A Naturalistic Study of Referred Children and Adolescents With Obsessive-Compulsive Disorder

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ABSTRACT

Objective: To report on clinical features, comorbidity, and response to pharmacotherapy in children and adolescents with obsessive-compulsive disorder (OCD) naturalistically followed and treated with serotonin reuptake inhibitors (SRIs). **Method:** A consecutive series of 94 patients (65 males, 29 females, age 13.6 ± 2.8 years), referred in the period January 2001–April 2004, diagnosed with a clinical interview (Diagnostic Interview for Children and Adolescents-Revised), and followed for 10 ± 6 months, were included in the study. **Results:** Contamination obsessions and washing rituals were associated with less impairment than other subtypes of OCD. Aggressive sexual obsessions and checking rituals as well as symmetry obsessions and ordering-repeating rituals were more frequently comorbid with tic disorders. According to the Clinical Global Impressions-Improvement scale (score 1 or 2), 63 subjects (67%) were responders to treatment. Nonresponders were more severely impaired and had a higher number of comorbid disorders, namely, bipolar disorder and conduct disorder ($p < .05$). Forty-seven patients (50%) received an SRI monotherapy, whereas the other 47 (50%) needed other medications. Patients receiving SRI monotherapy were less severely impaired; had a later onset of OCD; were at a younger age at the visit, had higher rates of depression and anxiety and lower rates of bipolar disorder, attention-deficit/hyperactivity disorder, and conduct disorder ($p < .05$).

Conclusions: Long-term naturalistic prospective studies in pediatric patients with OCD might represent an important source of information for everyday care regarding the effectiveness of a treatment over extended periods of time under routine clinical conditions. *J. Am. Acad. Child Adolesc. Psychiatry,* 2005;44(7):673–681. **Key Words:** obsessive-compulsive disorder, selective serotonin reuptake inhibitors.

Obsessive-compulsive disorder (OCD) in children and adolescents is a fluctuating, often chronic disorder with a wide range of clinical presentations and degrees of impairment. Although OCD has been considered a unitary disorder, factor-analytic studies of patients with OCD have identified at least four obsessive-compulsive symptom dimensions (Leckman et al., 1997). Implications for a more specific subtyping of the OCD phenotype may be crucial from a clinical point of view (i.e., different patterns of comorbidity, clinical course, response to treatment) as well as from a research perspective (i.e., different hereditability of these obsessive-compulsive traits) (Leckman et al., 1997).

High rates of comorbidity are reported in juvenile OCD, mainly with anxiety disorders, major depression, and tic disorders (Geller et al., 1996; Leonard et al., 1993; Riddle et al., 1990; Swedo et al., 1989), even though frequent comorbidity with disruptive behavior disorder (Geller et al., 1996; Leonard et al., 1993) and bipolar disorder (Geller et al., 1996; Masi et al., 2001, 2004a; Tillman et al., 2003) has been reported as well. The impact of comorbidity on clinical presentation, natural course, and response to treatment is still debated.

Even though effectiveness of cognitive-behavioral therapy (CBT) has long been documented in adults and in children and adolescents (Barrett et al., 2004), many patients with OCD can be refractory to these nonpharmacological interventions. Effectiveness of serotonin reuptake inhibitors (SRIs) has been supported by several double-blind, placebo-controlled studies,

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including clomipramine (De Veaugh-Geiss et al., 1992; Flament et al., 1985), sertraline (March et al., 1998), fluvoxamine (Riddle et al., 2001), fluoxetine (Geller et al., 2001), and paroxetine (Geller et al., 2004). A recent meta-analysis of published randomized, controlled medication trials in pediatric OCD (12 studies, 1,044 participants) showed a highly significant difference between medications and placebo, with clomipramine being superior to each of the selective serotonin reuptake inhibitors (SSRIs) (fluoxetine, paroxetine, sertraline, fluvoxamine) and with the SSRIs being comparably effective (Geller et al., 2003b). However, the overall effect sizes for medication was modest, suggesting the need for augmenting strategies or novel medications. Adjunctive medications are frequently used in ordinary clinical settings as augmenting strategies for unsatisfactory response to SRI monotherapy (McDougle, 1997), and/or to manage comorbid mental disorders, even though empirical evidence supporting effectiveness of augmenting strategies in children and adolescents is still scarce. Clinical features of children and adolescents responding to SRI monotherapy compared with those of patients refractory to SRI monotherapy are still debated.

A recent randomized, controlled 12-week study (Pediatric OCD Treatment Study (POTS) Team, 2004) explored the evaluation of CBT alone, sertraline alone, and combined CBT and sertraline in a sample of 112 patients with OCD ages 7 through 17 years. Even though CBT alone, sertraline alone, and combined treatment were superior to placebo, combined treatment was superior to both CBT alone and sertraline alone, which did not differ from each other. The remission rate for combined treatment did not differ from that for CBT but was higher than that for sertraline alone. According to the authors, these results suggest that children and adolescents with OCD should begin treatment with a combination of CBT plus an SSRI or CBT alone.

How far the results of randomized, controlled studies apply to everyday care cannot be judged without regular measurements of outcomes in daily practice. The systematic study of the outcome of pharmacological treatment in the naturalistic setting of routine clinical care is a poorly funded area, which may instead be critical to improve practice.

The aim of this study was to describe symptomatology, pattern of comorbidity, and response to pharmacological treatment in a large naturalistic sample of consecutively referred children and adolescents with OCD treated with SRIs under ordinary conditions.

METHOD

Sample

This was a naturalistic study based on a clinical database, as data concerning the outcome of routine care of a consecutive sample of patients were gathered without a predetermined research methodology. All the 467 patients aged between 7 and 18 years referred to our Pediatric Psychopharmacology Service as inpatients or outpatients in the period January 2001–April 2004 were screened for psychiatric disorders. Our Service is located within a third-level research hospital with a national catchment for children and adolescents with a wide range of neuropsychiatric disorders. The children were referred by other hospitals, community-based child and adolescent psychiatrists or pediatricians, or family members. Of these patients, a consecutive series of 98 white children and adolescents, constituting 21% of the entire sample, were diagnosed as having current OCD, using historical information, a clinical interview, the Diagnostic Interview for Children and Adolescents-Revised (DICA-R) (Reich, 1997), and symptoms ratings according to the *DSM-IV* criteria. Ninety-four of them (65 males and 29 females, 61 outpatients and 33 inpatients, age range 8–18 years, mean age 13.6 ± 2.8 years) were retained in the follow-up and were included in this study; four patients resided far from the hospital and were lost after the first diagnosis (Table 1). The high rate of patients with OCD may be accounted for by the frequent referral for childhood mood and anxiety disorders, given that our research group is particularly specialized in this field. After the diagnosis, the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) symptom checklist (Goodman et al.,

TABLE 1
Demographic Characteristics of Children and Adolescents With Obsessive-Compulsive Disorder

$N = 94$
Age range: 8–18 yr
Mean age: 13.6 ± 2.8 yr
Race: White
Social status (Hollingshead, 1957): II or III (middle to upper middle)
Gender
Males: 65 (69.1%)
Females: 29 (30.9%)
Regimen of recovery
Outpatients: 61 (64.9%)
Inpatients: 33 (35.1%)
Duration of the follow-up (mo)
Range: 3–24
Mean: 10 ± 6
Prior/concurrent treatments
Psychotherapy (psychodynamic or cognitive-behavioral): 63 patients (67%)
Before medication = 39 patients (41.5%), after medication = 24 patients (25.5%)