

# Recognising OCD in children

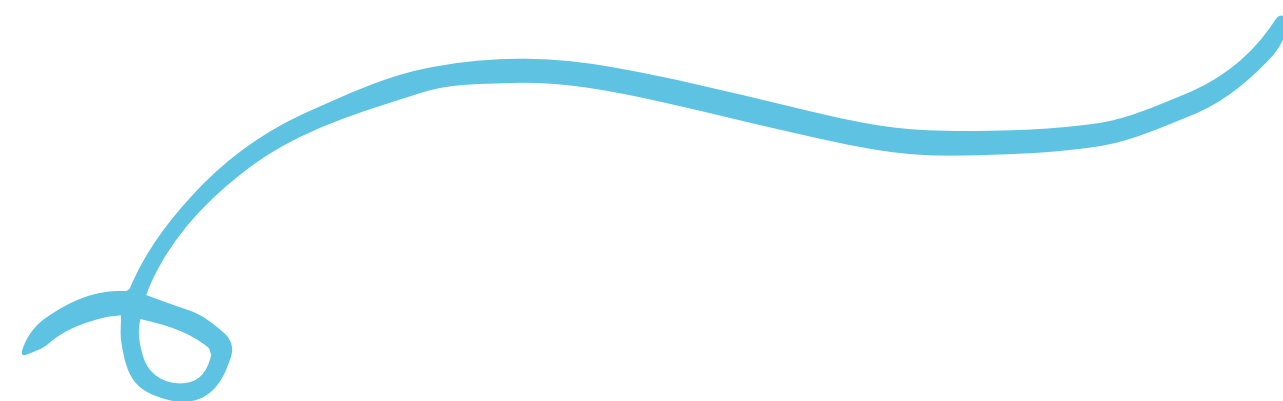
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## Can a young child develop Obsessive Compulsive Disorder?

Yes. Obsessive Compulsive Disorder (OCD) is thought to occur in between 1-4% of the child and adolescent population. In real terms that could mean that in an average primary school of 500 pupils there could be between 5 and 20 young people struggling with OCD. OCD is a serious condition that can cause major disruption to the lives of young people and their families. OCD tends not to go away on its own and without treatment it is likely to persist into adulthood. In fact, many adults who receive a diagnosis of OCD report that some symptoms started during childhood.

### How can one tell the difference between having normal worries and behaviours and having OCD?

OCD can be broken down into symptoms of intrusive thoughts (or obsessions) and repetitive behaviours (or compulsions). A key feature of someone who has OCD is their interpretation of intrusive thoughts: the belief that the person having the thoughts is “bad” in some way or the belief that such thoughts are indicative of something bad happening. However, everyone experiences intrusive thoughts related to topics that people with OCD worry about such as germs, leaving things unlocked, harm coming to family members and thoughts related to sex or aggression. What differentiates these normal worries from OCD obsessions is the amount of time spent thinking about them, the level of worry or distress they cause and the extent to which people feel compelled to ‘get rid of them’.



It is very common for ritualistic behaviours to be observed in young children (aged 3-7) such as a need for routines to be the same, lining up items such as toys or shoes, or becoming distressed by dirt or sticky substances. As described below - a period of watchful waiting is important here as many children will just grow out of such behaviours. What differentiates such developmental behaviours from OCD is the time spent completing the rituals, the level of interference they cause with completing daily activities and the amount of distress experienced if the child is prevented from completing such behaviours.

## Main key symptoms

OCD can be understood to be a combination of obsessions and compulsions.

### Obsessions

can include, but are not limited to, intrusive thoughts, worries and mental images surrounding the following topics:

- **Germ/contamination** - Concern with becoming ill or transferring germs and causing illness to others
- **Harm coming to oneself or others** - Through assault, burglary, fire, death
- **Need for symmetry and order** - Fear of something bad happening or general sense of unease in the context of asymmetry
- **Health or body appearance** - Excessive concern about becoming ill/catching a disease - Excessive concern with an aspect of body appearance (Not Body Dysmorphic Disorder or connected to weight and eating disorder)
- **Hoarding** - Excessive worry about losing things
- **Religious** - Concern with a god, morality and going to hell
- **Aggressive** - Fear of physically harming someone either through hand to hand conflict or more indirect such as hitting someone with a car
- **Sexual** - Fear of being a paedophile or having unwanted sexual relations i.e. intrusive thoughts of having sex with a parent or having homosexual sex when one has a heterosexual orientation and vice versa. For younger children this may relate more to intrusive thoughts of body parts such as breasts and penises or contact with body parts of pets
- **Transformation** - Fear of taking on undesirable characteristics or turning into a feared or disliked person or animal- core fear of losing one's own identity

## Compulsions

can include but are not limited to:

- **Washing/cleaning/extensive toileting rituals** - Ritualised or excessive handwashing - Excessive shower routine involving large amounts of soap/shower gel/antibacterial wash/bleach - Excessive time spent on the toilet/ excessive amounts of wiping or use of toilet paper/ asking people to check cleanliness/only using the toilet when able to shower after or avoiding using the toilet
- **Repeated checking** - Of locks, switches, drawers, taps, items such as books in school bags, safety of others through texting or phoning, homework to ensure that it is correct
- **Excessive reassurance seeking** - Repeatedly asking parents or authority figures such as teachers and doctors questions related to core fear- i.e. is this clean enough, is my homework correct, am I a good boy?
- **Lining things up or evening things up** - Need for items to be placed in the correct position or lined up perfectly with edges
- **Excessive praying** or engaging in other religiously symbolic behaviours to excess - Rituals can occur such as praying a certain number of times, apologising in an effort to avoid offending god or going to hell after any behaviour thought to be 'bad' or blasphemous.
- **Hoarding items** - Collecting items others would consider to be rubbish, struggling to throw things away, saving up so many items that they get in the way of entering a room or clutter up spaces
- **Excessive avoidance** - Avoidance of places and items that may be perceived to carry germs such as public transport, public toilets as well as avoidance of situations which could trigger anxiety and the need to engage in rituals
- **Confessing** - Feeling compelled to confess every detail of behaviour to check whether they have done something naughty, harmful or even illegal
- **Repeating** - Repeating an action such as walking into a room or re-writing homework over and over until it feels right or repeating phrases or sentences to seek reassurance or to bring luck
- **Touching/tapping** - Having to touch or tap items a certain number of times, often in an even way on both hands
- **Counting** - Counting to a certain number while completing activities. This is often associated with perceived lucky and unlucky numbers

A clear correlation can be observed between specific obsessions such as fear of contamination and compulsions such as excessive hand washing. However, there can be more obscure links such as walking back and forth through doors to prevent taking on feared characteristics or a need to complete rituals an undetermined number of times to achieve a 'just right' feeling. This type of "magical thinking" is common in young people with OCD.

## Special characteristics in preschool and school aged children:

In general, OCD presents very similarly in childhood as in adulthood. However, there are some differences of note. For example, younger children are less likely to have "insight" into their OCD, meaning that they may not readily recognise the irrationality or excessiveness of their obsessions or compulsions.

It is also common for obsessions to be less clearly articulated in younger children such that they may report a general fear of something bad happening but be unable to explain this any further or just a need to engage in compulsions until it feels just right. Compulsions in younger children may also be linked to a sense of disgust or discomfort rather than specific fear. The lack of a clearly defined fear should not be misinterpreted to mean that the problem is not OCD.

In those children who do endorse fears, there appear to be developmental patterns to the obsessions and compulsions most commonly endorsed.

Children under 4 are more likely to engage in rituals related to stranger and separation anxieties whereas children aged 4-7 are more likely to show fear of, and compulsions related to, contamination, death, burglary and assault. In childhood OCD, the most common obsessions are fear of contamination and germs followed by harm to self or others and morality and religiosity. As children approach puberty it is common, although not guaranteed, that obsessions may shift to mirror normal developmental changes to include sexual and aggressive obsessions. The most common compulsions are excessive or ritualised washing and checking although all compulsions described above are endorsed by children.



## Risk factors for developing OCD

There is no one factor that is understood to cause the onset of OCD, but research has identified several ‘vulnerability’ factors which can put people at heightened risk of developing OCD.

### Individual Factors:

These include genetic, biological and temperamental factors including:

- Abnormalities or an imbalance in levels of serotonin in the brain compared to people without OCD. It may be that structures in the brains of people with OCD work slightly differently, ‘absorbing’ or taking up too much serotonin to the neurons, or blocking the function of the protein which transports the serotonin between the neurons.

People with OCD often have the following qualities:

- Inflated levels of responsibility so sufferers are more likely to feel responsible for bad things happening to themselves and/or others.
- They may be described generally as a worrier and more likely to consider possible outcomes of a situation than their peers.
- They often find that they are ‘intolerant of uncertainty’ and feel very anxious about the unknown. The anxiety can drive a need to plan for all eventualities, to evaluate all possible outcomes of an action before making a decision and a need to feel in control.
- Doubting one has completed an action or completed something correctly has been found to be common among adults. Adult sufferers often report worrying about the accuracy of their memory despite studies demonstrating that it is no worse than people without OCD. It is possible that this is present in children although it has yet to be statistically confirmed.
- Heightened levels of perfectionism and a driven, hard-working attitude is frequently reported. This can result in people with OCD striving for things to be completed perfectly often leading to difficulties getting started or completing tasks.
- People with OCD tend to be described as very thoughtful and sensitive, noticing how others feel and trying to help or protect others.

### Systemic factors:

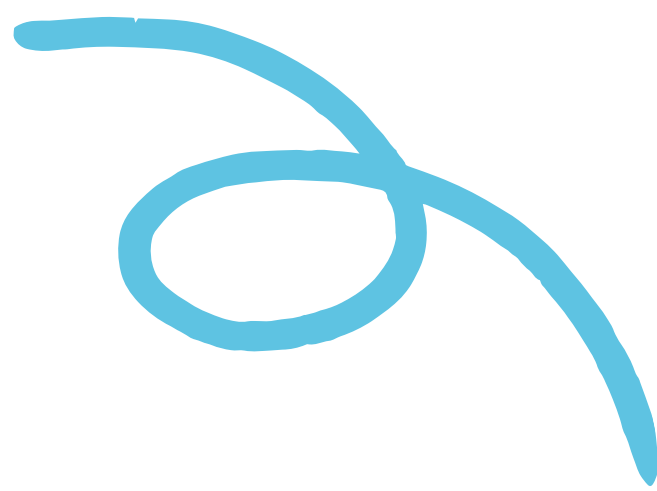
Within the broader system around the young person, in their family, peer group and school there can be several experiences thought to act as triggers or maintenance factors. These include, but are not limited to:

- Bullying by peers can lead to the child having negative beliefs about themselves and feeling responsibility for the situation.
- Heightened levels of stress, particularly related to situations in which the young person has limited control or cannot know the outcome, can lead to increased compulsions.
- Difficulties at home or situations, which require a young person to take on more responsibility for supporting a parent emotionally or with practical tasks, such as through the birth of a new sibling, can lead to an overvalued sense of responsibility.
- A bereavement or serious illness of a family member or someone close to the family can be associated with increased anxiety surrounding contamination or death.
- Parental mental health, including but not limited to OCD, anxiety or depression can act as a vulnerability factor, both through genetic vulnerabilities and learned responses to stressful situations.

## Watchful waiting

It is not always necessary to refer at the first signs of apparent OCD. As mentioned above, some children will go through phases of carrying out repetitive behaviours which they outgrow. If, however, a young person develops obsessions and/or compulsions that are causing significant distress or impairment in day-to-day life, the family should seek support. In the first instance, this usually involves going to the GP, who will provide advice and might discuss whether a referral to mental health services would be beneficial.

For teachers and school-based professionals it may also be possible to seek support from primary mental health clinicians or duty clinicians based in Child and Adolescent Mental Health Services (CAMHS) who can provide advice about whether a referral would be appropriate and how to go about making the referral.



## How to help

Talk about the young person's worries and about anything they may be struggling with such as exam stress, bullying, a bereavement or changes at home.

Provide education about anxiety- talk with the young person about how anxiety can be helpful to help us escape threat but that sometimes we can become a bit oversensitive like a faulty car alarm when our threat system is set off too much. Also talk about anxiety habituation, the fact that anxiety does feel uncomfortable but does lessen over time even without doing anything to change the situation, and the fact that the more we face our fears the easier it becomes to deal with them.

Encourage the child, with the support of their family to practice ERP, that is, Exposure- to face the feared situation in small manageable ways, and Response Prevention- resisting the urge to complete the compulsion until the anxiety goes down on its own.

There are also several really good self-help books available on amazon and in all good book shops which can be helpful before accessing support and while waiting for an appointment including:

“Breaking Free from OCD” (2008) written by Jo Derisley, Isobel Heyman, Sarah Robinson & Cynthia Turner.

“What to do When Your Brain Gets Stuck: A Kids Guide to Overcoming OCD” (2007) written by Dawn Huebne

## When to refer

A referral should be made when

- the young person and/or their family are experiencing heightened levels of distress about the behaviours/thoughts.
- Compulsions are interfering with the young persons' ability to engage with routine activities such as getting to school on time, completing typical school-based activities, seeing friends, maintaining a level of appropriate independence for their age; many families talk about needing to support their child to wash, brush their teeth, get dressed and even prepare or eat their food to support them to get out of the house or get to bed on time.

## Whom to refer to

The first point for a referral would be the GP who can assess the difficulties and make a referral to the local Child and Adolescent Mental Health Service (CAMHS). A Special Educational Needs Coordinator (SENCO) or the school nurse within school may also be able to make this referral and may have seen evidence of the OCD interfering with the child's performance in the school setting



## What are the treatments offered?

The National Institute for Health and Care (NICE) recommended evidence-based treatment is cognitive behaviour therapy (CBT) with exposure and response prevention (ERP). This should be offered in the first instance over a period of up to 14 weekly sessions initially. The majority of young people respond well to CBT for OCD. However, medication is also an evidence-based treatment and can be used in conjunction with CBT. These include a variety of Selective Serotonin Re-Uptake Inhibitors or SSRI's. CBT alone is highly effective for young people with OCD. Studies have indicated that between 70 and 80% of young people achieve symptom remission with effective treatment.

## Treatment in serious cases

In serious cases, where the OCD has caused substantial impairment, for example, when young people are unable to go to school due to their worries or where they are having to stay awake very late into the night completing rituals, and where community-based treatment has been tried, young people can be referred to a specialist service. This can include a process of weekly Cognitive Behavioural Therapy (CBT) with Exposure Response Prevention (ERP) and medication. Sometimes intensive treatment is offered for longer periods of time per day over a period of consecutive days, and, in the most serious cases, inpatient admission to a child and adolescent hospital may be necessary.