BD is an even higher risk factor for suicide than depression. Forty percent of children and 50% of adolescents with BD attempt suicide. High levels of irritability, impulsivity, and poor ability to consider consequences (substance abuse, and so on) increase the risk of completed suicide. Attempters are usually older, more likely to have mixed episodes and psychotic features, comorbid substance use, panic disorder, nonsuicidal self-injurious behaviors, a family history of suicide attempts, history of hospitalizations, and history of physical or sexual abuse. Ensuring safety is the first consideration. Hospitalization, partial hospitalization, intensive outpatient treatment, and intensive in-home services are used as needed for stabilization and safety.

Chapter 19

OBSESSIVE-COMPULSIVE DISORDER

Obsessive-compulsive disorder (OCD) is characterized by obsessions, compulsions, or both in the absence of another psychiatric disorder that better explains the symptoms (Table 19-1). Obsessions are persistent intrusive thoughts, images, or impulses. Compulsions are non-gratifying repeated behaviors aimed at reducing or preventing distress or anxiety. Usually the compulsions are performed to offset anxiety created by the obsessions. In children, due to low level of insight, rituals or compulsive symptoms may predominate over worries or obsessions. Symptoms are usually recognized as being excessive or unreasonable. Common examples of obsessions in children are fears of contamination, repeated doubts, need for orderliness, and aggressive or horrific impulses. Common compulsions are hand washing, ordering, checking, requesting or demanding reassurance, praying, counting, repeating words silently, and hoarding.

Prevalence of OCD in children and adolescents ranges from 1% to 4%, increasing with age. It is more common in boys at a younger age and in girls during adolescence.

At least 50% of youth with OCD have at least one other psychiatric illness. Psychiatric comorbidities include tics (20% to 30%), mood and anxiety disorders (up to 75%), disruptive behavior disorders (attention-deficit/hyperactivity disorder [ADHD] and oppositional defiant disorder), developmental disorders, body dysmorphic disorder, hypochondriasis, and obsessive-compulsive personality disorder.

Twin studies suggest that obsessive-compulsive symptoms are moderately heritable, with genetic factors accounting for 45% to 65% of variance.

Streptococcal infection causing inflammation in the basal ganglia may account for 10% of childhood-onset OCD and is a part of a condition referred to as *pediatric autoimmune neuropsychiatric disorders associated with streptococcal* (also known as *PANDAS*) infection. Antistreptolysin O, antistreptococcal DNAase B titers, and a throat culture assist in diagnosing a group A beta-hemolytic streptococcal infection. Early antibiotic therapy may help treat these cases.

Table 19-1 Criteria for Diagnosis of Obsessive-Compulsive Disorder

A. Either obsessions or compulsions
Obsessions are defined by (1), (2), (3), and (4).
1. Recurrent and persistent thoughts, impulses, or images experienced at some time during the disturbance as intrusive and inappropriate and causing marked anxiety or distress
2. Thoughts, impulses, or images are not simply excessive worries about real-life problems.
3. The person attempts to ignore or suppress such thoughts, impulses, or images or to neutralize them with some other thought or action.
4. The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion).
Compulsions are defined by (1) and (2).
1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession or according to rigidly applied rules.
2. The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts are not realistically connected with what they are designed to neutralize/prevent or are clearly excessive.
B. At some point, the person recognizes that the obsessions or compulsions are excessive or unreasonable. Note: This is not required for children.
C. The obsessions or compulsions cause marked distress; are time-consuming (taking >1 hour a day); or significantly interfere with a normal routine, occupational (or academic) functioning, or usual social activities or relationships.
D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an eating disorder).
E. The disturbance is not due to thedirect physiologic effects of a drug of abuse, a medication, or a general medical condition.
Specify the following:
With poor insight: if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable

OCD has been linked to a disruption in the brain's serotonin, glutamate, and dopamine systems. Overactivity in neural pathways involving orbital frontal cortex and the caudate nucleus has been implicated in OCD.

Physical examination may reveal rough, cracked skin as evidence of excessive hand washing. The Yale-Brown Obsessive-Compulsive Scale (also known as *Y-BOCS*) is regarded as the gold standard measure of obsessive-compulsive symptom severity. Although somewhat lengthy, it can be helpful in the clinical setting.

Cognitive-behavioral therapy (CBT) involving exposure and response prevention is considered the **treatment** of choice in milder cases. CBT provides durability of symptom relief and avoidance of potential pharmacotherapy-associated side effects. As with other anxiety disorders, CBT is at least