A College Student's Story with Childhood Onset OCD

Anxiety disorders are prevalent amongst individuals of all ages. Anxiety involves chronic fear and/or apprehension that persists without any direct threat to the individual. An anxiety disorder is diagnosed when the anxiety becomes severe often disrupting an individual's normal functioning (Pinel, 2011). Obsessive-compulsive disorder (OCD) in particular, is an anxiety disorder, which tends to develop in children between the ages of 7.5 and 12.5 years old (Sturm, 2009). The prevalence rate of OCD in children and adolescents is 1-3%, suggesting that it occurs as often in young people as in adults (Piacentini & Graae, 1997). The disorder has been associated with severe impairments in several aspects of a child's life (Lack et al., 2009). OCD is a neuropsychiatric condition characterized by recurrent obsessions and compulsions. Obsessions are persistent and intrusive images, thoughts, or impulses that cause anxiety and distress. Compulsions are repetitive mental acts or behaviors performed in order to reduce the individual's anxiety brought on by the obsessions (American Psychiatric Association [2003], 2003). Given the widespread nature of this disorder even among children, it is important to understand what factors contribute to the development of this syndrome, how it impacts one's life and what treatments can be used to alleviate symptoms. If OCD is left untreated in children, it becomes progressively worse and impacts the child's ability to engage in normal life activities hence reducing quality of life. Personally, OCD negatively impacted my quality of life by impairing my academic, social, and emotional functioning, as I spent several hours each day performing a variety of compulsions to reduce my anxiety.

In order to better understand how OCD disrupts an individual's life it is important to further examine obsessions and compulsions. The most frequent obsessions include fears of contamination, hypochondriacal fears of bodily dysfunctions, and fears of expressing undesirable/unwanted sexual or aggressive impulse (Davison, Blankstein, Flett, & Neale, 2010). I was diagnosed with OCD at eight years old, while in third grade. I began to develop obsessions and performed various compulsions to reduce the anxiety that was brought on by my thoughts. The most troubling obsession was an intrusive image of my mother being killed in a car accident, along with the thought that I would eventually become ill and pass away. These obsessions were the focus of my attention for a large portion the day. In order to reduce the distress and anxiety caused by my obsessive thoughts, I performed various repetitive behaviors known as compulsions (Davison et al., 2010). My compulsions included a variety of checking and counting rituals. For example, if I were to go to the bathroom, I would check if I had closed the tap five times, while counting to five in my head. My belief was that if I had left the bathroom without performing this compulsion, my mother would be killed in the car accident and/or I would become ill. Thus, I believed that by performing these compulsions, I would prevent the horrifying events from occurring; as a result my anxiety would diminish for a short period of time. It is well-documented in the clinical literature, that the temporary anxiety relief that accompagnies rituals is an important factor in maintaining OCD (Mash & Wolfe, 2005).

As mentioned earlier, OCD develops in childhood, and if left untreated becomes progressively worse, negatively impacting one's quality of life (Lack et al., 2009). Research conducted by Norberg, Calamari, Cohen, and Riemann (2008) echoes this conclusion as they found that quality of life was substantially impaired in individuals with OCD, especially for

those who displayed poor social interactions. The quality of my life was greatly diminished while suffering from OCD. I developed impairments in academic and social functioning and experienced significant emotional distress. While in school, I was unable to focus on the material being taught, and my performance began to suffer. Completing vocabulary quizzes and engaging in class writing activities was extremely difficult. While writing, I would often perform a compulsion that required erasing each word, and writing it three times. If I did not perform the compulsion, the anxiety caused by my obsessions would intensify, completely interfering with my ability to focus. As a result, completing schoolwork became a very challenging task, and teachers began to think that I suffered from a learning disability.

The disorder limited my social interaction with classmates. I would spend more time engaging in compulsions during recess, then interacting with friends. Furthermore, my poor performance in school tended to isolate me from the other children, as classmates began to think that I was not intelligent. Depression is often co-morbid with OCD (Mash & Wolfe, 2005; Piacentini & Graae, 1997). The fact that OCD was preventing me from performing well in school, along with becoming socially isolated, caused me to experience some symptoms of depression as well. I sometimes experienced a lack of motivation to engage in activities that I usually enjoyed and felt sad. It is clear that untreated OCD in children, has the potential to greatly reduce their quality of life. Is thus important for parents to recognize the symptoms and act appropriately to ensure their child receives necessary treatment.

The diathesis-stress paradigm is an interesting and useful model used to explain the onset of many disorders, including OCD. This model focuses on the interaction between a predisposition towards a disease, the diathesis, and life and/or environmental disturbances, the stress (cite another reference). A number of disorders appear to have a genetically transmitted

diathesis, as having a relative with the disorder increases one's risk of also developing the condition (Davison, 2010). Research suggests that genetic factors influence the development of OCD; as the prevalence is higher among relatives (Sturm, 2009; Davison et al., 2010). Empirical evidence from twin studies reveals a moderately high concordance rate for monozygotic twins but not for dizygotic twins (Butcher, Mineka, Hooley, Taylor, & Antony, 2010). I had a grandparent who suffered from OCD, which may have acted as a predisposition to the disorder. Children with an early onset of the disorder (ages 6 -10) are also more likely to have a family history of OCD than those with a later onset, suggesting a greater role of genetic influences in such cases (Swedo, Rapoport, Leonard, Lenane & Cheslow, 1989). This is consistent with my clinical profile.

There is also evidence to suggest neurobiological factors in the etiology of OCD. Studies have shown that people with OCD have abnormally active metabolic levels in the basal ganglia, the cingulate cortex, and the orbital frontal cortex (Butcher et al., 2010). According to the diathesis-stress paradigm, over activity of certain brain regions along with a decrease in serotonin levels, may act as predisposition to develop OCD (Davison et al., 2010). Having recurrent, obsessive thoughts from a young age and ritualistic, repetitive behaviors may establish neural pathways and/or connections in the CNS of afflicted children which become consolidated and integrated over time and resistant to change. This may explain the finding that one-half to two-thirds of children with OCD meet diagnostic criteria for the disorder 2-14 years later, rendering this a serious and chronic disorder (Albano, Knox & Barlow, 1995).

While individuals may possess a predisposition for a disorder, it is quite possible that the disorder does not develop. According to the diathesis-stress paradigm, what seems to trigger the development of the illness is a disturbance that causes stress (Davison et al., 2010). At the time,

there were several factors that were stress inducing in my life. I was extremely worried about the health of my grandmother, as she was undergoing cardiac by-pass surgery. At school, my homeroom teacher was an older woman, who had very little patience, was extremely anxious herself as well as being strict and loud. I remember feeling very unsettled and intimidated by this teacher. In addition, I had witnessed a car accident on the way to school one morning, which instilled a great deal of fear in me. These events took place in close proximity, creating an overabundance of stress, which may have triggered my obsessions. I then started performing compulsions to relieve my anxiety – hence triggering the vicious cycle of OCD.

Once I had developed the disorder, it was not long before my father, who is a clinical psychologist, noticed my behavior and immediately ensured that I received the best possible treatment to prevent my OCD from worsening. Some children suffering from OCD, have experienced significant improvements in their symptoms after the use of antidepressants like the serotonin reuptake inhibitors (Palermo et al., 2010; Butcher et al., 2010). I was not put on medication because once the drug is stopped, relapse is common (Butcher et al., 2010). Most of the anti-depressants currently prescribed have not being adequately tested on young children and, hence, not much is known about their long term side-effects. My mother was adamant that I not be put on medication.

Another treatment approach, which has been shown to be effective in treating children with OCD, is cognitive-behavioral therapy (CBT) (Ercan, Kandulu, & Ardic, 2012). A main component of CBT (for OCD) is exposure and response prevention (ERP). It involves having the individual expose himself, or herself, to a situation that will elicit a compulsive act and having the individual refrain from performing the usual ritual (Davison et al., 2010). The ritual is negatively reinforcing because it reduces the anxiety caused by the obsession. Preventing the

person from engaging in the ritual is essential, as they will realize that the anxiety triggered by the obsession will diminish naturally over time (Butcher et al., 2010). ERP allows the individual to engage in reality testing and it also facilitates extinction of maladaptive behaviors. At the same time, the individual acquires more healthy ways of coping with stress.

Other aspects of CBT that I was instructed on included relaxation exercises and systematic desensitization to help reduce my anxiety and cognitive restructuring to help manage and change my recurrent, maladaptive thoughts (Davis et al., 2010). My treatment for OCD entailed a prolonged period of CBT. The psychologist explained that by performing the compulsions in order to reduce my anxiety, I was feeding the obsessions. Thus the obsessions become worse and the anxiety created by the thoughts become more severe, further eliciting the need to perform compulsions. For a period of time, I engaged in ERP, in order to prevent feeding the obsessions. For example, when I left a room, I had to resist the temptation to check if the light was turned off. This would create strong feelings of anxiety, but they subsided after some time. I was taught that I had no control over my obsessions and that just thinking about something does not necessarily make it happen. I also started to understand that a compulsion was not going to prevent me from becoming ill or prevent my mother from having an accident. When an obsession entered my mind, instead of performing a compulsion, I started to remind myself that my obsessions were not based on reality and *I would shift my attention to something else* – my school work, socializing, playing hockey, etc. I found engaging in sports was extremely therapeutic or me, especially during this period of time.

In conclusion, OCD is a serious and chronic disorder and, if left untreated in children, becomes progressively worse and impacts the child's ability to engage in normal life activities, hence, reducing quality of life. Personally, OCD negatively impacted my quality of

life by impairing my academic, social, and emotional functioning. As Sturm (2009) suggests, diagnosis of this disorder may be difficult because of the secrecy that children possess. Because of the senseless and odd nature of OCD symptoms, many children try to hide their behaviors. Increasing awareness of OCD can, hopefully, help parents become better at identifying symptoms in their children. This will help unsure that children receive proper treatment, hence preventing the disorder from worsening over time. I was hesitant to tell my parents about the obsessions in my mind and the odd behaviors I was engaging in. Fortunately, my father has a lot of experience treated anxiety disorders, and quickly noticed my compulsions, even though I tried to perform them discretely. Since my OCD was diagnosed early, I was able to receive the treatment necessary to reduce most of the symptoms of the disorder.

Currently, OCD does not affect the quality of my life; I do not have impairments in academic functioning, social interactions or emotional difficulties. Through CBT I was able to reduce the symptoms of the disorder. By age 9, one year after being diagnosed with OCD, my life returned to normal. Presently, I do not consider myself completely OCD free; however, I have very good control over the disorder and it does not inhibit my ability to function in any capacity or situation. Occasionally when I experience stress in my life, for example during exam period, an obsession may enter my mind, and I will have a desire to perform a compulsion. I have trained myself to immediately dismiss the obsessions as nonsense, and to refrain from performing compulsions; as a result the anxiety quickly dissipates. My hope is that as I continue to age and mature, I will be completely free of obsessions, even in times of significant stress.