Mid-America (HHS Region 7)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Obsessive-Compulsive Disorder in Primary Care

UNMC MUNROE-MEYER INSTITUTE
NEBRASKA PARTNERSHIP FOR MENTAL HEALTHCARE ACCESS IN PEDIATRICS
A Good State of Mind
www.dhhs.ne.gov/NEPMAP
SAMHSA
Substance Abuse and Mental Health Services Administration

Disclaimer

At the time of this publication, Miriam Delphin-Rittmon served as Assistant Secretary for Mental Health and Substance Use and Administrator of SAMHSA. The opinions expressed herein are the views of the speakers and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

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The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Healing-centered/ trauma-responsive
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Announcements

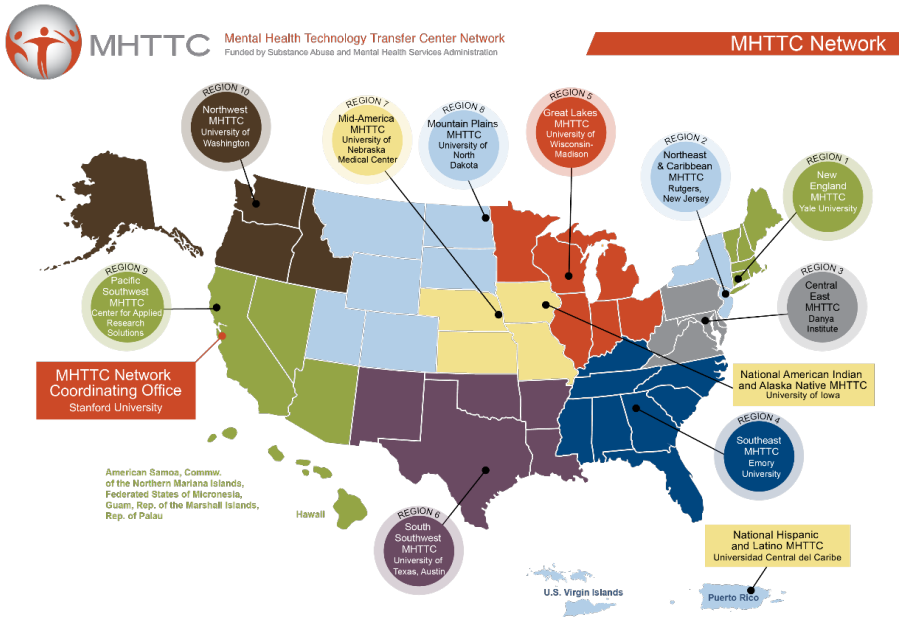
- This webinar is posted

https://mhttcnetwork.org/centers/mid-america-mhttc/tele-behavioral-health-consultation-tbhc-primary-care-webinar-series

Mid-America Mental Health Technology Transfer Center

Established to increase utilization of evidence-based mental health practices.

- Missouri, Iowa, Nebraska, and Kansas.
- Free training and technical assistance.
- SAMHSA grant awarded to the Behavioral Health Education Center of Nebraska at University of Nebraska Medical Center.
  (5 years, $3.7 million, grant number: H79SM081769)



Nebraska Mental Health Access Grant

- 5-year, $2.2 million HRSA grant through maternal and child health bureau
- Designed to improve timely access to behavioral healthcare for children in rural Nebraska
- The main goal is to provide primary care providers access to behavioral health supports

Goals

- Enhance **early screening** of behavioral health disorders
- Conduct a clinical demonstration project in a network of providers to **expand and diversify integrated behavioral health provision in PC** pediatric and family medicine practices, with a focus upon **rural** communities
- Evaluate the overall **effectiveness of increasing access to PCP's to behavioral health consultation**

https://www.unmc.edu/mmi/services/psychology/teleproviderconsult.html?msclkid=77c12956b5f311ec8c21922c759e3b30

Tele-Behavioral Health Consultation (TBHC)

- Behavioral health providers or case managers on-site at primary care clinics
- Behavioral health/care managers determine need for consultation with psychiatry
- Consultant consults with PCP (audio or audio-visual) on the same day
  - Child Psychiatry
  - Developmental Medicine
  - Psychiatric Nurse Practitioner

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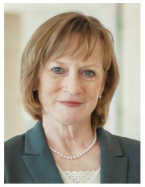
Behavioral Health Consultation for Primary Care Providers

The UNMC Tele-Behavioral Health Consultation Team (TBHC) provides psychiatry support to primary care providers in Nebraska who are managing pediatric patients with behavioral health problems. Providers are available to offer guidance on diagnosis, medications, and psychotherapy interventions to assist primary care providers in better managing patients in their practices. Support is available through phone and synchronous audio/video teleconference consultations to referring primary care providers.

How Does it Work?

1. The participating provider or representative initiates a request to Dani Porter at (402) 559-3838 or through the website at unmc.edu/mmi/departments/psychology/psych-patientcare/teleproviderconsult.html
2. A member of the TBHC team will contact the provider within the same business day to offer guidance.
3. The TBHC is not an emergency service. Emergencies will be routed to local emergency services.
4. The UNMC TBHC team does not prescribe medication. They provide support for prescribers.

Team Members



Terri Mathews, Ph.D., APRN-NP
Psychiatric Nurse Practitioner

Ryan Edwards, M.D.
Psychiatrist

Cindy Ellis, M.D.
Developmental-Behavioral Pediatrician

Scan me

Scan with your smartphone for more information!

University of Nebraska Medical Center

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The (UNMC Tele-Behavioral Health Consultation Team) is supported by an award from Nebraska Department of Health and Human Services (NEDHHS). The award is made possible by the Health Resources and Services Administration's (HRSA) Pediatric Mental Health Care Access Program, Grant No. UHCMC32322, with NEDHHS as lead state agency. The contents of the project are the responsibility of UNMC MMI and do not necessarily represent official views of, or endorsement by, HRSA or NEDHHS.

Primary Care Providers (PCPs)

- PCPs can request a consultation three ways:

  1) Visit our website:
  https://www.unmc.edu/mmi/services/psychology/teleproviderconsult.html

  2) QR Code

  3) Call 402-559-3838

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Obsessive Compulsive Disorder in Primary Care

Ryan Edwards, MD
Lauren Edwards, MD

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The Anxiety Subspecialty Treatment program (AnxST)

- General Psychiatry Clinical Services
- Child & Adolescent Psychiatry Clinical Services
- Geriatric Psychiatry Clinical Services
- The Anxiety Subspecialty Treatment program (AnxST)
- Reproductive Psychiatry

Mission Statement

The Anxiety Subspecialty Treatment program (AnxST) is a multidisciplinary anxiety clinic that bridges the Department of Psychiatry at the University of Nebraska Medical Center and the Department of Psychology at Nebraska Medicine. Lauren Edwards MD is the Medical Director; Justin Weeks PhD is the Psychotherapy Director. The AnxST team is comprised of psychologists, psychiatrists, psychiatric residents, advanced practice providers, masters-level therapists, psychotherapy trainees, and a registered psychiatric nurse. We meet as a team multiple times per week to coordinate patient care and ensure optimal outcomes for our patients across the varying levels of treatment we provide.

AnxST provides evidence-based treatment for all of the major anxiety and anxiety-related disorders:

- Social anxiety disorder (SAD)
- Panic disorder
- Generalized anxiety disorder (GAD)
- Specific phobias
- Obsessive-compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)

Treatment foci primarily include cognitive-behavioral therapy (CBT, in both individual and group format) and medication management in accordance with expert guidelines.

In addition to being a multidisciplinary clinic, AnxST is also a transgenerational anxiety clinic in that we provide services across all major age groups. While the majority of AnxST providers focus on adults (ranging from young adult to geriatric patients), our team includes a pediatric psychiatrist (Ryan Edwards, MD) and a pediatric psychologist (Tessa Holscher, PsyD).

Alongside clinical services, AnxST also conducts clinically-oriented research into anxiety and anxiety-related disorders. Opportunities to participate in research are currently available.

- No disclosures

- Obsessive-compulsive disorder (OCD) is defined by the presence of *either* obsessions (*worries* is a more user-friendly term for children) *or* compulsions (*rituals* is a more user-friendly term for children), although both may be present.
- Used to be categorized under Anxiety disorders in DSM-IV. Recategorized into OC "spectrum" disorders including BDD, hoarding, hair-pulling disorder, and skin-picking.

Diagnostic Criteria for Obsessive-Compulsive Disorder

A. Presence of <u>obsessions</u> or <u>compulsions</u> (or both):

- **<u>Obsessions</u>** defined by both:
  1. Recurrent and persistent thoughts, impulses, or images that are intrusive, **unwanted**, and inappropriate and cause marked anxiety or distress
  2. Attempts are made to ignore or suppress obsessions or to **neutralize** them

Diagnostic Criteria for Obsessive-Compulsive Disorder (cont.)

A. Presence of obsessions or compulsions (or both):

– **Compulsions** defined by both:

1. Repetitive behaviors or mental acts that one feels driven to perform in response to an obsession, or according to rigidly applied rules
2. The behaviors or acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are ***not connected in a realistic*** way with what they are designed to neutralize or prevent or are clearly *excessive*

Diagnostic Criteria for Obsessive-Compulsive Disorder (cont.)

B. The obsessions or compulsions cause **marked distress***, take **more than 1 hour/day**, or significantly affect functioning

C. Not due to the direct effects of a substance or another condition

D. Not better explained by the symptoms of another mental disorder (ie excessive worry in GAD)

- **marked distress = ego dystonic*

KIDS vs. Adults

- General features **distinct** from Adults:
  - Pediatric OCD generally has a prepubertal age of onset
  - is male predominant
  - is characterized by a distinct pattern of OC symptoms and psychiatric comorbidity.
- Additionally, pediatric OCD is more highly familial and generally has a *better prognosis*.
- Relative to OCD beginning in adulthood, pediatric OCD may in some cases be etiologically related to immune-mediated pathology (e.g., pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection [PANDAS]).

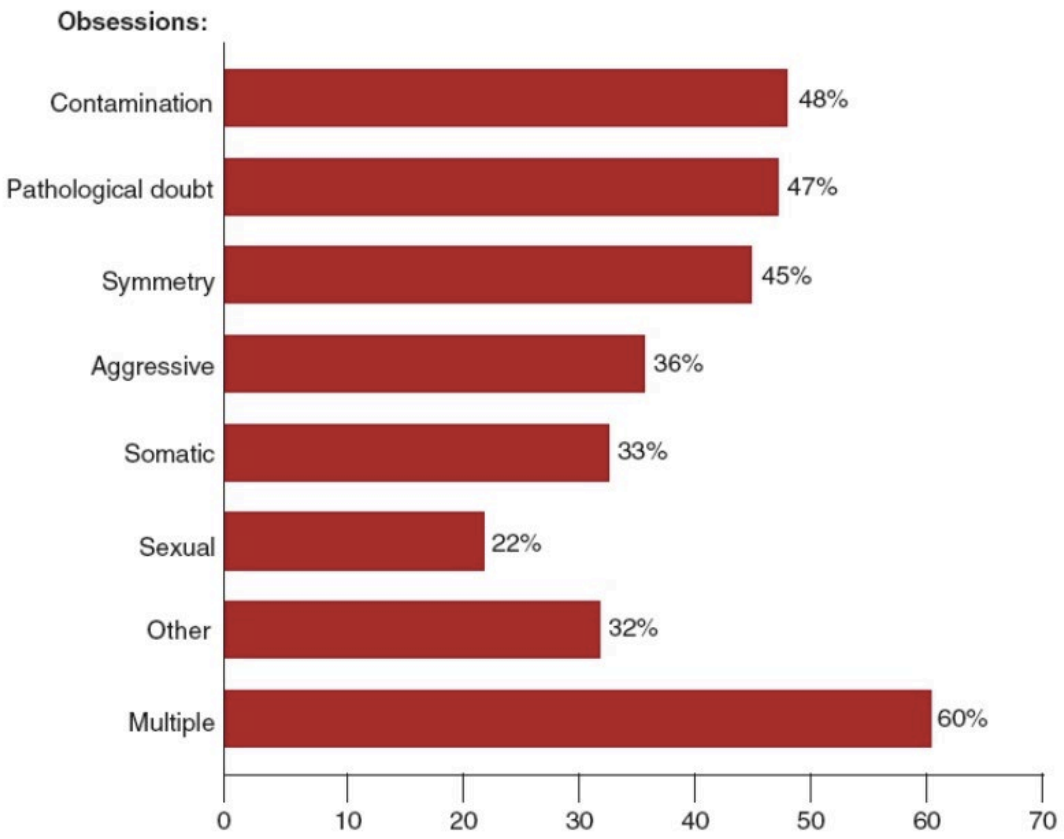
Making the Dx: the screen

- “Do you ever have unwanted thoughts that upset you and that you cannot suppress?”
  - “Do you ever have ideas, images or urges that make you anxious?”
  - Offer the most common obsessions to normalize (violent, sexual, blasphemous)
- For younger children the question might be phrased, “Do you have worries that just won’t go away?” It is reasonable to offer some examples at this time such as “worries about things not being clean” or “worrying that something bad might happen to yourself or a loved one.”
- For compulsions a similar probe might be, “Do you ever have to do rituals over and over even though you know they don’t make sense?”
  - “Do you do things or have habits that you don’t want because you feel anxious or worried about something?”
- For younger children the question might be phrased, “Do you have habits that you can’t stop?” Examples such as washing, checking, repeating, ordering, and counting can be offered.

Making the Dx:

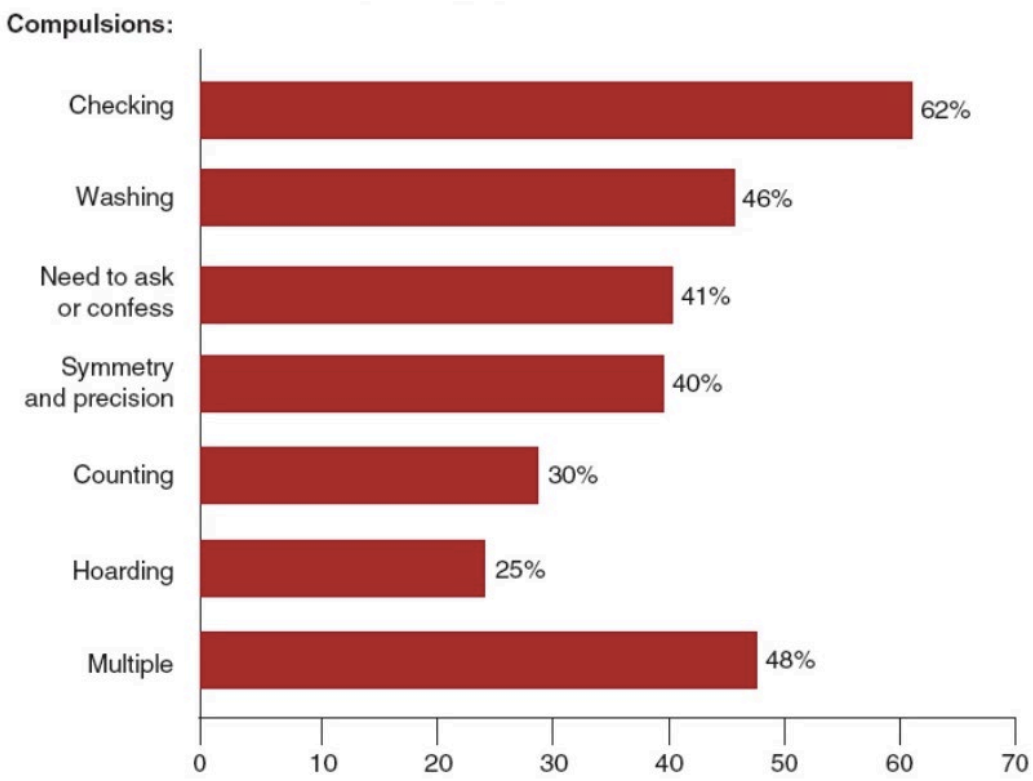
- If screening questions suggest that OC symptoms are present, clinicians should follow with more in-depth assessment using the DSM-5 criteria of
  - 1) time occupied by OC symptoms
  - 2) level of subjective distress
  - 3) functional impairment,
- Can use standardized inventory of symptoms and scalar assessment of severity, subjective distress, impairment, resistance, control, and insight, such as the (Children's) Yale-Brown Obsessive Compulsive Scale
  - Obsessions: Contamination, Aggressive, Sexual, Religious, Superstitions (cracks, numbers), Need to Know/Remember/Tell, Hoarding (fears losing)
  - Compulsions: Cleaning, Checking, Praying, Superstitious Repeating & Rituals, "Just Right" Repeating (touch, tap, order, arrange, counting), Ordering/Arranging, Confessing/Telling, Reassurance-seeking, Mental Rituals

- **Obsessions** – ADULTS



Obsessions – KIDS: Contamination, sexual or somatic obsessions, and **scruples** (overly moralistic thoughts) are the most commonly reported obsessions

- Compulsions – ADULTS



Compulsions – KIDS: Washing, repeating, checking, and ordering are the most commonly reported compulsions

Differential Diagnosis of OCD

- GAD
- Phobias
- MDD
- Body Dysmorphic Disorder or Hoarding
- Eating disorders
- Schizophrenia
- OCPD

OCD Concerns Distinct?

Obsession: Intrusive, far-fetched

Disorder	Fear	Behavior
OCD	Contamination, harm, symmetry	Cleaning, checking, ordering, avoidance
Separation	Harm to self or parent (kidnapping, accident, crime)	Checking, avoidance
Specific Phobia	Harm from specific object or situation (bugs, blood, heights)	Checking, avoidance
Social Phobia	Scrutiny, embarassment, negatively judged	Preparing, avoidance (tanning, teeth whitening, hair grooming)
GAD	“Every day worries”	Worrying
Panic	Harm from fear itself	Avoidance

Worry: Triggered, more common

Special DDx: Autism

- ASD Core symptoms: of this syndrome include stereotypic, repetitive behaviors and a restricted and narrow range of interests and activities that may easily be confused with OCD, especially in young children.
  - A small number of children with OCD (5%–7%) may also meet criteria for ASD
  - In OCD, symptoms are *ego-dystonic* and are associated with anxiety-driven obsessional fears.
  - Children with PDD engage in repetitive behaviors with apparent gratification and will become upset *only when their preferred activities are interrupted*. Left to their rituals, they do not display anxiety or discomfort.
  - While younger children with OCD may not be able to articulate their concerns, evidence of anxiety is usually discernible. If symptoms are typical of OCD (such as washing, cleaning, or checking), one can infer obsessional concern.

Developmentally Normative OCS

- Normative childhood OCS
  - Symmetry, ordering (e.g., lining up objects)
  - Just right routines (bedtime, mealtime routines)
  - Magical thinking
- Developmental trajectory
  - Onset in early toddlerhood, emotion-driven
  - Offset late childhood, w/ increasing cognitive capacity
- Function: ward off anxiety by bringing routine, predictability; incorporate rule learning to increase sense of safety

Developmentally Normative OCS

- Child Fear (Obsessions) Inventory
  - Fear strangers, bedtime, separation, death, violence, contamination, animals
- Parent-rated Childhood Routines (Compulsions) Inventory
  - Household activities, same pretend play, bedtime rituals, repeats actions over and over, food pref, particular order/certain way, arranging objects “just right”, clothing feels “just right”
- Predictive of later OCD, anxiety?

Developmentally Normative OCS

- Subclinical OCS: 80% healthy adults
- 70% of grade school children reporting worry "every now and then"
  - School performance, illness, getting teased, making mistakes, appearance.

Epidemiology and Course of OCD: Kids vs. Adults

- Average age of onset = 20 years
- There are **two** peaks of incidence for OCD across the life span, one occurring in **preadolescent children** and a later peak in **early adult life** (mean age of 21 years). Childhood onset occurs in at least 30%–50% of cases
  - Adults: 2-3% lifetime prevalence
  - KIDS: Prevalence rates of pediatric OCD are around 1%–2% in the United States and elsewhere
- Adults: Men = Women
- KIDS : male preponderance (3:2 male to female). Boys may have an earlier age at onset than girls.

Prognosis

- Adverse prognostic factors include
  - very early age at onset,
  - concurrent comorbid psychiatric diagnoses
    - particularly ODD
    - Not including tics (which confers better prognosis)
  - poor initial treatment response/ long duration of illness,
  - a positive first-degree family history of OCD.
- The long-term prognosis for pediatric OCD is better than originally thought and is **better than in individuals with adult-onset OCD**.

Prognosis:
Comorbid Tics → increased likelihood of remission

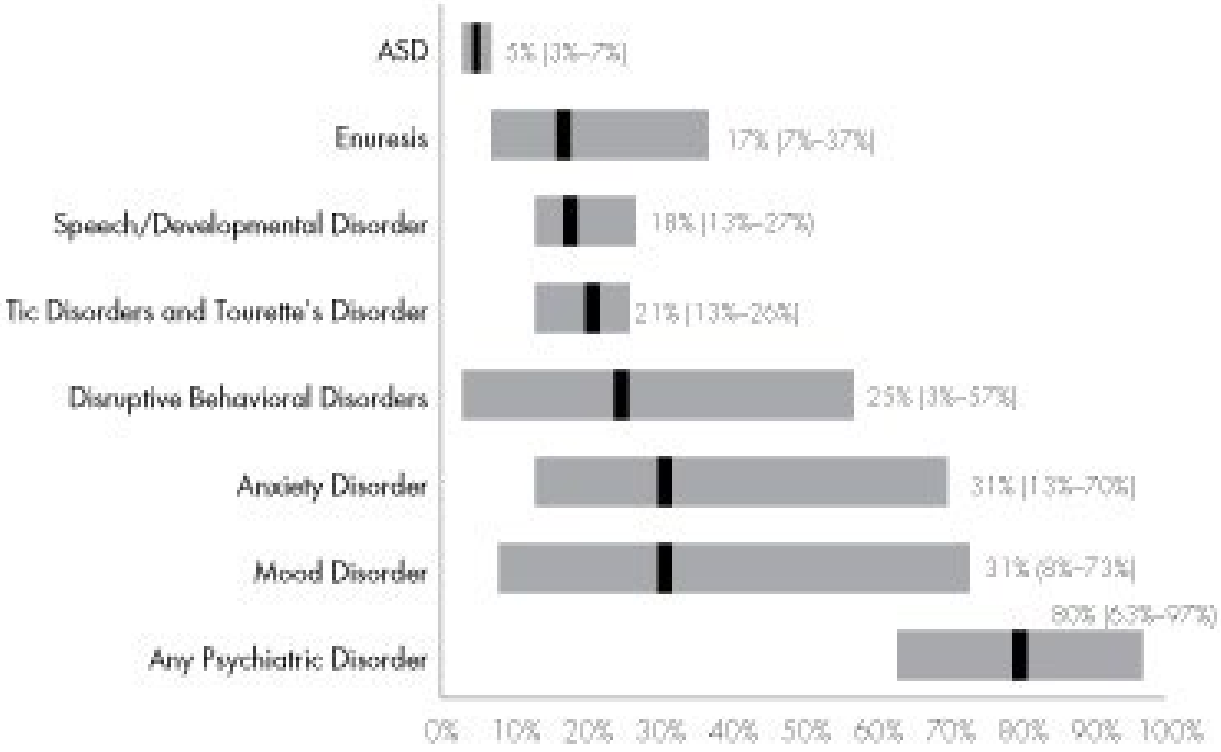
- Characterized by an early peak in OC symptom severity at 12.5 years and followed by an increased likelihood of remission
- Highly familial with FDR prevalence of 23.8% vs 14.9% (Rosario-Campos et al., 2005)
- Response to sertraline and fluvoxamine (but not clomipramine) may be reduced
- May respond better to neuroleptic augmentation

Comorbidities:

- MDD with OCD = 70-80%
- Social phobia with OCD = 25%

- Incidence of Tourette's disorder with OCD is 5 – 7%
  - 20 – 30% of OCD patients have a history of tics

Comorbidities: KIDS (rule, 70% -90%)



Heritability and Family/Environmental Factors

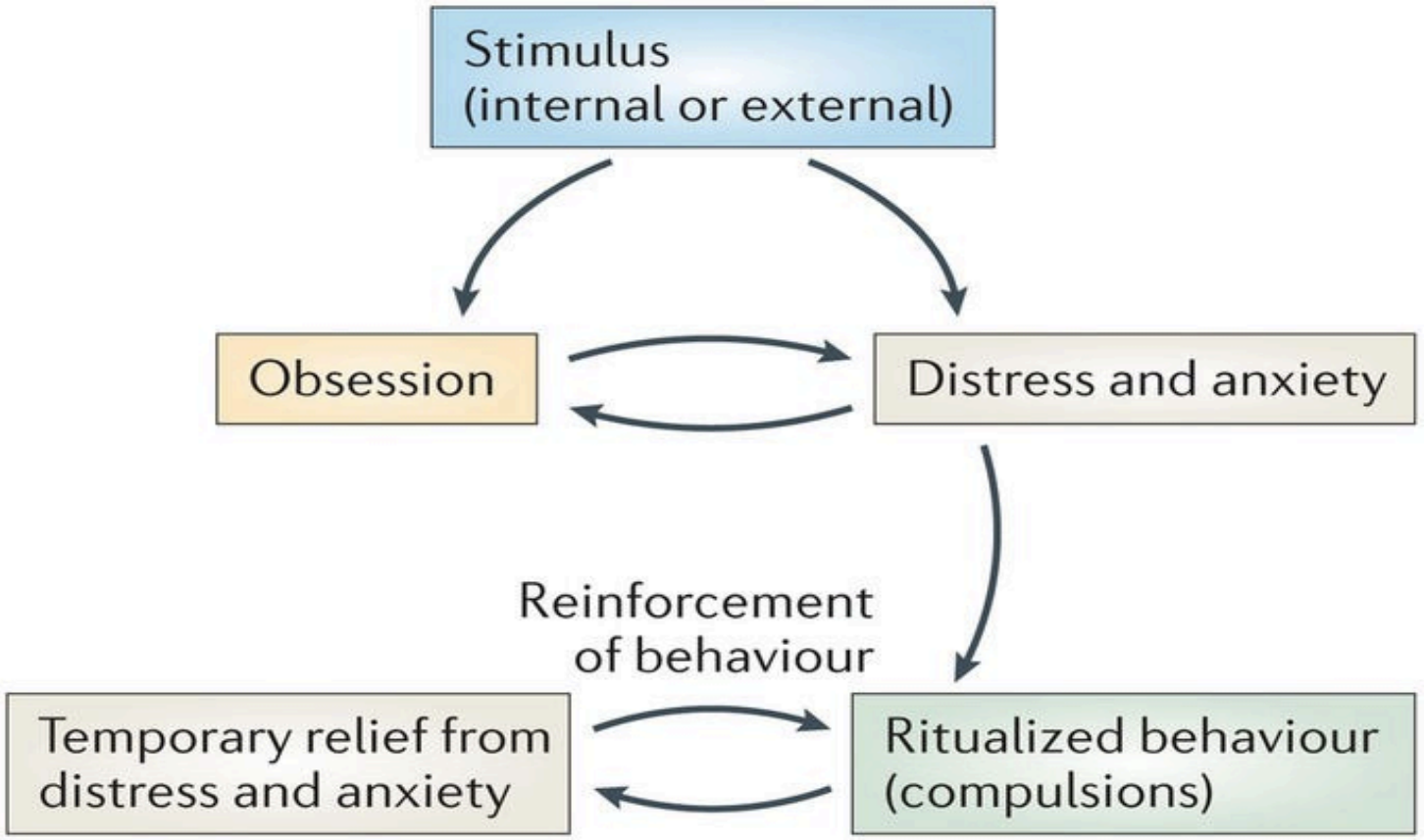
- 35% of 1st degree relatives of OCD patients have the disorder
- HOWEVER, nonheritable etiological factors contribute to the risk of developing OCD as much as, if not more than, genetic factors.
  - Many to MOST cases of OCD arise *without* a positive family history of the disorder. For example, twin studies show that even among monozygotic twins, OCD is *not* fully concordant.

Special note, family accommodation

- Family systems: Parents are often intimately involved in their children's OC symptoms and may unwittingly reinforce compulsive behaviors by providing verbal reassurance or other "assistance" to their children (e.g., handling objects that their children avoid, such as opening doors; laundering "contaminated" clothes and linens excessively; even wiping children on the toilet who will not do it themselves).

Neurobiology of OCD

OCD is diagnosed based upon process, not content of fear/anxiety



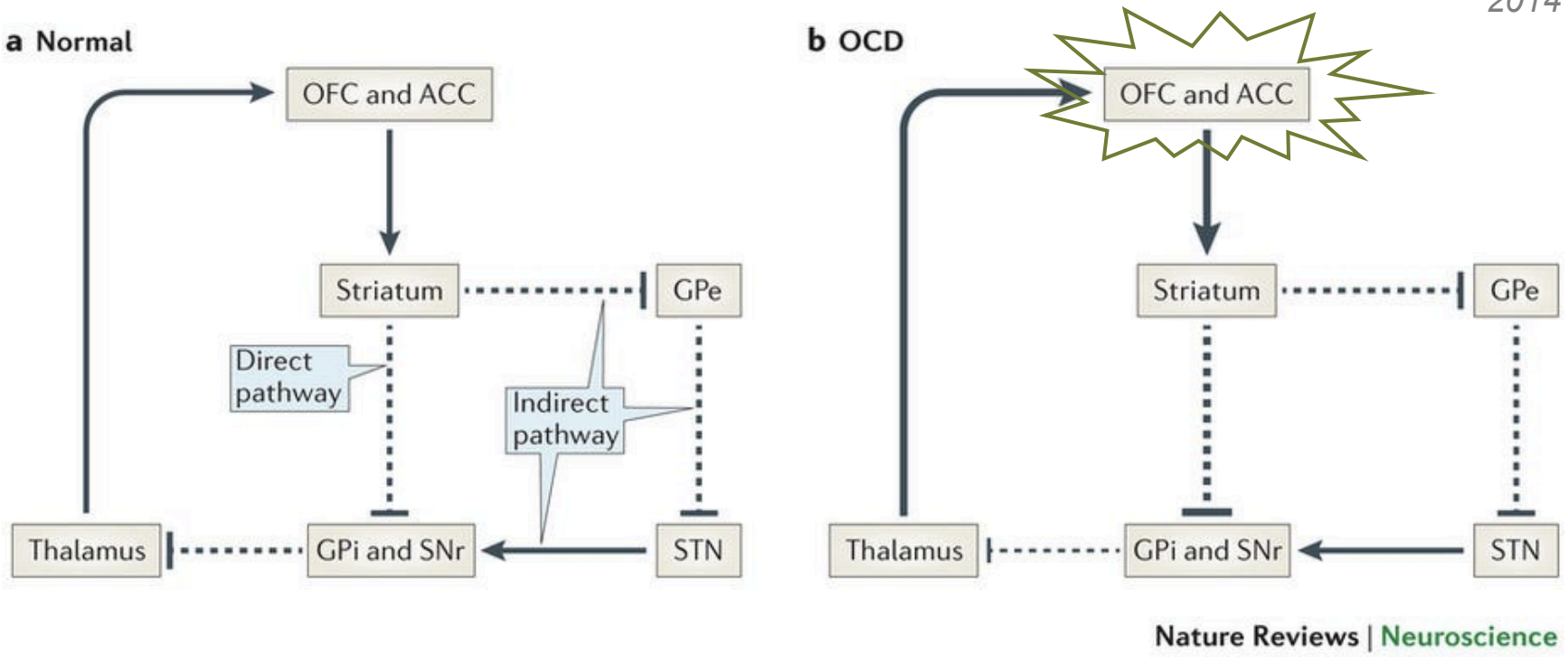
Neurobiology of OCD

- Cortico-striato-thalamo-cortical loop
  - Hyperactivation of the orbiotofrontal-subcortical pathway
  - As a result, exaggerated concerns about danger, hygiene, or harm – mediated by the OFC – may result in persistent conscious attention to the perceived threat (obsession) and subsequently, to the compulsions aimed at neutralizing the perceived threat
  - The temporary relief that results from performing compulsions leads to reinforcement and repetitive (or ritualistic) behavior when obsessions recur

- **SEROTONIN** key neurotransmitter

Cortico-striato-thalamo-cortical circuitry

Nature Reviews Neuroscience, 2014



Solid arrows depict glutamate (excitatory) pathways and dashed lines depict GABAergic (inhibitory) pathways. **A.** Normal function has a balance between the direct and indirect pathways so that the thalamus's input to the orbitofrontal cortex (OFC) and the anterior cingulate cortex (ACC) is appropriate. **B.** **In OCD, the indirect pathway cannot overcome the input of the direct pathway, and the thalamus is excessively disinhibited**

PANDAS and OCD

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections

1. Obsessive-compulsive disorder and/or a tic disorder
2. Prepubertal onset between 3 and 12 years of age, or Tanner I or II
3. Episodic course (abrupt onset and/or exacerbations)
4. Symptom onset/exacerbations temporally related to documented GABHS infections on two occasions
5. Association with neurological abnormalities
Note. GABHS = group A β-hemolytic streptococcus; PANDAS = pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection.

PANDAS and OCD

- Group-A beta-hemolytic streptococcal infection produces antibodies that cross-react with basal ganglia
- In acute and abrupt onset cases, antistreptolysin O and anti-DNase B titers may be helpful. A 0.2 log rise in either antibody or absolute levels more than twice the upper limit of the normal range suggest a recent GABHS infection. Intercurrent titers are also helpful as a baseline if there are subsequent exacerbations that may be associated with sudden increase in antibody levels.
- Titers at intervals of **less than 3 months are not likely to be helpful**

Treatment

- **Exposure and Response Prevention**
  - * ***Gold Standard treatment***
- **SSRIs** (FDA-approved)
  - Fluoxetine, fluvoxamine, paroxetine, sertraline
- TCA (only one)
  - **Clomipramine** (FDA-approved)
- Venlafaxine
- Risperidone
- Psychosurgical procedures – DBS, anterior cingulotomy

Cognitive Behavioral Therapy with Exposure and Response Prevention

- The principle of *exposure and response prevention* (ERP), as illustrated in next Figure, relies on the fact that anxiety usually attenuates after sufficient duration of contact with a feared stimulus.
- Repeated exposure is associated with decreased anxiety across exposure trials, with anxiety reduction largely specific to the domain of exposure, until the child no longer fears contact with specifically targeted phobic stimuli.
- Adequate exposure depends on blocking the negative reinforcement effect of rituals or avoidance behavior, a process termed *response prevention.*


Exposure
Anxiety-provoking obsession
Urge to ritualize
Response prevention
Anxiety not relieved
Compulsions performed
Habituation
Relief from anxiety
Obsessions diminish
Recurrent obsession

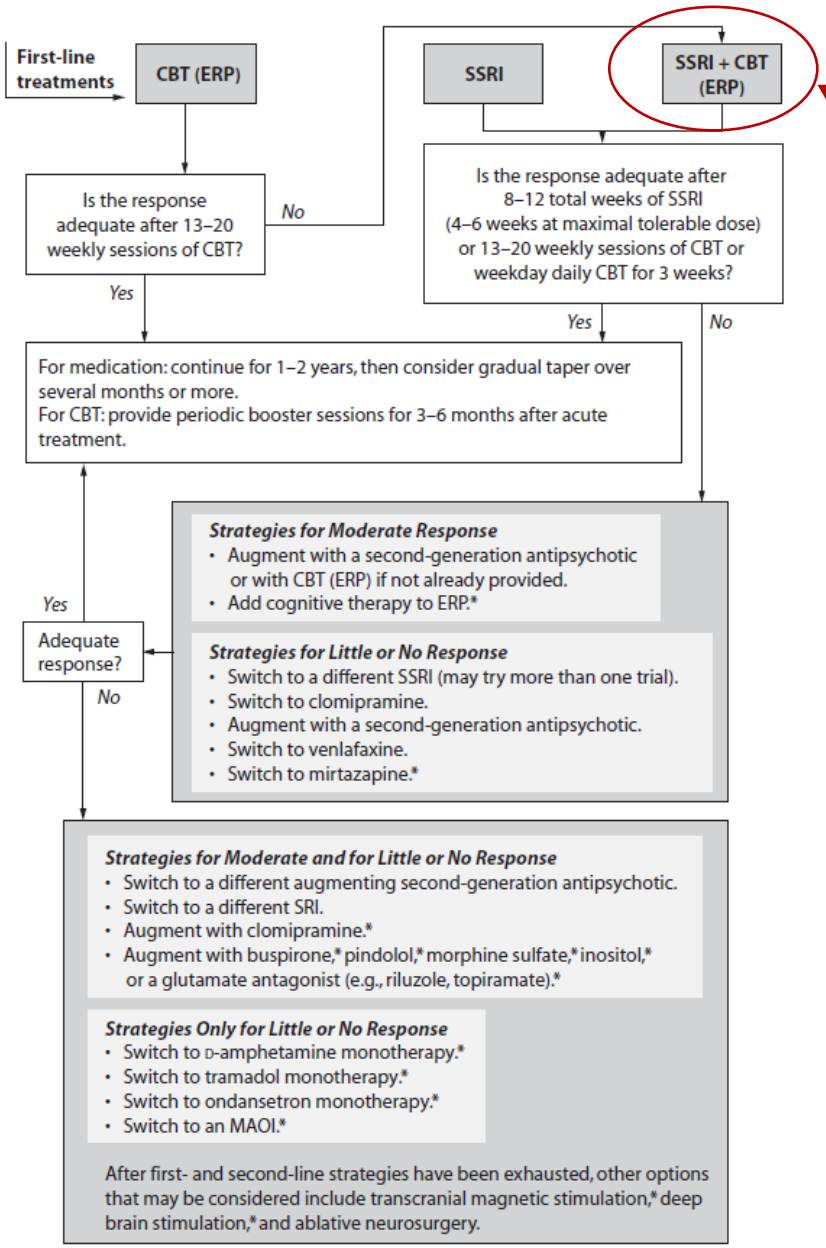
Moderators of response: CBT-ERP

- Follow-up studies indicated that FAMILY HISTORY of OCD usually predicts poorer response to CBT alone, so consider combined therapy in this situation especially
- **Moderators of response to CBT:**
  - Family accommodation
  - Pre-treatment severity
  - Poor insight
  - Co-morbid diagnosis: particularly ADHD and disruptive behavior disorders

Cognitive Behavioral Therapy with Exposure and Response Prevention

- (POTS; suggest that expert delivery will improve response rates to CBT. In the POTS study, CBT alone did not differ from sertraline alone, and both were better than placebo. For greatest efficacy, the combination of CBT with medication is the treatment of choice. *Recommendations from the POTS were to start treatment with either CBT alone or CBT plus medication.*

APA Practice Guidelines



*Consider starting here
if OCD w/ FH (Garcia 2010),
or based on illness severity

2nd and 3rd line:
Atypical vs. CMI
SNRI if MDD
Buspar
Riluzole, Memantine, NAC

Psychopharm: SSRIs equal?

- Yes…..across the population
- No……for individual patients
  - 71% of fluvoxamine non-responders, respond after switch to fluoxetine (RUPP)
  - Side effects
    - Nausea, diarrhea, sedation, headache
    - Activation in younger kids
      - Motor disinhibition
      - Responsive to lowering dose
      - Med side effect, NOT mania

Psychopharmacology

- Clomipramine and three SSRIs (fluoxetine, fluvoxamine, and sertraline) have U.S. Food and Drug Administration (FDA)–approved pediatric indications

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

Source. Adapted from Geller et al. 2003b.

Psychopharm: Dosing

- Fluoxetine: 5 to 10 mg, increase 10-20 mg q 2-4 weeks, initial target: 20 mg, max 80 mg (child) – 120 mg (adult)
- Sertraline: 25-50 mg, increase 50 mg q 2-4 weeks, initial target: 150 mg, max 300 mg (child) – 400 mg (adult)
- Citalopram: 5 to 10 mg, increase 10-20 mg increase q 2-4 weeks, initial target: 20 mg, max 40 – 80 mg
- Fluvoxamine: ↑ by ~50 mg/wk to maximum of 300 mg/day
- E-scitalopram: 5- 10 mg, max 30 mg (child) – 60 mg (adult)
- (Paroxetine)
- Younger children may require lower dosing
  - two-thirds (200 mg/d) of max fluvoxamine (300 mg/d) for same plasma concentration in children as in adolescents (Cheer 2001)
  - “Start low, go slow”
  - Although higher doses, may be required for OCD response (Bloch et al, 2009)

Clomipramine

- Clomipramine: 25 mg/day, max 200-300 mg
  - EKG, anti-cholinergic side effects
  - Meta-analysis comparing CMI, fluoxetine, sertraline, fluvoxamine, paroxetine
    - CMI superior to each SSRI, but all SSRIs comparable

TABLE 3. Pairwise Comparison of Pooled Effects of Medications and Placebo in 12 Randomized, Controlled Trials Included in a Meta-Analysis of Pharmacotherapy for Pediatric Obsessive-Compulsive Disorder[a]

Placebo or Medication	Clomipramine		Sertraline		Fluvoxamine		Fluoxetine		Paroxetine	
	z	p	z	p	z	p	z	p	z	p
Placebo	6.23	<0.001	3.84	<0.001	3.52	<0.001	5.56	<0.001	3.95	<0.001
Paroxetine	2.99	0.003	−0.36	0.72	−0.04	0.97	1.17	0.24		
Fluoxetine	2.24	<0.03	−1.86	0.06	−1.33	0.18				
Fluvoxamine	3.24	0.001	−0.36	0.72						
Sertraline	3.78	<0.001								

[a] The first row provides tests for each drug of the significance of its pooled standardized mean difference from placebo. Statistical significance indicates that the pooled observations found significant separation between the drug and placebo conditions. Rows two through four provide tests of the hypothesis that the standardized mean difference from placebo for the row drug is the same as the standardized mean difference for the column drug. Significant findings indicate that the magnitude of separation between the drug and placebo conditions differs between the drugs.

Adding clomipramine to an SSRI may be helpful

- Even low-dosage augmentation (25–75 mg/day of clomipramine) may be useful; however, **electrocardiogram indices must be monitored** when combining clomipramine with CYP450 2D6 (primary), or 3 A4 inhibitors such as fluoxetine, paroxetine, or fluvoxamine, as potentially toxic increases in clomipramine levels may occur.

Atypicals

- **Risperidone**, **aripiprazole**, **haloperidol**
  (*not* quetiapine, olanzapine)

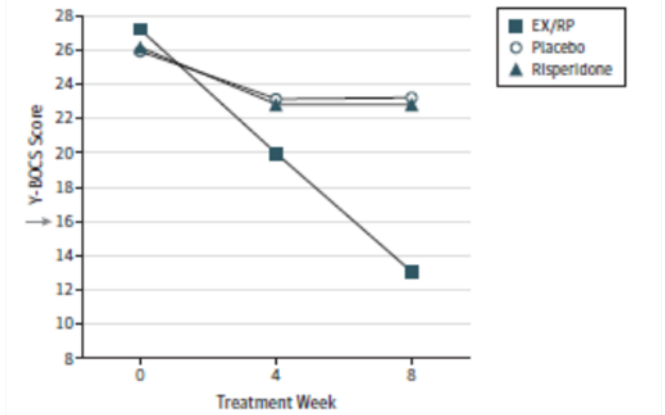
Meta-analyses Atypical Augmentation

Bloch et al, 2006: 30% responders risperidone, haloperidol (olanzapine, quetiapine *not* effective)

Dold et al, 2013: 30% responders risperidone aripiprazole, haloperidol inconsistent (olanzapine, quetiapine *not* effective)

Veale et al, 2014: risperidone, aripiprazole (olanzapine, quetiapine *not* effective)

SSRI augmentation with CBT better than Risperdol!



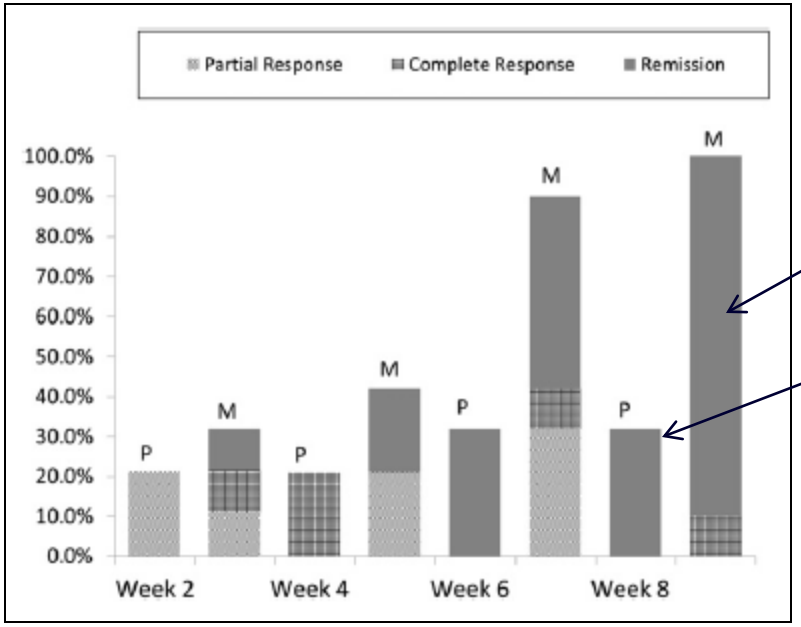
Simpson et al, 2009

Atypicals

- Atypicals: RCTs completed in adults; only case-series in kids. expert consensus suggests that many children with treatment-resistant OCD will *benefit from judicious augmentation with an atypical antipsychotic, particularly children with tic disorders, autism spectrum disorder symptoms, or mood instability*.
- One open label augmentation trial for pediatric tic-related OCD found that risperidone (mean dose 1.7mg daily) and aripiprazole (mean dose 8.2mg daily) were effective augmentation strategies for children who did not respond to SSRI monotherapy

Memantine

- Memantine: start 5 mg/day → 5 mg bid (Hezel et al, 2009)
  - 10 mg bid max, augmentation SSRI (Hezel et al, 2009)
- Glutamate antagonist
- Specific effect: OCD > GAD (Feusner et al, 2009)
- Double blind pbo-controlled study of memantine (Ghaleiha et al, 2013)



- Memantine 10 mg x 1 week → 20 mg (with fluvoxamine 200 mg/day)
- 19 memantine, 19 pbo
- 89% M remit, 32% P remit (YBOCS < 16)

- Side effects: GI, dizziness, bruising

N-Acetylcysteine

- NAC: 600 mg/d doubled weekly to 2400 mg/d based on effect and tolerance.

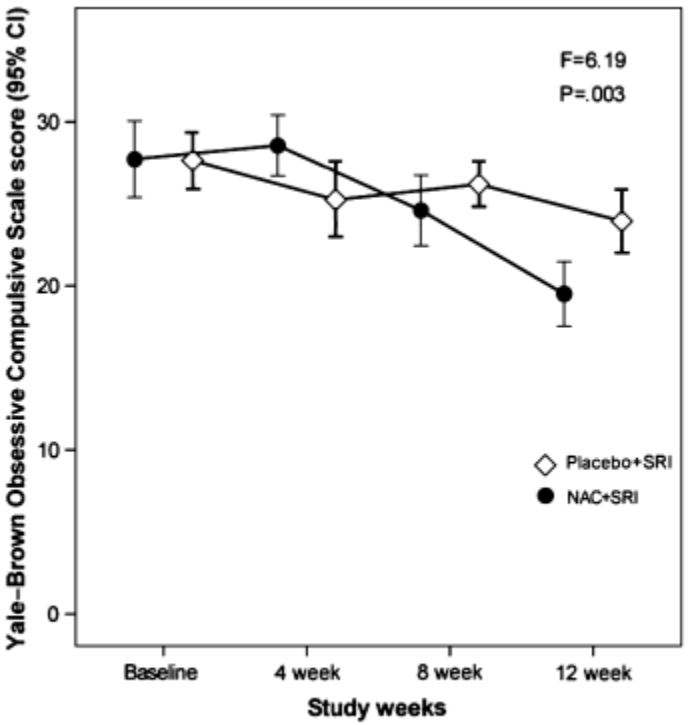


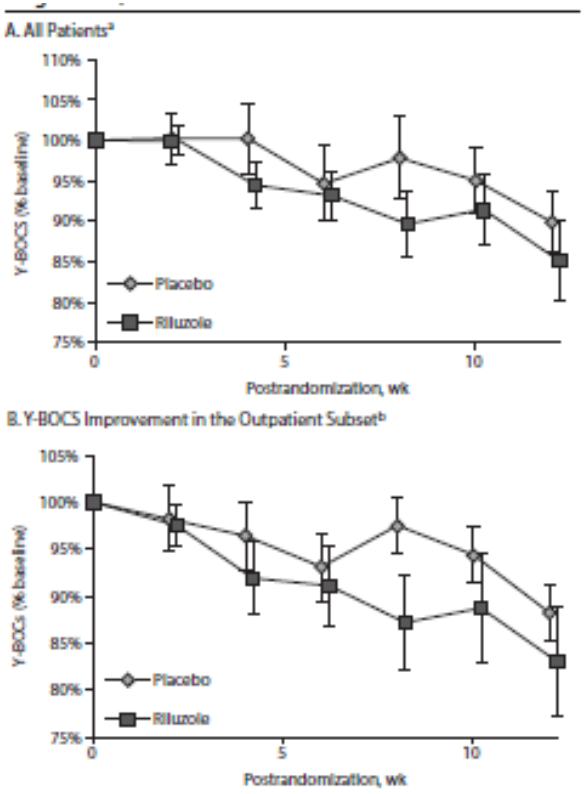
FIGURE 2. Trend of changes of Y-BOCS score over time in NAC group versus placebo group.

Asfhar et al, 2012

- 20 SSRI + NAC v 20 SSRI + pbo
- 52.6% vs. 15% responders
- Side effects: GI only

Glutamate Medications

- Riluzole: 50 mg po bid



Pittenger et al, 2012

- 30 riluzoe vs 30 pbo peds OCD (Grant et al, 2014)
- 17 riluzole vs 17 pbo (Pittenger et al, 2012)
- **No difference from** pbo
- Side effects: dizziness, muscle stiffnes, drowsy, tingly around mouth, GI, h/a, ALT/AST, pancreatitis

Other Medications

- Benzos: clonazepam 0.25 mg po bid (scheduled, short-term)
- Buspirone: 5 mg po tid
- Venlafaxine (GAD, Rynn et al, 2007; SoPho, March et al, 2007)
- Adderall

Stimulants and Tic Controversy

Cohen 2015

- 22 studies involving 2385 children with ADHD
- New onset or worsening of tic symptoms were commonly reported in both psychostimulant (event-rate 5.7%) and placebo groups (even-rate 6.5%). Risk similar to placebo.
- Type of stimulant, dose, duration of treatment, recorder, and participant age did not affect risk of new onset or worsening of tics.

Summary Points

- Obsessive-compulsive disorder (OCD) affects 1%–2% of children and adolescents and is frequently underdiagnosed and undertreated because of the hidden nature of its symptoms.
- Families often become entangled in their children's rituals.
- Most often, OCD in children is accompanied by comorbid psychopathology that has a significant impact on functioning and treatment outcome.
- Simple probes for the presence of anxiety, "worries," and rituals will identify most children with OCD.
- Gathering information from both parents and children is essential.
- Assessment should include a standardized quantitative or scalar measure of symptoms along with an inventory of "target" symptoms.
- CBT is the treatment of choice for mild to moderate childhood cases.
- Medications are reserved for cases of OCD that are more severe, have multiple comorbid conditions, are accompanied by poor insight, or are CBT resistant; medications are also recommended in situations where adequate CBT resources cannot be found.
- SSRIs are the first recommended medicines for OCD at any age.

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MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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