Recognizing OCD and Anxiety Disorders in Children

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Anxiety – an under recognized disorder

- Prevalence - pre-adolescent (8-10%) 
  - adolescent (9-15 %) (Hyman,2001)
- Military dependents -1/3 screened positive for Internalizing subscale(Flake et al, 2009)
- Both under-recognized and under treated
- Presentation varies with age and disorder
- Need to distinguish from developmentally appropriate anxiety

Disclosure

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Why screen?
- 8-15% of patients who present with anxiety
- 3.3% of patients diagnosed
- 40-50% of patients missed (Wren et al, 2003)
- Lifetime prevalence 50% have onset by age 14, 75% by age 24 (Kessler et al, 2004.)
- Under recognition and inadequate treatment implications for lifetime functioning.
- Increased risk of academic underachievement, substance use, disruption of normal development and depression.

Anxiety Disorders DSM-IV Diagnoses
- Obsessive Compulsive disorder
  Characterized by obsessions which cause distress and/or compulsions which serve to neutralize anxiety
- Specific Phobia
  Significant anxiety provoked by exposure to a specific feared object or situation, often leading to avoidance
- Post Traumatic Stress Disorder
  Re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal

ANXIETY DISORDERS DSM-IV Diagnoses
- Generalized Anxiety Disorder
  Excessive worry more days than not for at least 6 month about a number of events or activities
- Separation Anxiety
  Excessive anxiety concerning separation from the home or those to whom the child is attached
- Social Phobia
  Significant anxiety provoked by exposure to certain types of social or performance situations
PRESENTATION

- Generally, distress associated with normal activities + avoidance
- Physical complaints unexplained by medical conditions – headaches, stomachaches, nausea, vomiting, tremulousness, shortness of breath
- Sleep disturbance, irritability, anger or tearfulness when confronted with fearful stimuli
- May be misconstrued as oppositional behavior
- Symptoms differ with developmental stage

EARLY CHILDHOOD MANIFESTATIONS

- crying
- tantrums
- freezing
- clinging
- timid in unfamiliar situations

Middle Childhood and Adolescent Manifestations

- physiologic
- sweating
- restless
- dyspnea
- somatic
- avoidance
- perfectionism
- need for excessive reassurance

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Pediatric Symptom Checklist

- Patient score – 30 (cut off 30)
- Parent score – 28 (cut off 28)
- Subscore-Internalizing – 4
- Pertinent Positives: Complains of aches and pains
  Is afraid of new situations
  Has trouble sleeping
  Wants to be with parent more
  Seems to be having less fun

OCD PREVALENCE

- 2% US adolescents
- 2.3% Israel
- 3.9% New Zealand
- 4.1% Denmark

OCD : Age of Onset and Gender

- Bimodal distribution, with one peak in childhood (7.5-12.5), and another in early adulthood (21)
- Male : female ratio of 3:2 in pediatric population
- Adults: equal gender representation

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CLINICAL FEATURES

- Obsessions: intrusive, repetitive thoughts, ideas, images, or impulses – anxiety provoking and ego dystonic
- Compulsions: actions in response to an obsession – serve to reduce anxiety in a reinforcing cycle
- Time consuming (>1h/d) and cause distress and impairment
- “With poor insight” – applies to many children

Clinical Features: Obsessions

- Preschool children normally insist on routines and rituals – fades as get older
- Geller ’01: children and adolescents had higher rates of aggressive obsessions (incl. fears of catastrophic events such as death of self or loved ones) than adults (63% v. 69% v. 31%)
- Most common obsessions in pediatric age group – in context of developmental stages of attachment and independence. “Developmentally sensitive phenotype”

Clinical Features: Obsessions

- Religious obsessions were over represented in adolescents compared with children or adults
- Sexual obsessions under represented in children compared with adolescents and adults
- Most commonly reported obsessions: contamination, aggression, sex, the body, magic and scruples (fear of doing evil)
Clinical Features: Compulsions

- Common compulsions: washing, checking, repeating, ordering, and touching. Mental rituals common such as praying, chanting and counting.
- Reassurance seeking common – a vicarious form of checking
- “Just right” phenomenon – in response to uneasy, empty feeling – cannot stop until feels right – not in reaction to clear obsession – can be linked to obsessional slowness.

Pediatric Obsessive Compulsive Disorder Treatment Study (POTS)

- N = 112
- Ages 7-17 years
- 3 sites, 12 weeks
- Cognitive behavioral therapy (CBT), Sertraline (SER), combination (COMB), and placebo (PBO)

Children’s Yale-Brown Obsessive Compulsive Scale Intent to Treat (ITT)

- COMB > CBT = SER > PBO

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### SCARED

- Total score of 25 or greater
- Sub-scores for Panic, Generalized Anxiety, Separation Anxiety, Social Anxiety Disorder, and School Avoidance
- Sub-score for Separation anxiety – may be a bit more difficult in adolescent but hallmark is worry about self and parents including nightmares about something happening to parents or to themselves
- Child tends to avoid activities that will keep him away from family or home

### Further work-up

- SCARED: Screen for Child Anxiety Related Disorders
  - Sub-scores of type of anxiety disorder
  - Both youth and parent versions
- Structured interview
- Risks
- Differential diagnosis
- Assessment of impairment

### Separation Anxiety

- Childhood versus Adolescent manifestation
- Distinguish from other anxiety disorders
- Differential diagnosis including developmentally appropriate anxiety
- Assessment of severity – based on degree of functional impairment – home, school, social

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Risk Factors
- Family history in first degree relative
- Parental anxiety may model behavior and overprotectiveness
- Insecure attachment
- Parental illness, death, deployment or separation
- Temperamental traits of passivity and shyness
- Behavioral inhibition

Differential diagnosis
- Developmentally appropriate anxiety
- Medication or non-prescription drug effect – caffeine, stimulants, SSRI
- Medical-hyperthyroidism, asthma, migraine, cardiac arrhythmia, CNS disorder
- Depression
- ADHD or Asperger’s
- Bipolar or psychosis
- Learning disability

Assessment of Functional Impairment
- How much does the problem interfere in child’s life
- What domains does it affect – school, home, peers
- How much affect – mild, moderate, severe
- Does it interfere with developmental tasks
- Does child avoid activities that are important for development
Anxiety Disorders – DSM IV

- Generalized anxiety disorder – worrying around numerous areas of their lives – home, school, relationships, academic performance.

Social Phobia

- Diagnostic features: marked, persistent fear of social or performance situations where embarrassment might occur
- Avoidance or anxious anticipation interfere with functioning or social life.
- Children typically cry, demonstrate tantrums, freeze or cling to familiar, may demonstrate mutism.
- As children can not avoid feared situation may not identify their anxiety.

CAMS Child/Adolescent Anxiety Multimodal Study

- EFFICACY:
  Pharmacologic – 54.9% (placebo 23.7%)
  Cognitive Behavioral- 59.7%
  Both – 80%

2008- n=488 children age 7-17 with Social anxiety disorder (SAD) Generalized anxiety disorder (GAD) or Social phobia (SP)

(Walkup et al NEJM 359(26), 2008.)
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<th>Drug Name</th>
<th>Initial Dose</th>
<th>Increment</th>
<th>Maximum</th>
<th>Half Life</th>
<th>Common Side Effects</th>
<th>Pharmacologic Considerations</th>
<th>Special Considerations</th>
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<td>Fluoxetine</td>
<td>10-20mg</td>
<td>10-20mg</td>
<td>80mg</td>
<td>4-6 days</td>
<td>nausea, vomiting, weakness, sexual dysfunction</td>
<td>inhibits CYP2D6, long time to therapeutic</td>
<td>Discontinuation syndrome</td>
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<td>Sertaline</td>
<td>25-50mg</td>
<td>12.5-25mg</td>
<td>200mg</td>
<td>26h</td>
<td>nausea, sexual dysfunction, insomnia</td>
<td>mild inhibition CYP2D6</td>
<td>Discontinuation syndrome</td>
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<td>10mg</td>
<td>60mg</td>
<td>21-24h</td>
<td>nausea, dry mouth, dryness, sexual dysfunction</td>
<td>more anti-cholinergic</td>
<td>Higher discontinuation risk, drug interactions</td>
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<td>25-50mg</td>
<td>300mg</td>
<td>13.6-15.6h</td>
<td>nausea, dry mouth, dryness, sexual dysfunction</td>
<td>potent inhibition of P4502D6, higher discontinuation risk</td>
<td>Drug interactions</td>
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<td>Citalopram</td>
<td>10-20mg</td>
<td>10mg</td>
<td>60mg</td>
<td>35 hr</td>
<td>nausea, dry mouth, dryness, sexual dysfunction, insomnia, sexual dysfunction</td>
<td>less p4502D6 inhibition</td>
<td>Concern of slight increase overdose risk</td>
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<td>Escitalopram</td>
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<td>27-32h</td>
<td>nausea, diarrhea, delayed ejaculation, insomnia, somnolence, diarrhea, sweating</td>
<td>single isomer of citalopram, no clear advantage</td>
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**SSRI s**

- **Pharmacology**: block pre-synaptic reuptake pump, hepatic metabolism, induction of different enzymes
- **Black Box Warning**: FDA meta-analysis with slight increase suicide ideation, not suicide
- **Serotonin Syndrome**: autonomic instability, mental status change, neuromuscular hyperactivity
- **Discontinuation Syndrome**
- **Hypomania**

**SSRI**

- Length of treatment – no good data
- Generally maintain same dose 6-12 months after complete remission
- Identify low stress time to taper
- Resumption of meds if symptoms recur

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Psychoeducation - teach patient and family about nature of anxiety, how excessive levels of anxiety are learned and maintained and rationale for treatment technique

Somatic management - targets autonomic arousal, breaks associations between physiologic arousal and anxiety. Techniques: Relaxation, Diaphragmatic breathing, Self-monitoring

Cognitive Behavioral Therapy

Cognitive Restructuring - identifying maladaptive thoughts, beliefs and teaches realistic, coping focused thinking

Exposure - graduated systematic and controlled exposure to feared situation to provide experience with using anxiety management skills

Relapse prevention - focus on consolidating anxiety management skills

COPING CAT PROGRAM

16 Sessions of CBT
Goal to teach recognition of anxious arousal to cue management strategies
Sequence of training tasks and assignment
Recognize anxious self-talk, change to coping self talk
Self rate and reward
Empirically supported
Different manualized programs for children and adolescents (Coping cat, C.A.T project)

**COPING CAT**

**F.E.A.R.**

**Feeling Frightened?** Awareness of bodily reactions  
**Expect bad things?** Recognize self-talk  
**Attitudes and Actions to help:** Problem solving skills  
**Results and Rewards:** self-evaluation and self-reward

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**COPING CAT EVIDENCE**

- Randomized trials US and Australia 1 year follow-up (Kendall et al, 1997 and Barrett et al, 1996)  
- Longer term studies up to 7.4 years (Kendall et al, 2004)  
- Literature review for empirically-supported (Ollendick, King and Chorpita, 2006)  
- Manuals for both child and adolescent  
- Computer based training available – CBT4CBT  
- Knowledge of program can aide in primary care support of treatment

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**Indications for Referral**

- Severe anxiety with significant functional impairment – multiple domains  
- Moderate anxiety requiring more formal cognitive behavioral therapy  
- Patient unresponsive to therapy with adequate trial psychotropic medication, basic components CBT or both  
- Patient, parent or provider preference for specialist care  
- Safety concerns regarding suicidality or basic functioning

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Indications for Referral

- Complex diagnostic issues such as multiple diagnoses
- Child younger than 5 with significant emotional or behavioral issues

SUMMARY

- Anxiety disorders – common, under diagnosed and treated especially important in military families
- Lack of treatment may impact lifelong morbidity
- Identified evidence based treatments – both pharmacologic and Exposure CBT
- Mild to moderate can be treated in primary care office- psycho-education, somatic management and cognitive restructuring +/- SSRI
- Care management + Proper coding makes it practical in primary care