

Obsessive-Compulsive Disorder

Characterized by repeated behaviors intended to control recurring anxieties, obsessive-compulsive disorder probably affects at least one of your students.

By Leslie Z. Paige

Marcus's parents became concerned when he asked the same question every night: "How do people get AIDS?" They also noticed that Marcus frequently washed his hands, which had become red and chapped, and often kept them tucked into his armpits.

Similar concerns surfaced at school—Marcus frequently asked permission to leave the classroom to go wash his hands, kept them in his pockets, and often stopped by the nurse's office with questions about contagious ailments, particularly AIDS. He avoided interacting with other students—to the point that he now ate lunch at a corner table by himself. During a session with the school psychologist, Marcus indicated that he was overwhelmed with fear that he would contract AIDS although he never engaged in risky behavior.

Marcus' story is an example of obsessive-compulsive disorder (OCD), an anxiety disorder that can interfere with normal life and cause serious social and academic difficulty in school. Although OCD is a psychiatric disorder that requires professional diagnosis and treatment, there are several ways that school personnel can help students who have OCD.

Understanding OCD

Once thought a rare psychiatric illness, OCD is now known to be a more common disorder characterized by a cycle of obsessions and compulsions that cause extreme distress, dysfunction, and fear. It is not simply meticulousness or worrying. Obsessions are involuntary, recurring, and unwanted thoughts that cause feelings of anxiety or dread. They are irrational and interfere with normal thinking. Compulsive behaviors are repeated to try to control the obsessive thoughts.

Performing rituals provides temporary relief from the anxiety created by the obsessive thoughts. Sometimes there is a clear connection between the obsession and the compulsion (e.g., contamination and washing), but this may not always be the case (e.g., counting behaviors may be used to prevent harm to others). Often the urge to perform the compulsive behaviors becomes stronger over time. If the original compulsion becomes less effective in reducing anxiety, then other behaviors or more elaborate rituals are added to provide relief. The compulsive behaviors can become extremely time-consuming and interfere with normal functioning. Some people can delay the behaviors, but this is very difficult and they will nearly always need to perform the ritual later. Students who are able to delay their compulsions while in class, for example, may need a private place to go to perform rituals at a later time during the school day.

People who have OCD are not delusional. They usually recognize that these thoughts and behaviors are unreasonable but feel unable to control them. Symptoms tend to wax and wane, and they may worsen as a result of illness or stress. Washing; checking rituals; and preoccupation with disease, danger, and doubt are among the most common symptoms in childhood-onset OCD (Swedo, Rapoport, Leonard, Lenane, & Cheslow, 1989).

Approximately 2%–3% of people (including adolescents) have OCD, although this may be an underestimate because many symptoms are kept secret. OCD can emerge as early as preschool. The number of children who develop the disorder peaks at puberty and then again during early adulthood (National Institutes of Mental Health, Pediatric Obsessive-Compulsive Disorder Research, 2006). One-third of adults who have OCD developed

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symptoms as children. Although OCD occurs equally in both sexes, there is an earlier onset in boys than girls (National Institutes of Mental Health, 2006; Obsessive-Compulsive Foundation [OCF], 2006).

OCD is related to tic disorders, such as Tourette's syndrome, and some adolescents have both. OCD can also exacerbate other disorders, such as Attention Deficit Hyperactivity Disorder (ADHD), depression, and panic disorder (OCF, 2006). Relatively persistent in adults, child-onset OCD has a complete remission rate of 10%–50% by late adolescence (Zohar, 1999). Without treatment, OCD may become chronic and result in severely decreased functioning. The effects on adolescents can be considerable, including depression, agitation, poor attention and concentration, feelings of shame, slow performance, and other problems associated with poor academic functioning and difficulties with relationships (Paige, 2004).

Cause and Diagnosis

The cause of OCD is unknown, but research suggests that it may relate to a biochemical imbalance that interferes with the way the brain processes information and causes the brain to send false messages of danger. OCD may be a learned response to reduce anxiety or may be triggered by a stressful event.

Children and adolescents may hide their symptoms for fear of being regarded as crazy or weird. Adolescents may be particularly conscious of the stigma associated with OCD symptoms and may be adept at devising explanations for their behaviors or ways to avoid places or situations that trigger them. Compulsive rituals often begin gradually, and parents may unintentionally compensate for the behaviors. If children and adolescents have rituals that are developmentally appropriate (e.g., lining up stuffed animals in a certain way or wearing a lucky shirt for a ballgame) or appear healthy (e.g., washing hands after using the bathroom), parents may not initially be concerned by OCD symptoms. As a result, they may not seek treatment for their child until the behaviors become significantly disruptive (Snider & Swedo, 2000).

Treatment

Treatment success and effective strategies depend on the age of the student and the severity of the behavior. Common treatments include medication and cognitive behavioral therapy (CBT). Medications help decrease anxiety and reduce the intensity of the symptoms so the student is better able to ignore the obsessive thoughts. CBT helps the student cope with obsessive thoughts and reduce his or her need to perform compulsive behaviors. Many adolescents who have OCD fear that they are going crazy. CBT helps them understand the disorder, helps decrease their symptoms, explains their behaviors, and teaches them coping strategies that can be reinforced by parents and school staff members.

Effects on School Performance

OCD can have a significant negative effect on learning, particularly if left untreated. Complex rituals may cause attendance problems that appear similar to school avoidance. In school, students may avoid situations or places that increase their obsessive thoughts or may spend time performing rituals in secret, which can result in missed learning time and increased social isolation. Obsessive thinking may mimic the symptoms associated with Attention Deficit Disorder because students are distracted by their obsessive thoughts or are trying to delay performing a compulsive behavior. Teachers should understand that a student who has OCD and appears to be inattentive or agitated actually may be focused on distressing obsessive thoughts or trying hard to not tap a pencil a certain number of times. The compulsive behaviors may result in bullying or victimizing the student who has OCD. Obsessive thoughts may create agitation or social problems.

Helping Students With OCD

Raise awareness. Early identification and appropriate treatment are very important to managing—and recovering from—OCD. School personnel should be alert to the symptoms of OCD and seek appropriate advice from the school psychologist or school counselor. Prolonged or frequent absences from class, unexplained agitation, repetitive,



Common compulsions include:

- Excessive washing and cleaning
- Repetitive checking and rechecking
- Counting or repeating words (usually silently)
- Redoing, such as opening and closing, erasing and rewriting
- Hoarding useless items
- Praying (continuous or excessive)
- Symmetry (movements or objects need to match or be ordered in a certain way)

Common obsessions include:

- Contamination
- Harm to self or others
- Sexual thoughts
- Death
- Doubting
- Sin or guilt
- Belief that things need to be done in a certain way or number of times to avoid harm

Identification and Treatment of OCD

- 2%–3% of high school students—nearly 500,000 individuals—have OCD.*
- OCD is highly manageable, even curable in 10%–50% of cases, but early diagnosis and treatment are important.
- Adolescents may hide their symptoms for fear of being labeled crazy.
- A combination of medication and cognitive-behavior therapy can help diminish symptoms.

*Based on 2007 enrollment estimates from the U.S. Department of Education, National Center for Education Statistics (2006).

regimented behaviors might all be signs of a problem. Some behaviors may not be directly observed (e.g., hand washing) but can be inferred from indirect observations (e.g., raw, bleeding hands). Reduce stigma by educating staff members and students about OCD and explaining the fact that symptoms of the disorder are not in the adolescent's control and are no more his or her fault than shortness of breath is for a student with asthma.

Partner with parents. Parent involvement is essential to helping a student cope with OCD. Some parents may require education about the disorder and how the school can support their child. Some parents will seek collaborative support from school, but others may be concerned with privacy and resist school involvement in treatment plans. Parents and adolescents feel more confident and hopeful and interventions are implemented more effectively when parents are informed and are embraced as partners in decisions about how to help their child cope—and succeed—at school.

Collaborate with community providers. Ideally, school-based mental health profes-

sionals communicate with the student's health care provider regarding treatment plans and behavior limits. The school psychologist may be able to suggest strategies to decrease anxiety, reinforce coping skills, and enhance academic performance. The school nurse may need to administer medication during the school day. These school-based supports should be coordinated with the student's health care providers.

Provide appropriate support. Teachers should know how OCD affects learning and attention in general terms and how they affect a particular student. They should also know how to respond appropriately to a student who is distressed or disturbed by unwanted thoughts. Telling adolescents who have OCD to stop worrying or that nothing bad will happen is not sufficient, and punishing or embarrassing them is ineffective and may worsen the symptoms.

Well-structured classroom environments with clear expectations, smooth transitions, and a calm climate are helpful for all students, but especially for students who have OCD, whose symptoms may be exacerbated by stress. Some accommodations may be needed, such as allowing extra time to take a test because of a student's compulsion to check and recheck. The school should ensure that there is at least one staff member (e.g., a school psychologist or a counselor) to whom a student can turn when struggling with symptoms. The school may also need to arrange for a safe spot for a student who is feeling overwhelmed with intense thoughts or feelings. Some students may qualify for special education services if the disorder impairs learning or behavior to a significant degree.

Summary

OCD can cause extreme disruption and distress for adolescents at a time when both self-actualization and socialization are vital and disrupted learning can have serious consequences. Fortunately, OCD is also manageable when identified and treated early and consistently. School administrators can help students with OCD by ensuring that staff members understand the disorder, recognize symptoms, and are prepared to provide the appropriate

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support. Equally important, principals should work to eliminate the stigma against those who have OCD and other mental illnesses so that all students feel safe, valued, and supported by their school community.

Treatment for Marcus included medication and CBT in addition to special education services for ADHD. The IEP team determined that Marcus's obsessive thinking had interfered with his ability to concentrate and perform academically. In consultation with his therapist and the school psychologist, the IEP team added goals to address his OCD symptoms to his IEP. He is better able to control his fears of contamination, and his hand-washing behavior has decreased to near normal. By monitoring the condition of his hands, his parents and teachers can intervene as needed. **PL**

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Resources

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National Institutes of Mental Health
www.nimh.nih.gov/HealthInformation/ocdmenu.cfm

Teens Health
http://kidshealth.org/teen/your_mind/mental_health/ocd.html

OCD Foundation
www.ocfoundation.org

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