Obsessive-Compulsive and Tic-Related Disorders

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KEYWORDS

- Obsessive-compulsive disorder • Tic disorders • Tourette syndrome
- Exposure response prevention • Cognitive behavior therapy
- Habit reversal training

KEY POINTS

- Significant distress, functional impairment, and psychiatric comorbidity, collectively, compromise quality of life and achievement of developmental milestones for youth affected by obsessive compulsive disorder (OCD) and chronic tic disorders.
- The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, characterizes OCD as the presence of recurrent obsessions and/or compulsions that interfere substantially with daily functioning.
- A diagnosis of a tic disorder is given only when either a motor or a vocal tic is present; when both motor and vocal tics are present, the diagnosis of Tourette syndrome is assigned.
- A version of cognitive behavior therapy, known as exposure plus response prevention, is considered as a first line intervention for OCD, either alone or in combination with pharmacotherapy.
- Habit reversal training has been shown to be a promising treatment option for adults and youth with tic disorders, including Tourette syndrome.

INTRODUCTION

Obsessive-compulsive disorder (OCD) and tic disorders (TDs) affect many children and adolescents worldwide and are associated with substantial functional impairment in afflicted youth. Fortunately, in the last decade both conditions have been the focus of clinical research that has clarified key phenomenologic issues and provided empirical support for treatments including disorder-specific cognitive-behavioral interventions (eg, Refs[1–6]). The co-occurrence of these disorders, which seems to be common, poses a particular challenge to clinicians with respect to making treatment recommendations to families and to implementing the chosen interventions.

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This review provides information regarding the psychopathology of each of these conditions separately and when comorbid, as well as an outline of the empirically grounded and clinically informed approach to treatment of OCD and TDs. Moderator analyses of treatment response in the Pediatric OCD Treatment Study (POTS) I[7] indicated that secondary, comorbid tic symptoms predicted poorer response to pharmacotherapy alone but not to cognitive behavior therapy (CBT) alone or to combined treatment in a trial in which OCD was classified as the primary disorder.[8] However, the mediating variable that produced this result has yet to be fully uncovered. As yet, the converse (moderator analyses of the effect of OCD on treatment response in primary TDs) has not been explored in the context of a randomized treatment trial, and thus clinicians need to exercise their empirically informed judgment when considering treatment of primary TD when OCD is also present.

First the authors provide a focused review of psychopathology for each of these conditions, describe the core CBT protocols for treating each condition separately, and then take into consideration what is known about psychopathology and treatment when they are both present (see **Table 1** for a comparison of OCD, tics, and OCD with comorbid tics). The authors' view is that there is much reason for optimism that children who have comorbid OCD and TDs can be successfully treated, but that treating clinicians have several factors to keep in mind as they attempt to do so. Reduction of core symptoms in both OCD and TDs is important in improving the quality of life for affected youth and their families, but the judgment of which of the two conditions is driving current functional impairment and which disorder influences the symptoms of the other one directly must guide the initial treatment plan.

OBSESSIVE-COMPULSIVE DISORDER

Prevalence

OCD's prevalence rate in youth has been estimated at 1% to 3% (eg, Refs[9,10]) with variability occurring perhaps as a result of research method variance.[11] OCD is evident across development[12] and is associated with substantial dysfunction and psychiatric comorbidity.[13,14] The National Comorbidity Survey Replication Study involving over 9000 adult participants in the United States estimated that the 12-month prevalence rate of OCD was 1.0%[15]; epidemiologic studies with children and adolescents suggest similar lifetime prevalence rates in these samples (eg, Refs[9,10]). Data concerning younger children suggest that approximately 1 in 200 young people has OCD, which in many cases severely disrupts academic, social, and vocational functioning.[9]

Phenomenology

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR),[16] OCD is characterized as the presence of recurrent obsessions and/or compulsions that interfere substantially with daily functioning. Obsessions are "persistent ideas, thoughts, impulses, or images that are experienced as intrusive and inappropriate and cause marked anxiety or distress."[16(p457)] Compulsions are "repetitive behaviors or mental acts, the goal of which is to prevent or reduce anxiety or distress."[16(p457)]

There is typically a functional link between obsessions and compulsions in OCD, such that obsessions cause marked anxiety and distress and compulsions are performed in an attempt to reduce the distress or, in the case of patients with specific feared consequences, reducing the likelihood of a feared outcome (eg, catching a deadly disease, injuring someone as a result of an act of omission or commission).

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