Moris Ribon – Research Step 3

Finalized Formal Sentence Outline:

Thesis:
Effective remedies for Childhood OCD remain out of reach; after years of research, there is a couple of ways in which professionals treat it, but they have shown results that are tepid at best, with debilitating side effects.

I. Adults with OCD have an advantage over children because they are capable of understanding that their thoughts and behaviors are not only unreasonable but also abnormal.
   a. OCD begins at an early age. Symptoms begin to manifest between 6 and 15 years of age on men and 20 to 29 years for women.
   b. It causes a high degree of distress and behavioral issues in children.
   c. Children don't recognize their compulsive trait as being a problem.

II. OCD research dates back in history, when it was typically described as symptoms related to religious melancholy.
   a. OCD appears to have its roots in the western portion of the world in 17th century England.
   b. Attempts to identify OCD began in the 19th century.
   c. It used to be confused with other mental disorders, such as anxiety or panic.
   d. Sigmund Freud (1856- 1930) argued that OCD "conflicts between unacceptable, unconscious sexual or aggressive impulses and the demands of conscience and reality".

III. In the present, the ways in which children are treated for OCD varies and is predicated on the severity of symptoms.
   a. For children with mild to moderate symptoms, the first line treatment is cognitive behavioral therapy or CBT.
   b. Research has shown that CBT is quite effective.
   c. CBT has been used together with pharmacotherapy with the same effectiveness.
   d. In cases when medication is the sole treatment, the outcome is not as positive with devastating side effects.

IV. Parents of children who suffer from OCD should explore their options and available alternatives with qualified professionals.
   a. For parents concerned about medication side effects, CBT may be their only option.
   b. When CBT is administered, families are directly involved in treatment.
   c. Other treatment approaches such as relaxation therapies have been also used to treat OCD with some effectiveness in children with mild OCD.
   d. In cases of sever OCD, relaxation therapies don't work.
   e. Severe cases of OCD should only be treated with CBT and antidepressants.

Rough Draft:

Obsessive-compulsive disorder (OCD) may be best known as a mental disorder that manifests in frequent handwashing. Whenever it is presented on television it seems to always inflict an adult who is powerless to address their compulsive behavior, thus leading them to a life of social deprivations. What most people may not consider is that the manifestation, or onset, of OCD primarily begins at an early age, and that the consequences to children with OCD, while in many instances can be devastating, also affect their life course. This paper explores childhood OCD by detailing the numbers who are afflicted with the disorder, the differences that exist between adult and childhood OCD, and its history within the lexicon of medical thought throughout the centuries and by those who research it. OCD remains an elusive target for researchers, who have yet to pinpoint the root causes and, therefore, remain bereft of effective treatments. The following also discusses this issue by demonstrating both the pathophysiological and genetic aspects that are now understood, but have little consequence to date on how OCD is treated. There are a couple of ways in which OCD is treated and both have shown results that are tepid at best, and one of those leads to a range of other problems that can be even more debilitating. What seems evident is that effective remedies for childhood OCD remain out of reach for most.

OCD is described in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V), the clinical workbook used by psychiatrists and other mental health treatment professionals, as characterized by thoughts, images or urges that persistently reoccur and typically compel individuals to repeat behaviors or thoughts as a response (APA 235). While there appears to be no hard data concerning the numbers of people afflicted with OCD, current estimates place adult sufferers at 2.5-3% and 1-2% being children and adolescents (VCOY 1). While the statistics regarding those having OCD seem low it is still important to note that when compared to other mental disorders, such as schizophrenia and bipolar disorder, OCD is relatively common. Symptoms typical begin to manifest (onset) between six and 15 years of age for males, and 20 to 29 years of age for females (VCOY 1). Adults with OCD have an advantage over children because they are capable of understanding that their thoughts and behaviors are not only unreasonable but also abnormal. However, children typically don't recognize their compulsive and obsessive traits as being a problem, which causes a high degree of distress and behavioral issues.

Children do not have the cognitive abilities to recognize that obsessive thoughts and compulsive behaviors are abnormal. As a result, their OCD causes them a high degree of distress that in many instances leads to angry outbursts and tantrums. Their compulsive behaviors, such as frequent hand washing (a familiar example), are the primary way in which children cope with their obsessive thoughts, and as their levels of distress increase so too does the intensity or frequency of their compulsions (VCOY 1). The range of behaviors associated with OCD appear to manifest in several ways. According to the Centers for Disease Control and Prevention (CDC), they include: repeated thoughts, images or impulses that are unwanted and cause distress and anxiety; continually doing things by specific rules and in an exact order so that the obsessive thought is eliminated; thinking about or saying something repeatedly, for example, repeating words or counting with out loud or silently, and doing something over and over again, for example, procedures that must be strictly adhered to, placing items in a specific order and handwashing ("Obsessive-Compulsive Disorder."). Because children do not understand the

nature of their OCD they tend to believe that if they do not complete their compulsions something bad will happen, thus they are more prone than adults to spending increasingly more time engaged in their compulsive rituals (VYOD 1). In turn, children with OCD also tend to suffer at school and lack sufficient social skills that would allow them to function like other children. This induces a high degree of anxiety that eventually leads to future psychological issues that tend to increase over the life course.

OCD appears to have its roots in the western portion of the world in 17th century England where it was typically described by religious clerics as symptoms related to religious melancholy. The Stanford University School of Medicine notes that high-ranking church officials of the time reporting that some parishioners exhibited high degrees of distress over their concerns of saying or doing untoward things during sermons, continually expressing doubts when an issue had been resolved, or experienced obsessive thoughts that were considered blasphemous, and in the case of the latter would increase when attempting to suppress or stifle them ("History."). Attempts to identify OCD began in in the 19th century, primarily through early psychologists who tended to have difficulties differentiating between symptoms now understood as belonging to OCD with those now identified within the spectrum of anxiety disorders, for instance, common phobias or panic disorder. OCD would be characterized later in the century in terms of intellectual dysfunction yet would emerge at the beginning of the 20th century as a clinical term, but shrouded along with other disorders within a diagnosis of neurasthenia, which relates to a lack of development in the nervous system. Among others, Sigmund Freud (1856-1930) identified OCD as differing from neurasthenia, arguing that it was a maladaptive response to "conflicts between unacceptable, unconscious sexual or aggressive id impulses and the demands of conscience and reality". Freud's notion of OCD now seems out of step considering modern advancements in scientific and psychological research.

Since then, advances in medical and psychological research have discovered various pathophysiological and genetic factors for OCD. In this case, the pathophysiology of OCD refers to anomalies found in the brain. Researchers using functional neuroimaging have implicated three areas of the brain: the orbitofrontal cortex (OFC; a region located in the frontal lobes and involved with cognitive processes), the anterior cingulate cortex (ACC: located towards the inner portion of the brain and believed to be involved with higher-level functions such as emotion and impulse control), and the caudate nucleus (located towards the middle of the brain and believed to be responsible for inhibitory control of action (Maia, et al. 1253). In studies involving children with OCD researchers found an increase of blood flow passing through the caudate nucleus and the ACC, leading to the belief that blood flows through the two regions of the brain at increased rates through provocation, or when stressed. However, others theorize that there is a connection between the OFC, ACC and the basal ganglia region (the center of the brain), where the loops that connect each have been compromised in some way, causing a positive feedback loop essentially trapping obsessive thoughts (Maia, et al. 1255). But, even science cannot say for certainty that these two physiological anomalies are the definitive cause of OCD.

The above demonstrates that, like all mental disorders, OCD is a very difficult and elusive target. The two pathways described above typify the chasm that exists between researchers where at this time one theory competes with another. The situation seems almost the same in genetic research, where scientists have yet to identify the genetic basis for OCD. To genetic researchers, OCD is a neurobiological condition, evidenced by internal and external stimuli that are integrated in different responses. In children (and adults) with OCD, the responses are inborn and coordinated internally, and are triggered through environmental

conditions (Grados and Wilcox 968). This implies that the brain regions described previously play a role in the onset of OCD and that serotonin, a neurotransmitter, plays a critical role in the expression of OCD symptoms. However, beyond such speculation and findings there is far more work needed to be done. Family studies have found the prevalence of OCD to be upwards to seven times more likely, and research involving twins have consistently shown the existence of genetic factors combined with environment, but as of yet, the issue of the physiological origins of OCD is a mystery which is still awaiting answers.

The ways in which children are treated for OCD varies and is predicated on the severity of symptoms. For children with mild to moderate symptoms, the first line treatment is cognitive behavioral therapy, or CBT. In such cases, exposure and response prevention is taught in order to address anxieties that are suspected to trigger obsessive thoughts and compulsive behaviors (Mancuso, et al. 301). Therapists then teach children a variety of cognitive interventions that are ideally used to diminish and eventually extinguish the cues that trigger symptoms. Research has shown that CBT is quite effective and is used in numerous ways: individually, with families, and in intensive or group treatment settings (Mancuso, et al. 301). CBT has also been used as an adjunctive treatment when combined with pharmacotherapy, and while the combined therapeutic approach is reported to be just as effective in mild to moderate cases, in most instances where psychotropic medication is the sole treatment the outcomes aren't as positive. Typically, selective serotonin re-uptake inhibitors (SSRIs) are prescribed primarily for moderate to severe instances. Medications such as Anafranil and Prozac have been used and have demonstrable effects, but the side effects on young children can be devastating. Children prescribed with Anafranil have reported tremors, dizziness, constipation, sleep disturbances and dizziness, while those administered with Prozac reported experiencing insomnia, fatigue, agitation, decreased appetite and suicide ideation (Mancuso, et al. 302).

For parents who are concerned about medication side-effects, or question whether pharmacology is the right approach for their children, it appears that CBT may be their only alternative course at this time. As stated previously, in some instances where CBT is administered, families are directly involved in treatment. Several studies have reported some success by including the family, either by teaching CBT strategies to the child in tandem with teaching parents new strategies to support their child, or through intensive CBT treatments provided to each family member (Freeman, et al. 7). However, in such studies other treatment approaches were also used for both children and other family members, including relaxation and mindfulness therapies. In most cases, improvements were reported in cases where children suffered from mild to moderate OCD, but in cases of severe OCD it is highly suggested that children be administered CBT combined with an SSRI (Selective serotonin reuptake inhibitors), a commonly prescribed type of antidepressant, in the hope that symptoms will eventually diminish over time. Parents of children who suffer from OCD should explore their options and available alternatives with qualified professionals who are open to exploring treatment alternatives.

No different than other mental disorders, OCD is an elusive target for researchers who have yet to identify its physiological origins or cause. While advances in research have shown that potential anomalies exist within the brain, and that there is a substantial genetic connection that binds OCD generationally, to date all such findings remain tenuous and inconclusive. The efficacy of treatment is much the same, where CBT remains the front line therapeutic choice for mild to moderate cases, but in instances of severe OCD the treatment options are limited to medication. While researchers are now looking into treatment alternatives such as mindfulness

and relaxation therapies as adjuncts to OCD, there are no such adjunctive additions for pharmacological approaches, leaving children and their families to deal with a range of side effects that can sometimes be quite debilitating. Advances in research will someday identify the root cause of OCD and with no doubt find more effective treatments, a situation that must be disheartening for children who now suffer from OCD and their families.

Works Cited

American Psychiatric Association (APA). *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed., American Psychiatric Publishing, 2013, psy-gradaran.narod.ru/lib/clinical/DSM5.pdf. Accessed 15 Apr. 2017.

Centers for Disease Control and Prevention (CDC). "Obsessive-Compulsive Disorder." *Children's Mental Health*, 23 Mar. 2017, www.cdc.gov/childrensmentalhealth/ocd.html.

Commonwealth of Virginia Commission on Youth (VCOY). *Obsessive-Compulsive Disorder*. 2013. vcoy.virginia.gov/pdf/documents/collection/Obsessive-compulsive%20Disorder_0.pdf. Accessed 15 Apr. 2017.

Freeman, Jennifer, et al. "Evidence Base Update for Psychosocial Treatments for Pediatric Obsessive-Compulsive Disorder." *Journal of Clinical Child & Adolescent Psychology*, vol. 43, no. 1, 2013, pp. 1-31, doi:10.1080/15374416.2013.804386.

Grados, Marcos, and Holly C. Wilcox. "Genetics of Obsessive–Compulsive Disorder: A Research Update." *Expert Review of Neurotherapeutics*, vol. 7, no. 8, 2007, pp. 967-980, doi:10.1586/14737175.7.8.967.

Maia, Tiago V., et al. "The Neural Bases of Obsessive–Compulsive Disorder in Children and Adults." *Development and Psychopathology*, vol. 20, 2008, p. 1251–1283, doi:10.1017/S0954579408000606.

Mancuso, Elizabeth, et al. "Treatment of Pediatric Obsessive-Compulsive Disorder: A Review." *Journal of Child and Adolescent Psychopharmacology*, vol. 20, no. 4, 2010, p. 299–308, doi:10.1089/cap.2010.0040.

Sarvet, Barry. "Childhood Obsessive-Compulsive Disorder." *Pediatrics in Review*, vol. 34, no. 1, Jan. 2013, pp. 19-28, pedsinreview.aappublications.org/content/pedsinreview/34/1/19.full.pdf.

Stanford University School of Medicine. "History." *Stanford Medicine*, ocd.stanford.edu/treatment/history.html. Accessed 15 Apr. 2017.