PICO 2: Bør børn og unge med OCD tilbydes manualiseret familiebaseret kognitiv adfærdsterapi?

Review information

Authors

the Danish Health Authority[1]

[1][Empty affiliation]

Citation example: tDHA. PICO 2: Bør børn og unge med OCD tilbydes manualiseret familiebaseret kognitiv adfærdsterapi? Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Characteristics of studies

Characteristics of included studies

Barrett 2004

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group **Open Label:** YES **Cluster RCT:**
Participants	**Baseline Characteristics** family CBT Group format family CBT individual format Waitlist **Included criteria:** Subjects aged between 7-17Primary OCD diagnosis on the basis of DSM-IV.Subjects receiving concurrent psychopharmacological treatment were required to have remained on the same medication for at least a 3-month period and were required to maintain this medication over the course of treatment. IQ supspected to be within the normal range. One parent willing to attende weekly sessions. **Excluded criteria:** Primary major depression or another primary anxiety disorder, primary externalizing disorder (including ADHD, oppositional, defiant disorder or conduct disorder), Tourette's syndrome, autistic spectrum disorder, schizophrenia, organic mental disorder or mental retardation. Subjects receiving concurrent psychotherapy. **Pretreatment:** No significant differences across groups on any of the sociodemohraphic or pretreatment variables.
Interventions	**Intervention Characteristics** family CBT Group format family CBT individual format Waitlist
Outcomes	*CYBOCS symptomscore End of Treatment* ● **Outcome type**: ContinuousOutcome ● **Measure names**: ["Baseline"] ● **Direction**: Lower is better ● **Data value**: Endpoint *Remission (<10 CYBOCS) ed of treatment* ● **Outcome type**: DichotomousOutcome ● **Measure names**: ["Baseline"] ● **Direction**: Higher is better ● **Data value**: Endpoint

Identification	**Sponsorship source:** National Health and Medical Research Council Grant. **Country:** Australia **Setting:** University clinic **Comments:** **Authors name:** Paula Barrett **Institution:** School of Applied Psychology, Griffith University **Email:** p.barret@griffith.edu.au **Address:** Mount Gravatt Campus, Brisbane, Queensland, 4111, Australia.
Notes	*Birgitte Holm Petersen* on 15/08/2015 17:03 **Study Design** 3 arms:Individual family CBTGroup family CBTwaitlist *Hjalti Jonsson* on 23/08/2015 23:48 **Baseline Characteristics** Mean age, yr (SD) *Birgitte Holm Petersen* on 10/09/2015 22:41 **Dichotomous Outcomes** ADIS score parents not fullfilling criteria for OCD diagnosis

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Low risk	
Allocation concealment	Unclear risk	-
Blinding of participants and personnel	High risk	
Blinding of outcome assessors	Low risk	
Incomplete outcome data	Unclear risk	-
Selective outcome reporting	Unclear risk	-
Other sources of bias	Unclear risk	-

Freeman 2008

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group **Open Label:** YES **Cluster RCT:**
Participants	**Baseline Characteristics** family CBT Relaxation Training **Included criteria:** **Excluded criteria:** **Pretreatment:** The two treatment groups did not differ on any parent or child baseline characteristics.

Interventions	**Intervention Characteristics** family CBT Relaxation Training
Outcomes	*CYBOCS symptomscore End of Treatment* ● **Outcome type**: ContinuousOutcome ● **Measure names**: ["Baseline"] *Symptomscore min 30 % reduktion i CYBOCS end of treatment* ● **Outcome type**: DichotomousOutcome ● **Measure names**: ["Baseline"] ● **Direction**: Higher is better ● **Data value**: Endpoint
Identification	**Sponsorship source:** National Institut of Mental Health (R21 MH079217). **Country:** USA **Setting:** Child anxiety disorders speciality clinic within an academic medical center. **Comments:** **Authors name:** Jennifer B. Freeman **Institution:** The Bradley Hasbro Children's Research Center. **Email:** jennifer_freeman@brown.edu **Address:** Core West, 2nd Floor, 1 Hoppin Street, Providence, RI 02903
Notes	*Birgitte Holm Petersen* on 15/08/2015 17:58 **Continuous Outcomes** Intention to Treat groupcompleter analysis:CBT: n: 16CYBOCS: mean 11.50, SD: 7.68RT: n:15CYBOCS: mean:16.87, SD: 8.22 *Birgitte Holm Petersen* on 10/09/2015 21:00 **Dichotomous Outcomes** reduktion i symptomsscore målt på antal af n som havde <13 efter behandling

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Unclear risk	-
Allocation concealment	Unclear risk	-
Blinding of participants and personnel	High risk	
Blinding of outcome assessors	Low risk	
Incomplete outcome data	Low risk	
Selective outcome reporting	Low risk	
Other sources of bias	Low risk	

Freeman 2014

Methods	
Participants	
Interventions	
Outcomes	
Identification	
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Low risk	
Allocation concealment	Low risk	
Blinding of participants and personnel	High risk	
Blinding of outcome assessors	Low risk	
Incomplete outcome data	Low risk	
Selective outcome reporting	Low risk	
Other sources of bias	Low risk	

Lewin 2014

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group **Open Label:** YES **Cluster RCT:**
Participants	**Baseline Characteristics** Family-based Exposure/Response Prevention (E/RP) TAU **Included criteria:** Inclusion required: (1) Clinician diagnosis of primary OCD with diagnoses verified by administration of the Anxiety Disorders Interview Schedule (ADIS) - Child and Parent Versions (Silverman & Albano,1996) 2) clinical severity rating > 4; CYBOCS >16 (or CYBOCS Compulsions scale of > 8); 3) between ages of 3-8 years inclusive; 4) commitment of consistent parent to attend all sessionsFor youth on established pharmacotherapy, 8 weeks stability at current dose was required for SSRIs and 6 weeks for other medications. For newly initiatedpharmacotherapy, 12 weeks stability for SSRIs and 8 weeks for other mediations was required. **Excluded criteria:** (1) the presence of psychiatric illness that contraindicated study participation, e.g., autism; (2) IQ < 85; (3) non-English speaking or absence of language; (4) history of E/RP; (5) a recent change in psychotropic medication; or (6) concurrent psychotherapy or other behavioral interventions. Children randomizedto TAU were allowed to make medication changesfollowing randomization. **Pretreatment:** Pretreatment expectations for treatment outcome were slightly higher among parents randomized to E/RP vs. TAU (p = .04)There were no groupdifferences at baseline on any primary or secondary outcomes (seeTable 2).
Interventions	**Intervention Characteristics** Family-based Exposure/Response Prevention (E/RP) TAU
Outcomes	*CYBOCS symptomscore End of Treatment* ● **Outcome type**: ContinuousOutcome ● **Measure names**: ["Baseline"] *Family Accomodation Scale: Længste Followup*

	● **Outcome type**: ContinuousOutcome ● **Measure names**: ["Baseline"] ● **Direction**: Lower is better ● **Data value**: Endpoint *Symptomscore (min 30% reduktion i CYBOCS)* ● **Outcome type**: DichotomousOutcome ● **Measure names**: ["Baseline"] ● **Direction**: Higher is better ● **Data value**: Endpoint
Identification	**Sponsorship source:** Study was sponsored by a University of South Florida ResearchCounsel New Researcher Grant to Dr. Lewin. **Country:** USA **Setting:** University clinic **Comments:** **Authors name:** Adam B. Lewin **Institution:** University of South Florida **Email:** alewin@health.usf.edu **Address:** USF Dept. of Pediatrics, Rothman Center for Neuropsychiatry,880 6th Street South Suite 460 Box 7523, Child Development & RehabilitationCenter, St. Petersburg, FL 33701, USA.
Notes	*Birgitte Holm Petersen* on 15/08/2015 18:06 **Continuous Outcomes** FAS measurred by FA Measure of Family Accommodation, follow up data just available for treatment group. Data from post treatement for both groups

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Unclear risk	-
Allocation concealment	Unclear risk	-
Blinding of participants and personnel	Unclear risk	-
Blinding of outcome assessors	Low risk	
Incomplete outcome data	Low risk	
Selective outcome reporting	Low risk	
Other sources of bias	Low risk	

Peris 2013

Methods	
Participants	
Interventions	
Outcomes	
Identification	
Notes	

Risk of bias table

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Allocation concealment	Unclear risk	-
Blinding of participants and personnel	High risk	
Blinding of outcome assessors	Unclear risk	-
Incomplete outcome data	Low risk	
Selective outcome reporting	Low risk	
Other sources of bias	Low risk	

Piacentini 2011

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** family CBT PRT **Included criteria:** Participants 8 through 17 years.Inclusion criteria included the following: a prirnary DSM -IV diagnosis af OCD24; a CYBOCS total score >15; an IQ >70; and freedom from use af any psychotropic medication for OCD at study entry. **Excluded criteria:** Participants were excluded if they met criteria for any psychiatric illness that contraindicated study participation, including suicidality, psychosis, pervasive developmental disorder, mania, or substance dependence **Pretreatment:** No differences in demographic or clinical data.
Interventions	**Intervention Characteristics** family CBT PRT
Outcomes	*CYBOCS symptomscore End of Treatment* ● **Outcome type**: ContinuousOutcome ● **Measure names**: ["Baseline"] *Family Accomodation Scale: Længste Followup* ● **Outcome type**: ContinuousOutcome ● **Measure names**: ["Baseline"] ● **Direction**: Lower is better ● **Data value**: Endpoint *Social funktionsevne: Længste Follow-up* ● **Outcome type**: ContinuousOutcome ● **Measure names**: ["Baseline"] ● **Direction**: Lower is better ● **Data value**: Endpoint *Remission Symptomscore (CYBOCS: ≤ 9) End of Treatment* ● **Outcome type**: DichotomousOutcome ● **Measure names**: ["Baseline"]

	● **Direction**: Lower is better ● **Data value**: Endpoint
Identification	**Sponsorship source:** Disclosures: Dr. Piacentini has received grant support from the National Institute af Mental Health INIMHI, the Tourette Syndrome Association (TSA), and the Obsessive Compulsive Foundation. He has received royalties from Oxford Universily Press, including the manuals described in this paper, Guilford Press, and theAmericon Psychological Association. He has served on the speakers' bureau for the TSA. Hehas served osa consultanl toBeyerSchering Phormo.Dr.Bergman has received research support from the National Alliance for Research on Schizophrenia and Depression INARSAD). Dr. Chong has received grant support from NIMH and the TSA. She has served on the speakers' bureau for the TSA. She hos received royalties from Oxford University Press. Dr. Langley hos received research support from NIMH ond the Substonce Abuse ond Mental Heolth Services Administration . She has received royalties from Oxford University Press for the manuals described in this poper. Dr. Peris has received research support from NIMH and NARSAD . Dr. Wood hos received grant support from NIMH, the Orgonizotion for Autism Research, and Autism Speaks. He hos received royalties from WW Norton ond Company . Dr. McCrocken hos received research support from NIMH, Bristof.Myers Squibb, Asped , ond Seoside Pharmoceuticals . She has served as o consultant to Novophorm ond BloMorin . She has served on the speakers' bureau for the TSA, Veritos, ond CME Outfitters. **Country:** USA, State of California **Setting:** University of California + Participants were recruited from a pediatric OCD specialty clinic at a major university medical center **Comments:** **Authors name:** John Piacentini, R. Lindsey Bergman, Susanna Chang, Audra Langley, Tara Peris, , Jeffrey J. Wood, James McCracken, **Institution:** UCLA Semel Institute for Neuroscience and Human Behavior **Email:** jpiacentini@mednet.ucla.edu **Address:** UCLA Semel Institute, 760 Westwood Blvd, Room 6B-25 I , los Angela. CA 90024
Notes	*Birgitte Holm Petersen* on 15/08/2015 17:26 **Continuous Outcomes** social funktionsevne målt på COIS-RC Child Obsessive Compulsive Impact Scale—Revised Child-Report;ingen SD angivetConfidence Intervaller:family CBT: CYBOCS: 13.3 (10.7–15.9)FAS: 9.3 (6.4–12.2) COIS: 5.6 (3.3–8.0) PRT:CYBOCS: 17.2 (13.0–21.4)FAS: 15.2 (10.5–19.9)COIS: 14.3 (8.0–20.6) *Birgitte Holm Petersen* on 15/08/2015 17:34 **Study Design** psychoeducation and relaxation therapy *Birgitte Holm Petersen* on 15/08/2015 17:40 **Dichotomous Outcomes** Remitted defined as 0–10 CYBOCS at end of treatment *Morten Fenger* on 10/09/2015 17:57 **Continuous Outcomes** I outcome Social funktionsevne: længste follow-up er der to versioner af samme måleinstrument COIS-RC for den OCD-ramte unge (C=child) og COIS-RP for forældrene (P=parent). Jeg har sat værdierne ind for COIS-RC.Der oplyses ikke SD for outcome på CYBOCS, COIS-RC og FAS-PR. Men derimod CI.

Risk of bias table

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Sequence Generation	Unclear risk	-
Allocation concealment	Unclear risk	-
Blinding of participants and personnel	High risk	
Blinding of outcome assessors	Low risk	
Incomplete outcome data	Low risk	
Selective outcome reporting	Low risk	

Other sources of bias	Unclear risk	-

Reynolds 2013

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** family CBT Individual CBT **Included criteria:** Inclusion criteria were as follows: age 12-17 years; met criteria for obsessive-compulsive disorder according to the Diagnostic and Statistica/ Manual of Mental Disorders (4th ed.; DSM-IV; American Psychiatric Association, 1994); and if on medication, stable for 6 weeks **Excluded criteria:** Exclusion criteria were as follows: a diagnosis of psychosis or bipolar disorder, pervasive developmental disorder, IQ below 70, not living with parent or adult caregiver. Randomization was concealed and minimized by site (Norfolk or Suffolk, United Kingdom) and participant age (14 years and below, 15 years and over). **Pretreatment:** No differences in demographic or in clinical data.
Interventions	**Intervention Characteristics** family CBT Individual CBT
Outcomes	*CYBOCS symptomscore End of Treatment* ● **Outcome type**: ContinuousOutcome ● **Measure names**: ["Baseline"] *Remission (CYBOCS <10) end of treatment* ● **Outcome type**: DichotomousOutcome ● **Measure names**: ["Baseline"] ● **Direction**: Higher is better ● **Data value**: Endpoint *Dropout* ● **Outcome type**: DichotomousOutcome ● **Measure names**: ["Baseline"] ● **Direction**: Higher is better ● **Data value**: Endpoint *Symptomscore min 30% reduktion i CYBOCS end of treatment* ● **Outcome type**: DichotomousOutcome ● **Measure names**: ["Baseline"] ● **Direction**: Higher is better ● **Data value**: Endpoint *Symptomscore min 30% reduktion i CYBOCS længste follow-up* ● **Outcome type**: DichotomousOutcome ● **Measure names**: ["Baseline"] ● **Direction**: Higher is better ● **Data value**: Endpoint
Identification	**Sponsorship source:** This article presents independent research funded by the National Institute for Health Research (NIHR) Research for Patient Benefit program (Grant Reference: PB-PG-0706-10128). Peter E. Langdon is funded by an NIHR Postdoctoral Fellowship. **Country:** United Kingdom **Setting:** Universities in UK/ CBT was delivered in routine National Health Service (NHS) services by six clinicians

	Comments: **Authors name:** Shirley A. Reynolds **Institution:** Charlie Waller Institute, University of ReadingChal **Email:** s.a.reynolds@reading.ac.uk **Address:** Charlie Waller InstituteSchool of Psychology and Clinical Language Sciences, University of Reading, Earley Gate, Whiteknights, Reading RG6 6AL, United Kingdom
Notes	

Risk of bias table

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Allocation concealment	Low risk	
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Blinding of outcome assessors	Unclear risk	-
Incomplete outcome data	Low risk	
Selective outcome reporting	Low risk	
Other sources of bias	Unclear risk	-

Storch 2011

Methods	
Participants	
Interventions	
Outcomes	
Identification	
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
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Blinding of participants and personnel	High risk	
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Selective outcome reporting	Low risk	
Other sources of bias	Low risk	

Footnotes

Characteristics of excluded studies

Bolton 2011

Reason for exclusion	Wrong intervention

Merlo 2010

Reason for exclusion	Wrong intervention

Scott 2005

Reason for exclusion	Wrong study design

Stewart 2012

Reason for exclusion	Wrong study design

Storch 2007

Reason for exclusion	

Footnotes

Characteristics of studies awaiting classification

Footnotes

Characteristics of ongoing studies

Footnotes

References to studies

Included studies

Barrett 2004

Barrett P; Healy-Farrell L; March JS. Cognitive-behavioral family treatment of childhood obsessive-compulsive disorder: a controlled trial.. Journal of the American Academy of Child & Adolescent Psychiatry 2004;43(1):46-62. [DOI:]

Freeman 2008

Freeman JB; Garcia AM; Coyne L; Ale C; Przeworski A; Himle M; Compton S; Leonard HL. Early childhood OCD: preliminary findings from a family-based cognitive-behavioral approach.. Journal of the American Academy of Child & Adolescent Psychiatry 2008;47(5):593-602. [DOI:]

Freeman 2014

[Empty]

Lewin 2014

Lewin AB; Park JM; Jones AM; Crawford EA; De Nadai AS; Menzel J; Arnold EB; Murphy TK; Storch EA. Family-based exposure and response prevention therapy for preschool-aged children with obsessive-compulsive disorder: a pilot randomized controlled trial.. Behaviour Research & Therapy 2014;56(Journal Article):30-38. [DOI:]

Peris 2013

[Empty]

Piacentini 2011

Piacentini J; Bergman RL; Chang S; Langley A; Peris T; Wood JJ; McCracken J. Controlled comparison of family cognitive behavioral therapy and psychoeducation/relaxation training for child obsessive-compulsive disorder.. Journal of the American Academy of Child & Adolescent Psychiatry 2011;50(11):1149-1161. [DOI:]

Reynolds 2013

Reynolds,Shirley A.; Clark,Sarah; Smith,Holly; Langdon,Peter E.; Payne,Ruth; Bowers,Gemma; Norton,Elisabeth; McIlwham,Harriet. Randomized controlled trial of parent-enhanced CBT compared with individual CBT for obsessive-compulsive disorder in young people.. Journal of consulting and clinical psychology 2013;81(6):1021-1026. [DOI:]

Storch 2011

[Empty]

Excluded studies

Bolton 2011

Bolton,Derek; Williams,Tim; Perrin,Sean; Atkinson,Linda; Gallop,Catherine; Waite,Polly; Salkovskis,Paul. Randomized controlled trial of full and brief cognitive-behaviour therapy and wait-list for paediatric obsessive-compulsive disorder.. Journal of Child Psychology and Psychiatry 2011;52(12):1269-1278. [DOI:]

Merlo 2010

Merlo LJ; Storch EA; Lehmkuhl HD; Jacob ML; Murphy TK; Goodman WK; Geffken GR. Cognitive behavioral therapy plus motivational interviewing improves outcome for pediatric obsessive-compulsive disorder: a preliminary study.. Cognitive Behaviour Therapy 2010;39(1):24-27. [DOI: 10.1080/16506070902831773]

Scott 2005

Scott RW; Mughelli K; Deas D. An overview of controlled studies of anxiety disorders treatment in children and adolescents. Journal of the National Medical Association 2005;97(1):13-24. [DOI:]

Stewart 2012

Stewart, S. E.; Hezel, D.; Stachon, A. C.. Assessment and medication management of paediatric obsessive-compulsive disorder. Drugs 2012;72(7):881-893. [DOI: http://dx.doi.org/10.2165/11632860-000000000-00000]

Storch 2007

Storch EA; Geffken GR; Merlo LJ; Mann G; Duke D; Munson M; Adkins J; Grabill KM; Murphy TK; Goodman WK. Family-based cognitive-behavioral therapy for pediatric obsessive-compulsive disorder: comparison of intensive and weekly approaches.. Journal of the American Academy of Child & Adolescent Psychiatry 2007;46(4):469-478. [DOI:]

Other references

Additional references

Other published versions of this review

Classification pending references

Data and analyses

1 PICO 2: Bør børn og unge med OCD tilbydes manualiseret familiebaseret kognitiv adfærdsterapi?

Outcome or Subgroup	Studies	Participants	Statistical Method	Effect Estimate
1.1 CYBOCS symptomscore End of Treatment	2	70	Mean Difference (IV, Random, 95% CI)	-2.01 [-6.59, 2.57]

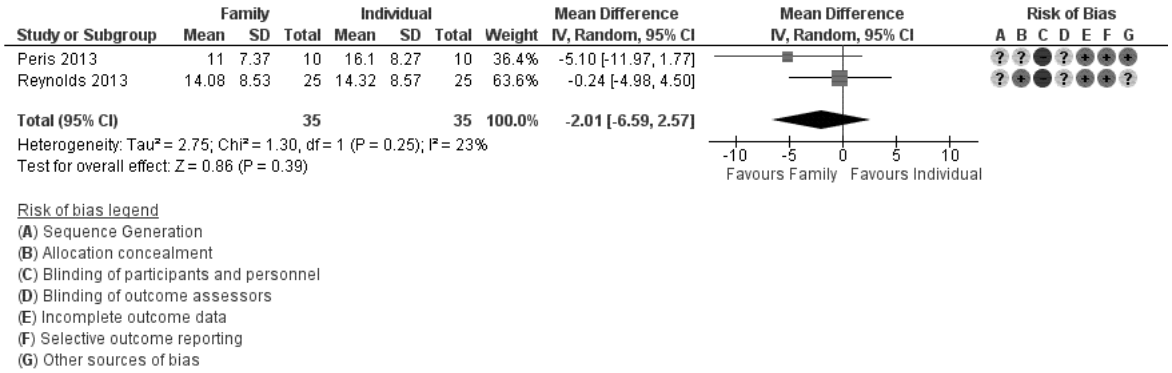
1.3 Dropout	2	70	Risk Ratio (IV, Random, 95% CI)	2.00 [0.40, 9.95]
1.4 Symptomscore min 30% reduktion i CYBOCS end of treatment	2	70	Risk Ratio (IV, Random, 95% CI)	1.29 [0.67, 2.49]
1.5 Symptomscore min 30% reduktion i CYBOCS længste follow-up	1	50	Risk Ratio (IV, Fixed, 95% CI)	1.07 [0.67, 1.72]
1.6 Social funktionsevne længste follow up	1	16	Mean Difference (IV, Fixed, 95% CI)	5.34 [-1.46, 12.14]
1.7 Family Accommodation Scale (FAS) længste follow up	1	16	Mean Difference (IV, Fixed, 95% CI)	-6.00 [-14.19, 2.19]
1.8 Remission Symptomscore (CY-BOCS: ≤ 9) end of treatment	1	20	Risk Difference (IV, Fixed, 95% CI)	0.30 [-0.10, 0.70]

3 PICO 2 ekstra: Family-based CBT vs "placebo"

Outcome or Subgroup	Studies	Participants	Statistical Method	Effect Estimate
3.1 CYBOCS symptomscore End of Treatment	6	363	Mean Difference (IV, Random, 95% CI)	-8.32 [-12.59, -4.04]
3.2 Family Accomodation Scale: Længste Followup	3	118	Mean Difference (IV, Random, 95% CI)	-5.93 [-13.32, 1.47]
3.3 Symptomscore (min 30% reduktion i CYBOCS)	2	73	Risk Ratio (IV, Random, 95% CI)	4.24 [0.78, 23.16]
3.4 Social funktionsevne: Længste Follow-up	3	213	Mean Difference (IV, Random, 95% CI)	-6.06 [-9.32, -2.80]
3.5 Remission Symptomscore (CYBOCS: ≤ 9) End of Treatment	3	165	Risk Ratio (IV, Random, 95% CI)	4.55 [1.39, 14.89]
3.6 dropout	3	229	Risk Ratio (IV, Random, 95% CI)	0.63 [0.32, 1.24]
3.7 Livskvalitet længste follow up	1	127	Mean Difference (IV, Fixed, 95% CI)	0.14 [-0.05, 0.33]

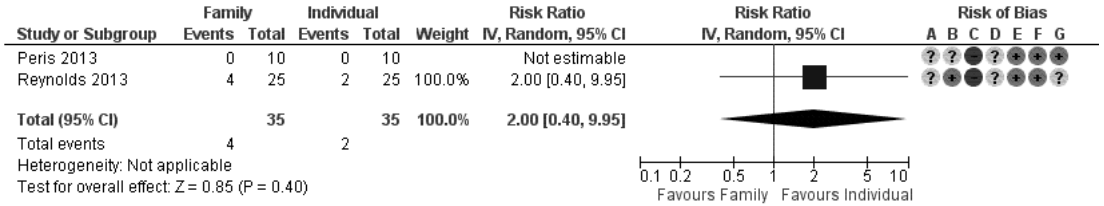
Figures

Figure 1 (Analysis 1.1)



Forest plot of comparison: 1 PICO 2: Bør børn og unge med OCD tilbydes manualiseret familiebaseret kognitiv adfærdsterapi?, outcome: 1.1 CYBOCS symptomscore End of Treatment.

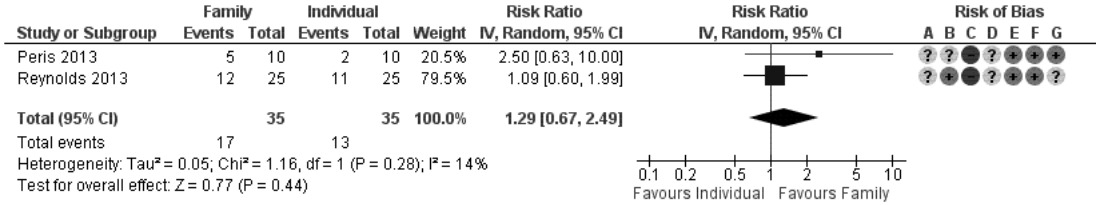
Figure 2 (Analysis 1.3)



Risk of bias legend
(**A**) Sequence Generation
(**B**) Allocation concealment
(**C**) Blinding of participants and personnel
(**D**) Blinding of outcome assessors
(**E**) Incomplete outcome data
(**F**) Selective outcome reporting
(**G**) Other sources of bias

Forest plot of comparison: 1 PICO 2: Bør børn og unge med OCD tilbydes manualiseret familiebaseret kognitiv adfærdsterapi?, outcome: 1.3 Dropout.

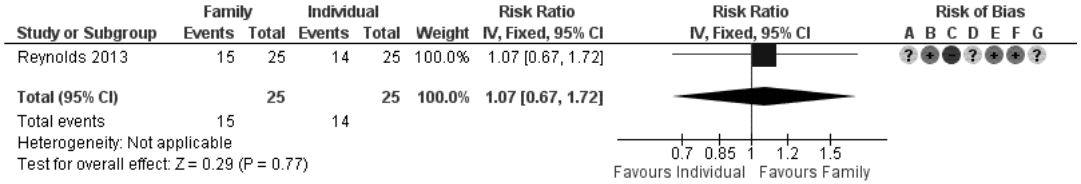
Figure 3 (Analysis 1.4)



Risk of bias legend
(**A**) Sequence Generation
(**B**) Allocation concealment
(**C**) Blinding of participants and personnel
(**D**) Blinding of outcome assessors
(**E**) Incomplete outcome data
(**F**) Selective outcome reporting
(**G**) Other sources of bias

Forest plot of comparison: 1 PICO 2: Bør børn og unge med OCD tilbydes manualiseret familiebaseret kognitiv adfærdsterapi?, outcome: 1.4 Symptomscore min 30% reduktion i CYBOCS end of treatment.

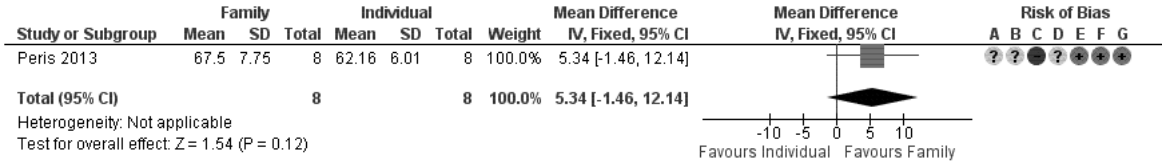
Figure 4 (Analysis 1.5)



Risk of bias legend
(**A**) Sequence Generation
(**B**) Allocation concealment
(**C**) Blinding of participants and personnel
(**D**) Blinding of outcome assessors
(**E**) Incomplete outcome data
(**F**) Selective outcome reporting
(**G**) Other sources of bias

Forest plot of comparison: 1 PICO 2: Bør børn og unge med OCD tilbydes manualiseret familiebaseret kognitiv adfærdsterapi?, outcome: 1.5 Symptomscore min 30% reduktion i CYBOCS længste follow-up.

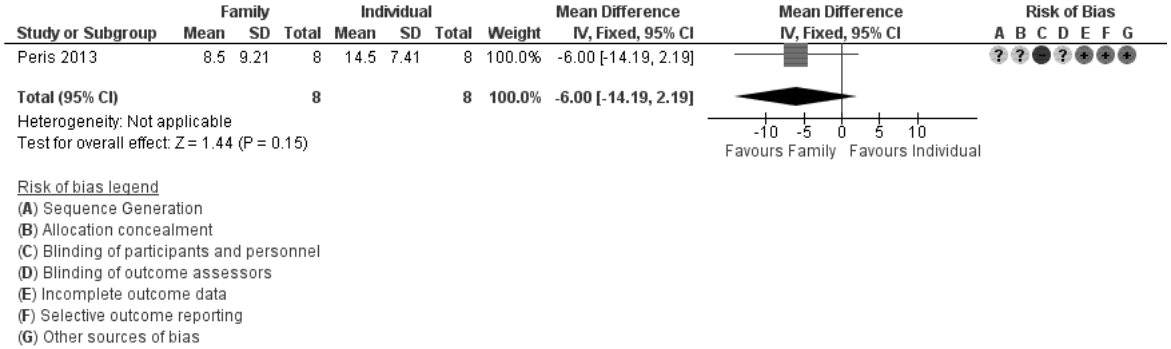
Figure 5 (Analysis 1.6)



Risk of bias legend
(**A**) Sequence Generation
(**B**) Allocation concealment
(**C**) Blinding of participants and personnel
(**D**) Blinding of outcome assessors
(**E**) Incomplete outcome data
(**F**) Selective outcome reporting
(**G**) Other sources of bias

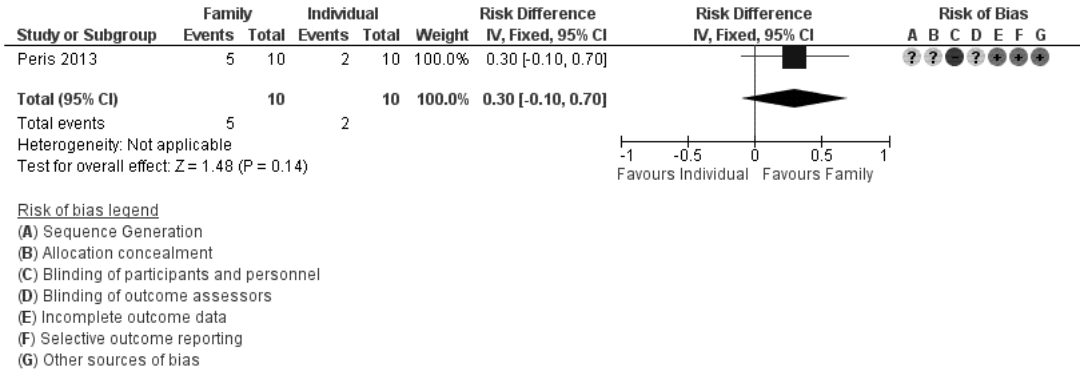
Forest plot of comparison: 1 PICO 2: Bør børn og unge med OCD tilbydes manualiseret familiebaseret kognitiv adfærdsterapi?, outcome: 1.6 Social funktionsevne længste follow up.

Figure 6 (Analysis 1.7)



Forest plot of comparison: 1 PICO 2: Bør børn og unge med OCD tilbydes manualiseret familiebaseret kognitiv adfærdsterapi?, outcome: 1.7 Family Accommodation Scale (FAS) længste follow up.

Figure 7 (Analysis 1.8)



Forest plot of comparison: 1 PICO 2: Bør børn og unge med OCD tilbydes manualiseret familiebaseret kognitiv adfærdsterapi?, outcome: 1.8 Remission Symptomscore (CY-BOCS: ≤ 9) end of treatment.