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Obsessive Compulsive Disorder (OCD) in Children/Youth: Information for Primary Care

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Summary: Obsessive compulsive disorder (OCD) is marked by obsessions and compulsions that cause distress. Obsessions are persistent thoughts, images, or impulses that are intrusive and pointless. Compulsions are repetitive behaviors that the patient feels driven to perform in response to the obsessions. Fortunately, various strategies including counseling/therapy (e.g. cognitive behaviour therapy), as well as medications exist to help with OCD.

Case

Dave is a 15-yo teenager who has always been somewhat anxious. Since the start of Gr. 11 however, he has been washing his hands numerous times a day, to the point that his hands are raw and sore from all the washing. He gets extremely upset if others touch him because he thinks he will be contaminated with disease causing germs. Stressors include parental separation and being bullied at school.

What are you going to do to help Dave?

Epidemiology

Point prevalence 0.2% (Waddell et al, 2002).

Lifetime prevalence of 1.9% to 3.0% and is significantly associated with both tics and ADHD.

Symptoms

Excessive cleaning (eg: handwashing, toothbrushing, showering)

Repeating rituals (eg: going in and out of doors, restarting phrases, rereading)

Checking rituals (checking the doors are locked, the appliances are tuned off, that the homework is perfect).

Hx/Interviewing Questions

For the patient:

- Obsessions: “Do you have any disturbing thoughts, images or urges that keep coming back to you, and that are hard to get out of your head? E.g. feeling contaminated or that terrible things are going to happen?”

- Compulsions: “Do you have any habits or rituals that absolutely have to do, other wise you feel upset? E.g. washing or cleaning over and over again, or counting things over and over again…

For caregivers, parents, family members:

- *Obsessions*: “Any thoughts that s/he gets over and over again?”
- *Compulsions*: “Any habits or rituals that s/he absolutely has to do, over and over again?”

Physical Exam (Px)

Behaviour

- Fear of contamination may lead to avoidance of shaking hands with the health care professional; avoidance of touching things such as doorknobs in the office; keeping on jackets and coats
- Need for symmetry may manifest in touching or doing things in a symmetrical fashion

Appearance

- Hands may appear red and chapped chapping from repetitive washing

DSM-5 Obsessive-Compulsive and Related Disorders

Obsessive-compulsive and related disorders include:

- OCD
- Body dysmorphic disorder
- Trichotillomania (hair pulling disorder)
- Hoarding disorder
- Excoriation (skin-picking)

DSM-5 Diagnostic Criteria for Obsessive-Compulsive Disorder

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or impulses that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

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

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behavior, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder).

Reference: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

Differential Diagnosis

Medical conditions that can cause or contribute to anxiety symptoms in general include:

- Gastric ulcer
- Asthma
- Thyroid problems
- Overuse of stimulant medications (e.g. ADHD medications, caffeine, diet pills, decongestants)

Medications that can mimic OCD include:

- Paediatric acute-onset neurologic syndrome (PANS) (formerly known as autoimmune and neurologic diseases associated with streptococcal infection (PANDAS)

Comorbid Diagnoses

Common comorbid diagnoses with OCD include:

- Major depressive disorder
- Panic disorder
- Body dysmorphic disorder
- Generalized anxiety disorder
- Social anxiety disorder
- Tourette syndrome and tic disorders
- Eating disorders
- Trichotillomania

Investigations

There are no unique laboratory measures for diagnosing OCD.

However, if the onset of obsessions or compulsions is believed to be associated with a PANDA or a recent infection, consider testing for

- Streptococal infection, e.g. throat swab
- Antistreptolysin O Titre (ASOT)

Management / Treatment

If OCD due to PANDAS is suspected

- Treat any active streptococcal infection

- Consider referral to Neurology and Psychiatry

Psychological Treatment

Mild to moderate OCD

- Cognitive behavioural therapy (CBT) with Cognitive restructuring and Exposure with response prevention (E/RP)

Medication Treatment

Medications may be indicated if OCD symptoms have not responded to non-medication treatment (such as CBT), or for moderate to severe OCD, or if CBT not available.

First-line

- SSRIs are first line as they are reasonably well tolerated
- Side effects typically insomnia, nausea, agitation, tremor, fatigue; may cause agitation in first 10 days or so
- How long to trial?
    - Trial of 10-12 weeks at an adequate dosage.
- Time to response?
    - Many OCD symptoms do not show improvement until 6-10 weeks

Medication	Dose Range	Comments
Sertraline	6-12 years: 25-200 mg/day; 13-17 years: 50-200 mg/day	FDA Approved for OCD treatment in adults and children 6-17 years.
Fluoxetine	6-12 years: 20-30 mg/day; 13-17 years: 20-60 mg/day	FDA Approved for OCD treatment in adults and children 7-17 years.
Fluvoxamine	6-12 years: 50-200 mg/day; 13-17 years: 50-300 mg/day	FDA Approved for OCD treatment in adults and children 7-17 years.

Reference: Vitiello B, Psych Annals 2010; drug dosage information from various sources

Second-line

- Alternative SSRI, or
- Clomipramine

Medication	Dose Range	Comments
Clomipramine	Up 3 mg/kg/day or 200 mg/day (whichever is less)	Clomipramine is felt to be effective, but is not first-line due to increased side effects compared to SSRIs FDA Approved for OCD treatment in adults and children 10-17 years

Case, Part 2

Given that Dave's symptoms of OCD are mild, and there do not feel he has any other significant diagnoses, you decide to provide education and recommend that the family see a therapist skilled in OCD. Fortunately, he forms a good connection with the therapist, and within a few visits, he is reporting significantly reduced distress from the OCD.

Self-Help Books

Foa EB, Wilson R. Stop obsessing: how to overcome your obsessions and compulsions. Revised. New York (NY): Bantam Books; 2001.

Grayson J. Freedom from obsessive-compulsive disorder: a personalized recovery program for living with uncertainty. New York (NY): Berkeley Publishing Group; 2004.

Hyman BM, Pedrick C. The OCD workbook: your guide to breaking free from obsessive-compulsive disorder. 2nd ed. Oakland (CA): New Harbinger Publications; 2005.

Purdon C, Clark DA. Overcoming obsessive thoughts: how to gain control of your OCD. Oakland (CA): New Harbinger Publications; 2005.

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Alario, A & Birnkrant, J (2008), Practical Guide to the Care of the Pediatric Patient, 2nd edition. Elsevier.

Clinical Practice Guideline, Management of Anxiety Disorders, Chtp 6, Obsessive Compulsive Disorder, Canadian Psychiatric Association

Geller et al.: Which SSRI? A Meta-Analysis of Pharmacotherapy Trials in Pediatric Obsessive-Compulsive Disorder, Am J Psychiatry 160:1919-1928, November 2003

Haapasalo-Pesu K et al.: Mirtazapine in the treatment of adolescents with major depression: an open-label, multicenter pilot study. J Child Adolesc Psychopharmacol. 2004 Summer;14(2):175-84. https://www.ncbi.nlm.nih.gov/pubmed/15319015

Kaplan & Sadock's synopsis of psychiatry : behavioral sciences/clinical psychiatry / Benjamin J. Sadock; 10th ed., Wolter Kluwer/Lippincott Williams & Wilkins, 2007.

Waddell, C; Offord, D; Shepherd, C; Hua, J; McEwan, K (2002), Child Psychiatric Epidemiology and Canadian Public Policy-Making: The State of the Science and the Art of the Possible, Can J Psychiatry, 47:825-832.

About this Document

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