



وزارة الصحة
Ministry of Health

MOH Protocol for the Management of Obsessive-Compulsive Disorder in Children and Adolescents

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• Introduction

Obsessive-Compulsive Disorder (OCD) is characterized by various groups of symptoms that consist mainly of obsessions and compulsions. Obsessions are recurrent, intrusive, and unwanted thoughts. In contrast, compulsions are repetitive behaviors or mental acts used to abate the distress of the obsessions¹. The prevalence rates of children and adolescent OCD are around 1% to 3% in the United States and elsewhere². In Saudi Arabia, no nationally representative study has been conducted to date. One regional study conducted by Alsubaie and his colleagues found the prevalence of OCD around 3.4 %, which falls within the worldwide range³. There appear to be two peaks of incidence for OCD across the life span, one occurring in preadolescent children five and a later peak in young adult life (mean age, 21 years)⁴. If all cases of children and adolescent OCD persisted in adulthood, one would expect an increasing cumulative prevalence of OCD across the life span as more cases are added to the population. Two major treatment strategies for OCD are cognitive-behavioral therapy (CBT) and serotonergic medications.

A. Purpose

In daily clinical practice, the management of children and adolescent with OCD is highly variable as many issues are still debated and not addressed by evidence-based medicine. Pharmacological treatment is a well-established strategy for managing moderate-to-severe children and adolescent OCD, while CBT is recommended for mild cases. There is a clear need for national protocols due to the extended role and high availability of literature on these treatment modalities. As a result of an initiative of the Ministry of Health of the Kingdom of Saudi Arabia, an expert board of child and adolescent psychiatrists and pharmacists with recognized practical experience in the clinical management of children and adolescent OCD were called to be part of a workgroup to invest a practical protocol for children and adolescent OCD.

B. Aim & Scope

Generally, these protocols aim to convey evidence-based recommendations for treating children and adolescents with OCD. These protocols also aim to propose updated decision-making algorithms for practitioners involved in treating these people, and attention is given to special patient populations.

C. Targeted Population/Audience

Children and adolescents who present in daily clinical practice with OCD.

D. End Users

The protocol is purposeful to be a helpful guideline and ready reference for the medical staff serving in settings where they will look after children and adolescents with OCD. Given the wide variety of expertise, disciplines, and staff roles within the ministry of health, it may not be possible to grasp the extent of specialist practice applied by expert practitioners across these disciplines and settings. Therefore, this protocol may be utilized in a diversity of ways which affords an overview of critical concepts and practical resources they may administer under supervision. The protocol should be applied within a framework of local policies and procedures.

E. Methodology

This is the first version of the Saudi practical protocol for managing OCD in children and adolescents. This protocol development is completed through 2 phases:

Phase 1: The multidisciplinary workgroup has been consisted of three child and adolescent psychiatrists, one child psychologist, and one clinical pharmacist who did a literature review and reviewed several guidelines such as the National Institute for Health and Care Excellence (NICE) Clinical Guideline for Obsessive-Compulsive and Body Dysmorphic Disorder treatment 2005⁵, the Canadian Clinical Practice Guidelines for the management of anxiety, Posttraumatic Stress and Obsessive-Compulsive Disorders 2014⁶, the Practice Parameter for the Assessment of Children and Adolescents With Obsessive-Compulsive Disorder 2012⁷ and the Maudsley Prescribing Guidelines in Psychiatry 14th Edition⁸. The recommendations used in this protocol have been mainly obtained from the Practice Parameter for the Assessment of Children and Adolescents With Obsessive-Compulsive Disorder 2012⁷ after being evaluated using the Appraisal of Guidelines, Research Evaluation II (AGREE II) Scale⁹ and getting the highest score, as well as minimal additions from National Institute for Health and Care Excellence (NICE) Clinical Guideline for Obsessive-Compulsive and Body Dysmorphic Disorder treatment 2005⁵, and the Maudsley Prescribing Guidelines in Psychiatry 14th Edition⁸ to fill some gaps which the main one could not fill.

Phase 2: The protocol was sent to a group of experts in the field of Child and Adolescent Psychiatry to provide their input and review. Their input was collected over three weeks, followed by further meetings and assessment for the feedback by the committee.

F. Updating

The first version of this protocol was created in 2022. The protocol will be updated every five years or if any changes or updates are released by international/national protocols, pharmacotherapy references, or MOH formulary.

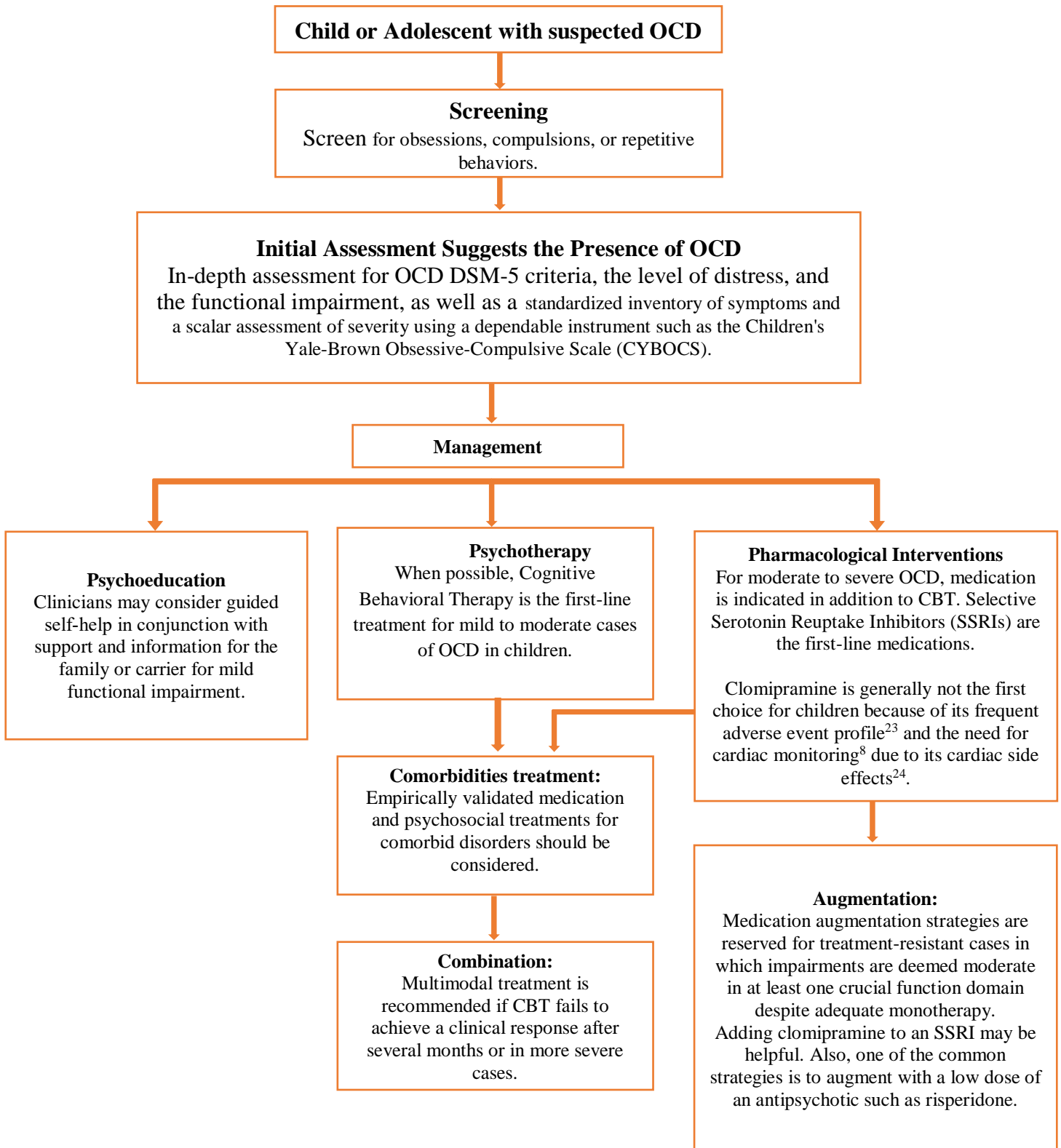
G. Conflict of Interest

This guidance was developed based on valid scientific evidence. No financial relationships with pharmaceutical, medical device, and biotechnology companies.

H. Funding

No fund was provided.

- **Diagnosis and Management Algorithm**



A. Screening and Meticulous assessment⁷

a. Screening

Always screen for the presence of obsessions and compulsions.

b. Meticulous assessment

If the initial assessment suggests the presence of OC symptoms, physicians should evaluate the child deeply. This includes the DSM-5 criteria, the level of patient's distress and the functional impairment¹, a standardized inventory of symptoms, and a scalar assessment of severity that is best grasped by a dependable instrument such as the Children's Yale-Brown Obsessive-Compulsive Scale (CYBOCS)²⁰. The deeper assessment also includes evaluation of the presence of comorbidities as it is the rule in the pediatric population with OCD¹¹, and some comorbidities, if they are not treated carefully, may negatively affect the outcome of the interventions¹². Family history should also be included in the assessment as some families may be highly enmeshed in their children's OCD as a part of their accommodation to relieve their anxieties which may reinforce the OC behaviors. The clinician should also assess for school history, which may hint at the child's function and the illness severity. A standardized intelligence testing, achievement, and neuropsychological assessment may be considered if the child has a chronic history of academic struggle. Besides that, a non-psychiatric assessment (medical) must be part of the thorough assessment. Clinicians should pay more attention to the nervous system symptoms as well as if there is a history of infection with Group A Beta Hemolytic Streptococci (GABH), which is a risk factor for Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) associated OCD¹³, especially if there are acute changes or exacerbation of previously remitted symptoms. However, no neuroimaging studies are needed to diagnose OCD or related comorbidities.

B. Management

a. Non-pharmacological interventions

i. Psychoeducation⁵

For OCD with mild functional impairment, clinicians may consider A guided self-help²⁷ in conjunction with support and information for the family or carers⁵.

ii. Psychotherapy⁷

When possible, Cognitive Behavioral Therapy is the first-line treatment for mild to moderate cases of OCD in children.

The protocol used by March et al. in the National Institute of Mental Health Pediatric Obsessive-Compulsive Disorder Treatment Study (POTS)¹⁴ consists of fourteen visits over

twelve weeks spread across five phases: psychoeducation, cognitive training, mapping OCD, exposure and response prevention (E/RP), and relapse prevention and generalization training.

Exposure and response prevention (E/RP) depends on the theory that worry usually deflates after enough duration of contact with a trigger. With repeated exposure and trials, the anxiety is expected to be less and less¹⁵. Sufficient exposure depends on stopping the negative reinforcement effect of rituals or avoidance behavior, a process called "response prevention."

b. Psychopharmacological interventions⁷

For moderate to severe OCD, medication is indicated in addition to CBT. Selective Serotonin Reuptake Inhibitors (SSRIs) are the first-line medications recommended for OCD in children and adolescents. They should be used according to several guidelines to monitor response, tolerability, and safety. Those medications involve fluvoxamine²⁰, fluoxetine²¹.

Clomipramine is generally not the first choice for children because of its frequent adverse event profile²³ and the need for cardiac monitoring⁸ due to its cardiac side effects²⁴. However, it is a valid option and considered at least after the failure of one of the mentioned SSRIs^{5,8}. Its use mandates an evaluation of the children and adolescent patient's medical condition and cardiac status in particular⁷.

Indications of medications treatment:

- Scores higher than 23 on the CY-BOCS.
- Clinical Global Impression Severity Scale of marked to severe impairment based on time occupied, subjective distress, and functional limitations.
- Any situation that could impede the successful delivery of CBT.
- Shortage of skilled CBT practitioners.

Factors that prevent the successful delivery of CBT:

- Concurrent psychopathology may decrease the acceptance of or adherence to CBT like multiple anxiety disorders, significant mood disturbance, and disruptive behavioral disorders, including ADHD.
- Poor insight.
- The need for close family involvement in non-intact families.

Initiation of medications:

Titration schedules should be conservative, with modest increases from the initial dose every three weeks or so to allow for an improvement to manifest before aggressively increasing doses.

Patience is key to successful outcomes because it may take twelve weeks for substantial benefits to occur. Treatment is generally continued for six to twelve months after stabilization and gradually withdrawn over several months with caution. CBT "booster" sessions may be helpful to assess for any symptoms of relapse during or after medication discontinuation and prolong remission. Two or three relapses of at least moderate severity should consider longer-term treatment (years)⁷.

Clinicians should be aware of behavioral side effects that are more likely in younger children, such as manic symptoms, which are sensitive to dose adjustments²⁵. Also, an assessment and monitoring of suicidality are mandatory after prescribing an SSRI⁸.

Doses guidelines⁷:

Drug	Starting dose (mg)		
	Preadolescent	Adolescent	Typical Dose Range (mg) (Mean Dose) ^a
Clomipramine	25	25	50–200
Fluoxetine	2.5–10	10–20	10–80
Fluvoxamine	12.5–25	25–50	50–300

i. Combination⁷

Multimodal treatment is recommended if CBT fails to achieve a clinical response after several months or in more severe cases.

For most excellent efficacy, the combination of CBT and medication is the treatment of choice and should be considered the default option for first-line treatment in moderate to severe OCD.

ii. Augmentation⁷

Medication augmentation strategies are reserved for treatment-resistant cases in which impairments are deemed moderate in at least one crucial domain of function despite adequate monotherapy.

The failure of at least two adequate trials of monotherapies and adequate CBT or ERP is required before labeling a child as treatment-resistant. Adequate trials of two monotherapies mean at least ten weeks of two SSRIs separately or an SSRI and

clomipramine at the maximum recommended or tolerated doses, with no change in dose for the last three weeks. Adequate CBT or ERP means eight to ten sessions of CBT or six to eight sessions of ERP. To label the case as resistant indicates persistent and substantial OCD symptomatology after applying the mentioned adequate trials⁷.

However, if resistance is suspected, re-assessment is highly needed. It is mandatory to assess the adherence to the interventions, the doses reached, tolerability, and the duration of the interventions⁷, and clarify the presence of comorbidities⁸. If the case is labeled as resistant, it is better to be referred to a specialist center⁸.

Medication Augmentation Strategies: Adding clomipramine to an SSRI may be helpful⁷. Also, one of the common strategies is to augment with a low dose of an antipsychotic such as risperidone²⁶.

Regular weight and adverse event monitoring should be done with baseline and follow-up assays of fasting lipid profile and serum glucose if this strategy is used⁷.

Comorbidities treatment⁷

Empirically validated medication and psychosocial treatments for comorbid disorders should be considered. A necessary intervention is treating the comorbidities well, which may help a better outcome. Additional CBT sessions are helpful for comorbid major depressive disorder. Also, family-based therapy may be incorporated for a comorbid eating disorder and supportive psychotherapy for the consequences of OCD like functional impairment in different domains of life such as school grades, self-esteem, and social aspects. Psychopharmacological and psychosocial interventions are needed for comorbid Attention-Deficit Hyperactivity Disorder. However, if ADHD is comorbid, it is better to be approached after treating the OCD⁷.

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