Childhood Obsessive-Compulsive Disorder

OCD

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OCD

- OCD is characterized by the presence of obsessions or compulsions (in most cases – both).
- Obsessions are recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted.
- Compulsions are repetitive behaviors or mental acts that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
- In order to meet the minimal threshold for diagnosis, the obsessions or compulsions must take more than an hour a day or cause significant distress or impairment.

OCD - Specifiers

- After an OCD diagnosis was reached, a specifier is given for level of insight. Better insight ⇨ better prognosis:
  - Good or fair insight – The individual recognizes their beliefs as definitely or probably not true.
  - Poor insight – The individual thinks the beliefs are probably true.
  - Absent insight / delusional beliefs – The individual is convinced the beliefs are true.
- In cases where the individual has a current or past history of a tic disorder, the specifier 'tic-related' is given. Course and therapy may be different in these cases.

Childhood OCD (1)

- The lifetime prevalence of OCD is 2%.
- In abut half the cases onset is in early adulthood (ages 18-35). In the other half, onset is between pre-adolescence (~ age 9) and late adolescence (age 18).
- Childhood and adult OCD are more similar than not. However, some differences exist (the following list is in no particular order):
  - Obsessions develop later than compulsions. It is not uncommon to see a child with clear compulsions, but no clear obsessions. If the child deems the compulsions as 'logically' unnecessary, that child has good insight even if he cannot articulate his obsessions.

Childhood OCD (2)

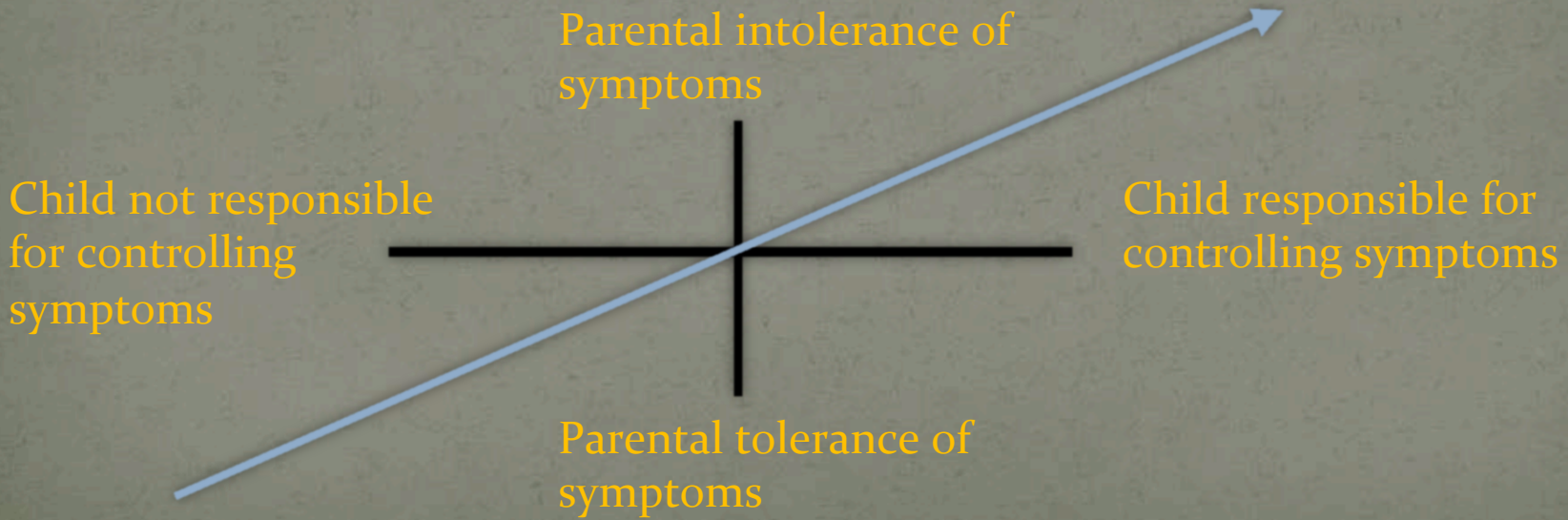
- some more differences:
  - Poor insight is more common in children; it does not inevitably lead to poor outcome.
  - Religious, moral and sexual obsessions are common; some children will require empathic prompting to disclose these.
  - Children tend to under-estimate the impact of their OCD. Partially, because many parents are involved in the compulsions (e.g., a parent who washes the same shirt twice a day upon the child's request).
  - Many parents believe that not allowing the child to perform the compulsions will cause an ever-lasting trauma. This is absolutely untrue.
  - Distinguishing between a complex tic and a 'simple' compulsion may be difficult (e.g., taping the finger may be either a tic or a compulsion). This distinction however is crucial when choosing treatment.

Childhood OCD (3)

- some more differences:
  - Most young children (2 to 6 year old) demonstrate some obsessive-compulsive behaviors that are part of normal development – for example:
    - wanting to wear the same thing over and over;
    - liking things done "just so,";
    - being comforted by ritualistic bedtime routines.
  - If normative, these age-dependent behaviors should diminish by middle childhood.

Therapy

- Controlled studies involving children and adults support the efficacy of Cognitive Behavioral Therapy (CBT) that emphasizes Exposure and Response Prevention (ERP).
- Parents involvement in the therapy is crucial for success.



Components of CBT (1)

- **Psychoeducation**
  - Both the child and the family need to have an accurate understanding of OCD.
- **Monitoring of Symptoms**
  - Identify and track frequency and duration of obsessions and compulsions.
  - Set targets to work towards.
- **Relaxation Training**
  - Deep Breathing, Muscle Tension Relaxation, Imagery
- **Cognitive Strategies**
  - Generate and reinforce accurate (not just positive) thoughts to challenge obsessions and compulsions; cognitive resistance; positive reinforcement.

Components of CBT (2)

- **Exposure & Response Prevention (ERP)**
  - Confronting an OCD-eliciting situation (action, object, place, thought, etc.) while preventing the associated compulsions and/or avoidance.
    - E.g., a child with contamination concerns must touch on purpose a 'contaminated' surface and then resist the urge to do the compulsion (like washing hands).
- **Homework**
  - Change cannot occur exclusively through CBT sessions therefore strategies must be practiced at home regularly (i.e., daily, sometime multiple times a day).

CBT Helpful Hints (1)

- Use developmental appropriate language and analogies.
  - E.g., fear thermometer.
- Generate lists of what's "good" and "bad" about the OCD behaviors.
  - Compare the lists to try to build motivation.
- For younger children, externalize the problem and give it a name.
  - E.g., "OCD Bully".
- It is sometimes difficult to determine the nature of obsessions in pediatric populations – that's okay.
  - If necessary, focus on compulsions; when compulsions decrease, so will the obsessions.

CBT Helpful Hints (2)

- ERPs are the most important active ingredients of CBT.
  - Encourage children to face their fears and do the opposite of what their OCD wants them to do – for example:
    - if they want to avoid something – **do it**;
    - if they feel they have to perform a ritual - **don't do it.**
- Parental involvement is critical, with consistency between all caregivers, especially in young children.
  - Whenever possible, both parents should have adequate psychoeducation about OCD and be involved in treatment
  - Parents should set clear expectations and boundaries, encourage their child to resist their OCD, avoid over-involvement, and look for positives.
  - Parents should not accommodate OCD, engage in behaviors that reinforce OCD symptoms, or criticize/blame/shame.

CBT Helpful Hints (3)

- For those successfully treated with CBT, many stay well and/or learn to manage future relapse symptoms.
  - Some may require additional “booster” sessions.
  - Relapse is more common after discontinuation of medication in those treated with medication only.

Medications

- When should medications be considered?
  1. After failure of a standard CBT trial.
  2. In combination with CBT, in moderate to severe cases.
- What medications should be used?
  - The efficacy of Selective Serotonin Reuptake Inhibitors (SSRIs) for OCD has been established by multiple placebo-controlled studies.
- In contrast with depression or non-OCD anxiety disorders. many cases of OCD require longer medication trials using higher doses of medications.
- In complex cases, a different class of medications may be employed instead.
  - Clomipramine (a tricyclic antidepressant) or
  - The SSRI may be augmented (e.g. with Risperidone, an antipsychotic).

OCD Genetics

- In recent years, the genetics of OCD has been studied in-depth.
- Large (>5,000 participants) GWAS studies, are beginning to yield positive results.
  As an example, see: Mattheisen, *Mol Psychiatry*, 2014.

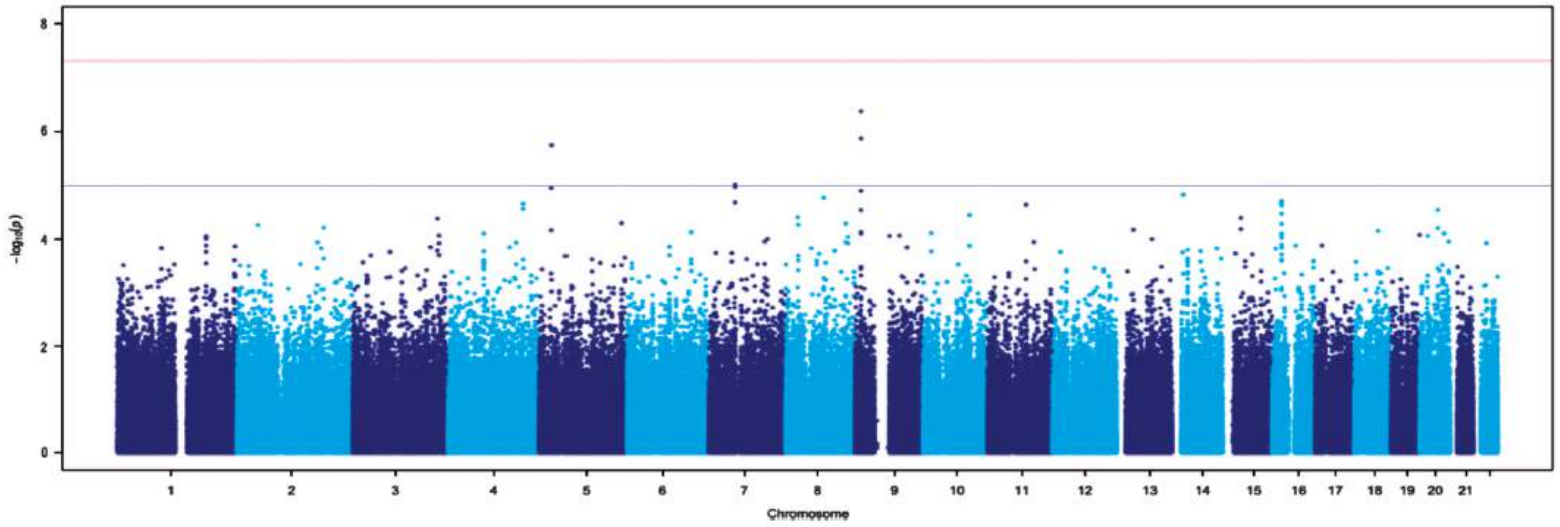
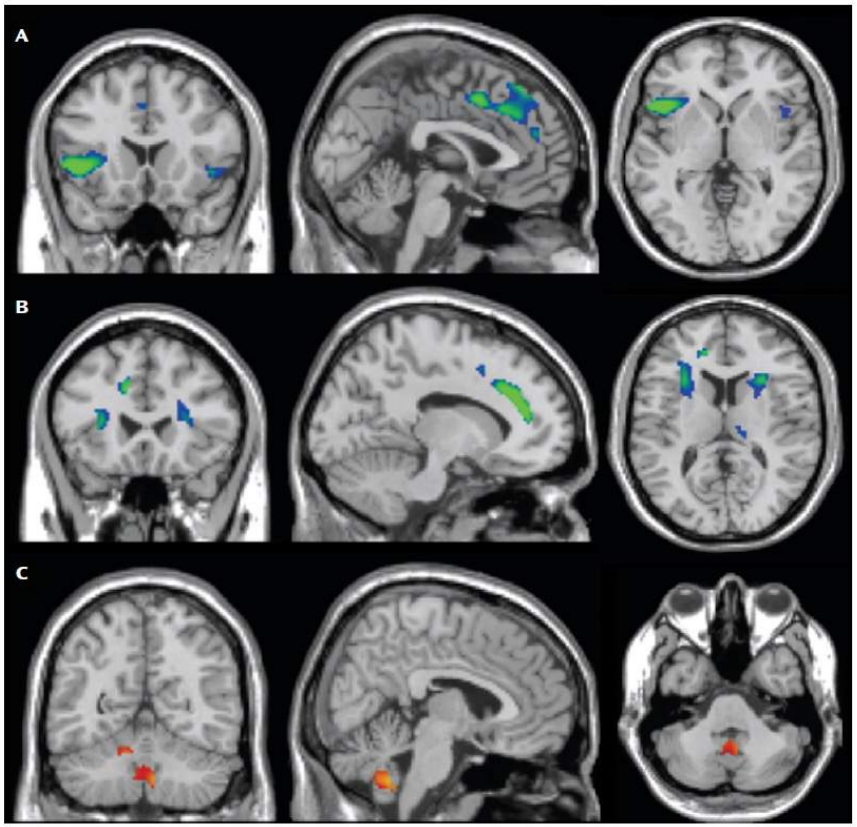


Figure 1. Manhattan plot for OCGAS–GWAS. Shown are the results for the hybrid analysis of the within- and between-family component of the OCGAS–GWAS. A thin blue line indicates level of suggestive evidence for association (1×10^{-5}) and a thin red line indicates genome-wide significance (5×10^{-8}). OCGAS–GWAS, the OCD Collaborative Genetics Association Study–genome-wide association study.

OCD Imaging

- In addition to genetics, imaging allows us to prod into the circuits and structures that sub-serve obsessive-compulsive behavior.
- See: Stella, *Am J Psychiatry*, 2014, as an example of a recent large (>700 participants) structural brain imaging study.

FIGURE 1. Regional Gray and White Matter Volume Differences Between OCD Patients (N=412) and Healthy Comparison Subjects (N=368)[a]



Self Assessment Question 1

- A child presents to you with mild to moderate OCD. What do you do?

Self Assessment Answer 1

- When possible, children and adolescents with mild to moderate OCD should begin treatment with CBT.
- CBT should be administered by a qualified practitioner with training in CBT for OCD; should involve parents in treatment, and should always include ERP.
- If CBT is not feasible, does not result in clinical improvement, or if symptoms worsen, treatment with an SSRI should be considered.

Self Assessment Question 2

- A child presents to you with moderate to severe OCD. What do you do?

Self Assessment Answer 2

- In moderate cases, consider a referral to a psychiatrist or psychologist for a thorough assessment (e.g., in order not to miss comorbid depression).
- In severe cases, consider a referral to a psychiatrist, for a thorough assessment and medication consultation.
- Remember: no matter how severe, all children should be considered for OCD-specific CBT.

Resources

Adults/Adolescents

- *The OCD Workbook: Your Guide to Breaking Free From Obsessive-Compulsive Disorder* by Bruce M. Hyman

Children

- *Up and Down the Worry Hill* by Aureen Pinto Wagner
- *Blink Blink Clop Clop: Why Do We Do Things We Can't Stop?* by E. Katia Moritz and Jennifer Jablonsky

Parents

- *Freeing Your Child from Obsessive Compulsive Disorder* by Tamar Chansky
- *OCD: A Parent's Guide to Helping Your Child* (DVD from Anxiety BC)

Clinicians

- *OCD in Children and Adolescents: A Cognitive-Behavioral Treatment Manual* by John March and Karen Mulle

Helpful Websites

http://www.anxietybc.com/

http://anxieties.com/