IN BRIEF

Obsessive-Compulsive Disorder

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Obsessive-compulsive disorder (OCD) is characterized by obsessions and/or compulsions that are time-consuming (eg, take >1 hour per day) or cause clinically significant distress or impairment in school, social, family, or other important areas of functioning. The unique features of pediatric OCD include an insidious onset rather than precipitating events seen in adults. Children are less likely to recognize the irrational nature of these symptoms, and the impairment is often reported by parents, caregivers, or teachers.

Obsessions are defined as recurrent, persistent, unwanted, and intrusive thoughts, images, or urges associated with distress or anxiety, which cause the individual to attempt to decrease, avoid, ignore, or neutralize those experiences with another thought or action, such as performing a compulsion. For children, obsessions around harm to family members can lead to feeling that their relationships with family and friends are hazardous.

Compulsions are defined as repetitive behaviors or mental activities that a person feels bound to perform, typically in response to an obsession. These compulsions are often not connected in any realistic way with what they were designed to neutralize or prevent. Compulsions can bring relief from anxiety and distress, and therefore are positively reinforced. With children, many of their compulsions may result in parents or family members accommodating the behaviors, resulting in additional reinforcement of OCD symptoms. For example, an affected child may insist that the family have no visitors at home for fear of contamination, creating significant family stress and dysfunction, thus leading to further OCD behavior.

Although the mean age at onset of OCD is 19.5 years, 25% of cases start by age 14 years, and these patients often present first to primary care. The prevalence rate of pediatric OCD in the United States is 1% to 2%, similar to rates of asthma and diabetes in youth. When presenting to the primary care provider (PCP), the patient and family should be provided with psychoeducation on OCD, that spontaneous recovery rarely occurs, and that the likelihood of responsiveness to OCD-specific therapy is high. Onset in childhood can lead to a lifetime of OCD if left untreated. The course of OCD is often complicated by the co-occurrence of anxiety disorders, attention-deficit/hyperactivity disorder, and tic disorders.

A pediatrician can make the diagnosis of OCD by assessing obsessions, compulsions, the amount of time spent on these behaviors, and the distress or impact it has on the child, family, and school. Unlike other psychiatric disorders, no specific time course is required to qualify for a diagnosis because symptoms may wax and wane over time. Secondary factors should be ruled out, such as

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occurrence or worsening of OCD during substance or medication use; onset after another medical etiology such as an infection, rheumatic fever, or Sydenham chorea; or another psychiatric disorder such as an anxiety or depressive disorder. No laboratory or neuroimaging tests are clinically validated to diagnose OCD.

The American Academy of Child and Adolescent Psychiatry publishes practice parameters for pediatricians addressing OCD. The first line of treatment for pediatric OCD depends on the severity of illness. For mild OCD, the recommendation is to use guided self-help books and psychoeducation on exposure and response prevention (ERP), a type of cognitive behavioral therapy (CBT). For moderate OCD, the treatment of choice is to start with CBT alone (where ERP is the main component). If this is ineffective, only partially effective, unavailable, or the OCD symptoms are interfering with CBT, then starting a selective serotonin reuptake inhibitor (SSRI) is recommended. The combination of CBT and medication is the treatment of choice in severe pediatric OCD. Medication should be continued for at least 1 year after remission of symptoms to minimize relapse. Thereafter, risks and benefits of continuing the medication must be assessed.

INDIVIDUAL THERAPY

ERP is the primary modality recommended for pediatric OCD. In this approach, with the therapist's support, the patient creates a "fear hierarchy" of obsessions and compulsions organized by level of distress. Patients activate their obsessions in a controlled setting and then make a choice with the help of a therapist to resist performing the compulsion, which habituates the obsession without the positive reinforcement of its accompanying compulsion. With the guidance of a therapist and coaching from family, the patient then repeats this process for each obsession and compulsion, gradually going higher on the fear hierarchy. The patient then learns how to do this independently. A typical course of ERP can last 12 to 20 sessions to see marked improvements.

PARENTAL AND SCHOOL SUPPORT

Supportive Parenting for Anxious Childhood Emotions (SPACE) is a parent-based treatment program for youth with OCD. This treatment involves coaching parents/caregivers to respond supportively to their anxious child or teen while reducing accommodations they have been making.

Another component of treatment for pediatric OCD involves engaging with schools to gradually decrease the accommodations that reinforce or allow OCD symptoms to continue, such as through a 504 plan or an Individualized Education Program.

PHARMACOLOGICAL TREATMENT

The first line of pharmacologic treatment of OCD is SSRIs. To date, the medications approved by the US Food and Drug Administration (FDA) for pediatric OCD are, in increasing order of approved age: sertraline (from age 6 years), fluoxetine (from age 7 years), fluvoxamine (from age 8 years), and clomipramine (from age 10 years). A meta-analysis of 12 randomized controlled trials in pediatric populations showed that pharmacologic intervention is significantly more effective than placebo, with an effect size of 0.43 (small to moderate). Before starting an SSRI, it is important to screen for a history of hypomania/mania from patients and their families. Parents/caregivers should also be informed about the black box warning of increased suicidal thoughts and behaviors among youth (pooled risk of ~1% across all OCD studies) and should monitor for this on a regular basis.

SSRIs show a slow incremental effect on symptoms as early as 1 to 2 weeks (statistical separation from placebo) and continue for at least 24 weeks, although the effects on core OCD symptoms may take weeks to months to become noticeable and are often first noted by others. SSRI trials should last at least 3 months, and doses should be gradually increased to optimize benefit.

If the initial SSRI is at maximum dose and results in only a partial or suboptimal response, then switching to a different SSRI is recommended. If a second SSRI does not yield additional benefit, clomipramine can be considered. A referral to a child and adolescent psychiatrist is recommended if the PCP is not comfortable with advanced pharmacotherapy or when symptoms do not improve despite adequate medication trials.

Patients with OCD often first present to the PCP rather than to a child and adolescent psychiatrist. Assessment of behavioral symptoms and level of impairment can facilitate appropriate diagnosis and treatment. Treatment guidelines for pediatric OCD recommend CBT with ERP for mild-moderate symptoms, CBT with ERP alone or in combination with an SSRI for moderate OCD, and CBT with ERP plus an SSRI for severe pediatric OCD.

COMMENTS: Given what really is an epidemic of emotional traumas affecting children and adolescents in response to ongoing stresses from COVID-19, pediatricians on the front line are being called on to provide care that many of us feel undertrained for, a situation exacerbated by the severe shortage of pediatric mental health professionals in this

country. Hopefully, educational efforts such as our In Brief provide a sense of support and, at least, a starting point in how to approach our patients' needs. And those needs are often especially complicated in that 1 psychiatric disorder affecting children is often accompanied by another: our authors make the point that children with OCD may also suffer from attention-deficit/hyperactivity disorder or from an anxiety or tic disorder, all of which need to be addressed.

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ANSWER KEY FOR MAY PEDIATRICS IN REVIEW

COVID-19: A Pediatric Update in Epidemiology, Management, Prevention, and Long-term Effects: 1. D; 2. D; 3. C; 4. E; 5. B.
Hospice and Palliative Medicine: Pediatric Essentials: 1. E; 2. B; 3.B; 4. E; 5. A.
Acute Kidney Injury: 1. A; 2. D; 3. C; 4. B; 5. A.