



Editors' Comment

Obsessive-Compulsive Disorder (OCD) affects over 3 million adult Americans regardless of socioeconomic, religious or ethnic background. Although OCD can strike at any age, it usually first appears in childhood or adolescence and often goes unrecognized. OCD is marked by unwanted obsessions and compulsions which can seriously affect a child's life, interfering with family and social relationships as well as academic achievement. OCD takes time and energy and can make daily life very stressful for children, who often feel shame and embarrassment. OCD is sometimes accompanied by other manifestations of anxiety, depression, or other disorders, factors which add to the importance of identification and treatment. Considerable progress, however, has been made in understanding and treating OCD. It responds well to treatment with medication and/or carefully targeted cognitive behavioral therapy (CBT). Treatment works best when the child's family is involved.

In this issue of the NYU Child Study Center Letter we discuss the thoughts and behaviors that mark the possible presence of OCD, differentiate it from the normal rituals and routines of childhood, prevalence, theories of causation, and the scientifically-based interventions that have been shown to be effective. Included is a description of Exposure and Response Prevention, a form of Cognitive Behavior Therapy, which is the only type of psychotherapy currently recognized by the American Psychological Association as being effective in treating OCD.

AG/HSK

Recognizing and Treating Obsessive-Compulsive Disorder in Children

Introduction

Dante, 7 years old, must do or touch things in a certain way ("I have to lift my hand off the table perfectly!"). He believes that if he does not do this, something horrible will happen to him or one of his parents. In addition, he avoids saying or encountering certain numbers (namely, 6 and 13). This greatly interferes with his ability to get ready for school in the morning, complete homework, or take part in a family meal. It often takes him twice or three times as long as it should to complete even the simplest of tasks, because he must hesitate and/or redo something over and over until he gets it "just right."

Kevin, 11 years old, can't bear to be around certain people, because he fears that by having any contact with them, he may become contaminated and take on what he terms their "dirty" qualities. When asked what might happen then, Kevin says that he will contract AIDS. This leads him to avoid letting strangers and kids at school bump into him, avoid touching things in public (he pulls his jacket sleeve over his hand whenever he must open a door), and wash profusely when he comes home from school. He also insists that the family wash immediately upon coming into the house and screams and throws tantrums if they do not comply.

Brianna, 17, can no longer drive the family car, because she is

convinced that she has run over someone whenever she feels a bump in the road. This causes her to check and recheck in the rearview mirror, as well as drive around the block several times just to go back and "make sure" that she did not hit anybody. She has also started to fear being around knives in any situation, due to intense fears that she will pick one up and stab someone. As a result, she can no longer be in the kitchen when food is being prepared and insists that only dull plastic knives be used when the family is eating dinner.

These children are suffering from Obsessive-Compulsive Disorder (OCD), a serious and often debilitating anxiety disorder.

What is Obsessive-Compulsive Disorder (OCD)?

OCD is characterized by the presence of both of the following:

Obsessions: recurrent thoughts, urges, or mental images that are unwanted and cause anxiety or distress. Often the obsessions are senseless, unpleasant, distasteful, or even repugnant. They are not simply excessive worries about real-life problems (e.g., chronic worrying about completing homework or performing well on tests).

Compulsions: The thoughts or

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actions a person suffering from OCD will perform in an attempt to ignore, suppress or “neutralize” their obsessions. Compulsions typically involve repetitive behaviors (washing, checking, avoiding) or mental acts (counting, silently repeating certain words, praying) that a person feels he or she must perform in order to reduce distress or prevent some dreaded event. They often have a bizarre quality, in that they are not realistically connected to what they are designed to neutralize or prevent.

How is OCD different from other childhood routines?

Most young children go through a period where they insist on elaborate rituals at mealtime, bathtime, or bedtime, as part of the process of understanding and mastering daily routine. These behaviors are probably not OCD because they are a part of normal development and typically subside in middle childhood.

For children with OCD, however, obsessive thoughts and compulsive rituals continue past the developmentally appropriate age, or become too frequent, intense, or distressing. Obsessions and compulsions also begin to interfere with daily functioning, meaning that they negatively impact a child's ability to attend school, complete homework, enjoy time with friends, or pursue hobbies. The disorder may also impact family functioning, as when parents must change their daily routine or give in to their child's demands to take part in the rituals in order to prevent the child from becoming too anxious or distressed. Adults with OCD typically recognize that their obsessions and compulsions are excessive or unreasonable. This is not always the case with children, however, since some do not yet have the necessary cognitive skills

to make this judgment.

What causes OCD?

In the past, OCD was thought to be the outward manifestation of “unconscious conflicts” or even “unconscious desires” (i.e., the person with unwanted images of doing harm to others was thought to truly want to do so!). This theory has been discredited and disproved, with current scientific evidence strongly suggesting a neurological origin, most probably an imbalance of serotonin in particular areas of the brain. Anxiety disorders, including OCD, tend to run in families, indicating a genetic component to the underlying cause.

How common is OCD?

OCD occurs in about 1 in 50 adults. The most recent epidemiologic studies suggest that OCD is present in 0.2 - 0.8 percent of children, and up to 2 percent of adolescents. These statistics translate into three to five children with OCD per average-sized elementary school and as many as twenty in a large urban high school.

OCD has been termed a “hidden epidemic” in young people, because it so often goes unrecognized or untreated. For instance, in a recent study of adolescents, less than 25% of those found to be suffering from OCD were in treatment, and none of them (including those receiving treatment) had been correctly identified as even having OCD! Young people are especially likely to feel bewildered and ashamed of their symptoms and attempt to hide them from their family members and friends.

What are the recommended treatments?

The *Expert Consensus Guidelines for Treatment of OCD*, based on a survey of treatment preferences

by 69 recognized clinicians and researchers in the field and published in the *Journal of Clinical Psychiatry* in 1997, recommends Cognitive-Behavioral Therapy (CBT), either alone or combined with medication. Many families, particularly those whose child is under the age of 12, prefer to start with CBT alone and only add medication later if it is needed.

CBT, specifically the form known as Exposure and Response Prevention (EX/RP), is the **only** type of psychotherapy currently recognized by the *American Psychological Association* as efficacious in treating OCD, meaning that CBT has been well-established in high-quality, scientifically-based treatment studies. Exposure and Response Prevention involves helping individuals to gradually bring themselves into contact with feared situations without performing their usual neutralizing rituals. This type of therapy requires a clinician who is specially trained in its techniques, and should not be attempted by parents alone.

How does CBT treatment typically proceed?

Phase I involves psychoeducation, where the therapist teaches children and their families about the disorder, anxiety in general, and the cognitive-behavioral model of treatment. The techniques that will be practiced in therapy, including exposure and response prevention, are introduced as “tools” that the child will acquire to “boss back” OCD and reclaim areas of their lives that OCD currently disrupts.

Phase II involves collaborative work between the child and therapist as they “map out” the child’s OCD symptoms, generate an exposure hierarchy, and begin

implementing EX/RP during subsequent session. The child and therapist work as partners against a common enemy – OCD – which enhances the trust a child must have in the therapist as exposures get underway. Typically, therapy sessions are used for exposures that the child is trying for the first time, and then independent practice sessions are planned for home so that the child can further master the skills and continue to “shrink” OCD.

In Phase III, CBT prepares children and their families for the cessation of active treatment. The likelihood of an eventual reemergence of symptoms is discussed explicitly, both to normalize the experience as well as to encourage children to take on more independence in planning and executing remaining exposures. In the last few sessions, therapists work carefully with children to develop a plan for relapse prevention, emphasizing that the same skills the children have mastered in therapy are those that they can use on their own whenever the need arises. Moreover, booster sessions are scheduled so that therapists and children can reconnect at regular intervals to address any problems or simply to check in and celebrate continued good health.

Treatment sometimes leads to a near- or total attenuation of symptoms. Most of the time, however, OCD has a chronic waxing and waning course, similar to other anxiety disorders. Symptoms may reoccur during times of stress, fatigue, or physical illness – and sometimes out of the blue. This does not mean that a child will experience a complete “relapse.” Rather, a reemergence of symptoms can serve as a signal to children that it is time to revisit the skills they learned in therapy and implement them as needed.

It is in this way that CBT teaches adaptable coping skills that

children will be able to use for the rest of their lives. For instance, the ability to recognize problems that are getting out of hand and then develop thoughtful plans to solve them is a general skill that children will find they can apply to a host of situations. This will in turn promote feelings of confidence and self-efficacy that can only enhance positive development and good mental health throughout childhood and beyond.

I think my child may have OCD – What can I do?

First, recognize that you have taken an important first step simply by reading this article. Continue to educate yourself, but be careful to seek reputable resources. We recommend the following websites:

<http://www.ocfoundation.org>
<http://www.freedomfromfear.org/>

If you are still strongly concerned, seek an evaluation with a therapist or clinic with a good reputation for addressing OCD in children with the proven treatments.

About the Author

Katherine Dahlsgaard, M. A., is a therapist in the Institute for the Treatment of Anxiety and Mood Disorders at the NYU Child Study Center, where she specializes in Exposure and Response Prevention (EX/PR), a form of Cognitive Behavioral Therapy. The recipient of the National Science Foundation fellowship award, Ms. Dahlsgaard has published widely in scientific journals and books on the topics of positive mental health, psychopathology, and child development.