- *Disturbo Ossessivo-Compulsivo*

Il ruolo dello psicologo

ARGOMENTI DI NEUROPSICHIATRIA DELL'INFANZIA E DELL'ADOLESCENZA:
NUOVE PROSPETTIVE DI RICERCA E LINEE DI TRATTAMENTO
Corso di Formazione Residenziale, Roma 19 Settembre 2013

Bambino Gesù
OSPEDALE PEDIATRICO

Processo di VALUTAZIONE nel DSM V

1. YBOCS - Yale-Brown Obsessive Compulsive Scale
2. FOCI - Florida Obsessive-Compulsive Inventory
3. BABS - Brown Assessment and Beliefs Scale

American Psychiatric Association, (2013). *Diagnostic and statistical manual of mental health disorders: DSM-5* (5th ed.). Washington, DC: American Psychiatric Publishing.

Processo di VALUTAZIONE nel DSM V

1. CYBOCS- Children Yale-Brown Obsessive Compulsive Scale
2. FOCI - Florida Obsessive-Compulsive Inventory
3. BABS - Brown Assessment and Beliefs Scale

American Psychiatric Association, (2013). *Diagnostic and statistical manual of mental health disorders: DSM-5* (5th ed.). Washington, DC: American Psychiatric Publishing.

CY-BOCS Symptom Checklist
Children's Yale-Brown Obsessive Compulsive Scale

- Scala di eterovalutazione
- Campione normativo 8-17 anni
- 50 items
- Ossessioni e compulsioni nelle ultime 2 settimane
- Presenza/assenza

(Scahill L., Goodman W.K. et al., 1997)

CY-BOCS Severity Rating Scale

- Gravità dei sintomi valutati in base a:

1. Tempo trascorso 0…….4
2. Interferenze 0…….4
3. Bisogno di aiuto 0…….4
4. Resistenza 0…….4
5. Controllo 0…….4

Range di gravità →

1. Livello sub-clinico (0-7)
2. Livello di lieve gravità (8-15)
3. Moderato (16-23)
4. Grave (24-31)
5. Estremo (32-40)

Processo di VALUTAZIONE nel DSM V

1. CYBOCS- Children Yale-Brown Obsessive Compulsive Scale
2. FOCI - Florida Obsessive-Compulsive Inventory
3. BABS - Brown Assessment and Beliefs Scale

American Psychiatric Association, (2013). *Diagnostic and statistical manual of mental health disorders: DSM-5* (5th ed.). Washington, DC: American Psychiatric Publishing.

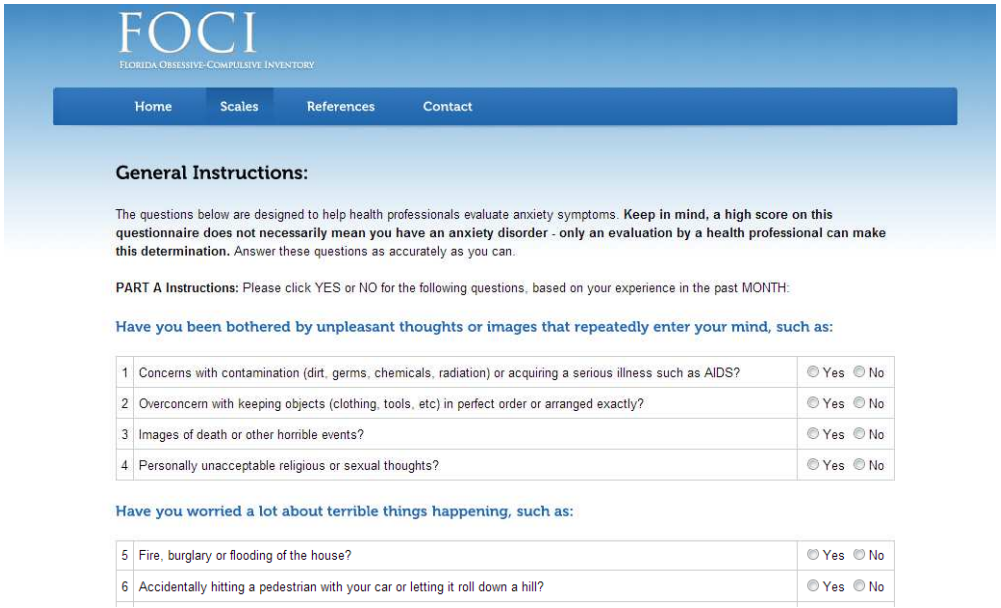
Processo di VALUTAZIONE nel DSM V

1. CYBOCS- Children Yale-Brown Obsessive Compulsive Scale
2. C-FOCI – Children Florida Obsessive-Compulsive Inventory
3. BABS - Brown Assessment and Beliefs Scale

American Psychiatric Association, (2013). *Diagnostic and statistical manual of mental health disorders: DSM-5* (5th ed.). Washington, DC: American Psychiatric Publishing.

C/FOCI – Children Florida Obsessive-Compulsive Inventory

Versione online



FOCI

FLORIDA OBSESSIVE-COMPULSIVE INVENTORY

Home | Scales | References | Contact

General Instructions:

The questions below are designed to help health professionals evaluate anxiety symptoms. **Keep in mind, a high score on this questionnaire does not necessarily mean you have an anxiety disorder - only an evaluation by a health professional can make this determination.** Answer these questions as accurately as you can.

PART A Instructions: Please click YES or NO for the following questions, based on your experience in the past MONTH:

Have you been bothered by unpleasant thoughts or images that repeatedly enter your mind, such as:

1	Concerns with contamination (dirt, germs, chemicals, radiation) or acquiring a serious illness such as AIDS?	Yes No
2	Overconcern with keeping objects (clothing, tools, etc) in perfect order or arranged exactly?	Yes No
3	Images of death or other horrible events?	Yes No
4	Personally unacceptable religious or sexual thoughts?	Yes No

Have you worried a lot about terrible things happening, such as:

5	Fire, burglary or flooding of the house?	Yes No
6	Accidentally hitting a pedestrian with your car or letting it roll down a hill?	Yes No

- 25 items
- Parte A: Symptom Checklist

Indagare i singoli sintomi

- Parte B: Severity Scale

Quantificare il grado di severità dei sintomi

Storch E.A., Goodman W.K. et al, 2009

Bambino Gesù
OSPEDALE PEDIATRICO

Processo di VALUTAZIONE nel DSM V

1. CYBOCS- Children Yale-Brown Obsessive Compulsive Scale
2. FOCI - Florida Obsessive-Compulsive Inventory
3. BABS - Brown Assessment and Beliefs Scale

American Psychiatric Association, (2013). *Diagnostic and statistical manual of mental health disorders: DSM-5* (5th ed.). Washington, DC: American Psychiatric Publishing.

BABS - Brown Assessment and Beliefs Scale

- Non è specifica per il DOC ma viene usata in tutte quelle condizioni psicopatologiche in cui può essere messo in discussione il livello di convinzione dei propri pensieri
- Intervista semistrutturata, 18 items
- Specifica per la valutazione dell'insight:

  Buono – scarso – assente
- Importante come strumento predittivo di risposta al trattamento in relazione all'insight

Eisen J.L., Phillips K.A et al., 1993

BABS - Brown Assessment and Beliefs Scale

BABS© KEYSHEET (R)

Patient Initials:_____Date of Interview:____/____/____

Rater:_____Diagnosis:_____

Treatment:_____

Principal Belief:_____

1. CONVICTION _____
2. PERCEPTION OF OTHERS' VIEWS _____
3. EXPLANATION OF DIFFERING VIEWS _____
4. FIXITY OF IDEAS _____
5. ATTEMPT TO DISPROVE BELIEFS _____
6. INSIGHT _____

TOTAL BABS© SCORE (total of items 1-6) _____

4. Fixity of ideas

If I were to question (or challenge) the accuracy of your beliefs, what would your reaction be? [PAUSE] Could I convince you that you are wrong? [PAUSE] Would you consider the possibility?

(If necessary, supply a nonconfrontational example.)

(Rate on the basis of whether the patient could be convinced, not whether s/he wishes s/he could be convinced.)

0.- Eager to consider the possibility that beliefs may be false; demonstrates no reluctance to entertain this possibility.
1.- Easily willing to consider the possibility that beliefs may be false; reluctance to do so is minimal.
2.- Somewhat willing to consider the possibility that beliefs may be false, but moderate resistance is present.
3.- Clearly reluctant to consider the possibility that beliefs may be false; reluctance is significant.
4.- Absolutely refuses to consider the possibility that beliefs may be false--i.e., beliefs are fixed.

5. Attempt to disprove ideas

Over the past week, how often have you tried to convince yourself that your beliefs are wrong?

(Interviewer should rate attempts patient makes to talk himself/herself out of the belief, not attempts to push the thoughts/ideas out of his/her mind or think about something else.)

0.- Always involved in trying to disprove beliefs, or not necessary to disprove because beliefs are not true.
1.- Usually tries to disprove beliefs.
2.- Sometimes tries to disprove beliefs.
3.- Occasionally attempts to disprove beliefs.
4.- Makes no attempt to disprove beliefs.

6. Insight

What do you think has caused you to have these beliefs? [PAUSE] Do they have a psychiatric (or psychological) cause, or are they actually true?

(Interviewer should determine what the patient actually believes, not what s/he has been told or hopes is true. Psychological etiology should be considered equivalent to psychiatric illness.)

0.- Beliefs definitely have a psychiatric/psychological cause.
1.- Beliefs probably have a psychiatric/psychological cause.
2.- Beliefs possibly have a psychiatric/psychological cause.
3.- Beliefs probably do not have a psychiatric/psychological cause.
4.- Beliefs definitely do not have a psychiatric/psychological cause.

Bambino Gesù
OSPEDALE PEDIATRICO

Presa in carica terapeutica:
Il trattamento psicoterapico del DOC

- Quale terapia?

J Clin Child Adolesc Psychol. 2013 Jun 9. [Epub ahead of print]

Evidence-Base Update for Psychosocial Treatments for Pediatric Obsessive-Compulsive Disorder.

Freeman J, Garcia A, Frank H, Benito K, Conelea C, Walther M, Edmunds J.

a Alpert Medical School of Brown University, Bradley/Hasbro Children's Research Center.

- I dati convergono a supporto della CBT come trattamento d'elezione per bambini e adolescenti con DOC
- In associazione con il trattamento farmacologico oppure no
- «Probabilmente efficace»

Bambino Gesù
OSPEDALE PEDIATRICO

Efficacia CBT nel DOC

Curr Neuropharmacol. 2013 Jan;11(1):109-13. doi: 10.2174/157015913804999414.

The Effects of Psychopharmacologic and Therapeutic Approaches on Neuro-imaging in Obsessive-compulsive Disorder.

Atmaca M.

Firat University School of Medicine Department of Psychiatry, Elazig/Turkey.

Gli effetti della terapia cognitivo comportamentale a livello cerebrale sono dimostrati da studi di neuroimmagine

Cambiamenti a livello strutturale e funzionale, anche in età evolutiva

Lazaro L, et al. *Brain changes in children and adolescents with obsessive-compulsive disorder before and after treatment: a voxel-based morphometric MRI study*. Psychiatr. Res. 2009;172(2): 140–6.

O'Neill J, et al. *MRSI correlates of cognitive-behavioral therapy in pediatric obsessive-compulsive disorder.* Prog. Neuropsychopharmacol. Biol. Psychiatry.2012;10:161–8.

Freyer T, et al. *Frontostriatal activation in patients with obsessive-compulsive disorder before and after cognitive behavioral therapy.* Psychol. Med. 2011;41(1): 207–16.

Maiko N, et al. *Functional MRI study of brain activation alterations in patients with obsessive-compulsive disorder after symptom improvement.* Psychiatry Res. Neuroimaging. 2008;163(3): 236–257.

Bambino Gesù
OSPEDALE PEDIATRICO

Il trattamento psicoterapico del DOC in età evolutiva

CRITICITA'

- Scarso o nullo insight
- Frequenti comorbidità
- Difficoltà nell'implementazione della tecnica dell'ERP
- L'esito è correlato al coinvolgimento attivo della famiglia

OBIETTIVI GENERALI

1. < Riduzione dei sintomi ossessivi
2. < Riduzione compulsioni
3. < Riduzione ansia
4. > Miglioramento della QoL

Principi base di terapia cognitivo-comportamentale
Con i GENITORI

- Ridefinire lo stile educativo genitoriale → supporto nell'acquisire abilità di trasmettere le regole efficacemente

Es: brevità e sintesi,

Poche regole, ma che si devono seguire

Coerenza tra i genitori

Valorizzazione degli aspetti positivi - rinforzo

Supporto come chiarificazione del significato del sintomo

Principi base di terapia cognitivo-comportamentale
Con il BAMBINO/RAGAZZO

- Insegnare strategie comportamentali di rinforzo
- Aumentare il livello di autostima
- Riconoscere le emozioni e facilitarne la corretta espressione
- Esplorare gli effetti negativi dei comportamenti inadeguati – ma anche le conseguenze positive che si potrebbero avere assumendo comportamenti diversi adeguati

Suggerimenti…

- Dare un «nomignolo» simpatico al disturbo
- Ascoltare il bambino, lasciarlo parlare
- Non rimproverarlo per mancanza di controllo su ossessioni/compulsioni
- Non assecondare i suoi rituali
- Rinforzi positivi del controllo del sintomo

GRAZIE

Bambino Gesù
OSPEDALE PEDIATRICO