Pediatric OCD Treatment: General/Non-ERP Therapists

The Center for OCD and Anxiety
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Objectives

Participants will be able to:

- Identify and describe the diagnostic criteria for OCD according to the DSM
- Identify at least 3 common manifestations of OCD symptoms in the pediatric population
- Describe 2 ways to apply and differentiate Exposure and Response prevention therapy to the pediatric population
- Identify at least 3 differential diagnoses common in the pediatric population

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- Review of OCD and Diagnostic Criteria
- Assessment and Identification in the Pediatric Population
  - Common themes and symptom presentation
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- Treatment
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  - Modifications and considerations for the pediatric population
- Working with Parents and Schools
- Common Differential Diagnoses
- Referral Resources

Brief Overview of OCD

- Obsessions:
  - An obsession is an unwanted experience:
    - Thought (statement, “what if?”), imagery, “movie playing”
    - Pulled into the imagination: “feeling” like something is really happening
    - Tunnel vision: completely fixated on the concern and unable to see the big picture
    - Intense emotion: at risk, in danger, a feeling of gloom, depressed, angry, panicked
    - Somatic symptoms: dizziness, decreased mental and sensory functions, nausea, arousal
    - Uncertainty and doubt: fears of never being able to be sure and disprove the thought

  - It is important to remember that the unwanted part of this “experience” is usually the mental/internal aspects; the trigger itself is usually an everyday occurrence

- Compulsions:
  - Anything that becomes a repetitive strategy of neutralizing and avoiding the intense uncomfortable experience of an obsession is a compulsion
  - Physical/Verbal examples:
    - tic like movements (blinking, shifting, vocalizations), arranging, re-doing, checking, washing, researching, asking for reassurance, avoiding/refusing to go places
  - Mental examples:
    - blocking thoughts, zoning out, arguing with thoughts, counting, repeating statements, praying
  - Function is creating the 'illusion of control' for the client around the anxiety
    - "If I do ABC, then XYZ won't happen"
    - "XYZ will happen because ABC happened, so I need to do EFG"
  - The compulsion does NOT need to logically follow the obsession (e.g. the obsession may be fear of harm coming to someone else and the compulsion could be washing one's hands)

DSM V/ICD-10 Diagnostic Criteria

- https://www.ncbi.nlm.nih.gov/books/NBK56452/
- Key reminder: DSM-5 requires the following for diagnosis:
  - Presence of obsessions, compulsions, or both
  - Time - consuming interference
  - Not attributable to substance or medical condition
  - Not better explained by another mental health disorder

Assessment/Identification in Pediatric Population

- Common “themes”/presentations in peds population:
  - Contamination
  - Emetophobia
  - Separation anxiety
  - School avoidance
  - Just right/symmetry
  - Perfectionism

Common Symptom Presentations

- Avoidance of school, social activities, turning in assignments
- Asking the same question or making a statement repeatedly for reassurance
- Behavior issues, outbursts, rage
- Isolation
- Difficulty making a decision

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

Spotting Sneaky Reassurance

- Considerations for age
  - Younger children naturally need taught more/lack more common sense experiences and information about the world
  - Identifying reassurance as something repeated or mis-applied
- A child may say something as a statement rather than a question and see if it gets a response
  - “I think I was just cheating in that game” (moral/”being bad” OCD)
  - “Someone at my lunch table left early because they were sick” (contamination OCD)
- Proximity/physical reassurance
  - Simple presence of a preferred person or object (parent, cell phone)

Case Example: Amy and Reassurance

- Amy's OCD themes: contamination, harm, and "being mean"
- Contamination:
  - "Is that safe to eat?"
  - "Can I wash my hands first?"
- Harm:
  - "Someone is going to get mad and hurt us."
  - "What if something happens to my brother and I'm not there?"
- Being mean/bad
  - "Was that okay?"
  - "I'm afraid someone is going to get in trouble now."

Treatment

- Basics of ERP
  - Scaling exposures
  - Being comfortable with purposefully inviting discomfort into sessions
- Contraindications for OCD
  - Teaching to therapize backwards
  - Avoiding reassurance
  - Being comfortable with discussing “taboo” topics/intrusive thought content
- Harm/SI
  - Assessing for mood congruent vs intrusive and distressing

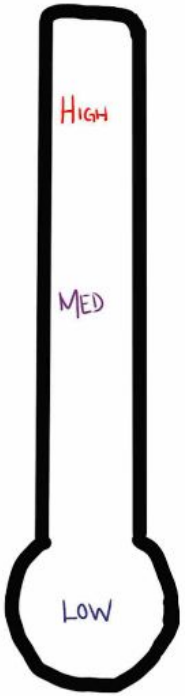
Overview of Exposure and Response Prevention (ERP)

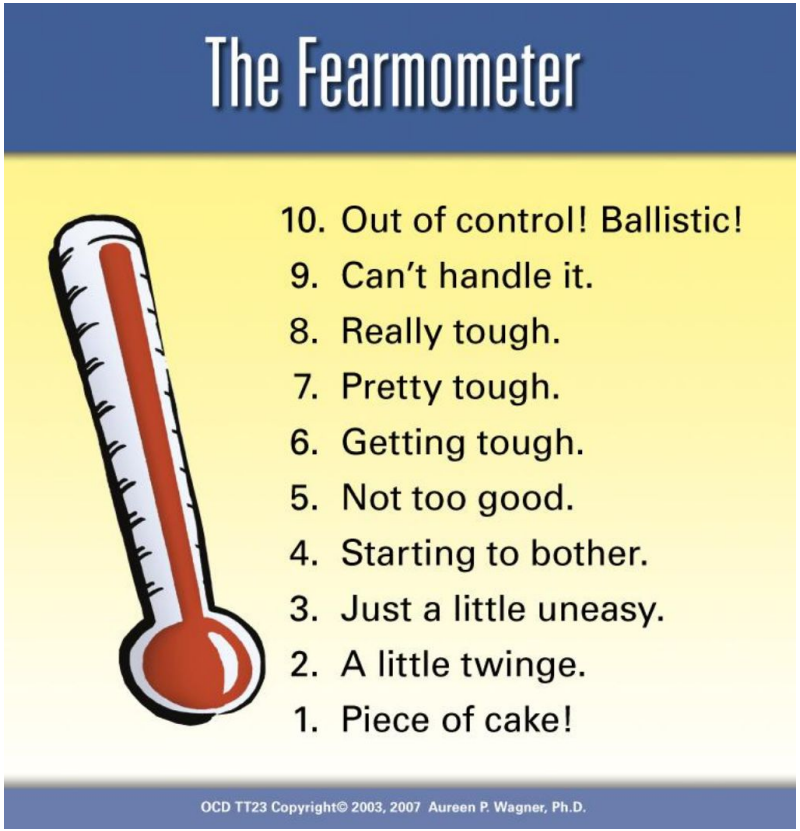
- Exposure with Response Prevention (ERP or EXRP) is based on the idea repeated exposure to the anxiety trigger and a change in the ritual response will lead to habituation either within the exposure or over time

- Inhibitory Learning Model is based on the idea that the trigger may always be present and habituation may not occur, but the ritual can be reduced/eliminated

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





Sample Fear Ladder: Contamination

EXPOSURE:	**CHILD LABELED AS:**
Open my own snack and eat one piece without washing or sanitizing	High
Touch an object then touch my cheek without washing or sanitizing	High
Limit hand washing to a timer of 2 minutes	Medium
Use hand sanitizer instead of washing hands before eating one snack	Medium

Motivation for ERP

- Kids may need more motivation for treatment because it's often the distressed parent that's bringing the child to treatment
- Reward systems can help
  - Sticker chart/token economy where the child earns a sticker for completing an exposure or "challenge", after 10 stickers they can do something fun in session or with family
- Motivational activities (what will be different without OCD?)
  - Ex: a client who's OCD makes them chew each bite 30 times to avoid choking writes a story about eating pizza at a birthday party without OCD
- Tracking progress
- Starting with getting back to preferred activities (sports, friends) then moving up the ladder to non-preferreds (school, chores)

Taboo Topics in OCD and Harm/SI

- Mood congruent SI
  - Presents as typically does in mood disorders
  - Low, depressed mood
  - Low motivation
  - Little presentation of anxiety or fear around the topic
  - Engage in assessment (Columbia screening) and safety planning
- Intrusive thoughts of suicide/self-harm and or harm to others
  - Cutting my fingers off with a knife while cutting food at dinner
  - Taking family weapon and shooting themself
  - Pushing someone down when they make me mad
  - Adolescent who fears getting driver's license due to thoughts of crashing the car
  - Intrusive thoughts of harming animals
- *Intrusive harm thoughts are distressing & may not be communicated by the child due to fears of getting in trouble or that this fear may become "real" if shared*

Case Example: Suicidal Statements in OCD

- Sam is a 10 year old who attends public school. He gets great grades but has a lot of anxiety in the mornings before school and has started to refuse to practice his instrument at home and complains of stomach aches before every baseball practice
- Sam frequently states, “I should just die” and “I don’t deserve to be alive”
- Parents share at the intake that Sam will make the same statements at home when he believes he did something wrong
- How would you assess?
    - What symptoms do you notice that may point to OCD?
    - How would you assess comprehensively for suicidality?

Parents and Schools

- School avoidance and/or excessive concern with school performance (perfectionism) are common signs of OCD for children and frequent drivers of referrals to therapy
- If symptoms are impacting school attendance or performance, this is typically the threshold for consideration to referral to OCD specialist
- Collaborate with the school and include a point person (counselor, teacher, etc) who can support the student and provide feedback from the school day
- SPACE: https://www.spacetreatment.net/
- Resources:
  - IEPs/504 plans and special education: https://www.pealcenter.org/
  - IOCDF Toolkit: https://anxietyintheclassroom.org/parents/
  - Educational Advocacy resources: https://connect.alleghenycounty.us/wp-content/uploads/2024/05/Education-Advocacy-Orgs-and-Resources.pdf

Case Example: Katie and Accommodations with School

- Katie (1) needs her parents to drive to school (2) a certain way and (3) refuses to go to school otherwise
  - Identifying the accommodations in place here:
    - 1 = parents are driving
    - 2 = specific route
    - 3 = avoidance and refusal
- Many of the existing accommodations can remain in place at the start of treatment to get the child to school
- ERP may look like first making small adjustments to the rituals - can the kid sit in a different seat of the car? Listen to something different on the radio?
- Reward system for conquering each step of the exposure
- Introducing a small accommodation at school arrival time
  - 10 minute break with the guidance counselor to do coping skills and ease transition into the classroom

Comorbidity and Differential Diagnosis

- Mood
- ASD
- ADHD
- Tic
- PANS

Mood/Regulation and Other Anxiety Disorders (ODD, MDD, DMDD, GAD)

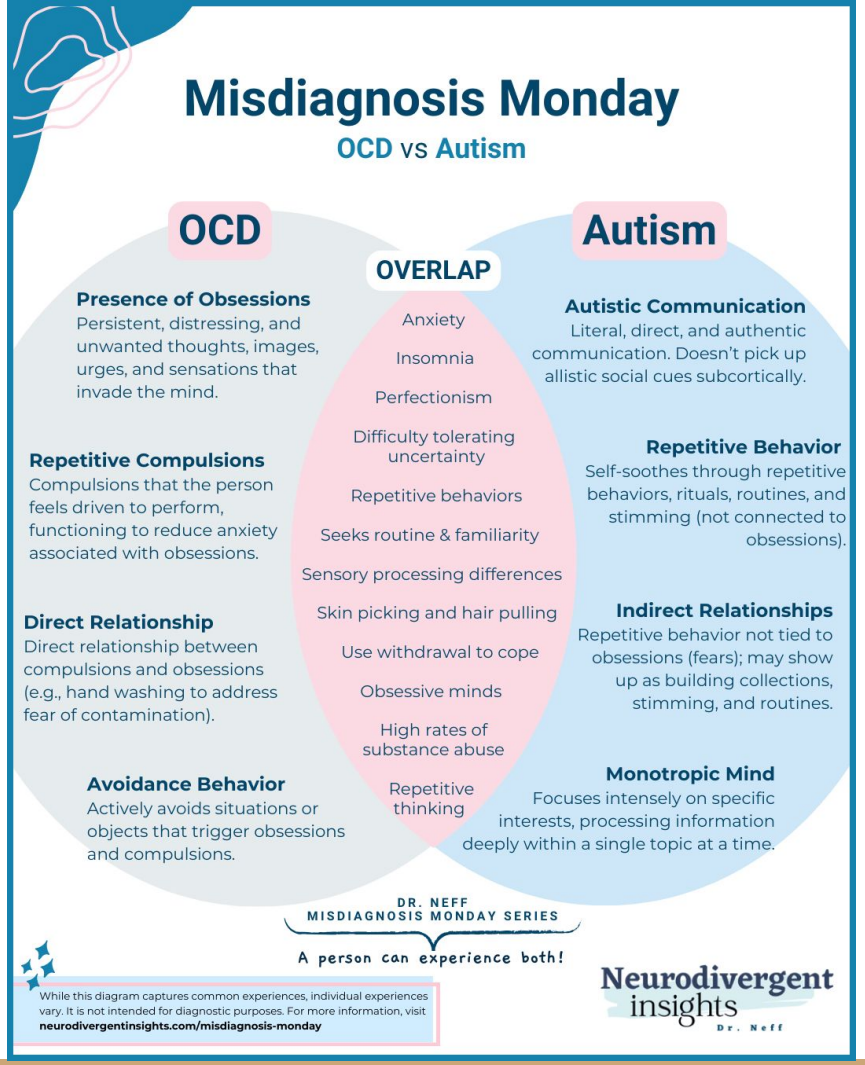
- Avoidance and reassurance: common in general and social anxiety disorders
- Defiance: when the need to complete compulsions is interrupted or not allowed, children may have large reactions
- Arguing: children may argue a rule that prevents them from completing compulsions
- Puberty onset: hormonal changes can spike anxiety and dysregulation

Distinguishing Features	
OCD	**Generalized Anxiety Disorder (GAD)**
Obsessions are typically odd, quite unrealistic, and/or seemingly magical in nature Example: Fear that neglecting to tap index finger on desk a certain number of times will cause classmates to fail	Worries include a broad range of common, real-life concerns Example: Worries about failing a difficult class
Compulsions present and performed in direct response to obsessions	Excessive rumination and worrying about the issues causing them to feel anxious

Distinguishing Features	
OCD	**Major Depressive Disorder**
Intrusive thoughts not dependent on mood	Mood congruent ruminations
Thoughts linked with compulsions	Ruminations not linked to compulsions
Ideations accompanied by feelings of doubt	Ideations exhibit more negative global perception
Obsessions tend to be odd, unrealistic, and/or magical in quality	Ruminations pertain to more routine worry about life

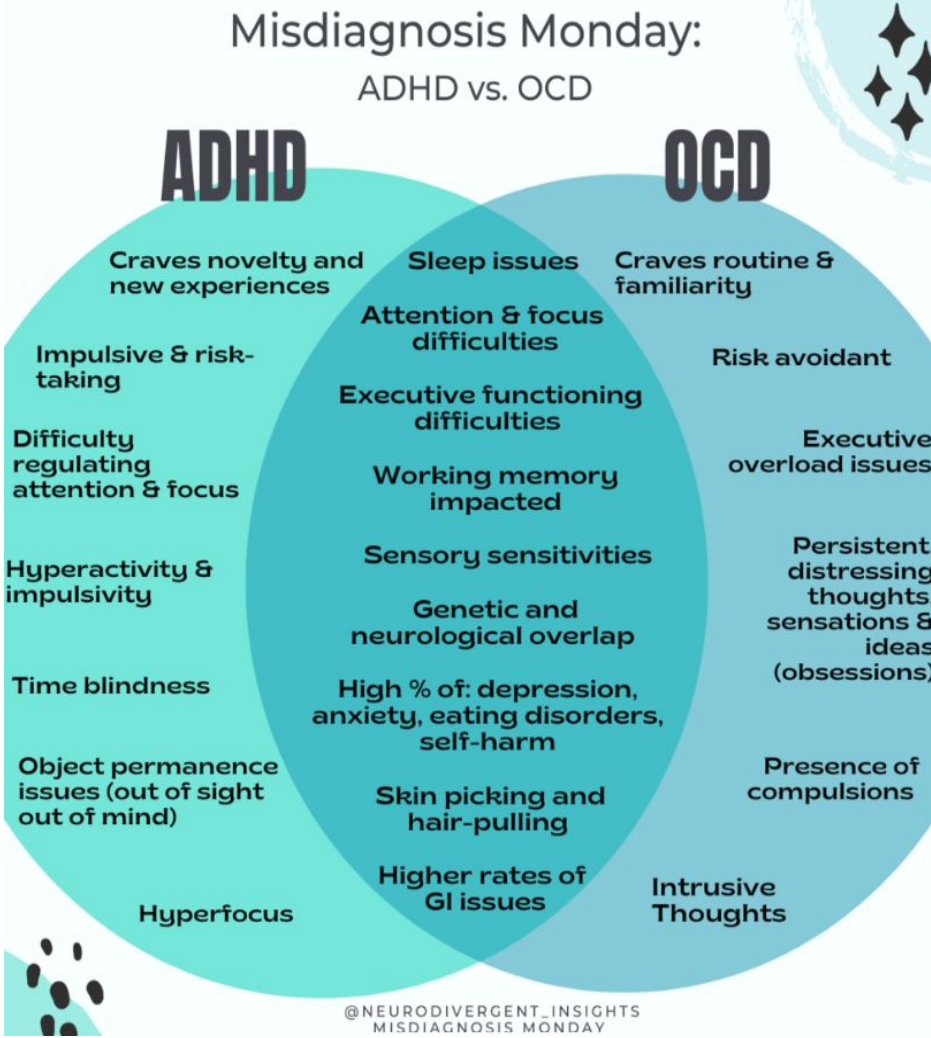
Autism Spectrum Disorder

- 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



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



Tic Disorder

- Repetitive movements or sounds (tapping, arranging objects, throat clearing etc).
- When used as a function to decrease anxiety and client has some control over them; OCD may be the culprit (just right, symmetry)

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/
- Refer to a child and adolescent psychiatrist who specializes in OCD if PANS/PANDAS is suspected

Finding OCD treatment options

- Where to go to learn more information: www.iocdf.org
- What type of therapy to look for:
  - ERP (Exposure and Response Prevention)
  - ICBT (Inference Based Cognitive Behavioral Therapy):
    - https://icbt.online/
  - ACT (Acceptance and Commitment Therapy)
- Support for families: iocdf.org/ocd-finding-help/supportgroups/
- Pittsburgh area resources:
  - The Center for OCD and Anxiety: https://pittsburghocdtreatment.com/contact/
  - UPMC Western Behavioral Health OCD IOP: https://www.upmc.com/services/behavioral-health/programs/child-adolescent/ocd/about

References

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- https://kids.iocdf.org/professionals/md/ocd-or-pandas/
- https://neurodivergentinsights.com/misdiagnosis-monday

Contact Information

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