

Recognising and treating obsessive compulsive disorder in children and adolescents

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Luke,* 7 years old, must do and touch things in a certain way (eg. he has to kiss and say goodnight to every family member in a specific order and do this three times every night). He believes that if he does not do this, something horrible will happen to his family (eg. they will die by the next morning or have a car accident when he's at school).

In addition, he avoids contact with most people because he fears he may become 'contaminated' by their 'germs'. He avoids strangers and sharing items at school and showers when he comes home from school.

He also insists his school clothes are washed daily and the family wash immediately upon entering the house. He screams and cries and cannot be consoled if they do not comply. It often takes him two or three times as long as it should to complete tasks because he hesitates and/or re-does something until he 'gets it right'.

His obsessive compulsive disorder (OCD) interferes with his sleep, ability to get ready for school on time, concentration, homework, family meals and friendships.

* Fictional name

Childhood OCD presents as it does in adulthood, with recurrent, intrusive, distressing obsessions (thoughts, urges, mental images) that may be perceived as senseless and cause significant distress and anxiety when resisted. Compulsions are repetitive behavioural rituals (eg. washing, checking, avoiding, hoarding) or mental actions (eg. counting, silently repeating certain words, praying) performed in an attempt to 'neutralise' the obsessions; they serve to reduce the distress and anxiety but are simultaneously experienced with a sense of urgency and pressure; they are sometimes not realistically connected to what they are designed to neutralise or prevent.

In about one-third of all OCD cases, onset is in childhood or adolescence (aged 5–15 years). Obsessive compulsive disorder can seriously affect a child's life, interfering with family and social relationships, as well as academic achievement. Obsessive compulsive disorder takes time and energy and can make daily life very stressful for children, who often feel shame and embarrassment.

Obsessive compulsive disorder is sometimes accompanied by comorbid disorders including depression, tics, or other anxiety disorders. Its course is typically chronic, waxing and waning over time, re-presenting at times of stress, fatigue or physical illness; although early recognition and treatment can sometimes lead to a near or total attenuation of symptoms for one-third of patients. Current evidence strongly implicates an imbalance of serotonin in the brain and familial/genetic contributions.

First line treatment is cognitive behaviour therapy (CBT), with or without medication. Cognitive behaviour therapy, specifically the form known as Exposure and Response Prevention (E+RP), is the only psychotherapy with sound empirical evidence in OCD. E+RP involves exposing the child to their feared situations without performing their usual neutralising rituals. This is highly specialised therapy and works best with a specially trained clinician and when the child's family is involved. When symptoms re-occur, CBT 'booster' sessions can be very effective.

Where medication is required, there is evidence from double blind studies that the selective serotonin reuptake inhibitors, fluvoxamine and sertraline, and the tricyclic antidepressant, clomipramine, are effective. Patients may not experience symptom relief until 6–12 weeks after commencing therapy, and initial worsening of their OCD symptoms or adverse effects may occur. Treatment is thus usually instigated in consultation with a child and adolescent psychiatrist.