

Psychosocial risk factors and treatment for children and adolescents with OCD

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Learning Aims

Outline:

- Define OCD
- Key associated comorbid disorders
- Psychosocial Risk Factors
- Psychosocial Treatment

Obsessions and Compulsions

- Obsessions: Thoughts urges or images that are experienced as unwanted, intrusive and out-of-character
- Compulsions: Repetitive intentional behaviours or mental acts that are often linked to obsessions and serve to reduce discomfort or anxiety

DSM Diagnostic Criteria

Criteria A: Essential Components

- Recurrent obsessions or compulsions
- Obsessions
 - Not simple excessive worry about real-life problems
 - Person attempts to ignore or suppress or to neutralise them with some other thought or action
 - Person recognises that they are a product of their own mind (not thought insertion)
- Compulsions
 - Driven to perform behaviour or mental act
 - Aimed at reducing distress or preventing dreaded situation
 - Not realistically connected to what they are trying to prevent or clearly excessive

DSM Diagnostic Criteria

- Criteria B:
 - The individual recognises the obsessive-compulsive symptoms are excessive or unreasonable
- Criteria C:
 - The obsessive-compulsive symptoms cause marked distress, are time consuming (>1hr/day), or significantly interferes with normal routine, functioning, or relationships
- Criteria D:
 - Not restricted to another Axis I disorder
- Criteria E:
 - Not due to direct physiological effects of a substance or general medication condition

Prevalence of OCD

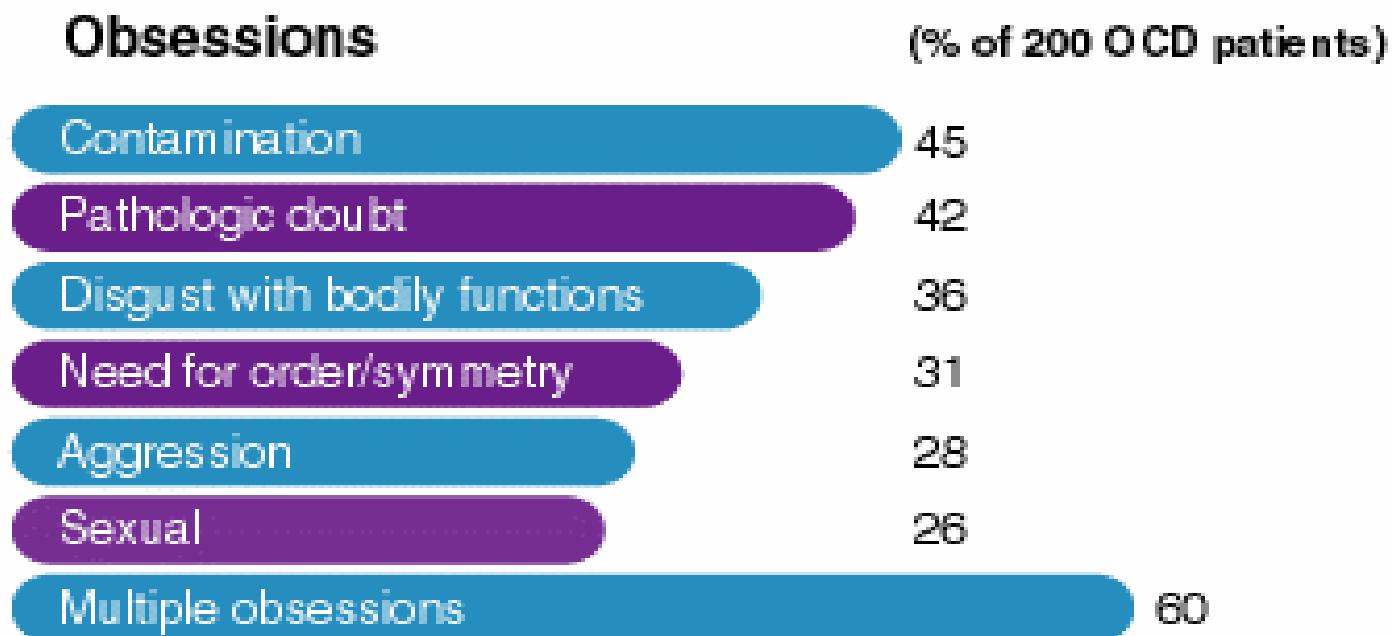
- The World Health Organisation lists obsessive-compulsive disorder as one of the five major causes of disability throughout the world.
- It is considered the fourth most common psychiatric condition, ranking after phobias, substance abuse disorders, and major depressive mood disorder.
- Prevalence of OCD is underestimated – why?
- 60% of all persons with a diagnosable anxiety disorder never see a mental health professional – they may turn to their family physician or another family member for help.

Age Onset of OCD

- Children : 0.5 – 1% (Flament et al., 1988)
- Late Adolescence: 2 – 3% (Rapoport et al. 2000)
- In children and adolescents, mean age onset is 10 years old with modal range of 6 to 15 years of age
- Boys more likely to have prepubertal onset and a family member with OCD or Tourette's Syndrome
- Girls more likely to develop OCD in adolescence and in their twenties

Obsessive Symptoms

Frequency of obsessive-compulsive symptoms



Compulsive Symptoms

Compulsions

(% of 200 OCD patients)



Common Symptoms

Common Obsessions	Common Compulsions
- Contamination fears of germs, dirt, etc.	- Washing
- Imagining having harmed self or others	- Repeating
- Imagining losing control of aggressive urges	- Checking
- Intrusive sexual thoughts or urges	- Touching
- Excessive religious or moral doubt	- Counting
- Forbidden thoughts	- Ordering/Arranging
- A need to have things “just right”	- Hoarding or saving
- A need to tell, ask, and confess	- Praying

Theories of OCD

- Most prominent psychological theory of OCD is cognitive-behavioral in nature.
- Obsessions are caused by catastrophic misinterpretation of the significance of intrusive thoughts/images/impulses.
- Through this catastrophic misinterpretation, neutral cues in the environment or internally are turned into threatening ones, leading to avoidance (compulsions).

Theories of OCD

- As a result of this avoidance, catastrophic misinterpretations are never challenged and thus persist. However, relief is achieved in the short term (compulsions negatively reinforced).
- Attempts are made to avoid, neutralize, or suppress obsessions, leading to a vicious cycle.
- Obsession → Neutralization → Relief → Confirmation of belief → Obsession

Psychosocial Risk Factors

- In addition to biological risk factors, there are a range of psychosocial circumstances that can have an impact on the child.
- These factors can increase the child's risk for developing OCD psychopathology or other more general problems that may require treatment.

Selected Examples of Psychosocial Risk Factors

- Comorbid Disorders
- Effects of Cumulative Life Stress
- Effects of Divorce
- Marital Violence
- Physical Abuse
- Sexual Abuse

Comorbid Disorders

Common comorbid disorders with OCD include:

Disruptive Behavioural Disorders

- ADHD
- Oppositional Defiant Disorder
- Conduct Disorder

■ Anxiety Disorders

- Social Phobia
- Generalised Anxiety Disorder
- Specific Phobia
- Post-Traumatic Stress Disorder
- Panic Disorder
- Separation Anxiety Disorder

■ Depressive Disorders

- Major Depressive Disorder
- Bipolar Disorder

■ Tic / Tourette's Disorder

■ Somatoform Disorders

- Body Dysmorphic Disorder
- Hypochondriasis

■ Developmental Disorders

- Autism

■ Eating Disorders

- Anorexia
- Bulimia

■ Impulse Control Disorders

- Trichotillomania
- Kleptomania

■ Neurological Medical Conditions

- Sydenham's Chorea
- PANDAS

Factoring in Comorbidities

- Depression:
 - Could be secondary to their OCD symptoms and may spontaneously decrease with successful OCD treatment.
 - Patients with mild to moderate depression can usually engage in and benefit from ERP without depression specific interventions.
 - Patients with comorbid depression may not respond to OCD interventions as well as non-depressed OCD patients do.
 - For concurrent OCD and Major Depression, expert consensus guidelines suggest combining CBT with an SSRI.

Factoring in Comorbidities

- Anxiety:
 - CBT can be used to treat OCD concurrent with other anxiety disorders with only slight modifications, such as:
 - Preliminary evidence suggests that treatment can or should be simultaneous rather than sequential.

Prevalence of Comorbid Disorders in OCD

Comorbidities	Estimated Prevalence
Attention Deficit Hyperactivity Disorder	13%
Major Depressive Disorder	28 to 31%
Simple Phobia	7 to 48%
Social Phobia	11 to 16%
Bipolar Disorder	15%
Eating Disorders	8 to 13 %
Panic Disorder	6 to 12%
Tourette's Disorder	5%

Effects of Cumulative Life Stress

- Experiencing numerous life changes within a restricted period of time has been found to be associated with a range of child health and adjustment problems.
 - Anxiety
 - Depression
 - Increased Rates of Drug Use
 - Recurrent Abdominal Pain
 - General Problems with Health and Adjustment

Effects of Cumulative Life Stress

- There is also evidence that *high levels of stress in expectant mothers can impact offspring.*
- Animal Studies – Stressed rats have longer pregnancies and more spontaneous abortions.
- Expectant mother's show links between life stress and pregnancy and birth complications.
- There is also some evidence to suggest links between stress during pregnancy and the development of difficult temperament and delays in motor and mental development.

Family Stresses

- Death of a parent, caregiver or another family member
- Partnership dissolution and separation
- New family relationships
- Problems with friendships
- Inconsistent parenting
- Physical or psychiatric illness within the family
- Family violence, including sexual abuse and other power relationships
- Suicidal behaviour within the family
- Poverty

Effects of Divorce

- Divorce is not a single event –rather it ushers in a range of major life stressors and life transitions that can impact on the child.
 - Changes in Residence
 - Changes in School
 - Loss of Friends
 - Possible Separation From One Parent
 - Possible Economic Hardships
 - Possible Parental Conflict
 - Possible Remarriage and new Step-family
- All of these can serve as significant stressors that can impact on the child in multiple ways.
- Divorce can have a major impact on the child in terms of both its short and long term effects.

Short-Term Effects of Divorce

- Short term effects usually take the form of emotional problems and behavioural difficulties.
- Such effects are not surprising as divorce often separates the child from one of the parents, with whom he/she may have a positive relationship.
- This may elicit anger and possibly guilt.
- Also, many of the contingencies and rules that have previously served to control the child's behaviour may have been disrupted.
- Emotional responses and changed rules and contingencies can have a major impact on behaviour.

Long-Term Effects of Divorce

- As children grow older, they often continue to view their parents divorce as the single most formative experience in their lives, with major divorce-related issues arising as they approach adulthood.
- Many confront issues of love, commitment, and marriage with anxiety and sometimes, very great concerns about betrayal, abandonment, and not being loved.

Marital Violence

- While there is less research on exposure to marital violence than on child abuse, the work that has been done suggests that *observing violence between parents can have a significant impact on the child and his/her behaviour.*
- The effects seem to be on increasing overall adjustment problems, anxiety, depression and other internalizing problems such as fearfulness and insecurity.

Marital Violence

- These features seem to be more pronounced in children who have been abused themselves.
- These children also show increased levels of aggression.
- They also often display inappropriate attitudes regarding violence as a means of resolving conflict and a greater willingness to use violence themselves.

Child Abuse and Neglect

Child abuse and neglect involves the:

- Physical or mental injury.
 - Injuries intentionally inflicted by hitting, punching, beating, kicking, throwing, biting, and burning.
 - The injury may have occurred during a single episode or multiple episodes and can range from minor cuts/abrasions to fatality-related head and internal injuries.
- Sexual abuse or exploitation.
- Physical Neglect
 - Leaving the child unsupervised at home
 - Failing to provide adequate food and nourishment, shelter, and clothing, and
 - Living in unsanitary conditions.
- Psychological Maltreatment
 - Belittling and degrading a child,
 - Threats to physically harm or abandon the child,
 - Exposing the child to domestic violence within the home.

Child Abuse: Etiology

- Views Emphasizing Parental Causes
 - Psychopathology
 - Lack of Empathy
 - Low Frustration Tolerance, Impulsivity
 - History of Abuse
- Views Emphasizing Child Characteristics
 - Problem Behaviour
 - Special Characteristics
- Views Emphasizing Social Factors
 - Stress- Poverty-Social Isolation-SES

Child Abuse: Effects

- Can result in significant psychological problems; both internalizing and externalizing in nature.
- Some suggestion that younger children have more internalizing problems while older children have more externalizing problems, although many display both.
- Generally findings suggest that 40 to 60% of abused children show evidence of emotional/ behavioral disturbance with around 15 to 20 % displaying severe disturbance.

OCD Causes: Summary

- While factors such as the ones considered here can often increase the risk of developing OCD and other various types of psychological, behavioural or physical difficulties, it is important to realise that they do not invariably have the same impact on all individuals.
- Individual factors that increase *resiliency* must be considered along with those that increase risk of negative outcomes when risk factors are considered within a clinical setting.
- Although a definitive cause of OCD has not yet been found, it is considered the product of interactions between biologic predisposition and various developmental and psychosocial influences

Psychosocial Assessment and Treatment

Assessment

- Clinical Interview
- Scales / Measures
 - Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS)
 - Obsessive Compulsive Inventory
 - Padua Inventory (PI-WSUR)
 - Obsessional Belief Questionnaire
 - Interpretations of Intrusions Inventory
 - Personal Significance Scale (PSS)

Assessment

- Requires comprehensive assessment of current and past symptom profile
- Previous pharmacological and psychological treatment
- Adherence to prescribed medication or treatment
- History of side-effects
- Consider psychosocial stressors or comorbid conditions (e.g., depression, anxiety or tic disorders) that may contribute to risk
- Assessment of self-harm or suicide risk (particularly if depression already diagnosed)
- Relationship with family/carers
- Functioning at school or work and with Peers
- Personality factors

Psychological Treatment

- Cognitive Behaviour Therapy

Main CBT Components

- **Relaxation Training**
 - Deep breathing
 - Progressive muscle relaxation (PMR)
- **Cognitive Strategies**
 - Reducing negative self-talk
 - Challenging unrealistic and dysfunctional thoughts
 - Considering different perspectives
- **Behaviour Strategies**
 - Behavioural exposures
 - Successive approximation
- **Problem-Solving Techniques**

CBT for OCD in children and adolescents

(March & Mulle, 1998)

- Week 1: Psychoeducation
- Week 2: Introducing the 'tool kit'
- Week 3: Mapping OCD
- Week 4: Completing the 'tool kit'
- Week 5-6: Being E/RP
- Week 7: Family Meeting
- Week 8-11: Moving up Hierarchy
- Week 12: Family Meeting
- Week 13-18: Complete E/RP
- Week 19: Relapse Prevention
- Week 20: Graduation
- Week 21: Booster Session

CBT Treatment Strategies

- Comprehensive Assessment
- Psychoeducation
 - Nature of Disorder
 - Maintaining Mechanisms
 - Nature of Treatment
- Exposure and Response Prevention (ERP)
 - Develop Exposure Hierarchy
 - Engage in Graded Exposure & Response Prevention
 - Review progress/problem solve
 - Relapse Prevention
- Systematic Desensitisation

Psychoeducation

Step 1: Learning about anxiety

- Anxiety is a normal and adaptive system in the body that tells us when we are in danger. Therefore, dealing with anxiety **NEVER** involves eliminating it, but rather managing it.
- Anxiety becomes a problem when a persons body tells them that there is danger when there is no real danger.

Step 2: Learning about OCD

Research shows that people with OCD tend to:

- Give **unhelpful meanings to obsessions**, and
- Use **unhelpful strategies to control obsessions**

Psychoeducation

Facts about unwanted thoughts:

- Everyone has unwanted or unpleasant thoughts sometimes; it's normal
- Just thinking about something won't make it happen. For example, if you think about winning a million-dollar lottery, it won't necessarily happen
- Thinking a bad thought does not mean you are a bad person. It also doesn't mean that you want to do anything bad

Thought Suppression

- Efforts at mental avoidance (i.e., trying to push thought out of one's mind) typically do not work
- Attempt to suppress thought actually requires activating the thought
- **Remember: Avoidance strengthens fear**

Psychoeducation

Unhelpful meanings given to obsessions

If everyone has unwanted thoughts from time to time, how come everyone doesn't have OCD?

- It is because of the **interpretation or meaning** that a person gives to the thoughts. The meaning given to an unwanted thought can turn it into an **obsession**, which happens much more frequently and with greater intensity.
- For example, if someone had the following unwanted thought: "What if I pushed someone into traffic?" The **interpretation** of the thought as important, meaningful, and dangerous will make the person have more of these unwanted thoughts.

Psychoeducation

Unhelpful strategies to control obsessions

- When a person sees intrusive, unwanted thoughts as threatening or dangerous and cause them a lot of anxiety, it is not surprising that they want to get rid of them! However, most of the strategies used to control obsessions can often make OCD worse
- All the strategies used (e.g., checking, seeking reassurance, washing, avoidance,) do not work because anxiety only goes down for a short time and comes back again. But, because they work in the short-term, the person is likely to use them again the next time they have an obsession. By doing so, the person never gets a chance to learn more effective strategies to manage their obsessions.

Psychoeducation

Unhelpful strategies to control obsessions

- Using these strategies also does not give the person a chance to find out whether the meaning or interpretation given to the obsession was really correct.
- These strategies produce the *opposite* effect the person wishes to achieve. That is, rather than the strategies helping you **control** the obsessions, they actually make them think about the obsessions even more!

Avoidance Maintains Problems

- Compulsions and avoidance are safety mechanisms that perpetuate OCD symptoms
- AVOIDANCE → Always maintains and strengthens the fear

The vicious cycle of OCD

Situation / Trigger

Obsession

Meaning given to the obsession

Anxiety

Behaviour / Action

Strategies used to cope with the obsessions (they are compulsions and other unhelpful behaviours)

Cognitive Therapy

- Identify and modify maladaptive automatic thoughts
- To modify, use questions such as:
 - What is the likelihood that will actually happen?
 - If it did happen, how bad would it be?
 - Is it something you can realistically prevent? (Control / responsibility issues)
- Examples:
 - “If I touch that doorknob, I’ll get sick and die.”
 - “The house will be robbed if I left the door unlocked.”
 - “I will get cancer from my radiation exposure.”
- Use written homework
 - Self-monitor the frightening thoughts and write them down
 - Write down the alternative, adaptive thoughts

CBT: Exposure & Response Prevention

- Patients are gradually exposed to anxiety-provoking stimuli while refraining (or prevented) from engaging in anxiety-reductive compulsive behaviors.
- Avoid providing the child with reassurance (e.g., you won't get sick) or accommodating anxiety driven behaviors (e.g., I'll open the door for you).
- CBT with exposure and response prevention (ERP) is the best established psychological treatment for OCD
- CBT (including ERP) is the main type of psychological treatment

(Abramowitz et al., 2005; Chambless et al., 1998)

CBT: Exposure & Response Prevention

1. Facing Fears – ERP

- Teaching a child or adolescent to gradually face their fears is one of the most effective ways to break the OCD cycle.
- Breaking the vicious cycle involves getting the child to understand their OCD better:
 - To face their fears, it is helpful for them to know that they are thinking (obsessions) and identify the triggers that bring on the obsessions and compulsions
 - This is best done by keeping track of the triggers on a daily basis for one week by using the obsessive fear monitoring form.
 - Because obsessions can happen frequently, writing down 3 triggers per day (i.e., one in the morning, one in the afternoon, and one in the evening) will be enough to give them a good overview of their obsessions and compulsions.
 - Teaching the child to gradually eliminate unhelpful coping strategies (such as compulsions or avoidance) and to learn
- New experiences allow for changes to the distress response so the child can have intrusive thoughts without feeling so upset.
 - Habituation
 - Learn situation was not dangerous

Example: Monitoring Form

Date	Triggers for Obsessions	Obsession	Fear (1-10)	Compulsions/ Coping Strategies
Jun 20	My pencil fell on the floor	This pencil is covered with germs from strangers. I could catch some terrible disease and pass it on to my family and friends	8	Scrubbed each finger carefully and washed for 3 minutes

CBT: Exposure & Response Prevention

2: Build a hierarchy (fear ladder)

- After about one week of tracking their obsessions and compulsions, the child should be ready to make a list of all the different situations that they fear.
- Get them to build a fear ladder by rank ordering the triggers from least scary to most scary. Get them to rate each trigger with personal subjective units of distress scale (SUDS). The ranking should be from least distressing to most distressing. For example, if a child has contamination fears, being at a friend's house may be a situation that is low on the fear ladder because it only evokes a fear of 1/10. But, using the bathroom in a shopping mall may be a situation that is very high on the ladder because it evokes a 9/10 fear.
- See **Examples of Fear Ladders** for some ideas about building your fear ladder.

CBT Case Example: Ordering / Symmetry / Exactness

- **Sample Hierarchy addressing Exactness:**

- Shave unevenly 100
- Read aloud without rereading (10 minutes) 95
- Comb hair only 10 strokes on one side, 20 on other 90
- Wear two slightly different socks 85
- Stretch right arm only 80
- Pull the car into driveway crookedly 70
- Rearrange items on desk randomly 65
- Leave bed unmade 60
- Leave clothing on the floor overnight 55
- Stack dishes “incorrectly” 45
- Leave books askew in shelf 35

CBT Case Examples: Ordering / Symmetry / Exactness

- Sub-hierarchy for Reading Aloud
 - Read aloud without rereading, alone (10 mins)
 - Read aloud without rereading, alone (5 mins)
 - Read aloud without rereading, in session (5 mins)
 - Read aloud without rereading, intentional variance in tone, alone (5 mins)
 - Read aloud without rereading, intentional variance in tone, in session (5 mins)
 - Read aloud without rereading, alone (one minute)
 - Read aloud without rereading, in session (one minute)
 - Read aloud without rereading, vary tone, alone (one minute)
 - Read aloud without rereading, vary tone, in session (one minute)
 - Read aloud without rereading, alone (one sentence)
 - Read aloud without rereading, in session (one sentence)
 - Read aloud without rereading, varying tone, alone (one sentence)
 - Read aloud without rereading, varying tone, in session (one sentence)

CBT Case Examples: Aggressive Thoughts / Images

- Sample Hierarchy for Aggressive Thoughts
 - Use large chopping knife with child nearby while allowing thoughts of stabbing child 100
 - Use small knife with child nearby 95
 - Imaginal exposure: stabbing child 90
 - Walk with child near the balcony at the mall 85
 - Stand near window on high floor with child 80
 - Play on sidewalk near street with child 75
 - Spend time alone playing with child at home 70
 - Imaginal exposure: slapping child 60
 - Spend time playing with child, spouse in next room 50
 - Hold child in lap, spouse nearby 35

CBT Case Examples: Checking

- Sample hierarchy for Doubting Obsessions with Checking Compulsions
 - Check appliances once before bed 100
 - Check door locks once before bed 95
 - Check appliances once before leaving house 90
 - Check door locks once before leaving house 85
 - Stop asking for reassurance from others 75
 - Proofread email only once 70
 - Do not look in mirror after leaving house 60
 - Do not reopen mail to be sent 50
 - Do not walk back to door to check lock 35

Exposure Hierarchy



- Make a OCD Thermometer (Subject Units of Distress Scale [SUDS])
- Create a list of events that cause rituals (easiest to hardest)
- Be creative and 'intense'
- Progress up that list slowly where the person does not engage in rituals.
- Tackle things one at a time.
- Don't leave the situation until anxiety drops.
- SUDS = Subjective Units of Distress (0-100 or 0-10)

CBT: Exposure & Response Prevention

3. Climbing the fear ladder

- Once the child has built a fear ladder, they are now ready to face their fears by putting themselves in situations that bring on their obsessions (*exposure*) while resisting doing anything to control the obsessions and the anxiety associated with them (*response prevention*).
- With support and modelling the child will confront each obsessions whilst abstaining from compulsions
 - Collaboration
 - Begin with in-session exposures
 - Gradually work to more difficult items
 - Between sessions, child practices these and related exercises at home

How to do exposure

- **Bottom up.** Start with the easiest item on the hierarchy (i.e., 2 / 10) first and work up
- **Track progress.** Ensure the child tracks their anxiety level throughout the exposure exercise in order to see the gradual decline in fear of a particular situation.
- **Don't avoid.** During exposure, try to stop the child from engaging in *subtle avoidance* (e.g., thinking about other things, talking to someone, touching the door knob only with one finger instead of the whole hand etc.). Avoidance actually makes it harder for the child to get over their fears in the long-term
- **Don't rush.** It is important to try to keep the child in the situation until their fear drops by at least one-half (e.g., from 6/10 to 3/10). Only focus on helping them overcome one fear at a time.

How to do Response Prevention

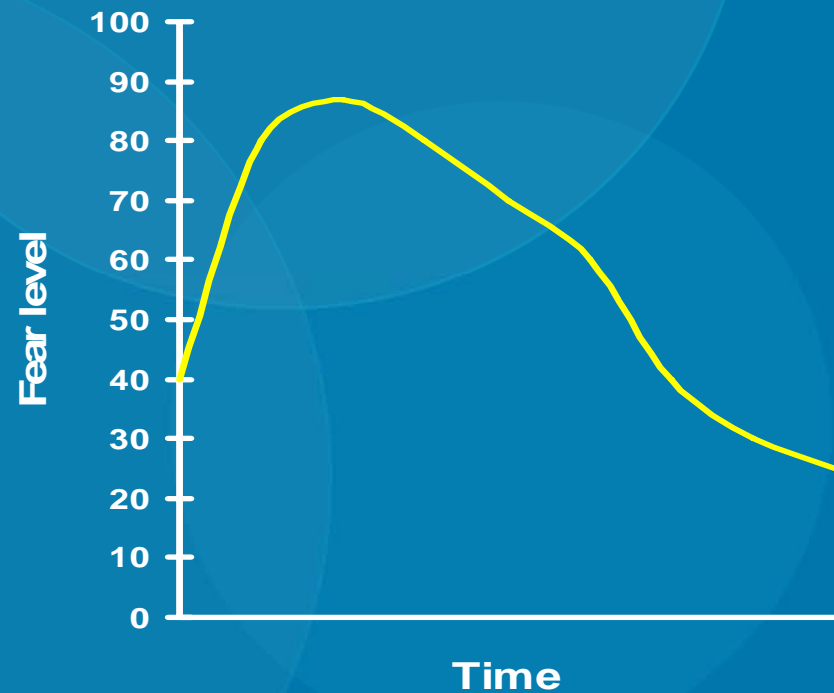
- **Resist the urge.** For exposure to work, it is important to help the child resist, as much as possible, carrying out their compulsions during or after the exposure. The whole point of ERP is to help the child learn to face their fear without having compulsions.
- **Modelling.** If the child has been performing compulsions for some time, it may be difficult for them to know how to face a feared situation without doing them. In this case, it can be helpful to show them how to. For example, wash hands quickly or leave home without rechecking appliances, and then model their behaviour.
- **Delaying and reducing ritualizing as an alternative.** If a child finds it difficult to resist a compulsion, try to help them delay acting on the compulsion rather than not doing it at all. Try to gradually prolong the delay so that eventually the child can resist the compulsion all together.

How to do Response Prevention

- **Re-exposure.** If the child ends up performing a compulsion, try to re-expose them to the same feared situation immediately, and repeat the practice until their fear drops by one-half.
- **How to move on.** Once the child experiences only a little anxiety when completing an exercise, help them move on to the next one. For example, after several practices they might feel very little anxiety when they wait 5 minutes to wash their hands after touching the floor. You can then challenge them to wait for 8 minutes before washing their hands after touching the floor. Again, get them to repeat this practice until their anxiety drops by one-half.

The Treatment of Fear

- **Exposure** to fear-eliciting stimuli or situations
- **Abstinence** from escape/avoidance behaviors
- Anxiety increases initially, followed by **habituation**



Adapting ERP for Children

- Make it fun and appealing
- Externalising OCD
- Metaphors / Fear Thermometer
- Ritual prevention is more gradual with children
- Cognitive Techniques are more useful and utilised

Family assessment and treatment

- Family functioning / relationships
- Environmental risk factors
- Level of support / supervision that can be provided
- Ensure that basic needs are met for the family
- Make referrals for their own treatment of mental health issues and/or relationship issues

Common Treatment Challenges

- Comorbidity
 - E.G., ADHD, Anxiety Disorders, Behavioural Disorders, Tic Disorders, developmental and/or cognitive deficits
- Developmental readiness, motivation, emotional overload
- Family reactions, effective participation in and support of treatment
- Access to evidence-based CBT for OCD!

Treatment Considerations

- Use of both medication and CBT results in a better outcome than use of either alone.
- Many patients with OCD are very secretive about their illness. Therefore, a detailed review of symptoms may be necessary.
- Many patients have somatic complaints (e.g., fatigue, pain, hypochondriacal symptoms, excessive worrying, chronic sadness). Thus, a comprehensive medical evaluation is essential to rule out any preexisting medical and psychiatric condition.

More Treatment Considerations

- The impact of OCD on interpersonal relationships, employment, marriage, and academic performance needs to be evaluated early in the diagnostic process.
- Coexisting psychiatric conditions (e.g., major depression, panic disorder, phobias, eating disorders) should be treated along with OCD.
- Although obsessive symptoms can be reduced with medications, the interpersonal relationships, social skills, work habits, and ability to resist compulsions require a comprehensive treatment plan that involves several aspects of each patient's life.

Treatment Summary

Implementation for clinicians

Diagnosis:

- Increase your awareness and recognition of symptoms of OCD - be aware of those at higher risk and how difficult initial disclosure is for many people with OCD
- Ask the 'right' questions – assessment

Treatment:

- Involve patients and when appropriate, family/carers, fully in treatment options
- Offer CBT (including ERP)
- Ensure other comorbid disorders are also treated
- If pharmacological treatment is required, regularly monitor side effects of SSRIs (self-harm and suicide)

Treatment Summary

- Early recognition, diagnosis and effective treatment
- Information about the nature of OCD and treatment options
- Respect and understanding
- What to do in case of relapse
- Information about support groups
- Awareness of family/carer needs

Conclusions

- Identification of OCD is challenging, yet the key to best practice and effective management
- OCD can be effectively treated
- First line intervention is CBT alone or Combined Treatment (CBT + SSRI)
- Pursue early evidence-based intervention to prevent chronic and debilitating course
- Recommended reading:
 - *“The Boy Who Couldn’t Stop Washing”* by Judith Rapoport
 - *“OCD in Children and Adolescents”* by March & Mullen

That's ALL!

