Obsessions and compulsions

Margot Levinson describes what is and – importantly – what is not paediatric OCD, and outlines assessment and treatment, in which logic and creativity are essential tools for the therapist

This article aims to explain paediatric Obsessive Compulsive Disorder (OCD), which is a disabling and distressing problem that can become chronic[1]. Therefore, early identification and therapy is recommended. I will explore prevalence, hypothesised causes, different ways in which OCD may manifest itself and common maintenance factors. An evidence-based, cognitive behavioural approach to treatment will be described and an anonymised, composite case study provided to show how research and theory are applied in practice.

Paediatric OCD affects between 0.5 and four per cent of children[2] and can be difficult to recognise. It is therefore important to conduct a thorough assessment. As OCD experiences are embarrassing or shameful and frightening, children are often reluctant to talk about them. They may also fear they are 'crazy'. Consequently, a trusting relationship needs to be built, even to accomplish an adequate assessment.

We all know youngsters who are obsessional about having their belongings in perfect order, or about cleanliness, or who get upset if things are not as they feel they should be. This is not OCD. Children often have superstitious rituals, such as not treading on the cracks between paving stones. This is not OCD. Children with learning difficulties and developmental disorders may crave routine, behave in obsessional ways and hate change and novelty. This is not OCD. However, it *is* the case that youngsters with other problems, such as general anxiety disorder (GAD), Tourette Syndrome, eating disorders or Asperger syndrome, may be experiencing OCD as well. There is a continuum from obsessionality through to OCD as a clinical problem.

Rituals may be logically unrelated to the obsession. Why should looking at the corners of an object in a certain order prevent your mother suffocating in her sleep?

Obsessional thoughts and compulsions

OCD diagnostic criteria are similar for adults, children and adolescents, and comprise obsessional thoughts (mental events) and compulsions (physical or mental behaviours). An obsessional thought is distressing, intrusive, recurrent and persistent. It is ego-dystonic ie it goes against the youngster's own beliefs about acceptable thoughts. Often, it is in the form of an image, for example of loved ones dying in a horrible way, such as being burned to death or abducted by violent intruders. It may also present as a morally unacceptable impulse, such as swearing at authority figures or touching a sister sexually. Obsessions usually represent unlikely, rare or impossible events. Younger children may not realise that obsessional thoughts are irrational because they have less experience and understanding of cause and effect and the likelihood of certain events occurring. They also sometimes present with compulsions but no identifiable thoughts. A compulsion is a repeated behaviour that the person feels they must perform to prevent the thought or image becoming a reality, for example repeated touching of objects in a certain order or thinking six 'good' thoughts after a 'bad' obsessional thought. Usually, the person feels it is their sole responsibility to prevent the dreadful outcomes and feels short-term relief from anxiety after performing the ritual and averting some catastrophe.

Common compulsions include repetitive hand-washing or showering, moving in a special way, checking electrical appliances, taps, doors and windows, an excessive need for symmetry, hoarding, repeating homework until it is perfect and restarting each time there is an error, and eating only certain foods. If a mistake is made in a ritual compulsive behaviour, it must be started again or another ritual employed to correct the mistake. Often, a ritual will need to be repeated a special number of times in sets of odd or even numbers or until it feels 'just right'. 'Just right' is usually correlated with mood, so the more upset the client, the more time the ritual will take. Rituals may be logically unrelated to the obsession. Why should looking at the corners of an object in a certain order prevent your mother suffocating in her sleep? Where rituals are logically related, they are 'over the top' like putting all your clothes in a plastic bag as soon as you come in from school, and showering for an hour, because you have been contaminated by germs at school. Adults recognise their behaviour is irrational but in children the requirement of insight is waived. A diagnosis of OCD also requires that compulsions use up more than an hour a day and that the problem be interfering seriously with the youngster's life[3].

What causes OCD?

There are many ideas about what causes OCD. Evolutionary psychology hypothesises that the gene pool needs individuals who mentally 'run' risk scenarios and are risk avoidant. It speculates that 'special movements' may be fragments of what were originally meaningful behaviours in the face of threat.

Critical parenting may lead to a heightened need for approval and the development of perfectionist traits. Feelings of responsibility for adverse events and the need for certainty and symmetry in life have been hypothesised to create a type of personality particularly vulnerable to OCD.

The behavioural explanation centres on classical conditioning following a random intrusive thought and an associated action, which is then negatively reinforced when the dreaded outcome does not occur.

Cognitive explanations include focusing on and overestimating threats; appraising intrusive thoughts/images as personally significant; trying to control and suppress thoughts; and lack of confidence in memory.

Evolutionary biology suggests that early stress and trauma may lead to permanent changes in the infant brain, which make the individual hypersensitive to stress and threat[4]. Biological explanations have considered genetic transmission, although the evidence is limited. And paediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) have been identified as a possible cause for children who develop OCD following severe throat infections.

Finally, it is possible that OCD rituals represent an attempt at self-protection from future harm after trauma or abuse. In practice, the therapist may find some combination of these explanations fit for the client and are useful in explaining 'why me?'.

Beliefs generated with OCD

OCD generates some unusual beliefs. The main ones are thought-action fusion (TAF) where it is believed that having the thought/image can make it happen, and is the same as wanting it to happen; thought-event fusion (TEF) where it is believed that having the thought will make it happen or has made it happen; and thought-object fusion (TOF) where it is believed that bad feelings or thoughts can be transferred to objects by touch or telepathy and then contaminate others who touch the object[5]. These ideas are interesting because they, like common superstitions (counting magpies) and some of the illogical OCD rituals, seem to hark back to a magical view of the world and human vulnerability in the face of an unpredictable and dangerous universe.

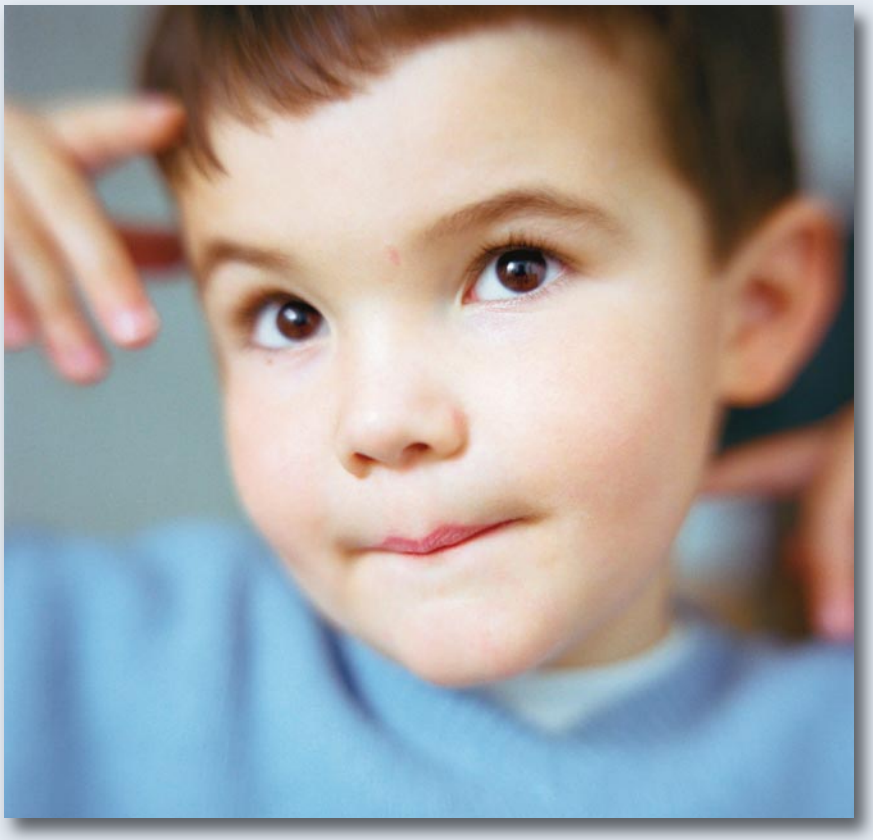
A thorough assessment is required to provide a detailed 'mapping' of what the youngster is thinking/imaging and exactly what they are doing. Therapists may need demonstration of a ritual. They need to know how the client's life and the lives of those around them are affected (families often become involved in helping with rituals to avoid the child becoming upset), how much time ritualising is taking up and how anxious the client is. It is useful to use a measure – Children's Yale Brown Obsessive Compulsive Scale (CY-BOCS) – as part of assessment.

Treating OCD

Treating OCD usually involves a combination of behavioural and cognitive strategies. But where therapy alone is ineffective, medication can be considered. Current evidence suggests that CBT with or without medication produces the best results[6]. Therapeutic experience suggests that sometimes medication itself becomes part of the problem, with youngsters being fearful that they will be poisoned or addicted, or that medication will make them want to kill themselves. Suicidal ideas have to be explored carefully to distinguish between these ideas as obsessional thoughts or as representing actual risks.

CBT starts with education about OCD and construction of a collaborative model of how it works. Clients are taught anxiety management techniques. The main evidence-based behavioural treatment is exposure and response prevention (ERP). This means exposing the client to that which they fear and preventing them from ritualising until their anxiety drops and they become habituated to the fear-evoking stimulus. In addition, they learn that the feared consequence does not occur and thus the ritual is redundant. A SUDS (subjective units of distress) scale is created, grading different levels of anxiety on a scale that describes the feeling in the client's own words and assigns it a number eg 0 = relaxed to 8 = petrified. A fear hierarchy is also constructed, going from the things the youngster is least frightened of to those they are most frightened of, providing a graded set of ERP goals.

OCD presents some unusual challenges. It is a 'closed' logical system, in that if the dreaded outcome doesn't happen, the client will say the ritual worked, and if it does, then the client will say they didn't do the ritual properly. Alternatively, if the dreaded outcome does not happen when the client ceases a ritual, s/he predicts it will happen at



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The principle cognitive treatment is a series of experiments using a 'theory A versus theory B' strategy. Theory A is that OCD is truthful, and theory B that it lies

an unspecified time in the future. This, of course, makes it difficult to disprove OCD's dire predictions.

The principle cognitive treatment is a series of experiments using a 'theory A versus theory B' strategy. Theory A is that OCD is truthful, and theory B that it lies[7]. The young person designs experiments that they believe constitute a real test. As the evidence 'stacks up' against theory A, the client learns not to trust OCD. Clients seek information about how the world works and undertake surveys and observations of how others understand the world and respond to potential threats.

With younger clients an 'externalisation metaphor' can be used, whereby they give OCD an uncomplimentary name (eg 'germster') and represent it in a drawing. The amount of control OCD has over the client's life is expressed in percentage terms (eg 70:30) and tracked throughout treatment. An ongoing narrative is constructed about how to 'beat' OCD, which is characterised as an interloper intent on making the client so worried that they waste time and do silly things. Over time, OCD is chased out of the client's life.

Gerry's story

Gerry was a 12-year-old white boy who lived with his mother, stepfather and younger brother. The family was close and supportive. Gerry's mum Mary had OCD herself. She had benefitted from CBT and took medication. Although her behaviour was rather obsessional and she had some rituals, overall Mary coped well and tried hard to prevent her OCD from affecting the children.

Gerry was big for his age although he was rather emotionally immature. He was passionate about and good at football. His academic ability was average. Gerry had friends but felt insecure in these relationships, so he did whatever his friends wanted, regardless of his own wishes. He worried constantly that his stepdad preferred his younger brother. He worried about his mum and feared being like her. Gerry was referred when Mary recognised he was distressed and performing rituals.

Assessment revealed obsessional thoughts and images:

- Fearing peers would plant drugs in his schoolbag and he would become an addict and his friends would reject him.
- Feeling he might be contaminated by dangerous chemicals at home and school, and poison the family.
- Fearing if he was tackled in football he would break a leg.
- Fearing that an intrusive image of the rest of the family being dead in a pool of blood after an attack by intruders would come true.
- Worries that sperm on bedclothes from 'wet dreams' could contaminate others and make them pregnant. This last obsession was not disclosed until some weeks after assessment.

Compulsions included:

- Checking his schoolbag three times every time he had carried the bag on his back.
- Refusing to touch chemicals in chemistry lessons, and household cleaners or their containers at home, such as soap powder, disinfectant, polish etc. He avoided the cupboard where these were kept and would not touch the handle. As he couldn't be sure he hadn't touched these things by mistake, he washed his hands in a 'special way' in sets of three until he felt it was 'just right' before touching anything he thought the family might touch.
- Focusing his gaze on the four corners of the goal net three times each time he had the thought he would be hurt.
- Checking six times that all the windows and doors in the house were locked securely after the family had gone to bed.
- Insisting his sheets and pyjamas were washed three times every day separately from other washing.

Mary was fed up with washing his pyjamas and sheets and concerned about Gerry's frequent hand washing and his staying up late to do checking. Gerry's hands were sore and cracked. Gerry worried that peers would notice the bag checking and behaviour in chemistry lessons and think he was 'weird'. Stepdad was worried about Gerry's behaviour, but also irritated by his refusal to touch household cleaners, repeated hand washing and compliance with his friends' wishes even when it meant doing something he disliked. They had frequent arguments.

Gerry and the therapist drew a model of how OCD was operating in his life. OCD was named 'doughbrain', and initially Gerry estimated it had 80 per cent control over him. Everyone was given some written and verbal information about OCD, 'fight/flight' and anxiety symptoms. In a session with Mum, it was explained to Gerry that perhaps he had not inherited OCD from Mary but may have inadvertently learned to worry a lot about unlikely events.

Gerry set himself goals of only washing his hands once at a time in a 'normal way', putting a dishwasher tablet in the machine, going to bed without checking when Mum said, washing his own sheets and pyjamas, only checking his bag once before he went to school and touching chemicals in chemistry lessons.

A SUDs scale and a fear hierarchy were constructed. Gerry was taught diaphragmatic breathing. Over the ensuing 12 sessions, Gerry worked his way with erratic motivation and progress through the fear hierarchy and ERP targets set in sessions. He was both given and found out for himself information on sex education and safe handling of cleaning materials. He talked to the science teacher about chemicals used in lessons and safety procedures. He designed experiments to check the validity of his football obsession, see if he could make other thoughts come true, and discover how

friends would react if he expressed his likes and dislikes. He began to assess the real likelihood of his worst fears coming true. He was encouraged to think logically, to observe the behaviour of others and to consider, how come he didn't used to think and behave in this way yet no disasters happened? Gerry quite quickly became fed up with washing his things every day. And a session with his stepdad reassured him he was loved and wanted.

All symptoms remitted and all goals were achieved. Although Gerry remained rather immature, he became more confident and started enjoying his life and friendships again. Finally, Gerry and the therapist constructed a relapse prevention plan and Gerry bought a book written by a teenager who had OCD[8]. ■

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