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

Charles F. Moore, MD
Mclean Southeast – MCPAP South
May 28, 2019

MCPAP
Massachusetts Child Psychiatry Access Program

Outline

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

MCPAP
Massachusetts Child Psychiatry Access Program

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.

MCPAP
Massachusetts Child Psychiatry Access Program

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?”).

MCPAP
Massachusetts Child Psychiatry Access Program

Unstuck

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

MCPAP
Massachusetts Child Psychiatry Access Program

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

MCPAP
Massachusetts Child Psychiatry Access Program

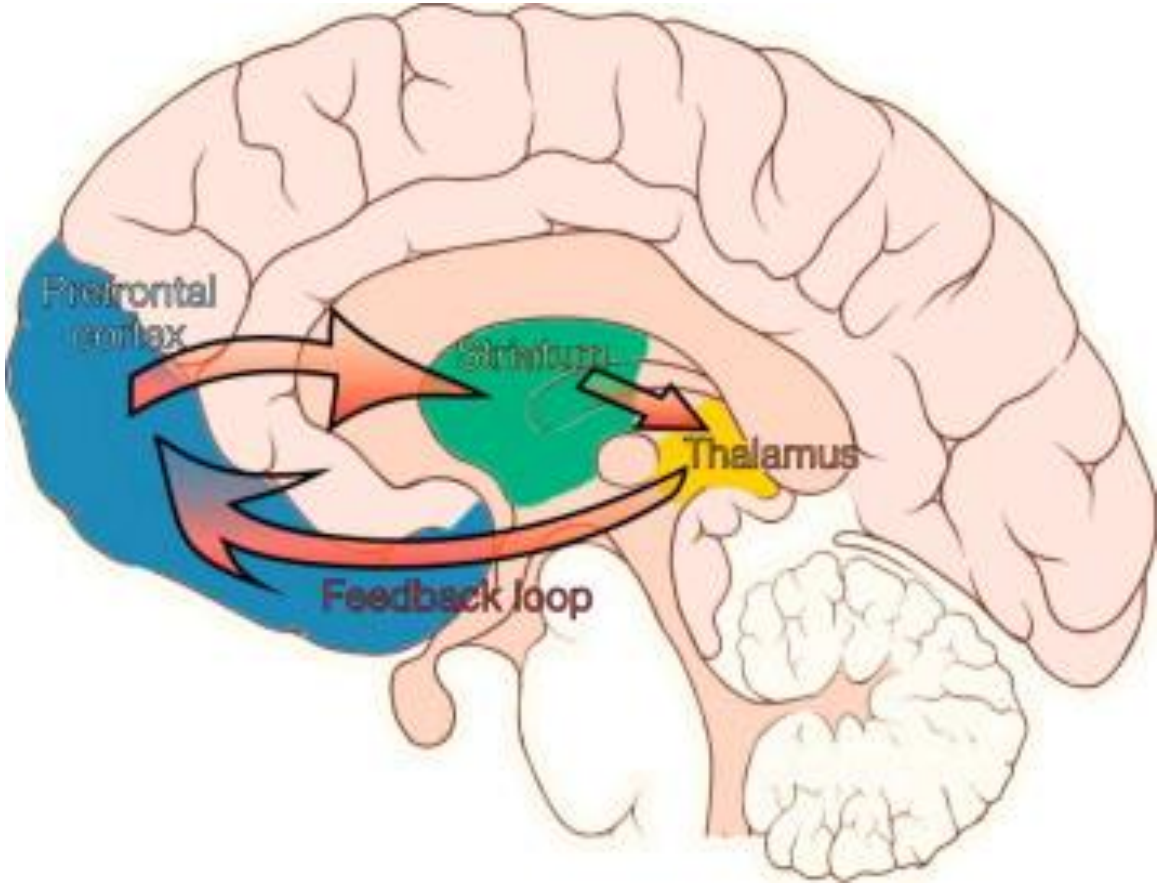
Impact on Families

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



MCPAP
Massachusetts Child Psychiatry Access Program

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%)

MCPAP
Massachusetts Child Psychiatry Access Program

Assessment / CY-BOC

40% of Children deny compulsions are driven by obsessive thoughts

Children can lack insight to realize their obsessions are irrational

MCPAP
Massachusetts Child Psychiatry Access Program

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 (eg., 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 46:1006-1011,1989

CY-BOC Symptom Checklist

MCPAP
Massachusetts Child Psychiatry Access Program

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

Obsession subtotal (add items 1-5) _____

Compulsion Rating Scale (circle appropriate score)

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

MCPAP
Massachusetts Child Psychiatry Access Program

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.

MCPAP
Massachusetts Child Psychiatry Access Program

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 Pediatrics[1] and the American Academy of Child and Adolescent Psychiatry[2].

MCPAP
Massachusetts Child Psychiatry Access Program

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.

MCPAP
Massachusetts Child Psychiatry Access Program

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.

MCPAP
Massachusetts Child Psychiatry Access Program

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.

MCPAP
Massachusetts Child Psychiatry Access Program

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.

MCPAP
Massachusetts Child Psychiatry Access Program

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 obsessions that cause anxiety, and compulsions to reduce that anxiety.	Sudden, rapid-onset of obsessive-compulsive behavior, as well as possible movement and behavioral abnormalities, including: • 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.

MCPAP
Massachusetts Child Psychiatry Access Program

Questions and Comments

MCPAP
Massachusetts Child Psychiatry Access Program