

Obsessive Compulsive Disorder and the School Counselor

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Abstract

The current article is designed to provide school counselors an understanding of obsessive-compulsive disorder (OCD). The causes, characteristics, and treatment approaches are presented with examples focusing on school-related issues. The article concludes with a discussion about the role that the school counselor can take in helping the child with OCD to have a successful school experience.

Obsessive Compulsive Disorder and the School Counselor

School counselors play a very important role in the educational process. While specific duties may vary from school to school depending upon student age level and population need, their overall function in all settings is to facilitate the optimal growth of each child (U. S. Department of Education, 1991). Unfortunately, history has demonstrated that population-specific barriers have sometimes restricted the achievement of this goal for students. In fact, it was not until the passage of the Education for All Handicapped Children Act in 1975 that children with disabilities were insured access to appropriate education (Individuals with Disabilities Education Improvement Act of 2004). Federal laws have been written with regulations that not only describe the obligations that teachers have in making reasonable accommodations for these children, but also provide implicit and explicit counselor responsibilities for helping to establish and maintain equal access in the educational system. For example, the regulations of Section 504 of the Rehabilitation Act of 1973 indicate that students with disabilities are “not [to be] counseled toward more restrictive career objectives than are nonhandicapped students with similar interests and abilities” (U.S. Office for Civil Rights, 2007, 34 C.F.R. Part 104.37).

It is easy to see how this mandate can be implicitly expanded to include an advocacy role within the school system to help insure that students with disabilities are neither foreclosed from opportunities for which they are capable nor restricted from appropriate participation in the classroom. With these goals in mind, counselors might serve as consultants to teachers, support personnel for students, and sources of referral for parents. As members of child study teams, they might also find themselves in key

positions to give input about the directions to pursue with children in the general student body who are exhibiting difficulties.

Informal classroom adaptations might be a sufficient way to handle a variety of challenges students and teachers confront. However, students with obsessive-compulsive disorder (OCD) would qualify for a legally protected educational plan under either Section 504 or the Individuals with Disabilities Education Act (IDEA) when the OCD interferes with learning. The 504 plan is designed to provide reasonable accommodations for those students who do not need special education services (U.S. Office for Civil Rights, 2007). When OCD is so disabling as to necessitate special education and related services, a more detailed individualized education plan (IEP) would be developed through IDEA (Department of Education, 2006). Counselors might find themselves serving as members of multidisciplinary teams that create and implement either of these educational plans. In addition, they might be included in the IEP itself as providers of related services designed to assist the student in benefiting from special education. It is, consequently, clear that the counselors' input within the school life of children and adolescents with disabilities can be wide-ranging. However, carrying out some of these responsibilities may be quite challenging for some counselors given the inconsistent level of disability-related training that exists across school counselor preparation programs (Milsom, 2002; Wood Dunn & Baker, 2002).

The dearth of articles concerning obsessive-compulsive disorder in education and school counseling journals is, perhaps, reflective of the paucity of such training for school personnel, in general. A survey of representatives from all Obsessive Compulsive Foundation affiliates across the country underlines the need in this area

(Wertlieb, 2006). Once considered to be very rare, researchers have recently found that the prevalence of OCD is quite significant, that being 1% among prepubescent children and up to 4% among adolescents (Carter & Pollock, 2000). The purpose of the current article is to provide the school counselor with a general overview of obsessive-compulsive disorder as well as its potential causes. There will be a discussion of the common characteristics with examples of how this disorder may manifest itself in relation to school. Treatment approaches will be discussed along with suggestions for the role that the school counselor can take in addressing the needs of the student with OCD.

General Overview of OCD

The person who is clinically diagnosed with OCD is characterized as having obsessions, compulsions or a combination of both. Nearly all children with OCD demonstrate the combination (McCracken, 2005). Obsessions involve intrusive thoughts, impulses, or images that persist to the degree of causing anxiety or distress. In contrast, compulsions are the repetitive behaviors (e.g., hand washing) or mental acts (e.g., counting to oneself, praying, silently repeating words) that are done to prevent or reduce anxiety or distress. Compulsions are generally impelled by the person's obsessions since the compulsive actions or thoughts ameliorate the intense anxiety. While adults typically realize that their obsessions and compulsions are not rational, children often do not have the same degree of insight (American Psychiatric Association, 1994), especially prior to adolescence (Geller et al., 2001).

It is important to differentiate between developmentally normal rituals and those that are OCD-based. Ritualistic routines are a common occurrence among toddlers; and

changes in such routines are difficult, especially in relation to bedtime, mealtime, and bathtime. In fact, it may not be until about age eight or nine that bedtime rituals disappear. Playtime is also characterized by rituals during the early years. It is not unusual, for example, for a preschooler to repeatedly line up trains or other toys in a specific manner. Such solitary play eventually transitions into a significant amount of ritually-based collective play. The elaborate rules and rhymes that young elementary-school-aged children use as they engage in such games as jump rope and hopscotch resemble the behaviors that might be observed in someone with OCD. While the outward appearance is similar, their processes are quite distinct. Normal rituals are thought to help children learn to master anxiety and develop social skills. They do not create anxiety themselves. In contrast, rituals associated with OCD are distressing, time consuming, and interfere with normal functioning (Leonard, Goldberger, Rapoport, Cheslow, & Swedo, 1990). An individual with OCD might attempt the same ritual over and over again, getting more and more frustrated and distressed if he or she feels that it has not been done exactly as it should. Sometimes the person with OCD brings other people into the ritual to confirm that the acts were done 'just so.'

Age of Onset and Duration of Illness

OCD has been reported in children as young as two years of age (Carter & Pollock, 2000). However, the most likely time of onset is either between the ages of 8 and 11 or approximately age 21. There is a clear gender difference in incidence during the prepubescent years with boys outnumbering girls two to one. The distribution becomes approximately equal across gender after puberty (Farrell, Barrett, & Piacentini, 2006).

Most researchers have concluded that youths who are diagnosed with OCD can expect their disorder to be chronic in nature. However, a recent meta-analysis of 22 longitudinal studies raises questions about this generalization. The researchers concluded that long-term persistence of OCD may be lower than initially believed. They found that less than half of the individuals taking part in the studies had fully symptomatic OCD upon follow-up. Age of onset was one of the factors found to be a good predictor of persistence level with earlier onset being more typical of greater OCD persistence. As might be expected, poorer initial treatment response was also found to be a predictor. The same effects seemed to be evident for both males and females. The authors caution, however, that additional studies need to be done to replicate these findings since ongoing treatment was not taken into account in the results and the time period for patient follow-up ranged from one to 15.6 years (Stewart et al., 2004).

Causes of OCD

OCD was once considered solely psychogenic in origin. However, there is increasing evidence that it is a neurobiological dysfunction with genetic underpinnings (Hemmings & Stein, 2006; Hudziak et al., 2004). Studies focusing on the inheritability of OCD have revealed that up to 18% of individuals affected have relatives with clinical or subclinical symptoms (Towbin & Riddle, 2002). Despite the recognition of this strong genetic component, the actual means of genetic transmission is complicated and has not yet been determined (Hemmings & Stein, 2006). In fact, the genetic mechanism behind OCD seems to vary between subgroups of individuals. Unlike the majority of children, there is a subset of youngsters who are thought to acquire OCD as a consequence of an autoimmune response to a streptococcal infection (Swedo, Leonard,

& Rapoport, 2004; Towbin & Riddle, 2002). It is thought that this autoimmune response occurs due to a genetic predisposition (Arnold & Richter, 2001; Dale & Heyman, 2002). A genetic vulnerability may also relate to why OCD may manifest itself in some individuals after suffering a trauma (Lochner et al., 2002). Storch and his colleagues (2005) depict how school bullying can be one of OCD's potential catalysts as they vividly describe the case of a 14 year old boy whose symptoms began after being subjected to a pattern of peer victimization in his school.

Associated Conditions

OCD typically does not present itself alone. Social phobia, panic disorder, and/or generalized anxiety disorder have often been found to accompany this condition (Tukel et al., 2002). Depression, the most frequently cited coexisting condition, has been described by some researchers as being present for one third to two-thirds of this population at some point during the course of the disorder (Fineberg, Fourie, Gale, & Sivakumaran, 2005). Researchers have posited that it may sometimes be a consequence of the negative impact OCD has on one's life. However, a clear cause/effect relationship between depression and OCD does not exist (Carter & Pollock, 2000). Attention-deficit hyperactivity disorder also seems to be over-represented within this population, having a comorbid rate estimated to be as much as 30% among boys with early onset of OCD (Geller et al., 2007).

Eating disorders and OCD have been described as having especially close ties with one another. Some researchers have even posited eating disorders to be a form of OCD since the rituals in both conditions are fueled by a fear that disastrous consequences will occur if those behaviors are not performed. Furthermore, the

relationship between eating disorders and OCD does not disappear when symptoms surrounding eating behaviors are removed from diagnostic assessments. Those with eating disorders often display a disproportionate amount of other OCD symptoms as well (Lavender, Shubert, deSilva, & Treasure, 2006). Researchers have, in fact, found OCD to be a common childhood predecessor to anorexia and bulimia nervosa (Kaye et al., 2004). The high comorbidity rate has led Serpell and her colleagues (2006) to emphasize the importance of assessing for OCD among those young people who present with eating disorders in order to insure appropriate treatment.

Knowledge of the additional conditions that a child with OCD is likely to manifest provides the school counselor with information crucial for understanding the child's behavior and providing the appropriate help. It is also important for the counselor to be aware that sometimes the diagnosis of OCD might have been overlooked in a child with another more prominently appearing condition. Tourette syndrome is a good example of such a disorder. Some researchers have approximated that up to 50% of individuals with this syndrome manifest obsessive-compulsive symptoms or clear-cut OCD. In contrast, less than 20% of individuals with OCD have chronic multiple tics.

Developmentally, children with Tourette syndrome seem to develop tics before obsessions and compulsions. However, by adulthood, obsessive-compulsive symptoms often become the predominant difficulty, even after the tics from Tourette syndrome might have dissipated (Goodman, Storch, Geffken, & Murphy, 2006).

There are also a disproportionate number of individuals with Pervasive Developmental Disorders, such as autism and Asperger syndrome, who have OCD (Russell, Mataix-Cols, Anson, & Murphy, 2005). However, it might not always be simple

to identify the specific OCD symptoms amid the various characteristics evident in these other disorders (Russell et al., 2005). For example, individuals with autism have sometimes been characterized as engaging in repetitive movements that are self-stimulatory in nature (Lewis & Bodfish, 1998). Therefore, the child who demonstrates repetitive finger movements might be manifesting this behavior for visual and/or tactile stimulation so as to obtain automatic reinforcement (Rapp & Vollmer, 2005). However, the child whose finger movements represent an OCD compulsion may be engaging in this behavior to decrease anxiety brought about by something such as a contamination obsession.

General Characteristics

The specific obsessions and compulsions that can exist for people with OCD are unlimited and typically change over time (Towbin & Riddle, 2002). It is for this reason that Section 504 agreements and IEPs must be regarded as quite fluid, adapting to the changing needs of the student involved. Despite the heterogeneity of specific symptomatology, there are some overall themes that are commonly seen. Contamination obsessions and its associated decontamination rituals of cleaning and washing are probably the most well recognized OCD symptoms, even showing its face in Shakespeare's literature. Like Lady Macbeth who could not stop washing her hands because she could not rid herself of an intense feeling of contamination, some individuals with OCD feel that their hands are covered with a contaminate that they cannot remove. Others are driven to repeatedly wash their hands for fear of contracting or spreading a disease (Sookman, Abramowitz, Calamari, Wilhelm, & McKay, 2005). Symptoms that involve checking and rechecking are another common theme. However,

like contamination, the driving force behind the checking might differ among individuals. The adult, for example, might repeatedly check to insure that the stove was shut off for fear of burning the house down (Sookman et al., 2005). The child, in contrast, might spend an inordinate amount of time checking and rechecking an answer on a test for fear of an error. Many individuals also exhibit rituals of a repetitive nature, doing the same actions over and over again until it feels 'just right.' Self-doubt can be so great in some individuals with OCD that they might not believe their perceptions (Adams & Burke, 1999). Rituals involving hoarding as well as ordering and arranging items are also common. Sometimes the ordering reflects the specific obsession of symmetry, such that a child, for example, might order his or her stuffed animals in a way to insure that they are in two exactly even rows. Obsessional symmetry is also reflected in such behavior as making sure to step an equal number of times with each foot (Grados, Labuda, Riddle, & Walkup, 1997). Recently, researchers have reported what they term transformation obsessions. Children with this form of obsession fear that they will take on some of the characteristics of someone else or turn into that person (Volz & Heyman, 2007).

The specific symptomatology of an individual's OCD can often be related to the surrounding environment (McCracken, 2005). For example, contamination and decontamination rituals might currently be related to fear about Acquired Immune Deficiency Syndrome (AIDS) whereas 50 years ago the focus might have been tuberculosis. In a similar way, researchers have found that OCD symptomatology may be influenced by the issues and conflicts of a given developmental period (Farrell et al., 2006; Geller et al., 2001). The most frequent obsessions exhibited by children and

adolescents seem to focus on a fear of injury or death to themselves or someone they love (Geller et al., 2001). Corresponding contamination obsessions are also quite prevalent (Carter & Pollock, 2000). The individual might, for example, fear that (s)he will be injured or die if a 'contaminated' object is touched. As the child matures into adolescence, some obsessions may reflect the sexual and religious preoccupations that are so common to this age group (Geller et al., 2001). A fear of potentially doing something bad or sinful might preoccupy their minds and thus lead to an inordinate amount of praying or atoning for the imagined wrongdoing (Black, 1999).

Every individual with OCD is touched by the disorder in a different way. However, symptoms for all individuals affected tend to wax and wane in intensity in conjunction with the stresses of life (Abramowitz, Brigidi, & Roche, 2001) and the individual's level of fatigue. The school counselor can be a key person to unmask the OCD behaviors for teachers so that neither blame nor punishment is doled out and instead appropriate accommodations are made.

Treatment

The mid-1960s appears to have been a turning point in therapeutic approaches for individuals with OCD. Up until that time, the emphasis was on some form of psychodynamic talk therapy with its basis in the theory of unconscious motivation (Abramowitz, 2006). However, in 1966, Meyer experimented with a behavioral approach, implementing what is now known as exposure and ritual prevention. Individuals living in an inpatient setting were asked to perform activities that triggered OCD anxiety (e.g., touching a door knob for an OCD exposure). With supervision and some living condition restrictions, they were expected to refrain from the accompanying

rituals (i.e., ritual prevention). So, for example, the water was turned off in a patient's room, thereby preventing that person from washing her hands. Gradually, the supervision and restrictions were removed, allowing the patient to function more independently. There were many bouts of agitation and weeping during the process due to the psychological pain that it evoked; but the outcome proved to be a reduction in OCD symptoms (Meyer, 1966). Meyer's small experiment led others to pursue additional research with exposure/ritual prevention. It is, now, recognized by many as a core component of the therapy of choice for those with OCD (Abramowitz et al., 2001). A fear hierarchy is typically developed and exposures generally start with situations that evoke the least anxiety (Abramowitz et al., 2001).

The importance of school personnel recognizing the overwhelming distress that can be caused by exposure to a situation high on the individual's hierarchy cannot be emphasized enough. While an ink stain, for example, might not even be noticed by a teacher, children who list that as high on the hierarchy would get overwhelmed with anxiety if a teacher expects them to sit at a desk with such a mark. The child might literally feel that he or she is going to die. Flooding the child with such exposures can make school far too anxiety-provoking to allow for any productive activity. Consequently, school counselors and other school personnel need to keep open lines of communication with the child's family, and when appropriate, get input from the OCD treatment provider that the child might be seeing outside of the school setting.

While exposure/ritual prevention might be at the core of much OCD therapy, there are also important cognitive components that are included. Consequently, the approach is termed cognitive-behavioral therapy (CBT). Cognitive interventions include

a reappraisal of the beliefs concerning the dangers inherent in the feared situations as well as a reappraisal of the beliefs concerning the power of one's thoughts (Swinson et al., 2006). For example, a child with OCD who gets very angry with a classmate might begin to obsess about the classmate going to hell, which in turn might precipitate praying rituals in order to dissipate the obsession and associated anxiety. The tremendous feeling of personal responsibility for the catastrophe that the child imagines will befall his or her classmate is likely to be a compelling force for relentless praying in order to forestall the tragedy. The cognitive aspect of therapy focuses, in part, on helping the child to learn that such assumptions are faulty (March & Mulle, 1998). In addition, individuals are taught how to "boss back" the OCD by using constructive self-talk. So for example, children might learn to tell themselves that a task is difficult, but that they can handle it (March & Mulle, 1998). The benefits of CBT are thought to yield not only short-term results, but also long-term ones since individuals are empowered with strategies that they can use during the often chronic and relapsing course of OCD (Asbahr et al., 2005). Despite the benefits that researchers have documented for CBT with its exposure/ritual prevention component, there are a significant number of people for whom this therapy does not seem to work. About 20 to 30 percent of individuals drop out of exposure/ritual prevention therapy and about 20 percent of those who remain do not demonstrate significant improvement (Abramowitz, 2006).

Pharmacological treatment with selective serotonin reuptake inhibitors such as Zoloft and Prozac is oftentimes used as adjunct to CBT (McCracken, 2005). The specific effect of medication has generally been found to be positive, but modest (Geller et al., 2003). At most, the symptoms are reduced by 30 to 40 percent, thus leaving

children and adolescents with many remaining OCD difficulties (Pediatric OCD Treatment Study Team, 2004). Research that has compared the individual effects of CBT and pharmacological treatment has revealed that CBT is, in fact, superior. However, medication has the benefit of potentially reducing an individual's anxiety enough to allow for participation in exposure/ritual prevention tasks (O'Connor et al., 2006). It follows that the Pediatric OCD Treatment Study Team (2004) has recommended that the best treatment option is for children and adolescents to receive medication in conjunction with CBT or CBT alone. However, the precise treatment approach for a child or adolescent with OCD is based on a variety of individualized factors. Information that school counselors and teachers can provide about a child's school functioning is a very important consideration for families as they weigh the different options with their community-based treatment providers.

Role of the School Counselor

Children with OCD may experience symptoms of this disorder during every aspect of the school day. School counselors are in a position to advocate for these students, helping teachers to understand that making reasonable accommodations for these children is comparable to making accommodations for those who are blind or deaf or have other types of disabilities. The accommodations that are developed do not enable the OCD behavior, but rather help these students to bypass their obstacles so that learning can take place. So, for example, students who cannot participate in chemistry lab because of contamination fears might be able to complete the labs online. Those who have difficulty answering test questions on a computer bubble sheet because they spend an inordinate amount of time making sure that each bubbled

response is colored in 'just so' could write out their responses on paper. The key in designing the accommodations is to have an understanding of the specific issues that the child or adolescent faces, how these symptoms impact learning, and how these symptoms might change over time.

The needs of the student with OCD involve more than academic accommodations, however. The decreased social competence evident in many of these students (Hanna, 1995) paired with the ambivalent feeling that these students are likely to have about their own self-worth (Bhar & Kyrios, 2007) leaves them vulnerable to increased self-derision if teased or bullied. The unfortunate result may be an increase in OCD symptoms (Storch et al., 2006) with academic performance suffering further. These social-emotional issues can be directly addressed through the expansion of some of the programs that school counselors might already have in place. A regular schedule of individual sessions with the student is a possibility, for example. However, the school counselor could also facilitate an extra-curricular group activity that is tailored to the student's interests and strengths while avoiding the known OCD triggers. Activities such as 'lunchtime with chess' or 'book club at noon' could help other pupils see the child as a friend and not just someone who might engage in odd behavior. These activities would provide the student a supportive space to have fun while developing social skills.

The counselor could also help to establish a plan that provides the student a place of sanctuary when he or she is in class and feels overwhelmed by OCD issues. For some students, sitting in the quietness of the library might be beneficial. For others, sitting with the counselor or other designated support person would be the preferred

option. Sometimes a short walk to get a drink of water is sufficient to interrupt the particular cycle of OCD (Adams, 2004). A pre-set plan would make it possible for the student to leave the classroom with only some form of nonverbal communication to the teacher, thus obviating the need to get a pass that might trigger further agitation.

School counselors can partner with classroom teachers to support the academic and emotional development of the student body, in general, and the student with OCD in particular. Some of the strategies are time intensive because they involve individual or group meetings with students. Other approaches rely on providing suggestions for teachers to implement independently or in concert with the counselor. Bibliotherapy is a perfect example of how the teacher and counselor can work together. The counselor can suggest classroom reading materials that highlight diversity and peer relationships. She or he can, then, go into the classroom to co-facilitate discussions about these books as well as related topics (Oliver & Young, 1994).

Conclusion

OCD is a neurobehavioral disorder that can impact learning and social-emotional development in profound ways. The behaviors that are often manifested can be misunderstood very easily and lead to inappropriate educational services. School counselors can play a variety of important roles to help insure that students with this disorder receive the education to which they are entitled.

The various responsibilities that school counselors typically assume give them the opportunity to share important information about OCD with teachers so that warning signs are not overlooked or misinterpreted. Knowledge about this disorder will also allow counselors to provide crucial information at multidisciplinary meetings when

decisions are being made about educational placement and programming for the child with OCD. In addition to the input that they can provide which is OCD-specific, school counselors can help in a more global way. Some of the interventions that they implement may be beneficial for the entire student body. Improving social skills, learning to be sensitive to differences, and recognizing the strengths within each person can make all of our youth more successful when they enter the adult world. The more inclusive environment that some of these programs can create is likely to give the student with OCD a greater chance for success.

School has its challenges for all students, but the child or adolescent with OCD confronts some especially difficult obstacles to overcome. Counselors who bring knowledge of OCD into the school and share that knowledge as they fulfill their various responsibilities can reduce some of those student obstacles. In so doing, these professionals may be able to help create a more positive and productive experience for the child or adolescent who has OCD.

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