

# Obsessive Compulsive Disorder in Children and Adults: Current Research and Interventions

*Summarized by Thomas T. Thomas*

It's an idea that won't go away, no matter how hard you try. Or a little ritual you have, like pulling the handle after you shut the car door, even though you distinctly remember locking it. Magnify these mental aberrations a hundred or a thousand times, and you begin to appreciate obsessive compulsive disorder, or OCD. The speaker at our May 28 meeting, **Margo Thienemann, MD**, works with the OCD Clinic at the Stanford University School of Medicine and is a member of The Children's Health Council in Palo Alto.

"Obsessive-compulsive disorder is classified as a type of anxiety," Dr. Thienemann said. "It's a neuropsychiatric syndrome, which means we know something about the physical dimension, but there is also a psychiatric or behavioral dimension."

The hallmark of the disorder is an overriding obsession: words, ideas and thoughts, even musical passages that come into the mind unbidden and are usually unpleasant. These ideas are linked to compulsions or repetitive, often ritualistic actions that the person does to satisfy or neutralize the obsession.

The obsessive idea might be that the person's house or family is not safe, and the corresponding compulsion might be continually checking that everyone is asleep, or that doors and windows are locked. If the obsession involves dirt and disease, the compulsion might be avoiding certain objects and surfaces, or washing your hands over and over. If the obsession involves feelings of inadequacy and imperfection, the compulsion might be redoing your homework or arranging the clothes in your closet until everything looks and feels "right."

OCD is usually a lifelong condition. Toddlers can experience it—especially in families with a history of the disorder—and it often peaks between the ages of eight and ten. Boys seem particularly vulnerable at puberty. The disorder is usually worse under stressful conditions and improves when the stressors are reduced.

The condition usually appears in conjunction with some other disorder such as anxiety, depression, tics, Tourette's syndrome, or one of the eating disorders. It also overlaps with schizophrenia and autism, but not all schizophrenics or autistics have OCD—only about 20 percent of cases.

However, Dr. Thienemann said, OCD's obsessions differ markedly from those that manifest with schizophrenia in its psychotic state. "People with OCD who fear a certain thing—like jumping out window or killing the baby—almost never do it. Even when the thought originates as spoken words, the patients still know it's coming from inside their own heads. On the other hand, a delusive schizophrenic who hears a command voice—'Do it!'—usually cannot distinguish that voice from something outside themselves."

Between 0.5 and 2 percent of the population exhibits some form of OCD, Dr. Thienemann said, and the symptoms are identical in adults and children. “The difference is that kids lack the insight to know that their compulsions don’t make any sense,” she said. For example, one little girl whose father traveled a lot felt he would only be safe if she kept facing in the direction he was traveling. An adult who felt this obsession would be able to understand that her actions could make no logical difference.

The causes of the disorder are not known. The propensity toward OCD can be inherited because, like Tourette’s, it shows up in families. But any apparent precursor, such as a particular traumatic event, is probably more of a trigger than a cause.

“There is a new syndrome, called Panda’s, which is linked to streptococcal infections,” Dr. Thienemann said. “Antibodies from the immune system are created to attack the infection but go on to attack the joints and then brain tissue. This causes a chorea-type disorder which affects mood and initiates OCD-type symptoms.”

OCD is known to be a functional brain abnormality but not necessarily a structural abnormality. That means it shows up on PET scans of the brain’s metabolic activity but not in the soft-tissue imaging of an MRI. The metabolic traces associated with OCD focus in the frontal lobes, above and behind the eyes, and in the basal ganglia at the brain’s center.

“The symptoms of OCD seem to cluster in the nest,” she said, meaning that the compulsive activities seem to be strongest closest to home. When the patient goes out or visits friends, the symptoms often disappear. “The symptoms also seem to be related to grooming activities—like the repetitive motions engaged in by rats and cats—which originate in the basal ganglia.”

Dr. Thienemann said that OCD also appears to be related to the patient’s world view. “It’s like the legal system. Most people can get along in life with less than total certainty and infallible proof of their beliefs. They feel okay with that. But an OCD sufferer who is, for example, afraid to touch a light blue carpet that was laid down three years ago because one of the carpet installers might have cut himself with a knife and left AIDS-tainted blood on the carpet fibers—that patient is hung up on the idea of total proof. ‘But how do you *know* there’s no AIDS virus?’ she might say. And of course, you cannot be *totally* sure.”

The doctor also acknowledged that OCD seems to be related to a certain developmental stage in children, when they are exploring games and rituals—“Step on a crack...”—and feel an urge to complete things, like collecting *all* the Barbie dolls. This phase, which is linked to finding patterns and rules for living in the world, usually passes when as adults we discover useful exceptions and become more flexible. But the child with OCD gets stuck at this stage.

The classical treatments for OCD are medication and behavioral therapy.

Medications are new for this disorder, having been prescribed only for about the past ten years. All are serotonin re-uptake inhibitors: Anafranil, Prozac, Zoloft, Luvox, and Paxil. “The danger with these drugs is that they are antidepressants and, especially with children, can kick the patient over into mania,” Dr. Thienemann said. “About 40 percent of kids on drug therapy get agitated and

irritable. Medications also require a relatively long time—twelve weeks—to begin showing an effect.”

This summer, the OCD Clinic at Stanford University is seeking patients ages eight to seventeen to participate in a new study of paroxetine, to see if the drug is safe for children and effective against the disorder.

“However, with very young children,” she said, “you want to start out with behavioral therapy.”

Such treatment usually begins by relabeling the condition and trying to externalize it. “You get the patient to say, ‘That strange idea is not me. It’s my OCD.’ Then you work with the patient to willingly expose him- or herself to the dreaded situation—touching the carpet that might have AIDS. Or you try to initiate response prevention by getting the patient to consciously break the comforting ritual—stop washing his or her hands.”

Usually, she said, the obsession is the worst thing in the patient’s world because it comes from within the psyche. For example, a minister’s son was afraid of inadvertently selling his soul to the devil. The daughter of a conservative Old World father could not wear or even touch anything red for fear it would lead to sexual promiscuity. The boy of highly educated parents who urged him to do well in school was afraid other people might think he was a nerd.

Dr. Thienemann has found that education is the most important part of treatment. Support groups have become a large part of her practice, for both children and their parents. “The kids can compare symptoms and find out they’re not alone and not so weird. The parents, who may be at their wit’s end, can share experiences and learn some of the right things to do for their child.” Including the parents is necessary because, as caregivers, they are directly involved in negotiating the goals of the child’s behavioral therapy and seeing that the child follows through with them.

“Obsessive compulsive disorder focuses on ideas of aggression, sex, and bodily contamination,” said Dr. Thienemann, “because these activities are closest to us. The actual nature of your obsession depends on where the hole is in your jelly donut—that’s where the sticky stuff comes out.”