Research Topics

Obsessive Compulsive Disorder

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Obsessive Compulsive Disorder (OCD) is a hidden handicap from which some children may suffer and which, if not recognised at an early age, can follow the child into adolescence and adulthood.

A 10 year old girl keeps apologizing for "disturbing" her class. She feels that she is too restless and is clearing her throat too loudly. Her teachers are puzzled and over time become annoyed at her repeated apologies since they did not notice any sounds or movements. She is also preoccupied with "being good all the time".

This child suffers an obsessive-compulsive disorder (OCD). The National Institute of Mental Health estimates that more than 3 percent of the school population – from young children to older adults - regardless of gender and social or cultural background have OCD. Sufferers often go undiagnosed for many years, partially because of a lack of understanding of the condition, and partially because of the intense feelings of embarrassment, guilt and sometimes even shame associated with what is often called the 'secret illness'. The disorder is two to three times more common than schizophrenia and bipolar disorder.

What is Obsessive-Compulsive Disorder?

Obsessions are intrusive, irrational thoughts -- unwanted ideas or impulses that repeatedly well up in a person's mind. Again and again, the child experiences disturbing thoughts, such as "My hands must be contaminated; I must wash them"; "I may have left the gas stove on"; "I am going to injure myself." On one level, the sufferer knows these obsessive thoughts are irrational but on another level, he or she fears these thoughts might be true. Trying to avoid such thoughts creates great anxiety.

OCD can take many forms. In general, sufferers experience repetitive, intrusive and unwelcome thoughts, images, impulses and doubts which they find hard to ignore. These thoughts form the obsessional part of 'Obsessive-Compulsive' and they usually (but not always) cause the person to perform repetitive compulsions in a vain attempt to relieve themselves of the obsessions and neutralise the fear. Some sufferers will have the obsessions but no physical outward compulsions.

Common obsessions include contamination and germs, causing harm to oneself or to others, upsetting sexual, violent or blasphemous thoughts, the ordering or arrangement of objects and worries about throwing things away. Sufferers try to fight these thoughts with mental or physical rituals. There are also compulsions, which involve repeatedly performing actions such as washing, cleaning, checking, counting, hoarding or partaking in endless rumination. Avoidance of feared situations is also common; however, this often results in further worrying and preoccupation with the obsessional thoughts.

Most sufferers know that their thoughts and behaviour are irrational and senseless, but feel incapable of stopping them. This has a significant impact on their confidence and self-esteem and as a result, their careers, relationships and lifestyles.

To sufferers and non-sufferers alike, thoughts and fears related to OCD can seem profoundly shocking. It must be stressed, however, that they are just thoughts – not fantasies or impulses which will be acted upon.

It would be fair to say that most individuals, at some stage in their lives, have come into contact with the phenomenon of obsessional or intrusive thinking and/or succumbed to the seemingly nonsensical need to perform an odd, and often unrelated, behaviour pattern in order to avert a real or imagined danger (e.g. touching a certain item of furniture before going to bed in order to 'ward off' a nightmare, or checking several times that the door and windows are locked before leaving the house when going on holiday). However, the key difference which segregates these little 'quirks' from the disorder is when the distressing and unwanted experience of obsessions and/or compulsions impacts, to a significant level, upon a person's everyday functioning – this represents a principal component in the clinical diagnosis of Obsessive-Compulsive Disorder.

OCD is often described as "a disease of doubt." Sufferers experience "pathological doubt" because they are unable to distinguish between what is possible, what is probable, and what is unlikely to happen.

Who gets OCD ?

Children from all walks of life can get OCD. It strikes people of all social and ethnic groups and both males and females. Symptoms typically begin during childhood, the teenage years or young adulthood.
What causes OCD?

A large body of scientific evidence suggests that OCD results from a chemical imbalance in the brain. For years, mental health professionals incorrectly assumed OCD resulted from bad parenting or personality defects. This theory has been disproven over the last 20 years. OCD symptoms are not relieved by psychoanalysis or other forms of "talk therapy," but there is evidence that behaviour therapy can be effective, alone or in combination with medication. People with OCD can often say "why" they have obsessive thoughts or why they behave compulsively but the thoughts and the behaviour continue.

Clinical researchers have implicated certain brain regions in OCD. They have discovered a strong link between OCD and a brain chemical called serotonin. Serotonin is a neurotransmitter that helps nerve cells communicate. In layperson's terms, something in the brain is stuck, like a broken record. Judith Rapoport, M.D., describes it in her book, The Boy Who Couldn't Stop Washing, as "grooming behaviours gone wild."

OCD will not go away by itself, so it is important to seek treatment for a child. Although symptoms may become less severe from time to time, OCD is a chronic disease. Fortunately, effective treatments are available that make life with OCD much easier to manage.

Cognitive Behaviour Therapy (CBT) routinely is described as the psychotherapeutic treatment of choice for adults, children, and adolescents who have been diagnosed with OCD. Unlike psychodynamic or insight-oriented psychotherapy, CBT helps the child understand,the disorder and develop strategies to identify problem situations and resist giving in to the obsessive thoughts and compulsive behaviors. Treatment relies heavily on exposing the individual to the problem situations and then preventing the compulsive response. The resulting anxiety then is managed by training children to use strategies that help them work with their anxiety in a more effective and less disruptive way.

However, exposure to the anxiety-producing object is the key to success in treatment. Thus, for children who compulsively wash their hands because they feel that the hands are dirty or contaminated, the therapist may have them intentionally touch things that are dirty and then have patients wait several hours before washing their hands. This results in very high anxiety after the initial contamination, followed by a gradual reduction in anxiety over time, until hand washing is allowed some hours later. In pediatric patients, this exposure is presented gradually, under the patients' control, after patients have been taught other ways of managing their anxiety and fear.

Often, the OCD is personified as something that makes the child perform an action. Thus, children learn to assess situations and ask themselves if they really want to do something, as opposed to the perception that the OCD is making them do something. For school-aged children, the development of mastery and control is a critical issue in their overall psychological growth; therefore, learning to overcome an irrational drive, such as one experienced with OCD, has a certain appeal to their own sense of mastery. Usually, the patient reports an overall reduction in obsessive thoughts, general anxiety, and the need to perform certain actions.