Obsessive-Compulsive Disorder (OCD)
"Clinical Pearls" for PCPs

☎ 877-SC-YAPPY (877-729-2779) ☎

I. CLINICAL HISTORY

Recommended Procedure	Clinical Pearls
◘ Assessment: OCD assessment – gather history of parental concerns and patient report. OCD inventories help identify the variety of obsessions and compulsions. ◘ Child Yale-Brown Obsession Compulsion (CY-BOC) o Subclinical (CY-BOC 0-15) o Moderate (CY-BOC 16-23) o Severe (CY-BOC >23) ◘ Consider screening for PANDAS/PANS particularly for those children presenting with sudden food refusal, separation anxiety, reported arthralgias, and secondary enuresis or encopresis	**Pearl**: Frequently, OCD has a history of being undetected or hidden for several months to sometimes years before an exacerbation flare is severe or comes to the attention of the family. With rapid onset for a pre-pubertal child, consider PANDAS/PANS, which may go undetected because of the waxing and waning nature of the illness. CY-BOC has 2 parts; one is a symptom inventory and the other tracks severity.
◘ Family History: OCD and Anxiety disorders are common ◘ Screen for family history of autoimmune disorders suggestive of possible PANDAS/PANS	**Pearl**: Parents with OCD may need additional referral support to enhance their own treatment before they are able to effectively collaborate in their child's OCD care. Asking a child which parent has anxiety is usually revealing. Children with PANDAS/PANS frequently have a family history of autoimmune disorders, particularly maternal thyroid disease.
◘ Assess parental behavioral efforts: inquire about how the parents have been managing behavior and provide guidance around parents who are overly accommodating or invalidating ◘ The Family Accommodation Scale is a useful scale to assess parental and family accommodating	**Pearl**: It is common for parents to be overly accommodating, especially if they have a history of anxiety symptoms. Under these circumstances, PCPs may provide guidance about typical age expectations and educate parents that reassurance seeking is often a core symptom of OCD. Parents should be advised to refrain from providing reassurance and be given a script for responding to reassurance seeking, e.g., "I'm not going to answer that question because we both know that you already know the answer, and it's better for us not to pay attention to these kinds of worries."
◘ Check for past psychiatric history, including a history of prior anxiety treatment or co-morbid psych history like ADHD or a learning disorder	**Pearl**: Children with OCD frequently have other anxiety disorders like Separation Anxiety, Social Anxiety, or Specific Fears/Phobias.

Commented [EF1]: I defer to Gretchen and Anita about this. I am not familiar with the RCADS but am not against including it.

Commented [GE2R1]: I have not seen the clinicians use that scale, so I don't have any specific opinion about it.

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II. MENTAL STATUS EXAMINATION

Recommended Procedure	Clinical Pearls
◘ Observe the child's behavior: document any noted tics, hand or skin excoriation from excess washing, atypical hyperactivity, and restlessness or mood lability	**Pearl:** Many children with OCD can manage their impulses in community or under observation. The presence of a comorbid tic, hyperactivity, and significant mood lability may suggest underlying PANDAS/PANS.
◘ Observe parent-child/child-sibling interaction	**Pearl:** Inquiring about family daily routines, especially morning or bedtime routines, may help gauge the degree of severity and family accommodations. For example, the parents might be engaged in ritualistic checking of closets or under the bed before bedtime every night.
◘ Interview the child	**Pearl:** Utilizing a questionnaire/screening form can help provide the child with language to name his/her obsessions and compulsions.

III. MEDICAL WORKUP

Recommended Procedure	Clinical Pearls
◘ Physical exam and review of symptoms	**Pearl**: You may find skin picking, excoriated hands from excessive washing, tics, bald patches/missing hair (trichotillomania), somatic worries, or repeated medical reassurance seeking.
◘ Assessment of PANDAS/PANS ◘ Basic Lab Work - IgE Level, IgA, IgM, IgG (subclass 1, 2, 3, 4), CBC, ANA, Ferritin, B-12, Vitamin D ◘ Viral/Bacterial Testing - Strep throat culture, 48-hour culture or perianal culture; Antistreptolysin O (ASO); Anti-DNAse B; Streptozyme; Lyme Disease and co-infections; Mycoplasma Pneumoniae IgA and IgM; Pneumococcal Antibody Titers; Epstein Barr Virus Panel; Coxsackie A & B Titers; HHV-6 Titers	**Pearl**: Consider treatment for presumptive PANDAS/PANS. Refer to treatment recommendation and guidelines. Consult with YAP-P. https://pandasnetwork.org/ Advance Studies - Cunningham Panel* – autoimmune autoantibody levels: ▪ Anti-Dopamine D1 receptor ▪ Anti-Dopamine D2L receptor ▪ Anti-Lysoganglioside GM ▪ Anti-Tubulin ▪ Calcium/calmodulin-dependent protein kinase II (CaMKII)
◘ Perform an assessment of medical conditions and concurrent medical treatments that may affect treatment planning	**Pearl**: Use caution about over-reassurance or over-engaging in medical assessments that are meant to reassure rather than rule out a reasonable differential concern.

Commented [EF3]: I put bald/patches/missing hair as I have known people who pluck eyelashes, eyebrows and other hairs.

Commented [MA4R3]: I like this...

Commented [MA5R3]: No experience with the Cunningham Panel and cannot find a lot of information about its general use. (Abe)

Commented [EF6R3]: Do you think it is still worth including? And Gretchen and Anita are you OK with the bald patches/missing hair?

Commented [GE7R3]: Yes

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IV. DIFFERENTIAL DIAGNOSIS

Recommended Procedure	Clinical Pearls
◘ Normal Development: brief obsessions lasting weeks to months can be developmentally appropriate. A child can have normal obsessive interests like repeatedly watching a favorite movie or lining up toys and collectables.	**Pearl**: Additional inputs from teachers or other caregivers can assist if there is uncertainty about normal vs more excessive obsessions.
◘ Oppositional Defiant Disorder (ODD) includes undoing defenses, lining up, or over possessiveness	**Pearl**: With ODD, there is a more chronic history of argumentativeness and over-attention to fairness. With OCD, there is more often pleading and acting out to accommodate their anxiety.
◘ Autism Spectrum Disorder (ASD)	**Pearl**: Perseveration and restricted interest range overlap with OCD. ASD has high co-morbid OCD association where OCD symptoms tend to be in the "Symmetry" subgroup.
◘ Attention Deficit Hyperactivity Disorder (ADHD)	**Pearl**: ADHD frequently is comorbid in children with OCD. Further assessment with Vanderbilt or other ADHD scales from parents and teachers may be needed.

V. ASSESSMENT OF RISK

Recommended Procedure	Clinical Pearls
◘ Safety Assessment: assess youth for suicidal thinking or self-harm behavior	**Pearl: Call or text 988 (Suicide and Crisis Lifeline)** and/or refer for emergency mental health services in the following situations: • Any evidence of recent suicidal behavior • Current active intent to engage in suicidal behavior • Current significant planning for suicidal behavior • Any degree of lack of cooperation in assessment from youth or family where risk for suicide has been identified • Evidence that youth or family will not or cannot access mental health services in times of worsening risk • Consider YAP-P consultation for complex or confusing situations

VI. TREATMENT PLANNING

Recommended Procedure	Clinical Pearls
◘ Note mild concerns like excessive hand washing or germ/emetophobia that are not interfering with school and family function.	**Pearl**: Provide psychoeducation and information for the patient, family, and caregivers regarding the need for gentle redirection. Consider parental self-guided treatment and support. Refer to the International OCD Foundation.
◘ Note moderate concerns like two or more OCD symptom categories and/or more severity that is impacting family, school, or social function	**Pearl**: Refer to individual therapist with capability/expertise in cognitive behavioral therapy (CBT) and/or Exposure and Response prevention (ERP) treatment. It is important that in addition to individual therapy, the family is engaged in treatment to help reinforce therapeutic interventions at home.
◘ Note severe concerns like child distress and significant impact with school, activities, and family functions	**Pearl**: In addition to a therapy referral, medication treatment initiation is recommended. Also, consider symptomatic treatment for challenges like acute anxiety or insomnia. For children with PANDAS/PANS, initiation of a 2-week course of antibiotics and NSAIDS may be warranted. Consult with YAP-P for further guidance.

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Commented [EF8]: I removed the reference to "Connors" scales as I believe these are proprietary. I added the "or other ADHD" scales so that it could include others used. Does this work for all?

Commented [AK9R8]: Sounds good

Commented [AK10R8]:

Commented [EF11]: Where do we refer kids/youth in SC? Is there a more specific service? Should we also put info about crisis lines or the 988 number in here somewhere?

Commented [GE12R11]: Maybe crisis line. But each area has their own E.R./psych hospital referrals so I wouldn't be too specific.

Commented [AK13R11]: 988 is good idea to put in.

Commented [EF14R11]: How does this look?

Commented [AK15]: I think M is missing in "moderate"

VII. MEDICAL MONITORING

Recommended Procedure	Clinical Pearls
◘ Acute Treatment Phase (2-12 weeks)	**Pearl**: Start low and go slow. If the youth experiences side effects, address these before advancing medication dose. Reassess at 2-4 weeks, 8 weeks, and 12 weeks. It is important to monitor medication response and tolerability after initiating treatment. Review risk of suicidal thoughts after initiating and/or increasing SSRI dose and develop a safety plan.
◘ Maintenance Phase (3-6 months)	**Pearl**: Support the patient and family with the slower time to treatment benefit. Medication treatment is largely incomplete. Maintain perspective that medication treatment is an adjunct to CBT/ERP therapy. Consider alternative SSRI medication trial following 12-to-16-week trial on highest tolerated dose. Establish optimal dosing by gradually increasing to recommend treatment doses, which are typically at the higher dosing range.
◘ Termination (6-12 months)	**Pearl**: Go slowly, titrating the dose by small increments, no more frequently than every 4 to 8 weeks. Consider a gradual decrease of SSRI medication following 6 months of OCD remission.

Commented [EF16]: Should we eliminate this? Not sure saying "follow guidelines" is much use.

Commented [MA17R16]: I believe we should keep it as simple as possible

Commented [AK18R16]: I agree, it is not clear what guidelines it is referring to.

Commented [AK19R16]:

Commented [EF20R16]: done

VIII. RESOURCES

Children's Yale-Brown Obsessive-Compulsive Scale

The Family Accommodation Scale

Vanderbilt Assessment Scales used for diagnosing ADHD

Anxiety and Depression Association of America (ADAA)

ADAA OCD Best Practices Page, which has information about treatment (including meds)

International OCD Foundation

PANDAS Physician Network

Commented [EF21]: I deleted the reference to an article by a McLean Anxiety mastery program clinician and also removed the link to the Connors scale

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