CLASSROOM CHALLENGES FOR STUDENTS WITH OBSESSIVE COMPULSIVE DISORDER AND SUPPORTIVE STRATEGIES FOR EDUCATORS

by

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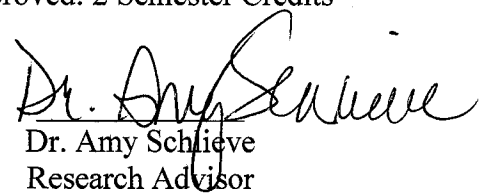

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ABSTRACT

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Classroom Challenges for Students with Obsessive Compulsive Disorder and Supportive Strategies for Educators

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The purpose of this study was to gain an understanding of the challenges children with obsessive compulsive disorder face within the classroom setting and to determine effective strategies that educators can use to identify children with obsessive compulsive disorder and assist them to succeed academically, socially, and personally. This study included a comprehensive review and critical analysis of research and literature associated with obsessive compulsive disorder and classroom management. A summary was presented and conclusions and recommendations were made in order to provide educators with a list of identification and supportive strategies that can be used to assist

students with obsessive compulsive disorder. Although many adults diagnosed with obsessive compulsive disorder have reported experiencing symptoms of the illness in childhood, its prevalence in children has been largely unexplored. The life altering effects obsessive compulsive disorder symptoms produce and the coexisting disorders that accompany it makes early intervention and management crucial. It is necessary for educators to be able to recognize and understand the symptoms of obsessive compulsive disorder in children and be able to apply supportive strategies to assist students who may be suffering from this disease.

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Chapter I

Introduction

"Compulsive" and "Obsessive" are words used often in everyday conversation. People may use these terms lightly as self-descriptors to explain their penny pinching or fears of being alone, however, to an individual who chronically suffers from these two adjectives, more serious definitions apply. The American Academy of Child and Adolescent Psychology (2003, n.p.) defined obsessions as "recurrent and persistent thoughts, impulses, or images that are unwanted and cause marked anxiety or distress." These obsessive thoughts are not simply worries or preoccupations about real-life problems, rather they are unrealistic, irrational, and extremely difficult to control. Individuals who experience these excessive thoughts attempt to reduce the anxiety produced as a result by engaging in compulsions or "repetitive behaviors, rituals, or mental acts" (AACAP, 2003, n.p.). When these obsessive thoughts become so frequent or intense, or these compulsive rituals become so extensive that they interfere with an individual's daily functioning, a diagnosis of obsessive-compulsive disorder (OCD) is made (Jenike, Baer, Minichiello, 1998).

Menzies and Silva (2003, p. 16) stated that, "individuals with OCD experience fear in the presence of specific stimuli and make efforts to avoid that stimuli." The anxiety that this produces earns obsessive compulsive disorder a classification under the larger umbrella of anxiety disorders. Anxiety, in fact, appears to be the most prevalent mood state found in OCD, characterizing at least 75% of patients (Steketee, 1993). This anxiety can be seen in almost every behavior and characteristic associated with OCD.

The principle features that distinguish this disorder from others are recurrent thoughts or images that are considered intrusive and that cause significant distress and ritualistic behaviors typically engaged in to rid or neutralize those obsessive thoughts (Menzies & Silva, 2003). In order to meet DSM-IV criteria for OCD, the individual must have either obsessions or compulsions (American Psychiatric Association, 1994). In actuality, however, most individuals have both.

Obsessive compulsive disorder has a long history, with symptoms dating back to the seventeenth century in the hand-washing rituals of the guilt ridden Lady Macbeth (Swinson, Antony, Rachman, & Richter, 1998). Many have believed obsessive behavior to be the work of the devil or witchcraft. Individuals displaying symptoms of obsessive compulsive disorder have often been feared, ostracized, and isolated throughout the course of history. Misunderstood stories of the bizarre behavior and rituals that surrounds this phenomenon and the vacillation between religious, medical, and psychological explanations for it only adds to the complicated mysteries that surround this affliction (1998).

Obsessive compulsive disorder can be an extremely devastating illness that wreaks havoc on an individual's economic, social, and family life. A few common obsessions of this disease include fear of germs, fear of having harmed one's self or others, a need to have things organized, and worrying about what one has said in a conversation. In the most common OCD sufferer, a given obsession may occur hundreds or thousands of times (Steketee & White, 1990). Compulsions are often considered the hallmark of OCD, because they are often observable to others in a way that obsessions are not (1990). Common compulsions that may go along with OCD obsessions are a

constant washing of the hands, retracing steps, hoarding, reassurance seeking, and constant ordering, cleaning, and double-checking.

The following case studies taken from Jenike, Baer, and Minichiello (1986, p. 5) illustrate the extreme behaviors these obsessions and compulsions can produce and the detrimental effects they can have on day-to-day functioning.

> *Cleaning compulsions:* A 30-year old male presented with fears of being contaminated by touching objects he considered dirty. He had to cover various "dirty objects" with paper towels before he was able to touch them. If, however, he did happen to touch door handles in public restrooms, the gas cap on his car, or other "dirty" objects, he experienced vague feelings of dirtiness and discomfort, and he would engage in extensive washing of his hands, along with any clothing he believed had come into contact with the object. The individual kept one hand "clean" at all times and refused to use it to touch anything or even shake hands. As a result of these OCD symptoms, the patient was unable to work full time because of avoidance behaviors, and his social life dwindled because he spent several hours each day engaged in cleaning.

Because of the extreme behaviors that this man's germ obsessions produced, he was unable to maintain employment or participate in social activities. His symptoms slowly worsened until they took over virtually all aspects of his life.

Below, Jenike, Baer, and Minichiello (1986, p. 5) provided another example, dealing with the common compulsion of "checking", and created for us a picture of the challenges this type of obsessive compulsive attack can have for its victims.

Checking rituals: A 50-year old female engaged in repetitive checking behaviors when she was not sure whether she had performed an action correctly. She would plug and unplug electric appliances 20 times or more to be sure that she actually took the plug out of the socket. She would do the same with light switches, turning them on and off repeatedly to ensure that she in fact had turned them off. She counted money over and over, and her arithmetic required so many recalculations that she could no longer work in her previous job as a bookkeeper. The patient was no longer able to read because she continually returned to sentences she had already read because she was not sure she had actually seen them.

These are only two of the numerous cases of OCD that exist and they only begin to illustrate the life altering effects this disorder may have in the lives of individuals who suffer from its afflictions.

As if the life-altering challenges OCD patients endure are not enough, characteristics of other illnesses are often experienced in conjunction. Additional disorders or syndromes that an individual may have simultaneously with their OCD symptoms are called comorbidities. The existence of comorbidities in obsessive compulsive disorder often appears to be the rule rather than the exception. Numerous characteristics of other disorders may co-exist with OCD such as depression, psychosis, and various types of personality and anxiety disorders (OCF, n.d.). These additional symptoms compound with the obsessive compulsive disorder to further complicate the lives of its sufferers.

At one time, obsessive compulsive disorder was believed to be fairly rare and only seen in adults. In the past decade, however, researchers have discovered that it is much more prevalent than once thought, being the fourth most common neurobiological disorder and affecting one in every fifty adults, and as many as one in every one hundred children (Schroeder, 1995). Half of all adults with OCD have reported childhood onset, however most of them admitted hiding their symptoms and not seeking treatment. This, Schroeder (1995, p. 75) stated was "because they were so aware of the bizarre nature of their obsessional thoughts and compulsive rituals and were reluctant to disclose them for fear that others would think them weak or crazy."

Prevalence of this disease in children in actuality remains only a sketchy hypothesis. It truly is a hidden problem that threatens to affect more individuals than may be realized. The hidden, secretive nature of this disorder and personal reports of childhood onset lends support to the researcher's belief that it is a more common occurrence in children than we may have once believed. Children who suffer from this disorder may not understand the bizarre compulsions and obsessions it produces, therefore may be unwilling and/or afraid to ask for help. They may not realize that the obsessions are not their fault and may experience feelings of shame, embarrassment, and inadequacy, going to great lengths to conceal their symptoms as a result. Childhood is the foundation laid for the remainder of life, where individuals form important concepts of self-esteem and independence. Without proper diagnosis and assistance in dealing with this disorder, children may grow up unaware that their "strange" thoughts and behaviors have a name (Schroeder, 1995). These children may suffer socially, personally, and academically as a result. This is why it is crucial to be able to recognize the signs of OCD

in children, understand the symptoms, and be able to provide appropriate classroom support and teaching strategies that will allow those students to deal with their obsessions and compulsions in a positive and productive manner.

Statement of the Problem

Consistent with the literature regarding obsessive compulsive disorder, its prevalence in children has been largely unexplored, however many adults diagnosed with OCD have reported experiencing symptoms of the illness in childhood. The life altering effects OCD symptoms produce and the coexisting disorders that may accompany it makes early intervention and management crucial. The interference that OCD can have in the learning and developmental process makes it necessary for educators to be able to recognize and understand the symptoms of OCD in children and be able to apply supportive strategies to assist students who may be unknowingly suffering from this disease.

Purpose of the Study

The purpose of this study was to gain an understanding of the challenges children with OCD face within the classroom setting and to determine effective strategies educators can use to identify children with OCD and assist them to succeed academically, socially, and personally. Data was collected at UW-Stout, by conducting a comprehensive review of the literature and drawing implications from that literature in the summer of 2004.

Research Objectives

The objectives of this research was to gain an understanding of the challenges children with OCD face within the classroom setting and to compile a variety of strategies that educators can use to identify and assist children with OCD.

Assumptions and Limitations

The researcher assumed that research would be readily available on the topic of obsessive compulsive disorder and that the symptoms specified for adults will be similar to those that children experience. The researcher also assumed that the literature found was accurate, current, and from reputable sources. The researcher acknowledges the limitation that OCD has been believed to be more prevalent in adults, therefore little research has been done in regards to children. Much of the information will need to be examined and reevaluated to allow the researcher to apply it to school age children.

Chapter 2

Review of the Literature

Introduction

This chapter will include a definition of obsessive compulsive disorder (also referred to as OCD) and an extensive discussion of its characteristics and symptoms. Prevalence and potential causes of the disorder will be examined, as well as the comorbitities that may exist along with OCD. Symptoms will then be discussed in regards to children with OCD and the difficulties they may face in an academic setting. In addition, strategies will be explored that teachers can use in classroom settings to identify and assist students with this disorder.

Definition, Characteristics, and Symptoms

According to the American Psychiatric Association (1997, p. 456) "obsessive compulsive disorder is characterized by recurrent obsessions and/or compulsions that cause marked distress and/or interference in one's life." The DSM-IV defines obsessions as follows:

1. Recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress.
2. The thoughts, impulses, or images are not simply excessive worries about real-life problems.
3. The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.
4. The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind.

The DSM-IV defines compulsions as:

1. Repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.

For a diagnosis of obsessive compulsive disorder to be made the DSM-IV also requires:

1. The obsessions or compulsions cause marked distress, are time consuming (take more than one hour per day), or significantly interfere with the person' normal routine, occupational functioning, or usual social activities.
2. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. Note: This does not apply to children.

Unfortunately, the seriousness of OCD cannot be understood from its definition alone. Obsessive compulsive disorder is a severe and debilitating anxiety disorder. In severe cases, which may define upward of 20% of those with the diagnosis, obsessions and compulsions can occupy the entire day and result in profound disability (Mascltis, Recter, & Richter, 2003). OCD can wreak havoc on all aspects of an individuals' life and can cause extreme isolation and alienation.

As defined earlier, obsessive compulsive disorder is characterized by recurrent obsessions and/or compulsions that are intense enough to cause severe anxiety, discomfort, and distress. Menzies and Silva (2003, p. 21) defined the obsessions that

surround OCD as "recurrent and persistent ideas, thoughts, images or impulses that intrude into consciousness and are experienced as senseless or repugnant." In other words, they form against one's will and the person recognizes that the thoughts make little or no sense and will attempt to either resist or get rid of them. These obsessions cause anxiety and discomfort not only because of the thoughts themselves, but because the individual realizes that they are powerless to control them. Rappaport (1989, p. 2) stated that "for some the senseless thoughts are meaningless (i.e. assigning numbers to everything, counting squares in the ceiling), for others however, the thoughts involve highly charged ideas (i.e. "I have just killed someone.")." Swinson, Antony, Rachman, and Richter (1998, p. 52) gave examples of common obsessions described by their patients in an attempt to highlight the serious nature these thoughts can take on.

- The thought of causing harm to children or elderly people.
- The thought of "unnatural" sexual acts.
- The impulse to physically and verbally attack someone.
- The impulse to violently attack and kill someone.
- The impulse to disrupt the peace at a gathering (i.e. shout obscenities or throw things.
- Blasphemous thoughts during prayers.
- The impulse to crash a car while driving.
- The thought of harm to, or death of a close friend or family member.
- The thought that something is wrong with ones health.
- The impulse to jump from a tall building or mountain/cliff.

Of course every individual is different and may or may not experience the same or

similar thoughts, however there is a strong likelihood that at some point throughout the course of the disorder, a violent obsession of some nature will surface.

Menzies and Silva (2003, p. 20) defined the disorder's compulsions as "repetitive, purposeful forms of behavior that are carried out because of a strong feeling or compulsion to do so." The behavior is usually performed in conjunction with the obsessive thought and is designed to prevent or reduce the anxiety or discomfort caused by the obsession or to prevent some dreaded event or situation from occurring. The compulsions are usually performed according to certain rules or routines that only the person experiencing the compulsion can understand. Menzies and Silva (2003, p. 21) stated "The activity or behavior being enacted is often clearly excessive and not connected in a realistic way with what it is designed to prevent and the individual generally recognizes this senselessness of the behavior and does not derive pleasure from carrying out the activity, although it provides a relief from tension." Severe compulsions can cause endless rituals to dominate each moment of every day. Examples of common compulsive behaviors outlined by Swinson, Antony, Rachman, and Richter (1998) are compulsive cleaning behaviors, compulsive checking, compulsive reassurance seeking, repeating/counting compulsions and compulsive hoarding. To gain a complete understanding of these compulsive behaviors more discussion and explanation follow.

Compulsive cleaning behaviors are an attempt to remove dirt or pollution that is not observable. The individual suffering from a cleaning compulsion believes that either they or their surroundings are contaminated with germs and they engage in behaviors to rid themselves of those germs. Swinson, Antony, Rachman, and Richter (1998, p. 54) stated "These attempts to remove "mental pollution" are inevitably unsuccessful." In

these cases two, five, or even 10 showers a day fails to produce a feeling of cleanliness. Often individuals with this compulsion will wash their hands so often in a day (50+ times) that they will bleed. One example of this cleaning compulsion is a patient who tried with indifferent success to wash away the fear and guilt induced by obsessive images of killing his relatives or acquaintances (1998).

Compulsive checking behaviors are intended to prevent harm from coming to someone and are almost invariably oriented toward the future (Swinson, Antony, Rachman, & Richter, 1998). They can be seen as a form of preventative behavior, an attempt to avoid the prospect of some adverse event. These compulsions involve double-checking to make sure appliances are turned off (i.e. lights, stove, coffee pots) and that doors and windows are locked. Often individuals experiencing checking compulsions will be up throughout the night, checking and double-checking these items. In these cases the checking rituals can produce (rather than relieve) even more anxiety in that the person may then think that while they were checking the lock they may have accidentally unlocked it and it becomes a vicious cycle.

Compulsive reassurance seeking is where people make repeated requests for reassurance. The person may need to be reassured in regards to each decision that they make no matter how minor. This type of compulsion may be extremely difficult in regards to relationships. From the researchers personal experience the person suffering from OCD usually requires constant reassurance that they are loved and that the other party is being faithful. Suspicious obsessions are coupled with these compulsions and it is one reason why an individual with OCD may have difficulties maintaining successful long-term relationships (Francis & Gragg, 1996).

Repeating compulsions involve redoing physical or mental acts a certain number of times or until it feels just right (Francis & Gragg, 1996). Turning light switches on and off, retracing steps, and touching doorknobs over and over again are a few of these repetitive behaviors. Individuals with these rituals often have special or lucky numbers that dictate the number of times they must repeat a behavior of this type, tying in the counting compulsions that can accompany OCD (1996).

Compulsive hoarding can result in an accumulation of piles of objects that occupy a steadily increasing amount of living space, with the affected person and family members having to navigate their way through mounds of clutter (Swinson, Antony, Rachman, & Richter, 1998). When a room becomes virtually unusable, it is closed off, and the space turned into an overflow storage area. For example, a patient who lived in a single-bedroom apartment built up a collection of articles (mainly gifts that she might want to donate) that gradually occupied the entire bedroom, forcing her to sleep on the couch in the sitting room. Even in this remaining space, she had to thread her way through steadily rising mounds of objects. The objects were placed on the floor and on all the furniture, including the bed, with the exception of one chair, which she used for sitting when she ate or watched television (Swinson, Antony, Rachman, & Richter, 1998). This type of compulsive behavior may begin simply as a nuscience and attributed to being eccentric, however it can quickly become out of control and destructive to the life of ones family.

These are some of the main compulsions that have been found to exist in an individual who suffers from obsessive compulsive disorder. The precise behaviors engaged in under each category, however, can take many different forms. It is impossible

to understand the true life altering nature of this disorder without looking at these real life examples of those who have experienced and lived with it.

Prevalence and Causes

At one time, obsessive compulsive disorder was thought to be fairly rare. In the past decade, however, we have learned that it is much more prevalent than once believed. OCD has been found to be twice as common as schizophrenia or panic disorders and is in fact the fourth most common psychiatric disorder in the United States population (Menzies & Silva, 2003). One in every fifty adults currently suffers from obsessive compulsive disorder and twice that many have had it at some point in their lives. Between 30% and 50% of these adults reported that their symptoms started during or before mid-adolescence (Watkins, 2001). Watkins suggested that at any given time 1% to 3% of adolescents are experiencing symptoms of obsessive compulsive disorder (2001). The prevalence estimate of OCD in children is at least 2-4% and an even larger number may have sub clinical OCD (Grados, Labuda, Riddle, & Walkup, 1997). Still further research has shown that children as young as five or six can show full-blown OCD attacks (Watkins, 2001). This recent insight into the number of children and adolescents that may be experiencing symptoms makes this disorder a crucial area of exploration.

OCD's mean age of onset has been found to be quite consistent across studies, ranging from 19.3 to 25.6 years, with 65% of cases becoming symptomatic before the age of 25, 30% reporting symptoms as children, and fewer than 15% developing symptoms after age 35 (Steketee, 1993). Prevalence data regarding the frequency of OCD is approximately equal for males and females however males appear to experience symptoms earlier with the mean age of onset for boys being 9 years and the mean onset

age for girls being 11 (Lane, Gresham, & O'Shaughnessy, 2002). Prevalence studies support this data showing that male children are two times more likely than females to be diagnosed with this disorder before the age of 10 (March, Leonard, & Swedo, 1995). An individuals symptoms of obsessive compulsive disorder can and usually do change throughout the lifespan. Children diagnosed with OCD before 6 to 8 years tend to show more compulsions than obsessions, however the nature of their symptoms tend to change as the child grows older (Lane, Gresham, & O'Shaughnessy, 2002). Subjects that tend to be the source of obsessions and compulsions tend to evolve from those experienced in childhood into new and more complicated topics as patients grow into adulthood.

Mental illness is usually believed to be either biological (such as a hereditary abnormality in the brain chemistry) or psychological (such as an emotional conflict resulting from childhood upbringing) in nature (Steketee & White, 1990). Obsessive compulsive behavior, however, is believed to be a result of a combination of these many factors acting together to cause the disease. Steketee (1993, p.14) states that nearly half of her patients who have OCD could identify clear precipitants such as sexual trauma, medical events, and childbirth, that they believed caused the onset of their OCD symptoms and almost all patients related increases in symptoms to life stresses. Because these reports represent only speculation on the part of the patient and are only an individual's "theory" regarding what they believe may have "caused" the onset of their OCD, these reports are not given much scientific significance (Steketee, 1993).

Although there is no single, proven cause of OCD, heredity is believed to play a major role. Research shows that OCD is a brain disorder that tends to run in families. This does not mean that a child who has a parent with OCD will definitely develop

symptoms and a child may still develop OCD with no previous family history (AACAP, 2003). If one parent has OCD, the likelihood the child will be affected is about 2 to 8 percent (OCF, n.d.). It is important to remember, however, that this statistic is an approximation, and several other factors may play a role when attempting to estimate the risk of a child developing OCD.

Research suggests that reduced levels of serotonin in the brain play a role in OCD, however no laboratory test can specifically determine that to be a sole factor (OCF, n.d.). What is known, however, is that OCD involves problems in communication between the sections of the brain that interfere with information processing. It is as if the brain gets stuck on a particular thought or urge that it can't let go of, therefore keeps replaying itself in the mind. People with OCD often say the symptoms feel like a "case of mental hiccups that won't go away" (OCF, n.d.). This is what causes the repetitive obsessions and compulsions that characterize the disease.

Comorbidities

Having two or more separate psychiatric diagnoses at the same time is referred to as a comorbidity (OCF, 1998). The existence of comorbidities in obsessive compulsive disorder appears to be the rule rather than the exception. Because individuals with a variety of other psychiatric disorders may exhibit the obsessive characteristics and ritualistic behaviors associated with OCD, properly diagnosing the illness in some patients may be complicated and tricky. To obscure matters even further, often more than one disorder may be diagnosed in a single patient, since the diagnosis of OCD is not exclusionary (March & Mulle, 1998). In terms of comorbidity issues, many individuals may have comorbid diagnoses of depression, eating disorders, social or other phobias,

and related anxiety disorders. Also, 5% to 7% of OCD children have been diagnosed with Tourette's disorder (Lane, Gresham, & O'Shaughnessy, 2002). The most common comorbid diagnoses involve other anxiety and mood disorders. Rates of comorbid anxiety disorders range from 15% to 75% and mood disorders have been found to coexist in 25% to 38% of youth with OCD (Francis & Gragg, 1996). This realization is crucial in that OCD can compound with other disorders to affect all aspects of a person's life. This emphasizes that the treatment of the whole person and all of the related issues they are experiencing is necessary to overcome these afflictions and live healthy and happy lives. Only a few of the OCD's numerous comorbidities will be identified and discussed in the following segments.

According to Steketee (1993), anxiety appears to be the most prevalent mood state in OCD, characterizing at least 75% of patients. Earlier, in fact, this researcher discussed the classification of OCD in DSM-IV as an anxiety disorder and that the nature of the obsessions and compulsions are directly related to high anxiety levels and the attempt to decrease that anxiety. The frequency of anxiety producing phobias occurring at some point in an OCD patient is high, ranging from 50% to 77%. The frequency with which OCD and panic disorders co-occur ranges from 11% to 27% (Steketee, 1993). Among children and adolescents with OCD, comorbidity with other anxiety disorders is common. Francis & Gragg (1996, p. 17) state that the most common comorbid anxiety disorders surrounding OCD are simple phobias (17%) and overanxious disorders (16%). Anxiety disorders have also been found to be common in close relatives of OCD children supporting the possible heredity cause of the disorder (Steketee, 1993).

Perhaps more than any other anxiety disorder, OCD is most often complicated by depression. Depressed mood state appears to be extremely common in many individuals who suffer from this disorder. A diagnosis of major depression has been found in 28-38% of OCD clients (Steketee, 1993). This depression likely occurs because of the debilitating nature of the OCD symptoms. Time-consuming rituals often prevent the initiation and pursuit of life goals. This leads individuals to miss out on social occasions, to fail to accomplish tasks within the work setting, to experience distress and tension in their important relationships and to experience recurrent embarrassment and shame (Mascltis, Rector, & Richter, 2003). Approximately two-thirds of OCD patients have suffered at least one major depression at some point in their life (OCF, 1998). Some schools of thought theorize that OCD causes the depression while others assert that OCD and depression simply tend to coexist (1998). Depression may further cause other diseases such as alcoholism and drug addiction. In fact, alcohol abuse typically follows the reported onset of OCD, suggesting that alcohol may serve as self-medication for the anxiety and depression that OCD patients experience.

It is not surprising that OCD has often been associated with the personality disorder that bears the same name of obsessive compulsive personality disorder (OCPD). However, fewer than 25% of those with OCD actually qualify for a diagnosis of OCPD according to most studies (Steketee, 1993). The primary feature distinguishing between these two disorders is that the repetitive acts of people with OCD are typically resisted (at least in the initial phases of the disorder), whereas in OCPD they are typically ego-syntonic (causing little or no distress) (1993). Rasmussen and Tsuang (1986) have identified common pre-morbid personality traits that may have a bearing on the

development of OCD. These include separation anxiety, resistance to change or novelty, risk aversion, ambivalence, excessive devotion to work, magical thinking, hypermorality, and perfectionism. Personality disorders that most frequently co-occur with OCD are avoidant, dependent, and histrionic.

Schizophrenia has a 12% comorbidity rate with OCD (Hollander & Benzaquen, 1997). In patients suffering from schizophrenia the frequency of obsessions and compulsions has varied ranging from 3.5% to 25% (1997). Whether obsessions can progress to the delusions experienced by schizophrenic patients is yet to be discovered, however it has been shown that some patients only experience OCD symptoms during a psychotic episode (Grangdev, 2002). Hallucinations and obsessions are similar in nature in that both may instruct the individual to perform certain actions. In fact obsessions can easily be mislabeled as hallucinations because sometimes patients may be referring to an inner voice or their own thoughts spoken aloud when they admit to voices (Gangdev, 2002).

Some cases of OCD may be associated with Tourette syndrome (TS). Tourette syndrome is characterized by multiple motor and one or more vocal tics that include involuntary rapid movement or vocalization (Robertson, Banerjee, Eapen, & Fox-Hiley, 2002). Between 55-74% of patients with Tourette's syndrome also have symptoms of OCD (Hollander & Benzaquen, 1997). Both OCD and Tourette syndrome patients perform repetitive behaviors to relieve unpleasant and unwanted urges, sensations and anxieties. The difference between the two disorders is that while compulsions in OCD are intentional behaviors, tics are unintentional and involuntary behaviors (1997).

Individuals with OCD are also more likely to have Attention deficit disorder, learning disorders, anorexia, separation anxiety disorder, and other anxiety disorders. Some of the anxiety disorders have similarities to OCD and are called obsessive-compulsive spectrum disorders. These include tricotillomania (compulsive hair pulling and twirling), body dysmorphic disorder (the obsession that part of one's body is unattractive or misshapen) and habit disorders such as nail biting and scab picking (Watkins, 2001). The exact relationship between these spectrum disorders and true OCD is not yet entirely clear and the only certainty is than no individual will experience the symptoms and potential comorbidities surrounding obsessive compulsive disorder in the in the same way.

Children with OCD

When one thinks of the term "mentally ill," the picture of an adult most likely comes to mind. But numerous types of mental illness can strike children as well and obsessive-compulsive disorder is one of these. In many ways the symptoms of OCD in both children and adults follow the same general principles. Obsessive-compulsive disorder in children, as in adults, is characterized by pathological obsessions and compulsions (Grados, Labuda, Riddle, & Walkup, 1997). While adults often recognize their obsessions and/or compulsions as excessive, this is not a requirement for making an OCD diagnosis in children. An OCD child's fears and phobias are not like so-called normal childhood fears (of the dark, of strangers, of getting lost, etc.), and according to Lane, Gresham, and O'Shaughnessy (2002, p. 237), "many children do not have the cognitive skills to understand whether their symptoms are "excessive," therefore in order to diagnose a child as having OCD, it is necessary for their obsessions or compulsions to

cause them a great deal of distress, interfere with their daily functioning, and be time-consuming (i.e. more than one hour per day being devoted to the obsession or compulsion).

Children and adults with OCD often experience similar obsessions and compulsions, however, children differ from adults cognitively, developmentally, and physiologically therefore they may manifest their symptoms in different ways. According to Watkins (2001), most individuals with OCD, even young ones, are at least intermittently aware that their symptoms do not make logical sense. Because children are less capable of abstract thought, and as a result may be less apt to understand that these obsessions are not their fault, they may experience feelings of shame, embarrassment, and inadequacy. Children will often go to great lengths to conceal their symptoms as a result.

OCD can make daily life very difficult and stressful for children. They may worry that they are "crazy" because they are aware their thinking is different than that of their friends and family. The Obsessive-Compulsive Foundation (1998, n.p.) acknowledged that "a child's self-esteem can be negatively affected because the OCD has led to embarrassment time and time again, or has made the child feel "bizarre" or "out of control." OCD symptoms can also take up a great deal of a child's time and energy, making it difficult to complete tasks such as homework or household chores. These obsessions or compulsions can continuously interfere with the child's normal routine, academic functioning, social activities, or relationships (AACAP, 2003).

Mornings and evenings can be especially difficult for children with OCD. In the morning, they often feel they must do their rituals exactly right, or the rest of the day will

not go well. Meanwhile, they are feeling rushed to be on time for school. This combination leads to feeling pressured, stressed, and irritable. In the evenings, they may feel compelled to finish all of their compulsive rituals before they can go to bed. At the same time, they know they must get their homework done and take care of any household chores and responsibilities. Some children stay up late into the night because of their OCD, and are then exhausted the following day (OCF, n.d.).

Children with OCD frequently don't feel well physically (OCF, n.d.). This may be due to the general stress of having the disorder, or it may be related to poor nutrition or the loss of sleep. In addition, obsessions and compulsions related to food are common, and these can lead to irregular or "quirky" eating habits. Because of these and other factors, many children with OCD are prone to stress-related ailments such as headaches or upset stomachs (OCF, 1998).

The types of obsessive thoughts that children experience may vary with the age of the child and may change over time (AACAP, 2003). A younger child with OCD may fear that harm will come to himself or a family member, for example an intruder entering an unlocked door or window. The child may compulsively check all the doors and windows of his home after his parents are asleep in an attempt to relieve anxiety. The child may then fear that he may have accidentally unlocked a door or window while last checking and locking, and then must compulsively check again (2003). An older child or a teenager with OCD may fear that he will become ill with germs, AIDS, or contaminated food. To cope with his/her feelings, a child may develop "rituals" (a behavior or activity that gets repeated). Sometimes the obsession and compulsion are linked; "I fear this bad

thing will happen if I stop checking or hand washing, so I can't stop even if it doesn't make any sense."

OCD in School

Obsessive Compulsive Disorder, as we have previously seen, can affect all aspects of one's life. One of the most difficult struggles that a child with OCD may face will likely revolve around their school environment. According to Parker and Stewart (1994, p. 563), "obsessive-compulsive personality traits contribute significantly to problems of school failure." It is the very nature of OCD symptoms that will often cause a student's academic performance and social acceptance to suffer. The following will examine the difficulties that compound when children experience symptoms of OCD in the school setting.

Children with OCD can experience intrusive thoughts that cycle over and over again in their mind. This causes them to not be as able to attend to and process the academic material being presented. Packer (2000, n.p.) stated that, "student's short-term and working memory are "tied up" with intrusive thoughts that interfere with their ability to attend to the lesson." The intrusive thoughts may also produce anxiety that preoccupies and distracts a student from attending. It is at this point that a vicious cycle begins to spiral out of control. The inability to attend causes the student to fall behind in the information, the more they fall behind the more anxiety they experience, and the more anxiety they feel the more their obsessions and compulsions increase in an attempt to reduce that anxiety.

On a non-observable level, the student may also be engaging in silent (mental) rituals or compulsions, such as having to count in their head or mentally recite something

(Packer, 2000). A student with OCD may become anxious if you attempt to interrupt them during a ritual because those rituals must often be completed in entirety and if interrupted they will be forced to start over again from the beginning. These silent rituals may greatly interfere with attention and processing of material and the student may be viewed as simply preoccupied or as a daydreamer. Mental rituals will slow the student down while reading and writing and may even slow the student down while attempting to walk down the hall (i.e. if they have to count their steps, make sure they are not stepping on any cracks, or ensure that each step with one foot is exactly the same length as the step with the other foot) (Packer, 2000). Even though the actual rituals being conducted are unobservable they may cause noticeable and seemingly odd behaviors (i.e. walking strange to avoid cracks, zoning out in class to complete counting rituals, etc.).

Compulsive behaviors are not always mental however and many can be extremely obvious to the observer. These usually involve behavioral compulsions that are out of the student's control. Observable rituals may include things such as touching things (i.e. if something is touched with one hand it then needs to be touched with the other), washing hands over and over again to avoid feelings of uncleanliness, turning the light switch on and off an exact number of times before they can enter or exit a room, checking and re-checking the lock on their locker, or perfectionist traits such as having to sharpen a pencil until the point is perfect, or packing up their book bag and organizing their desks "perfectly" and in complete symmetry (Packer, 2000).

These perfectionist traits are particularly difficult in high school where there is more pressure placed on students to be responsible for note-taking, completing assignments, and organization of materials. According to Parker and Stewart (2000, p.

268), these can be potential problem areas for the "student who may spend more time erasing and recopying than note-taking, who cannot complete an assignment to his/her satisfaction, and to whom organization of a simple binder can mean hours of redoing." A student who has this aspect of perfectionism may stay up all night working and reworking an essay or assignment and reorganizing or rewriting their notes.

Compulsive handwriting rituals are perhaps the most difficult rituals that a student with OCD must face in the school setting. The majority of information is given in lecture format where the student needs to be able to take notes and tests/evaluations are normally given in a written paper format as well. Common rituals in this area include having to dot their "I's" in a particular way, retrace particular letters ritualistically, having to count certain letters or words, having to completely blacken response circles on test forms, and erasing and rewriting work until it looks perfect (Packer, 2000). This may often cause the student to miss important information in their notes or be unable to finish a written test in the time frame allotted.

Academic issues are not the only roadblocks that a student with OCD must face in the school setting. Friendships and peer relationships are often stressful for those with OCD because they typically try very hard to conceal their rituals from peers. When the disorder is severe, however, this becomes impossible and the child may get teased or ridiculed by friends who react negatively to their unusual OCD-related behaviors (OCF, 1998). The disorder can also affect friendships because the amount of time spent preoccupied with obsessions and compulsions take away from quality time that could be spent together. Because of the social isolation that is often the result of childhood OCD it has been associated with low self-esteem, depression, isolation from peers, substance use,

and suicide attempts (Schroeder, 1995). This makes it crucial for educators to have the ability to recognize the symptoms of OCD in children and provide supportive strategies to assist them.

Strategies for Educators

Chances are high that a teacher may have students in their classroom who have fears they can't control and won't outgrow (Black, 1999). Based on the review of the literature it has become apparent that obsessive-compulsive personality traits contribute significantly to problems of school failure. Because of this, it is important for educators to be able to recognize the symptoms of OCD in children and to be able to provide supportive strategies to assist them in dealing with the issues that exist in partnership with this disorder. Even simple modifications in classroom environments and teaching strategies can be extremely beneficial in helping these children succeed, unfortunately most educators are not trained to deal with the behavioral problems that are associated with a child suffering from obsessive compulsive disorder (Black, 1999). In the following segment this researcher will examine literature that discusses how to identify OCD in children and how those children can be assisted in an academic setting.

School personnel have the opportunity to observe and interact with students for several hours every day, often spending more time with the children than they spend with their own families. This places educators in a unique position by giving them numerous occasions to witness and identify OCD symptoms in school-age children (March & Mulle, 1998). Many children and adolescents with OCD are secretive about their disorder therefore the signs of OCD may not be obvious to the casual observer. In fact many behaviors witnessed in students are desirable in a school setting, however when taken to

excess, these become warning signals of more serious problems (Parker & Stewart, 1994). It is essential that school personnel be aware of and attentive to the symptoms of OCD. If unheeded, these symptoms could evolve into a full-blown and more serious expression of the disease that could render the afflicted child unable to attend school or even function in a social setting (March & Mulle, 1998). Educators likely represent the first line of defense in the identification of OCD, therefore it is critical that all individuals involved in the educational process learn to identify OCD symptoms in the school setting, and provide support to those students who suffer from it.

Obsessions that are characteristic of OCD manifest themselves in many behaviorally observable ways. They may be extremely intrusive and interfere with the normal thinking process, thereby causing students experiencing obsessions to get "stuck" or fixated on certain points, and lose the need or ability to go on with the task at hand (March & Mulle, 1998). This fixation often causes delays for students in completing schoolwork, or can lead to a decrease in work production and poor grades. In some cases, a drastic change in academic performance may occur (Packer, 2000). Whenever a case of school failure is being evaluated the educator should consider the possibility of OCD. It is crucial to note that fixation on an obsessional thought may appear to be and is often mistaken for an attention problem, daydreaming, laziness, or poor motivation (March & Mulle, 1998).

Compulsive behaviors that educators may have the opportunity to observe in the school setting include changes in habits such as increased bathroom time, handwriting rituals, and excessive neatness and symmetry of books, desks, and/or lockers. Other common rituals may include things such as touching an object numerous times in a row,

having to sharpen a pencil until the point is perfect, washing their hands over and over again, turning the light switch on and off an exact number of times, checking and re-checking the lock on their locker, packing up their book bag "perfectly", and constantly seeking reassurance (Packer, 2000). Several of these behaviors will now be discussed more specifically in regards to signs that may assist in the identification of obsessive compulsive disorder in a student.

Washing and cleaning compulsions may appear in the school setting as subtle behaviors that are not obviously or immediately related to washing or cleaning (March & Mulle, 1998). For example, students who frequently excuse themselves from the classroom may be seeking a private place in which to carry out cleaning rituals. Another sign of excessive washing is the presence of chapped, cracked, and bleeding hands. Children have been known to wash with strong cleaning agents to free themselves of perceived contaminants (Nutrition Health Review, 1991). While contamination fears frequently lead to excessive washing, they may also produce the opposite effect: shoes may be untied, clothing may be sloppy or un-tucked, and hair may be dirty. In these cases the individual has a fear of contaminating objects or body parts that leads to their refusal to touch them at all (March & Mulle, 1998).

Checking rituals can be recognized in a school setting a variety of ways. While in school, the child may feel compelled to call home repeatedly in order to check on something, they may participate in rituals such as checking and rechecking answers on assignments to the point that they are submitted late or not at all, and may also repeatedly check their lockers to see if it is locked (March & Mulle, 1998).

Repeating rituals may assume many different forms in the classroom, including repetitious questioning, reading and rereading sentences or paragraphs in a book, or sharpening pencils several times in succession. A student who is experiencing repeating rituals may endlessly cross out, trace, rewrite letters or words, or erase and re-erase words on a paper until holes are worn in it (Black, 1999). According to Parker & Stewart (1994, p. 568) "neatness and correctness are virtues; however unnecessary erasing, redoing, and the inability to accept mistakes are concerns."

Obsessions revolving around a need for symmetry may result in a student compulsively arranging objects in the classroom in a balanced or symmetrical way. Some children may need to tie their shoelace so both shoes look exactly the same. Others might need to have books on a shelf, items on a desk, or problems on a page arranged in a precise order (Black, 1999). Symmetry-related rituals may also result in a child feeling compelled to take steps that are identical in length, or to place equal stress on each syllable of a word (March & Mulle, 1998). These are all extremely observable behaviors that educators need be aware of in their students.

Compulsive avoidance is when a child takes extreme measures to avoid certain objects, substances, or situations that are capable of triggering fear or discomfort (Black 1999). For example, fear of contamination may cause the child to avoid objects commonly found in the classroom, such as paint, glue, paste, clay, tape, and ink. A child may even inappropriately cover his or her hands with clothing or gloves or use shirttails or cuffs to open doors or turn on faucets. A student with an obsessive fear of harm may avoid using scissors or other sharp tools in the classroom (March & Mulle, 1998). In a

related vein, a child may circumvent the use of a particular doorway because passage through that entry may trigger a repeating ritual (Francis & Gragg, 1996).

Children and adolescents with OCD may also engage in compulsive reassurance seeking. For example, in school, they may continually ask teachers or other school personnel for reassurance that there are no germs on the drinking fountain or that they have not made any errors on a page. (March & Mulle, 1998). Most of the time, however, a teacher's comforting words have a short-lived effect, and the student soon seeks another dose of reassurance.

Behaviors that a student with obsessive compulsive disorder may display are not so different than normal personality traits in developing children and adolescents and are often seen as desirable in a school setting (i.e. neatness, cleanliness, etc.). When taken to the extreme, however, they may become disabling and negatively affect school progress. At this point those characteristics and behaviors should be identified as serious problems in need of treatment. Parker & Stewart (1994, p. 568) state "a lack of understanding about and awareness of what to look for in student behaviors may contribute to non-identification or mistaken labeling of these presenting symptoms."

The issues that educators face regarding children diagnosed with OCD are complex and time-consuming. Often the disorder not only adversely affects the child's educational performance but also leads to the inability to learn, inability to build or maintain satisfactory interpersonal relationships, inappropriate types of behavior or feelings under normal circumstances, a general pervasive mood of unhappiness or depression, or a tendency to develop physical symptoms or fears associated with personal or school problems (Black, 1999). School personnel may play an integral role in the daily

management of OCD symptoms in the school setting and the following strategies can help educators assist the child or adolescent with OCD to deal with the day-to-day struggles that they face.

Perhaps the most crucial form of support that can be given to a child with OCD is understanding and acceptance. The way that educators react to an individual's symptoms can affect the disorder astronomically. Negative comments or criticism from others often make OCD worse, while a calm and supportive environment can help improve the symptoms (OCF, n.d.). Try to be as kind and patient as possible since this is the best way to help get rid of the OCD symptoms. Telling someone with OCD to simply stop their compulsive behaviors will not help and can make the person feel worse since they are not able to comply. Instead, praise any successful attempts to resist OCD while focusing your attention on the positive elements in the person's life. It is extremely important to remember that nobody hates obsessive compulsive disorder more than the person who is suffering from it (OCF, n.d.).

Educators who have a student with OCD must be able to distinguish between problem behaviors that are a result of the disorder and those that are truly behavioral issues over which they have control. Students should not be punished for situations or behaviors that they are unable to improve because of their OCD symptoms (i.e. being tardy, absent, not attending to work) (March & Mulle, 1998). If the student is late to school every day because their rituals are interfering with them getting to school on time, disciplining or punishing them is only likely to make the situation worse (Packer, 2000). The student is already experiencing high anxiety levels and if you increase their anxiety

by punishing or threatening them, the need to engage in compulsive behaviors to reduce their anxiety will only increase (Packer, 2000).

Children and adolescents with OCD sometimes have low self-esteem and experience trouble with peer relationships, even to the point of being socially isolated (March & Mulle, 1998). Peers may exhibit negative reactions to the unusual behaviors that accompany the disorder (OCF, n.d.). For these reasons educators need to be sensitive to the emotional needs of their students. Never tolerating teasing directed toward children or adolescents with OCD and trying to structure class activities so that these students are included are two ways that an educator can begin to promote an accepting environment. Also, educating peers as to the nature of OCD may help to improve their understanding and tolerance of the OCD student's behavior. Designating one school employee as the individual to whom the child can turn when he or she is struggling may also help build the trust and stability that a child with OCD needs (March & Mulle, 1998).

Student responsibility for note-taking, writing, completing assignments, organizing materials, and reading assignments each represent a potential problem area for an individual with OCD (Parker & Stewart, 1994). For the student with OCD who has difficulty taking notes or writing due to writing compulsions, consider limiting the amount of handwritten work (Packer, 2000) or utilize accommodations such as tape-recording lectures, providing an outline of the lecture for the student, allowing another student to provide a carbon/photocopy of notes for the student, and permitting the student to put assignments, tests, and homework on the computer or on tape (March & Mulle, 1998). Having students with OCD practice note-taking skills may also be beneficial

(Parker & Stewart, 1994), as well as allowing them more time for completing assignments and other tasks.

For the student with OCD who has reading compulsions, classroom teachers may tape-record chapters in texts, allow someone else to read to the student, and assign shorter reading assignments to the student (March & Mulle, 1998). In some cases these techniques may cause the student to feel frustrated and demoralized so it is extremely important to make these decisions on a case-by-case basis.

Testing is an anxiety-producing event for many, those with OCD being no exception. To help students with OCD perform to their best potential several of the following accommodations may be made. Allowing breaks during the testing session, providing extra time to take the tests, providing a different test-taking location, permitting the student to write directly on the test booklet rather than filling in circles on computerized test sheets, and taking tests orally, are many of the accommodations that may be made (Packer, 2000).

It is extremely important to try keeping stress levels as low as possible. High stress and anxiety can cause the student to have a full-blown OCD attack (Black, 1999). Stress can be reduced by decreasing the student's workload (i.e. instead of having the child complete all items on a sheet, have them do only the odd or even numbered items) (March & Mulle, 1998) or allowing them to submit assignments or homework after the dates they are due (Packer, 2000).

One of the most important areas of necessity is for educators to have an open line of communication with the student affected by OCD and their parents and family. It is crucial to communicate frequently and honestly with parents, and be sure that the

communication goes both ways. Listen to parents, offer support, and let them know when their child has had a good day in school (Black, 1999). Families of children with OCD, particularly parents, frequently experience great emotional pain and frustration as they grapple with their child's illness, therefore, it is important to approach parents with an attitude of caring and concern (March & Mulle, 1998).

Gaining the trust of a child with OCD allows them to feel comfortable in sharing the issues that they are experiencing and is of utmost importance (Grados, Labuda, Riddle, & Walkup, 1997). Ask the student what support they need from you. Work collaboratively with them to try to find out what techniques will help them in their academic setting and what may trigger obsessive compulsive attacks (Packer, 2000). If an attack occurs, have a system as to how the student can "gracefully exit" the classroom to complete their rituals without attracting peer attention (2000). Children with OCD are first and foremost children and it is important to focus as much, if not more, attention on the positive aspects of their personality apart from the disorder. Identify the child's strengths and talents and be sure to point them out frequently to the student (Black, 1999). Also, try to compliment the student in front of his/her peers (Packer, 2000). Social problems are extremely common for students with OCD and this recognition may help others to accept and appreciate the good qualities that the student possesses. Most importantly, the student should never feel that they are alone. Being aware of and educated about their disorder is the first step in successfully dealing with it.

Chapter Three

Summary, Critical Analysis, and Recommendations

Summary

According to the DSM-IV (American Psychiatric Association, 1994), obsessive compulsive disorder is characterized by recurrent obsessions and/or compulsions that cause marked distress and/or interference in one's life. The American Academy of Child and Adolescent Psychology (2003, n.p.) defined obsessions as "recurrent and persistent thoughts, impulses, or images that are unwanted and cause marked anxiety or distress." Individuals who experience obsessive thoughts attempt to reduce the anxiety produced as a result by engaging in compulsions or "repetitive behaviors, rituals, or mental acts" (AACAP, 2003, n.p.). When these obsessive thoughts become so frequent and intense, or these compulsive rituals become so extensive that they interfere with an individual's daily functioning, a diagnosis of obsessive-compulsive disorder (OCD) is made (Jenike, Baer, Minichiello, 1998).

Obsessive Compulsive Disorder is more common than once believed being the fourth most common neurobiological disorder in the United States population (Menzies & Silva, 2003). Prevalence of this disorder has been thought to be greater in adults however many of those diagnosed have reported an onset of symptoms before or during mid-adolescence. No single cause of OCD has been uncovered, however it has been determined that it involves increased serotonin levels in the brain and that heredity may play a role.

The existence of comorbidities in obsessive compulsive disorder appears to be the rule rather than the exception. Because individuals with a variety of other psychiatric

disorders may exhibit the obsessive characteristics and ritualistic behaviors associated with OCD, properly diagnosing the illness in some patients may be complicated and tricky. To obscure matters even further, often more than one disorder may be diagnosed in a single patient, since the diagnosis of OCD is not exclusionary (March & Mulle, 1998). In terms of comorbidity issues, many individuals may have comorbid diagnoses of depression, eating disorders, social or other phobias, and related anxiety disorders to name a few.

OCD creates a tormented and anxious world for the people who suffer from it. It is a world filled with constant perceived dangers and insecurities. Characteristics of the disorder include obsessions and compulsions that are repetitive in nature and produce irrational fears, thoughts, and actions. Elaborate rituals and thoughts are often used in an attempt to ward off feared events, but no amount of mental or physical activity seems adequate, so doubt and anxiety are often present. What distinguishes OCD is that the experience of obsessions, and the performance of rituals, reaches such an intensity or frequency that it causes significant psychological distress and interferes in a significant way with overall functioning (Watkins, 2001). Common obsessions include but are not limited to fears of contamination, fears of harming others, and fears of harming oneself. Common compulsions include but are not limited to checking, cleaning, and excessive hand washing behaviors (2001).

OCD symptoms can occur in people of all ages and one in every 100 children have reportedly been diagnosed with having Obsessive Compulsive Disorder. One third to one half of adults with OCD report that it started during childhood, therefore the number of children actually affected remains unknown (OCF, n.d.). Children who suffer

from OCD experience many of the same obsessions and compulsions as adults. OCD symptoms can take up a great deal of a child's time and energy, continuously interfering with their normal routine, academic functioning, social activities, and/or relationships (AACAP, 2003).

Perhaps the greatest challenge for a child experiencing OCD symptoms lies within their school environment. Children with OCD can experience intrusive thoughts that cycle over and over again in their mind. This causes them to not be as able to attend to and process the academic material being presented. Perfectionist traits may exist in these children causing them to spend absurd amounts of time on simple tasks such as copying notes or organizing papers. Students with OCD try in vain, to hide the strange acts they engage in as a result of the disorder. These behaviors can cause difficulties in maintaining friendships and social connections.

It is apparent that obsessive-compulsive personality traits may contribute significantly to failure in the academic setting. This makes it important for educators to be able to identify the symptoms of OCD in children and make modifications in their classroom environments and teaching strategies to maximize the learning and comfort level of these students. Having a set of identification and coping strategies in place may prove to be useful to all school personnel.

Critical Analysis

OCD tends to be under diagnosed and under treated for a number of reasons. People with OCD may be secretive about their symptoms or lack insight about or an understanding of their illness. Also, many healthcare providers are not familiar with the symptoms of OCD and are not trained in providing the appropriate treatments (OCF, n.d.).

This is unfortunate since earlier diagnosis and proper treatment can help people avoid the suffering associated with OCD and lessen the risk of developing other associated problems, such as depression or marital and work difficulties.

According to Schroeder (1995), one in every one hundred children suffer from OCD. Watkins (2001, p. 10) however, stated that "between 30% and 50% of adults with OCD reported that their symptoms started during or before mid-adolescence." Recent gains in OCD research have consisted of differentiating normal ritualistic behavior in children from OCD symptoms refuting the impression that OCD in children is a rare condition (Grados, Labuda, Riddle, & Walkup, 1997). This supports the researcher's belief that OCD is a much more common phenomenon in children than generally believed. All children experience so-called "normal" childhood fears. Black (1999, p. 66) stated that "most children eventually outgrow fears of darkness, of strangers, and of getting lost, however kids with neurobiological disorders (such as OCD) usually keep their fears for a lifetime."

Children who display OCD symptoms are often dismissed by adults and their behaviors explained away as a "stage" that will be grown out of. Because children are aware of the bizarre nature of their thoughts and actions and feel shame and embarrassment as a result, they will often go to great lengths to hide the obsessions and compulsions they experience (AACAP, 2003). This coping strategy children use is, in the end, of a destructive nature and reinforces the importance the researcher has placed on identification strategies.

If not treated, OCD tends to be a long-term disorder. Some individuals experience waxing and waning symptoms over the years (Watkins, 2001). Still others experience

progressive worsening of their OCD until they are housebound and spend much of their days involved in obsessions and rituals (Grados, Labuda, Riddle, & Walkup, 1997). Obsessive compulsive disorder does not usually exist on its own and afflicted individuals are often diagnosed with other complicating disorders such as depression, psychosis, social phobias, and other anxiety disorders (March & Mulle, 1998). The comorbidities that surround OCD and the varying degrees of symptom severity that can affect individuals who suffer from it make it a crucial area for early identification and intervention.

Children and adults with OCD have similar obsessions and compulsions (Grados, Labuda, Riddle, & Walkup, 1997). According to Watkins (2001, n.p.), children differ from adults cognitively, developmentally, and physiologically therefore they are unable to fully comprehend the nature of their thoughts and actions. These statements suggest to this researcher that just because the symptoms of OCD are similar in children and adults does not mean that both are equally equipped to deal with those symptoms. Children are less developed physically, cognitively, socially, and emotionally therefore they are at a disadvantage when trying to cope with this disorder. For this reason it is necessary to have supportive strategies in place to help children cope in both their personal and academic lives.

Black (1999) listed the most common obsessions and compulsions that are most likely to surface in a school setting. Obsessions include a fear of contamination, fear of harm, illness, or death, obsession with numbers, and an obsession with evil. Compulsions include washing and cleaning rituals, checking compulsions, repeating compulsions, symmetry compulsions, avoidance compulsions and reassurance compulsions. Lane,

Gresham, and O'Shaughnessy (2002) supported this finding listing the same common obsessions and compulsions that teachers should be looking for when deciding whether a student should be referred for a psychological evaluation for Obsessive-Compulsive Disorder.

OCD can make a student's academic life extremely stressful. OCD symptoms can take up a great deal of a child's time and energy. Children with this disorder spend an inordinate amount of time engaging in ritualistic behaviors. They may feel compelled to complete all of their compulsive rituals in sequence and any interruption of those rituals forces them to start them over again from the beginning (OCF, n.d.). Packer (200, p.1) stated that, "children with OCD experience intrusive thoughts that preoccupies and distracts them from attending," and according to Schroeder (1995, p.75), "OCD has been associated with low self-esteem and depression." All of these findings support the researcher's understanding of the challenges OCD sufferers face within the classroom setting. Preoccupations with obsessions and rituals leave little time left over to attend to academics and friendships.

Chances are high that a teacher may have students in their classroom who have fears they can't control and won't outgrow however most educators are not trained to deal with the behavioral problems that are associated with a child suffering from obsessive compulsive disorder (Black, 1999). Many children and adolescents with OCD attempt to hide their symptoms therefore the signs may not be obvious to the casual observer. Educators spend several hours with a student each day giving them numerous occasions to witness and identify OCD symptoms in school-age children (March, &

Mulle, 1998). This supports the researchers belief that it is essential for school personnel to be aware of and attentive to the symptoms of OCD.

It is rather frightening to realize that not only can Obsessive Compulsive Disorder exist in children, but it can also have detrimental effects that can last a lifetime. Children with OCD may suffer personally, socially, and academically. For educators to do their part in combating this situation advancements must be made by educators to better identify and assist children who are experiencing symptoms of OCD and to be able to provide them with strategies that will help them to deal with those symptoms and become successful in school and social interactions.

The goal of every educator should be to make the academic experience a worthwhile and positive one for every student, those with OCD being no exception. Upon conducting a comprehensive review of the literature, the researcher has developed two sets of recommendations; one that will assist educators in identifying children with OCD, and the other that will give educators several strategies that they can use to assist their students in coping with the issues that arise as a result of the disorder.

Identification Recommendations

Based on the review and analysis of the literature the researcher will now recommend a list of ten behaviors that educators can look for to identify symptoms of obsessive compulsive disorder in students.

1. Watch for a change in habits such as increased bathroom time, handing in assignments late, taking longer to write notes, engaging in handwriting rituals, and excessive neatness and symmetry of books, desks, and/or lockers may all be clues.

2. Watch for the development of new habits such as touching objects numerous times in a row, washing hands over and over again, checking and re-checking the lock on their lockers, and turning light switches on and off an exact number of times, refusing to touch certain objects, and having to reenter the room until they get it "just right".
3. Watch for gradual declines in completing schoolwork Students may feel the need to check and recheck answers over and over again to the point that they are submitted late or not turned in at all.
4. Watch for students who may "zone out" or appear to be daydreaming in class. They may be participating in counting rituals where they feel the need to count to one hundred five times in a row at a certain pace and if they make a mistake may need to begin all over again.
5. Watch for constant ordering and reorganizing of materials, desk, book bag, or locker. This could indicate an obsession that revolves around a need for symmetry and organization. Books may need to be aligned just so in order for the student to get on with their day.
6. Watch for repeated behaviors such as repetitious questioning, reading and rereading sentences or paragraphs in a book, or sharpening pencils several times in a row. Students may have difficulties writing and may need to trace or rewrite letters and words over and over again.
7. Watch for increased requests for reassurance. Students with OCD may continually ask teachers other individuals for reassurance that they have not

made any errors on their paper or that there are no germs on the drinking fountain.

8. Watch for increasing social isolation. Students who suffer from OCD symptoms often attempt to hide them and as a result may find it easier to just avoid others than trying to cover up their behaviors.
9. Watch for extreme slowness in walking, writing, eating, and even tying shoes. These behaviors may also be related to the need to have things equal in that they may need to have all of their steps identical in length, chew the same number of times on each side of their mouth, make each letter on a page identical in height, and tie their shoelaces so both look exactly alike.
10. Watch for drowsiness in class. The rituals associated with obsessive compulsive disorder often take up so much of a child's day and night that they may not be getting the proper sleep that they need and as a result may struggle in class.

These ten identification recommendations encompass the majority of signals that may alert an educator to presence of OCD. The research acknowledges, however, that many symptoms overlap into other categories and each child may manifest those symptoms in different ways. It is virtually impossible to list all of the corresponding behaviors, however this brief snapshot should serve as a starting point for a diagnosis of OCD in your students.

Coping Recommendations

The researcher will now present a list of ten recommendations that educators can use when providing support and assistance to students who suffer from obsessive compulsive disorder.

1. Keep stress levels as low as possible. Don't threaten or punish a child with OCD who is tardy, forgets a homework assignment, or turns things in chronically late. Threats and punishment could cause the student to have a full-blown OCD attack by increasing their anxiety level.
2. Remind students with OCD of their strengths and talents. Children with OCD sometimes have low self-esteem so it is important to give them time to devote to the areas they are good at so that they are able to experience some feelings of success.
3. Organize classroom activities so the child with OCD has a partner. This will keep them on task and likely distract them from their obsessions for a period of time. This will also help them to maintain social interactions and friendships.
4. Communicate frequently and honestly with parents and be sure that they communicate with you. Families of children with OCD often are experiencing great frustration and pain so it is important to listen, offer support, and provide assistance to the family as needed.
5. Allow more time for completing tasks and tests. This will remove some pressure off of the student and allow them to relax more. Also taking tests in a

separate location may help to block out distractions that the student may experience in the normal classroom setting.

6. Limit handwritten work. Provide notes in handout form or audiotape lectures. Assigning a "buddy" to take notes for the student may also be a suggestion however should be used with caution as you do not want to draw unnecessary attention to the student's differences. Having students practice note-taking skills may also be beneficial.
7. Limit the amount of reading or break it into chunks. Consider going to books on tape or recording the material for your student to listen to. Provide summaries and outlines of the readings so that they are able to get through the necessary material with more ease.
8. Talk to the student to identify their needs. This will serve to gain their trust and allow them to share the issues that they are experiencing. Ask the student what support they need from you to make their academic life more manageable and work collaboratively with them.
9. Develop student contracts for turning in and double-checking their work. For example allow the student to only double-check their work twice, or let them know that if their answers are wrong they will get a second chance. (They likely will not need this second chance, however will serve to ease some anxiety).
10. Accommodate the situations over which the student has little or control. Students should not be punished for behaviors that they are unable to improve because of their OCD symptoms. If the student is late getting to school every

day because their rituals are interfering with them getting to school on time, punishing them will only make it worse.

Again, this set of recommendations is only a snapshot of the accommodations that can be made within the classroom and learning environment. All students will react in different ways and that is what makes it crucial to maintain an open line of communication with each individual in order to collaboratively develop the strategies that will work best for them. Providing appropriate classroom support and acceptance will help students who suffer from OCD to deal with their obsessions and compulsions in a positive and productive manner and ensure that they will be able to control their disorder rather than their disorder controlling them.

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