MCPAP
Massachusetts Child Psychiatry Access Program

NEWS

July 2019

Clinical Conversation: Understanding and Treating Obesive-Compulsive Disorder

Clinical Conversation: May 28, 2019
Presented by Charles Moore, MD, medical director of the MCPAP McLean-Southeast Region and McLean Southeast Adolescent Services

While obsessive compulsive disorder (OCD) affects only a small percentage of children and adolescents, for those with the disorder and their families, it has a profound impact on their everyday lives. At the MCPAP Clinical Conversation, Charles Moore, MD, medical director of the MCPAP McLean-Southeast Region and McLean Southeast Adolescent Services, offered insights on understanding and treating the disorder in primary care.

Understanding OCD

Definition

OCD is a psychiatric disorder characterized by a cycle of obsessions causing anxiety and compulsions that the person uses to relieve the anxiety and decrease his/her distress. Obsessions are unwanted ideas, thoughts, or images that are unpleasant and cause the child worry, anxiety, and doubt (for example: worries about germs and getting sick, extreme fears about bad things happening, disturbing thoughts about hurting others, or images of a sexual nature). Compulsions include behaviors such as excessive checking (for example that doors are locked), excessive hand washing and/or cleaning, ordering or arranging things, saying lucky words or numbers, or seeking excessive reassurance. "In younger children, the most common fears are germs and something bad happening to parents or the world. A common compulsion is hand washing," says Dr. Moore.

The key factor that distinguishes OCD obsessions and compulsions is the degree to which they interfere with everyday functioning.

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Incidence

OCD is diagnosed in 1-2 percent of children and adolescents, the same percentage as diabetes. This translates to 4-5 children in an average elementary school and 20 teens in a large high school.

In 75 percent of cases, OCD appears before age 18 and in 25 percent of cases before age 14. The average age of onset is between ages 8-12. More males are affected in childhood (25 percent have onset before age 10), and females are slightly more affected in adulthood.

Etiology

A strong body of research evidence points to a neurobiologic model of OCD pathophysiology, with dysregulation of frontal corticostriatal-thalamic circuits associated with OCD symptoms. MRI imaging shows that brain structure changes after OCD treatment.

OCD course

OCD is frequently chronic with a variable course of waxing and waning symptoms. When it occurs in childhood or adolescence, OCD can persist over a lifetime. However, 40 percent of those with childhood/adolescent OCD have remission by early adulthood.

Comorbidity

Most OCD patients have comorbidities: 75 percent with anxiety disorders, 33-39 percent with major depression disorders, 34-51 percent with ADHD, and 18-25 percent with Tourette's syndrome.

Family impact

When a child has OCD, family members are caught in the cycle of obsessions and compulsions, often engaging in family accommodation behaviors to help reduce the child's distress which exacerbate the disorder (see family involvement section below). They may also have feelings of isolation, frustration, shame and guilt. OCD has a genetic link: 10-25 percent of children with OCD have at least one parent with the disorder.

Diagnosis

Pediatricians have an important role to play in identifying OCD in patients: The disorder is often unrecognized and untreated because children are secretive about their OCD symptoms, which may be relatively subtle and manifest as a lack of interest in ordinary activities and unusual habits. Direct questioning of the parent and child is often necessary to uncover the disorder.

However, assessing young patients can be problematic: 40 percent of children deny that their compulsions are driven by obsessive thoughts; they also lack the insight to realize that their obsessions are irrational. "Parent and teacher reports should be given considerable weight in diagnosing OCD, especially in younger children," says Dr. Moore.

The standard assessment test for pediatric OCD used in the mental health setting is the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS), which includes a symptom checklist and severity rating scale for children and adolescents ages 6-17. For pediatricians who want to screen patients with OCD symptoms, MCPAP recommends CY-BOCS. One important factor in determining severity, reports Dr. Moore, is how well a child is able to resist compulsions.

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Treatment

CBT/ERP

Numerous clinical trials have affirmed the efficacy of treating OCD with a type of cognitive behavior therapy (CBT) known as exposure and response prevention (ERP). This therapy helps patients to face their fears (exposure) and refrain from performing compulsive behaviors. "It's an uncomfortable therapy that should be administered in a thoughtful way. A child needs a lot of support to face their fears and learn to resist compulsions," says Dr. Moore.
(To hear youth describe their experiences overcoming OCD, view the video "Unstuck" at *https://kids.iocdf.org/what-is-ocd-kids*.)

Finding a therapist

A therapist with ERP training is ideal but can be hard to find. Getting started with treatment is most critical, so a therapist with experience treating anxiety is a good alternative. The International OCD Foundation has listings of pediatric therapists and treatment programs. MCPAP can also help: "We encourage pediatricians to contact us. OCD doesn't always follow consistent treatment pathways. We can follow the case and guide care," says Dr. Moore.

More severe cases of OCD may need inpatient or residential care.

Medication

The Pediatric OCD Treatment Study (POTS), a randomized clinical trial, found that the most effective treatments for pediatric OCD were CBT alone or in combination with medication. Medication can support CBT but is not effective alone.

For patients with mild-to-moderate or less complicated OCD, the pediatrician can manage treatment with one of the following medications that are FDA approved for pediatric OCD:

Sertraline – Begin at 12.5 mg, gradually increasing the dose every 1-2 weeks to 100-150 mg, with a maximum dose of 200 mg. Use night time dosing if somnolence is experienced.

Fluvoxamine – Begin at 25 mg, increasing to 100-150 mg, with a maximum dose of 200 mg (age 8-11) or 300 mg (adolescents). Night time dosing and divided dosing are recommended over 100 mg due to frequent somnolence.

Fluoxetine – Begin at 5 mg, increasing to 20-30 mg for children and 30-60 mg for adolescents.

"Starting slowly is especially important with OCD patients who may be obsessively concerned about taking medication and having side effects. ERP may help with this," says Dr. Moore. "Once they learn to manage with OCD with therapy, they can taper off medication."

With any of these medications, it is important to follow the black box warning and monitor patients weekly for agitation, suicidality, and other side effects; in cases of severe agitation or suicidal intent or plan, refer to a hospital or crisis team for an emergency evaluation and consult with MCPAP.

Family involvement

Parents and caregivers are an integral part of a child's treatment for OCD. Therapy can help them to learn to cope with the child's behavior, avoid accommodation behaviors that reinforce the child's compulsions, and be the

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child's coach to continue treatment at home. The pediatrician can also support parents in managing the child's behavior.

PANS/PANDAS and OCD

Two autoimmune diseases triggered by infections - pediatric acute-onset neuropsychiatric syndrome (PANS) and pediatric autoimmune neuropsychiatric disorder associated with streptococcus (PANDAS) - cause symptoms similar to OCD. In PANS and PANDAS, the onset of OCD symptoms is abrupt and dramatic, unlike typical OCD in which subclinical symptoms gradually become more severe over time. The patient may also have severe separation anxiety, anorexia or disordered eating, urinary frequency, tics and/or involuntary motor movements, and acute difficulty with handwriting. For more guidance on treating PANS/PANDAS, see the MCPAP February newsletter at *www.MCPAP.org*.
"Parents often hope that medical treatment will relieve the OCD symptoms but they persist and need to be treated the same way as typical OCD," says Dr. Moore.

Resources

International OCD Foundation: *https://kids.iocdf.org/professionals/md/*, provides extensive resources for medical professionals and families

What's Happening for you at MCPAP

Clinical Conversations

We invite you to log in on the fourth Tuesday of each month from 12:15 - 1:15 p.m. to learn more about managing pediatric behavioral health issues in your practice.

Fall topics 2019

- **MCPAP Clinical Guidelines: PTSD**
- **Preschool Mental Health**
- **Suicide Prevention**
- **Racial Equity**
- **MCPAP Clinical Guidelines: Autism**

Next Clinical Conversation: Tuesday, September 24, 2019

If you are interested in receiving monthly Clinical Conversation invitations, updates, and newsletters please email us at *MCPAP@beaconhealthoptions.com*.
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