



2017

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Recommended Citation

(2017) "Adolescent OCD: Healing Through Parent Integration," *Intuition: The BYU Undergraduate Journal in Psychology*: Vol. 12 : Iss. 1 , Article 7.

Available at: <http://scholarsarchive.byu.edu/intuition/vol12/iss1/7>

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Adolescent OCD: Healing Through Parent Integration

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*Intuition: The BYU Undergraduate
Journal of Psychology*

Abstract:

Adolescent obsessive compulsive disorder (OCD) is often misdiagnosed and not effectively treated due to a lack of knowledge and resources. One of the main factors that contributes to these misdiagnoses is that there are a limited number of trained clinicians who specialize in adolescent treatment. Comorbidity among the diagnosis of OCD in adolescents also adds to the lack of effective treatment specific to OCD. Often OCD symptoms can remain hidden as these symptoms often manifest as heightened versions of normal behavior in response to normal thoughts and feelings, which may increase during puberty. Effective treatment of adolescent OCD decreases when parents reinforce maladaptive coping behavior such as asking questions, washing, and checking. Current effective treatments include cognitive behavior therapy (CBT), exposure and response prevention (ERP), and medication, all performed under the supervision of a clinician. To improve treatment availability for OCD, the development of a parent-based program may be the most practical option. This review compares successful common factors present in each type of treatment and investigates the possibility of adaptation within an environment that leads to a parent-based treatment program.

Key words: Obsessive Compulsive Disorder, Cognitive Behavior Therapy, Exposure and Response Prevention, Supportive Parenting for Anxious Childhood Emotions Program, adolescents, parents

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The phrase “I am just a little OCD” is often used by many to describe their desire to be neat, and this usage leads to the misconception that OCD is just another personality quirk. However, Obsessive Compulsive Disorder (OCD) is a general term for a more extensive disorder made up of unreasonable thoughts or fears that lead to habitual actions. This disorder may include involuntary impulses to confess, have dark thoughts, inflict self-injury, or perform ritual religious acts like praying compulsions (Geller et al., 1998). When exhibited among children, this disorder may be mistaken for personality, puberty, or depression. However, Walitza et al. (2011) reveals, “OCD is one of the more common mental illnesses of children and adolescents, with prevalence of 1% to 3%” (p. 174).” Because of the relatively common occurrence of OCD, parents need to be aware of the many facets of the disorder and possible treatments available. OCD has been the subject of continued research, and a number of studies have focused on the effects of various treatments of the disorder on adolescents. Most research on treatment for OCD has shown that the preferred methods include cognitive behavior therapy (CBT) and serotonin-based medications (Walitza et al., 2011). Indeed, Wagner (2003) suggests that even though CBT may be the most effective treatment for OCD,

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many adolescents fail to complete a course of CBT since few clinicians are specifically trained to work with adolescents. This lack of training and the prevalence of OCD combined contribute to the struggle that many adolescents face as they try to understand and work through compulsive behaviors.

In addition to the varying treatments mentioned above, specialized attention from parents may create an effective treatment for children with OCD (Lebowitz, 2013). Parents, having insights gained by being in the home with their child that only a limited number of clinicians gain through specialized training, may be the best aids in their child's treatment. Due to the fact, that parents are generally present in the home, they have the opportunity to build a relationship of trust and confidence, allowing them to deliver treatment in a fair and consistent environment. Notably, adolescents rarely have the awareness or motivation required to change their behavior on their own and need the assistance of a parent (Labouliere, Arnold, Storch, & Lewin, 2013). Using parents as a new source of treatment would enable more adolescents to receive the assistance they require (Lebowitz, 2013).

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Misunderstanding of OCD Leads to Underestimating the Symptoms

OCD is commonly overgeneralized in our society as a personality trait rather than a disorder, and this belief may make those with the disorder less likely to receive treatment. Furthermore, the limited specialized professional help compounds the lack of treatment for adolescents with OCD (Wagner, 2003). Besides these concerns, symptoms of OCD can also be obscured by puberty or comorbid conditions like depression and general anxiety (Brown, Lester, Jassi, Heyman, & Krebs, 2015). Consequently, parents can help prevent or resolve comorbidity-caused misdiagnoses with an increased awareness of the diagnosis criteria that identify the distinct differences between OCD and similar disorders like anxiety or depression as found in Diagnostic and Statistical Manual of Mental Disorders (DSM-V, 2013). First, those with OCD generally have obsessions (recurrent and persistent thoughts) and compulsions (repetitive behaviors). Second, these obsessive symptoms are time consuming (e.g. more than an hour a day) are time consuming, may interfere with regular activities, and must be a source of distress. Third, the symptoms cannot be attributed to another medical condition or the effects of a substance. Finally, the dis-

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turbance cannot be better explained by the symptoms of another mental disorder (American Psychiatric Association, 2013). DSM-V clarifies that children who may not understand the inappropriateness of their impulses can still be diagnosed with OCD, even if they don't show any resistance to their compulsions (American Psychiatric Association, 2013). Any combination of the above behaviors or resulting compulsions serve as a warning sign and should prompt closer observation by a parent.

The “Hidden” Aspects of OCD

Along with understanding basic symptoms, knowledge of scientific findings about OCD enable those affected and those observing to grasp how OCD continues to be hidden and misunderstood. Salkovskis (1985) argues that metacognitive-behavioral models show that OCD is a person's overactive response to normal intrusive or negative thoughts. For example, a “non-affected” mind might have an intrusive thought of germs covering a door knob. The person with the “normal” mind would then be able to process that there are probably germs on the door knob but the worst that might happen from touching the knob is getting a cold. An individual with OCD may have the same thought, yet believe that they might become seriously

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ill or even die from what might be on the door knob. Afraid of what they have contracted and how it may affect others around them, the affected person may withdraw from everyone around them. Due to dysfunctional interpretive patterns, the ensuing thoughts are often seen as increased perceptions of danger and self-responsibility. This in turn may lead to compulsions and attempts to avoid intrusive thoughts through particular coping behaviors (severe avoidance, for example) and cycling feelings of relief and tension (Salkovskis, 1985).

An understanding of neurological chemical changes is critical in understanding OCD in adolescents. For instance, Rutter and Rutter (1993) explains that in adolescents, the mind is going through chemical changes that result in alterations to identity (how an individual perceives their place in the world; e.g. popular or a listener), alterations to identity, increases in self-consciousness, and changes in cognitive flexibility. (as cited in Blakemore, 2006). Blakemore (2006) proposes that adolescents' minds go through a qualitative shift and become more self-aware and self-reflective. The preceding information sheds light on why twenty percent of all OCD cases are manifested in adolescents ages 10 or younger with a median age of 11 (Kessler et al., 2005). Although most OCD cases manifest by age 11, the

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average age of treatment is 13. This delay in treatment can be attributed to symptoms being hidden by the one affected (Walitza et al., 2008). However, an affected individual's tendency to hide symptoms isn't the only reason why treatment is often delayed as discussed later.

Unidentified parent aspect: Enabling

A closer look at the progression and development of OCD reveals that an observer (a parent in an adolescent's case) can actually perpetuate the compulsive behavior, instead of identifying compulsions and dealing with them in a proactive way. Often, this occurs in the form of allowing behaviors to continue without resistance. One such way of enabling negative behaviors is by answering checking compulsions; for example, parents may constantly reassure a child that they (the parents) are not leaving the house if he or she has a fear of being alone (Walitza et al., 2011). Researchers conclude that this behavior is indulged or tolerated by parents in order to avoid aggressive outbursts from the adolescent (Walitza et al., 2011). Thus, while increased attention regarding behavior and symptoms is needed to help diagnose more children, increased attention can also prove detrimental and must be exercised with caution. For example, Wal-

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Walitza et al. (2011) describes a 10-year-old girl who began blowing large puffs of air after her grandfather passed away. She did not want to think about family when she was away from home. Furthermore, she had to wash her hands when she touched someone outside the family she did not like (Walitza et al., 2011). In this case, parents encouraged the behavior by allowing certain thought processes to continue outside the home without trying to understand or educate her on her false processing. While the results in this case study caused by the parent's behavior were unintentional it is clear how the results were still damaging. Furthermore, parents can use the principles outlined below, to become informed on how to combat these types of behaviors, and healing can occur in the home through parent's efforts and using adapted CBT tools.

Escaping the Prison: Treatment

The three most widely recognized treatments for OCD include CBT, exposure and response prevention (ERP) and medication. However, there is still a continuing discussion on the most effective treatment for the disorder. Walitza et al. (2011) concludes that CBT yields the best outcome for treatment due to the support built by the therapeutic relationship and positive

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long-term prevalence. However, Barrett, Farrell, Pina, Peris, and Piacentini (2008) asserts that ERP is the cornerstone of effective treatment based on its significant remission rates of forty to eighty-five percent. Despite the proven effectiveness of a combination of medication and a therapy program, the fact that it cannot be duplicated in the home by parents without the help of a therapist makes this a non-viable option for self-implemented treatment (Walitza et al., 2011). It is also important to note that many of the treatments, diagnostic categories, and practices now used by clinicians were initially created for adults and therefore must be adapted to children (Steinberger & Schuch, 2002).

Comparing Effective Treatments for OCD: CBT vs. ERP

Once a parent begins to understand how each type of therapy affects OCD behavior, a program could be developed to focus on their child's specific negative coping behavior. CBT uses both exposure and cognitive restructuring in the form of changing current thought processes to deter negative coping behavior (Barrett, Farrell, Pina, Peris, & Piacentini, 2008). This is done through a three-part system (Kramer, Bernstein, & Phares, 2014). First, the maladaptive thoughts must be identi-

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fied as they occur. Second, individuals must refute or challenge the thoughts when they occur. Third, doctors should give the individual the skills to replace the maladaptive thought with more accurate or adaptive thoughts (Kramer, Bernstein, & Phares, 2014). On the other hand, ERP uses exposure to obsessive fear stimuli to build up resistance and diminish the need for coping behaviors (Foa & Kozak, 1986). The main difference between these therapies is that CBT is designed to address the behavior and cognitive portion of the disorder directly, while ERP addresses the causes of OCD coping behaviors, and other aspects (like cognitive processes) are naturally treated.

Certainly, one of the most compelling aspects of CBT is that it addresses one of the core problems of OCD—the hyper-reaction to normal stimuli (Salkovskis, 1985). Salkovskis (1996) explains that the cognitive portion of CBT helps restructure an individual's thoughts to challenge the unrealistic reactions the mind initially presents such as taking responsibility for harm or constant self-doubt (as cited in Chu et al., 2015). One such example of unrealistic reactions might be avoiding other people in fear of getting them sick because of touching a doorknob as described earlier. However, despite the general success of CBT, Benito, Conelea, Garcia, and Freeman (2012)

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report that the extensive use of a CBT therapy can lead to higher anxiety during mid-treatment. Furthermore, Hedtke, Kendall, and Tiwari (2009) argue that “safety behaviors” or “crutch behaviors” that occur because of heightened anxiety are associated with a lower treatment success rate. For the program to be successful for adolescents, a parent must be aware of anxiety levels in their child and be prepared for subsequent behaviors.

ERP is similar to CBT, though it has a few vital differences. ERP is normally preferred by most therapists because it has a higher success rate over time (Craske et al., 2008). However, because ERP produces higher anxiety rates in the short term, parents may have a harder time managing a consistent program on their own. Those who practice ERP believe that through repeated exposures, coping behaviors will decrease in response to emotional processing or desensitization (Chu et al., 2015). If parents can react appropriately to the heightened levels of short-term anxiety then ERP will likely be more successful overall. Lebowitz (2013) asserts that ERP “encourages independent coping and confrontation of avoided triggers” (p. 425). Unlike CBT, ERP does not usually lead to an escalation of coping behaviors with the increased anxiety because the individual is focused on the immediate exposure task (Chu et al., 2015).

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Therefore, by increasing anxiety in the short term through ERP, responsiveness and long-term results will improve.

Identifying the True Independent Variable in Each

Treatment: The Parents

The continuing analysis of these treatments in studies focuses on the effectiveness of treatment in treating OCD. These varying studies often conclude that the success rates are dependent on the type of treatment. However, Ginsburg, Kingery, Drake, and Grados (2008) identify that the only common factor of poorer responses to CBT were the severity of symptoms and the presence of a disjointed family environment. In addition, Garcia et al. (2010) demonstrate that increased family adjustment introduced in the home, and comorbid conditions present within the subject decrease CBT effectiveness. A better hypothesis based on these findings might be that parent accommodation has an equal or greater influence on anxiety reduction than the type of treatment.

It is important to know the types of treatments as well as the common structure and possible hindrances to these programs (Brown, Lester, Jassi, Heyman, & Krebs, 2015). There are other factors that can have an impact on the effectiveness

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of treatment for OCD, some of which cannot be controlled. For instance, the severity of symptoms, other comorbid conditions, and how an individual cognitively interprets various stimuli are all likely to impact the effectiveness of treatment, but cannot be controlled by either parents or therapists (Storch et al., 2008). Most notably, what can be controlled is the parent's verbal response and accommodation level toward the compulsive behavior. The more a parent can prevent negative coping behaviors, the more effective both CBT and ERP will be (Storch et al., 2007). Therefore, it is crucial that parents, as well as those diagnosed with OCD, take active participation in changing adaptation behaviors and in therapy.

Discussion

As discussed above, effective OCD treatments have already been developed; multiple studies have supported the validity of ERP, CBT, and medication. However, the limited amount of trained professionals limits treatment options (Wagner, 2003), especially since most programs need a trained professional to adapt them for an adolescent (Steinberger & Schuch, 2002). During most treatments, parent accommodation to compulsions is rarely addressed, giving adolescents a major disad-

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vantage. Without the influence of properly instructed parents, children are likely to grow up without knowing how to manage their symptoms. Active, helpful parents may lead to adolescents diagnosed with OCD becoming better-adjusted adults and lower the need for treatment and medication in this population of adults.

Forging the Parent/Child Alliance

Families adjusting their lifestyle in an effort to ease a child's anxiety is a common occurrence (Lebowitz et al., 2013). As discussed above, it is common for families to become their adolescent's primary enablers, which only increases the length and severity of OCD-related troubles (Storch et al., 2007). This may decrease a child's willingness to participate in any treatment at all (Lebowitz, 2013). However, through changing parenting behaviors, outcomes can be improved.

Many studies have been done to evaluate parenting in regards to OCD treatment. Family dynamic studies focus on modifying multiple problems such as accommodation, conflict, and communication (Lebowitz, 2013); ultimately, they show that the main concern when treating OCD is accommodating behavior. One way parents can avoid accommodating behavior

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is by replacing it with non-violent resistance (NVR). Lebowitz (2013) states that NVR is “uniquely suited to coping with children’s deregulated reactions without fanning the fire” (p. 426). During NVR treatment, parents accept that they have a limited ability to control or change the behavior of their child and instead focus on aligning their own behavior with a desired belief or path (Lebowitz, 2013). NVR effectively provides parents with a plan to use alternative behaviors in place of the previous destructive helping behaviors. Parents are undoubtedly terrified at the prospect of having a seriously mentally ill child; however, it’s imperative that boundaries be observed in order to provide a stable and consistent environment to support the healing process (Labouliere et al., 2013).

Rescuing May: Utilizing SPACE.

NVR is an effective tool for parents when helping their adolescent with OCD. Many program utilize NVR as the basis of their treatment; one such program is called the Supportive Parenting for Anxious Childhood Emotions Program (SPACE) created by Lebowitz and Omer (as cited in Lebowitz, 2013, p. 426). This program specializes in reducing accommodation behaviors and reducing a child’s symptoms through steps that

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retrain parents as they aid their child. SPACE has six steps. First is parental introduction and education; SPACE teaches the difference between protective, short-term alleviation and supportive behavior. Second, parents must monitor and document all accommodating behaviors. Third, parents create a plan and write the plan out to present to the child. Fourth, parents must establish cooperation between one another and present a unified front. Fifth, parents should find a trusted friend or family member outside the home that can provide social support. Sixth, parents must deal with aggressive outbursts that may have triggered accommodating behavior previously. When implemented correctly, SPACE can allow parents to successfully help their adolescent.

The following SPACE case study involves 13-year-old May, her parents, and a therapist. From the ages of nine to thirteen May had fears of germ contamination, which led her to fear exposure to harmful chemicals, radiation, asbestos, and other environmental hazards. Her family accommodated her intrusive thoughts by leaving all windows closed, cleaning everything with only plain water, and answering questions about their possible exposure to various things while outside the home (Lebowitz, 2013). Despite her family seeking profession-

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al help, May “admitted her worries may be inflated, but stated that if this were the case, it was because her parents and siblings were ‘grossly irresponsible’ and therefore she needed to be extra careful” (Lebowitz, 2013, p. 429). This illustrates the destructive pattern that accommodation can have on the individual and the family.

Recognizing that May’s symptoms had to be properly treated, her parents implemented the SPACE program. First, the family successfully addressed only her open window fear. After diminishing her response to open windows, they dealt with her compulsion to ask questions. In response, May retaliated by destroying her parents’ bedroom. The supporting therapist instructed them to leave it as it was and contact one of the supporters to express an understanding of her distress, but explain how her behavior was unacceptable (Lebowitz, 2013). Understandably, it is tempting for parents to return to accommodating behavior during setback, yet a review of May’s earlier behavior will serve as a reminder of the continuous cycle. Eventually, May became more compliant to the implementation of each new stage and began individual treatment (Lebowitz, 2013). It became clear that as May’s parents changed their behavior, May was able to focus on her symptoms and take an active part in

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her own recovery.

Moving Forward: A Conclusion

Ultimately, it is imperative that parents adapt their behavior and become a solid example and voice of reason for their children. The hardest part of this disorder for adolescents is that they don't have enough life experience to know what is normal in terms of their overactive responses. An adolescent with OCD has to deal with growing up fighting their own thoughts and attempting to fit into society (Salkovskis, 1985). The plan to alter a parent's behavior stems from the logical assumption that children will learn new behaviors while their parents are also learning. While a parental intervention program may create more anxiety and stress in the short term, in the long run it will benefit the whole family (Chu et al., 2015). Parent-based therapy has the potential to aid children who are not receiving treatment or refuse treatment, ultimately helping adolescents live out a more normal childhood and become well-adjusted adults.

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