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# IACAPAP Textbook of Child and Adolescent Mental Health

ANXIETY DISORDERS

Chapter F3

# Obsessive Compulsive Disorder in Children and Adolescents

Pedro Gomes de Alvarenga,
Rosana Savio Mastrorosa &
Maria Concecao de Rosario

**Companion Powerpoint Presentation**

Adapted by Julie Chilton

The “IACAPAP Textbook of Child and Adolescent Mental Health” is available at the IACAPAP website http://iacapap.org/iacapap-textbook-of-child-and-adolescent-mental-health

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IACAPAP

International Association for Child and Adolescent Psychiatry and Allied Professions

...because every child matters

OCD in Children and Adolescents

# Outline

- The Basics
- Historical Overview
- Epidemiology
- Clinical Features
- Etiological Features
- Assessment
- Treatment
- Support Groups and Associations

OCD in Children and Adolescents

# The Basics

- Obsessions and/or compulsions
- Time consuming
- Cause distress or interference
- Cost of $8 billion/year in US
- Clinically and etiologically heterogeneous
- Unique early onset subgroup
- 50-80% begin before age 18
- ~60% remain with symptoms

# Historical Overview

- Identified in 17th century
- Religious melancholy and possession by outside forces
- 1838 Esquirol's "monomania"
- End of 19th century "neurasthenia"
- Early 2Oth century  Janet and Freud
- Psychastenia
- Children not required to have insight

Jean Dominique Esquirol

# Epidemiology

- Lifetime prevalence 1-3%
- 1/3 to ½ have symptoms before puberty
- Point prevalence in children and adolescents:
  - 0.7% in US study
  - 0.25% in UK study
- Incidence has 2 peaks:
  - Age 7-12; M>F
  - ~Age 21; F>M

# Clinical Features

- Obsessions &/OR compulsions
- Time consuming
- Subjective distress
- Interfere with life

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# Clinical Features of Obsessions

- Intrusive
- Unwanted
- Unpleasant
- Uncomfortable
- Distressing
- Anxiety provoking
  - Ideas
  - Images
  - Fears
  - Thoughts
  - Worries

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# Clinical Features of Compulsions

- Repetitive behaviors or mental acts
- Done to ignore, reduce or eliminate anxiety or distress
- Executed according to rules
- Compulsions without obsessions more likely in younger children
- Rituals of touching often confused with complex tics
- Possibility  of sensory phenomena

# Age at onset

- No consensus
- Age when started *vs* interfered with functioning
- Early onset ~ 10
- Late onset ~ 17
- Important as early onset may be distinct subgroup

# Early onset

- In adults:
  - Greater severity
  - Persistence of symptoms
  - Less responsive to treatment
- Fewer obsessions
- More tic-like compulsions
- More sensory phenomena
- More comorbid tic disorders

# Early onset

May have higher symptom severity in:

- Aggressive obsessions and related compulsions
- Sexual and religious obsessions and related compulsions
- Symmetry, ordering and arranging obsessions and compulsions

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# Symptom dimensions subgrouping

Alternative to subdivision of patients by age of onset

- Contamination/cleaning
- Obsessions/checking
- Symmetry/ordering
- Hoarding

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# Clinical Continuum with OCD

Obsessive Compulsive Spectrum Disorders:

- OCD
- Body Dysmorphic Disorder
- Tic Disorders
- Trichotillomania
- Impulse Control Disorders

All share:

- Intrusive thoughts, anxiety, repetitive behaviors
- Shared genetic and pathophysiologic mechanisms

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# Common comorbidities

- 60 to 80 % have one or more comorbidities
- Most common:
  - Tic disorders
  - ADHD
  - Other anxiety disorders
  - Mood disorders
  - Eating disorders

# Common comorbidities: OCD and Tics

- 20-59% children with OCD have tics
- 9% adolescents with OCD have tics
- 6% adults with OCD have tics
- “Tic-related OCD” subgroup:
  - Increased transmission in 1st degree relatives
  - M>F
  - Earlier age at onset
  - Differential treatment response

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# Course and Outcome

Heterogeneous:

- Abrupt *vs* insidious
- Average diagnosis 2.5 years after onset
  - Secrecy, shame, and guilt
  - Resembles normal childhood routines
- Variable content
- Changing symptoms over time
- Some thematic consistency
- Chronic or relapsing/remitting
- Very favorable outcome when treated early

# Assessment: Screening Questions

**Table F.3.2 Screening questions to help in the identification of obsessive compulsive symptoms**

| Has your child ever shown: |
| --- |
| • Concerns about catching a disease after touching something or unduly worrying about dirt, leading to repetitive hand washing? |
| • A preoccupation with ordering or arranging things so much so that it interferes with normal life of schooling? |
| • A need for things to look, feel or sound "just right"? |
| • Excessive worries, fears or concerns with aggressive, sexual or religious thoughts? |
| • An excessive need to collect or hoard objects? |

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# Clinical Assessment

- Screening questions
- Parent interview
- Teacher input
- Play activity or drawing
- Rule out normal ritualistic behavior of childhood
- Assess role of family
- Rating scales: CYBOCS, DYBOCS, USP-SPS, FAS

# Etiology

- Genetic
  - Heritability 45-65%
  - Susceptibility loci: chromosomes 1q,3q,6q,7p,9p,10p,15q
  - Glutamatergic expression
- Non-genetic
  - Possible triggers: emotional stress, traumatic brain injury
  - Associations: excessive weight gain during gestation, prolonged labor, preterm birth, jaundice, substance exposure in utero
  - Group A B-hemolytic streptococcal infection
  - Fronto-cortico-striato-thalamic circuits
  - Neuropsychological deficits
  - Serotonin and oxytocin
  - Familial Accommodation

# Family Accommodation

- Parents, siblings etc, participate in OCD symptoms:
  - Answering doubting questions repetitively
  - Not limiting time-consuming washing tasks
  - Helping with ordering rituals
  - Helping with hoarding rituals
  - Facilitating avoidance
- Reinforces symptoms
- Poor outcome

# Treatment

Before beginning treatment:

- Identify worst OCD symptoms
- Length of illness
- Impact on the patient's life
- Difficulties working with the family
- Assess comorbidity

# Treatment

- Cognitive Behavioral Therapy
- Medication
- Psychoeducation

https://www.youtube.com/watch?v=G5dlLL3FFzg&feature=youtu.be

NICE Guidelines from UK

http://www.nice.org.uk/guidance/cg31

AACAP Practice Parameters

http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx

# Treatment

Cognitive Behavioral Therapy (CBT)

- Effect size ~1.25
- Components
  - Exposure
  - Response prevention
  - Cognitive restructuring
  - CBT alone for mild to moderate cases
  - CBT plus meds for severe or treatment resistant
- 12-25 sessions
- Best outcome WITH family involvement

https://www.youtube.com/watch?v=ds3wHkwiuCo&feature=related

# Treatment

- Psychoeducation
  - Possible clinical symptoms
  - Impact of comorbidity
  - Treatment options
  - Duration of illness
  - Duration of treatment
  - Risks of family accommodation
  - How best to deal with family member with OCD

https://www.youtube.com/watch?v=ikBeDCSFpqs&feature=relmfu

# Treatment

## Psychoeducation: CBT Manuals and Self-Help Books

- *Talking Back to OCD: The Program that Helps Kids and Teens Say "No Way" and Parents Say "Way to Go"* by John March
- *Obsessive Compulsive Disorders: A Complete Guide to Getting Well and Staying Well* by Fred Penzell
- *Freeing Your Child from Obsessive Compulsive Disorder* by Tamar Chansky
- *What to Do When Your Child has Obsessive Compulsive Disorder: Strategies and Solutions* Aureen Pinto Wagner

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# Treatment

- Medication
  - Effect size ~0.46
  - First line=Selective Serotonin Reuptake Inhibitors (SSRI's)
    - *Fluoxetine, *fluvoxamine, paroxetine—age 8
    - *Sertraline—age 6
    - Citalopram, escitalopram– no FDA approval but clinically useful
  - Tricyclic Antidepressant
    - Clomipramine (>age 5)
  - Highest response rates with medication AND CBT

*most evidence

# Treatment

Non-responders or partial responders to medication:

- Check for comorbidities
- Combine with CBT
- Change to another SSRI or clomipramine
- Augment with antipsychotic
  - Haloperidol
  - Quetiapine
  - Risperidone

# Support Groups and Associations

http://www.geonius.com/ocd/organizations.html

# Thank You!