The Impact of Obsessive-Compulsive Disorder in Children on Daily Functioning

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PSYC 1A Introduction to Psychology, M, W 11:20-12:40 p.m.

Gavilan College

November 24, 2008
Why I Chose to Write on My Topic

I chose to write on my topic regarding OCD in children because it’s a disorder that has affected me in my younger years. It’s a touchy subject but the more I learn about OCD, the more I have come to understand my old habits and rituals. If I could educate myself on how it impacts children, maybe I could educate parents on how to cope with their child’s disorder. I believe it’s important to help others as many people don’t realize they need to be helped. Many children do not realize they need help and it’s up to the adults to take care of them and help them in all aspects of their life including disorders. I certainly hope my children never experience this disorder but if they do ill know how to help them cope in schools, social activities, and daily functioning.

Having OCD as a child has changed my perspective on life. Counting and repeating everyday after school stressed me out. Some days I would cry because I could not complete my rituals. I felt I would be punished or not be able to eat dinner, play, or go to sleep unless I finished my routine. I also wondered if other family members or friends noticed my odd behavior. I was cautious everywhere I went, and at a certain time each day my rituals had to be done. I’m very thankful that my disorder was not severe, and that I was able to talk myself out of doing and the rituals or routines. I remember waking up one day and repeating to myself that today I will no longer count the rocks outside or walk into a room with my right foot first or complete any other ritual. I still have memories of my OCD, but I have accepted them because I know it does not define me. I learned that I’m in control of myself and body, although it took awhile to get over the intrusive thoughts, I felt even more relieved when I stopped. Nowadays, I try not to sweat the small stuff and tend to be easy going because life is too short and I want to live as stress free as possible.
I have a very close friend who shows similar signs of OCD. I believe her disorder is mild and minimal but I’m hoping this paper will help her. She is not a child experiencing OCD, but as an adult she can analyze some of the research found to better understand her motives. She is a very wonderful person, but gets very frustrated. For example, when we drive somewhere together, she has to check to make sure her truck is locked about three times once we park. Usually she will check the door by pulling on the handle, look to make sure it is locked inside, then go back again to use her automatic lock button. She then becomes satisfied and believes her truck is locked. Although her actions will have us chuckling and giggling, it’s definitely not funny. It’s ironic to me that my best friend and I have had some sort of OCD. Is it possible that our environment has influenced this disorder? I believe educating yourself and educating others will help a world full of confusion and understanding your disorder is vital to overcoming it. I know my friend will overcome her repetitive behaviors because she recognizes them and is willing to learn more about OCD, like myself.

Since OCD has affected myself and others that I know personally, learning more about the research of OCD will hopefully help answer some lingering questions such as; was OCD my fault? Is it a disorder caused by trauma? Were other children frustrated with their rituals as well? I remember being very confused by my actions, but felt deep down that my rituals must be completed. Maybe if parents recognized the signs of this disorder they can help them cope. Children have no concept of OCD, and I wanted to do this paper to see if parenting influenced this disorder, and how severe cases of OCD affected everyday functioning. I can educate others from my own experience, but by doing this paper may help me too truly understand the disorder I have overcome.
Impact of Obsessive-Compulsive Disorder

**What the Research Says About My Topic**

Obsessive-compulsive disorder (OCD) affects children and adults of all ages but I’m particularly focusing on the impact of OCD in children on daily functioning. “Among children, this disorder often results in academic difficulties, social problems, and disruptions at home/family environment and in addition, a history of pediatric OCD has been associated with impairment in adulthood” (Merlo, Storch, Murphy, Goodman, & Geffken, 2005, p. 195). “Estimates indicate that two-thirds to 80% of adults with OCD report onset of their OCD symptoms in childhood” (Verhaak & de Haan, 2007, p. 354). Most OCD characteristics include repetition, rituals, cleanliness, perfectionism, and order. They feel their actions are justified and they will constantly repeat rituals which must be completed in order to feel a sense of relief. Rituals may be repeated several times or more a day depending on the severity. Children are especially affected by OCD because they do not fully understand why they feel such actions are necessary and do not understand the meaning of compulsions. Since OCD is an ongoing disorder, children normally have a hard time with school work. They usually have trouble focusing on assignments and homework which becomes a big issue at school and at home. Completing homework is difficult because they’re constantly thinking about their rituals or perfectionism. This disorder also disrupts families because tantrums, crying, and throwing a fit will result if they are not allowed to finish each ritual. It then becomes frustrating and the child may feel their life will end without it. “Pediatric OCD has been estimated to affect between 2 and 4% of the population and more children may go undiagnosed or misdiagnosed” (Merlo et al., 2005, p. 196).

OCD children function daily with these rituals because of intrusive thoughts and external events which they believe will occur or may be accountable for if the ritual is not performed.
OCD functions include “washing or checking, but can also present as repeating, touching, counting, ordering, and hoarding” (Libby, Reynolds, Derisley, & Clark, 2004, p. 1076). The participants included in the research done by Libby et al. (2004), consisted of young people aged between 11 and 18. Three groups were studied to evaluate the differences in cognitive appraisals. The groups included 28 children with OCD, 28 with other anxiety disorders, and 62 participants were considered the non-clinical group. The results have found that young people with OCD have higher levels of inflated responsibility than young people with other anxiety disorders and a non-clinical group (Libby et al., 2004). The Thought-Action Fusion – Likelihood Other (TAF-LO), which means the specific error of equating an intrusive thought as increasing the likelihood of an event occurring to significant others, was found to be “significantly higher in the OCD group compared with the anxious group and the non-clinical group, suggesting a specific association” (Libby et al., 2004, p. 1081). They also found that fear of being judged by others or having intolerable anxiety if they make an error could be linked to inflated responsibility and thought-action fusion (Libby et al., 2004).

According to research by Zandt, Prior, and Kyrios (2006), “sameness behavior occurred at significantly higher rates in younger children with OCD compared to older children with the disorder, but there was no significant relationship between repetitive movements and age” (p. 255). The participants used by Zandt et al. (2006) consisted of 54 children and adolescents ages 7-16 years. “The OCD group consisted of 17 children” (p. 253). Results from the Repetitive Behavior Questionnaire (RBQ) done by Zandt et al. (2006), show that “children with ASD and OCD engage in similar levels of sameness behavior and repetitive movements” (p. 259). Although they did find that children with OCD were more likely to endorse in compulsions such as washing, checking, and repeating than ASD children. “A number of
executive functioning tests were also administered and the relationship between these results and repetitive behavior was examined, it showed greater executive function impairment, as rated by parents, was related to higher rates of repetitive behavior in the ASD and control group, but not for the OCD group” (Zandt et al., 2006, p. 256). This finding was very interesting to me. They also found that “individuals often feel compelled to perform a ritual or compulsion, which may be temporarily relieve anxiety” (Zandt et al., 2006, p. 252).

Other findings have sadly shown that children with OCD are victimized regularly by peers. A study conducted by Storch, Ledley, Lewin, Murphy, Johns, Goodman, and Geffken (2006) have shown that children with OCD were less well liked by peers. According to Storch et al. (2006) “boys and girls are impacted by peer victimization frequently and may take diverse forms, including overt (e.g., hitting, kicking, and yelling)” (p. 447). Storch et al. (2006) hypothesized that more severe OCD symptoms would result in more peer victimization. Basically, the more severe this disorder the more it impacts children on having friendships with other children. Participants of this study consisted of 31 boys and 21 girls and ages ranged from 8 to 17 years, with an average age of 12.0 years. These participants completed questionnaires following the clinical interview and the Children’s Yale-Brown Obsessive-Compulsive Scale (CY-BOC). They used the Schwartz Peer Victimization Scale which included questions like; “How often do other kids gossip or say mean things about you?” This measure has good internal consistency (Storch et al, 2006). They found that depression and loneliness can be resulted if the child has a severe case of OCD because they are neglected by peers. Based on the Children’s Depression Inventory data, 12% OCD children reported clinically significant levels of depression and 14% reported clinically significant levels of loneliness. The data conducted by Storch et al. (2006) “suggest that peer victimization is common among OCD children, with more than
one quarter being victimized regularly by their peers” (p. 452). Healthy children or even children with diabetes experienced much less peer victimization. Another study found, 37% of children reported difficulty making friends, 31% reported difficulty keeping friends, and 34-43% reported difficulty engaging age-appropriate peer activities (e.g., sleeping at a friends house). Peer victimization was found to be significantly related to compulsion and obsession severity and the more severe a child is affected by OCD, the more peer victimization, depression, and loneliness will occur and result in further external and internal behaviors (Storch et al., 2006), which generally supported their hypothesis. It also seems that parents are more aware of external problems compared to internal problems (Storch et al., 2006). Parents may notice their child being impacted by other children because of anger and aggression which is an external problem. On the other hand, parents may not notice internal experiences such as peer victimization impacting their child’s emotions such as sadness and feeling lonely, although it is also less likely for children to share their internalizing problems with their parents (Storch et al., 2006).

Children need the help, comfort, love, and support from their parents to overcome such turmoil from peers.

“Many rituals and avoidance behaviors are observable to peers” (Storch et al., 2006, p. 447). Other children may recognize their strange behavior. A child with OCD may leave the classroom to “wash their hands or might take longer than other children to complete school work because they have to rewrite and rewrite assignments” (Storch et al., 2006, p. 447). A simple classroom assignment has now become a disruption at school. Storch et al. (2006) also believed that extracurricular activities can trigger OCD and stated that “sharing a baseball glove is very difficult for a child with contaminated-related OCD, may be too exhausting after a day of having to cope with OCD, and may interfere with rituals that must be done at home once the
school day is over” (p. 447). Not wanting to play a sports game because it interferes with a certain ritual is a prime example of how children with OCD are impacted by daily functioning. Storch et al. (2006) also believed “clinicians and parents can coach children to “put off” their compulsions until the end of the school day when they get home, although some, but not all people with OCD can accomplish this by reassuring themselves that they can wash their hands, or recopy their work, or engage in some other compulsion eventually, even if not right now” (p. 453). They may have to miss out of fun activities during recess which is just a time for children to play and have a good time. OCD children are threatened by many contamination-related fears such as germs. Also some children with intense rituals use their free time to complete those rituals. Storch et al. (2006) also believed that “the nature of some children’s OCD symptoms might cause them to avoid classmates because of fear of contamination or of “catching” qualities of other children, such as becoming rude by touching a child who is rude” (p. 447). The avoidance of other children impacts their social life. They will be teased and be known as odd or different. This also starts a bullying behavior by other children that fuels attacks (Storch et al., 2006). Although it is also very possible for some children to reengage in social activities once the compulsions and obsessions stop and if they haven’t stopped it is still necessary to help these children re-engage in the social world by helping them discover interests such as joining a sports team, it is also important for parents and teachers to help OCD children develop skills to establish friendships (Storch et al, 2006). On the other hand, other children may have social skill deficits from many years of avoidance and other peers may choose not to accept them because they are unwilling to give second chances (Storch et al., 2006).

Farrell and Barrett (2003) found that cognitive processes of TAF, perceived severity of harm, self-doubt, and cognitive control appear to be comparable between children, adolescents,
and adults. Their participants included children and adolescents aged 6 to 17 years and consisted of 34 of the children aged between 6 and 11, and 39 adolescents aged 12 to seventeen years. Adults aged 18 to 66 were also used in this study. They also found that children experience less intrusive thoughts which are less uncontrollable than those experienced by adolescents and adults with OCD (Farrell & Barrett, 2003). Meaning, responsibility attitudes, probability biases, and thought suppression may develop in later stages. For depression frequency, children reported significantly less depressive thoughts than adults but not adolescents (Farrell & Barrett, 2003). This research resulted in the conclusion that children experienced less intrusive thoughts compared to adults, “with significantly less sadness, worry, and disapproval and removal strategies associated with these thoughts in comparison to both adolescents and adults” (Farrell & Barrett, 2003, p. 108).

Yoshida, Taga, Matsumoto, and Fukui (2005) used the PBI self-rating questionnaire on children with OCD which measures parental rearing attitudes, had some very interesting results. Their studies showed that parents, especially fathers have overly interfering rearing attitudes. Mothers also impact a child’s OCD levels by overly interfering maternal rearing attitudes. Using the PBI, Yoshida et al. (2005) study found that the parental protection in the OCD group with severe obsessive traits were significantly higher than that in healthy volunteers. It also showed that parental rearing attitudes are suggested to have influence to the occurrence of OCD and depression with obsessive traits (Yoshida et al., 2005), although it seemed strange and interesting to me that this study showed that depressive patients with low obsessive traits experienced controlling and interfering rearing by their mothers, but not their fathers. Parents also impact their child’s behavior by lacking sympathy, lack of male nurture, and emphasizing cleanliness.

The Obsessive Compulsive Cognitions Working Group found six important related
beliefs which include inflated responsibility, over-importance of thoughts, importance of controlling one’s thoughts, perfectionism, and overestimation of threat and intolerance for uncertainty. Verhaak and de Haan (2007) who studied 39 children and adolescents, believed that thought-action-fusion (TAF) is related to magical thinking. To prevent content overlap, questionnaires that measure cognitive dysfunctions (as opposed to symptomatology of the disorder), are used in this study. It was believed that OCD children’s daily lives are impacted by magical thinking because it is confused with reality, although the study done by Verhaak and de Haan (2007) indicates that there is no association between the severity of OCD and magical thinking. They also expected children to be impacted by social threat, personal failure, and physical threat, using CATS containing statements referring to the overestimation of threat (i.e., something awful is going to happen). Their findings were very interesting because it contradicted the central role of thought-action-fusion in OCD children, which contradicted many other studies including Libby et al (2004). Based on the findings of TAF in OCD, they expected an association between severity of OCD and the extent to which magical thinking or thought-action-fusion is reported but this connection has yet to be found.

In conclusion, the research has clearly shown that OCD in children impacts their daily functioning by interfering with school activities and assignments, extracurricular activities, making friendships, and home behavior. It seems that every minute in their daily lives are impacted by compulsions or obsessions. This disorder not only impacts their way of thinking, but also impacts every day normal functioning. Children with severe cases of OCD miss out on fun and excitement such as playing baseball, or acting in a school play because of their compulsions and obsessions or fear of contamination. The research also shows that parental attitudes and expectations relative to their children can escalate OCD in their children. This is
extremely sad to me because I believe having a happy and loving childhood helps mold children into successful, good hearted adults. So for those children who already show signs of OCD, their parents need to be more attentive and help their child day in and day out to cope with OCD.

**What I Learned Personally, Interpersonally, and Professionally**

I learned personally that children with OCD may show similar symptoms compared to ASD. I had this disorder as a child, and I’ve learned a lot about what I was going through by writing this paper. I will also be more cautious in labeling a person with OCD because many other disorders mimic this disorder.

I learned interpersonally to help befriend any child with OCD because these children experience depression and loneliness much more significantly than a person with no disorder and peer victimization can escalate the severity of OCD.

I learned professionally that some customers at work that ignore me or refuse to let me help them may have social problems due to OCD or another disorder.

**How I Plan to Apply What I Learned Personally, Interpersonally and Professionally**

I plan to apply what I learned personally by becoming less judgmental, and more compassionate and understanding towards others who suffer from OCD or any disorder. I also plan to stay aware of what I’ve learned to help myself if my OCD comes back.

I plan to apply what I learned interpersonally by encouraging others with OCD to participate in social activities, sports, or any activity to keep their minds off of their usual rituals. I will also be more careful about others feeling, and remember everyone just wants to be liked.

I plan to apply what I learned professionally by being more patient and friendly with customers who seem timid, afraid, or even shy. I will also try to be more sincere and understanding to others who seem rude because they could be a victim of some sort of disorder.
References


