mg, 1 hour before ERP sessions 5-9 (total 5 times/doses)	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Farrell 2013 23722990	Psychological/behavioral	Placebo + ERP	.	Nine 90-minutes sessions, 9 weeks.	In person Trained therapist Individual	.	.	.
Farrell 2022 35084071	Psychological/behavioral intervention	Placebo augmentation of intensive exposure therapy (CBT)	ERP/Exposure	Four sessions over 4 weeks	Virtual/home synchronous In person/clinic; MD Individual	Antidepressant, NR	Antipsychotic, NR	.
Farrell 2022 35084071	Psychological/behavioral intervention + Pharmacological intervention	D-cycloserine + CBT	Psychoeducation, ERP/Exposure	Three 180-210minute weekly sessions, then 90-120 minutes final 1-month booster session	Virtual/home synchronous In person/clinic; MD Individual	Antidepressant, NR	Antipsychotic, NR	.
Fatori 2018 30025255	Psychological/behavioral intervention	CBT	General CBT/not specified	Fourteen 100-minute sessions over 14 weeks	In person/clinic; NR Group	.		.
Fatori 2018 30025255	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Fluoxetine	.	.	.	Fluoxetine, 10-60mg daily, 14 weeks	.	.
Flament 1985 3899048	Pharmacological intervention: Tricyclic antidepressants (TCA)	Clomipramine	.	.	.	Clomipramine, mean (SD): 141 (30) mg/day, range 100-200 mg., starting dose: 50 mg, increased daily by 50 mg, up to 3 mg/kg/day (maximum, 200 mg/day), as tolerated; at the end of the treatment phase, the dosage was tapered, daily, 5 weeks	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Flament 1985 3899048	Placebo/no treatment	Placebo	.	.	.	.	.	.
Franklin 2011 21934055	Medication management (MM) + CBT	.	Psychoeducation, Cognitive restructuring, Coping/relaxation, ERP/Exposure, manual: OCD in Children and Adolescents: A Cognitive-Behavioral Treatment Manual	Fourteen 60-minute sessions over 12 weeks	In person/clinic; MD/PhD Individual	Sertraline 125 mg (mean recommended dose)	Fluoxetine 40 mg (mean recommended dose)	Fluvoxamine, Citalopram, Paroxetine Clomipramine Escitalopram Venalfaxine
Franklin 2011 21934055	Medication management (MM) + I-CBT	.	Psychoeducation, ERP/Exposure	Seven 45-minute sessions over 12 weeks	In person/clinic; MD/PhD Individual	Sertraline	Fluoxetine	Fluvoxamine, Citalopram, Paroxetine Clomipramine Escitalopram Venalfaxine
Franklin 2011 21934055	Medication management (MM)	.	.	Seven 35-minute sessions over 12 weeks	In person/clinic; MD Individual	Sertraline*, 109.1mg (9.2)	Fluoxetine*, 36.4mg (2.7)	Fluvoxamine*, 148.3mg (17.4); Citalopram*, 38.1mg (6.3); Paroxetine* 34.6mg (5.5); Clomipramine* 91.7mg (8.3); Escitalopram* 18.3mg (7.3); Venalfaxine* 100.0mg
Franklin 2023	Psychological/behavioral intervention	TH-CBT	ERP/Exposure	6hours/day 5days/week	Virtual/home synchronous; MD/PhD Group and Individual family-focused	.	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Franklin 2023	Psychological/behavioral intervention	IP-CBT	ERP/Exposure	6hours/day 5days/week	In person/clinic; MD/PhD Group and Individual family-focused	.	.	.
Freeman 2008 18356758	Pharmacological intervention: supplement/complementary	Family-based relaxation treatment	Coping/relaxation	Twelve 90/60-minute sessions over 14 weeks	Virtual/home synchronous. MD Individual family-focused	.	.	.
Freeman 2008 18356758	Psychological/behavioral intervention	Family-based CBT	Psychoeducation, Cognitive restructuring, ERP/Exposure	Twelve 90/60-minute sessions over 14 weeks	Virtual/home synchronous. MD Individual family-focused	.	.	.
Freeman 2014 24759852	Complementary /Integrative therapies	FB-RT: Family-based Relaxation Treatment	Psychoeducation, Coping/relaxation	Twelve 60-minute sessions over 14 weeks	In person/clinic, PhD Individual family-focused	.	.	.
Freeman 2014 24759852	Psychological/behavioral intervention	EX/RP: exposure plus response prevention	Psychoeducation, Cognitive restructuring, Coping/relaxation, ERP/Exposure	Twelve 60-minute sessions over 14 weeks	In person/clinic, PhD Individual family-focused	.	.	.
Geller 2001 11437015	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Fluoxetine	.	.	.	Fluoxetine, 10mg and after 2 weeks 20mg daily, 13 weeks		.
Geller 2001 11437015	Placebo/no treatment	.	.	.	.	.	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Geller 2003 12880497	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Paroxetine	.	.	.	Paroxetine, phase 1, 10-60 mg/day, started at 10mg/day; titrated up in 10mg increments ≤ once a week. dose ≤ 40 mg/day until after week 6, unless clinically indicated. The maximum daily dose allowed was 60mg/day., once daily, 16 weeks	Paroxetine, phase 2, final dose from Phase 1 once daily, subsequent 16 weeks	.
Geller 2003 12880497	Placebo/no treatment	.	.	.	.	Paroxetine, phase 1, 10-60mg/day, started at 10mg/day; titrated up in 10mg increments ≤ once a week. dose ≤ 40 mg/day until after week 6, unless clinically indicated. The maximum daily dose allowed was 60mg/day., once daily, 16 weeks	Placebo, phase 2 Dose tapering of patients randomized to placebo was achieved in a blind fashion such that decreases occurred in 10mg increments per week, beginning at the start of Phase II, once daily, subsequent 16 weeks	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Geller 2004 15502598	Paroxetine	.	.	.	.	Paroxetine, 10-50mg/day (for the first week patient received 10 mg/day), upward in 10-mg/day increments, no more frequently than every 7 days, to a maximal dose of 50 mg/day., Once daily, 10weeks	.	.
Geller 2004 15502598	Placebo	.	.	.	.	.	.	.
Ghanizadeh 2017 28659986	Pharmacologic (citalopram + placebo)	.	.	.	.	Placebo	Citalopram, 20 to 40 mg daily, 10 weeks	.
Ghanizadeh 2017 28659986	Pharmacologic (N-Acetylcystein) (NAC) + citalopram	.	.	.	.	N-Acetylcystein (NAC), 2400mg, during the first week 600 mg/day, increasing to 1200 mg/day in two divided doses in the second week. The patients were administered 1800 mg/day during weeks 4 and 5. The daily dose for NAC from week 6 to the end of this trial was 2400 mg/day, daily, 10 weeks	Citalopram, 20 to 40 mg daily, 10 weeks	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Grant 2014 24356715	Pharmacological intervention: other	Riluzole	.	.	.	One capsule 10mg daily, then dose was increased daily by one capsule until maximum dose of 100mg/day (five 10-mg capsules twice daily), 12 weeks	.	Antipsychotic, NR Stimulant, NR Alpha agonist Anti-seizure
Grant 2014 24356715	Placebo/no treatment	.	.	.	.	.	.	.
Guo, 2008	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Sertraline	.	.	.	Sertraline, 50 mg/day, increased to 100-150 mg/day, once in the morning, 8 weeks	.	.
Guo, 2008	Pharmacological intervention: Tricyclic antidepressants (TCA)	Clomipramine	.	.	.	Clomipramine, 50 mg/day, increased to 150-250 mg/day, divided into 2 times, 8 weeks	.	.
He, 2007	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Fluvoxamine	.	.	.	Fluvoxamine, 25 mg/day, increased to 100-200 mg/day, 8 weeks	.	.
He, 2007	Pharmacological intervention: Tricyclic antidepressants (TCA)	Clomipramine	.	.	.	Clomipramine, 25 mg/day, increased to 100-175 mg/day, 8 weeks	.	.
Hollmann 2022 36329915	Psychological/behavioral intervention	CBT	Cognitive restructuring, ERP/Exposure	Fourteen 90-minute sessions over 14 weeks	Virtual/home synchronous, MD/PhD Individual family-focused	.	.	.
Hollmann 2022 36329915	Placebo/no treatment	Waitlist	.	.	.	.	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Lenhard 2017 27993223	Psychological/behavioral intervention	Internet-based CBT	Psychoeducation, ERP/Exposure	Twelve sessions over 12 weeks	Virtual/home asynchronous, MD/PhD Individual family-focused	.	.	.
Lenhard 2017 27993223	Placebo/no treatment	Waitlist control	.	.	.	.	.	.
Leonard 1989 2686576	Pharmacological intervention: Tricyclic antidepressants (TCA)	Clomipramine	.	.	.	Clomipramine, targeting 3 mg/kg as tolerated, 25 mg (≤25 kg) or 50 mg (>25 kg) and increased by one capsule each week. The maximum dosage did not exceed 250 mg/d or 5 mg/kg, 5 weeks	.	.
Leonard 1989 2686576	Pharmacological intervention: Tricyclic antidepressants (TCA)	Desipramine	.	.	.	Desipramine, targeting 3 mg/kg as tolerated, 25 mg (≤25 kg) or 50 mg (>25 kg) and increased by one capsule each week. The maximum dosage did not exceed 250 mg/d or 5 mg/kg, 5 weeks	.	.
Leonard 1989 2686576	Pharmacological intervention: Tricyclic antidepressants (TCA)	Follow up study: clomipramine only	.	.	.	Clomipramine, daily dose did not exceed either 250 mg or 5 mg/kg., kept constant from part 1 8 months	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Leonard 1989 2686576	Pharmacological intervention: Tricyclic antidepressants (TCA)	Follow up study: clomipramine then desipramine then clomipramine	.	.	.	Clomipramine, daily dose did not exceed either 250 mg or 5 mg/kg., kept constant from part 1 Months 1-3 and 6-8	Desipramine, daily dose did not exceed either 250 mg or 5 mg/kg., kept constant from part 1 Months 4-7	.
Lewin 2014 24657310	Placebo/no treatment	TAU	Unspecified TAU	NR	NR NR	.	.	.
Lewin 2014 24657310	Psychological/ behavioral intervention	E/RP	Psychoeducation, ERP/Exposure, manual: Freeman & Garcia, 2009	Twelve 60-minute sessions over 6 weeks	In person/clinic; MD Individual family-focused	.	.	.
Li 2020 31800306	Pharmacological intervention: supplement/complementary	N-acetylcysteine (NAC)	.	.	.	N-acetylcysteine (NAC), 2700mg, week1: 900mg/d, week2: 1800mg/d, week3-12: 2700mg/d, daily, 12 weeks	.	.
Li 2020 31800306	Placebo/no treatment	.	.	.	.	.	.	.
Liebowitz 2002 12447029	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Fluoxetine - first entrance	.	.	.	Fluoxetine, 20mg, week 1-2, daily, 2 weeks	Fluoxetine, 40 mg, 3-4, daily, 2 weeks	Fluoxetine, 60 mg, 5-6 daily, 2 weeks; Fluoxetine, 80mg, 7-8, daily, 2weeks
Liebowitz 2002 12447029	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Fluoxetine - Maintenance	.	.	.	Fluvoxamine	.	.
Liebowitz 2002 12447029	Placebo/no treatment	First entrance	.	.	.	.	.	.
Liebowitz 2002 12447029	Placebo/no treatment	Maintenance	.	.	.	.	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Liu, 2012	Pharmacological intervention: combination of drugs	Fluvoxamine with risperidone	.	.	.	Fluvoxamine, 50mg/tablet, starting dose 25 mg/day, maximum dose 200mg/day	Risperidone, 1mg/tablet, starting dose 1mg/day, maximum dose 3mg/day	.
Liu, 2012	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Fluvoxamine alone	.	.	.	Fluvoxamine	.	.
Ma, 2014	Psychological/behavioral intervention + Pharmacological intervention	.	ERP/Exposure	60–90-minute sessions 2/week	In person/clinic; NR Individual	.	.	.
Ma, 2014	Pharmacological intervention: Serotonin and norepinephrine reuptake inhibitors (SNRIs)	Sertraline	.	.	.	Sertraline, 12.5-200 mg/day, dose adjusted within 2 weeks, gradually increased, maximum 200 mg/day, daily, NR	.	.
March 1990 19630661	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Clomipramine	.	.	.	Clomipramine, 75-200mg, 3.5 mg/kg, daily, 8 weeks	.	.
March 1990 19630661	Placebo/no treatment	.	.	.	.	.	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
March 1998 9842950	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Sertraline	.	.	.	Sertraline, mean 167mg/day children/180mg/day adolescents, starting 25mg/day children and 50mg/day adolescents; titrated up 50mg/week over 4 weeks to a max of 200mg/day as tolerated, daily, 12 weeks	.	.
March 1998 9842950	Placebo/no treatment	Placebo	.	.	.	.	.	.
Mataix-Cols 2014 24262813	Psychological/behavioral intervention + Pharmacological intervention	CBT + post-session DCS	Psychoeducation, ERP/Exposure	Fourteen sessions over 17 weeks	In person/clinic; NR Individual	D-cycloserine, 50 mg Immediately after each of the ten ERP sessions, 10 weeks	.	.
Mataix-Cols 2014 24262813	Psychological/behavioral intervention	CBT + Placebo	Psychoeducation, ERP/Exposure	Fourteen sessions over 17 weeks	NR Individual	Placebo, immediately after each of ten (CBT) sessions, ERP, 10weeks	.	.
Merlo 2010 19675960	Psychological/behavioral intervention	CBT + Motivational interviewing	General CBT/not specified	Three 20–30-minute sessions over 3 weeks	In person/clinic, MD/PhD NR	.	.	.
Merlo 2010 19675960	Psychological/behavioral intervention	CBT + psychoeducation	Psychoeducation, General CBT/not specified	Three 20–30-minute sessions over 3 weeks	NR, MD/PhD Family-focused	.	.	.
Nai 2009	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Sertraline	.	.	.	Sertraline, 50 mg/day, increased to 100-150 mg/day, once in the morning, 2 weeks	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Nai 2009	Pharmacological intervention: Tricyclic antidepressants (TCA)	Clomipramine	.	.	.	Clomipramine, 50 mg/day within 2 weeks, 150~250mg/day divided into 2 times for 8 weeks	.	.
Nasiry 2020	Psychological/behavioral intervention	Cognitive Bias Modification of Interpretation (CBMI)	General CBT/not specified, manual: Cognitive Bias Modification of Interpretation (CBMI)	NR	Virtual/home synchronous, MD Individual	.	.	.
Nasiry 2020	Placebo/no treatment	.	.	.	.	.	.	.
NCT01933919	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Fluvoxamine	.	.	.	Fluvoxamine, 25mg once a day, week 1 then increased 25 mg/day/week up to a max of 150 mg	.	.
NCT01933919	Placebo/no treatment	.	.	.	.	.	.	.
Neziroglu 2000 11191690	Psychological/behavioral intervention + Pharmacological intervention	Fluvoxamine + ERP	ERP/Exposure	Twenty 90-minute sessions weekly over 20 weeks	In person/clinic, MD/PhD Individual	Fluvoxamine, 50mg daily, 52 weeks	.	.
Neziroglu 2000 11191690	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Fluvoxamine	.	.	.	Fluvoxamine, 50mg daily, 52 weeks	.	.
Noras 2022 35748547	Pharmacological intervention: other	Fluvoxamine + placebo syrup	.	.	.	Fluvoxamine, NR	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Noras 2022 35748547	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Fluvoxamine + herbal supplement (E. amoenum - M. officinalis)	.	.	.	Fluvoxamine, NR	.	.
Peris 2013 22548378	Psychological/behavioral intervention	Positive Family Interaction Therapy (PFIT)	Psychoeducation, Cognitive restructuring, ERP/Exposure, manual: Piacentini, Langley, & Roblek, 2007	Twelve 60-minute sessions over 14 weeks	In person/clinic; PhD Individual family-focused	.	.	.
Peris 2013 22548378	Psychological/behavioral intervention	Standard Treatment	Psychoeducation, Cognitive restructuring, ERP/Exposure, manual: Piacentini, Langley, & Roblek, 2007	Twelve 60-minute sessions over 14 weeks	In person/clinic; PhD Individual family-focused	.	.	.
Peris 2017 29173737	Psychological/behavioral intervention	Positive Family Interaction Therapy PFIT	Psychoeducation	Twelve 60-minute sessions over 12 weeks and 60-minute of family therapy every other week.	In person/clinic; PhD Individual family-focused	.	.	.
Peris 2017 29173737	Psychological/behavioral intervention	ST	Psychoeducation, Cognitive restructuring, ERP/Exposure	Twelve 90-minute sessions over 12 weeks	In person/clinic; PhD Individual family-focused	.	.	.
Piacentini 2011 22024003	Psychological/behavioral intervention	FCBT (family CBT)	Psychoeducation, ERP/Exposure	Twelve 90-minute sessions over 14 weeks	In person/clinic; PhD Individual family-focused	.	.	.
Piacentini 2011 22024003	Psychological/behavioral intervention	Psychoeducation/Relaxation Training (PRT)	Psychoeducation, Coping/relaxation	Twelve 90-minute sessions over 14 weeks	In person/clinic; PhD Individual family-focused	.	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
POTS Team 2004 15507582	CBT	.	Psychoeducation, Cognitive restructuring, ERP/Exposure, manual: March 1998	Fourteen 60-minute sessions over 12 weeks	In person/clinic; NR Individual	.	.	.
POTS Team 2004 15507582	Pacebo	.	General CBT/not specified	Nine 30 minutes sessions over 12 weeks	In person/clinic; MD Individual	.	.	.
POTS Team 2004 15507582	CBT+sertraline	.	Psychoeducation, Cognitive restructuring, ERP/Exposure, manual: March 1998	NR	In person/clinic; MD Individual	Sertraline, 20 mg/day to 200 mg/day, over 6 weeks, once a day	.	.
POTS Team 2004 15507582	Sertraline	.	General CBT/not specified	Nine 30 minutes sessions over 12 weeks	In person/clinic; MD Individual	Sertraline, 25 mg/day to 200 mg/day, over 6 weeks, once a day, 12 weeks	.	.
Rempel 2023 37048570	Psychological/behavioral intervention	App-based mindfulness meditation training	Psychoeducation, Cognitive restructuring, Coping/relaxation, manual: 7Mind	Sixteen 7–12 minutes sessions twice/week over 8 weeks	Virtual/home synchronous, MD Individual	.	.	.
Rempel 2023 37048570	Complementary /Integrative therapies	App-based audiobook	Coping/Relaxation	One hundred twelve sessions twice daily over 8 weeks	Virtual/home synchronous, MD Individual	.	.	.
Reynolds 2013 24060194	Psychological/behavioral intervention	Parent-enhanced CBT	General CBT/not specified	Fourteen sessions over 14 weeks	In person/clinic; MD/PhD Group	.	.	.
Reynolds 2013 24060194	Psychological/behavioral intervention	Individual CBT	General CBT/not specified	Fourteen sessions over 14 weeks	In person/clinic, MD/PhD Individual	.	.	.
Rezvan 2013 23413047	Psychological/behavioral intervention	Attachment-based therapy	Attachment-based therapy	Eight 60-minute sessions over 8 weeks	In person/clinic, MD Individual	.	.	.
Rezvan 2013 23413047	Placebo/no treatment	TAU	.	.	.	.	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Riddle 1992 1429406	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Fluoxetine	.	.	.	Fluoxetine, 20mg Daily, 8 weeks	.	.
Riddle 1992 1429406	Placebo/no treatment	.	.	.	.	.	.	.
Riddle 2001 11211371	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Fluvoxamine	.	.	.	Fluvoxamine, 25mg, 25mg at bedtime for 3 days, increased 25mg every 3-4 days until 200mg, 2 caps/day, weeks 4-10	.	.
Riddle 2001 11211371	Placebo/no treatment	.	.	.	.	.	.	.
Rosa-Alcázar 2017 27792972	Psychological/behavioral intervention	Cognitive-behavioral family-based treatment (CBFP)	Psychoeducation, Cognitive restructuring, Coping/relaxation, ERP/Exposure	Twelve 60-minute sessions over 12 weeks	In person/clinic, MD/PhD Individual family-focused	.	.	.
Rosa-Alcázar 2017 27792972	Psychological/behavioral intervention	Parent Training	Psychoeducation, ERP/Exposure	Twelve 60-minute sessions over 12 weeks	In person/clinic, MD/PhD Individual family-focused	.	.	.
Rosa-Alcázar 2019 31516500	Psychological/behavioral intervention	CBFT Parents and child	Psychoeducation, ERP/Exposure	Twelve 60-minute sessions over 12 weeks	In person/clinic, MD Individual family-focused	.	.	.
Rosa-Alcázar 2019 31516500	Psychological/behavioral intervention	CBFT Mother and child	Psychoeducation, ERP/Exposure	Twelve 60-minute sessions over 12 weeks	In person/clinic, MD Individual family-focused	.	.	.
Rosa-Alcázar 2019 31516500	Psychological/behavioral intervention	CBFT mother only	Psychoeducation, ERP/Exposure	Twelve 60-minute sessions over 12 weeks	In person/clinic, MD Individual	.	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Salemink 2015 25724385	CBM-I	Cognitive Bias Modification training of Interpretations (CBM-I)	Psychoeducation	Eight 30-minute sessions over 11 days	Virtual/home synchronous, NR Individual	.	.	.
Salemink 2015 25724385	Placebo/no treatment	.	.	.	.	.	.	.
Schuberth 2023	Psychological/behavioral intervention	CBT+ PMT (parent management training)	Psychoeducation, ERP/Exposure	Twelve 90-minute sessions over 12 weeks	In person/clinic; PhD Group family-focused	.	.	.
Schuberth 2023	Psychological/behavioral intervention	CBT	Psychoeducation	Twelve 90-minute sessions over 12 weeks	In person/clinic; PhD Group	.	.	.
Selles 2021 34079488	Psychological/behavioral intervention	Hospital-based CBT	Psychoeducation, Cognitive restructuring, ERP/Exposure	Seven 180-minute sessions biweekly over 12 weeks	In person/clinic; MD Individual	.	.	.
Selles 2021 34079488	Psychological/behavioral intervention	Home-based CBT	Psychoeducation, Coping/relaxation, ERP/Exposure	Seven 180-minute sessions biweekly over 12 weeks	Virtual/home synchronous, MD Individual	.	.	.
Shabani, 2019	Psychological/behavioral intervention + Pharmacological intervention	Acceptance and Commitment Therapy + SSRI	Psychoeducation, ACT/Acceptance and commitment, manual: Armstrong et al. (2013)	Ten 60-minute sessions over 10 weeks	In person/clinic, MD/PhD Group	Clomipramine, 25 mg, increasing every 3–4 days until maximum results were achieved with the fewest side effects	Fluoxetine 20 mg, increasing every 3–4 days until maximum results were achieved with the fewest side effects	Fluvoxamine 50 mg, increasing every 3–4 days until maximum results were achieved with the fewest side effects ; sertraline 50 mg, increasing every 3–4 days until maximum results were achieved with the fewest side effects

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Shabani, 2019	Psychological/behavioral intervention + Pharmacological intervention	Cognitive Behavioral Therapy + SSRI	Psychoeducation, Cognitive restructuring, ERP/Exposure	Twelve 60-minute sessions over 12 weeks	In person/clinic, MD/PhD Group	Clomipramine 25 mg, increasing every 3–4 days until maximum results were achieved with the fewest side effects	Fluoxetine 20 mg, increasing every 3–4 days until maximum results were achieved with the fewest side effects	Fluvoxamine 50 mg, increasing every 3–4 days until maximum results were achieved with the fewest side effects; 50 mg, increasing every 3–4 days until maximum results were achieved with the fewest side effects
Shabani, 2019	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	.	.	.	.	Clomipramine 25 mg, increasing every 3–4 days until maximum results were achieved with the fewest side effects	Fluoxetine 20 mg, increasing every 3–4 days until maximum results were achieved with the fewest side effects	Fluvoxamine 50 mg, increasing every 3–4 days until maximum results were achieved with the fewest side effects; sertraline 50 mg, increasing every 3–4 days until maximum results were achieved with the fewest side effects
Shen, 2020	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Escitalopram	.	.	.	Escitalopram, 10 mg per time, can increase up to 20 mg per time within 7~14 days, once a day, 6 weeks	.	.
Shen, 2020	Pharmacological intervention: Tricyclic antidepressants (TCA)	Clomipramine	.	.	.	Clomipramine, 25 mg per time, can increase up to 50 mg/day within 7~14 days, twice a day, 6 weeks	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Simons 2006 16785776	Psychological/behavioral intervention	Metacognitive Therapy	Metacognitive Therapy	Twenty sessions over 20 weeks	In person/clinic, MD/PhD Individual	.	.	.
Simons 2006 16785776	Psychological/behavioral intervention	ERP	ERP/Exposure	Twenty sessions over 20 weeks	NR, MD/PhD Individual	.	.	.
Skarphedinsson 2015 25239489	Psychological/behavioral intervention	CBT	Psychoeducation, Cognitive restructuring, ERP/Exposure, manual: March and Mulle as well as an adapted version by Piacentini]	Ten 90-minute sessions over 16 weeks	In person/clinic, NR Individual family-focused	.	.	.
Skarphedinsson 2015 25239489	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Sertraline	ERP/Exposure	.	.	Sertraline, 100mg - 200 mg, A starting dose of 25 mg per day was titrated up to 100 mg per day by week 4; if response was considered inadequate, the dose was increased gradually up to a maximum of 200 mg per day by week 8, 6 sessions, 16 weeks	.	.
Storch 2007 17420681	Psychological/behavioral intervention	Intensive CBT	General CBT/not specified	Fourteen 90-minute sessions	In person/clinic; MD Individual family-focused	.	.	.
Storch 2007 17420681	Psychological/behavioral intervention	Weekly CBT	General CBT/not specified	Fourteen 90-minute sessions	NR, MD Individual family-focused	.	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Storch 2010 20817153	Psychological/behavioral intervention + Pharmacological intervention	CBT+DCS	Psychoeducation, Cognitive restructuring, ERP/Exposure	Ten 60-minute sessions	In person/clinic, MD/PhD Individual	D-cycloserine, 0.7mg/kg. Children with weight 25–45kg took 25mg (0.56–1.0 mg/kg/day), between 46–90kg took 50mg (0.56–1.08mg/kg/day), NR, one hour before sessions 4–10, NR	.	.
Storch 2010 20817153	Psychological/behavioral intervention	CBT+ Placebo	Psychoeducation, Cognitive restructuring, ERP/Exposure	Ten 60-minute sessions	In person/clinic, MD/PhD Individual	Placebo, one hour before sessions 4–10	.	.
Storch 2011 21684018	Psychological/behavioral intervention	Web-camera CBT	Psychoeducation, Cognitive restructuring, ERP/Exposure	Fourteen 60–90-minute sessions over 12 weeks	Virtual/home synchronous, PhD Individual family-focused	.	.	.
Storch 2011 21684018	Placebo/no treatment	Waitlist	.	.	.	.	.	.
Storch 2013 24184429	Psychological/behavioral intervention + Pharmacological intervention	Regular Sertraline + CBT	Psychoeducation, Cognitive restructuring, ERP/Exposure, manual: the protocol used in POTS (POTS, 2004)	Fourteen 60-minute sessions over 14 weeks	In person/clinic; PhD Individual	Sertraline, 25 mg/d, from 25 mg/day to 200 mg/day over 9 weeks unless higher doses were not tolerated, after which the dosage was adjusted as a function of tolerability. Once daily dose, typically following breakfast, 18 weeks	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Storch 2013 24184429	Psychological/behavioral intervention + Pharmacological intervention	Slow Sertraline + CBT	Psychoeducation, Cognitive restructuring, ERP/Exposure, manual: the protocol used in POTS (POTS, 2004)	Fourteen 60-minute sessions over 14 weeks	In person/clinic; PhD Individual	Sertraline, 25 mg/day, as previously unless unable to tolerate higher doses, children remained on 25mg/day for the first two weeks, 50mg/day from weeks 3-4, 75mg/day for weeks 5-6, 100mg/day for week 7, 150mg/day for week 8, and 200mg/day for week 9 until the end of the study, once daily dose, typically following breakfast, 18 weeks	.	.
Storch 2013 24184429	Placebo/no treatment	Placebo + CBT	Psychoeducation, Cognitive restructuring, ERP/Exposure, manual: the protocol used in POTS (POTS, 2004)	Fourteen 60-minute sessions over 14 weeks	In person/clinic; PhD Individual	Placebo, 25 mg/day, 18 weeks	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Storch 2016 27367832	Psychological/behavioral intervention + Pharmacological intervention	D-Cycloserine Plus CBT	Psychoeducation, Cognitive restructuring, ERP/Exposure	Ten sessions weekly over 8 weeks	NR, PhD Individual family-focused	D-cycloserine, Children weighing 25 to 45 kg took 25 mg (approximately 0.56-1.0 mg/kg/d), and children weighing at least 46 kg took 50 mg provided in two 25-mg capsules (approximately 0.50-1.08 mg/kg/d) 1 hour before sessions 4 through 10	.	.
Storch 2016 27367832	Psychological/behavioral intervention	Placebo Plus CBT	Psychoeducation, Cognitive restructuring, ERP/Exposure	Approximately 10 sessions over 8 weeks	NR, PhD Individual family-focused	placebo	.	.
Tuerk, 2023	Psychological/behavioral intervention	CBT	General CBT/not specified	Twelve sessions over 12 weeks	In person/clinic, NR Individual	.	.	.
Tuerk, 2023	Psychological/behavioral intervention	ERP	ERP/Exposure	NR sessions over 12 weeks	Virtual/home asynchronous, NR Group	.	.	.
Turner 2014 25457928	Psychological/behavioral intervention	Telephone CBT	Psychoeducation, ERP/Exposure	Fourteen sessions over 17 weeks	Virtual/home synchronous, PhD Individual family-focused	.	.	.
Turner 2014 25457928	Psychological/behavioral intervention	CBT	Psychoeducation, ERP/Exposure	Fourteen sessions over 17 weeks	In person/clinic, PhD Individual family-focused	.	.	.
Williams 2010 19921305	Psychological/behavioral intervention	CBT	General CBT/not specified	Ten 60-minute sessions over 10 weeks	NR, MD/PhD NR	.	.	.
Williams 2010 19921305	Placebo/no treatment	.	.	.	.	.	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Wolters 2016	Psychological/behavioral intervention	CBT	Psychoeducation, Cognitive restructuring, ERP/Exposure, manual: Dutch treatment manual 'Bedwing je dwang' ('Control your OCD'; De Haan & Wolters, 2009)	Sixteen 45–60-minute sessions over 16 weeks	In person/clinic, MD/PhD Individual family-focused	.	.	.
Wolters 2016	Placebo/no treatment	An eight-week waitlist followed by CBT	.	.	.	.	.	.
Wolters 2021	Psychological/behavioral intervention	CBM-I + CBT	Psychoeducation, Cognitive restructuring, ERP/Exposure, manual: 'Control your OCD' (De Haan & Wolters, 2009; Wolters, de Haan, Hogendoorn, Boer, & Prins, 2016	Twelve 60–75-minute sessions over 16 weeks	In person/clinic, MD/PhD Individual	.	.	.
Wolters 2021	Psychological/behavioral intervention	Waitlist + CBT	.	.	.	.	.	.
Xie, 2020	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Escitalopram	.	.	.	Escitalopram, <12 years: 5mg/day, >12 years, 10 mg/day once a day, 6 weeks	.	.
Xie, 2020	Pharmacological intervention: Tricyclic antidepressants (TCA)	Clomipramine	.	.	.	Clomipramine, <12 years: 12.5 mg, 2 times a day >12 years, 25 mg of 2 times a day, 6 weeks	.	.

Study Year PMID	Arm Name	Arms Description	Treatment components	Sessions	Setting; provider type	Medication 1, dose, titration, frequency, duration	Medication 2, dose, titration, frequency, duration	Other Medications
Zhang, 2014	Psychological/behavioral intervention + Pharmacological intervention	CBT + Sertraline	Cognitive restructuring	Ten sessions biweekly over 12 weeks	In person/clinic, NR	Sertraline: average 138. 7 (56. 5) mg /day over 12 weeks	.	.
Zhang, 2014	Pharmacological intervention	Sertraline	.	.	.	Sertraline, initial dose 50 mg/day, increase up to 100 to 200 mg/day over 12 weeks over 12 weeks	.	.
Zhu, 2008	Pharmacological intervention: Selective serotonin reuptake inhibitors (SSRI)	Sertraline	.	.	.	Sertraline, 50 mg/ day, increased to 100-150 mg/day, once in the morning, 2 weeks	.	.
Zhu, 2008	Pharmacological intervention: Tricyclic antidepressants (TCA)	Clomipramine	.	.	.	Clomipramine, 50 mg/day within 2 weeks, 150~250mg/d divided into 2 times for 8 weeks	.	.

Abbreviations: App = Application; BW = Body weight; CBFT = Cognitive Behavioral Family-based Therapy; CBM-I = Cognitive Bias Modification training of Interpretation; CBT= Cognitive Behavioral Therapy; d = Day; DCS = D-cycloserine; E/RP, E-RP, ERP = Exposure and Response Prevention; GCBT = Group Cognitive Behavioral Therapy; iCBT, I-CBT = Internet-based Cognitive Behavioral Therapy; IP-CBT= In-person Cognitive Behavioral Therapy; max = Maximum; MD = Doctor of medicine; NR = Not reported; PhD = Doctor of philosophy; PMID = PubMed Identifier; POTS = Pediatric OCD Treatment Study; SSRI = Selective Serotonin Reuptake Inhibitor; ST = Standard Treatment; TAU = Treat as usual; TH-CBT= Telehealth-based Cognitive Behavior Therapy. *Mean actual dose for all groups.

Table C–2.3.1 Key Question 2: Sample Characteristics, Part 1

Study, Year, PMID	Age, mean (SD) [range]	Age at symptom onset, mean (SD) [range]	Male, N (%)	Race and ethnicity, N (%)	Other relevant SDH factors, N (%)	Duration of OCD, mean (SD) [range]
Alaghband-Rad, 2009, 19190958	.	.	17 (58.6)	.	.	.

Study, Year, PMID	Age, mean (SD) [range]	Age at symptom onset, mean (SD) [range]	Male, N (%)	Race and ethnicity, N (%)	Other relevant SDH factors, N (%)	Duration of OCD, mean (SD) [range]
Asbahr, 2005, 16239861	13.1 (2.54)	8.9 (2.92)	26 (65)	.	.	4.2 (2.44) years
Aspvall, 2021, 33974020	13.4 (2.6) [8-17]	9.3 (3.2) Onset OCD, (year) 11.75 (2.6)	29 (38.2)	.	Parent occupational status: Working 143 (94.1) Student 3 (2) On sick leave (3.9) Parent educational level: Primary school 2 (1.3) Secondary school 16 (10.5; College/university (<2y) 16 (10.5) College/university (>2y) 113 (74.3) Doctorate 5 (3.3)	.
Barrett, 2003, 12647571	11.21 [7-16]	.	14 (58.3)	.	.	.
Barrett, 2004, 14691360	11.9 (2.7)	.	38 (49.3)	.	.	.
Bolton, 2008, 17207457	13 [8-17]	.	14 (70)	.	.	22 months [8-60]
Bolton, 2011, 21644984	14.4 (2.1)	.	41 (42.7)	.	.	3.2 (2.7) years
Comer, 2017, 27869451	6.65 (1.3) [4-8]	.	13 (59.1)	White 20 (91.0) Biracial: 1 (4.5) Hispanic origin 1 (4.5)	.	>3months
de Haan, 1998, 9785713	13.7 (3.0) [9-19]	10.8 (3.2)	11 (50)	.	.	30.3 (30.7) months [7-144]
DeVeaugh-Geiss, 1992, 1537780	14.25	.	39 (65.0)	.	.	3.75 years
Farrell, 2013, 23722990	13.11 (3.33)	.	41	White 94% Asian 6%	.	.
Farrell, 2022, 35084071	11.95 (2.46) [7-17]	.	47	.	.	.
Fatori, 2018, 30025255	11.8 (3.2)	6.4 (2.75)	40 (48.2)	White 76 (91.6) Black or African American 1 (1.2) Asian 1 (1.2) Mixed 5 (6.0)	.	.
Flament, 1985, 3899048	14.5 (2.3) [10-18]	10.2 (3.9) [8-16]	14 (73.7)	.	.	4 years [1-10]

Study, Year, PMID	Age, mean (SD) [range]	Age at symptom onset, mean (SD) [range]	Male, N (%)	Race and ethnicity, N (%)	Other relevant SDH factors, N (%)	Duration of OCD, mean (SD) [range]
Franklin, 2011, 21934055	13.60 (2.77) [7-17]	.	58 (46.8)	White 115 (92.7) Black or African American 3 (2.4) Asian 2 (1.6) Mixed: 1 (0.8) Not reported: 3 (2.4) Hispanic origin 2 (1.6)	.	.
Franklin, 2023	14.19 (2.31) [7-17]	.	500 (38.88)	White 961 (74.73) Black or African American 20 (1.56) Asian 40 (3.11) Alaska Native 8 (0.62) Native Hawaiian and Other Pacific Islander 3 (0.23) Multiracial 29 (2.26) Other 1 (0.08) Hispanic origin 72 (5.60)	.	.
Freeman, 2008, 18356758	7.11 (1.26) [4-8]	4.99 (1.27)	18 (43)	White 34 (80) Asian 1 (2) Alaska Native 1 (2) Multiracial: 1 (2) Unknown: 6 (12) Hispanic origin 1 (2)	Married and living together 35 (83.3)	>3 months
Freeman, 2014, 24759852	7.2 (1.12)	5.08 (1.7)	60 (47.2)	White 114 (89.76) Black or African American 2 (1.57) Asian 3 (2.36) Mixed: 4 (3.15) NR 4 (3.15) Hispanic origin 6 (4.7)	.	.
Geller, 2001, 11437015	11.4 (2.9)	.	49 (47.6)	White 85.6% Black or African American 1.9% Asian 0.96% Other 3.8% Hispanic origin 6.7%	.	.
Geller, 2003, 12880497	11.7 (2.73) [6-18]	10 (3.15)	105 (54.4)	White 176 (91.2) Black or African American 3 (1.6) Asian 4 (2.1) Other 10 (5.2)	.	.

Study, Year, PMID	Age, mean (SD) [range]	Age at symptom onset, mean (SD) [range]	Male, N (%)	Race and ethnicity, N (%)	Other relevant SDH factors, N (%)	Duration of OCD, mean (SD) [range]
Geller, 2004, 15502598	11.3 (3.00) Children: 9.1 (1.49) Adolescents: 14.3 (1.62) [7-17]	7.5 (3.09)	117 (57.6)	White 179 (88.2) Black or African American 13 (6.4) Hispanic origin 11 (5.4)	.	4.2 (2.89) years
Ghanizadeh, 2017, 28659986	16.3 (3.2)	.	14 (48.3)	.	.	.
Grant, 2014, 24356715	14.5 (2.4) [7-17]	.	44 (73.3)	.	.	.
Guo, 2008,	15.1 (1.94) [12-18]	.	57.4%	Asian (100)	.	9.65 (7.92) months [1-36]
He, 2007,	13.9 (2.1) [8-16]	.	55	Asian (100)	.	10.7 (4.2) [6-22]
Hollmann, 2022, 36329915	13.2 (2.9) [7-18]	.	36 (60)	.	**Mother:** Undergraduate degree or higher, 35 (58.3) No academic degree, 22 (36.7) **Father:** Undergraduate degree or higher, 31 (51.7) No academic degree, 24 (40.0)	30.92 (30.8) months
Lenhard, 2017, 27993223	14.60 (1.71) [12-17]	10.55 (2.82)	21 (31)	.	Education: Primary 1%, High school 25%, College 4%, Vocational 4%, University 49%, Doctoral degree 1%, Other 13%	.
Leonard, 1989, 2686576	13.86 (2.87) [7-19]	10.23 (5.8) [5-16]	31 (63.3)	.	.	3.63 (2.74) years [1-10]
Lewin, 2014, 24657310	5.8 (1.6) [3-8]	.	22 (71)	White 27 (87) Black or African American 1 (6) Asian 1 (6) Latinx 4 (13)	Married 81% Both parents (same) 77% Both parents (different residence) 6.5% Lives with single parent (mom) 13% Lives with mom/stepdad 3%	.

Study, Year, PMID	Age, mean (SD) [range]	Age at symptom onset, mean (SD) [range]	Male, N (%)	Race and ethnicity, N (%)	Other relevant SDH factors, N (%)	Duration of OCD, mean (SD) [range]
Li, 2020, 31800306	11.9 (3.0) [8-17]	.	3 (27)	White 11 (100)	.	.
Liebowitz, 2002, 12447029	12.7 (2.7)	.	18 (41.8)	White 35 (81.4) Black or African American 3 (7.0) Asian 1 (2.0) Alaska Native 1 (2.0) Other 1 (2.0) Hispanic origin 2 (5.0)	.	.
Liu, 2012	15.3 (5.4) [7-18]	.	51	Asian (100)	.	2.65 (1.16) [8 months - 5 years]
Ma, 2014	11.58 (0.05)	90% of population: 10 years, 10% of population: <7 years	.	.	.	5.8 (0.2) months [3-24]
March, 1990, 19630661	15.0 (2.2) [10-17]	.	11 (69)	.	.	41.2 (29.4) months
March, 1998, 9842950	12.6 (NR) [6-17]	.	71 (52)	White 116 (85) Black or African American 6 (4.4) Asian 1 (0.7) Other 8 (5.8) Hispanic origin 6 (4.4)	.	3.8 years
Mataix-Cols, 2014, 24262813	14.95 (2.1)	.	14 (51.9)	.	.	.
Merlo, 2010, 19675960	13.3 (3.0)	.	10 (62.5)	White 13 (81.3) Hispanic 2 (12.5) Mixed 1 (6.3)	.	.
Nai, 2009	15.1 (1.9) [12-18]	.	57.8%	Asian 100%	.	9.65 (7.92) months [1-36]
Nasiry, 2020	9.46 (1.44) [7-12]	.	16 (45.7)	.	.	2.31 (1.49) years
NCT01933919	13.5 (2.74)	.	20 (54.1)	.	.	.
Neziroglu, 2000, 11191690	14.5 (2.4)	9.9 (11.7)	60%	.	.	.

Study, Year, PMID	Age, mean (SD) [range]	Age at symptom onset, mean (SD) [range]	Male, N (%)	Race and ethnicity, N (%)	Other relevant SDH factors, N (%)	Duration of OCD, mean (SD) [range]
Noras, 2022, 35748547	14.72 (1.43) [13-17]	.	21 (52)	.	Education: Father: HS: 16 (40) Bachelor's: 13 (37.5) Master's: 11 (27.5) Mother: HS: 22 (55) Bachelor's: 12 (30) Master's: 6 (15)	.
Peris, 2013, 22548378	12.35 (2.58)	.	11 (55)	White 12 (60) Black or African American 2 (10) Persian 3 (15) Hispanic origin Latino: 3 (15)	15 (75) came from homes with intact marriages	.
Peris, 2017, 29173737	13.12 (2.68)	.	57%	White 40 (65) Black or African American 2 (3) Asian 4 (7) Mixed racial/ethnic background 7% Iranian 5% Hispanic origin 8 (13)	.	.
Piacentini, 2011, 22024003	12.2 (2.5)	.	26 (36.6)	White 55 (77.5) Black or African American 2 (2.8) Asian 3 (4.2) Other 4 (5.6) Hispanic origin 7 (9.9)	Current Living Situation Both Biological Parents 73.2% Single Parent 18.3% Other 8.5%	.
POTS Team, 2004, 15507582	11.7 (2.7)		56 (50.0)	White 103 (92) Black or African American 4 (4) Asian 11 (1) Native Hawaiian and Other Pacific Islander 3 (3)	.	.
Rempel, 2023, 37048570	15.3 (2.1) [10-20]	.	25 (43.1)	.	.	.
Reynolds, 2013, 24060194	14.5 (1.5)	.	.	.	.	.
Rezvan, 2013, 23413047	[10-12]	10.3 years [7.5-12.5]	0 (0)	.	.	.
Riddle, 1992, 1429406	11.8 (2.3)	.	6 (42.9)	.	.	.
Riddle, 2001, 11211371	12.9 (NR)	.	53.3%	White (95.8)	.	.
Rosa-Alcázar, 2019, 31516500	6.65 (0.74) [5.2-7.9]	.	33 (75)	White 44 (100)	.	0.65 (0.16) year

Study, Year, PMID	Age, mean (SD) [range]	Age at symptom onset, mean (SD) [range]	Male, N (%)	Race and ethnicity, N (%)	Other relevant SDH factors, N (%)	Duration of OCD, mean (SD) [range]
Salemink, 2015, 25724385	15.4 (2.3)	.	6 (37.5)	.	.	5.5 (3.6) years
Schuberth, 2023,	13.92 (2.57)	9.07 (3.01)	51 (43.6)	White 78 (66.7) Asian 13 (11.1) Mixed 10 (8.5) Hispanic origin 1 (0.9)	.	4.38 (2.74) years
Selles, 2021, 34079488	14.4 (2.7) [7-19]	10.0 (3.2)	14 (56)	White 15 (60) Asian 7 (28) Native Hawaiian and Other Pacific Islander 1 (4) Hispanic origin 2 (8)	Education: Father: ≤High school: 2 (8) college: 7 (28) Undergraduate: 10 (40) Advanced: 6 (24) Mother: ≤High school, 2 (8) college: 4 (16) Undergraduate: 11 (44) Advanced: 8 (32)	.
Shabani, 2019	14.96 (1.47)	12.42 (1.87)	38 (55.1)	.	.	.
Shen, 2020		.	75.7%	Asian 100%	.	.
Simons, 2006, 16785776	13.9 (3.1)	.	6 (60)	.	.	7.7 (11.2) months
Skarphedinsson, 2015, 25239489	14.0 (2.7)	.	24 (48)	At least one Scandinavian parent 49 (98)	Family status Biological parents living together 31 (62) divorced 19 (38) SES High 30 (62) Low 18 (37.5)	.
Storch, 2007, 17420681	13.3 (2.7)	.	18 (45)	White 37 (92.5) Native Hawaiian and Other Pacific Islander 3 (7.5)	Family income, mean $96,055 (49,855)	.
Storch, 2010, 20817153	12.2 (2.8) [8–17]	.	19 (63)	Ethnicity Caucasia 29 (97)	.	.
Storch, 2011, 21684018	11.10 (2.59) [7-16]	.	19 (61.3)	White 23 (74) Black or African American 1 (3) Asian 2 (6.5) Other 4 (13) Hispanic origin 1 (3)	.	.

Study, Year, PMID	Age, mean (SD) [range]	Age at symptom onset, mean (SD) [range]	Male, N (%)	Race and ethnicity, N (%)	Other relevant SDH factors, N (%)	Duration of OCD, mean (SD) [range]
Storch, 2013, 24184429	11.9 (3.5)	.	61.2%	.	.	.
Storch, 2016, 27367832	12.8 (5.04)	.	66 (46.5)	White 126 (88.7) Black or African American 5 (3.5) Asian 3 (2.1) Alaska Native 0 (0.0) Native Hawaiian and Other Pacific Islander 0 (0.0) Unknown 8 (5.6), More than one race 0 (0.0) Hispanic origin 22 (15.5)	.	.
Tuerk, 2023	12.7 (2.1)	.	12 (43)	White 18 (64) Black or African American 0 (0) Asian 3 (11) Native Hawaiian and Other Pacific Islander 2 (7) Multiracial 2 (7) Hispanic/Latino origin 0 (0)	.	.
Turner, 2014, 25457928	14.35 (2.13)	11.0 (3.37)	39 (54.2)	.	.	.
Williams, 2010, 19921305	13 (NR)	.	13 (61.9)	.	.	.
Wolters, 2016,	12.5 (2.6)	.	16 (39.0)	.	.	.
Wolters, 2021,	13.6 (2.9)	.	40 (54)	.	.	.
Xie, 2020	15.0 (1.3) [2-18]	.	(59.3)	Asian 100%	.	13.5 (2.0) months [5-20]
Zhang, 2014	16. 01 (1. 85) [12-18]	.	(57. 5)	Asian 100%	.	.
Zhu, 2008	15.3 (1.9) [12-18]	.	0	Asian 100%	.	9.0 (7.7) months [1-35]

Abbreviations: HS = High school; N = Sample size; OCD = Obsessive Compulsive Disorder; PMID = PubMed Identifier; POTS = Pediatric OCD Treatment Study; SD = Standard deviation; SDH = Social Determinant History

Table C–2.3.2 Key Question 2: Sample Characteristics, Part 2

Study, Year, PMID	CY-BOCS, mean (SD)	CGI-S, mean (SD)	Comorbidities; N%	Previous treatment, N%
Alaghband-Rad, 2009, 19190958	.	.	.	None of them had received previous treatment for OCD
Asbahr, 2005, 16239861	26.7 (5.8)	5.3 (0.8)	Anxiety 12 (30); Depression 7 (17.5); Bipolar spectrum disorders 1 (2.5); Tics/Tourette's 21 (52.5); ADHD 9 (22.5); ODD 6 (15)	.
Aspvall, 2021, 33974020	23 (3.7) Range: 16-33	.	Anxiety 7 (4.6); Depression 18 (11.8); Tics/Tourette's 14 (9.2); ADHD 10 (6.6);	CBT for OCD 15 (9.9), CBT for other 17 (11.2), Other 25 (16.4)
Barrett, 2003, 12647571	22.42	.		.
Barrett, 2004, 14691360	22.54 (5.31)	.	Anxiety 46 (59.7); Depression 6 (7.79)	.
Bolton, 2008, 17207457	.	.		.
Bolton, 2011, 21644984	22.7 (5.8)	.	Depression 8 (9.4); Tics/Tourette's 2 (2.1); ADHD 7 (8.3); ODD 12 (13.5)	.
Comer, 2017, 27869451	23.05 (3.7)	4.75 (0.8)	Anxiety 5 (22.7); 4 (18.2); 4 (18.2); Trauma /stressor related disorders 2 (9.1)	.
de Haan, 1998, 9785713	22.5 (6.6)	.	Anxiety 2 (9); Depression 1 (4.5); Tics/Tourette's1 (4.5)	Previous treatment (counseling) but no behavior therapy or drug therapy 8 (36.3)
DeVeaugh-Geiss, 1992, 1537780	.	.	.	.
Farrell, 2013, 23722990	.	.	Anxiety 8 (47.1); Depression 2 (11.7); ADHD 4 (23.5)	CBT 4 (24), CBT+SRI 13 (76)
Farrell, 2022, 35084071	27.3 (4.0)	.	.	.
Fatori, 2018, 30025255	.	.	Anxiety 65 (80.2); Depression 16 (19.8); Tics/Tourette's17 (21.)	Previous psychiatric treatment 27 (32.9), Previous psychotherapy 28 (34.1)
Flament, 1985, 3899048	.	.	.	Hospitalization: 8 (42.1); Psychotherapy: 13 (68.4); Behavioral therapy 5 (26.3); Medications 15 (78.9)
Franklin, 2011, 21934055 POTSII	26.29 (5.05)	4.93 (.90)	Anxiety/Mood 55 (44.4); Tics/Tourette's 19 (15.3); ADHD 27 (21.8); ODD: Externalizing 2 (1.6)	First SRI trial: 63/124 (50.8); One other past SRI trial: 36/124 (29); two past SRI trials: 11/124 (8.9); three past SRI trials: 8/124 (6.5); four past SRI trials: 3/124 (2.4); five past SRI trials: 2/124 (1.6) 61 (49.2)
Franklin, 2023	24.04 (5.15)	.	Anxiety 735 (57.15); Depression 604 (46.97); Trauma /stressor related disorders 47 (3.65)	.
Freeman, 2008, 18356758	22.4 [11-32]	3.96 (0.95)	Anxiety 23 (54.8); Tics/Tourette's 4 (9.5); ADHD 8 (19)	Either medication and/or psychotherapy 7 (16)

Study, Year, PMID	CY-BOCS, mean (SD)	CGI-S, mean (SD)	Comorbidities; N%	Previous treatment, N%
Freeman, 2014, 24759852	25.55 (4.23)	4.69 (0.82)	Anxiety 59 (46.46); Depression 1 (0.79); Tics/Tourette's 29 (22.83)/14 (11.02); ADHD 18 (14.17); ODD 18 (14.17); ODD: Externalizing 31 (24.41)	.
Geller, 2001, 11437015	25.1 (5.0)	4.8 (2.4)	.	.
Geller, 2003, 12880497	9.75 (0.66)	.	Anxiety 44 (22.8); Depression 8 (4.1); Tics/Tourette's 22 (11.4); ADHD 26 (13.5); ODD 7 (3.6)	None 138 (71.5), psychotherapy 21 (10.9), pharmacotherapy 25 (13), psychotherapy + pharmacotherapy 9 (4.7)
Geller, 2004, 15502598	24.8 (5.01)	.	Anxiety 14 (6.9); ADHD 19 (9.4)	Psychotherapy 20 (9.8), Pharmacotherapy 25 (12.3), psychotherapy and pharmacotherapy 17 (8.4)
Ghanizadeh, 2017, 28659986	.	.	.	.
Grant, 2014, 24356715	28.2 (3.8)	.	Tics/Tourette's 28 (47); ASD/PDD 17 (28.3)	.
Guo, 2008	.	.	.	.
He, 2007	.	.	.	.
Hollmann, 2022, 36329915	24.6 (2.4)	5.0 (0.46)	Anxiety 12 (20); Depression 7 (11.7); Tics/Tourette's 6 (10); ASD/PDD 1 (1.67); ADHD 10 (16.7)	Any 31 (51.7)
Lenhard, 2017, 27993223	22.55 (4.10)	.	Anxiety 13% Panic anxiety disorder 7%; Social anxiety disorder 9%; Depression 7%; Tics/Tourette's 6%; Trauma /stressor related disorders 1%; ADHD 9%	CBT 1 (1.5), general counseling 25 (37.3)
Leonard, 1989, 2686576	.	.	.	Psychotherapy 37 (75.5), behavioral therapy 3 (6.1), antidepressants 19 (38.8), neuroleptic 8 (16.3), anxiolytic 4 (8.2), hospitalized 13 (26.5)
Lewin, 2014, 24657310	24.49 (5.74)	3.88 (0.77)	Anxiety 22 (71); ADHD 13 (42); ODD 11 (35)	.
Li, 2020, 31800306	.	.	Anxiety 1 (9); Depression 1 (9); Bipolar spectrum disorders 3 (2); Tics/Tourette's 3 (27)	.
Liebowitz, 2002, 12447029	.	.	Anxiety 19 (44.2); Depression 9 (20.9); ADHD 3 (0.07); ODD 4 (0.09)	.
Liu, 2012	.	.	.	.
Ma, 2014	.	.	.	.
March, 1990, 19630661	.	.	.	.
March, 1998, 9842950	22.79 (NR)	4.7 (NR)	Anxiety 7 (3.7); Depression 4 (2.1); Tics/Tourette's 8 (4.3); ADHD 9 (4.8)	.
Mataix-Cols, 2014, 24262813	25.65 (3.6)	.	Anxiety 3 (11.1); Depression 1 (3.7); Tics/Tourette's 3 (11.1); ADHD 1 (3.7)	.

Study, Year, PMID	CY-BOCS, mean (SD)	CGI-S, mean (SD)	Comorbidities; N%	Previous treatment, N%
Merlo, 2010, 19675960	.	.	.	.
Nai, 2009	.	.	.	.
Nasiry, 2020	.	.	.	.
NCT01933919	26.2 (5.69)	.	.	.
Neziroglu, 2000, 11191690	25.4 (5.7)	5.3 (0.5)	.	.
Noras, 2022, 35748547	.	.	.	.
Peris, 2013, 22548378	25.45 (3.53)	5.45 (0.69)	.	.
Peris, 2017, 29173737	25.48 (3.51)	5.28 (0.80)	Anxiety 28 (45); Depression 9 (15); Tics/Tourette's 7 (12); ASD/PDD 3 (5); ADHD 14 (22); ODD/CD 6 (10)	At baseline, SSRIs 23%, stimulants 2%
Piacentini, 2011, 22024003	.	.	Anxiety 33 (46.5); Depression 3 (4.2); Tics/Tourette's 8 (11.3); ADHD 9 (13.9); ODD 3 (4.2)	Any Psychiatric 25.4%, SSRI/SRI 21.1%, Stimulant 7.0%, Other 3.7%
POTS Team, 2004, 15507582	24.6 (4.1)	4.8 (0.72)	Anxiety 70 (63); Tics/Tourette's 18 (16); ADHD 30 (27)	.
Rempel, 2023, 37048570	17.41 (0.88)	.	.	.
Reynolds, 2013, 24060194	.	.	Anxiety 33 (66%); Trauma /stressor related disorders 3 (6%)	.
Rezvan, 2013, 23413047	29.5 (3.0)	.	.	.
Riddle, 1992, 1429406	.	.	Anxiety 3 (21.0); Depression 2 (14.2); ADHD 1 (7.1)	.
Riddle, 2001, 11211371	.	.	.	Psychotherapy 40 (33.3), OCD medication 38 (31.7), Other medication 4 (3.3)
Rosa-Alcázar, 2019, 31516500	22.7 (3.95)	.	Anxiety 8 (18.2); Depression 2 (4.5); Trauma /stressor related disorders 16 (36.4)	.
Salemink, 2015, 25724385	22.4 (6.6)	.	.	.
Schuberth, 2023	.	.	Anxiety 25 (25.8); Depression 3 (3.1); Tics/Tourette's 18 (18.6); ASD/PDD 1 (1.0); ADHD 22 (22.7); ODD 4 (4.1)	Any OCD treatment 71 (78.9); CBT with ERP 17 (18.9); Medication(s) for OCD 58 (64.4)
Selles, 2021, 34079488	.	.	Anxiety 10 (39); 1 (4); Depression 1 (4); Tics/Tourette's3 (12); ASD/PDD 1 (4); Trauma /stressor related disorders 1 (4); ADHD 5 (19); Social phobia 3 (12); Panic disorder 1 (4)	Prior psychosocial treatment for OCD 15 (60); SRIs 9 (36)
Shabani, 2019	24.33 (4.15)	.	.	.
Shen, 2020	.	.	.	.

Study, Year, PMID	CY-BOCS, mean (SD)	CGI-S, mean (SD)	Comorbidities; N%	Previous treatment, N%
Simons, 2006, 16785776	22.0 (7.9)	.	.	.
Skarphedinsson, 2015, 25239489	26.4 (5.6)	.	Anxiety 12 (24); Depression 3 (6); Tics/Tourette's 12 (24); ADHD 7 (14); ODD 1 (2)	.
Storch, 2007, 17420681	.	.	Anxiety 11 (27.5); Depression 7 (17.5); Tics/Tourette's 5 (12.5); ADHD 12 (30)	Medication alone 9 (22.5), Psychotherapy alone 2 (5.0), Medication and psychotherapy 18 (45.0)
Storch, 2010, 20817153	25.1 (4.1)	4.9 (0.8)	Anxiety 5 (16.7); Depression 3 (10); Tics/Tourette's 3 (10); ADHD 14 (46.7); ODD 4 (13.3)	SSRI 9 (30), Atomoxetine 2 (6.7), Alpha-2 adrenergic agonist 2 (6.7), TCA 1 (3.3), SNRI 1 (3.3), Stimulant 1 (3.3)
Storch, 2011, 21684018	23.3 (3.2)	3.24 (0.9)	.	Prior CBT 12 (38.7), supportive psychotherapy 7 (22.6)
Storch, 2013, 24184429	25.1 (4.7)	.	Tics/Tourette's 11 (23.4); Trauma /stressor related disorders: Internalizing 24 (51.1), Externalizing 10 (21.3)	.
Storch, 2016, 27367832	24.36 (5.41)	3.55 (3.3, 3.8)	Anxiety 41 (28.87); Depression 21 (14.79); ADHD 37 (26.1)	SSRI 42 (29.58), Atypical antipsychotic 3 (2.1), Stimulant 7 (4.9)
Tuerk	23.68 (4.61)	.	Tics/Tourette's 9 (32)	.
Turner, 2014, 25457928	24.88 (3.94)	.	Anxiety 39 (54.2); Depression 7 (9.7); Tics/Tourette's 6 (8.3); ADHD 1 (1.4); ODD 1 (1.4)	Previous CBT Treatment, 21 (29.17)
Williams, 2010, 19921305	.	.	Anxiety 8 (38.1); ADHD 2 (9.5)	.
Wolters, 2016	24.2 (3.8)	.	Anxiety 24 (58.5); Depression 8 (19.5); ADHD 6 (14.6)	.
Wolters, 2021	25.1 (5.6)	.	Anxiety 54 (73); Depression 53 (72); ADHD 14 (19)	.
Xie, 2020	.	.	.	.
Zhang, 2014	.	.	.	.
Zhu, 2008	.	.	.	.

Abbreviations: ADHD = Attention-deficit/Hyperactivity Disorder; ASD = Autism spectrum disorder; CBT= Cognitive behavioral Therapy; CD = Conduct Disorder; CGI-S = Clinical Global Impression-Severity; CY-BOCS = Children's Yale-Brown Obsessive Compulsive Scale; ERP = Exposure and Response Prevention; OCD = Obsessive Compulsive Disorder; ODD = Oppositional-defiant Disorder; PDD =Pervasive Developmental Disorder; PMID = PubMed Identifier; POTS = Pediatric OCD Treatment Study; SD = Standard deviation; SNRI = Serotonin Norepinephrine Reuptake Inhibitor; SRI = Serotonin Reuptake Inhibitor; SSRI = Selective Serotonin Reuptake Inhibitor; TCA = Tricyclic antidepressant.

Appendix D. Results: Risk of Bias and Assessment of Methodological Quality

Risk of Bias Assessments

Table D–1.1. KQ 1. Risk of Bias for Brief Assessment Tools

Study	Was a consecutive or random sample of patients enrolled?	Was a case-control design avoided?	Did the study avoid inappropriate exclusions?	Were the index test results interpreted without knowledge of the results of the reference standard?	If a threshold was used, was it prespecified?	Is the reference standard likely to correctly classify the target condition?	Were the reference standard results interpreted without knowledge of the results of the index test?	Did all patients receive a reference standard?	Did all patients receive the same reference standard?	Were all patients included in the analysis?	Overall rating
Abramovitch, 2022, 35697331	Unclear	No	Yes	Unclear	No	Yes	Yes	Yes	Yes	Yes	Moderate
Abramovitch, 2022, 35091252	Unclear	No	Yes	Unclear	No	Yes	Yes	Yes	Yes	Yes	Moderate
Andersen, 2012, 23171745	Yes	No	Yes	Unclear	No	Unclear	Yes	Yes	Yes	Yes	Moderate
Bamber, 2002, 12364847	No	No	Unclear	Unclear	No	Unclear	Unclear	No	No	No	High
Battle, 2013,	Unclear	No	Unclear	Unclear	Unclear	Yes	Unclear	Yes	Yes	Yes	Moderate
Hudziak, 2006, 16423147	No	No	Yes	Unclear	No	Yes	Unclear	Yes	Yes	Yes	Moderate
Ivarsson, 2008, 18280696	Unclear	No	Yes	Unclear	No	Yes	Yes	Yes	No	Yes	High
Lambe, 2021, 37431399	No	No	Yes	Unclear	No	Yes	Yes	Yes	Yes	Yes	Moderate
Piqueras, 2017, 27283942	No	No	Unclear	Unclear	No	Yes	Yes	No	No	Yes	High
Piqueras, 2015, 27703719	No	No	Unclear	Unclear	No	Yes	Yes	Yes	No	Yes	High
Rough, 2020, 32030629	Yes	No	Yes	Unclear	No	Yes	Yes	Yes	No	Yes	High

Study	Was a consecutive or random sample of patients enrolled?	Was a case-control design avoided?	Did the study avoid inappropriate exclusions?	Were the index test results interpreted without knowledge of the results of the reference standard?	If a threshold was used, was it prespecified?	Is the reference standard likely to correctly classify the target condition?	Were the reference standard results interpreted without knowledge of the results of the index test?	Did all patients receive a reference standard?	Did all patients receive the same reference standard?	Were all patients included in the analysis?	Overall rating
Saad, 2017, 28151703	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Low
Sattler, 2018, 2019-05127-008	No	No	Yes	Yes	No	Yes	Yes	Yes	No	Yes	High
Shafran, 2003, 12550826	No	No	Yes	Unclear	Unclear	Yes	Yes	Yes	No	Yes	High
Skarphedinsson, 2021, 34293000	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Moderate
Stewart, 2005, 16379516	No	No	Unclear	Yes	No	Yes	Yes	Yes	Yes	Yes	moderate
Storch, 2006, 16046257	No	No	Unclear	Yes	No	Yes	Yes	Yes	No	Yes	High
Storch, 2011, 21353458	No	No	Unclear	No	Yes	Yes	Yes	Yes	Yes	Yes	Moderate
Uher, 2007, 17906247	Yes	Yes	Unclear	Unclear	Unclear	Yes	Yes	Yes	Yes	Yes	Low
Whiteside, 2012, 22078243	Unclear	No	Yes	Unclear	No	Yes	Yes	Yes	Yes	Yes	Moderate
Zemestani, 2022, 33409771	No	No	No	Yes	No	Unclear	Yes	No	No	Yes	High
Zemestani, 2021, 2021-61128-001	No	No	Unclear	No	No	Yes	Yes	No	No	Yes	High

Table D–2.1. KQ 2. ROB RCTs

Study	Random sequence generation	Allocation concealment	Blinding of participants and personnel	Blinding of outcome assessor	Incomplete outcome data	Selective Reporting	Intention-to-treat-analysis	Interventions adequately described	Cohorts similar	Clear reporting with no discrepancies	Overall rating
Alaghband-Rad, 2009, 19190958	Unclear	Unclear	Unclear	Unclear	Low	Low	Unclear	Low	High	Low	Moderate
Asbahr, 2005, 16239861	Low	Unclear	High	Low	High	Low	High	Low	Low	Low	High
Aspvall, 2021, 33974020	Low	Unclear	High	Low	Low	Low	Low	Low	Low	Low	Low
Barrett, 2003, 12647571	Low	Low	Low	Low	Low	Low	Unclear	Low	Low	Low	Low
Barrett, 2004, 14691360	Low	Unclear	High	Low	High	Low	Low	Low	Unclear	Low	Moderate
Bolton, 2008, 17207457	Low	Low	High	Unclear	Low	Low	Low	Low	Low	Low	Moderate
Bolton, 2011, 21644984	Low	Unclear	High	Low	Low	Low	Low	Low	Low	Low	Low
Comer, 2017, 27869451	Low	Unclear	Low	Low	Low	Unclear	Low	Low	Low	Low	Low
de Haan, 1998, 9785713	Unclear	Unclear	High	High	Low	Low	Low	Low	Low	Low	High
DeVeaugh-Geiss, 1992, 1537780	Unclear	Unclear	Unclear	Unclear	Low	Low	Low	Low	Low	Low	Moderate
Farrell, 2013, 23722990	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low
Farrell, 2022, 35084071	Low	Low	Low	Low	Low	Unclear	Low	Low	Low	Low	Low
Fatori, 2018, 30025255	Low	Low	High	Low	Low	Low	Low	Low	Low	Low	Low
Flament, 1985, 3899048	Unclear	Unclear	Low	Low	High	Low	Low	Low	Unclear	High	High
Franklin, 2011, 21934055	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low
Freeman, 2008, 18356758	Unclear	Low	Low	Low	Unclear	Low	Low	Low	Low	Low	Low

Study	Random sequence generation	Allocation concealment	Blinding of participants and personnel	Blinding of outcome assessor	Incomplete outcome data	Selective Reporting	Intention-to-treat-analysis	Interventions adequately described	Cohorts similar	Clear reporting with no discrepancies	Overall rating
Freeman, 2014, 24759852	Low	Low	Low	Low	Unclear	Low	Low	Low	Low	Low	Low
Geller, 2001, 11437015	Unclear	Unclear	Low	Low	Low	Low	Low	Low	Low	Low	Low
Geller, 2003, 12880497	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low
Geller, 2004, 15502598	Low	Unclear	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Ghanizadeh, 2017, 28659986	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low
Grant, 2014, 24356715	Low	Low	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Guo, 2008	Unclear	Unclear	Unclear	Unclear	Low	Low	Low	Low	Low	Low	Moderate
He, 2007	Unclear	Unclear	Unclear	Unclear	Low	Low	Low	Low	Low	Low	Moderate
Hollmann, 2022, 36329915	Low	Low	Low	Unclear	Unclear	Low	Low	Low	Low	Low	Low
Lenhard, 2017, 27993223	Low	Low	High	Low	Low	Low	Low	Low	Low	Low	Low
Leonard, 1989, 2686576	Unclear	Unclear	Low	Low	Low	Low	Low	Low	Low	Unclear	Low
Lewin, 2014, 24657310	Low	Unclear	Low	Low	Unclear	Low	High	Low	Low	Low	Moderate
Li, 2020, 31800306	Low	Low	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Liebowitz, 2002, 12447029	Unclear	Unclear	Unclear	Low	Low	Low	Low	Low	Low	Low	Low
Liu, 2012	Low	Unclear	Unclear	Unclear	Low	Low	Low	Low	Low	Unclear	Low
Ma, 2014	Unclear	Unclear	Unclear	Unclear	Low	Low	Low	Low	Low	High	High
March, 1990, 19630661	Low	Unclear	Low	Low	Low	Low	Low	Low	Low	Low	Low
March, 1998, 9842950	Low	Low	Low	Low	Low	Low	Low	Low	Low	Unclear	Low

Study	Random sequence generation	Allocation concealment	Blinding of participants and personnel	Blinding of outcome assessor	Incomplete outcome data	Selective Reporting	Intention-to-treat-analysis	Interventions adequately described	Cohorts similar	Clear reporting with no discrepancies	Overall rating
Mataix-Cols, 2014, 24262813	Low	Unclear	Low	Low	Low	Low	Low	Low	Low	Low	Low
Merlo, 2010, 19675960	Unclear	Unclear	Unclear	Unclear	Low	Low	Unclear	Low	Unclear	Low	Moderate
Nai, 2009	Unclear	Unclear	Unclear	Unclear	Low	Low	Low	Low	Low	Low	Moderate
Nasiry, 2020,	Unclear	Unclear	Unclear	High	Low	Unclear	Unclear	Low	Low	Unclear	high
NCT01933919	Unclear	Unclear	Low	Unclear	Low	Low	Low	Low	Low	Low	low
Neziroglu, 2000, 11191690	Unclear	Unclear	High	Unclear	Low	Low	Low	Low	Unclear	Low	moderate
Noras, 2022, 35748547	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low	low
Peris, 2013, 22548378	Low	Unclear	Unclear	Low	Low	Low	Unclear	Low	Low	Low	low
Peris, 2017, 29173737	Low	Unclear	High	Low	Low	Low	Unclear	Low	Low	Low	moderate
Piacentini, 2011, 22024003	Low	Unclear	Unclear	Low	Low	Low	Low	Low	Low	Low	low
POTS Team, 2004, 15507582	Low	Low	Unclear	Low	Low	Low	Low	Low	Low	Low	low
Rempel, 2023, 37048570	Low	Low	Unclear	Low	Low	Low	Low	Low	High	Low	low
Reynolds, 2013, 24060194	Low	Low	High	Low	Low	Low	Low	Low	Low	Low	low
Rezvan, 2013, 23413047	Low	Unclear	Low	Low	Unclear	Unclear	Unclear	Low	Unclear	High	moderate
Riddle, 1992, 1429406	Unclear	Unclear	Low	Low	Low	Low	High	Low	Low	Low	moderate
Riddle, 2001, 11211371	Unclear	Unclear	Low	Low	Low	Low	Low	Low	Low	Low	moderate
Rosa-Alcázar, 2019, 31516500	Low	Low	Low	Low	Low	Unclear	Low	Low	Low	Low	low
Salemink, 2015, 25724385	Unclear	Unclear	Low	Low	Low	Low	Low	Low	Low	Low	low

Study	Random sequence generation	Allocation concealment	Blinding of participants and personnel	Blinding of outcome assessor	Incomplete outcome data	Selective Reporting	Intention-to-treat-analysis	Interventions adequately described	Cohorts similar	Clear reporting with no discrepancies	Overall rating
Selles, 2021, 34079488	Low	Low	Low	Low	Unclear	Unclear	Low	Low	Low	Low	low
Shabani, 2019,	Low	Low	High	Low	Low	Low	Low	Low	Low	Low	moderate
Shen, 2020	Low	Unclear	Unclear	Unclear	Low	Low	Low	Low	Low	High	moderate
Skarphedinsson, 2015, 25239489	Low	Unclear	High	High	High	Low	Low	Low	Low	Low	high
Storch, 2007, 17420681	Unclear	Unclear	High	Low	Low	Low	Low	Low	Low	Low	low
Storch, 2010, 20817153	Low	Unclear	Low	Low	Low	Low	Low	Low	Low	Low	low
Storch, 2011, 21684018	Low	Unclear	High	Low	High	Low	Low	Low	Low	Low	high
Storch, 2013, 24184429	Low	Unclear	Low	Low	Low	Low	Low	Low	Low	Low	low
Storch, 2016, 27367832	Low	Unclear	Low	Low	Low	High	Low	Low	Low	Low	low
Tuerk, 2023	Low	Low	High	Low	Low	Low	High	Low	Low	Low	moderate
Turner, 2014, 25457928	Low	Low	High	Low	Low	Low	Low	Low	Low	Low	low
Williams, 2010, 19921305	Low	Low	High	Low	Low	Low	Low	Low	Low	Low	low
Wolters, 2016	Low	Unclear	High	Unclear	Low	Low	Low	Low	Low	Low	moderate
Wolters, 2021	Low	Unclear	High	Low	Low	Low	Low	Low	Low	Low	low
Xie, 2020	Unclear	Low	Unclear	Unclear	Low	Low	Low	Low	Low	High	high
Zhang, 2014	Unclear	Unclear	Unclear	Unclear	Low	Low	Low	Low	Low	Unclear	moderate
Zhu, 2008	Unclear	Unclear	Unclear	Unclear	Low	Low	Low	Low	Low	Low	moderate

Table D–2.1. KQ 2: ROB NRCS

Study	Blinding of participants and personnel	Blinding of outcome assessor	Incomplete outcome data	Selective Reporting	Intention-to-treat-analysis	Appropriate analysis method used to control for potential confounding domains?	Cohorts similar	Clear reporting with no discrepancies	Overall RoB
Franklin, 2023	High	High	Unclear	Low	High	Low: Propensity score (regression or matching)	High	Low	High
Schuberth, 2023	High	Unclear	Low	Low	High	Low RoB: Propensity score (regression or matching)	High	Low	High

Appendix E. Results: Evidence Tables

Key Question 1

For the full extractions and results for Key Question 1, please see OCD_KQ1 appendix.xlsx. Below are the results for full diagnostic tools where they were evaluated specific cut-points to classify an individual as having OCD or a prediction algorithm or model to predict the probability of OCD.

Semi-Structured Diagnostic Interviews, OCD-Specific: CY-BOCS

Three eligible studies evaluated the diagnostic accuracy of various CY-BOCS thresholds, compared to a reference standard that included specialist diagnostic interviews. The CY-BOCS includes 10 items, that evaluate the severity of obsessions and compulsions across 5 dimensions: frequency, interference, distress, resistance, and control in children and adolescents, aged 6 to 17 years.{Scahill, 1997 #212} The scale ranges from 0 to 40, with higher values representing more severe disease. Two studies were case-control designs with OCD prevalence of 79% in Novara 2020 and 55% in Shabni 2019,{Novara, 2020 #25;Shabani, 2019 #54} and the other study only included children with OCD.{Stewart, 2005 #42} RoB was high for two{Shabani, 2019 #54;Stewart, 2005 #42} and moderate for the third.{Novara, 2020 #25} Results for each study are shown in Table 3.3.4. Because only two studies provided both sensitivity and specificity data, the studies were not meta-analyzed. The studies were consistent in that a CY-BOCS score >16 has a sensitivity of at least 75%, with 100% specificity in one study; sensitivity was near 100% with a score >17 in one study, but with a lower specificity (79%). Shabani 2019, reported that, in a cohort of 128 children (70 with OCD; 58 with another anxiety disorder), the AUC for the CY-BOCS was high at 0.93 (95% CI 0.88 to 0.97).{Shabani, 2019 #54}

Table E-1. Sensitivity and specificity for CY-BOCS

Study (N OCD/N Control) RoB	Cutoff	Sensitivity, % (95% CI)	Specificity, % (95% CI)
Novara 2020{Novara, 2020 #25} (53/14) moderate	16	75 (62, 86)	100 (77, 100)
Shabani 2019{Shabani, 2019 #54} (58/70) high	17	99 (92, 100)	79 (67, 89)
Stewart 2005{Stewart, 2005 #42} (79/NA) high	16	76 (65, 85)	NA

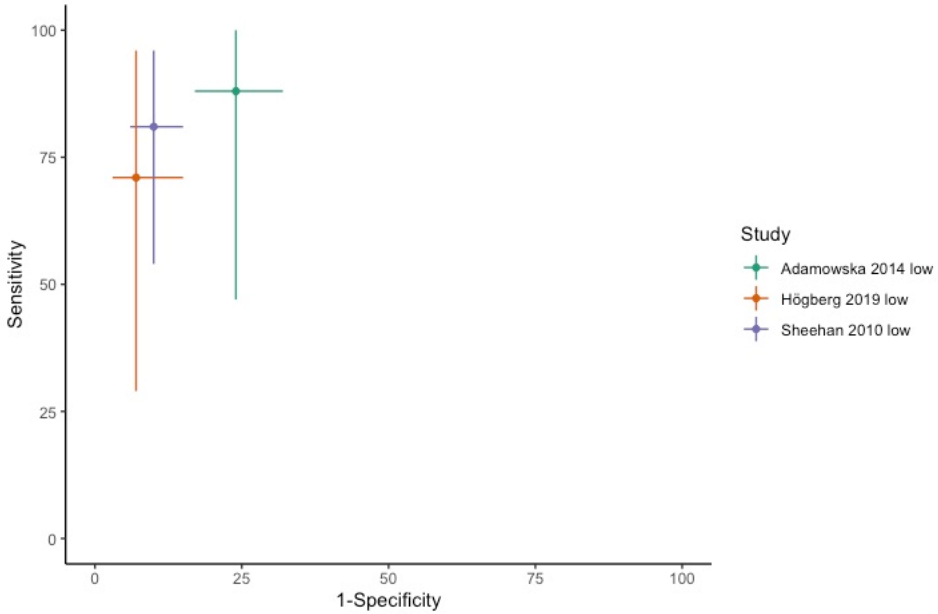
Abbreviations: CI = confidence interval; OCD = obsessive compulsive disorder; RoB = overall risk of bias for study

The shading differentiates studies but does not provide any unique meaning.

Semi-Structured Diagnostic Interviews, Not OCD-Specific

We found 5 studies that addressed the diagnostic accuracy of non-OCD specific semi-structured diagnostic interviews{Adamowska, 2014 #41;Fisher, 1993 #37;Högberg, 2019 #32;Krebs, 2012 #51;Sheehan, 2010 #38} in 807 children. None of these tools is specific to OCD, and only one was evaluated by more than one study. Three low-risk-of-bias studies evaluated the **MINI-KID**,{Adamowska, 2014 #41;Högberg, 2019 #32;Sheehan, 2010 #38} a structured clinical diagnostic interview for children 6 to 17 years old, in populations where all children were at risk for OCD, and 6% to 7% were found to have OCD. The sensitivities of the MINI-KID for these populations ranged from 71% to 88% and the specificities ranged from 76% to 93% (see Figure 3.3.5) when compared to a full clinical diagnosis based on the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Figure E-1. Sensitivity and specificity of the MINI-KID



Listed studies present the study author, year, and overall risk of bias rating. The dot represents the reported sensitivity/1-specificity, and the crosses indicate the 95% confidence interval.

The Development and Well-Being Assessment (**DABWA)** consists of a series of clinical interviews, which are designed to generate ICD-10 and DSM-IV or DSM-5 psychiatric diagnoses for subjects aged 2 to 65 years old. The performance of the DAWBA package was evaluated in a single low-risk-of bias study of 51 children (37 with OCD and 14 clinical controls). DABWA diagnosis, based on clinician rating or computer-generated diagnostic prediction, was compared to a consensus diagnosis.{Krebs, 2012 #51}

Sensitivity was somewhat higher with the clinician than the computer rating (84%, 95%CI 69% to 94% compared to 74%, 95%CI 57% to 87%), but specificity was somewhat lower (54%, 95%CI 25% to 81% compared to 62%, 95%CI 32% to 86%). Compared to consensus, both the computer and clinicians tended or over-predict which children had comorbid disorders: 79% of OCD participants were identified as having one or more comorbid disorders in the computer-rated group, compared to 58% in the clinician-rated group and 50% in the consensus group.

The **DISC-2.1** is a structured diagnostic instrument to assess common psychiatric diagnoses in children 6 to 17 years old. The study that evaluated DISC-2.1 was at high RoB due to using a case-control design and different reference standards for cases and controls The combination of parent and child report had the best sensitivity (88%; 95% CI 64 to 99),{Fisher, 1993 #37} when compared to diagnoses based on parent or child report alone.

Key question 2

Results tables for all studies included in KQ2 analyses are below. The full data are available in SRDR+.

RCTs Omitted from Meta-analyses Evaluating Novel Comparators

Table E-2. Randomized Controlled Trials Omitted from Meta-analyses

Study	N	Comparison	Details	CY-BOCS NMD	Std. Error
Rezvan, 2013	24	ABI vs. WL		-7.3	1.168
Bolton, 2011	60	briefERP vs. WL	5 sessions of ERP s vs. 12 sessions over 12 weeks	-8.1	2.056
Bolton, 2011	72	briefERP vs. ERP	5 sessions of ERP s vs. WL	3.8	1.845
Merlo, 2010	16	MI+ERP vs. ERP		-6.6	4.454
Rosa-Alcázar, 2019	44	ERP vs. parentTraining		-1.2	1.132
Salemink, 2015	16	CBM-I+ERP vs. ERP		-1.9	3.262
Selles, 2021		homeERP vs. ERP			
Storch, 2007	40	intensiveERP vs. ERP	Daily ERP for 3 weeks (14 session) vs. weekly ERP for 14 weeks	-3.8	2.240

Tuerk, 2023	28	App+ERP vs. ERP		-2.4	1.609
Wolters, 2021	79	CMB-I+ERP vs. ERP		0.1	17.695
Grant, 2014	60	riluzole vs. placebo		1.2	1.351
Li, 2020	11	NAC vs. placebo		-6.0	2.993
Ghanizadeh, 2017	29	NAC+SSRI vs. SSRI		-6.9	3.241
Shabani, 2019	44	ACT+SSRI vs. ERP+SSRI		1.2	1.199
Shabani, 2019	47	ACT+SSRI vs. SSRI		-3.3	1.080
Franklin, 2011	82	ERP+SSRI vs. iERP+SSRI		3.9	1.530
Franklin, 2011	84	iERP+SSRI vs. SSRI		-6.5	1.494

Children's Yale-Brown Obsessive Compulsive Scale Total (CY-BOCS)

Table E-3. Randomized Controlled Trials—(C)Y-BOCS

Study, Year, PMID	Treatment Contrast	N	Treatment Duration (wks)	CFB Treatment 1 (95% CI)	CFB Treatment 2 (95% CI)	NMD (95% CI)
Asbahr, 2005, 16239861	ERP vs. SSRI	40	12	-20.7 (-24.2, -17.2)	-20 (-23, -17.1)	-0.7 (-5.2, 3.9)
Aspvall, 2021, 33974020	Remote ERP vs. ERP	152	16	-10.3 (-11.5, -9.1)	-10.2 (-11.6, -8.8)	-0.1 (-1.9, 1.7)
Barrett, 2003, 12647571	ERP vs. Control	20	14	-15.7 (-19.9, -11.6)	1.2 (-2, 4.4)	**-17 (-22.2, -11.7)**
Barrett, 2004, 14691360	ERP vs. Control	75	14	-14 (-15.8, -12.3)	1.1 (-0.9, 3.1)	**-15.1 (-17.8, -12.5)**
Bolton, 2008, 17207457	ERP vs. Control	20	12	-10.6 (-13.2, -8)	-0.4 (-4.9, 4.1)	**-10.2 (-15.4, -5)**
Bolton, 2011, 21644984	briefERP vs. Control	60	12	-9 (-11.8, -6.2)	-0.9 (-3.8, 2)	**-8.1 (-12.1, -4.1)**
Bolton, 2011, 21644984	briefERP vs. ERP	72	12	-9 (-11.8, -6.2)	-12.8 (-15.1, -10.5)	3.8 (0.2, 7.4)
Bolton, 2011, 21644984	ERP vs. Control	60	12	-12.8 (-15.1, -10.5)	-0.9 (-3.8, 2)	**-11.9 (-15.6, -8.2)**
Comer, 2017, 27869451	Remote ERP vs. ERP	22	14	-8 (-11.7, -4.3)	-9 (-13, -5)	1 (-4.5, 6.5)

Study, Year, PMID	Treatment Contrast	N	Treatment Duration (wks)	CFB Treatment 1 (95% CI)	CFB Treatment 2 (95% CI)	NMD (95% CI)
DeVeaugh-Geiss, 1992, 1537780	TCA vs. Control	60	8	-10 (-12, -8)	-2.3 (-4.6, 0)	**-7.7 (-10.7, -4.7)**
Farrell, 2013, 23722990	DCS+ERP vs. ERP	17	9	-16.2 (-19.7, -12.7)	-15.1 (-19.9, -10.3)	-1.1 (-7.1, 4.9)
Farrell, 2022, 2022-28058-001 (PsycINFO)	DCS+ERP vs. ERP	100	12	-0.2 (-3, 2.6)	0.7 (-2.3, 3.7)	-0.9 (-4, 2.2)
Fatori, 2018, 30025255	ERP vs. SSRI	83	14	-11.7 (-14.2, -9.2)	-10.1 (-12.9, -7.3)	-1.6 (-5.3, 2.2)
Franklin, 2011, 21934055	ERP+SSRI vs. SSRI	82	12	-7.3 (-16.8, 2.1)	-4.7 (-13.6, 4.1)	-2.6 (-15.6, 10.3)
Freeman, 2008, 18356758	ERP vs. Control	42	14	-8.5 (-11.5, -5.5)	-4.6 (-7.5, -1.7)	-3.9 (-8, 0.2)
Freeman, 2014, 24759852	ERP vs. Control	127	14	-12.8 (-17.7, -8)	-6.3 (-11.2, -1.4)	-6.5 (-13.5, 0.4)
Geller, 2001, 11437015	SSRI vs. Control	103	13	-9.5 (-11.6, -7.4)	-5.2 (-7.8, -2.6)	**-4.3 (-7.6, -1)**
Geller, 2004, 15502598	SSRI vs. Control	203	10	-8.8 (-10.4, -7.2)	-5.3 (-6.8, -3.8)	**-3.4 (-5.6, -1.2)**
Ghanizadeh, 2017, 28659986	NAC+SSRI vs. SSRI	29	10	-9.7 (-13.1, -6.3)	-2.8 (-8.2, 2.6)	**-6.9 (-13.3, -0.5)**
Grant, 2014, 24356715	riluzole vs. Control	60	12	-5.5 (-7.4, -3.5)	-6.7 (-8.5, -4.9)	1.2 (-1.5, 3.8)
Guo, 2008, Guo-2008_SR-35121274 (From SRs)	TCA vs. SSRI	54	8	-13.1 (-14.9, -11.3)	-12.6 (-14.9, -10.3)	-0.5 (-3.5, 2.5)
He, 2007, He-2007_SR-35121274 (From SRs)	TCA vs. SSRI	60	8	-11.8 (-13.2, -10.4)	-11.8 (-13.4, -10.2)	0 (-2.2, 2.2)
Hollmann, 2022, 36329915	Remote ERP vs. Control	60	16	-13.5 (-16.4, -10.6)	-2.3 (-4, -0.7)	**-11.2 (-14.6, -7.8)**
Lenhard, 2017, 27993223	Remote ERP vs. Control	67	12	-6 (-7.9, -4.1)	-1.5 (-2.8, -0.1)	**-4.6 (-6.9, -2.2)**
Lewin, 2014, 24657310	ERP vs. Control	31	6	-12.2 (-15.8, -8.6)	-0.5 (-3.2, 2.2)	**-11.7 (-16.2, -7.2)**
Li, 2020, 31800306	NAC vs. Control	11	12	-7 (-11.5, -2.5)	-1 (-4.7, 2.7)	**-6 (-11.9, -0.1)**
Liebowitz, 2002, 12447029	SSRI vs. Control	43	16	-9.7 (-13.5, -6)	-4.1 (-8, -0.3)	**-5.6 (-11, -0.2)**
Liu, 2012, Liu-2012_SR-37347947 (From SRs)	AAP+SSRI vs. SSRI	96	6	-12.1 (-13.5, -10.6)	-9.4 (-10.7, -8.1)	**-2.6 (-4.5, -0.7)**
Ma, 2014, Ma-2014_SR-35121274 (From SRs)	ERP+SSRI vs. SSRI	38	12	-7.5 (-9.6, -5.5)	-10.7 (-12.9, -8.4)	3.1 (0, 6.2)

Study, Year, PMID	Treatment Contrast	N	Treatment Duration (wks)	CFB Treatment 1 (95% CI)	CFB Treatment 2 (95% CI)	NMD (95% CI)
March, 1990, 19630661	TCA vs. Control	16	11	-5.2 (-10.4, 0)	-1.8 (-3.9, 0.3)	-3.4 (-9, 2.2)
March, 1998, 9842950	SSRI vs. Control	187	12	-6.8 (-8.5, -5.1)	-3.4 (-5, -1.8)	**-3.4 (-5.7, -1.1)**
Mataix-Cols, 2014, 24262813	DCS+ERP vs. ERP	27	17	-15.9 (-19.4, -12.4)	-14.7 (-17.5, -11.9)	-1.2 (-5.7, 3.3)
Merlo, 2010, 19675960	MI+ERP vs. ERP	16	3	-21.6 (-26.6, -16.7)	-15 (-22.2, -7.8)	-6.6 (-15.4, 2.1)
Nai, 2009, Nai-2009_SR-35121274 (From SRs)	TCA vs. SSRI	64	8	-13.2 (-15.1, -11.3)	-12.8 (-14.9, -10.7)	-0.4 (-3.2, 2.4)
Neziroglu, 2000, 11191690	ERP+SSRI vs. SSRI	10	10	-10 (-14.5, -5.5)	-3.8 (-7.6, 0)	**-6.2 (-12.1, -0.3)**
POTS, 2004, 15507582	ERP vs. Control	56	12	-12 (-15, -9)	-3.7 (-5.4, -2)	**-8.3 (-11.8, -4.8)**
POTS, 2004, 15507582	ERP vs. ERP+SSRI	56	12	-12 (-15, -9)	-12.6 (-15.4, -9.8)	0.6 (-3.5, 4.7)
POTS, 2004, 15507582	ERP vs. SSRI	56	12	-12 (-15, -9)	-7 (-9.9, -4.1)	**-5 (-9.2, -0.8)**
POTS, 2004, 15507582	SSRI vs. Control	56	12	-7 (-9.9, -4.1)	-3.7 (-5.4, -2)	-3.3 (-6.7, 0.1)
POTS, 2004, 15507582	SSRI vs. ERP+SSRI	56	12	-7 (-9.9, -4.1)	-12.6 (-15.4, -9.8)	5.6 (1.6, 9.6)
POTS, 2004, 15507582	ERP+SSRI vs. Control	56	12	-12.6 (-15.4, -9.8)	-3.7 (-5.4, -2)	**-8.9 (-12.2, -5.6)**
Peris, 2013, 22548378	FI+ERP vs. ERP	20	14	-14.5 (-18.5, -10.5)	-9.3 (-13.7, -4.9)	-5.2 (-11.2, 0.8)
Peris, 2017, CN-01446723 (Cochrane)	FI+ERP vs. ERP	62	12	-11.9 (-14.1, -9.8)	-8 (-10.3, -5.6)	**-4 (-7.1, -0.8)**
Piacentini, 2011, 22024003	ERP vs. Control	71	14	-11.4 (-20.2, -2.6)	-8.1 (-21.8, 5.6)	-3.3 (-19.6, 13)
Rempel, 2023, 37048570	Mindfullness vs. Control	58	8	4.3 (2.1, 6.6)	3.9 (2.1, 5.6)	0.5 (-2.9, 3.8)
Reynolds, 2013, 24060194	FI+ERP vs. ERP	50	14	-9.8 (-12.7, -6.8)	-10 (-12.9, -7.1)	0.2 (-3.9, 4.4)
Rezvan, 2013, 23413047	ABI vs. Control	24	12	-7.1 (-8.8, -5.4)	0.2 (-1.4, 1.7)	**-7.2 (-9.5, -5)**
Riddle, 1992, 1429406	SSRI vs. Control	13	8	-10.7 (-15.1, -6.3)	-5.4 (-11.3, 0.5)	-5.3 (-12.3, 1.7)
Riddle, 2001, 11211371	SSRI vs. Control	120	10	-6 (-7.9, -4.1)	-3.3 (-5.1, -1.5)	-2.7 (-5.4, 0)

Study, Year, PMID	Treatment Contrast	N	Treatment Duration (wks)	CFB Treatment 1 (95% CI)	CFB Treatment 2 (95% CI)	NMD (95% CI)
Rosa-Alcázar, 2019, 31516500	ERP vs. parentTraining	44	12	-12.2 (-13.4, -11.1)	-11.1 (-12.9, -9.2)	-1.2 (-3.4, 1)
Shabani, 2019, CN-02003764 (Cochrane)	ACT+SSRI vs. ERP+SSRI	44	12	-7 (-8.7, -5.3)	-8.2 (-9.9, -6.6)	1.2 (-1.1, 3.5)
Shabani, 2019, CN-02003764 (Cochrane)	ACT+SSRI vs. SSRI	47	12	-7 (-8.7, -5.3)	-3.7 (-5, -2.4)	**-3.3 (-5.4, -1.2)**
Shabani, 2019, CN-02003764 (Cochrane)	ERP+SSRI vs. SSRI	47	12	-8.2 (-9.9, -6.6)	-3.7 (-5, -2.4)	**-4.5 (-6.6, -2.4)**
Shen, 2020, Shen-2020_SR-35121274 (From SRs)	TCA vs. SSRI	89	6	-8.7 (-12.6, -4.7)	-11.9 (-16.1, -7.7)	3.2 (-2.6, 9)
Storch, 2007, 17420681	intensiveERP vs. ERP	40	14	-16.4 (-19.2, -13.6)	-12.6 (-16, -9.2)	-3.8 (-8.2, 0.6)
Storch, 2010, 20817153	DCS+ERP vs. ERP	30	9	-17.3 (-20, -14.6)	-15 (-17.9, -12.1)	-2.3 (-6.3, 1.7)
Storch, 2011, 21684018	Remote ERP vs. Control	31	12	-14.2 (-18.8, -9.7)	-2.7 (-6.4, 0.9)	**-11.5 (-17.3, -5.7)**
Storch, 2013, 24184429	ERP+SSRI vs. ERP	47	19	-9.9 (-12.6, -7.2)	-9.5 (-12.3, -6.7)	-0.4 (-4.3, 3.5)
Storch, 2016, 27367832	DCS+ERP vs. ERP	142	9	-10.3 (-12.5, -8.2)	-9.4 (-11.5, -7.3)	-0.9 (-4, 2.1)
Tuerk, 2023, Tuerk-2023_adhoc (ad hoc)	App+ERP vs. ERP	28	6	-4 (-6.2, -1.8)	-1.6 (-3.8, 0.6)	-2.4 (-5.6, 0.8)
Turner, 2014, 25457928	Remote ERP vs. ERP	72	17	-12.7 (-15.1, -10.2)	-12.4 (-14.1, -10.6)	-0.3 (-3.2, 2.7)
Williams, 2010, 19921305	ERP vs. Control	21	12	-11 (-14.8, -7.2)	-1.4 (-5.3, 2.4)	**-9.6 (-14.9, -4.2)**
Wolters, 2016, CN-01166610 (Cochrane)	ERP vs. Control	41	8	-4.4 (-6.4, -2.4)	-0.3 (-2.6, 1.9)	**-4.1 (-7, -1.1)**
Wolters, 2021, CN-02248290 (Cochrane)	CMB-I+ERP vs. ERP	79		-14.3 (-39, 10.3)	-14.4 (-38.8, 9.9)	0.1 (-34.6, 34.8)
Xie, 2020, Xie-2020_SR-35121274 (From SRs)	TCA vs. SSRI	81	6	-9.2 (-18, -0.4)	-12.8 (-16.7, -8.9)	3.6 (-6.1, 13.2)
Zhang, 2014, Zhang-2014_SR-35121274 (From SRs)	ERP+SSRI vs. SSRI	40	12	-14.6 (-16.5, -12.7)	-10.3 (-12.4, -8.2)	**-4.3 (-7.1, -1.5)**
Zhu, 2008, Zhu-2008_SR-35121274 (From SRs)	TCA vs. SSRI	61	8	-13.1 (-15, -11.2)	-12.5 (-14.5, -10.5)	-0.6 (-3.3, 2.1)
de Haan, 1998, 9785713	ERP vs. TCA	22	12	-12.4 (-16.9, -7.9)	-6.2 (-12.6, 0.2)	-6.2 (-14, 1.6)

Study, Year, PMID	Treatment Contrast	N	Treatment Duration (wks)	CFB Treatment 1 (95% CI)	CFB Treatment 2 (95% CI)	NMD (95% CI)
NCT01933919, 2017, NCT01933919 (from SRs)	SSRI vs. Control	37	10	-10.5 (-12.9, -8.1)	-6.6 (-10.1, -3.1)	-3.9 (-8.1, 0.3)

Table E-4. Randomized Controlled Trials—Remission

Study, Year, PMID	Treatment Contrast	Total N	Treatment Duration (wks)	n/N Treatment 1	n/N Treatment 2	OR (95% CI)
Asbahr, 2005, 16239861	ERP vs. SSRI	33	12	7/16	13/17	0.24 (0.05, 1.07)
Barrett, 2003, 12647571	ERP vs. Control	24	14	11/12	0/12	**191.67 (7.07, 5193.16)**
Bolton, 2011, 21644984	briefERP vs. Control	60	12	18/36	2/24	**11 (2.25, 53.84)**
Bolton, 2011, 21644984	briefERP vs. ERP	72	12	18/36	22/36	0.64 (0.25, 1.62)
Bolton, 2011, 21644984	ERP vs. Control	60	12	22/36	2/24	**17.29 (3.51, 85.2)**
Comer, 2017, 27869451	Remote ERP vs. ERP	22	14	7/11	7/11	1 (0.18, 5.68)
He, 2007, He-2007_SR-35121274 (From SRs)	TCA vs. SSRI	60	8	26/30	27/30	0.72 (0.15, 3.54)
Hollmann, 2022, 36329915	Remote ERP vs. Control	47	16	18/28	12/19	1.05 (0.31, 3.52)
Lenhard, 2017, 27993223	Remote ERP vs. Control	67	12	5/33	0/34	13.32 (0.71, 251.2)
POTS Team, 2004, 15507582	CBT vs. Control	56	12	15/28	1/28	**31.15 (3.7, 262.07)**
POTS Team, 2004, 15507582	CBT vs. ERP+SSRI	56	12	15/28	6/28	**4.23 (1.31, 13.62)**
POTS Team, 2004, 15507582	CBT vs. SSRI	56	12	15/28	11/28	1.78 (0.62, 5.15)
POTS Team, 2004, 15507582	SSRI vs. Control	56	12	11/28	1/28	**17.47 (2.07, 147.78)**
POTS Team, 2004, 15507582	SSRI vs. ERP+SSRI	56	12	11/28	6/28	2.37 (0.73, 7.71)
POTS Team, 2004, 15507582	ERP+SSRI vs. Control	56	12	6/28	1/28	7.36 (0.82, 65.84)

Study, Year, PMID	Treatment Contrast	Total N	Treatment Duration (wks)	n/N Treatment 1	n/N Treatment 2	OR (95% CI)
Peris, 2017, CN-01446723 (Cochrane)	FI+ERP vs. ERP	61	12	18/31	8/30	**3.81 (1.29, 11.2)**
Piacentini, 2011, 22024003	ERP vs. Control	57	14	17/40	3/17	3.45 (0.85, 13.93)
Shen, 2020, Shen-2020_SR-35121274 (From SRs)	TCA vs. SSRI	89	6	15/44	19/45	0.71 (0.3, 1.67)
Storch, 2011, 21684018	Remote ERP vs. Control	31	12	9/16	2/15	**8.36 (1.4, 49.88)**
Storch, 2016, 27367832	DCS+ERP vs. ERP	142	9	35/70	33/72	1.18 (0.61, 2.28)
Turner, 2014, 25457928	Remote ERP vs. ERP	66	17	19/33	20/33	0.88 (0.33, 2.35)
Wolters, 2021, CN-01166610 (Cochrane)	ERP vs. Control	63	8	20/31	15/32	2.06 (0.75, 5.67)
Farrell, 2022, NA	DCS+ERP vs. ERP	100	12	18/49	18/51	1.06 (0.47, 2.41)

OCD Global Severity

Eighteen studies, 17 RCTs[3-19] and one RCT crossover[20] enrolling a total of 1153 participants assessed OCD severity using the Clinical Global Impressions-Severity (CGI-S) scale at baseline and at the end of intervention. One study[20] used CGI-OCD. CGI-S is a widely used 7-point clinician rating of severity (0 is no illness, and 7 is extremely severe symptoms).[10]

Nine studies assessed the comparative effect of CBT (basically ERP) alone or as a combination, and nine studies assessed a medication as a primary intervention or as a combination. Studies which delivered ERP alone differed in setting (e.g., remote vs in person), specific components (e.g., psychoeducation, cognitive restructuring, exposure and response therapy), and intensity (e.g., daily vs. weekly). Eight studies compared ERP alone to no Active treatment (Control)[7, 10, 11, 21] or traditional ERP[4, 5, 17] or SSRI[3]. One study assessed a combination of ERP plus SSRI with SSRI[14]. Five studies compared pharmacological agent alone (SSRI or riluzole) with placebo.[8, 9, 12, 13, 20] Four studies compared a combination of pharmacological agent (e.g., DSC, SSRI) plus ERP with placebo plus ERP.[6, 15, 18, 19]

Six studies were rated as moderate risk of bias overall,[4, 9, 11, 14, 19, 20] primarily for lack of blinding or incomplete outcome data. Three studies were rated as high risk of bias overall,[3, 16, 17] for the combination of lack of blinding and incomplete outcome data. Nine studies were rated as low risk of bias overall[5-8, 10, 12, 13, 15, 18]

CGI-S (Clinical Global Impression–Severity)

Behavioral Interventions

Eight studies assessed the comparative effect of CBT (ERP) delivered alone, and one as a combination with pharmacological agent.

Behavioral Intervention versus No Active Treatment

Four studies assessed OCD severity on CGI-S in participants receiving different types of CBT (ERP) versus Control (noActive Treatment)

ERP vs. Control

Two studies compared family-based ERP to Control (no active treatment).[7, 11] The OCD severity on CGI-S significantly decreased in family ERP group compared to Control.

Table E-5.OCD severity on CGI-S: ERP vs. Control

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD (95% CI)
Freeman, 2014, 24759852 RCT POTS Jr	ERP	PE/CoRe/CR/ ERP	CGI-S	62: 4.71 (0.89)	59: -2.1 (1.17)	-1.07 (-1.48, -0.66)
.	Control	BehavCntrl	.	64: 4.67 (0.76)	64: -1.03 (1.17)	.
Lewin, 2014, 24657310 RCT	ERP	ERP	CGI-S	17: 3.82 (0.81)	17: -1.35 (1.19)	-1.42 (-2.1, -0.74)
.	Control	None	.	14: 3.93 (0.73)	14: 0.07 (0.71)	.

Abbreviations: BehavCotrl = Behavioral Control, CGI-S = Clinical Global Impression-Severity; CI = confidence interval; CoRe = coping and relaxation; CR = cognitive restructuring; ERP = exposure and Response Therapy; meanCFB = Mean change form baseline, N= sample size; NMD = net mean difference; PE = psychoeducation; PMID = PubMed ID; RCT = Randomized clinical trial; SD = standard deviation; **Bold** = statistically significant.

[a]Calculated by research team.

Remote ERP vs. Control

Two studies assigned participants to either remote ERP: Therapist-guided, internet-delivered ERP and internet-delivered family ERP[10, 16] or waitlist. The OCD severity on CGI-S significantly decreased in remote CBT compared to waitlist.

Table E-6. OCD severity on CGI-S: Remote ERP vs. Control

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD (95% CI)

Hollmann, 2022, 36329915 RCT	Remote ERP	CR/ERP	CGI-S	30: 4.93 (0.52)	30: -2.58 (1.38)	-2.1 (-2.65, -1.55)
.	Waitlist	None	.	30: 5.07 (0.37)	30: -0.48 (0.70)	.
Storch, 2011, 21684018 RCT	Remote ERP	PR/CR/ERP	CGI-S	16: 3.75 (0.93)	16: -2.19 (1.52)	-1.93 (-2.87, -0.99)
.	Waitlist	None	.	15: 2.73 (0.84)	15: -0.26 (1.14)	.

Abbreviations: CGI-S = Clinical Global Impression-Severity; CI = confidence interval; CR = cognitive restructuring; ERP = exposure and Response Therapy; meanCFB = Mean change form baseline, N= sample size; NMD = net mean difference; PE = psychoeducation; PMID = PubMed ID; RCT = Randomized clinical trial; Remote ERP = internet-delivered ERP, SD = standard deviation; **Bold** = statistically significant.

[a]Calculated by research team.

Behavioral Intervention versus Behavioral Intervention

Three studies each compared different types of CBT (ERP).

Remote ERP vs. ERP

Two RCTs assigned participants to either internet-delivered ERP or traditional ERP.[4, 5] The two RCTs found no evidence of significant difference between internet-delivered ERP and in-person ERP.

Table E-7. OCD severity on CGI-S: Remote ERP vs. ERP

Study, Year, PMID, Design	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD[a] (95% CI)
Aspvall, 2021, 33974020 RCT	Remote ERP	PE/ERP	CGI-S	74: 4.36 (0.67)	74: -1.45 (1.0)	0.02 (-0.30, 0.34)
.	ERP	PE/ERP	.	78: 4.26 (0.67)	78: -1.47 (1.04)	.
Comer, 2017 278694 RCT	Remote ERP	ERP	CGI-S	11: 4.9 (0.7)	11: -1.7 (1.3)	-0.4 (-1.52, 0.72)
.	ERP	ERP	.	11: 4.6 (0.9)	11: -1.3 (1.39)	.

Abbreviations: CGI-S = Clinical Global Impression-Severity; CI = confidence interval; ERP = exposure and Response Therapy; meanCFB = Mean change form baseline, N= sample size; NMD = net mean difference; PE = psychoeducation; PMID = PubMed ID; RCT = Randomized clinical trial; Remote ERP = internet-delivered ERP; SD = standard deviation; **Bold** = statistically significant.

[a]Calculated by research team.

Intensive ERP vs. ERP

Only one study compared daily (intensive) ERP to weekly ERP.[17] The OCD severity on CGI-S significantly decreased in daily ERP compared to weekly ERP.

Table E-8. OCD severity on CGI-S: Intensive ERP vs. ERP

Study, Year, PMID, Design	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD[a] (95% CI)
Storch, 2007, 17420681 RCT	Intensive ERP (daily)	Not specified	CGI-S	20: 4.2 (0.8)	20: -2.8 (0.85)	-1.2 (-1.77, -0.63)
.	ERP (weekly)	Not specified	.	20: 3.5 (0.8)	20: -1.6 (0.98)	.

Abbreviations: CGI-S = Clinical Global Impression-Severity; CI = confidence interval; ERP = exposure and Response Therapy; meanCFB = Mean change form baseline, N= sample size; NMD = net mean difference; PE = psychoeducation; PMID = PubMed ID; RCT = Randomized clinical trial; SD = standard deviation; **Bold** = statistically significant.

[a]Calculated by research team.

Behavioral Intervention versus Pharmacological Intervention

ERP vs. SSRI

Only one study for this outcome,[3], assigned participants to either group ERP or SSRI. Participants in group ERP had a greater reduction in OCD severity reported on CGI-S than sertraline.

Table E-9. OCD severity on CGI-S: ERP vs. SSRI

Study, Year, PMID, Study Design	Arm Name	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD (95% CI)
Asbahr, 2005, 16239861 RCT	EPR	PE/ERP	CGI-S	20: 5.35 (0.88)	20: -2.85 (NR)	-0.85[b]
.	SSRI	Sertraline	.	19: 5.30 (0.73)	19: -2 (NR)	.

Abbreviations: CGI-S = Clinical Global Impression-Severity; CI = confidence interval; ERP = exposure and Response Therapy; meanCFB = Mean change form baseline, N= sample size; NMD = net mean difference; PE = psychoeducation; PMID = PubMed ID; RCT = Randomized clinical trial; SD = standard deviation; SSRI = Selective Serotonin Reuptake Inhibitor; **Bold** = statistically significant.

[a]Calculated by research team; [b]95% CI could not be calculated due to missing data.

Combination of Behavioral Treatment

Behavioral plus Pharmacological Intervention versus Pharmacological Intervention

ERP plus SSRI vs. SSRI

Only one study[14] for this outcome assigned participants to either ERP plus fluvoxamine or fluvoxamine alone. OCD severity reported on CGI-S significantly decreased in ERP plus fluvoxamine compared to fluvoxamine alone.

Table E-10. OCD severity on CGI-S: ERP plus SSRI vs. SSRI

Study, Year, PMID, Study Design	Arm Name	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD (95% CI)
Neziroglu, 2000, 11191690 RCT	ERP + SSRI	Fluvoxamine + ERP	CGI-S	5: 5.6 (0.55)	5: -1.2 (0.52)	-0.1 (-1.63, -0.37)
.	SSRI	Fluvoxamine	.	5: 5 (0)	5: -0.2 (0.49)	.

Abbreviations: CGI-S = Clinical Global Impression-Severity; CI = confidence interval; ERP = exposure and Response Therapy; meanCFB = Mean change form baseline, N= sample size; NMD = net mean difference; PE = psychoeducation; PMID = PubMed ID; RCT = Randomized clinical trial; SD = standard deviation; SSRI = Selective Serotonin Reuptake Inhibitor; **Bold** = statistically significant.

[a]Calculated by research team.

Pharmacological Interventions

Pharmacological Intervention versus No Active Treatment

Five studies assessed OCD severity in participants randomized to pharmacological intervention alone versus Control (placebo).

SSRI vs. Control

Three RCTs,[8, 12, 13] and one RCT crossover[20] compared SSRI to placebo.[20] reported OCD severity on subscale of CGI-S (CGI-OCD). The net improvement in OCD severity reported on CGI-S/CGI-OCD varied across studies, with two studies[8, 20] reporting a significant net improvement favoring SSRI.

Table E-11. OCD severity on CGI-S: SSRI vs. Control

Study, Year, PMID, Study Design	Arm Name	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD (95% CI)
Geller, 2001, 11437015 RCT	SSRI	Fluoxetine	CGI-S	71: 4.6 (0.7)	71: -1.3 (1.3)	-0.7 (-1.16, -0.24)
.	Placebo	None	.	32: 4.8 (0.8)	32: -0.6 (1.0)	.
Liebowitz, 2002, 12447029 RCT	SSRI	Fluoxetine	CGI-S	21: 4.38 (0.67)	21: -1.09 (1.2)	-0.43 (-1.15, 0.29)
.	Placebo	None	.	22: 4.57 (0.87)	22: -0.66 (1.21)	.
March, 1998, 9842950 RCT	SSRI	Sertraline	CGI-S	92: NR	92: -1.0 (1.34)	-0.3 (-0.67, 0.07)
.	Placebo	None	.	95: NR	95: -0.7 (1.27)	.
Riddle, 1992, 1429406 RCT (cross-over)	SSRI	Fluoxetine	CGI-OCD	7: 4.6 (0.8)	7: -1.5 (0.75)	-1 (-1.79, -0.21)

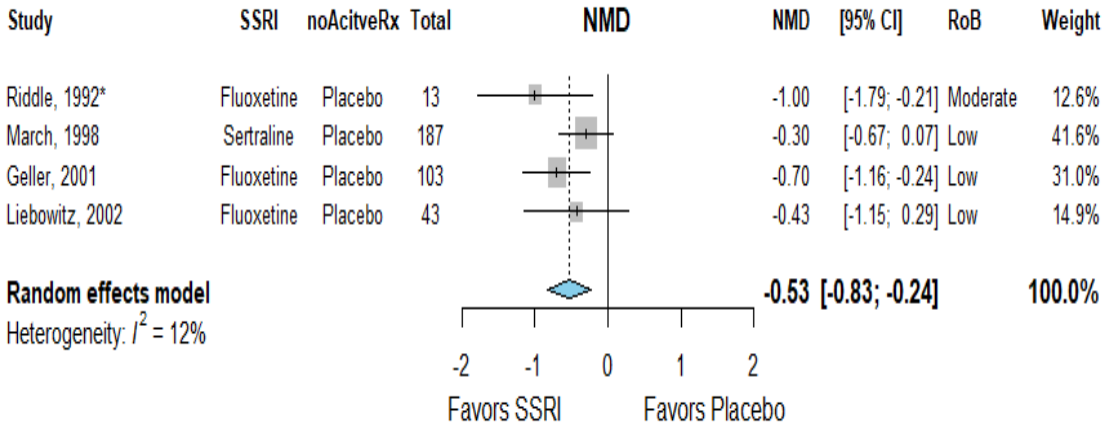
Study, Year, PMID, Study Design	Arm Name	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD (95% CI)
.	Placebo	None	.	6: 4.3 (0.5)	6: -0.5 (0.7)	.

Abbreviations: CGI-S = Clinical Global Impression-Severity; CI = confidence interval; meanCFB = Mean change form baseline, N= sample size; NMD = net mean difference; NR = Not reported; PMID = PubMed ID; RCT = Randomized clinical trial; SD = standard deviation; SSRI = Selective Serotonin Reuptake Inhibitor; **Bold** = statistically significant.

[a]Calculated by research team.

Meta-analysis provided evidence that SSRIs are better than placebo for OCD severity. The severity of OCD significantly decreased in SSRI compared to placebo.

Figure E-2. Meta-analysis of OCD severity on CGI-S: SSRI vs. Control



Abbreviations; Control = No acitve treatment, CI = confidence interval, NMD = Net mean difference, RoB = Risk of bias, SSRI = Selective serotonin reuptake inhibitors.

*OCD severity was assessed one month post-treatment using CGI-OCD, a subscale of CGI-S

Riluzole vs. Control

Only one study for this outcome assessed the comparative effect of riluzole.[9] There was no significant net difference in CGI-S score between riluzole and placebo.

Table E-12. OCD severity on CGI-S: Riluzole vs. Control

Study, Year, PMID, Study Design	Arm Name	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD (95% CI)
Grant, 2014, 24356715 RCT	Riluzole	Riluzole	CGI-S	30: 5.59 (0.63)[b]	30: -0.55[c] (0.81)	0.05[d] (-0.35, 0.45)
.	Placebo	Placebo	.	30: 5.63 (0.67)[b]	30: -0.6[c] (0.77)	.

Abbreviations: CGI-S = Clinical Global Impression-Severity; CI = confidence interval; meanCFB = Mean change form baseline, N= sample size; NMD = net mean difference; PMID = PubMed ID; RCT = Randomized clinical trial; SD = standard deviation; **Bold** = statistically significant.

[a]Calculated by research team, [b]Estimated marginal mean, [c]Difference in estimated marginal means; [d]Net estimated marginal mean difference.

Combination of Pharmacological Treatment

Pharmacological plus Behavioral Intervention versus Behavioral Intervention

Four studies compared a combination of pharmacological agent plus behavioral intervention to behavioral intervention.

DCS plus ERP vs. Placebo plus ERP

Three RCTs measured CGI-S in participants received either a combination of D-cycloserine (DSC) plus ERP or placebo plus ERP.[6, 18, 19] The three RCTs did not find significant net difference in CGI-S between DSC plus ERP and placebo plus ERP.

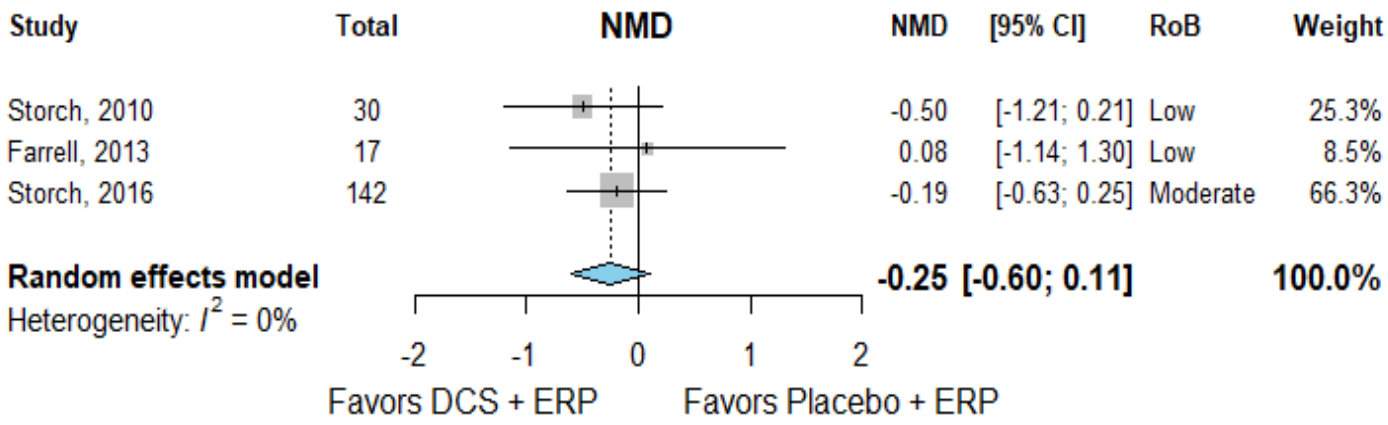
Table E-13. OCD severity on CGI-S: DCS plus ERP vs. Placebo plus ERP

Study, Year, PMID, Study Design	Arm Name	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD (95% CI)
Farrell, 2013, 23722990 RCT	DCS+ERP	DCS + ERP	CGI-S	9: 5.67 (0.7)	9: -2.67 (1.43)	0.08 (-1.14, 1.30)
.	ERP	Placebo + ERP	.	8: 5.38 (0.7)	8: -2.75 (1.13)	.
Storch, 2010, 20817153 RCT	DCS+ERP	DCS + PE/CR/ERP	CGI-S	15: 4.6 (0.83)	15: -2.6 (0.93)	-0.5 (-1.20, 0.21)
.	ERP	Placebo + PE/CR/ERP	.	15: 5.1 (0.74)	15: -2.1 (1.04)	.
Storch, 2016, 27367832 RCT	DCS+ERP	DCS + PE/CR/EPR	CGI-S	70: 3.67 (1.13)	70: -1.39 (1.33)	-0.19 (-0.63, 0.25)
.	ERP	Placebo + PE/CR/ERP	.	72: 3.43 (1.13)	72: -1.2 (1.32)	.

Abbreviations: CGI-S = Clinical Global Impression-Severity; CI = confidence interval; CR = Cognitive restructuring; DSC = D-cycloserine; ERP = exposure and Response Therapy; meanCFB = Mean change form baseline, N= sample size; NMD = net mean difference; PE = psychoeducation; PMID = PubMed ID; RCT = Randomized clinical trial; SD = standard deviation; **Bold** = statistically significant.

Meta-analysis provided evidence that DSC plus ERP did not significantly decrease OCD severity reported on CGI-S compared to placebo plus ERP (summary NMD –0.25, 95% CI –0.6 to 0.11).

Figure E-3. Meta-analysis of OCD severity on CGI-S: DCS plus ERP vs. Placebo plus ERP



Abbreviations; CI = confidence interval, DCS = D-cycloserine, ERP = Exposure and Response Therapy, NMD = Net mean difference, RoB = Risk of bias.

SSRI plus ERP vs. Placebo plus ERP

One three arm study,[15], randomized participants to regular or slow sertraline or placebo. All participants received ERP. The change in OCD severity reported on CGI-S did not significantly differ in participants assigned to regular or slow sertraline plus ERP compared to placebo plus ERP.

Table E-14. OCD severity on CGI-S: SSRI plus ERP vs. Placebo plus ERP

Study, Year, PMID, Study Design	Arm Name	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD (95% CI)
Storch, 2013, 24184429 RCT	SSRI + ERP	Regular sertraline + PE/ CR/ERP	CGI-S	14: 4.36 (0.49)	14: -1 (1.17)	0.26 (-0.47, 0.99)
.	ERP	Placebo + PE/ CR/ERP	.	16: 4.63 (0.72)	16: -1.26 (0.82)	.
Storch, 2013, 24184429 RCT	SSRI + ERP	Slow sertraline + PE/ CR/ERP	CGI-S	17: 4.82 (0.64)	17: -1.17 (0.97)	0.09 (-0.52, 0.70)
.	ERP	Placebo + PE/ CR/ERP	.	16: 4.63 (0.72)	16: -1.26 (0.82)	.

Abbreviations: CGI-S = Clinical Global Impression-Severity; CI = confidence interval; CR = Cognitive restructuring; DSC = D-cycloserine; ERP = exposure and Response Therapy; meanCFB = Mean change form baseline, N= sample size; NMD = net mean difference; PE = psychoeducation; PMID = PubMed ID; RCT = Randomized clinical trial; SD = standard deviation; SSRI = Selective Serotonin Reuptake Inhibitors. **Bold** = statistically significant.

[a]Calculated by research team

Remission Based on the Children's Yale-Brown Obsessive Compulsive Scale Total (CY-BOCS)

Number of Studies
Comparisons
"Significant" results

Table E-15. Children's Yale-Brown Obsessive Compulsive Scale Total

Study, Year, PMID	Timepoint	Intervention Arms	Intervention Description	n/N (%)	RR (95% CI)	P value
Geller, 2003, 12880497	12wk	TCA	Paroxetine	2/95 (2.1)	1.03 (0.15, 7.18)	0.976
		Placebo	Placebo	2/98 (2)		
Storch, 2016, 27367832	10wk	CBT + NMDA agonist	CBT + D-cycloserine	0/70 (0)	NA	NA
		CBT	CBT + Placebo	0/72 (0)		
Franklin, 2011, 21934055	Study period	SSRI + iCBT	SSRI + internet CBT	1/40 (2.5)	1.05 (0.07, 16.23)	0.972
		SSRI	SSRI	1/42 (2.4)		
Storch, 2013, 24184429	Study period	SSRI + CBT	Regular Sertraline + CBT	1/14 (7.1)	1.21 (0.08, 17.71)	0.887
		SSRI + CBT	Slow Sertraline + CBT	1/17 (5.9)		

Functional Impairment

Twelve studies, all RCTs[7, 10, 12, 15-17, 19, 22-26] enrolling a total of 844 participants assessed function impairment using the Child Obsessive–Compulsive Impact Scale (COIS) at baseline and at the end of intervention. COIS is a 56-item, parent- or child-report measuring the degree to which the child experiences OCD-related impairment across several domains of functioning: school, social, and home/family activities.[16] The COIS-R (the revised version) is a 33-item, using a 0 (not at all) to 3 (very much) Likert-scale.[25]

Eight studies assessed the comparative effect of CBT (basically ERP) alone or as a combination, and four studies assessed a medication as a primary intervention or as combination. Studies which delivered ERP alone differed in setting (remote versus in-person, home versus hospital), and intensity (daily versus weekly). Seven studies compared ERP alone with no active treatment (Control) or another form of ERP[7, 10, 16, 17, 22, 25, 26]; and one study compared ERP as a combination with family intervention to ERP alone.[24] Only one study compared pharmacological agent alone (SSRI) with placebo.[12] Three studies compared a combination of pharmacological agents (e.g., DSC, SSRI) plus ERP to placebo plus ERP.[15, 19, 23]

Three studies were rated as moderate risk of bias overall,[19, 22, 24] primarily for lack of blinding or incomplete outcome data. Two studies were rated as high risk of bias overall,[16, 17] for the combination of lack of blinding and incomplete outcome data. Seven studies were rated as low risk of bias overall[7, 10, 12, 15, 23, 25, 26]

COIS (The Child Obsessive–Compulsive Impact Scale)

Behavioral Interventions

Seven studies assessed the comparative effect of CBT (ERP) delivered alone, and one as a combination with family intervention.

Behavioral Intervention versus No Active Treatment

ERP vs. Control

Three RCTs assessed functional impairment in participants randomized to either ERP or no active treatment (Control).[7, 22, 25] The three RCTs were different in regard to the setting (e.g., full ERP versus brief), or component of the ERP delivered (e.g., family-based ERP). One study was three-arm RCT assigned participants to full or brief ERP versus waitlist.[22] There was significant net improvement in functioning reported on COIS-C (COIS-child rated) in ERP compared to waitlist. Similar significant net improvement in COIS-P (COIS-parent rated) was reported in ERP compared to waitlist[7, 22, 25] showed no significant net difference in functioning on COIS-RP between ERP and waitlist.

Table E-16. Functional Impairment on COIS: ERP vs. Control

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD (95% CI)[a]
Bolton, 2011, 21644984 RCT	ERP	General ERP/NS	COIS-C	36: 21.7 (12.7)	36: -15.1 (11.19)	-17.1 (-23.04, -11.16)
.	Control	None	.	24: 22.4 (11.4)	24: 2 (11.71)	.
Bolton, 2011, 21644984 RCT	Brief ERP	Brief ERP/NS	COIS-C	36: 21.6 (13.8)	36: -15.3 (11.95)	-17.3 (-23.4, -11.20)
.	Control	None	.	24: 22.4 (11.4)	24: 2 (11.71)	.
Bolton, 2011, 21644984 RCT	ERP	General CBT/NS	COIS-M	36: 23.2 (12.2)	36: -15.2 (10.77)	-16 (-22.42, -9.58)
.	Control	None	.	24: 27.6 (9.8)	24: 0.8 (13.42)	.
Bolton, 2011, 21644984 RCT	Brief ERP	Brief ERP/NS	COIS-M	36: 19.5 (14.2)	36: -7.7 (13.28)	-8.5 (-15.40, -1.60)
.	Control	None	.	24: 27.6 (9.8)	24: 0.8 (13.42)	.
Freeman, 2014, 24759852 RCT POTS Jr	ERP	Family-PE/CoRe/CR/ERP	COIS-R	63: 23.97 (16.43)	63: -12.29 (14.64)	-5.35 (-10.05, -0.65)
.	Control	behavCntrl	.	64: 23.46 (12.68)	64: -6.94 (12.27)	.

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD (95% CI)[a]
Piacentini, 2011, 22024003 RCT	ERP	PE/ERP	COIS-RC	48: 15.4 (10.6)	39: -9.8 (8.71)	-9.2 (-15.81, -2.59)
.	Control	behavCntrl	.	22: 14.9 (13.64)	16: -0.6 (12.29)	.
Piacentini, 2011, 22024003 RCT	ERP	PE/ERP	COIS-RP	47: 22.4 (11.89)	39: -11.8 (10.99)	-1.6 (-9.03, 5.83)
.	Control	behavCntrl	.	22: 21.4 (18.19)	17: -10.2 (13.85)	.

Abbreviations: behavCntrl = Behavioral control; CI = confidence interval; COIS-C = The Child Obsessive–Compulsive Impact Scale-child rated, COIS-M = The Child Obsessive–Compulsive Impact Scale-mother rated, COIS-P= The Child Obsessive–Compulsive Impact Scale-parent rated, COIS-R = The Children's OCD Impact Scale-Revised; COIS-RC = Child Obsessive Compulsive Impact Scale-Revised Child-Report; COIS-RP = Child Obsessive Compulsive Impact Scale-Revised Parent-Report; CoRe = Coping and relaxation; CR = Cognitive restructuring; ERP = exposure and Response Therapy; meanCFB = Mean change from baseline; N = Sample size; NMD =Net mean difference; Control = No active treatment; PE= Psychoeducation; PMID= PubMed ID; SD= Standard deviation; **Bold** = statistically significant

[a]Calculated by research team.

Remote ERP vs. Control

Two studies compared the effect of remote ERP: Therapist-guided, internet-delivered ERP[10] and internet-delivered family ERP[16] to no active treatment (Control); Functional impairment on COIS-C (COIS-child rated) significantly decreased in internet-delivered ERP compared to Control.[10, 16] Functional impairment on COIS-P (COIS-parent rated) varied across these two studies, with significant net improvement favoring internet-delivered ERP.[16]

Table E-17. Functional Impairment on COIS: Remote ERP vs. Control

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD[a] (95% CI)
Hollmann, 2022, 36329915 RCT	remoteCBT	CR + ERP	COIS-C	30: 19.7 (17.04)	30: -11.69 (14.84)	-6.42 (-12.85, 0.006)[a]
.	Control	None	.	30: 17.44 (10.86)	30: -5.27 (10.11)	.
Hollmann, 2022, 36329915 RCT	remoteCBT	CR + ERP	COIS-P	30: 25.87 (18.1)	30: -13.77 (16.18)	-6.94 (-14.22, 0.34)
.	Control	None	.	30: 22.75 (12.14)	30: -6.83 (12.33)	.
Storch, 2011, 21684018 RCT	remoteCBT	PE/CR/ERP	COIS-C	16: 38.77 (24.09)	16: -22.71 (22.0)	-30.76 (-44.27, -17.25)
.	Control	None	.	15: 15.40 (9.59)	15: 8.05 (16.08)	.
Storch, 2011, 21684018 RCT	remoteCBT	PE/CR/ERP	COIS-P	16: 42.81 (23.43)	16: -26 (24.0)	-24.61 (-39.45, -9.77)

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD[a] (95% CI)
.	Control	None	.	15: 28.59 (13.34)	15: -1.39 (17.87)	.

Abbreviations: CI = confidence interval; COIS-C = The Child Obsessive–Compulsive Impact Scale-child rated; COIS-P= The Child Obsessive–Compulsive Impact Scale-parent rated; CR = Cognitive restructuring; ERP = Exposure and Response Therapy; meanCFB = Mean change from baseline; N = Sample size; NMD = Net mean difference; Control = No active treatment; PE= Psychoeducation; PMID= PubMed ID; Remote ERP = Remote ERP (internet-delivered ERP); SD= Standard deviation; **Bold** = statistically significant

[a]Calculated by research team.

Behavioral Intervention versus Behavioral Intervention

Intensive ERP vs. ERP

Two RCTs each compared different types of ERP.[17, 26] Selles 2021 assigned participants to either home-intensive or hospital-intensive ERP. Storch 2007 assigned participants to daily or weekly ERP. The two RCTs found no evidence of difference in functioning between the comparative ERP groups.

Table E-18. Functional Impairment on COIS: IntensiveERP vs. ERP

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD (95% CI)[a]
Selles, 2021, 34079488 RCT	Home-intensive ERP	PE/CoRe/ERP	COIS-C	12: NR	12: -6.1 (12.9)	-4.8 (-14.64, 5.04)
.	IntensiveERP	hospital clinic PE/CoRe/ERP	.	14: NR	14: -1.3 (12.6)	.
Selles, 2021, 34079488 RCT	Home-intensive ERP	PE/CoRe/ERP	COIS-P	12: NR	12: -13.7 (12.11)	-9 (-18.79, 0.79)
.	IntensiveERP	hospital clinic PE/CoRe/ERP	.	14: NR	14: -4.7 (13.36)	.
Storch, 2007, 17420681 RCT	IntensiveERP (daily)	Not specified	COIS-P	20: 44.2 (25.9)	20: -26 (22.46)	-12.8 (-28.99, 3.39)
.	ERP	Not specified	.	20: 39.1 (29.8)	20: -13.2 (29.31)	.

Abbreviations: CI = confidence interval; COIS-C = The Child Obsessive–Compulsive Impact Scale-child rated; COIS-P= The Child Obsessive–Compulsive Impact Scale-parent rated; CoRe = coping and relaxation; ERP = Exposure and Response Therapy; intensiveERP = Intensive ERP; meanCFB = Mean change from baseline; N = Sample size; NMD =Net mean difference; PE = Psychoeducation; PMID= PubMed ID; SD= Standard deviation; **Bold** = statistically significant

[a]Calculated by research team.

Combination with Behavioral Intervention

One study for this outcome assessed the comparative effect of a combination of behavioral intervention with other behavioral intervention.

PFIT plus ERP vs. ERP

Only one RCT assessed functioning in participants assigned to either a combination ERP plus PFIT (Positive Family Interaction Therapy) or ERP.[24] The study found a significant net difference in functioning between PFIT plus ERP and ERP alone.

Table E-19. Functional Impairment on COIS: PFIT plus ERP vs. ERP

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD[a] (95% CI)
Peris, 2017, 29173737 RCT	PFIT + ERP	ERP	COIS-RP	32: 26.91 (14.76)	32: -12.97 (13.39)	-12.67 (-19.93, -5.41)
.	ERP	ERP	.	30: 26.52 (12.90)	30: -0.3 (15.59)	.

Abbreviations: CI = confidence interval; COIS-RP= Child Obsessive-Compulsive Disorder (OCD) Impairment Scale Parent-Report Revised; ERP = Exposure and Response Therapy; meanCFB = Mean change from baseline; N = Sample size; NMD =Net mean difference; PFIT = Positive Family Interaction Therapy; PMID= PubMed ID; SD= Standard deviation; **Bold** = statistically significant.

aCalculated by research team.

Pharmacological Interventions

One study assessed the comparative effect of CBT (ERP) delivered alone, and three studies as a combination with behavioral intervention.

Pharmacological Intervention versus No Active Treatment

SSRI vs. Control

Only one study assessed functioning in participants randomized to SSRI or no active treatment (placebo).[12] The study showed a significant net improvement in functioning on COIS-P in SSRI (fluoxetine) compared to placebo.

Table E-20. Functional Impairment on COIS: SSRI vs. Control

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)a	NMDa (95% CI)
Liebowitz, 2002, 12447029 RCT	SSRI	Fluoxetine	COIS-P	21: 62.61 (33.71)	21: -36.08 (29.91)	-22.36 (-42.97, -1.75)
.	Control	None	.	22: 58.29 (39.32)	22: -13.72 (38.69)	.

Abbreviations: CI = confidence interval; COIS-P= The Child Obsessive–Compulsive Impact Scale-parent rated; meanCFB = Mean change from baseline; N = Sample size; NMD =Net mean difference; Control = No active treatment (Placebo); PMID= PubMed ID; SD= Standard deviation; SSRI = Selective Serotonin Reuptake Inhibitor; **Bold** = statistically significant.

aCalculated by research team.

Combination with Pharmacological Intervention

Pharmacological plus Behavioral Intervention versus Behavioral Intervention

Three RCTs compared a combination of pharmacological agent plus behavioral intervention to behavioral intervention.

DCS plus ERP vs. Placebo plus ERP

Two RCTs assessed functioning in participants assigned to either a combination of DSC (D-cycloserine) plus ERP or placebo plus ERP.[19, 23] One study reported non-significant net increase in functional impairment rated by parents in DSC plus ERP compared to placebo plus ERP.[23] The other study found non-significant net improvement in functioning rated by parents in DCS plus ERP group compared to placebo group.[19]

Table E-21. Functional Impairment on COIS: DCS plus ERP vs. Placebo plus ERP

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)a	NMDa (95% CI)
Farrell, 2022, 35084071 RCT	DCS + ERP	DCS + ERP	COIS-P	49: 39.2 (26.5)	49: -20 (24.42)	4.6 (-5.49, 14.69)
.	ERP	ERP	.	51: 49.3 (29.3)	51: -24.6 (27)	.
Storch, 2016, 27367832 RCT	DCS + ERP	DCS + PE/CR/EPR	COIS-P	70: 16.28 (13.77)	70: -6.34 (13.93)	-0.6 (-5.2, 4.0)
.	ERP	PE/CR.ERP	.	72: 14.88 (13.83)	72: -5.74 (14)	.

Abbreviations: CI = confidence interval; COIS-P= The Child Obsessive–Compulsive Impact Scale-parent rated; CR = cognitive restructuring; DCS = D-cycloserine; ERP = Exposure and Response Therapy; meanCFB = Mean change from baseline; N = Sample size; NMD =Net mean difference; PE = Psychoeducation; PMID= PubMed ID; SD= Standard deviation; **Bold** = statistically significant.

aCalculated by research team.

SSRI plus ERP vs. Placebo plus ERP

One three arm study,[15] assigned participants to regular or slow sertraline or placebo. All participants received ERP. Results showed no significant net difference in functioning between regular or slow SSRI (sertraline) and placebo.

Table E-22. Functional Impairment on COIS: SSRI plus ERP vs. Placebo plus ERP

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD[a] (95% CI)
Storch, 2013, 24184429 RCT	SSRI + ERP	Regular sertraline + PE/ CR/ERP	COIS-C	14: 14.31 (11.62)	14: -8.14 (10.43)	-1.47 (-9.38, 6.44)
.	ERP	PE/ CR/ERP	.	16: 16.27 (13.03)	16: -6.67 (11.66)	.

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD[a] (95% CI)
Storch, 2013, 24184429 RCT	SSRI + ERP	Slow sertraline + PE/ CR/ERP	COIS-C	17: 17.2 (12.97)	17: -8.73 (13.56)	-2.06 (-10.67, 6.55)
.	ERP	PE/ CR/ERP	.	16: 16.27 (13.03)	16: -6.67 (11.66)	.
Storch, 2013, 24184429 RCT	SSRI + ERP	Regular sertraline + PE/ CR/ERP	COIS-P	14: 19.92 (13.27)	14: -2.65 (14.69)	2.08 (-8.47, 12.63)
.	ERP	PE/ CR/ERP	.	16: 17.4 (15.17)	16: -4.73 (14.72)	.
Storch, 2013, 24184429 RCT	SSRI + ERP	Slow sertraline + PE/ CR/ERP	COIS-P	17: 24.6 (18.86)	17: -9.96 (17.37)	-5.23 (-16.19, 5.73)
	ERP	PE/ CR/ERP	.	16: 17.4 (15.17)	16: -4.73 (14.72)	.

Abbreviations: CI = confidence interval; COIS-C = The Child Obsessive–Compulsive Impact Scale-child rated; COIS-P= The Child Obsessive–Compulsive Impact Scale-parent rated; CR = cognitive restructuring; ERP = Exposure and Response Therapy; meanCFB = Mean change from baseline; N = Sample size; NMD =Net mean difference; PE = Psychoeducation; PMID= PubMed ID; SD= Standard deviation; SSRI = Selective Serotonin Reuptake Inhibitor; **Bold** = statistically significant.

aCalculated by research team.

Family Accommodation

Family accommodation is a change in the family's behavior with the goal of reducing distress in children with OCD, but "high degrees of family accommodation are associated with greater symptom severity and with poorer response to treatment."[27] Among 13 studies, 11 RCTs[4, 5, 11, 16, 17, 24-26, 28-31] and two NRCSs[32, 33] that enrolled a total of 702 participants assessed family accommodation using the Family Accommodation Scale (FAS). FAS (The Family Accommodation Scale) (FAS; Calvocoressi et al., 1995) is a 13-item parent-rated Questionnaire. It is scored on a 5-point Likert-type scale that assesses the degree to which family members have accommodated the child's OCD symptoms during the previous month (9 items) and the level of distress/impairment that the family members and patient experience as a result of the family accommodating or not accommodating the child (4 items).[17] For FAS the low score the better.

All studies assessed the comparative effect of CBT. No study assessed a medication as a primary intervention or as a combination with CBT. CBT in the 13 studies was delivered alone or in combination with another intervention (e.g., family therapy). Studies that delivered CBT alone differed in setting, specific components (e.g., psychoeducation, cognitive restructuring, exposure and response therapy), and intensity. Seven studies compared CBT with another form of CBT,[4, 5, 17, 25, 26, 31, 33] three studies compared a combination of CBT plus a family intervention with CBT alone,[24, 30, 32] and three studies compared CBT to a nonactive treatment (TAU or waitlist).[11, 16, 29]

Five RCTs were rated as moderate risk of bias overall,[4, 11, 24, 29] primarily for lack of blinding or incomplete outcome data. One NRCS was rated as moderate risk of bias.[33]Three studies were rated as high risk of bias overall,[16, 17, 32] for the combination of lack of blinding and incomplete outcome data, and in the case of one NRCS for possible confounding based on baseline differences between arms.[32] Five studies were rated as low risk of bias overall.[5, 25, 26, 30, 31]

Family Accommodation Scale (FAS)

Seven studies assessed FAS in participants receiving a specific type of CBT or general CBT.[4, 5, 16, 25, 26, 31, 33] The FAS was assessed before and after treatment.

The seven studies each compared different CBT types or approaches [I'm going by the table that differentiates stepped from internet CBT, but I don't know the studies or the interventions.] Three RCTs found statistically significant (or near-significant) net improvements in FAS for CBT (including Psychoeducation and ERP/Exposure) versus Psychoeducation plus Relaxation Training (PRT) (Piacentini 2011[25]), CBT with the child together with either their mother or both parents versus CBT with the mother alone (Rosa-Alcázar 2019[31]), and daily (intensive) CBT versus weekly CBT (Storch 2007[17]).

Two RCTs and the two NRCSs found no evidence of differences between internet-delivered and in-person CBT (Aspvall 2021[4] and Comer 2017[5]), [Whatever Rosa-Alcázar 2017 is comparing] (Rosa-Alcázar 2017[33]), and home-based versus hospital clinic based CBT (Selles 2021[26]).

Table E-23. Family accommodation, FAS CBT versus CBT

Study, Year, PMID, Design	Arm	CBT Components	Scale	Baseline N: Mean (SD)	N: MD (SD)[a]	NMD[a] (95% CI)
Aspvall, 2021, 33974020 RCT	Internet CBT	PE + ERP	FAS-self rated	74: 19.5 (14.4)	74: -12.5 (12.61)	0 (-4.29, 4.29)
.	CBT	PE + ERP	.	78: 21.4 (16)	78: -12.5 (14.37)	.
Comer, 2017 278694 RCT	Internet CBT	ERP	FAS	11: 21.1 (6.7)	11: -10 (8.9)	-3.7 (-10.32, 2.92)
.	CBT	ERP	.	11: 15.79 (11.25)	11: -6.3 (6.8)	.
Piacentini, 2011, 22024003 RCT	CBT with ERP	PE + ERP	FAS-Parent	48: 17.5 (10.6)	39: -8.2 (9.4)[a]	-5.4 (-10.79, -0.007)
.	CBT	PE + CoRe	FAS- Parent	22: 18 (10.29)	17: -2.8 (9.5)[a]	.

Study, Year, PMID, Design	Arm	CBT Components	Scale	Baseline N: Mean (SD)	N: MD (SD)[a]	NMD[a] (95% CI)
Rosa-Alcázar, 2019, 31516500 RCT	CBT (parents + child)	PE + ERP	FAS-Mother	14: 22.36 (2.13)	14: -10.43 (1.88)	-5.16 (-6.92, -3.41)*
.	CBT (mother + child)	PE + ERP	FAS-Mother	15: 23.33 (3.02)	15: -9.26 (2.81)	-3.99 (-6.02, -1.96)*
.	CBT (mother only)	PE + ERP	FAS-Mother	15: 23.00 (2.70)	15: -5.27 (2.86)	.
Rosa-Alcázar, 2019, 31516500 RCT	CBT (parents + child)	PE + ERP	FAS-Father	14: 18 (2.26)	14: -8.64 (2.12)	-6.11 (-8.08, -4.13)*
.	CBT (mother + child)	PE + ERP	FAS-Father	15: 19.4 (2.03)	15: -4.8 (2.41)	-2.27 (-4.30, -0.23)*
.	CBT (mother only)	PE + ERP	FAS-Father	15: 19.53 (3.23)	15: -2.53 (3.22)	.
Selles, 2021, 34079488 RCT	Home- based CBT	PE + CoRe + ERP	FAS- self rated	12: NR	12: -9.5 (13.17)	4.7 (-5.87, 15.27)
.	Intensive CBT at hospital clinic	PE + CoRe + ERP	FAS- self rated	14: NR	14: -14.2 (14.32)	.
Storch, 2007, 17420681 RCT	Intensive CBT (daily)	Not specified	FAS	20: 24.2 (10.0)	20: -13.5 (9.58)	-8.7 (-14.61, -2.79)
.	CBT (weekly)	Not specified	FAS	20: 16.3 (10.4)	20: -4.8 (9.49)	.

Statistically significant net mean differences are in bold font.
Abbreviations: CBT = Cognitive behavior therapy; CBFT = Cognitive-Behavioral Family-Based Treatment; CI = confidence interval; CoRe = coping and relaxation; CR = cognitive restructuring; ERP = exposure and response therapy; FAS-P = Family Accommodation Scale-parent version; MD = mean difference; N= sample size; NMD = net mean difference; NR = not reported; NRCS = nonrandomized comparative study, NS = not significant; PE = psychoeducation; PMID = PubMed ID; RCT = randomized controlled trial.

* This is three arm study. The calculated comparisons are versus CBT mother only (the control group).[a]Time point of assessment one month after end of treatment.

Three studies, all RCTs, assessed family accommodation in participants randomized to CBT or waitlist/TAU.[11, 16, 29] The three RCTs were different in regard to the setting or component of the CBT delivered. Two studies assigned participants to virtual CBT: Therapist-guided, internet-delivered CBT and internet-delivered family CBT,[16, 29] or waitlist. One RCT assigned participants to ERP versus TAU (Lewin, 2014). The three RCTs found statistically significant net improvements in FAS in participants assigned to CBT compared to TAU or waitlist. Results provided evidence that family accommodation reported on FAS significantly improved in CBT groups, regardless of CBT setting or component, compared to those who were in control group (summary NMD –6.18, 95% CI –9.44 to -2.91).

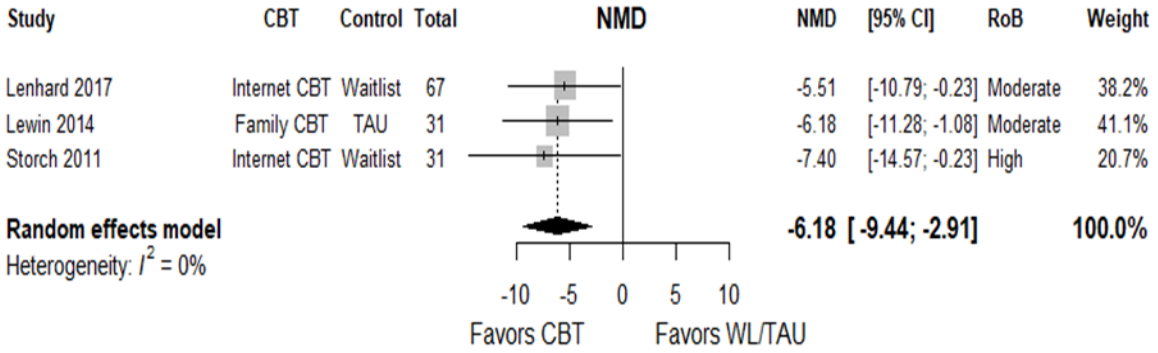
Table E-24. Family accommodation on FAS: CBT versus Treatment as Usual/Waitlist

Study, Year, PMID, Study name	Arm	CBT components	Scale/ Subscale	Baseline N: Mean (SD)	N: MD (SD)	NMD (95% CI)
Lenhard, 2017, 27993223 RCT	Internet CBT	PE/ERP	FAS-PR	33: 15.79 (11.25)	33: -4.56 (10.38)	-5.51 (-10.79, -0.23) P=0.003
.	Waitlist	None	FAS-PR	34: 16.18 (10.93)	34: 0.95 (11.66)	.
Lewin, 2014, 24657310 RCT	Family CBT	ERP	FAa	17: 19.71 (6.76)	17: -8.47 (7.11)	-6.18 (-11.28, -1.08)
.	TAU	None	FA	14: 25.93 (6.86)	14: -2.29 (7.28)	.
Storch, 2011, 21684018 RCT	Internet CBT	PR/CR/ERP	FASa,b	16: 25.67 (8.62)	16: -9.61 (12.17)	-7.4 (-14.57, -0.23)
.	Waitlist	None	FAS	15: 16.21 (6.93)	15: -2.21 (7.87)	.

Abbreviations: CBT = Cognitive behavior therapy; CI = confidence interval; CoRe = coping and relaxation; CR = cognitive restructuring; ERP = exposure and Response Therapy; FAS-P = Family Accommodation Scale-parent version; MD = mean difference; N= sample size; NMD = net mean difference; NR = not reported; NS = not specified; PE = psychoeducation; PMID = PubMed ID; **Bold** = statistically significant

[a]FA, measure of family accommodation adapted from Calvocoressi et al., 1999, [b]Administrated by clinician Abbreviations: FAS; Family Accommodation Scale; ERP = Note; value in **Bold** is significant

Figure E-4. Meta-analysis of Family Accommodation (FAS): CBT versus Control



Abbreviations; ICBT = internet-delivered Cognitive behavior therapy; ERP = Family-based exposure and response prevention therapy, W-CBT = webcam-delivered CBT; NMD = net mean difference, RoB = Risk of bias, TAU = treat as usual; WL = Waitlist

Three studies, two RCTs{Peris 2013 #88;Peris 2017 #100} and one NRCS[32] assessed family accommodation in participants assigned to either CBT plus a family intervention or CBT only. In general, the results were variable, with only one study reporting a significant net mean difference favoring CBT combined with parent training.

Table E-25. FAS: Combined CBT plus family intervention versus CBT only

Study, Year, PMID, Study Design	Arm Name	Arm Description	Scale	Baseline N: Mean (SD)	N: MD (SD)	NMD (95% CI)
Peris, 2013, 22548378 RCT	FI + CBT	PE/CR/ERP	FAS	10: 25.9 (10.97)	10: -18 (9.51)	-6 (-13.86, 1.86)
.	CBT	PE/CR/ERP	FAS	10: 26.5 (8.25)	10: -12 (8.4)	.
Peris, 2017, 29173737 RCT	FI + CBT	ERP	FAS	32: 27.94 (11.02)	32: -17.13 (10.44)	**-9.89 (-15.10, -4.67)**
.	CBT	ERP	FAS	30: 25.44 (8.95)	30: -7.24 (10.51)	.
Schuberth, 2023, NR, NRCS	PMT + CBT	PE/ERP	FAS	37: NR	37: -7.73 (9.37)	MD: -1.23 (-4.24, 1.78)*
.	CBT	PE/ERP	FAS	80: NR	80: NR	.

Abbreviations: CBT = Cognitive behavior therapy; CI = confidence interval; CoRe = coping and relaxation; CR = cognitive restructuring; ERP = exposure and Response Therapy; FAS-P = Family Accommodation Scale-parent version; MD = mean difference; N= sample size; NMD = net mean difference; NR = not reported; NS = not specified; PE = psychoeducation; PFIT= Positive Family Interaction Therapy; PMID = PubMed ID; **Bold** = statistically significant

* Adjusted mean difference between groups at post-treatment.

Abbreviations: FAS = Family Accommodation Scale; Values in **Bold** are statistically significant, but the bolding does not provide any unique information.

Quality of Life

Six RCTs and one NRCS, enrolling a total of 1642 participants measured quality of life at baseline and end of intervention using different tools; Child Health Utility 9D (CHU9D), Manchester Short Assessment of Quality of Life (MANSA), Pediatric Quality of Life Enjoyment and Satisfaction Questionnaire (PQ-LES-Q), Pediatric Quality of life Inventory (PEDSQL), EQ-5D.

CHU9D is a self-reported measure of quality of life with 9 items rated from 1 to 5, yielding a total score of 9-45, with higher scores indicating greater quality of life.[4] MANSA a brief and modified version of LQLP (Lancashire Quality of Life Profile). Like in the LQLP, satisfaction is rated on 7-point rating scales (1 = negative extreme, 7 = positive extreme). ,[22]; PQ-LES-Q is a 15-item rating scale with items scored from 1 (very poor) to (very good); the first 14 items are summed based on the original Q-LES-Q, with higher scores reflecting greater enjoyment and satisfaction, Freeman, 2014 #71; Franklin 2023. PedsQLTM 4.0, Generic Core Scales.

Physical functioning consists of eight questions. Emotional functioning and social functioning consist of 5 questions each. Each question ranges from 0 to 4 on a Likert scale. Higher scores show worse conditions. EQ-5D is a widely used measure in health economic evaluations and consists of five dimensions measuring health-related functioning and quality of life, that is, pain/discomfort, anxiety/depression, self-care, mobility and usual activities. It also consists of a 0–100 visual analogue scale (VAS) used to measure subjective ratings of health.

Six studies assessed the comparative effect of CBT (basically ERP) alone and one study assessed the comparative effect of a combination of pharmacological agents. ERP differed across these studies in regard to setting (remote vs. in-person, home vs. hospital). Two studies compared ERP to no active treatment,[7, 22] three studies compared remote ERP to either no active treatment[29] or ERP.[4, 34] One study compared home-intensive ERP to hospital-intensive ERP Selles, 2021 #138}and one study compared a combination of N-Acetylcysteine (NAC) plus ERP to placebo plus ERP.

Three studies were rated as moderate risk of bias overall, primarily for lack of blinding or concealment. Three studies were rated as low risk of bias overall,[7, 26, 35] and the NRCS[34] was rated as high risk of bias overall primarily for lack of blinding and possible confounding based on baseline differences between arms.

Child Health Utility 9D

Behavioral Interventions

Behavioral Intervention vs Behavioral Intervention

Remote ERP vs. ERP

One RCT assessed quality of life using CHU9D in participants assigned to internet-delivered ERP compared to traditional ERP (in-person ERP).[4] The study found no significant difference in quality of life on CHU9D between internet-delivered ERP and traditional ERP.

Table E-26. Quality of life on CHU9D: Remote ERP vs. ERP

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD (95% CI)
Aspvall, 2021, 33974020 RCT	Remote ERP	PE/ERP	CHU9D	74: 19.9 (5.7)	74: -3 (5.7)	0.3 (-1.54, 2.14)
.	ERP	PE/ERP	.	78: 20.0 (5.5)	78: -3.3 (5.88)	.

Abbreviations: CHU9D = Child Health Utility 9D, CI = Confidence interval; ERP = Exposure and Response Prevention; meanCFB = Mean from baseline; N= Sample size; NMD = Net mean difference; PE = Psychoeducation; PMID = PubMed ID; RCT = Randomized Controlled Trial; Remote ERP = Remote ERP (internet-delivered ERP); SD = Standard deviation; **Bold** = statistically significant.

[a]Calculated by research team

MANSA (Manchester Short Assessment of Quality of Life)

Behavioral Interventions

Behavioral versus No Active Treatment

ERP vs. Control

One three arm RCT for this outcome compared full and brief ERP each to no active treatment (Control).[22] The study found a significant difference in quality of life between full ERP and Control. Quality of life did not significantly differ between brief ERP and noAcitveRx.

Table E-27. Quality of life on MANSA: ERP vs. Control

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD (95% CI)
Bolton, 2011, 21644984 RCT	ERP	General ERP/NS	MANSA	36: 37.3 (9.2)	36: 7.3 (8.66)	4.8 (0.67. 8.92)
.	Control	None	.	24: 35.0 (8.0)	24: 2.5 (7.51)	.
Bolton, 2011, 21644984 RCT	Brief ERP	Brief ERP/NS	MANSA	36: 36.6 (9.4)	36: 2.8 (9.61)	0.3 (-4.05, 4.65)
.	Control	None	.	24: 35.0 (8.0)	24: 2.5 (7.51)	.

Abbreviations: CI = Confidence interval; ERP = Exposure and Response Prevention; MANSA = Manchester Short Assessment of Quality of Life; meanCFB = Mean change from baseline; N= Sample size; NMD = Net mean difference; Control = No active treatment; NS= Not specified; PMID = PubMed ID; RCT = Randomized Controlled Trial; SD = Standard deviation; **Bold** = statistically significant.

[a]Calculated by research team

PQ-LES-Q (Pediatric Quality of Life Enjoyment and Satisfaction Questionnaire)

Behavioral Interventions

Behavioral Intervention versus No Active Treatment

ERP vs. Control

One RCT for this outcome compared family-based ERP to noAcitveRx (no active treatment).[7] The study did not report this outcome at baseline, but only reported mean score for each arm at post-intervention. There was no significant difference on PQ-LES-Q at post-intervention between ERP and Control.

Table E-28. Quality of life on PQ-LES-Q: ERP vs. Control

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: Mean (SD)	MD[a] (95% CI)
Freeman, 2014, 24759852 RCT POTS Jr	ERP	Family- PE/CoRe/CR/ERP	PQ-LES-Q	63: NR	63: 4.16 (0.55)	0.14 (-0.05, 0.33)
.	Control	behavCntrl	.	64: NR	64: 4.02 (0.55)	.

Abbreviations: behavCntrl = Behavioral control; CI = Confidence interval; CoRe = Coping and Relaxation; CR= Cognitive Restructuring; ERP = Exposure and Response Prevention; MD = Mean difference; N= Sample size; Control = No active treatment; NR = Not reported; PE = Psychoeducation; PMID = PubMed ID; POTS = Pediatric OCD Treatment Study; PQ-LES-Q = Pediatric Quality of Life Enjoyment and Satisfaction Questionnaire; RCT = Randomized Controlled Trial; SD = Standard deviation; **Bold** = statistically significant.

[a]Calculated by research team

Behavioral Intervention versus Behavioral Intervention

Remote ERP vs. ERP

One NRCS assessed quality of life in participants received either internet-delivered ERP or in-person ERP. The study found no significant difference in quality of life on PQ-LES-Q between internet-delivered ERP and in-person ERP.

Table E-29. Quality of life on PQ-LES-Q: Remote ERP vs. ERP

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)a	NMDa (95% CI)
Franklin, 2023, NR NRCS	Remote ERP	Internet ERP	PQ-LES-Q	590: 57.56 (15.84)	590: 9.34 (15.94)	-1.24 (-3.11, 0.63)

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)a	NMDa (95% CI)
.	ERP	ERP	.	591: 57.11 (16.17)	591: 10.58 (16.85)	.

Abbreviations: CI = Confidence interval; ERP = Exposure and Response Prevention; meanCFB = Mean from baseline; N= Sample size; NMD = Net mean difference; NRCS = Non-Randomized Controlled Study; PMID = PubMed ID; PQ-LES-Q = Pediatric Quality of Life Enjoyment and Satisfaction Questionnaire; Remote ERP = Remote ERP (internet-delivered ERP); SD = Standard deviation; **Bold** = statistically significant.

[a]Calculated by research team

Home-intensive ERP vs. Hospital-Intensive ERP

One RCT assessed quality of life using PQ-LES-Q in participants assigned to either home-intensive ERP or hospital-intensive ERP.[26] Analysis of Quality of life reported on PQ-LES-Q showed no significant difference between home-intensive ERP and hospital-intensive ERP.

Table E-30. Quality of life on PQ-LES-Q: Home-intensive ERP vs. Intensive ERP

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)a	NMDa (95% CI)
Selles, 2021, 34079488 RCT	Home-intensive ERP	PE/CoRe/ERP	PQ-LES-Q	12: 52.09 (9.66)	12: -1.09 (9.99)	-1.65 (-8.92, 5.62)
.	Intensive ERP	PE/CoRe/ERPb	.	14: 48.29 (9.15)	14: 0.56 (8.76)	.

Abbreviations: CI = Confidence interval; CoRe = Coping and Relaxation; ERP = Exposure and Response Prevention; meanCFB = Mean change from baseline; N= Sample size; NMD = Net mean difference; PE = Psychoeducation; PMID = PubMed ID; PQ-LES-Q = Pediatric Quality of Life Enjoyment and Satisfaction Questionnaire; RCT = Randomized Controlled Trial; SD = standard deviation; **Bold** = statistically significant.

[a]Calculated by research team; [b]Hospital-intensive ERP.

PedsQL (Pediatric Quality of Life Inventory)

Behavioral Interventions

No studies for this outcome assigned participants to behavioral interventions.

Pharmacological Interventions

Combination with Pharmacological Interventions

NAC plus SSRI vs. SSRI

One RCT[35] assessed different quality of life domains, at baseline and post-treatment, in participants assigned to either a combination of N-Acetylcysteine (NAC) plus citalopram or placebo plus citalopram. NAC group had a non-significant net improvement in Quality-of-life domains (Physical and Social functions) compared to placebo. Analysis of emotional function showed a significant net improvement favoring NAC.

Table E-31. Quality of Life domains on PedsQL: NAC plus SSRI vs. Placebo plus SSRI

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)[a]	NMD[a] (95% CI)
Ghanizadeh, 2017, 28659986 RCT	NAC + SSRI	NAC + Citalopram	Physical Function on PedsQL	18: 11.1 (5.1)	18: -4.3 (5.15)	-3.8 (-8.89, 1.29)
.	SSRI	Citalopram	.	11: 10.4 (7)	11: -0.5 (7.61)	.
Ghanizadeh, 2017, 28659986 RCT	NAC + SSRI	NAC + Citalopram	Emotional Function on PedsQL	18: 9.3 (4.5)	18: -5.1 (4.36)	**-7.1 (-13.43, -0.77)**
.	SSRI	Citalopram	.	11: 17 (11.5)	11: 2 (10.15)	.
Ghanizadeh, 2017, 28659986 RCT	NAC + SSRI	NAC + Citalopram	Social Function on PedsQL	18: 7.7 (4.8)	18: -4.4 (4.36)	-2.1 (-5.67, 1.47)
.	SSRI	Citalopram	.	11: 7.7 (5.6)	11: -2.3 (5.0)	.

Abbreviations: CI = Confidence interval; meanCFB = Mean change from baseline; N= Sample size; NAC = N-Acetylcysteine; NMD = Net mean difference; PedsQL = Pediatric Quality of Life Inventory; PMID = PubMed ID; RCT = Randomized Controlled Trial; SD = Standard deviation; SSRI = Selective Serotonin Reuptake Inhibitors; **Bold** = statistically significant.

[a]Calculated by research team.

EQ-5D-Y VAS (Five Dimensions Questionnaire Youth version Visual Analogue Scale)

Behavioral Interventions

Behavioral Intervention versus Control

Remote ERP vs. control

One RCT assessed quality of life using EQ-5D-Y VAS in participants randomized to either Therapist-Guided, Internet-Delivered ERP or no active treatment (Control).[29] The study showed no significant net difference in EQ-5D-Y VAS score between internet-delivered ERP and noActieRx.

Table E-32. Quality of Life domains on EQ-5D-Y VAS: remote ERP vs. control

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: meanCFB (SD)a	NMD (95% CI)
Lenhard, 2017, 27993223 RCT	Remote ERP	PE/ERP	EQ-5D-Y VAS	33: 66.11 (22)	33: 0.0007 (0.051)	0.0041 (-0.018, 0.026)
.	Control	None	.	34: 66.2 (22)	34: -0.0034 (0.041)	.

Abbreviations: CI = Confidence interval; ERP = Exposure and Response Prevention; EQ-5D-Y VAS = Five Dimensions Questionnaire Youth version Visual Analogue Scale (VAS); meanCFB = Mean change from baseline; N= Sample size; NMD = net mean difference; Control = No active treatment; PE= Psychoeducation; PMID = PubMed ID; RCT = Randomized Controlled Trial; Remote ERP = Remote ERP (internet-delivered ERP); SD = Standard deviation; **Bold** = statistically significant.

[a]Calculated by research team.

Parent Satisfaction with Services

Three RCTs [4, 5, 30] enrolling a total of 192 participants measured parent satisfaction with services using The Client Satisfaction Questionnaire (CSQ-8) or the 7-Item inventory at the end of intervention. CSQ-8 is an 8-item scale that is used to measure satisfaction with the treatment, each item is rated from 1 to 4, yielding a total score of 9-36 where higher scores indicate greater satisfaction.[4] The 7-item inventory includes items such as, “To what extent has this program met your needs?” and “If a friend's child were in similar need, would you recommend the program?” Items were rated on a 4-point Likert scale with 0=not at all and 4=very much (maximum score= 28).[30]

The three studies assessed the comparative effect of CBT (basically ERP) alone or as a combination with family intervention. No study assessed the comparative effect of pharmacological agents. Two studies compared remote ERP (internet-delivered ERP) to traditional ERP (in-person ERP).[4, 5] One study compared a combination of ERP plus family intervention to traditional ERP.[30]

One study was rated as moderate risk of bias overall, [4] primarily for lack of blinding or concealment. Two studies were rated as low risk of bias overall.[5, 30]

CSQ-8 (The Client Satisfaction Questionnaire)

Behavioral Interventions

Behavioral Intervention vs Behavioral Intervention

Remote ERP vs. ERP

Two studies assessed parent satisfaction with internet-delivered ERP compared to traditional ERP (in-person ERP).[4, 5] One study[4] found that parents were significantly less satisfied with internet-delivered ERP than traditional ERP. Another[5] found no significant difference in satisfaction rated by mother between internet-delivered ERP and traditional ERP.

Table E-33. Parent Satisfaction on CSQ-8: Remote ERP vs. ERP

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: Mean (SD)	MD[a] (95% CI)
Aspvall, 2021, 33974020 RCT	Remote ERP	PE/ERP	CSQ-8 Parent rated	-	74: 25.25 (5.06)	-2.62 (-4.14, -1.1)
.	ERP	PE/ERP	.	-	78: 27.87 (4.47)	.
Comer, 2017, 278694 RCT	Remote ERP	ERP	CSQ-8 Mother rated	-	10: 28.55 (4.5)	-1.95 (-5.00, 1.10)
.	ERP	ERP	.	-	10: 30.5 (2)	.

Abbreviations: CI = Confidence interval; CSQ-8 = The Client Satisfaction Questionnaire; ERP = Exposure and Response Prevention; MD = Mean difference; N= sample size; PE = psychoeducation; PMID = PubMed ID; Remote ERP = Internet-delivered ERP; RCT = Randomized Controlled Trial; SD = Standard deviation; **Bold** = statistically significant.

[a]Assessed at post-treatment only, as this assessment was not applicable at baseline.

The 7-Item Inventory

Behavioral Intervention

Combination with Behavioral Intervention

PFI plus ERP vs. ERP

Only One RCT for this outcome compared a combination of ERP plus a family intervention with traditional ERP alone.[30] The study found no significant difference in satisfaction rated by mother between ERP plus family intervention and traditional ERP.

Fathers in the same study were more satisfied with ERP plus family intervention than traditional ERP. Significance could not be known due to missing data.

Table E-34. Parent Satisfaction on the 7-Item Inventory: PFI plus ERP vs. ERP

Study, Year, PMID, Study name	Arm	Arm Description	Scale	Baseline N: Mean (SD)	N: Mean (SD)	MD[a] (95% CI)
Peris, 2013, 22548378 RCT	PFIT + ERP	PE/CR/ERP	Mother Rated	-	10: 24.9 (4.61)	0.8 (-2.78, 4.38)
.	ERP	PE/CR/ERP	.	-	10: 24.1 (3.47)	.
Peris, 2013, 22548378 RCT	PFI + ERP	PE/CR/ERP	Father Rated	-	NR: 26.71 (1.5)	7.11[b]
.	ERP	PE/CR/ERP	.	-	NR: 19.6 (1.34)	.

Abbreviations: CI = Confidence interval; CR = Cognitive Restructuring; ERP = Exposure and Response Prevention; MD = Mean difference; N= Sample size; NR = Not reported; PE = Psychoeducation; PFIT = Positive Family Interaction Therapy; PMID = PubMed ID; RCT = Randomized Controlled Trial; SD = Standard deviation; **Bold** = statistically significant.

[a]Assessed at post-treatment only, as this assessment was not applicable at baseline. [b]Confidence interval could not be calculated, as the N for each arm was not reported, however, total number of fathers was 12 per reported.

Other scales

One study reported on parental satisfaction using a questionnaire developed by the researchers. No significant effect on parental satisfaction was observed when comparing telephone CBT versus in-person CBT.

Table E-35. Parental satisfaction

Study, Year, PMID	Timepoint	Intervention Arms	Intervention Description	n/N (%)	RR (95% CI)	P value
Turner, 2014, 25457928	Study Period	CBT	Telephone CBT	33/36 (93.1)	1.00 (0.85, 1.18)	1.000
		CBT	In-person CBT	32/36 (88.9)		

Abbreviations: % = percent, CBT = cognitive behavioral therapy, CI = confidence interval, n = event, N = total sample analyzed, PMID = PubMed identifier, RR = relative risk, wk = week. Note: bold indicates a significant difference.

One study reported on patient satisfaction using a questionnaire developed by the researchers. No significant effect on parental satisfaction was observed when comparing telephone CBT versus in-person CBT.

Table E-36. Patient satisfaction

Study, Year, PMID	Timepoint	Intervention Arms	Intervention Description	n/N (%)	RR (95% CI)	P value
	Study Period	CBT	Telephone CBT	35/36 (96.3)	1.06 (0.95, 1.19)	0.311

Study, Year, PMID	Timepoint	Intervention Arms	Intervention Description	n/N (%)	RR (95% CI)	P value
Turner, 2014, 25457928		CBT	In-person CBT	33/36 (92.6)		

Abbreviations: % = percent, CBT = cognitive behavioral therapy, CI = confidence interval, n = event, N = total sample analyzed, PMID = PubMed identifier, RR = relative risk, wk = week. Note: bold indicates a significant difference.

Adverse events leading to withdrawal or discontinuation

Seven studies reported on adverse events leading to withdrawal or discontinuation.[3, 13, 36-40] Three studies reported on the comparison of TCA versus Placebo,[13, 37, 38] two on CBT versus SSRI,[36, 40] one compared different TCAs,[39] one on CBT versus TCA.[3]

Paroxetine showed higher risk of reporting adverse events leading to withdrawal after study period (RR 3.57; 95%CI 1.01-12.60)[38] and Sertraline after 12 weeks follow-up (RR 4.13, 95%CI 1.20, 14.16).[13] No other study reported significant adverse events leading to withdrawal related to intervention.

Table E-37. Adverse events leading to withdrawal or discontinuation

Study, Year, PMID	Timepoint	Intervention Arms	Intervention Description	n/N (%)	RR (95% CI)	P value
Geller, 2004, 15502598	Study period	TCA	Paroxetine	10/98 (10.2)	3.57 (1.01, 12.60)	0.048
		Placebo	Placebo	3/105 (2.9)		
POTS, 2004, 15507582	12wk	CBT	ERP	0/28 (0)	NA	NA
		SSRI	Sertraline	1/28 (3.6)		
Leonard, 1989, 2686576	Study period	TCA	Clomipramine	1/45 (2.2)	NA	NA
		TCA	Desipramine	0/45 (0)		
March, 1998, 9842950	12wk	TCA	Sertraline	12/92 (13)	4.13 (1.20, 14.16)	0.024
		Placebo	Placebo	3/95 (3.2)		
Geller, 2003, 12880497	16wk	TCA	Paroxetine	8/95 (8.4)	0.75 (0.32, 1.78)	0.511
		Placebo	Placebo	11/98 (11.2)		
Franklin, 2011, 21934055	Study period	Remote CBT + SSRI	Remote CBT + SSRI	5/42 (11.9)	1.59 (0.41, 6.21)	0.504
		SSRI	SSRI	3/40 (7.5)		
Asbahr, 2005, 16239861	Study period	CBT	ERP	0/20 (0)	NA	NA
		TCA	Sertraline	1/20 (5)		

Abbreviations: % = percent, CBT = cognitive behavioral therapy, CI = confidence interval, ERP = exposure and response prevention, n = event, N = total sample analyzed, PMID = PubMed identifier, POTS = Pediatric OCD Treatment Study, RR = relative risk, SSRI = slow serotonin reuptake inhibitor, TCA = tricyclic antidepressant, wk = week. Note: bold indicates a significant difference.

Adverse events, serious/severe

Four studies reported on serious/severe adverse events.[15, 19, 36, 37] One study reported on the comparison of TCA versus Placebo,[37] one on NMDA versus CBT,[19] one on CBT versus SSRI,[36] and one on regular versus slow titration of an SSRI.[15] No significant risk rations of serious/severe adverse events were observed.

Table E-38. Adverse events, serious (grade 3 or 4)

Study, Year, PMID	Timepoint	Intervention Arms	Intervention Description	n/N (%)	RR (95% CI)	P value
Geller, 2003, 12880497	12wk	TCA	Paroxetine	2/95 (2.1)	1.03 (0.15, 7.18)	0.976
		Placebo	Placebo	2/98 (2)		
Storch, 2016, 27367832	10wk	CBT + NMDA agonist	CBT + D-cycloserine	0/70 (0)	NA	NA
		CBT	CBT + Placebo	0/72 (0)		
Franklin, 2011, 21934055	Study period	SSRI + iCBT	SSRI + internet CBT	1/40 (2.5)	1.05 (0.07, 16.23)	0.972
		SSRI	SSRI	1/42 (2.4)		
Storch, 2013, 24184429	Study period	SSRI + CBT	Regular Sertraline + CBT	1/14 (7.1)	1.21 (0.08, 17.71)	0.887
		SSRI + CBT	Slow Sertraline + CBT	1/17 (5.9)		

Abbreviations: % = percent, CBT = cognitive behavioral therapy, CI = confidence interval, n = event, N = total sample analyzed, NMDA = N-methyl-D-aspartate, PMID = PubMed identifier , RR = relative risk, SSRI = slow serotonin reuptake inhibitor, TCA = tricyclic antidepressant, wk = week. Note: bold indicates a significant difference.

Adverse events, total

Ten studies reported on total adverse events.[4, 8, 18, 36, 41-45] One study reported on the comparison of different TCAs,[41] two on NMDA versus placebo,[18, 43] one on CBM-I versus waitlist,[45] one on TCA versus placebo, one on antipsychotic drug versus TCA,[42] one on SSRI versus placebo,[8] one on SSRI versus CBT,[36] one on internet CBT versus in-person CBT,[4] and one on SSRI versus TCA.[44]

One study reported a reduced risk of total adverse events using Fluvoxamine versus Clormipramine (RR 0.48, 95%CI 0.27-0.83).[41] Another study comparing SSRI and TCA reported that participants treated with Sertraline reported reduced adverse events than those treated with Clomipramine (RR 0.42, 95%CI 0.24-0.72).[44] No other study reported significant adverse events leading to withdrawal related to intervention.

Table E-39. Adverse events, total

Study, Year, PMID	Timepoint	Intervention Arms	Intervention Description	n/N (%)	RR (95% CI)	P value
Wolters, 2021	Study period	CBM-I + CBT	Internet Cognitive Bias Modification + CBT	0/40 (0)	NA	NA
		Waitlist + CBT	CBT	0/39 (0)		
NCT01933919, 2017,	Study period	TCA	Fluvoxamine	13/19 (68.4)	0.87 (0.59, 1.27	0.476
		Placebo	Placebo	15/19 (78.9)		

Study, Year, PMID	Timepoint	Intervention Arms	Intervention Description	n/N (%)	RR (95% CI)	P value
He, 2007	Study period	TCA	Fluvoxamine	10/30 (33.3)	0.48 (0.27, 0.83)	0.010
		TCA	Clormipramine	21/30 (70)		
Liu, 2012	Study period	TCA + antipsychotic	Fluvoxamine + Risperidone	3/44 (6.8)	1.00 (0.21, 4.69)	1.000
		TCA	Fluvoxamine	3/44 (6.8)		
Mataix-Cols, 2014, 24262813	Study period	CBT + NMDA agonist	CBT + D-cycloserine	0/13 (0)	NA	NA
		CBT + Placebo	CBT + Placebo	0/14 (0)		
Storch, 2010, 20817153	Study period	CBT + NMDA agonist	CBT + D-cycloserine	0/15 (0)	NA	NA
		CBT + Placebo	CBT + Placebo	0/15 (0)		
Franklin, 2011, 21934055	Study period	SSRI + iCBT	SSRI + internet CBT	33/40 (82.5)	0.94 (0.78, 1.12)	0.503
		SSRI	SSRI	37/42 (88.1)		
Geller, 2001, 11437015	Study period	SSRI	Fluoxetine	53/71 (74.6)	0.88 (0.72, 1.08)	0.217
		Placebo	Placebo	27/32 (84.4)		
Aspvall, 2021, 33974020	Study period	iCBT	Internet CBT	47/74 (63.5)	0.95 (0.75, 1.20)	0.669
		CBT	In-person CBT	52/78 (66.7)		
Nai, 2009,	Study period	SSRI	Sertraline	10/32 (31.3)	0.42 (0.24, 0.72)	0.002
		TCA	Clomipramine	24/32 (75)		

Abbreviations: % = percent, CBT = cognitive behavioral therapy, CI = confidence interval, n = event, N = total sample analyzed, NMDA = N-methyl-D-aspartate, PMID = PubMed identifier, RR = relative risk, SSRI = slow serotonin reuptake inhibitor, TCA = tricyclic antidepressant, wk = week. Note: bold indicates a significant difference.

Suicidal thoughts and behavior

One study reported on suicidal thoughts and behavior using a questionnaire developed by the researchers.[38] No cases were reported in both regular sertraline plus CBT and slow sertraline plus CBT groups.

Table E-40. Suicidal thoughts and behavior

Study, Year, PMID	Timepoint	Intervention Arms	Intervention Description	n/N (%)	RR (95% CI)	P value
Geller, 2004, 15502598	Study Period	SSRI	Paroxetine	1/98 (1)	NA	NA
		Placebo	Placebo	0/105 (0)		

Abbreviations: % = percent, CI = confidence interval, n = event, N = total sample analyzed, PMID = PubMed identifier, RR = relative risk, SSRI = slow serotonin reuptake inhibitor, wk = week. Note: bold indicates a significant difference.

Withdrawals/discontinuation

Eleven studies reported on withdrawals and discontinuation.[8, 9, 13, 15, 19, 29, 36-38, 46, 47] One study reported on the comparison of CBT versus SSRI,[36] one on different TCAs,[37] two on TCA versus placebo,[13, 38] one on iCBT versus placebo,[29] one on CBT versus TCA,[47] one on ACT versus CBT,[46] one on SSRI versus placebo,[8] and one on different SSRIs.[15] No study reported significant effect of intervention on the risk of withdrawal or discontinuation.

Table E-41. Withdrawals/discontinuation

Study, Year, PMID	Timepoint	Intervention Arms	Intervention Description	n/N (%)	RR (95% CI)	P value
March, 1998, 9842950	Study Period	TCA	Sertraline	18/92 (19.6)	1.43 (0.74, 2.75)	0.283
		Placebo	Placebo	13/95 (13.7)		
Franklin, 2011, 21934055	Study period	SSRI + iCBT	SSRI + internet CBT	5/40 (12.5)	0.48 (0.18, 1.25)	0.133
		SSRI	SSRI	11/42 (26.2)		
Lenhard, 2017, 27993223	Study period	iCBT	CBT	1/33 (3)	0.52 (0.05, 5.41)	0.584
		Waitlist	Placebo	2/34 (5.9)		
Shabani, 2019	Study period	ACT + SSRI	CBT + SSRI	2/22 (9.1)	0.67 (0.12, 3.61)	0.645
		CBT + SSRI	CBT + SSRI	3/22 (13.6)		
Geller, 2003, 12880497	Study period	TCA	Paroxetine	53/95 (55.8)	0.84 (0.67, 1.06)	0.137
		TCA	Placebo	65/98 (66.3)		
Geller, 2004, 15502598	Study period	TCA	Paroxetine	33/98 (33.7)	1.41 (0.91, 2.20)	0.123
		Placebo	Placebo	25/105 (23.8)		
Skarphedinsson, 2015, 25239489	Study period	TCA	Sertraline	7/22 (32)	1.27 (0.52, 3.09)	0.599
		CBT	CBT	7/28 (25)		
Grant, 2014, 24356715	Study period	Glutamate inhibitor	Riluzole	7/30 (23.3)	7.00 (0.92, 53.47)	0.060
		Placebo	Placebo	1/30 (3.3)		
Storch, 2016, 27367832	Study period	CBT + NMDA agonist	CBT + D-cycloserine	3/70 (4.3)	NA	NA
		CBT + Placebo	CBT + Placebo	0/72 (0)		
Storch, 2013, 24184429	Study period	SSRI + CBT	Regular Sertraline + CBT	6/14 (42.9)	1.46 (0.56, 3.78)	0.439
		SSRI + CBT	Slow Sertraline + CBT	5/17 (29.4)		
Geller, 2001, 11437015	Study period	SSRI	Fluoxetine	22/71 (31.0)	0.83 (0.47, 1.46)	0.509
		Placebo	Placebo	12/32 (37.5)		

Abbreviations: % = percent, ACT = acceptance and commitment therapy, CBT = cognitive behavioral therapy, CI = confidence interval, n = event, N = total sample analyzed, NMDA = N-methyl-D-aspartate, PMID = PubMed identifier, POTS = pediatric OCD (Obsessive compulsive disorder) treatment study, RR = relative risk, SSRI = slow serotonin reuptake inhibitor, TCA = tricyclic antidepressant, wk = week. Note: **bold** indicates a significant difference.

Predictors/Mediators of effect

Full extractions for the single-arm predictor studies are in OCD_KQ2_predictor_studies_appendix.xlsx. The following tables summarize the results.

Table E-42. RCT predictors/mediators

Study	Comparison (n)	Behavioral Intervention, Components	Outcome	Age	Gender	Comorbidity*	CY-BOCS (baseline)	FAS (base-line)	FAD (base-line)
Barrett, 2005, 16175105	Individual CBFT (24) vs. group CBFT (29) or waitlist (24)	Psychoeducation, Cognitive restructuring, ERP	CY-BOCS (lower post-treatment score)	NS	.	.	.	.	.
Wilhelm, 2018, 30149332	CBT + DCS (70) vs. CBT + placebo (72)	Psychoeducation, Cognitive restructuring, ERP	CY-BOCS (lower post-treatment score)	NS	NS	NS	.	.	.
Barrett, 2005, 16175105	Individual CBFT (24) vs. group CBFT (29) or waitlist (24)	Psychoeducation, Cognitive restructuring, ERP	NIMH GOCS (% reduction)	NS	.	NS	+	.	–
Wilhelm, 2018, 30149332 (Storch 2016)	CBT + DCS (70) vs. CBT + placebo (72)	Psychoeducation, Cognitive restructuring, ERP	CY-BOCS <12	NS	NS	NS	.	.	.

Cell coloring applied for visual emphasis only; it does not provide unique information.
Abbreviations: + = increase in predictor/predictor (or noted predictor) present predicts statistically significant increase in outcome; – = decrease in predictor/predictor present predicts statistically significant increase in outcome; . = study did not evaluate predictor; NS no significant relationship; ? = significant relationship but direction unclear (not used in this table); CBT = cognitive behavioral therapy, CBFT = cognitive behavioral family therapy, CY-BOCS = Children's Yale-Brown Obsessive Compulsive Scale, DCS = D-cycloserine, ERP = exposure and response therapy, FAS = Family Accommodation Scale, FAD = Family Assessment Device, OCD = Obsessive Compulsive Disorder, TCBT = telephone cognitive behavioral therapy,

* The comorbidities assessed by studies were anxiety, depression, and tics.

Table E-43. Single-arm study predictor/mediators

Study; Study Name/Site	N; Age, Baseline CY-BOCS Score, Mean (SD)	Intervention, Components	Regression Quality	Outcome	Age	Age at onset/ duration	Gender	Comorbidity	CY-BOCS (base-line)	Insurance	Medication	Minoritized Group	Treatment	COIS (base-line)	FAS (base-line)	Symptoms (base-line)	Other
Riise, 2019, 31134420; Haukeland University hospital, Norway	N=63; Age =14.4 (1.9); Baseline CY-BOCS Score=26.52 (3.99)	Psychoeducation, ERP	Adequate	CY-BOCS (lower post-treatment score)	.	.	.	.	+*	.	.	.	.	NS	NS	.	.
Nakatani, 2011, 21726224; Maudsley Hospital (London, UK) 1996-2007	N=109; Age =NR; Baseline CY-BOCS Score=NR	Psychoeducation, Cognitive restructuring, ERP	Inadequate	CY-BOCS (lower post-treatment score)	.	NS	NS	NS	–	.	–	.	.	.	.	.	.

Study; Study Name/Site	N; Age, Baseline CY-BOCS Score, Mean (SD)	Intervention, Components	Regression Quality	Outcome	Age	Age at onset/ duration	Gender	Comorbidity	CY-BOCS (baseline)	Insurance	Medication	Minoritized Group	Treatment	COIS (baseline)	FAS (baseline)	Symptoms (baseline)	Other
Brown, 2015, 25301176; Maudsley Hospital (London, UK) 2007-2012	N=98; Age =NR; Baseline CY-BOCS Score=NR	Psychoeducation, ERP	Adequate	CY-BOCS (lower post-treatment score)	NS	.	.	NS	–	.	NS	.	.	.	.	.	.
Torp, 2015, 25721185; NordLOTS, stage 1	N=269; Age =12.8 (2.7); Baseline CY-BOCS Score=24.6 (5.1)	ERP	Adequate	CY-BOCS (lower post-treatment score)	–	NS	NS	NS	.	.	.	.	.	.	NS	.	.
Højgaard , 2020, 31203735; OCD Center at he Rogers Memorial Hospital in Oconomowoc, Wisconsin	N=314; Age =15.56 (1.20); Baseline CY-BOCS Score=25.65 (5.63)	Cognitive restructuring, ERP	Adequate	CY-BOCS (lower post-treatment score)	NS	.	NS	NS	–	.	.	.	NS	.	.	.	.
Rudy, 2014, 25193378; University of Florida OCD Program	N=78; Age =13.2 (2.72); Baseline CY-BOCS Score=NR	Psychoeducation, Cognitive restructuring, ERP	Adequate	CY-BOCS (lower post-treatment score)	NS	.	NS	.	–	.	.	.	.	NS	NS	.	.
Garcia, 2023, none; Bradley Hospital Pediatric Anxiety Research Center, 2013-2022	N=185; Age =12.2 (3.3); Baseline CY-BOCS Score=28.9 (4.6)	ERP	Adequate	CY-BOCS (reduction)	NS	.	NS	+ (Anxiety Mood ADHD ASD Tics)	+	NS	NS	–‖	–†	.	.	.	.
Storch, 2008, 17986317 University of Florida OCD Program	N=92; Age =13.6 (3.3); Baseline CY-BOCS Score=NR	Psychoeducation, Cognitive restructuring, ERP	Inadequate	CGI-S (reduction)	.	.	.	.	.	.	.	.	.	.	.	+¶	
Farrell, 2020, 37669531; Griffith U, Queensland AU	N=63; Age =12.2 (2.8); Baseline CY-BOCS Score=25.7 (5.3)	CBT/not specified	Adequate	CY-BOCS (reduction)	NS	.	?	– (ADHD)	.	.	.	.	.	.	.	.	.

Study; Study Name/Site	N; Age, Baseline CY-BOCS Score, Mean (SD)	Intervention, Components	Regression Quality	Outcome	Age	Age at onset/ duration	Gender	Comorbidity	CY-BOCS (baseline)	Insurance	Medication	Minoritized Group	Treatment	COIS (baseline)	FAS (baseline)	Symptoms (baseline)	Other
Selles, 2018, 29179016; British Columbia Children's Hospital Provincial OCD Program	N=85; Age =13.9 (2.49); Baseline CY-BOCS Score=23.36 (4.98)	Psychoeducation, Cognitive restructuring, ERP	Inadequate	CY-BOCS (reduction)	.	.	.	.	NS	.	.	.	.	.	.	.	.
Jassi, 2023, 34914003; Maudsley Hospital (London, UK) 2005-2018	N=323; Age =14.6 (2.2); Baseline CY-BOCS Score=NR	Psychoeducation, ERP	Adequate	CY-BOCS (reduction)	.	.	.	–(ASD)	.	.	.	.	.	.	.	.	.
Duholm, 2022, 33861384; NordLOTS, stage 1	N=269; Age =12.8 (2.7); Baseline CY-BOCS Score=24.6 (5.1)	ERP	Inadequate	CY-BOCS (reduction)	.	.	.	.	.	.	.	.	.	.	.	NS	.
McGuire , 2013, 23623154; Storch 2008, standard clinic	N=144; Age =12.62 (2.81); Baseline CY-BOCS Score=26.24(4.65)	Psychoeducation, Cognitive restructuring, ERP	Adequate	CY-BOCS (reduction)	.	.	.	NS	.	.	.	.	.	.	NS	.	.
Storch, 2008, 17986317; University of Florida OCD Program	N=92; Age =13.6 (3.3); Baseline CY-BOCS Score=NR	Psychoeducation, Cognitive restructuring, ERP	Inadequate	CY-BOCS (reduction)	.	.	.	.	.	.	.	.	.	.	.	NS	.
Hybel, 2017, 28881220; NordLOTS, stage 1	N=50; Age = NR; Baseline CY-BOCS Score = 25.34 (5.26)	ERP	Inadequate	CY-BOCS (reduction)	.	.	.	.	.	.	.	.	.	.	.	.	–§
Wolters, 2021, 2022-96874-001; Wolters Study 1	N=59; Age =15.3 (2.4); Baseline CY-BOCS Score=25.4 (5.3)	CBT/not specified	Adequate	CY-BOCS (reduction)	NS	.	NS	.	NS	.	.	.	.	.	.	.	.

Study; Study Name/Site	N; Age, Baseline CY-BOCS Score, Mean (SD)	Intervention, Components	Regression Quality	Outcome	Age	Age at onset/ duration	Gender	Comorbidity	CY-BOCS (baseline)	Insurance	Medication	Minoritized Group	Treatment	COIS (baseline)	FAS (baseline)	Symptoms (baseline)	Other
Højgaard , 2019, 30656432; NordLOTS, stage 1	N=269; Age =12.8 (2.7); Baseline CY-BOCS Score=24.6 (5.1)	ERP	Adequate	CY-BOCS <16	?	NS	NS	.	.	.	.	.	.	NS	NS	NS	.
Højgaard , 2020, 31203735; OCD Center at he Rogers Memorial Hospital in Oconomowoc, Wisconsin	N=314; Age =15.56 (1.20); Baseline CY-BOCS Score=25.65 (5.63)	Cognitive restructuring, ERP	Adequate	CY-BOCS <16	NS	.	NS	NS	NS	.	.	.	NS	.	.	.	.
Torp, 2019, 31622874; NordLOTS, stage 1	N=248; Age =NR; Baseline CY-BOCS Score=24.6 (5.1)	ERP	Adequate	CY-BOCS <16	+	NS	NS	NS	.	.	.	.	.	NS	NS	.	.
Selles, 2020, 31228561; UBC-POP, NordLOTS, stage 1; DCS-CBT, Griffith,	N=573; Age =12.67 (2.87); Baseline CY-BOCS Score=24.95 (5.24)	Psychoeducation, Cognitive restructuring, ERP	Adequate	35% reduction in CY-BOCS score	+	.	.	.	+	.	.	.	.		.	.	–‡
Rudy, 2014, 25193378; University of Florida OCD Program	N=78; Age =13.2 (2.72); Baseline CY-BOCS Score=NR	Psychoeducation, Cognitive restructuring, ERP	Adequate	ADIS CSR<4 and/or CY-BOCS<10	NS	.	NS	.	NS	.	.	.	.	NS	.	.	.
Farrell, 2020, 37669531; Griffith U, Queensland AU	N=63; Age =12.2 (2.8); Baseline CY-BOCS Score=25.7 (5.3)	CBT/not specified	Adequate	FAS (post-treatment score)	NS	.	NS	– (ADHD)	.	.	.	.	.	.	.	.	.

Study; Study Name/Site	N; Age, Baseline CY-BOCS Score, Mean (SD)	Intervention, Components	Regression Quality	Outcome	Age	Age at onset/ duration	Gender	Comorbidity	CY-BOCS (baseline)	Insurance	Medication	Minoritized Group	Treatment	COIS (baseline)	FAS (baseline)	Symptoms (baseline)	Other
Weidle, 2015, 25527002; NordLOTS, stage 1	N=269; Age =12.8 (2.7); Baseline CY-BOCS Score=24.6 (5.1)	ERP	Inadequate	QOL: KINDL - child report (change)	.	.	.	NS	.	.	.	.	.	NS	NS	.	.
Weidle, 2015, 25527002; NordLOTS, stage 1	N=269; Age =12.8 (2.7); Baseline CY-BOCS Score=24.6 (5.1)	ERP	Inadequate	QOL: KINDL - parent report (change)	.	.	.	NS	.	.	.	.	.	NS	NS	.	.

+ = increase in predictor/predictor present predicts statistically significant increase in outcome; – = decrease in predictor/predictor present predicts statistically significant increase in outcome; NS no significant relationship; ? = significant relationship but direction unclear; CBT = cognitive behavioral therapy, COIS = Child Obsessive Compulsive Impact Scale, CY-BOCS = Children's Yale-Brown Obsessive Compulsive Scale, ERP = exposure and response therapy, FAS = family accommodation scale, OCD = Obsessive Compulsive Disorder, QOL = quality of life

* Not significant at post treatment; lower score predicted higher score at 6 months; || youth identifying as Black, Asian, other, more than one race, or Latinx Ethnicity; † 4hr/day treatment predicted greater symptom reduction than 6hr/day; ¶ symptoms included symmetry/ordering, contamination/cleaning, sexual/religious obsessions, aggressive/checking, hoarding ‡ Limited child recognition of impairment and greater baseline avoidance predicted reduced likelihood of achieving response to CBT; § Executive function: baseline LVEF high performers = lower response to CBT; baseline BRIEF = NS

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