

More Than Just Monsters Under the Bed: Assessing and Treating Pediatric OCD

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Anxiety is part of normal development. The majority of very young children will have periodic fears of monsters under the bed or in the closet, worries that someone will break into the house while they are sleeping, and will insist on eating the same food or wearing the same clothes. Ritualistic games, repetitive play and superstitions are other typical aspects of child development. At times, however, parents and clinicians are faced with discerning when these fears and ritualistic behaviors stop being developmentally appropriate and become clinically relevant behavior. Repetitive, ritualistic behavior is used to reduce anxiety that is frequently, but not always, associated with unwanted and intrusive obsessional thinking.

As many as 80% of patients with obsessive-compulsive disorder have a pediatric onset, with a male preponderance of 67% in children and 64% in adolescents (Geller et al., 1998). Without treatment, OCD often persists into adulthood and is associated with long-term negative outcomes, such as psychiatric comorbidity and reduced social functioning.

To meet diagnostic criteria for OCD, obsessions and/or compulsions must be time-consuming (over an hour a day) and cause distress to the patient and/or family, with impairment of peer and/or family relationships, school performance and/or daily functioning. Obsessive-compulsive disorder is often underdiagnosed due to the complexity of the symptom presentation, the overshadowing of comorbid disorders (such as disruptive behavior), and youth embarrassment related to symptoms. Common obsessions include fears of harm, contamination, religious fears and need for symmetry. Common compulsions include washing or cleaning, repetition of routines, reassurance seeking, and ordering/arranging (Scahill et al., 2003).

Clinical Characteristics

Childhood onset OCD has several characteristics not seen in the adult onset illness: children do not always view their symptoms as nonsensical; often experience obsessions and/or compulsions as "overwhelming" and therefore do not make attempts at resistance or control; and they often lack insight into their illness. Children (especially younger

ones) may have compulsions without obsessions. Disruption and difficulties with school, home and social functioning are commonly reported by parents (Piacentini et al., 2003). Family members often inadvertently contribute to maintenance of symptoms by accommodating the child in attempts to decrease the child's distress and family dysfunction.

Table

Information Resources For Parents and Families

Web sites

Although there are a number of useful informational Web sites available to learn more about pediatric OCD, there are two sites that stand out. Both sites provide general information and assistance in locating treatment providers.

Obsessive-Compulsive Foundation

<www.ocfoundation.org>

Anxiety Disorders Association of American

<www.adaa.org>

Books to recommend to parents

Freeing Your Child from Obsessive-Compulsive Disorder (2001), by Tamar E. Chansky, PhD (Three Rivers Press).

How I Ran OCD Off My Land: A Guide to Cognitive-Behavioral Psychotherapy for Children and Adolescents with Obsessive-Compulsive Disorder (1994), by John March, MD, MPH, and Karen Mulle, MSW.

Obsessive-Compulsive Disorder: Help for Children and Adolescents (2000), by Mitzi Waltz (O'Reilly & Associates).

Up and Down the Worry Hill: A Children's Book About Obsessive-Compulsive Disorder and Its Treatment (2000), by Aureen Pinto Wagner, PhD (Lighthouse Press, Inc.).

What To Do When Your Child Has Obsessive-Compulsive Disorder: Strategies and Solutions (2002), by Aureen Pinto Wagner, PhD (Lighthouse Press, Inc.).

Source: Lack CW et al. (2006)

These functional difficulties can be further exacerbated due to the high rates of comorbidity between OCD and other psychiatric illnesses, including attention-deficit hyperactivity disorder (ADHD) and depression. Those children with sudden and dramatic onset may belong to the subgroup termed PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcus).

Assessment

Many factors can make childhood onset OCD difficult to accurately diagnose: an insidious or subclinical onset, a fluctuating course, varying symptom constellation, secretiveness regarding symptoms and poor insight. Chapped and bleeding hands, blocked toilets,

frequent lengthy showers, multiple erasures on schoolwork and avoidance behaviors are clues that aid in diagnosis. For the PANDAS subtype, onset of symptoms after an illness such as strep throat or upper respiratory infection may be elicited (Larson et al., 2005). Assessment should include an in-depth interview with the child and parents with attention to potential comorbid

conditions and compulsions. Its checklist includes over 70 typical obsessions and compulsions and is useful in both identifying and rating symptoms. In addition, this scale lends itself well to tracking effects of treatment, with a decrease of 25% or more being clinically significant. The other widely used rating scale is the Leyton Obsessional Inventory-Child Version (LOI-CV) (Berg et al., 1986), a 20-item measure for general obsessive rituals and thoughts, fears of contamination, and school habits. Another popular rating scale, the Child Behavior Checklist (CBCL) (Achenbach and Dumenci, 2001), allows parents to rate their child's behavior on a number of domains including anxiety, social withdrawal, oppositionality and overall adjustment. In addition, it includes a psychometrically strong OCD subscale (Hudziak et al., 2004). The CY-BOCS appears to be more sensitive in tracking changes due to treatment than the LOI-CV (Geller et al., 2003b).

Treatment

Pediatric OCD is associated with functional disruption in a number of areas. Fortunately, there are treatments with strong empirical support for their efficacy. Cognitive-behavioral therapy (CBT) and/or pharmacotherapy with selective serotonin reuptake inhibitors have become the first-line of treatment.

Cognitive-behavioral therapy for OCD is a structured approach that teaches skills for responding to symptoms, and it is effective for both the child and family. The efficacy of CBT has been supported in clinical trials and has shown excellent maintenance of symptom reduction at follow-up in pediatric populations (Abramowitz et al., 2005). The premise that compulsions are performed to reduce or avoid anxiety associated with obsessions underlies CBT for pediatric OCD.

Cognitive-behavioral therapy is composed of three core components: exposure, response prevention and cognitive restructuring. *Exposure* relies on the gradual decrease in anxiety after an exposure to a feared or ritual-provoking stimulus. This leads to decreased elevations in anxiety and more rapid attenuation of distress in future exposures. *Response-prevention* is based on the assumption that rituals and compulsions serve to reduce anxiety in the short-term through negative reinforcement, escape and/or avoiding distress. Individuals with OCD perform rituals to relieve anxiety and never have the

conditions, developmental difficulties, family history and function. Detailed medical information, such as an infection history and symptoms of autoimmune or neurological disorders, should be obtained. Suicidal ideation and any self-harm behaviors should be assessed and carefully documented.

A number of measures have been developed to assess the severity of pediatric OCD symptoms. The Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) is one of the most widely used OCD rating scales (Scahill et al., 1997). Using the scale, the clinician rates the amount of time occupied in the symptom, degree of interference in daily life, amount of subjective distress, amount of internal resistance, and degree of control over both obses-

experience of naturally reducing anxiety. Response-prevention does exactly that: the patient must avoid performing their compulsion so the anxiety can be reduced through habituation. Children with OCD commonly possess inaccurate estimates of danger, responsibility and likelihood of occurrences; anxious thoughts involve inaccurate interpretations of events. Therefore, cognitive techniques teach children how to "talk back" to obsessions, helping them to recognize and reframe those obsessions in a realistic manner.

et al., 1998). Pharmacological treatment should be considered: if there is risk of harm to the child or others; if there is impairment in functioning; if good effort with therapy shows little progress; if psychosis or bipolar depression is present; or if comorbid conditions are interfering with therapy. The impact of comorbidity on treatment response needs further research and exploration. In many patients, OCD is comorbid with tics or ADHD and thus frequently requires combination pharmacotherapy. Children with opposi-

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At the initiation of therapy, the patient and physician develop a hierarchy of situations that the patient avoids or in which the patient finds it difficult to inhibit compensatory rituals. This hierarchy, often called a "fear-ladder," is then used in following sessions. The therapist and child (and often parents) move up the ladder by exposing the child to these situations or events and asking the child to abstain from engaging in their rituals. The child's willingness to engage in exposures and response prevention depends on many factors, including developmental level, motivation and general understanding of the therapy and their disease. The therapist and parents can often lessen problems by not allowing the ritual to result in escape/avoidance/decreased anxiety and providing rewards for completion of therapy homework assignments.

Since family members can accommodate the child's symptoms by aiding avoidance, helping with rituals or even inadvertently participating in rituals (e.g., providing reassurance), their participation in treatment is essential (Lewin et al., 2005; Snider and Swedo, 2000). Therapists can help parents and siblings identify actions that help maintain symptoms, encourage family members not to assist the child in performing rituals, and provide suggestions for rewards. (Resources for parents and families can be found in the **Table**.)

Pediatric randomized, controlled trials with SSRIs (fluoxetine [Prozac], paroxetine [Paxil], sertraline [Zoloft]) and clomipramine (Anafranil) have demonstrated efficacy in treating pediatric OCD (DeVaughn-Geiss et al., 1992; Geller et al., 2004, 2001; March

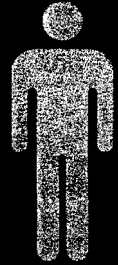
et al., 1998). Pharmacological treatment should be considered: if there is risk of harm to the child or others; if there is impairment in functioning; if good effort with therapy shows little progress; if psychosis or bipolar depression is present; or if comorbid conditions are interfering with therapy. The impact of comorbidity on treatment response needs further research and exploration. In many patients, OCD is comorbid with tics or ADHD and thus frequently requires combination pharmacotherapy. Children with opposi-

tional defiant disorder have the lowest response rate in trials with paroxetine (Geller et al., 2003a) and are not likely to be as successful in CBT trials unless pretreatment with parent training occurs.

Choosing an appropriate psychotropic should be based on medical history, concomitant medications and adverse effect profile. There are two important issues that should be addressed with children taking SSRIs. First, 10 weeks to 12 weeks at adequate dosage is necessary to evaluate the efficacy of the medication. Second, multiple trials may be needed, as poor response to one SSRI does not mean that all SSRIs will be ineffective. If symptoms remain unresponsive to trials of multiple SSRIs, then augmentation might be considered. While adult OCD treatment literature describes the use of numerous augmentation agents (Pallanti et al., 2004), there is a paucity of data on treatment-resistant OCD in the pediatric literature. In case reports, SSRIs have been augmented with low-dose risperidone (Risperdal) (Thomsen, 2004), with buspirone (BuSpar) (Thomsen and Mikkelsen, 1999) and clomipramine (Figuroa et al., 1998). Patients with comorbid tic disorders may benefit from serotonin reuptake inhibitor augmented with antipsychotic medications (McDougle et al., 2000). Some side effects of the SSRIs include nervousness, insomnia, restlessness, nausea and diarrhea. Concerns regarding increased suicidality in children and adolescents taking SSRIs (4% versus 2% in placebo controls) prompted the U.S. Food and Drug Administration to require black box warning labels on SSRIs to increase physician awareness

(Please see Pediatric OCD, page 56)

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Reference: 1. Goff DC, Sullivan LM, McEvoy JP, et al. A comparison of ten-year cardiac risk estimates in schizophrenia patients from the CATIE study and matched controls. *Schizophr Res*. 2005;80:45-53.

Pediatric OCD

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and knowledge, although there is a great deal of controversy regarding both the new requirements and the findings (Winters, 2005). The Pediatric Obsessive Compulsive Treatment Study (POTS)—a large-scale, multisite, randomized, placebo-controlled trial of CBT, sertraline, and a combination CBT and sertraline in children with OCD (The Pediatric OCD Treatment Study [POTS] Team, 2004)—found both CBT alone and sertraline alone superior to placebo. Greater symptom reduction was found in patients receiving CBT in combination with sertraline.

The POTS study highlights the importance of collaboration and information sharing between clinicians (pediatricians, internists, psychiatrists, psychologists and other mental health care professionals) not only to improve patient care and long-term outcomes, but also to help stimulate more research on effective treatment for children and adolescents with OCD.

Mr. Lack is currently a graduate student in clinical psychology at Oklahoma State University. He is completing his predoctoral training at the University of Florida, where he works in both the Department of Psychiatry and the Department of Clinical and Health Psychology. Mr. Lack has indicated he has nothing to disclose.

Dr. Storch is currently an assistant professor of clinical psychology with a joint appointment in the departments of Psychiatry and Pediatrics. He has published over 85 peer-reviewed papers focused on OCD, anxiety disorders and related topics, and has made numerous presentations at professional meetings. Dr. Storch also has a special interest in the dissemination of effective psychological treatment approaches for OCD, as well as in the development and validation of OCD assessment measures. Dr. Storch has indicated he has nothing to disclose.

Dr. Murphy is currently an associate professor and division chief of Child and Adolescent Psychiatry at the University of Florida. She is also the director of the Pediatric Anxiety and Tic Disorder Clinic at the University of Florida in Gainesville, and heads the Autism and Neurodevelopmental Disabilities Program at the University of Florida. The Principal Investigator on two major NIMH grants and author of over 90 publications, Dr. Murphy's current research efforts are aimed at understanding the role of infections and immune dysfunction in the onset of childhood psychiatric disorders. She is a member of the National Tourette Syndrome Association Medical Advisory Board and Regional Obsessive Compulsive Foundation Scientific Advisory Board. Dr. Murphy has indicated she has nothing to disclose.

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