

Pharmacotherapy for OCD and Other Fear-Related Disorders

Evidence, Efficacy, and Clinical Applications for
Pediatricians

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References: None



Financial Disclosures



I have none to disclose.

Learning Objectives

- 1 Recognize when medication is indicated
- 2 Choose and titrate a first-line agent
- 3 Monitor benefit, activation, and safety
- 4 Know when nonresponse is not “resistance”
- 5 Escalate and refer using a stepped-care frame

Medication is an adjunct to exposure-based care, not a substitute

ERP first

For mild to moderate pediatric OCD when high-quality exposure and response prevention is available.

Add an SSRI

For moderate to severe illness, major impairment, limited ERP access, or inadequate ERP response.

Combine

Medication may reduce symptom burden enough to permit meaningful exposure practice.

Clinical pearl

The 2025 pediatric meta-analysis ranked ERP-containing treatments highest; SSRIs and clomipramine were effective, but medication-only effects were smaller.

Diagnostic clarity before pharmacotherapy

1 Identify the OCD loop

Intrusive thought, image, urge, or “not-right” experience → distress → ritual, reassurance, mental act, or avoidance → short-term relief.

2 Establish function and impairment

Ask what the behavior prevents, neutralizes, or makes feel complete. Quantify time, distress, interference, avoidance, and family accommodation.

3 Map the full phenotype

Do not stop at contamination and washing. Systematically assess checking, symmetry, “just-right,” mental rituals, taboo thoughts, reassurance, confession, and avoidance.

Clinical rule: prescribe for a well-characterized OCD syndrome, not for “anxiety plus repetitive behavior.”

Pediatric OCD is broader than contamination and washing

74.3%

Reassurance seeking

62.4%

“Just-right” behaviors

58.4%

Symmetry / exactness

31.7%

Ritualized avoidance

Why item-level assessment matters:

- Most youth in the specialty-clinic sample endorsed symptoms across multiple dimensions.
- Sensitive or stigmatized symptoms may not be volunteered without direct, normalized questioning.
- Avoidance can function like a compulsion and may be missed if assessment focuses only on visible rituals.
- Family accommodation can make severity appear lower while maintaining the disorder.

Ask directly about:

- mental rituals
- reassurance
- avoidance
- “just-right” experiences
- responsibility fears
- hidden checking

OCD or generalized anxiety? Follow the symptom's function

More consistent with OCD

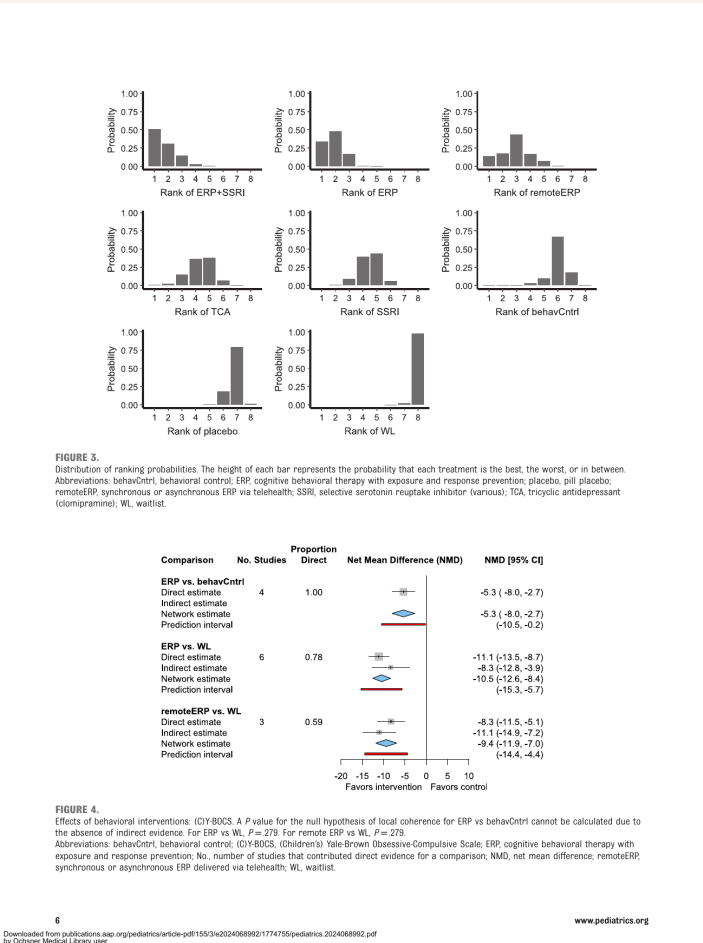
- Intrusive, unwanted thought, image, urge, or sensory “not-right” experience
- Neutralizing ritual, mental act, checking, reassurance, confession, or avoidance
- Rigid rules or repeated behavior performed until safe, certain, complete, or “just right”
- Content may be taboo, bizarre, or difficult to disclose
- Relief is brief and reinforces repetition

More consistent with GAD

- Worry centers on multiple real-life domains and anticipated future outcomes
- The thinking is usually experienced as problem-solving, even when excessive
- Repetitive reassurance may occur, but is not necessarily linked to a ritualized neutralization sequence
- No clear compulsion or “must-do” act is required to reduce the worry
- Shared features such as rumination and intolerance of uncertainty do not establish OCD

Neurocognitive group differences are research findings, not stand-alone diagnostic tests.

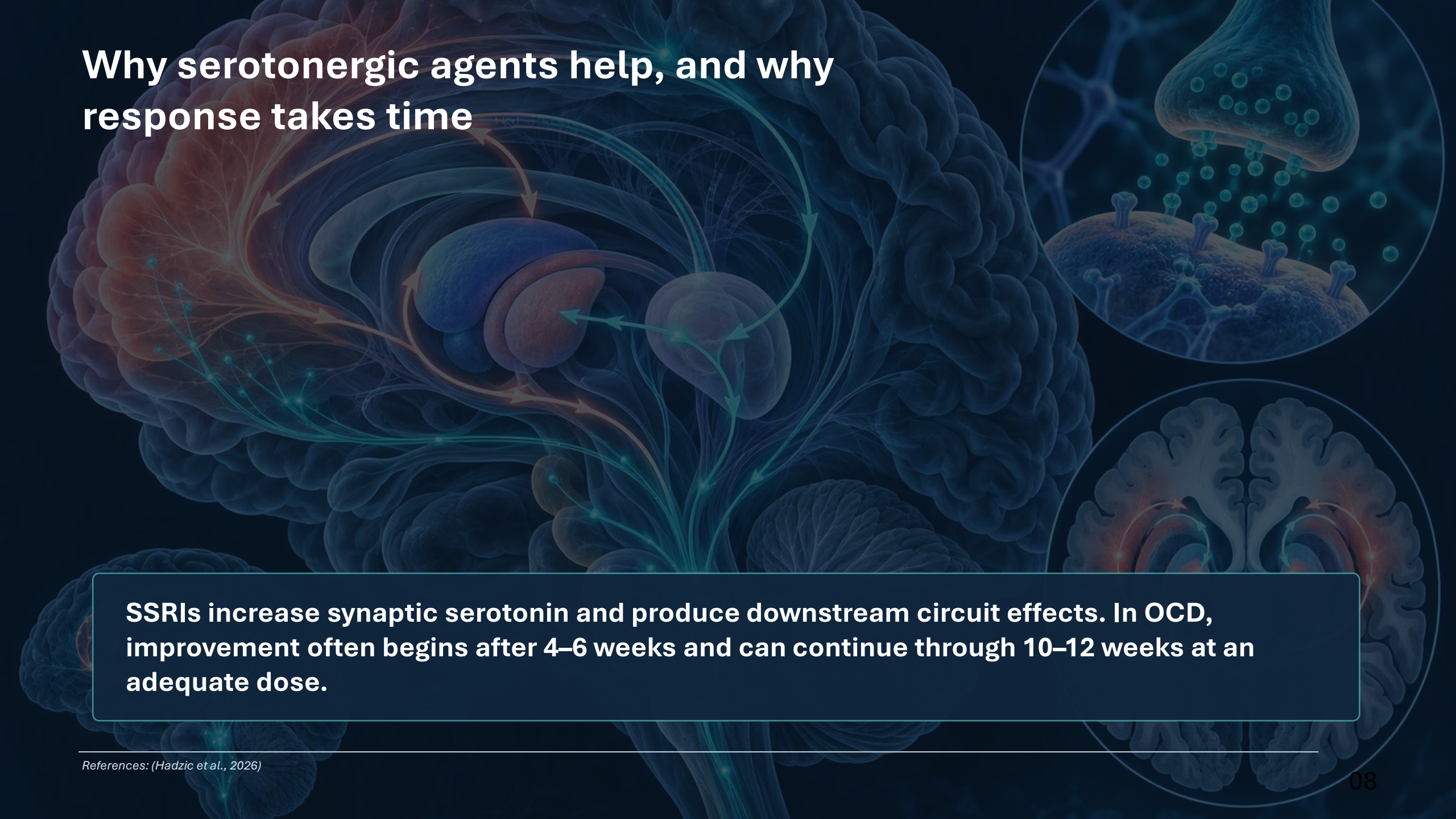
What the newest pediatric synthesis shows



Network meta-analysis: 71 RCTs

- SSRIs vs placebo: CY-BOCS NMD -4.4
- Clomipramine vs placebo: NMD -4.5
- ERP vs SSRI: NMD -2.7
- ERP + SSRI vs SSRI: NMD -3.0
- Remote ERP performed similarly to in-person ERP

Why serotonergic agents help, and why response takes time



SSRIs increase synaptic serotonin and produce downstream circuit effects. In OCD, improvement often begins after 4–6 weeks and can continue through 10–12 weeks at an adequate dose.

When should primary care add medication?

Moderate-severe symptoms

Marked time burden, distress, avoidance, or impaired school/home function

Cannot engage in ERP

Distress, rigidity, depression, ADHD, or poor insight blocks exposure work

ERP unavailable or delayed

Start evidence-based medication while actively pursuing ERP access

Partial response to ERP

Residual symptoms remain functionally impairing

Comorbidity needs treatment

Anxiety or depression may support SSRI selection; screen bipolar risk

First-line pharmacotherapy for pediatric OCD

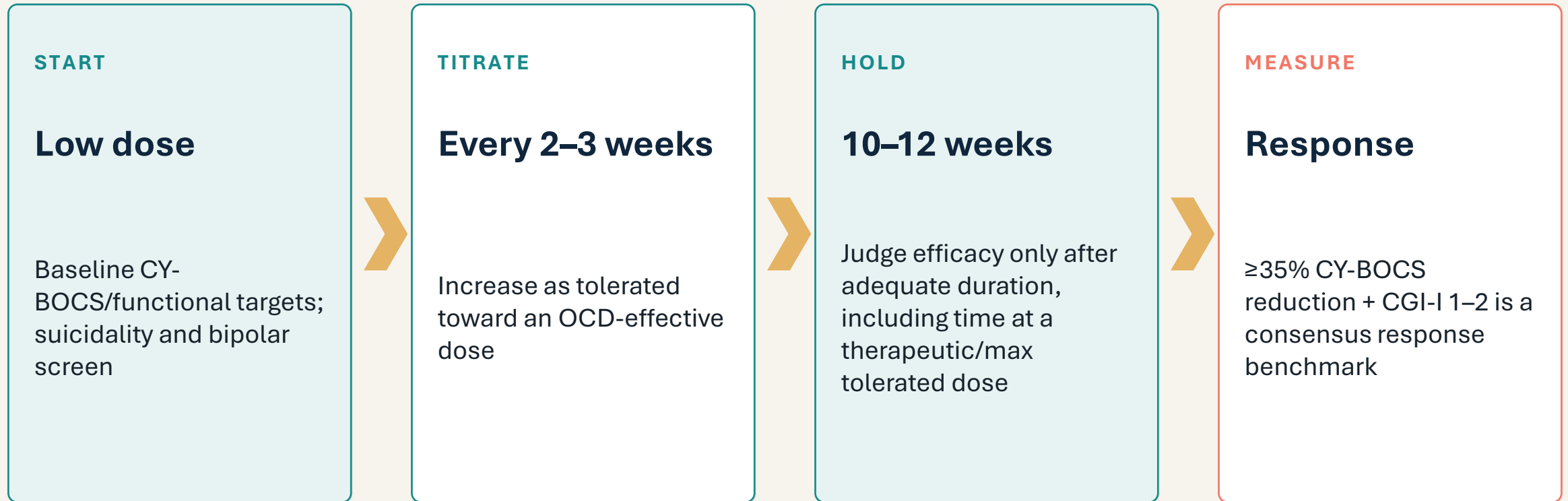
Medication	Start	Usual OCD target	Primary-care considerations
Fluoxetine	10–20 mg	20–60 mg/day	Long half-life; activating for some; CYP2D6 inhibition
Sertraline	25–50 mg	100–200 mg/day	Broad pediatric use; GI effects; relatively fewer interactions
Fluvoxamine	25–50 mg	100–300 mg/day	Sedation and interaction burden; CYP1A2/2C19 inhibition

Choose among evidence-based SSRIs by prior/family response, adverse-effect profile, half-life, comorbidity, and interactions. No SSRI has established superiority.

Dose ranges are educational and do not replace individualized prescribing or product labeling.

References: (Rajalakshmi et al., 2026); (Hadzic et al., 2026)

A practical SSRI trial: start low, titrate deliberately, wait long enough



Safety monitoring: the first month matters

Activation

Restlessness, disinhibition, irritability, insomnia. Slow titration; reduce dose if clinically significant.

Suicidality

Assess at baseline and after initiation/dose changes; provide family guidance on what requires urgent contact.

Mood switch

Ask about prior hypomania/mania and family bipolar history before prescribing.

Common effects

GI symptoms, headache, sleep changes, appetite/weight change; many are early and transient.

Set expectations with families using concrete evidence

−4.4

Mean CY-BOCS difference for SSRIs vs placebo in the 2025 network meta-analysis.

−4.5

Mean CY-BOCS difference for clomipramine vs placebo.

−3.0

Additional mean benefit for ERP + SSRI versus SSRI alone.

How to translate this clinically

Medication usually produces meaningful reduction, not instant elimination, of symptoms. Define target behaviors and functional outcomes before starting so “better” is observable.

Other fear-related disorders: what generalizes, what does not

GENERALIZES

- SSRIs are commonly first-line medication for pediatric anxiety when symptoms are moderate–severe or CBT alone is insufficient.
- Sertraline, fluoxetine, and escitalopram are common evidence-based choices; treatment should still include exposure-based CBT.

OCD-SPECIFIC

- OCD often needs a longer trial and doses toward the higher end of usual ranges.
- Compulsions and family accommodation require ERP, not reassurance-based symptom management.

Avoid turning medication into a safety behavior



Preferred Framing

- Benzodiazepines do not treat core OCD symptoms.
- Short-term use can interfere with exposure learning and carries dependence/rebound risks.
- If medication is needed while waiting for SSRI benefit, use a clearly defined, time-limited plan and avoid linking dosing to each spike in anxiety.

Clomipramine: effective, but not the first move

Why it works

Potent serotonin reuptake inhibition with established pediatric OCD efficacy.

When to consider

After inadequate response to two adequate SSRI trials, typically with specialist involvement.

- Anticholinergic burden, sedation, orthostasis, weight gain
- QT prolongation/arrhythmia and seizure risk
- Baseline and follow-up ECG; serum levels in selected cases
- Overdose toxicity and clinically important CYP interactions

Before “treatment-resistant”: audit the treatment

✓ **Correct
diagnosis?**

✓ **High-fidelity
ERP delivered?**

✓ **Adequate SSRI
dose?**

✓ **Adequate
duration?**

✓ **Adherence
confirmed?**

✓ **Comorbidity
treated?**

✓ **Family
accommodation
addressed?**

A useful working definition: failure of two adequate SSRI trials, or an SSRI plus clomipramine, plus adequately delivered high-fidelity CBT/ERP.

Second-step evidence is promising but methodologically weak



2026 Systematic Review

40

studies

5

RCTs

1,373

participants

- Most studies were uncontrolled and at high risk of bias.
- Pooled OCD remission: 39% post-treatment; 53% at follow-up.
- No reliable evidence that CBT, medication, or combined second-step treatment is superior.

Augmentation: specialist territory

Option	Pediatric Evidence	Practical Position
Risperidone / aripiprazole	Mostly open-label or naturalistic	Consider after two adequate SSRI trials + optimized ERP; monitor metabolic and motor effects
Clomipramine augmentation	Limited pediatric data; interaction risk	Requires ECG, serum-level strategy, and expertise
Memantine / NAC / riluzole / ketamine	Small, mixed, or preliminary studies	Experimental or third-line; avoid routine primary-care use
D-cycloserine + ERP	No added benefit in pooled pediatric RCTs	Do not use routinely

References: (Rajalakshmi et al., 2026); (Steele et al., 2025); (Hadzic et al., 2026)

Comorbidity changes the plan

Tics

ERP still matters. Tic-related OCD may respond less well to SSRI alone; augmentation evidence favors risperidone/aripiprazole.

ADHD

Treating ADHD generally does not worsen OCD and may improve ability to participate in ERP.

Bipolar Spectrum

SSRIs can destabilize mood. Prioritize mood stabilization and specialist collaboration.

Depression / Suicidality

Treat concurrently; severe depression or suicidality may prevent ERP engagement and require a higher level of care.

Case: 13-year-old with contamination OCD

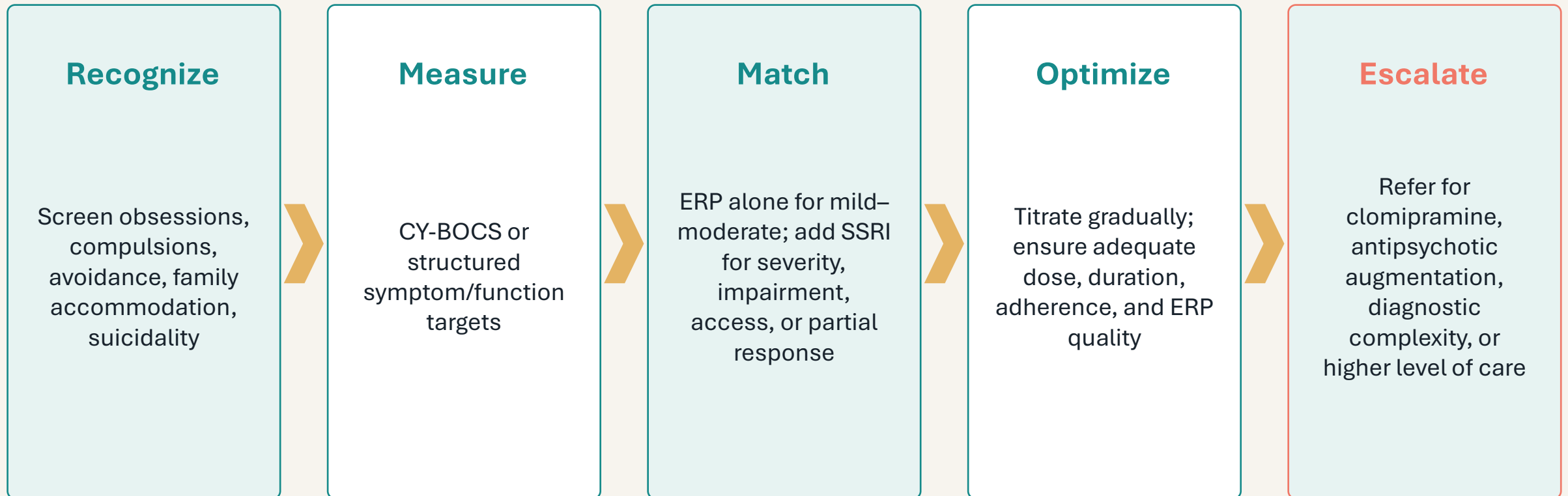
Presentation

- CY-BOCS 25
- 2–3 hours/day washing
- Missing first period
- Family providing repeated reassurance
- ERP waitlist is 10 weeks

Your plan

- 1 Confirm OCD + screen comorbidity and risk
- 2 Set targets: school arrival, washing duration, reassurance
- 3 Begin low-dose evidence-based SSRI and titrate every 2–3 weeks
- 4 Arrange ERP; coach family to reduce accommodation
- 5 Reassess tolerability early and response after an adequate trial

A primary-care algorithm



Medication works best when it creates room for exposure, development, school, and family life.

Questions & Discussion Points

Where do medication decisions become difficult in your practice?

Discussion Prompts

- Starting medication while waiting for ERP
- Talking with families worried about activation or suicidality
- Deciding when to refer for augmentation

Five sentences to remember Monday morning

- 01 ERP is foundational; medication is added when severity, access, or partial response warrants it.
- 02 Fluoxetine, sertraline, and fluvoxamine are evidence-based first-line medications for pediatric OCD.
- 03 Think in adequate trials: gradual titration, OCD-effective dose, and 10–12 weeks before declaring failure.
- 04 Monitor activation, suicidality, sleep, GI effects, and bipolar risk, especially early and after dose changes.
- 05 Before augmenting, verify diagnosis, adherence, ERP quality, family accommodation, and comorbidity.

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