Child Mind® Institute

Parents Guide to OCD

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Children with obsessive-compulsive disorder (OCD) have intrusive thoughts and worries that make them extremely anxious, and they develop rituals they feel compelled to perform to keep those anxieties at bay. This guide explains the often confusing behaviors that can be associated with OCD, and the treatments most effective for helping kids who develop it.

What Is OCD?

OCD is an anxiety disorder, and kids who have it struggle with either obsessions or compulsions or both. Obsessions are unwanted and intrusive thoughts, images or impulses. Obsessions make kids feel upset and anxious. Compulsions are actions or rituals kids are driven to perform to get rid of anxiety.

To understand how OCD works, think about a mosquito bite. When you get bitten by a mosquito, it itches, so to make it feel better you scratch. While you scratch the bite it feels great, but as soon as you stop scratching, the itching gets worse. That's how OCD plays out. When a child with OCD feels anxious he'll do something to fix it temporarily, but that ritual makes it worse over time.

Kinds of obsessions and compulsions

OCD obsessions fall into a variety of categories, including the below list.

Contamination: Kids with this obsession are sometimes called "germophobes." These are the kids who worry about other people sneezing and coughing, touching things that might be dirty, checking expiration dates or getting sick. This is the most common obsession in children.

Magical thinking: This is a kind of superstition, like "step on a crack, break your mother's back." For example, kids might worry that their thoughts can cause someone to get hurt, or get sick. A child might think, "Unless my things are lined up in a certain way, Mom will get in a car accident."

Scrupulosity: This is when kids have obsessive worries about offending God or being blasphemous in some way.

Aggressive obsessions: Kids may be plagued by a lot of different kinds of thoughts about bad things they could do. "What if I hurt someone? What if I stab someone? What if I kill someone?"

The "just right" feeling: Some kids feel they need to keep doing something until they get the "right feeling," though they may not know why it feels right. So they might think: "I'll line these things up until it just kind of feels right, and then I'll stop."

Compulsions can be things that kids actively do — like line up objects or wash hands — or things done mentally, like counting in their head. A compulsion could also be an avoidance of something, like a child who avoids touching knives, even flimsy plastic ones, because she's afraid of hurting someone. Because compulsions are things that parents might notice, it is common for parents to be more aware of them than obsessions.

Kinds of OCD compulsions include (but are not limited to):

Compulsions are things parents are more likely to notice.

Cleaning compulsions, including excessive or ritualized washing and cleaning

Checking compulsions, including checking locks, checking to make sure a mistake wasn't made and checking to make sure things are safe

Repeating rituals, including rereading, rewriting, repeating actions like going in and out of a doorway

Counting compulsions, including counting certain objects, numbers and words

Arranging compulsions, including ordering things so that they are symmetrical, even or line up in a specific pattern

Saving compulsions, including hoarding and difficulty throwing things away

Superstitious behaviors, including touching things to prevent something bad from happening or avoiding certain things

Rituals involving other persons, including asking a person the same question repeatedly, or asking a parent to perform a particular mealtime ritual

Signs of OCD

OCD often first develops around ages six to nine. The disorder can manifest as early as five. Young children experience the disorder differently than adolescents and adults do. A young child may not recognize that his thoughts and fears are exaggerated or unrealistic, and he may not be fully aware of why he is compelled to perform a ritual; he just knows that it gives him a "just right" feeling, at least momentarily. Over time, in the 9-12 range, it evolves into magical thinking and becomes more superstitious in nature.

In either case, a child with OCD will respond to his anxiety in a way that is very rigid and rule-bound and interferes with normal functioning. Parents might notice signs such as:

— Repeated hand washing, locking and relocking doors or touching things in a certain order

— Extreme or exaggerated fears of contamination, family members being hurt or harmed or doing harm themselves

— Use of magical thinking, such as, "If I touch everything in the room, Mom won't be killed in a car accident."
— Repeatedly seeking assurances about the future
— Intolerance for certain words or sounds
— Repeatedly confessing "bad thoughts" such as thoughts that are mean (thinking a family friend is ugly), sexual (imagining a classmate naked) or violent (thinking about killing someone)

How OCD can go undetected

Signs of OCD might not always be obvious. Compulsions can be very subtle, so parents and other caregivers might not notice when a child is doing them, or they might not understand that a particular behavior is a compulsion. Other signs might be invisible to parents, like when a child compulsively counts to a certain number in her head.

As children get older and realize that some of their fears are nonsensical, or their behaviors unusual, they might also go to greater efforts to conceal their OCD symptoms from parents, teachers and friends. Children with OCD can sometimes manage to suppress their symptoms in certain situations, like at school, only to explode at home because of the tremendous effort.

OCD can also be mistaken for a different disorder. Many children with OCD are distracted by their obsessions and compulsions, and it can interfere with their ability to pay attention in school. A teacher might notice a child having difficulty focusing and assume she has ADHD, since her OCD isn't apparent. It could also be mistaken for a different anxiety disorder. And it can be overlooked when a child with OCD also develops depression, which kids with OCD are at risk for, especially without treatment.

Treatment

Cognitive behavioral therapy

The first step in treatment is helping children understand how OCD works. It often helps to put OCD in a context that children can understand. For example, a clinician might explain that OCD functions like a bully. If a bully asks for your lunch money and you give in because you're afraid, then the bully will be happy and go away. But the next day the bully will come back for more, because he knows you are afraid. The more you give in to a bully the more he will ask for. OCD functions the same way. The goal of treatment is to help a child learn how to stand up to his bully.

The gold-standard treatment for OCD is a kind of cognitive behavioral therapy called exposure and response prevention, or ERP. ERP works by helping children face the things that trigger their anxiety in structured,

incremental steps, and in a safe environment. This allows children to experience anxiety and distress without resorting to compulsions, with the support of the therapist. Through facing their triggers children learn to tolerate their anxiety and, over time, they discover that their anxiety has actually decreased.

For example, a child with fears about germs and contamination would create a "fear hierarchy" with his therapist. They would work together to identify all of the contamination situations he fears, rate them on a scale of 0-10, and then tackle them one at a time until his fear subsides. The child would start with a low-level trigger, such as touching clean towels, and build to more difficult triggers, such as holding something from the trash.

Because children often have symptoms that are specific to settings outside the clinical office, at home or in restaurants, for instance, it is important for treatment to move outside the office as needed. Your clinician should provide ERP in real world locations where your child experiences anxiety, and make sure that parents know how to reinforce ERP skills outside of treatment, too.

For most cases of mild to moderate OCD, treatment once a week for 12-15 weeks is usually enough to get strong results.

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Working with parents

Parents spend the most time with their children, so it is essential for family to be involved in treatment. You should expect your child's clinician to work closely with you, explaining how treatment works and giving you and your child homework to practice the skills your child is learning in therapy.

Because children often come to parents looking for reassurance or to help with an obsession or compulsion, it is also important for parents to learn the best way to respond to their child without reinforcing her OCD. When a parent gives reassurance, it makes the child feel better in the moment, but that relief is fleeting and can actually reinforce the child's anxiety in the long run. It also doesn't help her learn any coping skills to help herself — only that asking mom or dad will help.

Similarly, if your child has an aversion to a certain word, your family might have learned to avoid saying that word and apologize if someone accidentally uses it. However inadvertent, this also reinforces the OCD because it doesn't give the child a chance to overcome her anxiety. Your child's clinician should work with you on finding ways to respond to requests for reassurance that are supportive without reinforcing OCD symptoms.

Intensive cognitive behavioral therapy and hospitalization

For children with severe symptoms, weekly or even twice-weekly therapy sessions might not be effective enough. If your child's symptoms are seriously interfering with school performance, family life and friendships, and if typical treatment isn't helping, you may want to consider a treatment program that is more intensive.

Some institutions that specialize in OCD, like the Child Mind Institute, offer intensive treatment programs that allow children to be seen several times a week, compressing treatment and helping children make more gains faster. These programs can have a transformative effect on children struggling with severe OCD, and can many times prevent hospitalization.

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An inpatient hospitalization program is another option for children with severe OCD who are not getting the help they need from traditional outpatient treatment. After an inpatient OCD hospitalization, a child may be recommended to participate in an intensive outpatient program to help ease his transition away from being in a clinical environment and to help him maintain the gains he has made.

Medication treatment

While the primary treatment for OCD is cognitive behavioral therapy, children with more severe cases are often treated with a combination of CBT and medication. A class of antidepressant medication called SSRIs, or selective serotonin reuptake inhibitors, can be used to help reduce a child's anxiety, which in turn allows the child to be more responsive to therapy. Medication can be decreased or discontinued as the child learns skills to help her overcome her anxiety on her own.

Sometimes other types of medicines can be prescribed to control excessive irritability or anger that may be complicating treatment.

Related Disorders

It is not uncommon for children with OCD to struggle with more than one disorder. Depression, eating disorders and panic disorder can frequently occur alongside OCD. If your child is diagnosed with multiple mental health disorders, it is important for him to receive specialized treatment for each disorder. Cognitive behavioral therapy for OCD, for example, will help a child with his OCD but will not help with his depression.

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Care should be taken during diagnosis to determine if a child only has obsessive-compulsive disorder, or if the child has OCD and another disorder, or perhaps a disorder that is similar to OCD but is actually a separate disorder such as acute-onset OCD or a disorder on the "obsessive-compulsive spectrum."

The obsessive-compulsive spectrum

There is a spectrum of disorders that share some characteristics with OCD and are treated in similar ways. These include:

- **Trichotillomania**
- **Tourette's syndrome**
- **Illness anxiety disorder (or somatic symptom disorder)**
- **Hoarding**
- **Body dysmorphic disorder**
- **Skin picking (or excoriation disorder)**
- **Chronic tic disorders**

While these disorders have similar clinical characteristics — and some experts believe that they may have the same underlying neurobiological causes as OCD — they differ from OCD in certain ways and therefore require a specialized treatment.

One distinction worth making is between OCD and two other disorders that involve obsessive thoughts: illness anxiety disorder (a child is obsessed with the idea that she has a serious illness despite not having symptoms) and body dysmorphic disorder (a child obsesses on a minor or imagined flaw in her appearance). The difference is the extent to which a child believes her thoughts. For example, a child with OCD may know her obsessions are irrational and yet have so much anxiety that she feels the need to perform compulsions to reduce the anxiety anyway. A child with illness anxiety disorder or body dysmorphic disorder, however, may believe her thoughts are based in reality. Children with these disorders usually need cognitive therapy and strategies to gain insight into the irrationality of their obsessions before they can begin exposure and response prevention therapy. If they receive ERP before they are cognitively prepared for it, then their anxiety may actually worsen over time.

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Hoarding, skin picking, trichotillomania and tic disorders including Tourette's can be treated by exposure and response prevention and other behavioral strategies.

Working With the School

Many times children with OCD will experience symptoms at school. If this is the case for your child, it will be helpful to get his school on board with treatment. Often the first step is helping teachers and administrators at the school understand OCD. Educating the school is particularly important because many behaviors associated with OCD can be mistaken for something else, like oppositional behavior, learning problems or another disorder. For example, a child's OCD symptoms might make him distracted, which could look like ADHD, or make him take a very long time on tasks and tests, which could look like a learning problem. An emotional outburst might be caused by another student triggering his OCD. When teachers understand what a child's particular challenges are — and that he's not just being difficult — they will be better able to help him.

You child's clinician should be able to give specific advice on the best way to work with the school, including explaining your child's OCD triggers, setting up a plan for how the teacher can help your child if he feels his symptoms coming on, and minimizing any behavioral problems or challenges. Clinicians sometimes will go into the school to help train teachers on how to support students with OCD.

Your child's clinician may also be able to suggest strategies to help your child focus on learning, such as preferential seating and private testing rooms to minimize distraction, or extended time on tests and papers and use of a laptop to minimize negative consequences from perfectionism.

Additional Resources:

- childmind.org/teachers-guide-ocd
- childmind.org/parents-guide-getting-good-care
- childmind.org/ocd

The Child Mind Institute is an independent nonprofit dedicated to transforming the lives of children and families struggling with mental health and learning disorders. Our teams work every day to deliver the highest standards of care, advance the science of the developing brain, and empower parents, professionals and policymakers to support children when and where they need it most. Together with our supporters, we're helping children reach their full potential in school and in life. We share all of our resources freely and do not accept any funding from the pharmaceutical industry. Learn more at **childmind.org**.