Pediatric OCD Treatment: Advanced OCD Therapists

Objectives

By the end of the presentation, participants will be able to:

- Identify two evidence based tools and one strategy for assessing OCD symptoms in children.
- Differentiate OCD from at least two other disorders.
- Identify 3 evidence-based treatment approaches for OCD.
- Discuss medication management and collaboration with psychiatrists
- Learn strategies for working with families and schools

Part 1: OCD - Beyond the Basics

- Assessment
  - CYBOCS
  - CHOCI
  - FAS
- Within OCD
  - BDD
  - BFRB's
  - Tourettic OCD (just right/completeness vs "true" tourettes)
- Differential diagnosis/Comorbidities
  - ARFID and eating disorders
  - ASD
  - ADHD
  - Trauma
  - PANS/PANDAS

Assessment

- Children's Yale - Brown Obsessive Compulsive Scale (CY-BOCSII)
  - Clinician - administered scale to assess severity of OCD symptoms in children
  - Questionnaire is structured to explore the severity and impact of obsessions and compulsions
  - Parent involvement is often needed as insight may be limited on child's end (due to severity of symptoms and/or age)
- CHOCI (Children's Obsessive Compulsion Inventory)
  - Self - report measure to assess the presence and severity of obsessions and compulsions
  - Due to child's insight, other input may still be needed
- Family Accommodation Scale for OCD (FAS-OC)
  - Measures extent of family accommodation for OCD symptoms
  - Helps for understanding how family dynamics influence symptoms
  - Ask parents to log accommodations to watch for patterns

Strategies for Assessment

- Children don't always understand the motivation behind their behaviors.
- Assessment may need to be ongoing in order to determine if OCD is present. (Don't expect to have it all figured out after the first session)
- Observations and parent input are key to assessment
- Play based assessment can also be helpful, watching if the child washes their hands or avoids touching puzzle pieces for example
- Understanding the impact of family, school, and social circle will also illustrate the severity of illness

Strategies for Assessment Continued….

When assessing, tailor questions so that kids can understand easier

- Moral Scrupulosity: “Do you worry about having bad thoughts at school?”
- Contamination: “Do you worry about getting sick?”
- Harm: “Are there different rules you have to follow to keep everyone safe?”
- Avoidance: “Are there places that you get really upset when you have to go there?”
- Hoarding: Use pictures - which one is trash?

Within OCD

- BDD
- BFRBs
- Tourettic OCD (just right/completeness vs “true” tourettes)

BDD

International OCD Foundation | Disorders Related to OCD

People with BDD and people with OCD both:

- Do repetitive checking.

People with BDD:

- Have checking behaviors and obsessions that only focus on their body or the way they look. Are very likely to seek cosmetic surgery.

People with OCD:

- Do not usually have thoughts or behaviors that focus on the way they look.

BFRBs

International OCD Foundation | Disorders Related to OCD

Body Focused Repetitive Behaviors (BFRBs) (TRICHOTILLOMANIA / HAIR-PULLING DISORDER AND SKIN-PICKING / DERMOTILLOMANIA / EXCORIATION DISORDER)	People with BFRBs and people with OCD both:	People with BFRBs:
	▪ Do repetitive behaviors. ▪ Do repetitive behaviors in response to feeling uncomfortable.	▪ Get a good feeling from pulling out their body hair or picking at skin; some use it to relieve stress. ▪ Respond better to habit reversal and to different medicines then people with OCD. **People with OCD:** ▪ Repeat their behaviors to get away from bad feelings like anxiety.

Differential Diagnosis Example

- “Just right” OCD vs Tourettic OCD vs Tourette Syndrome

	“Just Right OCD”	Tourettic OCD	Tourette Syndrome
Urge or involuntary movement/vocalization (without an obsession present)	Intrusive thought or feeling about “incompleteness”	Combo obsession and urge	Urge without obsession being present
Purpose of behavior	Relieve discomfort	Relieve discomfort of thought and urge	Relieve the sensory discomfort
Is Control Present?	Yes, fully voluntary	Semi-voluntary	No, completely involuntary
Treatment	ERP	ERP & teach awareness of premonitory urges to replace tics with less noticeable responses	CBIT

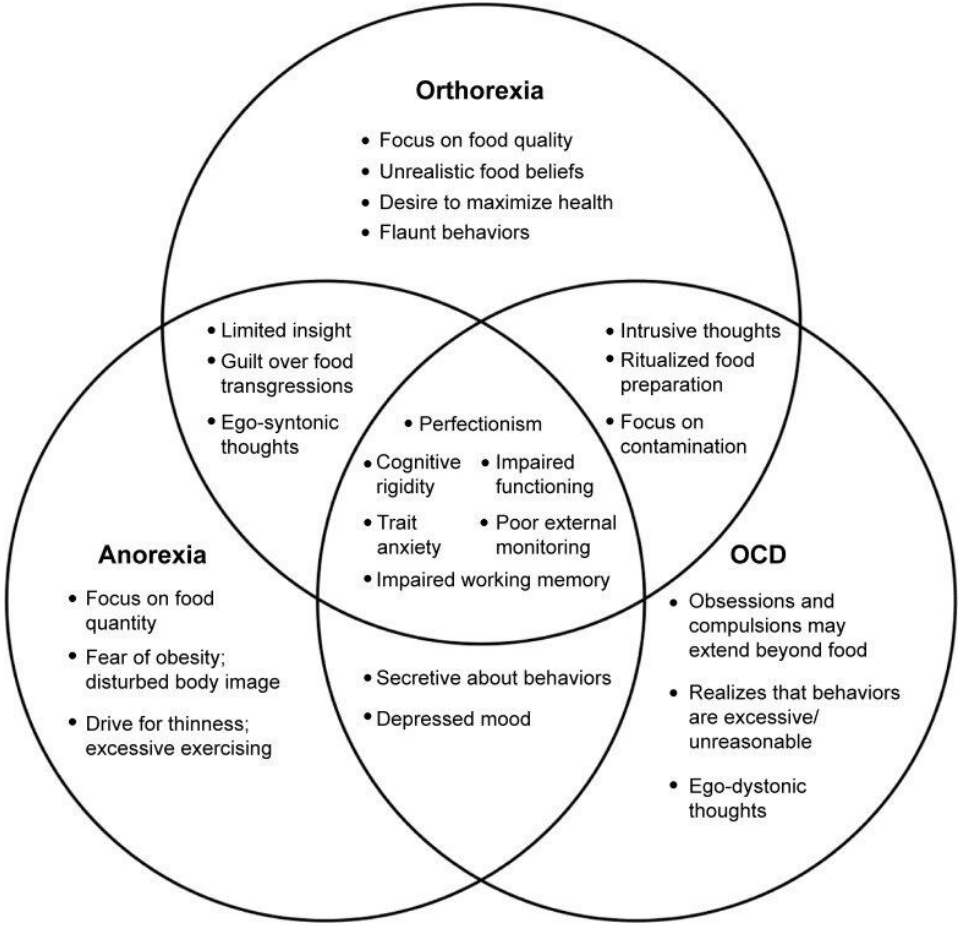
Differential Diagnosis and Comorbidities

- ARFID and eating disorders
- ASD
- ADHD
- Trauma or PTSD
- PANS/PANDAS

Differential Diagnosis Example

- ARFID vs Eating Disorders vs OCD

	ARFID	Eating Disorders	OCD
Trigger	Sensory sensitivities, fear of choking	Preoccupation with weight and appearance	Intrusive thoughts about contamination, moral themes, etc
Purpose of behavior	Relieve discomfort	Achieve or maintain weight goals/ body shape goals	Reduce anxiety from obsessions
Compulsion	Avoidance, limit to “safe foods”	Restrictive eating, binging, purging, excessive exercise	Handwashing, checking, counting



Venn diagram showing unique and overlapping features of orthorexia... | Download Scientific Diagram

ASD

Autism Spectrum Disorder (ASD):

Rigidity: compulsions may take the form of a bedtime routine or specific behaviors that need to be followed the same way each time.

Repetitive behaviors: compulsions may need to be repeated until they're "just right" or a certain number of times

Ex: Matt is an 10-year-old boy who was referred to therapy due to suspected ASD. Matt's external behaviors include the following: arranging items on his desk in an "exact" manner, organizing his legos by color when he has free time, following a strict routine prior to eating, going to bed, and going to school. These behaviors cause difficulty for Matt to concentrate at school. At home, his parents accommodate the behaviors. Matt spends most time alone in his room organizing things by size and color.

- Observed behaviors may appear consistent with typical ASD behaviors. However, Matt reported excessive fear about things not being "just right". Since the function of the behavior was aimed at *reducing anxiety* caused by the obsessions, Matt would benefit from ERP therapy.

ADHD

Attention Deficit Hyperactivity Disorder (ADHD):

Difficulty focusing: a child with OCD may be focused on obsessions and not be able to focus on schoolwork

Agitation/ restlessness: a child who's unable to complete compulsions can appear agitated or may not be able to sit still

Ex: Clara is a 12-year-old girl who has counting compulsions. When at school, Clara has trouble focusing and is preoccupied with counting the number of words the teacher says. If Clara loses her place, she feels very uncomfortable and wants to escape the situation. She gets angry if the teacher tries to interrupt her counting compulsion.

- Observed behaviors may appear consistent with typical ADHD behaviors. However, Clara's inability to focus is easier to understand once the counting compulsion has been discovered.

PTSD

Post Traumatic Stress Disorder (PTSD):

Intrusive Thoughts: PTSD often has intrusive thoughts tied to a traumatic event rather than following a theme (contamination, harm, etc)

Avoidance: can appear like a compulsion due to avoiding triggers of the event

Ex: Evan in a 17-year-old boy who avoids driving with his friends. Earlier in the school year, a classmate died in a car accident. Evan and his peers all had a difficult time processing the event. Prior to this, Evan still didn't like driving with his peers. Evan is meticulous about keeping his car clean and believes that his friends are "gross". Evan gets disgusted easily if his friends eat in his car or track mud into his car.

- Observed behaviors may appear consistent with typical avoidance behaviors associated with a traumatic event. However, Evan's need to keep his car immaculate is more on par with OCD behaviors.

PANS/PANDAS

- Sudden onset or dramatic increase of compulsive behavior and/or anxiety following an illness (commonly Strep Throat, Lyme Disease, Sinus Infection, and COVID)
- Separation anxiety as a common symptom
- IOCDF resource: https://kids.iocdf.org/professionals/md/ocd-or-pandas/

Is it OCD or is it PANDAS/PANS?

International OCD Foundation

If you have a patient presenting with repetitive behaviors and chronic anxiety, it may be Obsessive Compulsive Disorder (OCD) or it may be a subtype of OCD: ***Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcus* (PANDAS)/*Pediatric Acute-Onset Neuropsychiatric Syndrome* (PANS)**. There are recognizable differences between these conditions:

	PEDIATRIC OCD	PANDAS/PANS	
AGE	Typically see first onset between 8–12 years old.	Typically affects children between 4–14 years old.	
TIMELINE	Subclinical symptoms become gradually more severe over time.	Acute, dramatic onset of symptoms.	
SYMPTOMS	Patient may experience a wide range of symptoms, cycling between obsessions that cause anxiety, and compulsions to reduce it. Common obsessions may include fears of contamination; pathological doubt; unwanted thoughts and/or images of an aggressive, religious, or sexual nature; or the need for symmetry. Common compulsions may involve excessive checking, washing and/or cleaning, or reassurance seeking; or counting, ordering, or arranging things.	Sudden, rapid-onset of obsessive-compulsive behavior, as well as possible movement and behavioral abnormalities, including: • Severe separation anxiety • Anorexia or disordered eating • Urinary frequency • Tics and/or purposeless motor movements • Acute handwriting difficulty	
CAUSE	There is a probable familial/genetic link and possible involvement of the cortico-striato-pallidothalamic (CSPT) pathway. Chronic avoidance of anxiety-producing stimuli is also seen as a contributing factor.	**PANDAS:** Hypothesized to be the result of autoimmune antibodies mistakenly attacking the basal ganglia in the brain following a *Streptococcus pyogenes* (Group A Strep) infection.	**PANS:** Hypothesized to be the result of autoimmune antibodies mistakenly attacking the basal ganglia in the brain, following an infection such as mycoplasma, mononucleosis, Lyme, and H1N1.

Case Example: Max and PANS/PANDAS

- Presenting symptoms:
  - School refusal, intense emotional response, will not go in the school building
  - Avoids playdates
  - Sitting on the bench at hockey practice, crying before and during
  - Strict rules for when and where mom and dad can go and for how long
- Sudden onset, “overnight” following a strep throat infection
- Previously very outgoing, extroverted child
- Participated in intensive outpatient treatment, symptoms would “flare” and increase when he had a cold or other illness

Part 2: Treatment

- ERP refresher
  - Delivering psychoed to various developmental stages
  - Differentiating fear ladders
  - Information seeking vs reassurance seeking
- Treatment buy in and readiness
  - Rapport and pacing with focus on child as the client
- Adjunctive therapies
  - ICBT
  - Behavioral (external motivators, token economies)
  - ACT
- Parents
- School
- TIB's
- When to recommend residential/hloc/family based
- Neuropsych and ADOS (separate assessments and how to refer)

ERP Refresher

ERP stands for Exposure and Response Prevention. ERP is the “gold standard” for treating OCD.

- Exposure involves gradual exposure to feared trigger
- Response prevention involves resisting the urge to complete the compulsion
- ERP is done in a process of starting with least anxiety provoking exposures and gradually increasing tolerance

Psycho-Ed by Age

Young Children: use comparisons to help understand (boss or worry monster), encourage labeling OCD to separate it, teach children to learn the OCD tricks

Preteens: focus more on the cycle of OCD and how the compulsions only offer temporary relief

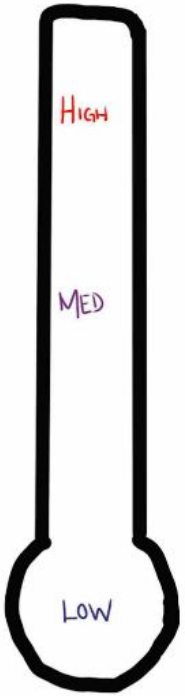
Teens: focus on how OCD impacts their life (school, friendships, etc) to empower them in treatment to take back control

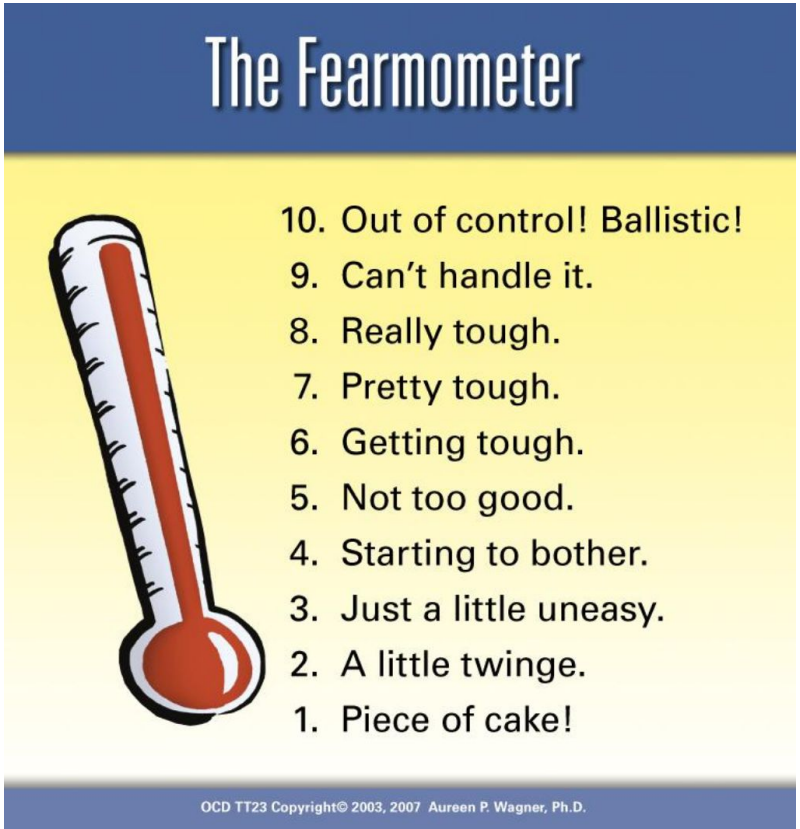
Family Involvement: Typically needed across the age spectrum

Explaining OCD to Kids

Fear Ladders

- Can be tailored to fit the age of the client
- Low/Medium/High or Easy/Hard can be used in place of numbers





Reassurance Seeking

An information seeker…	**A reassurance seeker…**
Asks a question once	Asks the same question over and over again.
Asks a question because they are curious	Asks a question to feel less anxious about something
Is happy with the answer	Will argue about the answer, or insist that it be repeated or changed.
Asks someone who can provide the best answer (for example, an expert on the topic)	Often asks people who can't answer the question (who are not experts on the topic)
Asks questions that are answerable	Often asks questions that can't be answered
Seeks the truth	Seeks a desired answer
Can accept uncertain answers ("maybe's" or "probably's")	Needs absolute, definitive answers
After getting the answer, can make a decision or draw a conclusion and move on	Continues to pursue information without ever making a decision or forming a conclusion

Reassurance Examples

Straightforward Questions:

“Someone at my lunch table left early because they were sick. Will I get sick?”

“Did I wash my hands enough?”

“Did I do this the right way?

Statements:

“I think I did it the right way.”

“I guess that’s not dangerous, though.”

“I think I don’t need to wash my hands again.”

Reassurance, Cont'd.

Indirect Reassurance:

- Showing a parent an assignment or drawing while waiting for praise or reassurance that they did it right
- Looking at a parent's facial expression when performing a task to see if they're doing it correctly

Helpful Tools for ERP

- Boss Backs provide a non-engagement response type of language to help kids stand up to OCD.
  - Ex: write OCD fears on note cards vs boss backs on the others. The child can practice saying the boss backs to OCD
- Use toys, games, or drawings to make exposures less intimidating.
  - Ex: draw OCD monsters and defeat them with ERP superpowers, role play bossing back OCD
- Use humor
  - Give silly nicknames to OCD thoughts, say OCD fears in funny voices

Treatment Buy In/Readiness

- Pacing and focus on child as the client
- In order to motivate children to engage in ERP, rapport is essential
- **Let them be the expert**: ask them to teach you about their OCD
- **What's in it for them?:** make sure you set goals together and find out what they would like to get out of treatment
- **Play/Creativity:** Use games, crafts, drawing to make exposures less intimidating
- **Celebrate Wins:** offer stickers or let the client choose a game to play at the end of the session to celebrate completing exposures

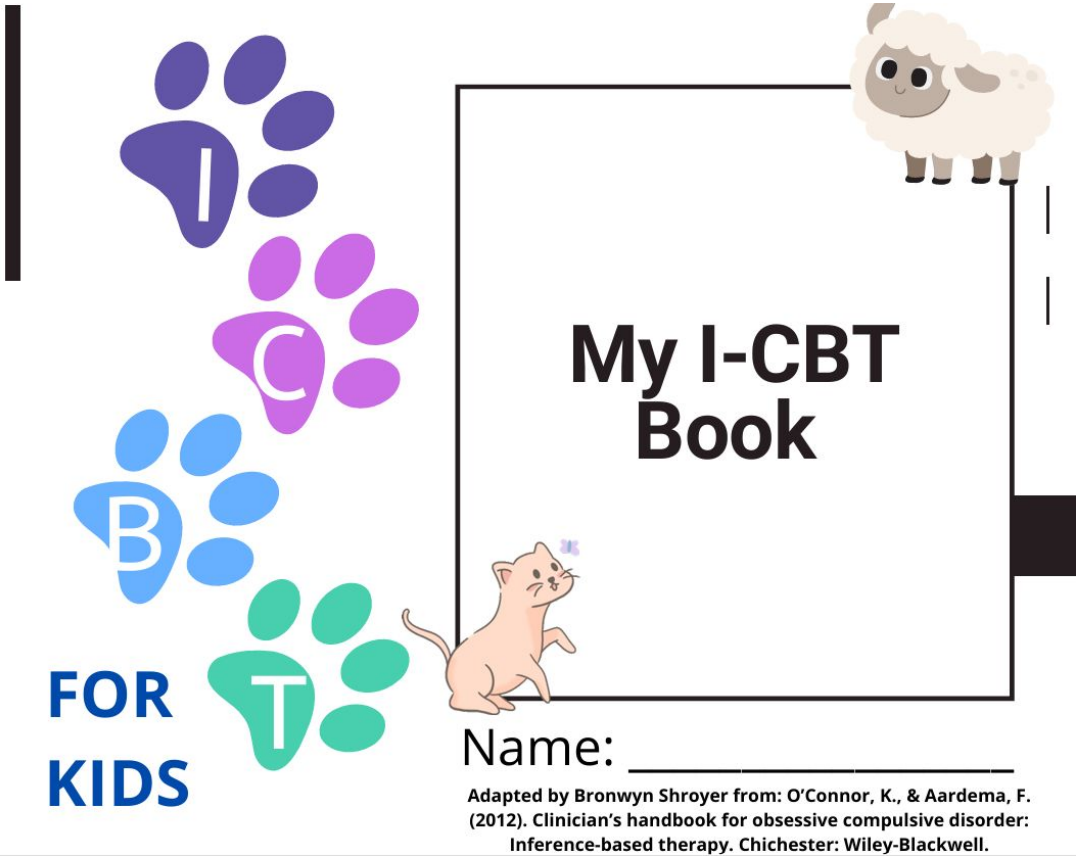
Case Example: Megan and Treatment Motivation

- Main symptom is emetophobia
  - Onset was actual event (food poisoning at a restaurant and getting sick in a hotel)
  - Developed into avoidance of most foods (fear of getting sick), avoidance leaving the home (fear of getting sick away from mom and dad)
  - Was hospitalized for malnutrition, participated in an IOP that was not OCD specific (targeted anxiety and coping skills), discharged back to OCD outpatient
- Treatment motivation for outpatient OCD/ERP
  - Started with preferred activities (outings to stores) paired with rewards (buying an item in the store), moved up to more challenging but still preferred (restaurants with preferred foods)
- Treatment barrier: beginning to work on non-preferreds i.e. taking the bus, eating in the school cafeteria:
  - Used control/forced choices with slow decrease of accommodations and rewards:
    - “Mom and dad expect you to take the bus home at least 1 day per week. You can pick the day though, let’s figure out which one works best”.

Adjunctive Therapies

ICBT (Inference Based Cognitive Behavioral Therapy)

- Focuses on challenging inferences (reasoning process) that fuels OCD, rather than the obsessions and compulsions. It addresses how kids interpret situations when their thinking shifts to the “OCD Story”
  - Use understandable language - “OCD story”, “trick”
  - Draw the OCD story
  - Find the thinking traps
  - Build confidence with reality testing



Therapy Materials for Kids – Inference-based Cognitive-Behavorial Therapy

ACT

Acceptance and Commitment Therapy

- Helps kids learn to accept thoughts and feelings without trying to control them or get rid of them
- Looks at values and teaches kids to choose actions based on values
- Helps increase psychological flexibility and decreases shame

ACT Continued

Defusion takes the power out of thoughts.

- Ex: leaves on the stream. The child can imagine placing thoughts on a leaf and watch it float away. Can be done concretely by cutting out leaves and making a paper stream

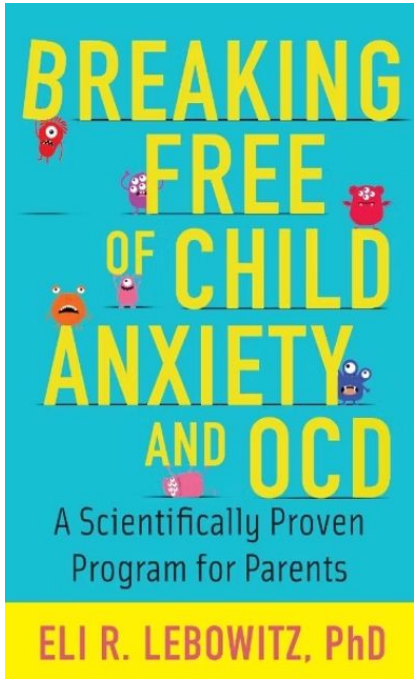
Values helps the child understand what's important to them and commit to actions that reflect their values rather than what OCD says. Clarifying values helps the child learn that their thoughts don't define them.

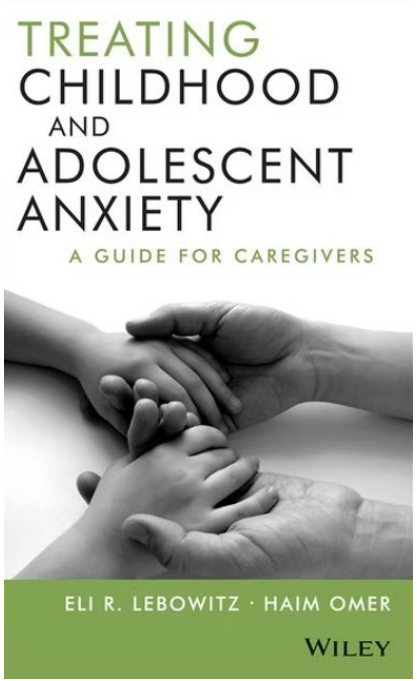
- Ex: playing a board game with friends despite the fear of contamination.

Parents

- Working with parents
  - External motivators (and how to handle the parents who don’t want to do that) - explain parents are normally the ones bringing kids and how motivators can help - earn points for exposures. Start with preferred activities then to non-preferred over time.
  - SPACE (Supportive Parenting for Anxious Childhood Emotions) to manage their own anxieties and expectations. Parents are the client, not the child. Focuses on parent responses and reducing accommodations.
  - Confidentiality - review limits with what can be shared so that parents understand the expectations
  - Safety planning (intrusive harm thoughts vs mood congruent SI; SIB as a ritual)
  - Train parents to reduce accommodations
  - Collaborate on external motivators like token economies
  - Clarify roles and responsibilities in supporting child but not dictating tx

Resources for Parents





School

- Dealing with schools and IEPS
  - Address OCD's impact on learning and participation
  - Address school avoidance
  - How to coach parents to request an evaluation for an IEP or 504 plan
  - Adjusting existing IEP goals for anxiety when goal is return to school
    - Get releases for the school (counselor, school psychologist etc)
    - Attend IEP meetings if able
    - Providing psychoeducation to schools on OCD and pace of treatment
      - Many without understanding of OCD see this as behavioral/refusal
    - Knowing what resources are in your client's district or school
      - Each district has different resources and abilities to accommodate/provide support
      - I.e. not every district has a different emotional support classroom vs a life skills classroom
    - Additional resources at: Anxiety In The Classroom | School Anxiety | Free Resources

Basics of Medication/Collaboration with Psychiatrists

Navigating difficulties with medication compliance related to OCD

- Severity dose response

OCD tends to respond to higher doses of SSRI medications:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2888928/

- Contamination fears - chemicals, it being tampered with, fear of overdosing etc
- Magical thinking/numbers (difficulty going up to a dose that has the feared number i.e jumping from 40mg to 60mg)
- Side effects and health anxiety/compulsions

TIB's

- Parents
  - Providing reassurance (ex: "your hands are clean, please stop washing them and come eat dinner!")
  - Avoiding activities that trigger OCD (ex: switching to virtual school options to avoid contamination triggers)
  - Accommodating (ex: buying extra soap, doing extra loads of laundry)
- Exposures around already non-preferred tasks
  - Hygiene, school, homework
  - It's important to watch for avoidance in this area due to potentially worsening OCD symptoms
  - Rewards are helpful in this area because kids don't have motivation to begin with when it comes to non-preferred tasks.

Severity and Levels of Care

Severity/ Interference with Functioning

- Severe symptoms that cause the patient engaging in OCD behaviors for hours out of the day and interfere with work, school, and relationships
- Little to no progress is made with outpatient therapy or medications

Treatment Resistance

- The child hasn’t started to get better with ERP and medication
- The child can’t fully engage due to severity of symptoms

When to Refer

Risk Factors

- Safety concerns (SI, SIB)
- Medical risk due to compulsions (ex: malnutrition from not eating enough due to ARFID)

Comorbidity

- Co-occuring mental health diagnoses that complicate treatment

Where to Refer

Visit IOCDF for updated directory link: Clinics & Programs Archive | International OCD Foundation

McLean - OCD Institute at McLean Hospital - A Center for Children & Adults

Rogers - Behavioral Health & Recovery Services – Rogers Behavioral Health

Neuropsychological Tools

- ADOS - separate assessment for ASD
- Know that you need to ask for ADOS, go to psychologist (therapists aren't ethically allowed, formal evaluation is needed by a psychologist) formal process. Refer out.
- How to refer - Hope Learning Center, Watson Institute, Center for Autism and Developmental Disorders, Wesley Family Services
- CADD Child and Adolescent Outpatient Clinic
- Neuropsych picture, IQ scale, social functioning vs ADOS psychologist trained
- Ask if psychologist is trained in it

Questions

References

https://www.spacetreatment.net/CE Treatment

https://anxietyintheclassroom.org/

https://pmc.ncbi.nlm.nih.gov/articles/PMC2888928/isorder - PMC

https://iocdf.org/expert-opinions/expert-opinion-measuring-oc-symptoms/

https://www.researchgate.net/figure/Venn-diagram-showing-unique-and-overlapping-features-of-orthorexia-nervosa-anorexia_fig1_273156296

https://iocdf.org/about-ocd/related-disorders/

https://icbt.online/materials-for-kids/

https://tourette.org/

https://www.nationaleatingdisorders.org/

https://iocdf.org/autism/treatment/

https://www.verywellhealth.com/ocd-and-adhd-co-occurrence-and-diagnosis-5208849

https://pubmed.ncbi.nlm.nih.gov/38452939/curring PTSD in intensive OCD treatment: Impact on treatment trajectory vs. response - PubMed

https://kids.iocdf.org/professionals/md/ocd-or-pandas/

https://sunshineacademy.sunshine-support.org/course/identifying-and-supporting-children-and-young-people-with-pans-pandas

Wagner, S. (2007). *Treatment of OCD in Children and Adolescents: Teaching Tools Explanded (2nd ed.).* Lighthouse Press Inc.

Contact Information

- The Center for OCD and Anxiety: www.pittsburghocdtreatment.com
- Ashley Montrenes, LCSW — ashley@pittsburghocdtreatment.com
- Olivia Wolfe, LPC — olivia@pittsburghocdtreatment.com