

# *Obsessive Compulsive Youth: The Matrix of Support*

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Obsessive-compulsive disorder (OCD) was once considered rare<sup>1</sup>, but recent studies indicate a prevalence of 1% to 2% in children and adolescents.<sup>2</sup> The age of onset of OCD is earlier in boys than in girls<sup>3</sup>, with the mean age of onset reported between eight and 11 years.<sup>4</sup> Since OCD is relatively common, and can cause significant morbidity for the child/adolescent, it is important to identify and treat in a timely fashion.

Obsessions are repetitive, intrusive thoughts, images, or ideas that are viewed as distressing to the individual. Compulsions are repetitive actions or mental acts that an individual performs to undo an obsession, and the individual recognizes that the action is absurd. The criteria for OCD involves the child/adolescent spending more than an hour a day on the obsession/compulsion, and/or it interferes with functioning at home, school, or the community.<sup>5</sup> Young children may not view either obsessions or compulsions as abnormal, and they many not realize that a compulsion cannot undo an obsession.<sup>6</sup>

## *How do kids with OCD present?*

Initially, children and adolescents may be secretive about their symptoms. Over time, the family tries to adapt to the symptoms, or limit them,<sup>6</sup> as they often do not understand what is happening. Family physicians are often contacted when the symptoms

### **Peter's story**

Peter, 11, is brought to your office by his mother. She is becoming increasingly overwhelmed by her son's constant need for reassurance. Peter has been asking his mother if his hands are clean. He will not eat at the supper table with the family because he thinks his 9-year-old sister has germs, and that she has put germs on the table. He believes if the germs are on the table they will get on his food and he will get sick. Peter says that he has to wash his hands 45 times a day to make sure there are no germs. He will not touch the taps after he has washed his hands. Peter now wants his mother to wash her hands at the same time he washes his. His mother reports that Peter's paternal aunt has similar traits because she cleans her house for four hours a day to ensure it is free of germs.



**What is appropriate management for Peter?  
See page 105 for the answer.**

become distressing to the parents and/or child/adolescent.<sup>3</sup> A compulsion is often the presenting symptom in a young child (Table 1).<sup>7-9</sup> In some circumstances, the child may present with only obsessions, which may be sexual, aggressive, or self-injurious.<sup>9</sup> Children sometimes describe obsessions as "voices" in their heads that cause their ritualistic behaviours<sup>10</sup>.

Table 1

**Types of compulsions**

**Common compulsions**

- Washing
- Checking
- Counting
- Repeating
- Touching

**Other Compulsions<sup>8</sup>**

- Counting objects
- Repeating actions a certain number of times
- Touching in patterns
- Completing actions until they are “just right”

*What causes OCD?*

The cause of OCD is unknown, but research suggests it may be the result of a frontal lobe-limbic-basal ganglia dysfunction. Neurotransmitter dysregulation, genetic susceptibility, and environmental triggers appear to play a role in OCD development.<sup>11,12</sup> An earlier onset of OCD appears to be associated with increased genetic loading and a greater likelihood of personal and familial tic disorders.<sup>13,14</sup>

The family physician should be aware of organic causes of OCD (Table 2).

*What should the family physician do?*

One of the first things the family physician needs to determine is whether the rituals described are normal rituals or compulsions. Preschool children often insist on sameness, order, or symmetry, and may be frustrated if things are out of place. Routines, such as at

bedtime, may serve to alleviate anxiety at times of separation, uncertainty, or transition. School-age children are fascinated with collections, rules, and rituals. When rituals cause distress, cannot be suppressed, and occur more than an hour per day, they have become compulsions.<sup>9</sup>

In assessing children/adolescents with OCD, it is important to interview both the children/adolescents and the parents independently. Physicians should interview the parent first, to obtain a chronologic picture of the presenting symptoms in prepubertal children. When interviewing the children alone, the physician should ask them to describe their “worries” or “urges” in their own words, rather than using the technical terms of “obsessions” and “compulsions.” Both the child/adolescent and the parent(s) should be asked about:

- the onset of the problem,
- the frequency of the compulsions or obsessions,
- the content of the obsessions/compulsions,

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Table 2

### Organic causes of OCD

- Carbon monoxide poisoning
- Tumours
- Post-viral encephalitis
- Traumatic brain injury
- Other basal ganglia pathologies
- Medications, such as dopamine agonists

OCD: Obsessive compulsive disorder

- what relieves the problem,
- how much the obsessions/compulsions interfere with the child's daily routine,
- the impact of the symptoms on the rest of the family, and their understanding of the problem.

Finally, ask the children what would happen if they could not carry out their "urge" or "habit."<sup>9</sup> Since a significant proportion of children with OCD have tics,<sup>16</sup> inquiry about tics is imperative.

### Understanding the family's role

The family physician needs to be aware of the family's role. The child's symptomatology can have a tremendous impact on other family members and vice versa. Anxious family members may model avoidance, anxious interpretations of, and responses to, feared stimuli (e.g., germs), as well as maladaptive anxious coping styles (e.g., excessive hand



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washing). Family members may unwittingly become part of a more elaborate ritual that, in turn, reinforces the anxiety and the behavior.<sup>10</sup> A parent affected with OCD may actively collaborate with a child's compulsions or model obsessive compulsive behaviours.<sup>17</sup>

### How is OCD managed?

If the family physician determines the child or adolescent has had a short course of obsessions and/or compulsions that do not cause significant distress, inform the family it is not severe at this time. However, the family physician should monitor the symptoms and, if there is no improvement or dissipation of symptoms in two to four weeks, more intensive intervention is necessary.<sup>9</sup>

The first step in treatment is psychoeducation about OCD with both the child/adolescent and the parent(s).

When the child has significant symptoms of OCD, but does not have other significant psychopathology or family problems, the initial treatment choices are cognitive-behavioural therapy (CBT) or medication (alone or in combination). Medication should be considered if:

- the child is spending more than one hour a day engaged in OCD,
- the child is having disabling symptoms,
- the child's sleep is impaired, or
- the child is struggling to function at home and/or at school.<sup>9</sup>

Serotonin reuptake inhibitors (SSRIs) are the medications of choice.<sup>6</sup> The medication should be started at a low dose and increased every two to four weeks up to a therapeutic effect or the highest dose recommended (Table 3).<sup>6</sup> The adequate trial period is a full dose for 10 to 12 weeks.<sup>18</sup> If treatment with the chosen SSRI fails, another SSRI, or clomipramine, may be tried.<sup>19</sup> Sertraline, fluvoxam-

Table 3

**SSRIs for children and adolescents**

Drug	Dose range (mg) for children < 12	Dose range (mg) for adolescents
Citalopram	10-20	10-50
Fluvoxamine	25-100	25-150
Fluoxetine	5-20	10-60
Paroxetine	10-20	10-50
Sertraline	25-100	25-150

SSRI: Selective serotonin reuptake inhibitors

ine, paroxetine, and citalopram require a two-week elimination period, and fluoxetine requires a five-week elimination period, before another antidepressant is introduced. This elimination period avoids drug interactions.<sup>6</sup> Sertraline has been shown to trigger or exacerbate tics, so it may not be an appropriate choice if the patient has a personal or family history of tics.<sup>20</sup> In difficult to treat cases, and in those with comorbid tics, augmentation with an atypical neuroleptic, such as risperidone, may be considered. There is a minimal role for the anxiolytics, such as benzodiazepines, in adolescents. Benzodiazepines should be avoided in children because of their side-effect of disinhibition.<sup>6</sup>

If a child has an acute onset of OCD, the family physician should determine if the child has had a streptococcal throat infection. A documented positive throat culture indicates an infection treatable with antibiotics.<sup>21</sup> Immunomodulatory interventions, such as plasmapheresis and intravenous immunoglobulin, are still investigational.<sup>18</sup>

The most effective psychologic intervention is cognitive behaviour therapy (CBT). Unless

**What about Peter?**

Peter and his mother were informed that Peter was experiencing obstructive compulsive disorder (OCD). They were both given books to provide them with more information about OCD. Both Peter and his mother were referred to a therapist within the community who is experienced in using compulsive behaviour treatment (CBT) to treat children who have OCD. Peter's mother was advised to stay out of her son's rituals, and she was taught strategies to do so. Peter underwent CBT.

His family physician started him on fluvoxamine, 25 mg, and gradually increased the medication to a dose of 100 mg per day. After approximately 10 weeks, his symptoms have improved, and he continues on fluvoxamine and CBT.

Peter and his mother have been informed that he should remain on the fluvoxamine until he is symptom-free for one year. At that point, a decision to gradually taper the fluvoxamine will be discussed.

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### Take-home message



- The family physician should be able to identify OCD in children/adolescents.
- If the diagnosis of OCD is made, it is important to educate the child/adolescent and parent(s).
- The child/adolescent should be referred to a therapist for cognitive behaviour treatment if the child is older than 8.
- The parent(s) should be referred to a therapist to learn strategies to help their child with OCD.
- The child/adolescent with significant symptoms of OCD should be placed on a SSRI and the dose should be optimized.
- If placed on a SSRI, the children/adolescents should be treated until they are at least one-year symptom-free.

the family physician has special training in CBT, the child/adolescent should be referred to a therapist with experience in CBT. The indicators for a good response to CBT include:

- a motivated child/adolescent willing to co-operate with treatment,
- parental support and involvement in CBT,
- the presence of overt rituals and compulsions,
- the ability to monitor and report symptoms, and
- the absence of complicating comorbid conditions.<sup>9,18</sup>

The child will need to have sufficient cognitive capacity to work with CBT, and generally age eight is the age at which normally developing children can work with these strategies. Younger children may be taught to use relaxation and distraction strategies to “trick their OCD”.<sup>22</sup>

Family involvement in treatment is essential. The main goals of family intervention are to educate the

family about OCD and to help family members limit their involvement in the child's symptoms and repetitive requests for reassurance. The latter is essential in allowing the child to gain a sense of control and in decreasing parental frustration, which may escalate with the child's symptoms.<sup>23</sup>

### *For how long should medications be prescribed?*

Guidelines concerning the duration of treatment of children/adolescents with OCD who have responded to medication have not been established. The general approach is to maintain drug treatment for nine months to one year after symptom resolution, at which point discontinuation may be considered.<sup>19</sup> It is recommended that medication be tapered gradually.<sup>24</sup> Dose reduction should occur at relatively low stress periods, when recrudescence symptoms are least likely to be disruptive.<sup>18</sup> Some children may be on medication for years, since followup studies suggest chronicity of symptoms in a high proportion of patients with childhood-onset OCD.<sup>6</sup>

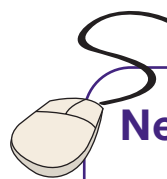
### *What happens to kids with OCD?*

OCD can be a lifelong disorder with a waxing and waning course or dramatic exacerbations and remissions.<sup>10</sup> At two- to seven-year followup, children and adolescents with a more poor outcome were found to have more OCD symptoms after five weeks of treatment, the presence of a lifetime history of a tic disorder, and presence of a parental psychiatric diagnosis.<sup>25</sup> It is key for physicians to recognize OCD early, and to facilitate quick treatment to prevent the development of significant and recurrent symptoms which may interfere with the child/adolescent's and/or family's functioning.<sup>6</sup>

CME

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### Net Reading

1. Obsessive Compulsive Foundation:  
[www.ocfoundation.org](http://www.ocfoundation.org)

[www.stacommunications.com](http://www.stacommunications.com)




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