

Obsessive-Compulsive Disorder (OCD) in Children and Adolescents*

Obsessive-Compulsive Disorder (OCD) is often misunderstood and minimized (e.g., *He likes being neat. She like things organized.*) Of course, some kids are just being neat and organized in ways that are not a problem. However, for some, OCD is a serious, chronic mental health problem that can substantially interfere with learning, behavior, relationships, and well-being (NIMH, 2024; Walitza et al., 2020). Up to 50% of adults with OCD report onset in childhood or adolescence. Many youth hide symptoms due to shame or fear of misunderstanding, delaying identification by adults (NIMH, 2024; Rapoport et al., 2000)

Schools play a critical role in early observation, support, and collaboration with families and mental health providers. When OCD goes unrecognized, students are at increased risk for academic failure, school avoidance, emotional distress, and long-term impairment. OCD is not a personality trait and should not be used casually to describe preferences for order or cleanliness.

What Is OCD?

Obsessive-Compulsive Disorder is characterized by:

Obsessions – intrusive, unwanted thoughts, images, or urges that cause marked distress or anxiety

Compulsions – repetitive behaviors or mental acts performed to reduce anxiety or prevent a feared outcome

OCD symptoms are time-consuming, difficult to control, and interfere with daily functioning (American Psychiatric Association, 2022; NIMH, 2024).

Approximately 1–3% of children and adolescents meet criteria for OCD.

OCD symptoms vary widely and are often misinterpreted as inattentiveness, oppositional behavior, perfectionism, or lack of motivation.

Students with OCD may appear slow to complete work, avoid transitions, request frequent breaks, or disengage academically due to the internal effort required to manage symptoms (Anxiety and Depression Association of America (ADAA), 2024; Sulkowski et al., 2018).

Common *Obsession* Themes in Youth

- Contamination and illness
- Fear of harm coming to oneself or others
- Excessive doubt or intolerance of uncertainty
- “Just-right” or perfectionistic concerns
- Scrupulosity (religious or moral fears)
- Intrusive violent or sexual thoughts (without intent or risk of acting on them)
- Numbers, counting, symmetry, or order

Common *Compulsions* in School Settings

- Repeated checking (locks, work, belongings)
- Rewriting, erasing, rereading excessively
- Repetitive reassurance-seeking from teachers
- Avoidance of bathrooms, cafeterias, lockers, or shared materials
- Counting, touching, or repeating actions “until it feels right”
- Mental rituals that are not observable

Common Misidentification and Comorbidity

OCD frequently co-occurs with:

>Other anxiety disorders >Tic disorders >ADHD >Depression

Because symptoms overlap with ADHD, learning and behavior problems, OCD is often misdiagnosed, particularly in culturally and linguistically diverse communities (Nazeer et al., 2020; Stiede et al., 2024). For a lengthy list of *Obsessions and Compulsions*, see

<https://adaa.org/understanding-anxiety/obsessive-compulsive-disorder/ocd-at-school> .

*The material in this document builds on work done by Gloria Martinez Camacho a participant with the national Center for MH in Schools & Student/Learning Supports at UCLA in 2025.

The center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA. Website: <https://smhp.psych.ucla.edu/>

First-Line Clinical Interventions for OCD

Cognitive Behavioral Therapy (CBT) with Exposure and Response Prevention (ERP) is considered the gold-standard treatment for pediatric OCD (Steele et al., 2025; IOCDF, n.d.). Under professional guidance, ERP involves gradual exposure to feared situations while resisting compulsive responses.

Medication – Selective Serotonin Reuptake Inhibitors (SSRIs) – also may be prescribed by qualified medical professionals, particularly for moderate to severe symptoms (Steele et al., 2025). SSRIs are a class of antidepressants commonly used to treat depression, anxiety disorders, and other mental health conditions by increasing serotonin levels in the brain. Key types include Sertraline (Zoloft), Fluoxetine (Prozac), and Escitalopram (Lexapro). Common side effects include nausea, headache, insomnia, and sexual dysfunction.

What Schools Can Do

Schools can make a major contribution to the mental health and well being of children and adolescents. For this potential to be realized, however, school efforts must be conceptualized as far more than expanding access to mental health services or adding social emotional learning to the curriculum.

These efforts need to be embedded within a unified, comprehensive, and equitable system for addressing barriers to learning and teaching. Such a system must be elevated as a primary and essential component of school improvement policy and practice, rather than treated as an auxiliary or add on initiative (Adelman & Taylor, 2024).

Schools support, but do not replace clinical treatment

Schools are uniquely positioned to notice early indicators of mental and physical health concerns, prevent secondary problems, and connect students and families with effective supports. When concerns are identified early and addressed collaboratively, students are far more likely to engage in learning, develop resilience, and thrive academically and socially.

With specific respect to obsessive compulsive disorder (OCD), schools do not diagnose students. However, as with all mental health concerns, schools are essential partners in:

- Early identification – Observing persistent patterns of distress, anxiety, or behaviors that interfere with learning, participation, or peer relationships.
- Reducing stigma and promoting understanding – Using formal and informal teaching and everyday interactions to increase awareness, affirm neurodiversity, support help seeking, and demonstrate respect for individualized interventions.
- Referral – Communicating concerns sensitively and constructively with families and, when appropriate, facilitating connections to external professionals.
- Planning – Collaborating in the development and implementation of appropriate supports, such as Section 504 plans or Individualized Education Programs (IEPs).
- Monitoring and coordination – Working with families and primary providers to monitor progress and ensure continuity and alignment of supports across settings.

Examples of Direct School Supports*

School based practices that can directly support students with OCD include:

- Minimizing punitive or disciplinary responses to OCD related behaviors
- Ensuring routines and transitions are predictable and clearly communicated
- Providing appropriate and flexible classroom accommodations
- Reducing stressors and offering alternatives that avoid reinforcing rituals or excessive reassurance seeking
- Ensuring regular access to school based student and learning support staff

*It is important to emphasize that these practices are not exclusive to students with OCD. They represent good practice for supporting all students experiencing learning, behavior, or emotional challenges, and they align with a systemic approach to promoting mental health, equity, and success for every learner.

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