

# Obsessive Compulsive Disorders

## Diagnostic Criteria

300.3 ( F42.2 )

1. Presence of obsessions, compulsions, or both:
  - Obsessions are defined by (1) and (2):
    1. Recurrent and persistent thoughts, urges, or images 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.
2. 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.
3. 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.
4. 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).

Specify if:

- **With good or fair insight:** The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.
- **With poor insight:** The individual thinks obsessive-compulsive disorder beliefs are probably true.
- **With absent insight/delusional beliefs:** The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

Specify if:

- **Tic-related:** The individual has a current or past history of a tic disorder.

## Assessment and Treatment of OCD in Childhood

- OCD no longer considered an anxiety disorder in DSM 5.
  - OCD spectrum disorders
- Childhood OCD vs. Adult OCD
  - Prepubertal onset
    - Mean age of onset is 9-10 yrs
    - Majority 6 to 12.5 yrs
    - Age of clinical presentation is 2+ yrs after onset
  - Male predominant
    - 3:2 M to F
  - More highly familial
  - Better prognosis
- Most common obsessions (“worries”)
  - Contamination
  - Sexual or somatic obsessions
  - Scruples
- Most common compulsions (“rituals”)
  - Washing
  - Repeating
  - Checking
  - Ordering
- Epidemiology
  - 1-2% prevalence in the US
  - Two peaks of incidence across the lifespan: preadolescent children and early adult life (mean age 21yrs)
  - Childhood onset occurs in 30-50% of cases
- Comorbidity
  - Comorbid psych dx’s in >50% of children with OCD
  - High rates of tic disorders; and mood, anxiety, DBD, ADHD, enuresis
  - Earlier age of onset predicts higher risk of ADHD and anxiety disorders
  - Older age of onset associated with mood and psychotic disorders
- Genes and Environment
  - Pediatric OCD is more highly familial than adult OCD
  - Genetic and environmental factors are equally important in development of pediatric OCD
  - In OCD-affected children, significant associations between adverse perinatal experiences (eg. dystocic delivery, use of forceps, breech presentation,

prolonged hypoxia) and earlier age at onset, increased OCD severity, and increased risk for comorbid psych dx's

- Role of family in pediatric OCD
  - Often intimately involved in OC sx
  - May unknowingly reinforce compulsive behaviors
    - Reassurance
    - Handling objects that children avoid (eg. opening doors)
    - Laundering “contaminated” clothes/linens excessively
    - Wiping children on the toilet who won't do it themselves
  - Family members are key to both maintaining pathology and to acting as proxy therapy agents (eg. Family Accommodation Scale for OCD)
- Course and Prognosis
  - Majority of cases have gradual onset without h/o precipitating stressors
  - Persistence rates are 41% for full OCD and 60% for full or subthreshold OCD
    - Based on mean follow-up period of 5.7 years
    - Persistence associated with earlier age at onset, longer duration of OCD, inpatient treatment
  - Long-term prognosis for patients pediatric OCD is better than for those with adult-onset OCD
    - Adverse prognostic factors: very early age of onset, concurrent psychiatric dx's, poor initial tx response, long duration of illness, positive first-degree family h/o OCD
- Making the Diagnosis
  - Simple probes:
    - “Do you ever have unwanted thoughts that upset you and that you cannot suppress?” or “Do you have worries that just won't go away?”
    - “Do you ever have ideas, images, or urges that make you anxious?”
    - “Do you ever have to do rituals over and over even though you know they don't make sense?” or “Do you do things or have habits that you don't want because you feel anxious or worried about something?” or “Do you have habits you can't stop?”
  - Follow up with more in-depth assessment
    - Time occupied by OC sx
    - Level of subjective distress
    - Functional impairment
  - Consider the CY-BOCS (Children's Yale-Brown Obsessive Compulsive Scale)

- 10-item anchored ordinal scale (0-4) assessing time occupied, degree of life interference, internal resistance, degree of control, all for both obsessions and compulsions
  - Can assess parental accommodation and reinforcement with the Family Accommodation Scale
  - Differential Diagnosis
    - ASD can be confused for OCD
      - Stereotypic, repetitive behaviors, restricted and narrow range of interests
      - A small number of children (5-7%) may also meet criteria for DSM-IV Asperger's syndrome or PDD
      - In OCD, symptoms are ego-dystonic and associated with anxiety-driven obsessional fears
- Clinical Examination
  - Consider information from all available sources, covering family, school, and community systems
  - Consider group-A beta-hemolytic strep as a potential precipitant for PANDAS-associated (PANDAS = pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections) OCD in acute and dramatic onsets
    - ie. following strep throat or scarlet fever
- Treatment
  - CBT is first-line treatment in mild- to moderate cases of OCD
    - Exposure and response prevention (ERP) is central to CBT for OCD
      - Considered "graded exposure"
    - Greater treatment effect than medications
  - Consider medication in moderate to severe cases, and in cases complicated by comorbid diagnoses and significant psychosocial stressors
  - SSRIs and clomipramine (TCA) are most commonly used and FDA-approved
    - Clomipramine is significantly superior to SSRIs
    - Overall medication effect size is 0.48, and clomipramine effect size is 0.85
  - Treatment of choice is combination of CBT and medication
    - Showed greatest decrease in symptom scores and the greatest remission rate, with an effect size of 1.7 per meta-analysis

**Pharmacological Treatments Dose range for serotonin reuptake inhibitors in children with obsessive-compulsive disorder**

Drug	Starting dose, mg		Typical dose range, mg (mean dose) <sup>a</sup>
	Preadolescent	Adolescent	
Clomipramine <sup>b,c</sup>	6.25–25	25	50–200
Fluoxetine <sup>c,d</sup>	2.5–10	10–20	10–80 (25)
Sertraline <sup>c,d</sup>	12.5–25	25–50	50–200 (178)
Fluvoxamine <sup>b,c</sup>	12.5–25	25–50	50–300 (165)
Paroxetine <sup>e</sup>	2.5–10	10	10–60 (32)
Citalopram <sup>d</sup>	2.5–10	10–20	10–60

**Pharmacological Treatments Effect size by drug in meta-analysis of pediatric obsessive-compulsive disorder trials**

Drug	Standardized mean difference	95% confidence interval
Paroxetine	0.405	0.204–0.606
Fluoxetine	0.546	0.353–0.738
Fluvoxamine	0.375	0.167–0.584
Sertraline	0.327	0.160–0.493
Clomipramine	0.693	0.475–0.910