Pediatric Obsessive-Compulsive Disorder
Assessment & Treatment
- Prevalence
- Onset
- Gender
- Diagnostic Criteria
- Comorbidity
- Treatment
- Questions
Prevalence

- U.S. Youth 1-3%  
  (McKay & Storch, 2009)

- Higher w/ DD

- 80% of adults with OCD had childhood onset  
  (Kessler, 2005).

- Fourth most common psychiatric disorder in the United States ranking after phobias, substance abuse disorders, and major depressive disorder.  
  (Leahy & Holland, 2000).
Onset

- Usual onset in late teens or early twenties (Kessler, 2005 & Wewetzer et al., 2001).
  - 6-15 years for males
  - 20-29 years for females

- Lapse between mean age at onset (age 14.5) and age of appropriate treatment (age 31.5). Average -17 yrs.
Gender

- Pre-pubertal ratio of boys to girls 3:1–2
- Post-pubertal the ratio reverses, boys to girls 1:1.35
- Boys tend to have higher rates of comorbid tic disorders
DSM-IV-TR - Obsessions

- Recurrent and persistent thoughts, impulses or images
- Experienced as intrusive and inappropriate and cause **marked anxiety or distress**
  Waived for children
- Not simply excessive worries about real life problems
Thoughts, impulses or images, that are ignored, suppressed, or otherwise neutralized with some other thought or action.

Recognizes the thoughts are a product of their own mind, i.e. not imposed from without.
DSM-IV-TR - Compulsions

- Repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession, or according to rules that must be rigidly applied

- The behaviors or mental acts are aimed at preventing or reducing stress, or preventing a dreaded event or situation
DSM-V

- Anxiety and Obsessive-Compulsive Spectrum Disorders.
- Hoarding – *Hoarding Disorder*
- Examples provided for: “not better accounted for by the symptoms of another DSM-5 disorder”
- Insight will be:
  - Good or fair
  - Poor
  - Absent
Obsessions and Compulsions

- At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **Does not apply to children**

- The obsessions or compulsions are time-consuming (e.g., more than 1 hour a day), or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Common Obsessions

- Contamination
- Harm
- Aggressive
- Sexual
- Scrupulosity/Religiosity
- Forbidden Thoughts
- Symmetry
- Need to tell ask or confess
- Magical Thoughts/Superstition
Compulsions

- Driven to perform repetitive behaviors or mental acts to reduce the distress associated with the obsession
- Exist to temporarily neutralize or alleviate obsessions and accompanying dysphoric affects
- Compulsions are most often observable behaviors, but can be internal, mental acts
- Often performed according to rigidly applied rules.
Common Compulsions

- Washing
- Repeating
- Checking
- Touching
- Counting/Praying
- Magical Rituals
- Ordering/Arranging
- Hoarding
- Reassurance
Six Common Beliefs

- Inflation of responsibility
- Over-importance of thoughts
- Excessive need to control thoughts
- Overestimation of risks
- Intolerance of uncertainty
- Perfectionism

( Obsessive-Compulsive Working Group, 1997)
Considerations in Childhood

- Only obsessions or compulsions are rare
- However, approximately 40% of children with OCD deny that their compulsions are driven by obsessions
- Consider development of mastery and control: For example, children often prefer or insist on elaborate bedtime rituals
- OCD contributes to dysfunction rather than mastery.
Considerations in Childhood

- Consider cultural beliefs such as cleanliness or religious obligations.
- The prognosis of children with poor insight is worse - similar to adults.
- Symptoms can begin abruptly or begin subtly and slowly increase in severity.
Comorbidity

- Tic disorders and ADHD most common when onset is prior to puberty.
- Post puberty - depression and anxiety
- Also other anxiety disorders, disruptive behaviors, and learning disorders are common
- Also more common are the body focused repetitive disorders such as nail biting, skin-picking, trichotillomania, etc.
Comorbidity

- Over the course of their lifetime, up to 80% of patients with OCD may experience depressive episodes.
- Childhood depression not uncommon – Often diagnostically overlooked – Impacts the ability to treat
- Estimated that 75% of patients with OCD have a secondary or co-morbid diagnosis
  (Kaplan 2004.)
Differential Diagnosis

- ADHD
- Obsessions or ritualistic behavior may be present for a variety of psychiatric disorders
- Distinguishing between tics and compulsions can be difficult when the rituals are simple, repetitive movements such as tapping and touching.
Complicating the picture - nearly two-thirds of children with OCD have comorbid tics and 20%–80% of children with Tourette’s Syndrome report obsessive-compulsive symptoms.

The majority of children do not receive a correct diagnosis and treatment (POTS 2004).

Children with an autism spectrum disorder may also have repetitive thoughts and exhibit specific stereotypic compulsive behaviors.
PANDAS

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcus (PANDAS) Inflammatory Reaction

- Presence of OCD and/or tic disorder
- Pre-pubertal onset
- Symptom severity episodic in nature, associated with Group A Streptococcal (GAS) infections(s)

Although the exact prevalence of PANDAS OCD remains unknown, symptoms typically include sudden onset characterized by an episodic course with symptom recurrence experienced by approximately 50% of patients.
OCD has a strong genetic component (twin studies), investigators have linked the disorder to a region of chromosome 9 (Treichel 2006).

OCD is five times more likely to be present in first degree relatives of someone with OCD (Menzies 2008).
Impairment

- Academic Difficulties
  - Work completion issues
  - School attendance
- Restriction of personal and family social activities
- Increased family conflict
- Self-imposed stigma
- Isolation
Family-Based Approach

- Parents as agents of change
- Help parent understanding of treatment principles
- Parent as an “at-home coach” and support
- Reduce family accommodation of OCD symptoms
- Encourage and support optimal child effort during exposures and related work
Assessment

- Clinical Interview
- Measures Include
  - Broadband Measure: CBCL or BASC
  - CDI, ECBI, Conner’s
  - Child Yale-Brown Obsessive Compulsive Scale (CY-BOCS)
  - Anxiety Disorder Interview Schedule (ADIS)
  - Multidimensional Anxiety Scale for Children (MASC)
  - Child Obsessive-Compulsive Impairment Scale (COIS)
Cognitive Behavioral Treatment

- Assessment
- Psycho-education
- Socializing child and family to treatment
- Develop symptoms hierarchy
- Active treatment via exposure and response prevention (ERP)
- Conclude treatment
- Offer booster sessions as needed.
Cognitive Behavioral Treatment

Gold Standard in Treatment (DeRubeis & Crits-Christoph, 1998); 63% to 83% of participants obtained benefit, many long term (Abramowitz, 1997; Foa & Kozak, 1996; Stanley & Turner, 1995).

Cognitive approaches highlight the role of dysfunctional beliefs and interpretations that sustain rituals. More appropriate and applicable to treating adults – Consider developmental level
Cognitive therapy must be implemented appropriately as it can reinforce rituals or engender new ones.

Use CT to externalize OCD symptoms or motivate children. The OCD monster; Visualize and draw OCD as a separate entity. Provides children an image to fight against.

Use imagination and story to facilitate the child’s understanding and increase motivation.
## Hierarchy Development

<table>
<thead>
<tr>
<th>SUDS Level</th>
<th>Description</th>
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<tbody>
<tr>
<td>99</td>
<td>Touching an unknown sticky substance, without washing</td>
</tr>
<tr>
<td>95</td>
<td>Holding loose hair</td>
</tr>
<tr>
<td>90</td>
<td>Touching known sticky substances (e.g. egg), without washing</td>
</tr>
<tr>
<td>85</td>
<td>Touching unknown trash articles</td>
</tr>
<tr>
<td>60</td>
<td>Using a public restroom</td>
</tr>
<tr>
<td>60</td>
<td>Witnessing a political argument</td>
</tr>
<tr>
<td>60</td>
<td>Witnessing other sensitive-subject arguments (i.e. religion)</td>
</tr>
<tr>
<td>60</td>
<td>Seeing parents spend a lot of money at one time</td>
</tr>
<tr>
<td>60</td>
<td>Touching loose hair with finger</td>
</tr>
<tr>
<td>55</td>
<td>Touching known sticky substance (e.g. syrup), without washing</td>
</tr>
<tr>
<td>50</td>
<td>Touching a known sticky substance (e.g. soda), without washing</td>
</tr>
<tr>
<td>30</td>
<td>Touching a dirty railing</td>
</tr>
<tr>
<td>30</td>
<td>Walking into a public bathroom</td>
</tr>
</tbody>
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Cognitive Behavioral Treatment

How does it work?

ERP breaks the association between specific stimuli, situations, or anxiety-provoking thoughts and reliance on anxiety reducing rituals (Foa, Abramowitz, Franklin, & Kozak, 1999)

Facilitates habituation and may affect action of basolateral amygdala, hippocampus, and the medial prefrontal cortex (Quirk & Mueller, 2007)
Obsessive-Compulsive Cycle

- Obsession
- Fear/Anxiety
- Reduction in Distress
- Compulsions

Negative Reinforcement

(Piacentini et al, 2006)
Cognitive Behavioral Treatment

Onset

1st Trial
2nd Trial
3rd Trial
4th Trial
5th Trial

100
90
80
70
60
50
40
30
20
10
0

Onset 5min 10min 15min 20min 25min 30min 35min 40min
Medication

SSRI's:
- citalopram (Celexa®)
- escitalopram (Lexapro®)
- fluvoxamine (Luvox®)
- fluoxetine (Prozac®)
- paroxetine (Paxil®)
- sertaline (Zoloft®)

TCA's:
- clomipramine (Anafranil®)
Questions

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