



MCPAP Clinical Conversations: OCD Assessment and Treatment Guidelines for Primary Care

Charles F. Moore, MD
Mclean Southeast – MCPAP South
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Outline

- Introductions
- Discussion of Format
- Presentation
- Comments and Questions (15-20 mins)

Talk goals

Recognition and assessment of OCD

When to consider PANDAS/PANS

How to use CY-BOC

Effective Parental Guidance

Therapy Referral

Medication treatment selection and monitoring

OCD Background

Obsessive compulsive disorder (OCD) is a condition in which a person gets caught in a cycle of obsessions that cause anxiety and compulsions that he or she uses to try to get rid of the anxiety.

- **Obsessions** are unwanted ideas, thoughts, images, or urges that are generally unpleasant for the child and cause a lot of worry, anxiety, and doubt.
- **Compulsions (or rituals)** are behaviors the child feels he or she must do in order to get rid of the upsetting feelings. A child may also believe that engaging in these compulsions will somehow prevent bad things from happening.

Obsessions

Worrying about germs, getting sick, or dying.

Extreme fears about bad things happening or doing something wrong.

Feeling that things have to be “just right.”

Disturbing and unwanted thoughts or images about hurting others.

Disturbing and unwanted thoughts or images of a sexual nature.

Compulsions

Excessive checking (re-checking that the door is locked, that the oven is off).

Excessive washing and/or cleaning.

Repeating actions until they are “just right” or starting things over again.

Ordering or arranging things.

Mental compulsions (excessive praying, mental reviewing).

Frequent confessing or apologizing.

Saying lucky words or numbers.

Excessive reassurance seeking (e.g., always asking, “Are you sure I’m going to be okay?”).

Unstuck

<https://kids.iocdf.org/what-is-ocd-kids/>

Epidemiology

OCD, with a prevalence rate of 1 – 2%.

OCD Dx in 2% of MCPAP Calls

This translates to:

- Around 4 – 5 children in an average elementary school.
- Around 20 teens in a large high school

75% of all OCD appears before age 18.

Mean age of onset is 19.5

25% of OCD starts before 14

Boys are affected more in childhood (2-3:1) (nearly 25% of males have onset before 10)

Females slightly more affected in adulthood (1.35:1)

OCD Course

Frequently chronic with waxing and waning course

Onset in childhood or adolescence can lead to lifetime OCD

40% with Child/Adolescent OCD may have remission by early adulthood

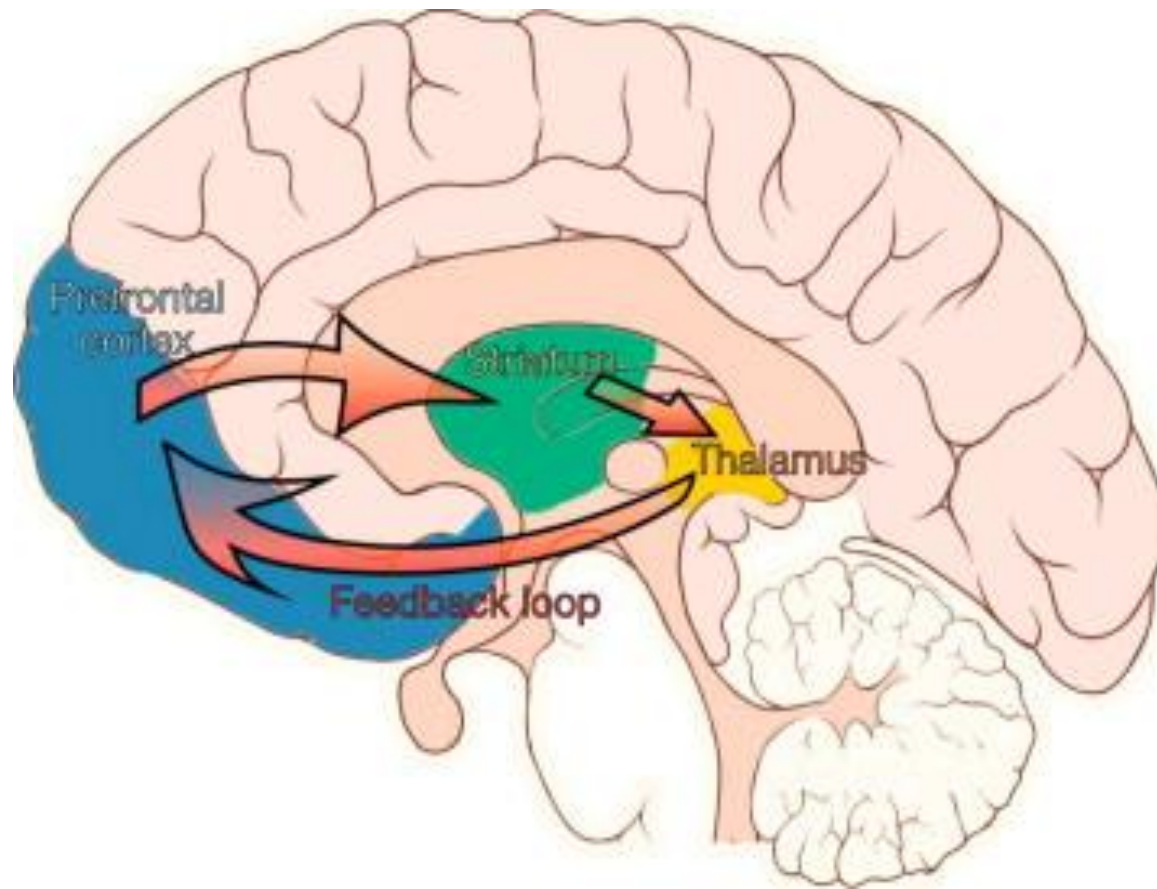
Impact on Families

Having a child or teen with OCD can be very difficult for the entire family, leading to feelings of isolation, frustration, shame, and guilt.

Family members may have become involved in the child's compulsions, engaging in **family accommodation behaviors** in an effort to help reduce their child's distress.

Genetic link: OCD may also be present in other family members. 10-25% have at least one parent with OCD

Neuroanatomy OCD Theory



Comorbidity

Anxiety Disorders (76%)

Major Depression Disorders (33-39%)

ADHD (34-51%)

Body Dysmorphic Disorder

Trichotillomania

Excoriation Disorder

Oppositional Defiant Disorder (17-51%)

Tic Disorder (26%)

Tourette's Syndrome (18-25%)

Assessment / CY-BOC

40% of Children
deny compulsions
are driven by
obsessive thoughts

Children can lack
insight to realize
their obsessions
are irrational

Current Past

- AGGRESSIVE OBSESSIONS**
- Fear might harm self
- Fear might harm others
- Violent or horrific images
- Fear of blurting out obscenities or insults
- Fear of doing something else embarrassing*
- Fear will act on unwanted impulses (e.g., to stab friend)
- Fear will steal things
- Fear will harm others because not careful enough (e.g. hit/run motor vehicle accident)
- Fear will be responsible for something else terrible happening (e.g., fire, burglary)
- Other: _____
- CONTAMINATION OBSESSIONS**
- Concerns or disgust w/ with bodily waste or secretions (e.g., urine, feces, saliva Concern with dirt or germs)
- Excessive concern with environmental contaminants (e.g. asbestos, radiation toxic waste)
- Excessive concern with household items (e.g., cleansers solvents)
- Excessive concern with animals (e.g., insects)
- Bothered by sticky substances or residues
- Concerned will get ill because of contaminant
- Concerned will get others ill by spreading contaminant (Aggressive)
- No concern with consequences of contamination other than how it might feel
- SEXUAL OBSESSIONS**
- Forbidden or perverse sexual thoughts, images, or impulses
- Content involves children or incest
- Content involves homosexuality*
- Sexual behavior towards others (Aggressive)*
- Other: _____
- HOARDING/SAVING OBSESSIONS**
(distinguish from hobbies and concern with objects of monetary or sentimental value)
- _____
- RELIGIOUS OBSESSIONS (scrupulosity)**
- Concerned with sacrilege and blasphemy
- Excess concern with right/wrong, morality
- Other: _____
- OBSESSION WITH NEED FOR SYMMETRY OR EXACTNESS**
- Accompanied by magical thinking (e.g., concerned that another will have accident dent unless less things are in the right place)
- Not accompanied by magical thinking
- MISCELLANEOUS OBSESSIONS**
- Need to know or remember
- Fear of saying certain things
- Fear of not saying just the right thing
- Fear of losing things
- Intrusive (nonviolent) images
- Intrusive nonsense sounds, words, or music
- Bothered by certain sounds/noises*
- Lucky/unlucky numbers
- Colors with special significance
- 3 superstitious fears
- Other: _____

Current Past

- SOMATIC OBSESSIONS**
- Concern with illness or disease*
- Excessive concern with body part or aspect of Appearance (e.g., dysmorphophobia)*
- Other: _____
- CLEANING/WASHING COMPULSIONS**
- Excessive or ritualized handwashing
- Excessive or ritualized showering, bathing, toothbrushing grooming, or toilet routine involves cleaning of household items or other inanimate objects
- Other measures to prevent or remove contact with contaminants
- Other: _____
- CHECKING COMPULSIONS**
- Checking locks, stove, appliances etc.
- Checking that did not/will not harm others
- Checking that did not/will not harm self
- Checking that nothing terrible did/will happen
- Checking that did not make mistake
- Checking tied to somatic obsessions
- Other: _____
- REPEATING RITUALS**
- Rereading or rewriting
- Need to repeat routine activities jog, in/out door, up/down from chair)
- Other: _____
- COUNTING COMPULSIONS**
- _____
- ORDERING/ARRANGING COMPULSIONS**
- _____
- HOARDING/COLLECTING COMPULSIONS**
(distinguish from hobbies and concern with objects of monetary or sentimental value (e.g., carefully reads junk mail, piles up old newspapers, sorts through garbage, collects useless objects.)
- _____
- MISCELLANEOUS COMPULSIONS**
- Mental rituals (other than checking/counting)
- Excessive listmaking
- Need to tell, ask, or confess
- Need to touch, tap, or rub*
- Rituals involving blinking or staring*
- Measures (not checking) to prevent: harm to self-harm to others terrible consequences
- Ritualized eating behaviors*
- Superstitious behaviors
- Trichotillomania *
- Other self-damaging or self-mutilating behaviors*
- Other: _____

Adapted from Goodman, W.K., Price, L.H., Rasmussen, S.A. et al.:
 "The Yale-Brown Obsessive Compulsive Scale"
 Arch Gen Psychiatry 46:1006-1011, 1988

CY-BOC Symptom Checklist

Note: Scores should reflect the composite effect of all the patient's obsessive compulsive symptoms. Rate the average occurrence of each item during the prior week up to and including the time of interview.

Obsession Rating Scale (circle appropriate score)

Item	Range of Severity				
1. Time Spent on Obsessions Score:	0 hr/day 0	0-1 hr/day 1	1-3 hr/day 2	3-8 hr/day 3	> 8 hr/day 4
2. Interference From Obsessions Score:	None 0	Mild 1	Definite but manageable 2	Substantial impairment 3	Incapacitating 4
3. Distress From Obsessions Score:	None 0	Little 1	Moderate but manageable 2	Severe 3	Near constant, disabling 4
4. Resistance to Obsessions Score:	Always resists 0	Much resistance 1	Some resistance 2	Often yields 3	Completely yields 4
5. Control Over Obsessions Score:	Complete control 0	Much control 1	Some control 2	Little control 3	No control 4

Obsession subtotal (add items 1-5) _____

Compulsion Rating Scale (circle appropriate score)

Item	Range of Severity				
6. Time Spent on Compulsions Score:	0 hr/day 0	0-1 hr/day 1	1-3 hr/day 2	3-8 hr/day 3	> 8 hr/day 4
7. Interference From Compulsions Score:	None 0	Mild 1	Definite but manageable 2	Substantial impairment 3	Incapacitating 4
8. Distress From Compulsions Score:	None 0	Mild 1	Moderate but manageable 2	Severe 3	Near constant, disabling 4
9. Resistance to Compulsions Score:	Always resists 0	Much resistance 1	Some resistance 2	Often yields 3	Completely yields 4
10. Control Over Compulsions Score:	Complete control 0	Much control 1	Some control 2	Little control 3	No control 4

Compulsion subtotal (add items 6-10) _____

Y-BOCS total (add items 1-10)

Total Y-BOCS score range of severity for patients who have both obsessions and compulsions:
 0-7 Subclinical 8-15 Mild 16-23 Moderate 24-31 Severe 32-40 Extreme

CY-BOC Severity Scale

POTS

Multisite randomized controlled trial to help figure out possible best practices for treating pediatric OCD.

POTS compared 4 study groups:

- CBT alone
- CBT/SSRI medication combined
- SSRI medication alone
- Placebo medication alone.

Results indicated that the most effective treatments for pediatric OCD were CBT alone, or CBT in combination with medication.

CBT/ERP

Pediatric OCD is best treated by a licensed mental health professional using a type of cognitive behavioral therapy (CBT) called **exposure and response prevention** (ERP).

In ERP, kids learn to face their fears (**exposure**) without giving in to compulsions (**response prevention**).

Licensed mental health professionals will guide them through this process, and children will learn that they can allow the obsessions and anxiety to come and go without the need for their compulsions.

OCD Medication Treatment

The therapist will work with the child/teen to set a hierarchy of their fears, and work with them to tackle each in a systematic fashion.

Psychiatric medication may be considered if the child's symptoms are very severe and/or not helped by ERP alone.

- **Serotonin Reuptake Inhibitors (SRIs)** have been found to be the most helpful in reducing OCD symptoms in children and teens, making ERP easier to do and more effective.

These are consistent with the recommendations from the American Academy of Pediatrics¹ and the American Academy of Child and Adolescent Psychiatry².

Medication for OCD

4 approved by the FDA **sertraline (>6yo)**, **fluvoxamine (>8yo)** **fluoxetine (>7yo)**.

Test dose for 1 week (e.g. sertraline 12.5mg, fluvoxamine 25mg, fluoxetine 5mg)

Gradually increase every 1-2weeks to target doses

- **Sertraline** target 100 to 150mg – max dose 200mg – night time dosing if somnolence
- **Fluvoxamine** target 100 to 150mg – max dose 200mg (8-11), 300mg (adolescents); typical nighttime dosing, divided dosing recommended over 100mg, somnolence frequent
- **Fluoxetine** target 20-30mg for children and 30-60mg for adolescents

Monitor weekly for agitation, suicidality & other side effects; for severe agitation or suicidal intent or plan, refer to hospital or crisis team for emergency evaluation; consult with MCPAP.

Family Involvement

Parents, caretakers, and other family members are an important part of a child's OCD treatment, and should be involved in many ways.

Therapy will help the family to reduce any accommodation behaviors they may have, as well as to actively engage them as “coaches” in helping the child continue their treatment outside the office.

What is PANDAS/PANS?

Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcus (PANDAS) involves the sudden, rapid-onset of obsessive-compulsive behavior, as well as possible movement and behavioral abnormalities, following a *Streptococcus pyogenes* (Group A Strep) infection.

Pediatric Acute-Onset Neuropsychiatric Syndrome (PANS) occurs when similar symptoms are observed due to other infections agents, such as mycoplasma, mononucleosis, Lyme disease, and the H1N1 flu virus.

What is PANDAS/PANS?

The conditions are hypothesized to be caused by autoimmune antibodies mistakenly attacking the basal ganglia rather than the intended infectious agent.

The hallmark of PANDAS/PANS is the abrupt, dramatic onset of OCD symptoms, as observed by clinicians or as reported by parents.

Compared to “garden-variety” pediatric OCD, PANDAS/PANS is **very rare**.

How is PANDAS/PANS treated?

IMPORTANT! *Regardless of medical intervention, the patient should be referred to mental health treatment concurrently, or as soon as possible once medically stable.*

Test for active infections.

Treat any active infections according to the standards of care for each.

- May require a more aggressive dosage/course with meds.
- PANDAS/PANS have a relapsing and remitting course, and thus follow up monitoring is recommended.

OCD vs. PANDAS/PANS

	Pediatric OCD	PANDAS/PANS
Age	Typically see first onset between 8 – 12 years old	Typically affects children between 4 – 14 years old.
Timeline	Subclinical symptoms become gradually more severe over time.	Acute, dramatic onset of symptoms.
Symptoms	Patient may experience a wide range of symptoms, cycling between <u>obsessions</u> that cause anxiety, and <u>compulsions</u> to reduce that anxiety.	Sudden, rapid-onset of obsessive-compulsive behavior, as well as possible movement and behavioral abnormalities, including: <ul style="list-style-type: none"> • Severe separation anxiety • Anorexia or disordered eating • Urinary frequency • Tics and/or purposeless motor movements • Acute handwriting difficulty
Treatment	Team up with an OCD specialist in the mental health field for ERP treatment with SSRIs as indicated.	Test for active infections, treat any active infections thoroughly, and team up with an OCD specialist for ERP treatment with SSRIs as indicated.

Questions and Comments