Understanding Obsessive Compulsive Disorder

by David L. Smoot, Ph.D.

Fears, worries, and ritualistic behavior or habits are common in children. However, some children become "stuck" in unrealistic thoughts and habits that they cannot overcome. Some people have described the symptoms of OCD as a case of mental hiccups that will not go away. Historically, OCD symptoms have been poorly understood and misdiagnosed. Today, we know a lot more about how to help children like those described below.

Case Studies

Paul was a serious, almost sad looking, 11 year old boy. About two months before his parents brought him to my practice, he began telling them that he was afraid he had killed someone during his customary practice of throwing rocks in the field behind his house. He became more and more convinced that someone was lying dead in the field. In my office, he admitted that he was also distressed by violent images of hurting others.

Samuel was referred for an evaluation because his teachers and parents thought he had ADHD. As a matter of fact, Samuel was failing to finish his work, he did not seem focused, and he did not participate in class discussions. After extensive interview, however, I found that Samuel was routinely counting the letters in words his teacher said. If the number was not even, he would add a letter in his head. Naturally, it was very difficult for him to concentrate while doing such a complex task.

Natalie lived in extraordinary fear of being contaminated by germs. When she opened a door, she pulled the sleeve of her shirt over her hand so she would not have to touch the doorknob directly. She always wore turtleneck shirts so she could pull the collar over her nose and mouth to ward off germs. She would not use the first tissue in a box, but would yank out the first few before getting one she could use.

Jeremy did not really know why, but he believed he had to get dressed in a certain order. Every day, it was underpants, socks, pants, then shirt. Never changing the routine, he believed he had to start over if he ever got out of sequence. Because of his determination to only wear certain clothes, he often had horrible conflicts with his mother over getting dressed in the morning. Jeremy also had the overwhelming urge to "balance out" his actions. That is, if he bumped into something with his left shoulder, he believed he next had to go back and bump it with his right. He would repeat this again and again until he felt he "got it right."

Will was a hoarder. He kept everything he ever used or found. Thinking he may need these articles at some point, he refused to throw away scraps of paper, old boxes, candy wrappers, string, etc. He screamed at his mother if she ever tried to throw away or even disturb his things. It got to the point where she was helping him gather these little tidbits in her efforts to bring peace into his life.

What is it?

Obsessive-compulsive disorder (OCD), one of the anxiety disorders, can range from mild to very serious in terms of how severely it affects the young person's life. As you can see from the case studies above, there are many types of obsessions and compulsions that afflict young people with OCD. Children with OCD become trapped in a rut of repetitive and intrusive obsessions and compulsions that bother them greatly. They often know the obsessions and compulsions are pointless and time-consuming; nevertheless, they are unable to stop engaging in them.

Obsessions are defined as repetitive thoughts or worries that intrude on the child's thinking. Compulsions are activities or rituals that are performed to make the anxiety caused by the obsessions go away. So when the child who is mortally afraid of germs experiences something "yucky," he or she may feel compelled to wash repeatedly until the anxiety goes away. OCD rituals can be categorized into the following types:

Category of OCD Behavior	Description
Washer	May wash hands or other parts of the body excessively. This OCD behavior may lead to severe chapping and even bleeding of the skin.
Counter	These children may feel they have to count up to a certain "lucky" number or they may repeatedly count things in their environment (e.g., tiles on the floor, books on a shelf, etc.)
Checker	Frightened of intruders, these children repeatedly check windows, doors, etc. Some check to see if appliances are turned off, homework is done perfectly, etc.
Hoarder	The child who hoards believes the proverbial rainy day is right around the corner and is saving everything just in case. Useless objects can begin to engulf the space in a child's room, but they can become enraged or extremely anxious if someone messes with their things.
Repeater	This child believes that something bad might happen unless he or she repeats an act a number of times. He or she may scrub hair a certain number of times, chew food before swallowing a certain number of times, etc.
	This child believes an activity must be

Orderer	done in a certain sequence or that things must be arranged in a certain order. "Something just does not feel right" until he or she has ordered things to satisfaction.
Cleaner	The cleaner, like the washer, is likely to be obsessed about germs. He or she may spend hours washing counters, walls, tables, door knobs, etc. to eliminate germs and the risk of disease.
Pure Obsessive	A difficult type of behavior to treat, the purely obsessive child is overcome with guilt, intrusive thoughts about violence, worry, etc. There may be no compulsions going along with the obsessions, though sometimes the compulsions are done in the child's mind (e.g., counting, praying, chanting) and are difficult to identify.

The Diagnostic and Statistical Manual-Fourth Edition defines OCD in the following way. The child or adolescent with OCD:

- Experiences obsessions and/or compulsions on a frequent basis. Although the person often knows the symptoms are senseless and distressing to carry out, the individual has not been able to stop even though highly motivated to do so.
- Has compulsions that are carried out to help get rid of the anxiety. Compulsions are typically visible acts such as washing or repeating, but may also be hidden, mental acts such as counting, chanting, etc.
- Spends excessive time involved in ritual compulsions or obsessive worries. OCD behavior, in order to be diagnosed, must be distressing to the individual and/or must take up an inordinate amount of time (more than an hour a day). Many children complain about the activities they miss or the time they "must" devote to their rituals.
- Has fears that are not simply exaggerated fears about otherwise sensible concerns. Many individuals with OCD realize that their rituals are pointless, but this level of insight is not always evident in children.

Who Gets it?

Prevalence: Researchers estimate that one in 200 children and adolescents suffers from OCD. Studies indicate that at least one-third of cases of OCD in adults began in childhood. Although Obsessive-Compulsive Disorder was previously thought to be relatively rare in the general population, recent community studies have estimated that about 2.5% of people suffer from OCD at some point in their

lifetimes. In any given year, it is estimated that about 1.5% - 2.1% of the population may have OCD.

Normal vs. OCD: Almost all children show some obsessive-compulsive habits and rituals during early development. Younger children often resist changes in routine, insist parents follow various rituals around bedtimes, baths, etc. Of course, it is also perfectly normal for young children to jump over cracks in the sidewalk so they will not "break mother's back." Habits or rituals begin to trigger concern when they are upsetting to the child, when he or she cannot stand it if prevented from carrying out the ritual, and if the ritual demands increasing amounts of time (taking more than one hour per day).

Biological Basis: OCD has been shown to have a strong biological basis in the brain. Numerous studies have demonstrated that OCD and related disorders tend to run in families as well. Adults with OCD have been found through neuroimaging techniques to have differences relative to normal adults in the circuits linking the basal ganglia to the cortex. These circuits use a neurological transmitter called serotonin to communicate with each other. Medications that increase the availability of serotonin in the brain often help individuals with OCD. Moreover, these abnormalities have responded or changed toward a more normal presentation following either medication or cognitive-behavioral (talking) therapy.

A small subset of children with OCD or other similar disorders may actually be reacting to a streptococcal infection related to strep throat. This subtype of OCD has been termed *Pediatric Autoimmune Neuropsychiatric Disorder Associated with Strep*, or simply **PANDAS**. On occasion, I have seen children who suddenly developed severe OCD symptoms after a bout of strep had made its way through their family. The way strep infections cause OCD reactions is complex, but it again involves the basal ganglia of the brain, the region of the brain mentioned above as linked with OCD. Some children or adolescents can be benefitted from antibiotic therapies if their OCD is a reaction to strep.

Early Risk: Many OCD children show early risk signs even before OCD fully develops. They may be overly anxious and fearful, they are eager to please, and they may excessively seek reassurance. This type of child is constantly checking in with a parent asking, "Is this ok?" or "Did I do this right?" Sometimes parents of these children worry their child is not independent enough. Some parents, however, foster this dependence by always "doing for their child" what he or she could do independently.

Gender: According to the National Institute of Mental Health (NIMH), boys are more likely than girls to be diagnosed with OCD during childhood. Girls are more likely than boys to be diagnosed during teen years, and the number of girls and boys diagnosed with OCD equalizes as they near adulthood.

What Goes Along with It?

OCD is sometimes accompanied by depression, anxiety disorders, eating disorders, ADHD, learning disabilities, Tourette Syndrome, or tic disorders. Rare cases include hair pulling or picking at the skin. Some children with OCD have nonverbal reasoning problems compared with their good verbal reasoning skills. This means the child can talk about and understand information at a fairly high level, but has trouble visualizing solutions, handling hands-on material, writing, or drawing. These problems often make school work challenging and social skills awkward.

External Links
www.ocdfoundation.org
www.nimh.nih.gov/publicat/ocd.cfm
www.anxieties.com

How Is It Identified?

It is imperative that the clinician involved is very familiar with OCD and the way it presents in children and adolescents. It is extremely common for OCD to pose as some other condition, such as ODD or ADHD. The clinician must listen for clues as to OCD's presence during a full diagnostic interview with parents. When indicated, the clinician should also interview the child directly and ask questions about OCD symptoms. I have found in my experience that many children are surprised, even relieved, to learn that other children experience the same anxieties and urges they do. The parents and usually the child may also fill out checklists specific to OCD such as the YBOCS (Yale-Brown Obsessive Compulsive Scale) or the Leyton Obsessional Inventory - Child Version. These help to determine the baseline number and severity of the symptoms. Other general rating forms should be used as well to explore the conditions that can go along with OCD. When indicated, a comprehensive educational and psychological evaluation may be needed to determine whether learning disabilities or other emotional disorders are present. The clinician should also remember to ask about the time and severity of onset. If onset was sudden and severe, it is worthwhile to collaborate with the parents and physician to determine if strep-related triggering of OCD has occurred.

What Treatments are Available?

On the negative side, one can conclude legitimately from the case studies and other information that children with OCD are very distressed, avoid many of the normal situations that make life enjoyable, and get negative reactions from adults and peers. *However*, the positive side is that treatments have been demonstrated to be very helpful for individuals with OCD. The most common and effective treatments for OCD can be described as**cognitive-behavioral therapy (CBT)** and **psychiatric medications**. Medication and CBT have been found to be equally effective in the treatment of OCD, though CBT seems to help the person achieve longer-lasting results. Since medication was covered in an earlier section, only CBT will be described here.

There are three basic types of CBT used for children and teens in the treatment of OCD: Exposure/Response Prevention (E/RP), Cognitive Therapy (CT), and Anxiety Management Training (AMT). All three techniques lend themselves well to a "coaching" kind of therapy in which the therapist helps the child learn about and practice skills. These skills then help the child overcome challenges and achieve goals related to eliminating OCD symptoms. E/RP involves exposing the child to known obsessive triggers (e.g., sticky messes) and preventing the desired compulsive response (e.g., washing). E/RP must be done carefully using a hierarchy of increasingly more challenging obsessive triggers. CT involves identifying the thought patterns that enable OCD to take root in the child and helping the child "fight back" against OCD. John March, M.D., of Duke University Medical Center , has developed a successful treatment manual called *How I drove OCD out of my territory.* In this manual, Dr. March describes many cognitive interventions including developing a perspective that OCD is an invader who has taken over decisions and situations that rightfully should be under control of the person. Children are encouraged to fight back and regain control over their lives. Other CT methods include correcting distorted beliefs (e.g., touching a toilet seat leads to cancer) and accepting that there are other ways to relieve anxiety (see AMT) besides engaging in compulsions. Finally, AMT may include relaxation training, exercise, recognition of early warning signs of anxiety, etc.

What can parents do to help?

Education is the most important step parents can take to help their child with OCD. Parents need to become experts, not only on their child's personality and history, but also on childhood OCD. Many books, videos and websites are now available to help parents advocate for their child suffering from OCD. Your patient understanding will help you gradually remove yourself from your child's rituals. Remember Will from the case studies whose mother helped him hoard trivial things so he would not yell? She had to learn to resist his demands and help him stand up to OCD as well. Parents should be gentle with their OCD child even when rituals and fears are exasperating. Some evidence suggests that OCD symptoms may worsen in times of stress and conflict. Parents certainly do not want to unintentionally make the problems worse because they are venting their frustration on their child. For school-age children, parents will want to work closely with teachers so they too will understand OCD and the impact this disorder has on classroom behavior. All adults in the child's life — parents, teachers, grandparents — should understand how to help the child work through anxiety and not criticize the child for his or her obsessions and compulsions. Your child's therapy can only succeed if you are willing to take an active role in understanding, advocating for, and encouraging your child to overcome OCD.

RESOURCES

Books:

Foa, E. and Wilson R. (1991). *Stop Obsessing! How to Overcome Your Obsessions and Compulsions*. New York : Bantam Books.

Foster CH. (1994). *Polly's Magic Games: A Child's View of Obsessive-Compulsive Disorder.* Ellsworth , ME : Dilligaf Publishing.

Johnston HF (1993). *Obsessive Compulsive Disorder in Children and Adolescents: A Guide*. Obsessive-CompulsiveInformation Center .

Moritz, E.K. and Jablonsky, J. (1998). *Blink, Blink, Clop, Clop, Why Do We Do Things We Can't Stop?* ChildsWork, ChildsPlay.

Rapoport, J. (1991). *The Boy Who Couldn't Stop Washing : The Experience and Treatment of Obsessive Compulsive Disorder.* Penguin Books.

Video:

OCD In School-Aged Children. Obsessive-Compulsive Foundation.

The Touching Tree. Jim Callner, writer/director, Awareness films. Distributed by the O.C. Foundation, Inc.,Milford , CT. (about a child with OCD).

Self-Help Resources:

Obsessive-Compulsive Foundation
PO Box 70
Milford , CT 06460-0070
(203) 878-5669
(203) 874-3843 (recorded information)
www.ocfoundation.org

OC Information Center
2711 Allen Boulevard
Middleton , WI 53562