Treatment Options

The two treatments that have been shown to be the most effective in treating childhood OCD are medication and cognitive-behavioral psychotherapy (CBT). These two treatments are often used together to best help the child overcome their illness, especially at the beginning of psychotherapy to help decrease the child's anxiety enough to proceed with therapy. Both affect brain chemistry, which in turn affects behavior.

Medication

- Certain medications can regulate serotonin, which can be effective in reducing obsessive thoughts and compulsive behaviors.
- Presently, four medications have been approved by the FDA for use in children: clomipramine (Anafranil®), fluoxetine (Prozac®), fluvoxamine (Luvox®) and sertraline (Zoloft®).
- Medication is generally considered for use when the child experiences severe symptoms, to improve the effectiveness of psychotherapy, or when psychotherapy is not available to the child.

Psychotherapy

- Cognitive-behavioral therapy can help the child learn to change his or her thoughts and feelings by first changing their behavior.
- Exposure and Response Prevention (ERP), is used to aid children with OCD in decreasing anxiety and thus decreasing their need to engage in compulsive behavior.
- In ERP, the child is placed in situations that expose them to their worrying thoughts (obsessions) while also preventing the child from doing the behaviors or rituals (compulsions) that normally decreases his or her anxiety.
- While the child may be more anxious initially, over repeated exposures, the child's anxiety subsides.

References and Resources

On the Web

Obsessive Compulsive Foundation of Metropolitan Chicago
www.ocfchicago.org

Obsessive Compulsive Foundation
www.ocf.org

National Institute of Mental Health (NIMH)
www.nimh.nih.gov/healthinformation/ocdmenu.cfm

Worry Wise Kids
www.worrywisekids.org/anxiety/ocd.html

Readings for Parents

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Albert Whitman.

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Up and Down the Worry Hill: A Children's Book About Obsessive Compulsive Disorder and Its Treatment (2nd ed.).
Lighthouse Press, Inc.

Talley, L. (2004).
A Thought is Just a Thought: A Story of Living With OCD.
Lantern Books.

Readings for Adolescents

Spencer Hesser, T. (1999).
Kissing Doorknobs.
Laurel Leaf.

Harrar, G. (2004).
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Houghton-Mifflin: Boston.

Hayman, I., & Wells, J. (2006).
Touch and Go Joe: An Adolescent's Experience of OCD.
Jessica Kingsley Publishers: London.

If you are concerned that your child may have obsessive-compulsive disorder you should first seek out a mental health professional so your child can receive a thorough diagnostic evaluation. The treatments listed below are offered to serve as a brief outline of possible options, but are not intended to replace the advice of your child's physician or mental health professional.

For more information, please contact:

Department of
Psychological Services
Elaine Kersten Children's Center

255 Revere Dr, Suite 200
Northbrook, IL 60062

T 847 412 4366
F 847 412 4360
www.jcfs.org

Jewish Child & Family Services is a partner in serving our community, supported by the Jewish United Fund/Jewish Federation of Metropolitan Chicago.

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Authored by Anna Loney, M.A., March 2007

JCFS

A Guide for Understanding
Obsessive-Compulsive Disorder
In Children and Teens

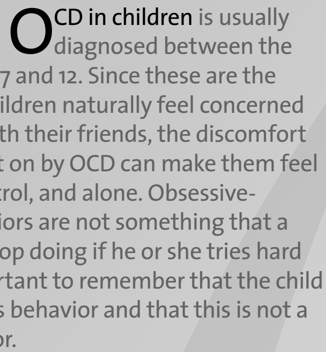
Every night after his mom and dad go to bed, Caleb gets out of bed and checks to make sure his family members are safe in their beds and checks to make sure all doors are locked. Sometimes Caleb does this over and over again. He has a tantrum if he is not allowed to do this.

What is Obsessive-Compulsive Disorder?

It is important to remember that the child cannot control this behavior.

All children have worries and doubts. However, children who have obsessive-compulsive disorder (OCD) cannot stop worrying. Those worries (obsessions) compel them to behave in certain ways repetitively (compulsions). The rituals or habits decrease the child's anxiety caused by the obsessions only temporarily. Because the rituals make the child feel better for a period of time, the child is likely to engage in that behavior repeatedly in an attempt to feel less anxious.

An estimated 1-2% of children in the United States experience OCD, which is characterized by this pattern of rituals and obsessive thinking. The child will spend at least an hour each day occupied by his or her rituals. In OCD, these thoughts and behaviors cause the child a lot of distress and can cause problems or disruptions in daily routines, in school and home functioning, and in relationships with family and friends. The condition is more prevalent than many other childhood disorders or illnesses, but children often keep the symptoms hidden from their families because they are embarrassed about them.



OCD in children is usually diagnosed between the ages of 7 and 12. Since these are the years when children naturally feel concerned about fitting in with their friends, the discomfort and stress brought on by OCD can make them feel scared, out of control, and alone. Obsessive-compulsive behaviors are not something that a child can simply stop doing if he or she tries hard enough. It is important to remember that the child cannot control this behavior and that this is not a sign of misbehavior.

It is also important to distinguish between normal developmental rituals or a child's preferences for routines found in childhood and those that characterize OCD. The main difference is that children with OCD experience significant distress if the ritual is prevented or if the sequence of behaviors is interrupted. Whereas most children's rituals will generally dissipate during childhood, the behaviors of children with OCD will not.

Compulsions

- Grooming rituals, including hand washing, showering, and teeth brushing; the child may have elaborate bathing or showering rituals; he or she may report that a specific washing and grooming pattern must be followed daily
- Repeating rituals, including going in and out of doorways, needing to move through spaces in a special way, checking to make sure that an appliance is off or a door is locked, and checking homework
- Rituals to undo contact with a "contaminated" person or object
- Touching rituals
- Rituals to prevent harming self or others
- Ordering or arranging objects
- Counting rituals
- Hoarding and collecting things
- Cleaning rituals for the house or other items
- Asking those around them for reassurance or insisting that things are done "right"

Recognizing OCD is often difficult because a child can become adept at hiding the behaviors. It is not uncommon for a child to engage in ritualistic behavior for months, or even years, before parents know about it. Also, a child may not engage in the ritual at school, so parents might think that the ritual is just a phase the child is going through. When a child with OCD tries to contain these thoughts or behaviors, this creates anxiety. A child who feels embarrassed or as if he or she is "going crazy" may try to blend the OCD into the normal daily routine until he or she just can't contain it anymore. It is common for a child to ask the parent to join him or her in the ritualistic behavior.

Initially, the parent might not notice what is happening. Tantrums, excessive crying, overt signs of worry, or difficult behaviors (e.g. a "meltdown") are common when parents fail to participate in their child's rituals. It is often this behavior, as much as the OCD itself that brings families into treatment. Environmental and stress factors can signal the onset of OCD. These can include ordinary developmental transitions (such as starting school) as well as significant losses or changes (such as the death of a loved one or moving).

Several different factors are believed to contribute to an individual's development of OCD. Scientists have shown that OCD is caused by an imbalance in brain chemicals, particularly serotonin; however, the exact way in which this imbalance develops is not clearly understood at this time. Certain structures of the brain in individuals with OCD are more sensitive to cues in the environment and have difficulty suppressing behavioral response patterns.

OCD also tends to be more common in children with a family history of OCD, suggesting a genetic link. OCD has also been linked to the contraction of a certain type of strep infection. Lastly, while OCD is not caused by stress or life events, these things have been shown to trigger OCD in some and can exacerbate symptoms in those who have already developed the disorder. It is important to remember that parents cannot cause their child to develop OCD and that children who have developed OCD cannot control their behavior as it relates to their illness.

Obsessions

- fear of dirt or germs
- fear of contamination
- need for symmetry, order, and precision
- religious obsessions
- preoccupation with body wastes
- lucky and unlucky numbers
- sexual or aggressive thoughts/images
- fear of illness or harm coming to oneself or relatives; the child may have fears of catching a life threatening illness
- preoccupation with household items
- intrusive sounds or words; he or she may complain about an inability to stop hearing intrusive and recurrent songs or rhymes
- need for perfection

First, the child has to do something and then the parent has to do something else. If a child says, "I didn't touch something with germs, did I?" the parent might have to respond, "No, you're okay." This ritual will begin again for a certain number of times.

Possible Signs of OCD

- raw, chapped hands from constant washing
- unusually high rate of soap or paper towel usage
- high, unexplained utility bills
- a sudden drop in test grades
- unproductive hours spent doing homework
- holes erased through test papers and homework
- requests for family members to repeat strange phrases or keep answering the same question
- a persistent fear of illness
- a dramatic increase in laundry
- an exceptionally long amount of time spent getting ready for school or for bed
- a continual fear that something terrible will happen to someone
- constant checks of the health of family members
- reluctance to leave the house at the same time as other family members