Obsessive Compulsive Disorder: a child & adolescent mental health perspective

P. Ganeson¹ & U. Chowdhury²
CAMHS Academic Unit, Dunstable Health Centre

¹Lead Clinician in Community Psychiatric Nursing,
²Consultant in Child and Adolescent Psychiatry

Introduction

Obsessive Compulsive Disorder (OCD) is a distinctive and frequently disabling condition characterised by unwanted thoughts or images (obsessions) and unwanted repetitive acts and rituals (compulsions). Many people have OCD symptoms and are reluctant to seek help or share their concerns for fear of being ridiculed or stigmatised. In order to make a clinical diagnosis, there needs to be a degree of impairment in terms of time consumed with OCD symptoms, and distress or interference in functioning (American Psychiatric Association 1994). Common obsessions and compulsions are listed in Table 1.

It used to be thought that OCD was a condition that affected adults only, but studies in the last 15 years have shown that the condition is prevalent in children, occurring in 1 in 100 children (Vallenli-Basile et al 1994, Heyman et al 2001). It is still debatable as to whether OCD in childhood is exactly the same condition as that in adulthood. The similarities are that both age groups share relatively the same clinical phenotype and both respond to the same pharmacological intervention. However, recent studies (Geller et al 1998) show that childhood OCD is associated with a unique peak age of onset indicating a bimodal incidence of the disorder (peak age of onset is 10 and 21 years). In the early-onset age group, there is a male preponderance and a distinct pattern of co-morbidity with attention deficit hyperactivity disorder and tic disorders. This is in keeping with other neuro-developmental disorders.

The Child and Adolescent Mental Health Service (CAMHS) in Luton and Bedfordshire provides out-patient, clinic-based, community services in four locations: Dunstable, Luton, Bedford and Mid-Bedfordshire. Each clinic is staffed by a multi-disciplinary team that provides assessment and treatment for emotional and behavioural difficulties in children, adolescents and their families. Patients are normally seen up to the age of 18. Referrals can be made by various...
professionals, including general practitioners, nurses, social workers and special educational needs coordinators.

What do we feel is of interest/distinctive about the Service?
We are not aware of any other community-based primary care service with a special interest in providing care for children with OCD. The OCD clinics we are aware of are national tertiary referral centres. We are aware that we are probably dealing with a slightly different population to a specialist centre in that the patients we see will present earlier and may therefore have symptoms that are not yet entrenched. This has implications for our interventions in terms of possible outcome—better outcomes are usually associated with early intervention. We have also tended towards a ‘chronic care’ model, which basically accepts that OCD is a life-long condition that one does not cure entirely. The patient will therefore need ongoing support to prevent relapse. This is at variance with current trends in the NHS that look towards short-term work.

Assessment:
In order to develop consistency across the service, we developed local guidance for assessment and management based on a number of international guidelines and protocols and the evidence base in relation to children (American Academy of Child and Adolescent Psychiatry 1998, Rapoport and Inoff-Germain 2000). The National Institute of Clinical Excellence (NICE) Guidelines on OCD is due to be published later this year (October 2005) and we anticipate that our guidance will be similar. We did not wish our guidance to be long and detailed as we felt this may put clinicians off from using them. We thus highlighted some of the areas that we felt need to be asked in addition to standard history and examination (Table 2).

We are keen that clinicians recognise and ask about co-morbid conditions that occur with OCD, such as tic disorders and depression. The prevalence of co-morbid mood disorders ranges from 20% to 73% (Flament et al 1990, Geller et al 1990). However, many professionals still do not recognise or

<table>
<thead>
<tr>
<th>OBSESSIONS</th>
<th>COMPULSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTAMINATION</td>
<td>WASHING/CLEANING</td>
</tr>
<tr>
<td>AGGRESSIVE</td>
<td>CHECKING</td>
</tr>
<tr>
<td>SEXUAL</td>
<td>REPEATING</td>
</tr>
<tr>
<td>HOARDING</td>
<td>COUNTING</td>
</tr>
<tr>
<td>MAGICAL THOUGHTS</td>
<td>ORDERING</td>
</tr>
<tr>
<td>SOMATIC</td>
<td>ARRANGING</td>
</tr>
<tr>
<td>RELIGIOUS</td>
<td>HOARDING</td>
</tr>
</tbody>
</table>

Table 1: Common obsessions and compulsions
Table 2: Assessment

<table>
<thead>
<tr>
<th>Define the problem: what symptoms are present, when do they occur, where do they occur, what are the precipitating factors etc...</th>
</tr>
</thead>
<tbody>
<tr>
<td>What coping mechanisms are used?</td>
</tr>
<tr>
<td>What is the level of distress / impairment?</td>
</tr>
<tr>
<td>Is the child / adolescent depressed?</td>
</tr>
<tr>
<td>Any evidence of tic related disorders?</td>
</tr>
<tr>
<td>Any evidence of other neuro-developmental disorders?</td>
</tr>
<tr>
<td>Are the obsessions / compulsions developmentally appropriate?</td>
</tr>
<tr>
<td>Is school work affected by OCD?</td>
</tr>
<tr>
<td>How is the family coping? Are family members caught up in the rituals?</td>
</tr>
<tr>
<td>Does the family provide support?</td>
</tr>
</tbody>
</table>

acknowledge that depression can affect young people.

In addition to the above questions, we also suggest that it is good practice to use a rating scale, such as: the children’s version of the Yale Brown Obsessive Compulsive Disorder Scale (Scahill et al 1997); the Children’s Obsessive-Compulsive Inventory (ChOCI) (Shafran et al 2003); or, the children’s version of the Leyton Obsessional Inventory (Berg et al 1986). This gives a measure of severity as well as acting as a baseline to monitor progress, should treatment commence. We also routinely use, with every patient, the Strengths and Difficulties Questionnaire (Goodman 1997) and the Health of the Nation Outcome Scales (Gowers et al 1998).

**Intervention:**

**Psychoeducation**

This is an important part of the treatment that is offered. The more one knows about OCD, the more one feels in control, hence we give a brief explanation of the biological basis for OCD. This helps to stop the child being labelled as ‘naughty’ by their parents. We also give the family a copy of a fact sheet, ‘OCD in Young People’, written by the Royal College of Psychiatrists (see: ‘sources of further information’), which explains, in lay terms, what OCD is. In some cases, the child and family are reassured within the first session with a full explanation of OCD and require no further intervention. We also send the referring GPs a fact sheet on OCD and related conditions as well as our report. GPs are extremely busy people and hence basic fact sheets are often welcomed by the majority.

**Family intervention**

Children develop within the context of the family and thus a treatment package should reflect this. Family members often get caught up in the rituals and routines surrounding OCD and may contribute to the maintenance of symptoms (Waters and Barrett 2000). Family focussed interventions on psychosocial factors are also likely to be more effective and durable than...
interventions that target the child. It has also been shown that high levels of hostility and criticism have been associated with poor treatment outcome and relapse in adults (Chambless and Steketee 1999). Another reason for involving the family is that the rates of OCD in family members is higher than the general population and thus helpful interventions for the targeted individual may have secondary benefits to other potentially vulnerable members (Waters et al 2001).

Family interventions include:

- Exploring the effect of OCD on the family
- Improving coping strategies
- Improving communication skills
- Psychoeducation
- Reducing parental involvement in the symptoms
- Increasing positive family interactions

The family is encouraged to become part of the ‘expert team’ that helps the child fight OCD and thus can prove to be a useful source of support away from the clinics.

**Individual work with children and adolescents**

The individual work is based on protocols developed by March and Mulle in their book, ‘OCD in Children and Adolescents: a cognitive behavioural treatment manual’ (March and Mulle 1998). The techniques for individual work include: externalisation of OCD; the development of cognitive tactics and coping strategies (a cognitive ‘toolkit’) to assist with exposure and response prevention—for example, positive self talk; increasing self efficacy; generating a hierarchy of obsessions and compulsions to tackle (with the child); the use of exposure and response prevention on targets chosen by the child (usually in vivo), and usually with some support from their parents.

Some clinicians feel that the cognitive element is not really necessary and that it is ‘purely’ the ‘exposure and response prevention’ component of the treatment approach which is most effective. Although we have not formally researched this, we feel that both elements are necessary, together with relapse prevention.

Another useful book is ‘Think Good-Feel Good –a Cognitive Therapy Workbook for Children and Young People’ by Paul Stallard (2002), which contains useful summary worksheets that children find helpful.

We acknowledge that there needs to be a degree of flexibility when following a protocol and the therapist should adapt the session to suit the child’s pace and personality.

**Medication**

Although there has been a lot of controversy about Selective Serotonin Re-uptake Inhibitors (SSRIs) in the media in relation to young people and suicide in those prescribed anti-depressants for depression, SSRIs are considered by many clinicians to play a useful part in the treatment and management of OCD. SSRIs such as sertraline (recently licensed for use in children with OCD) and fluoxetine are the drugs of first choice. It is important to discuss potential side effects that may occur so that the family and child do not lose trust in medication should these occur.

**Evidence base:**

The actual clinical evidence base in
relation to CBT and medication in children is small. However, the majority of clinical practice seems to rest on extrapolations from adult research which supports work based on exposure and response prevention (Hollander 1997). One may thus say that in terms of evidence based practice in OCD, the inclusion of exposure and response prevention is the key factor or something you may have to explicitly justify not using (for reviews, see Shafron 1998 & Emslie et al 1999).

Liaison with schools and other services
OCD can often have an impact on the child’s functioning in the classroom and with homework. For instance, children with checking rituals will often re-read a line in a text book several times until it is ‘just right’ or a child may need to perform a counting ritual in the classroom before s/he can sit down. If the child’s education is affected, we often, with the child and parents permission, talk to the child’s teacher and give a brief explanation of the difficulties. This prevents the child being unfairly treated. We sometimes write letters asking for the child’s condition to be taken into account during examinations, which can be a particularly stressful time. This is only done with the child’s and parents consent. Children with OCD are also vulnerable to being bullied. If there is associated depression, then the consequences may be devastating for the child. Addressing these issues with teachers and making sure that schools implement their anti-bullying policy is essential.

Other services that we liaise with include general practitioners, paediatricians and adult mental health clinicians.

OCD Support Group

Parents:
When we see parents at the initial consultation, we are often aware of the huge amount of stress that parents of children with OCD are under. As a result of this, we decided to hold a meeting for parents to see whether any of them would be interested in attending a parent support group. We sent letters to six of the parents whose children were currently attending the Dunstable clinic. Only two sets of parents replied. One set of parents said that they supported the idea but could not come to regular sessions due to other commitments. The other set of parents said that they also supported the idea of a support group but their adolescent son with OCD did not want his illness talked about in any way with others and thus they felt they could not attend. There were no other replies. Given our assessment of parental stress levels at consultation we were initially surprised by the poor response to the idea of setting up a parents group. One possible explanation is that the people we wrote to had children that were in the middle of or near the end of their treatment. The need for parental support may not be as intense as when first presenting to the clinic. We may decide to revisit the idea of a support group in the future, should there be demand from parents across the service.

Children:
Support groups for children with OCD may be a valuable way of increasing awareness and education on aspects of OCD. It can also provide much needed psycho-social support to the often isolated individual. We currently have no plans to set up a group but, if there is enough interest, we may consider
running a group or even a workshop so that children with OCD can meet others with a similar condition.

We recognise that a lot of support is needed for the child and family and therefore we provide details of the voluntary organisation, Obsessive Action—a national charity which provides information and support for families suffering from OCD (see ‘sources of further information’).

‘Guidance’ document
The aim was to develop service wide consistency. Our guidance provides recommendations in relation to assessment and treatment, linking both with evidence-based practice. We are aware that producing a document may generate all sorts of political problems within a large multi-disciplinary team. There are different ideologies within the teams, some of which take exception to the medical model ideology that our document represents. There are also potential legal issues associated with the title of the document, hence we decided to call it ‘guidance’ as opposed to guidelines.

Research and Audit
As we are still in the early stages of developing our service we have not yet engaged in audit or research. However potential audit areas include outcomes (including reviews using YBOCS) and record keeping. We hope to commence this once we engage a few more cases.

Conclusion
There is evidenced-based literature for the treatment of OCD. Since OCD is now recognised to occur in children (and the majority of adult cases originate in childhood), we have set up a special interest group within our CAMH Service to focus on this disorder. Our aim is to raise the profile of OCD amongst clinicians and ensure that children and adolescents with OCD are thoroughly assessed and effective interventions are administered. We aim to improve the support networks for these children and adolescents, focusing on family work and also liaising with support agencies. In keeping with continuing professional development requirements, we also plan to set up a regular seminar on OCD / Anxiety Disorders, which will act as a forum for academic discussion and general support for clinicians.

References:


**Sources of further information**

Obsessive Action, Aberdeen Centre, 22-24 Highbury Grove, London N5 2EA Tel 020 7226 4000; email: admin@obsessive-action.demon.co.uk Website: [http://www.obsessive-action.demon.co.uk](http://www.obsessive-action.demon.co.uk)

The Mental Health and Growing Up series contains 36 fact sheets on a range of common mental health problems. Available on the Royal College of Psychiatrists’ website at [http://www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)

The [National Institute of Clinical Excellence (NICE)](http://www.nice.org.uk) guidelines on OCD is actually published later this year (October 2005). [www.nice.org.uk](http://www.nice.org.uk)