Information about:

Obsessive Compulsive Disorder (OCD)

Revised September 2009
Introduction

Information About Obsessive Compulsive Disorder is part of a series of information packets developed by the Vermont Family Network (VFN). Designed to provide basic information, the packet includes fact sheets, articles, advocacy tips, and resources for families of children with special needs and for the professionals working with them.

After reading the packet, we hope that you’ll have a greater understanding of obsessive compulsive disorder and the ways in which parents and professionals can support children at home, in school, and in the community. We’ve selected information from a variety of sources, and many articles are on the Internet.

Thank you to BEST (Building Effective Strategies for Teaching), Vermont Department of Education, for making this publication possible. Thanks also go to the organizations and authors who gave us permission to use their articles and fact sheets. Use of any specific articles in this packet is meant for information purposes only and doesn’t indicate any endorsement on the part of VFN of the views and opinions of the authors.

Because your comments are important to us, we’ve included a reader’s response form at the end of the packet. Please take a few minutes to fill it out and return it to our office. Thank you.

Contents

<table>
<thead>
<tr>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obsessive Compulsive Disorder in Children and Adolescents</td>
<td>1 - 2</td>
</tr>
<tr>
<td>American Academy of Child and Adolescent Psychiatry</td>
<td></td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>3 - 4</td>
</tr>
<tr>
<td>National Institute of Mental Health (NIMH)</td>
<td></td>
</tr>
<tr>
<td>OCD in Children</td>
<td>5 - 8</td>
</tr>
<tr>
<td>The Obsessive Compulsive Foundation (OCF)</td>
<td></td>
</tr>
<tr>
<td>Tips for Accommodating Students with OCD</td>
<td>9 - 10</td>
</tr>
<tr>
<td>Leslie Packer, PhD</td>
<td></td>
</tr>
<tr>
<td>Advocating for Your Child: 25 Tips for Parents</td>
<td>11 - 14</td>
</tr>
<tr>
<td>David Fassler, MD</td>
<td></td>
</tr>
<tr>
<td>Resources</td>
<td>15 - 23</td>
</tr>
<tr>
<td>Reader’s Response Form</td>
<td>24 - 25</td>
</tr>
</tbody>
</table>
Obsessive-Compulsive Disorder In Children And Adolescents

No. 60; Updated June 2001

Obsessive-Compulsive Disorder (OCD), usually begins in adolescence or young adulthood and is seen in as many as 1 in 200 children and adolescents. OCD is characterized by recurrent intense obsessions and/or compulsions that cause severe discomfort and interfere with day-to-day functioning. Obsessions are recurrent and persistent thoughts, impulses, or images that are unwanted and cause marked anxiety or distress. Frequently, they are unrealistic or irrational. They are not simply excessive worries about real-life problems or preoccupations. Compulsions are repetitive behaviors or rituals (like hand washing, hoarding, keeping things in order, checking something over and over) or mental acts (like counting, repeating words silently, avoiding). In OCD, the obsessions or compulsions cause significant anxiety or distress, or they interfere with the child's normal routine, academic functioning, social activities, or relationships.

The obsessive thoughts may vary with the age of the child and may change over time. A younger child with OCD may have persistent thoughts that harm will occur 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 over and over again.

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.”

Research shows that OCD is a brain disorder and tends to run in families, although this doesn't mean the child will definitely develop symptoms if a parent has the disorder. Recent studies have also shown that OCD may develop or worsen after a streptococcal bacterial infection. A child may also develop OCD with no previous family history.

Children and adolescents often feel shame and embarrassment about their OCD. Many fear it means they're crazy and are hesitant to talk about their thoughts and behaviors. Good communication between parents and children can increase understanding of the problem and help the parents appropriately support their child.

Most children with OCD can be treated effectively with a combination of psychotherapy (especially cognitive and behavioral techniques) and certain medications for example, serotonin reuptake inhibitors (SSRIs). Family support and education are also central to the success of treatment. Antibiotic therapy may be useful in cases where OCD is linked to streptococcal infection.

Seeking help from a child and adolescent psychiatrist is important both to better understand the complex issues created by OCD as well as to get help.

For additional information see Facts for Families: www.aacap.org/cs/root/facts_for_families/facts_for_families_numerical_list
Obsessive-Compulsive Disorder

Everyone double-checks things sometimes—for example, checking the stove before leaving the house, to make sure it’s turned off. But people with OCD feel the need to check things over and over, or have certain thoughts or perform routines and rituals over and over. The thoughts and rituals of OCD cause distress and get in the way of daily life.

The repeated, upsetting thoughts of OCD are called obsessions. To try to control them, people with OCD repeat rituals or behaviors, which are called compulsions. People with OCD can’t control these thoughts and rituals.

Examples of obsessions are fear of germs, of being hurt or of hurting others, and troubling religious or sexual thoughts. Examples of compulsions are repeatedly counting things, cleaning things, washing the body or parts of it, or putting things in a certain order, when these actions are not needed, and checking things over and over.

People with OCD have these thoughts and do these rituals for at least an hour on most days, often longer. The reason OCD gets in the way of their lives is that they can’t stop the thoughts or rituals, so they sometimes miss school, work, or meetings with friends, for example.

What are the symptoms of OCD?

People with OCD:

- have repeated thoughts or images about many different things, such as fear of germs, dirt, or intruders; violence; hurting loved ones; sexual acts; conflicts with religious beliefs; or being overly neat.

- do the same rituals over and over such as washing hands, locking and unlocking doors, counting, keeping unneeded items, or repeating the same steps again and again.

- have unwanted thoughts and behaviors they can’t control.

- don’t get pleasure from the behaviors or rituals, but get brief relief from the anxiety the thoughts cause.

- spend at least an hour a day on the thoughts and rituals, which cause distress and get in the way of daily life.

When does OCD start?

For many people, OCD starts during childhood or the teen years. Most people are diagnosed at about age 19. Symptoms of OCD may come and go and be better or worse at different times.

Is there help?

There is help for people with OCD. The first step is to go to a physician or health clinic to talk about symptoms. People who think they have OCD may want to bring this booklet to the physician, to help them talk about the symptoms in it. The physician will do an exam to make sure that another physical problem isn’t causing the symptoms. The physician may make a referral to a mental health specialist.

Doctors may prescribe medication to help relieve OCD. It’s important to know that some of these medicines may take a few weeks to start working. Medications can be prescribed by M.D.s (usually a psychiatrist) and in some states also by clinical psychologists, psychiatric nurse practitioners, and advanced psychiatric nurse specialists. Check with your state’s licensing agency for specifics.
The kinds of medicines used to treat OCD are listed below. Some of these medicines are used to treat other problems, such as depression, but also are helpful for OCD.

- antidepressants,
- antianxiety medicines, and
- beta-blockers.

Physicians also may ask people with OCD to go to therapy with a licensed social worker, psychologist, or psychiatrist. This treatment can help people with OCD feel less anxious and fearful.

There is no cure for OCD yet, but treatments can give relief to people who have it and help them live a more normal life. If you know someone with signs of OCD, talk to him or her about seeing a physician. Offer to go along for support. To find out more about OCD, call 1-866-615-NIMH (1-866-615-6464) to have free information mailed to you.

Personal story

"I couldn’t do anything without rituals. They invaded every aspect of my life. Counting really bogged me down. I would wash my hair three times as opposed to once because three was a good luck number and one wasn’t. It took me longer to read because I’d count the lines in a paragraph. When I set my alarm at night, I had to set it to a number that wouldn’t add up to a ‘bad’ number."

"Getting dressed in the morning was tough, because I had a routine, and if I didn’t follow the routine, I’d get anxious and would have to get dressed again. I always worried that if I didn’t do something, my parents were going to die. I’d have these terrible thoughts of harming my parents. That was completely irrational, but the thoughts triggered more anxiety and more senseless behavior. Because of the time I spent on rituals, I was unable to do a lot of things that were important to me."

"I knew the rituals didn’t make sense, and I was deeply ashamed of them, but I couldn’t seem to overcome them until I had therapy."

Who pays for treatment?

Most insurance plans cover treatment for anxiety disorders. People who are going to have treatment should check with their own insurance companies to find out about coverage. For people who don’t have insurance, local city or county governments may offer treatment at a clinic or health center, where the cost is based on income. Medicaid plans also may pay for OCD treatment.

Why do people get OCD?

OCD sometimes runs in families, but no one knows for sure why some people have it, while others don’t. When chemicals in the brain are not at a certain level it may result in OCD. Medications can often help the brain chemicals stay at the correct levels.

To improve treatment, scientists are studying how well different medicines and therapies work. In one kind of research, people with OCD choose to take part in a clinical trial to help physicians find out what treatments work best for most people, or what works best for different symptoms. Usually, the treatment is free. Scientists are learning more about how the brain works, so that they can discover new treatments.

This page last reviewed: September 17, 2009

The National Institute of Mental Health (NIMH) is part of the National Institutes of Health (NIH), a component of the U.S. Department of Health and Human Services.
OCD in Children

What Is Life Like For Children Who Have OCD?

OCD can make daily life very difficult and stressful for children. OCD symptoms often take up a great deal of a child's time and energy. This makes it difficult to complete tasks such as homework or household chores. Children worry that they are "crazy" because they are aware their thinking is different than their friends and family. A child's self-esteem can be negatively affected because the OCD has led to embarrassment or has made the child feel "bizarre" or "out of control."

Mornings And Evenings Can Be Especially Difficult For Children With OCD

In the morning, they feel they must do their rituals right, or the rest of the day will not go well. Meanwhile, they are rushed to be on time for school. This combination of factors leads to feeling pressured, stressed, and irritable. In the evenings, they feel compelled to finish all of their compulsive rituals before they go to bed. They know they must get their homework done and take care of any household chores and responsibilities. Some children stay up late because of their OCD, and are often exhausted the following day.

Children with OCD frequently don't feel well physically. This may be due to the stress of having the disorder, or it may be poor nutrition or the loss of sleep. Obsessions and compulsions related to food are common, and these can lead to irregular or "quirky" eating habits. Many children with OCD are prone to stress-related ailments such as headache, or an upset stomach.

Children with OCD have episodes in which they are extremely angry with their parents. This is because the parents have become unwilling (or are unable!) to comply with the child's OCD-related demands. For example, children with obsessions about germs may insist that they be allowed to shower for hours, or demand that their clothes be washed numerous times or in a particular way. Even when parents set reasonable limits, children with OCD can become anxious and angry. However, this anger does not justify physical or verbal abuse between parent and child. If violence or abuse occurs within the home, it should not be tolerated. Professional help should be sought.

Friendships and peer relationships are stressful for those with OCD because they try hard to conceal their rituals from peers. When the disorder is severe, this becomes impossible, and the
child may get teased or ridiculed. Even when the OCD is not severe, it affects friendships because of the time spent preoccupied with obsessions and compulsions, or because friends react negatively to unusual OCD-related behaviors.

Children with OCD appear more likely to have additional psychiatric problems than those who do not have the disorder. Comorbidity means having two (or more) separate psychiatric diagnoses at the same time. Below is a list of psychiatric conditions that frequently occur along with OCD:

- Additional anxiety disorders (such as panic disorder or social phobia)
- Depression/dysthymia
- Disruptive behavior disorders (such as oppositional defiant disorder, or attention-deficit hyperactivity disorder)
- Learning disorders
- Tic disorders/Tourette’s syndrome
- Trichotillomania (hair pulling)

Body dysmorphic disorder (imagined ugliness) Sometimes comorbid disorders can be treated with the same medication prescribed to treat the OCD. Depression, additional anxiety disorders, and trichotillomania may improve when a child takes anti-OCD medication.

On the other hand, ADHD, tic disorders, and disruptive behavior disorders usually require additional treatments, including medications that are not specific to OCD. A booklet of this size cannot address all the possible comorbid conditions a child with OCD could have, nor all the possible medication approaches used for these comorbid disorders.

In general, using the smallest amount of medication effective in controlling symptoms, starting low and going slow are common sense approaches. In unusually complicated situations, or in situations where the OCD appears resistant to drug treatment, a consultation with an expert in the area of childhood OCD is warranted.

**What Are The Chances That My Child Will Inherit OCD?**

OCD often runs in families. However, it appears that genes are only partially responsible for causing the disorder. If the development of OCD were completely determined by genetics,
pairs of identical twins would both have the disorder, or both not have it. For example, eye color is entirely determined by genes and identical twins always have the same color eyes. If one identical twin has the disorder, there is a 13 percent chance that the other twin will not be affected. This supports the idea that genes are only part of the cause of OCD. Other factors are also important. No one really knows what that other factor might be, although some have suggested that it may be a viral infection that occurs at a critical point in a child’s development, or perhaps an exposure to an environmental toxin.

Some experts speculate that there may be different types of OCD. Some types are inherited while other types are not. There is evidence that OCD that begins in childhood may be different from OCD that begins in adulthood. Individuals with childhood-onset OCD appear more likely to have blood relatives that are affected with the disorder than are those whose OCD first appears when they are adults.

If a parent is affected with OCD we can estimate how likely it will be that their child will also have the disorder. If one parent has OCD, the likelihood the child will be affected is about 2 to 8 percent. It is important to remember that this statistic is an approximation. Several other factors should be considered when attempting to estimate the risk of a child developing OCD. One factor is whether or not the parents themselves have a family history of OCD. If a parent who has OCD has blood relatives with the disorder, the risk for the child increases. Conversely, if a parent has OCD but none of their blood relatives are affected, then the risk decreases.

Another factor is whether the parent has OCD that began when they were an adult or began when they were a child. If the parent's OCD did not start until adulthood, there is probably a decreased likelihood that his or her offspring will be affected. Conversely, if the parent's OCD is the “variety” that starts in childhood, the chances of passing the disorder on are increased.

Another factor is the family history of tic disorders (such as Tourette's syndrome) or other anxiety disorders. If a child has parents or other blood relatives with tic disorders or anxiety disorders, then the child is probably at increased risk for OCD. Besides, having blood relatives with OCD means that not only does the child have increased risk for OCD, but may also have an increased risk for developing a different anxiety disorder or a tic disorder. In summary, having blood relatives with OCD, anxiety disorders, and tic disorders all increase a child's risk of developing any of these same disorders.

As the above information indicates, it is difficult to estimate the chances that a parent will pass OCD on genetically to their child. This is an area of active research, and new
developments appear frequently. Prospective parents may wish to consult with a genetics counselor prior to attempting to conceive a child. This can help assure that they have the most up-to-date information available.

Acknowledgment

This information was compiled by J. Jay Fruehling, M.A., Information Specialist and The Child Psychopharmacology Information Service University of Wisconsin-Madison, Department of Psychiatry [www.psychiatry.wisc.edu] and was edited by Hugh F. Johnston, M.D., University of Wisconsin, Madison and John S. March, M.D., Duke University, Durham, North Carolina and was funded in part by donations from the Daphne Seybold Culpepper Memorial Fund, Ticking Hearts, Mr. and Mrs. Irwin Lancer, The Andrade family, Meryl and Christopher Lewis, Annoymous, Robert Selig, and Stephen Josephson, Ph.D.

This information was commissioned by the Obsessive-Compulsive Foundation (OCF) as a service for children with Obsessive-Compulsive Disorder (OCD) and for those who care for them. Its purpose is to provide concise information about the drug treatment of childhood OCD, and to deliver answers to many of the frequently asked questions about this treatment.

The views expressed represent the opinions of the author They are based on the medical literature as well as the clinical experience of Drs. March and Johnston. Each child is unique and because OCD can manifest itself in many different ways, it is difficult to make blanket recommendations regarding the medication treatment of childhood OCD.

Because of this, the goal of this information is to provide drug treatment information and recommendations, but it is not a blueprint for treatment. This information is best utilized in fostering effective communication and collaboration with a doctor familiar with the diagnosis and treatment of childhood OCD.
Tips for Accommodating Students with Obsessive-Compulsive Disorder

Strategies to Consider or Explore:

- Allow more time for completing tasks and tests. Other testing accommodations may include testing in an alternate location, providing breaks during testing, and allowing the student to write directly on the test booklet (see below). In some cases, you may need to allow the student to take tests orally.
- For students with compulsive writing rituals, consider limiting handwritten work. Common compulsive writing rituals include having to dot i’s in a particular way or 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. Scantron forms may be particularly problematic for a student who feels that s/he has to perfectly darken in each circle -- in such cases, a reasonable test accommodation would be to have the student circle their answers or record their answers directly in the test booklet. If writing lecture notes is problematic, the student may need to tape record lectures or the teacher may need to arrange for providing the student with a hard copy outline of the lecture notes. Alternatively, if the student’s compulsions are not triggered by keyboarding, have the student use a notebook computer or word processor to record lecture notes.
- For students with compulsive reading rituals, consider limiting the amount to be read or breaking it up into chunks. If reading rituals and intrusive thoughts are severe, consider going to books on tape or recording the material for your student to listen to. In some cases, having someone else read aloud to the student may work, but older students may feel frustrated and demoralized by that.
- If the student has perfectionistic traits, they may stay up all night working and reworking an essay or paper. Talk to the parent to find out if this is happening so that you don't inadvertently reinforce the problem by complimenting the student on the 'perfect' work. If the problem is severe, you may need to contract with the student as to how much reworking is allowed or you may need to establish a system whereby they turn their work in at the end of the school day and not take it home as 'homework.'
- During a quiet discussion, consult with the student and inquire as to what support he or she needs from you. Ask whether gentle refocusing and redirection would be welcomed. By working collaboratively with your student, you will find out what techniques help your student and what may © 2004, Leslie E. Packer, PhD and Challenging Kids, Inc. This handout may be reproduced for noncommercial personal use.
- Try to reduce triggers to compulsive rituals, if possible. If you know that a student will "have to" engage in a ritual if they see the pencil sharpener, can you put the sharpener out of sight? If they "have to" touch people, can you take one step back so that the intensity of the trigger is reduced for them?
- Be alert to peer problems or teasing or harassment associated with compulsive rituals. If the student is being ridiculed for their rituals or obsessive fears, consider conducting a peer education program on OCD. The OC Foundation has a 45-minute film called "The Touching Tree" that may be appropriate for younger students.
- Conference privately with the student when they are not "stuck" to figure out some "graceful exit" excuses that they or you can use to help them get out of the classroom without attracting peer attention. Consider giving the student a “permanent pass” that they can use to leave the classroom without calling attention to himself or herself if they need to go speak with the counselor or to take a walk to help get “unstuck.”
- If the student is having trouble retrieving information or facts that they have learned, a “free recall” procedure where you simply ask a question and they have to answer is likely to
underestimate the extent of their knowledge. Using multiple choice questions or providing a word bank will increase their ability to show you what they know.

- The educational team, in collaboration with the student, parents, and outside treating professionals should determine how to handle late assignments. Some sources recommend always allowing students with OCD to submit assignments late without penalty, but if there is too little structure or limits, the student may not be able to get themselves to turn the work in. This, too, needs to be handled on a case-by-case basis.

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Advocating for Your Child: 25 Tips for Parents
by David Fassler, M.D.

According to the Surgeon General, 1 child in 5 will experience significant problems due to a psychiatric disorder. The good news is that we can help many, if not most, of these youngsters. The real tragedy is that so few, less than 1 in 3, are receiving the comprehensive treatment they really need.

Children and adolescents with emotional and behavioral problems deserve access to the best possible mental health care. Unfortunately, such services are often difficult to obtain. Parents can help by being informed, involved and persistent advocates on behalf of their children.

The following outline offers specific tips and suggestions which parents may find useful in such advocacy efforts:

1. Get a comprehensive evaluation. Child psychiatric disorders are complex and confusing. A full assessment will often involve several visits. Effective treatment depends on a careful and accurate diagnosis.

2. Insist on the best. Talk to physicians, therapists, guidance counselors and other parents. Find out who in your community has the most experience and expertise in evaluating and treating your child’s particular condition. Check the clinician’s credentials carefully. Are they appropriately licensed or certified in your state? If he or she is a physician, are they “Board Certified”? Push schools, insurance companies and state agencies to provide the most appropriate and best possible services, not merely services which are deemed sufficient or adequate.

3. Ask lots of questions about any diagnosis or proposed treatment. Encourage your child to ask any questions he or she may have, as well. Remember that no one has all the answers, and that there are few simple solutions for complex child psychiatric disorders. In addition, all treatments have both risks and benefits. Make sure you and your child understand the full range of treatment options available so you can make a truly informed decision.

4. Insist on care which is “family centered” and which builds on your child’s strengths. Ask about specific goals and objectives. How will you know if treatment is helping? If your child’s problems persist or worsen, what options and alternatives are available?

5. Ask about comprehensive “wrap around” or individualized services, geared specifically to the needs of your child and family. Are such services available in your state or community? If not, why not?
6. Be prepared. One of the most important things you can do to help your child is to keep all information, including past consultation and treatment reports, in an organized place. Insist on receiving your own copies of all evaluations. Records can easily be misplaced, delayed or even destroyed. Maintaining your own file with all relevant information can help avoid unnecessary duplication of previous treatment efforts.

7. Feel free to seek a second opinion. Any responsible mental health professional will be glad to help with referrals or by sharing information. If you have any questions at all about your child’s diagnosis or the proposed course of treatment, by all means, arrange an independent consultation with another clinician.

8. Help your child learn about their condition. Use books, pamphlets and the Internet. Make sure the information is age-appropriate. Answer questions with honest, accurate and consistent information, but don’t overload children with more detail than they need or want.

9. Learn the details of your insurance policy, and learn about the laws governing insurance in your state. For example, in some states, insurance companies must provide access to a specialist, such as a child and adolescent psychiatrist, within a certain distance from your home. If no such specialist is available as part of the company’s “network”, you may be able to receive treatment from a provider of your choice, with the insurance company responsible for full payment.

10. Work with the schools. Insist on access to appropriate mental health consultation services. Suggest inservice training programs to enhance awareness about child psychiatric disorders. Request copies of your child’s educational records, including the results of any formal testing or other evaluations. Ask to be included in any and all school meetings held to discuss your child.

11. Learn about the reimbursement and funding systems in your state. The more you know, the better you can advocate on behalf of your child. How does Medicaid work? Which services are covered and which are excluded? Is there a “waiver program” which allows increased flexibility based on the specific needs of children and families? Is your child eligible? If not, why not? What other sources of funding are potentially available?

12. Get to know the state insurance commissioner and healthcare “ombudsperson” or consumer representative. Ask them to attend regular meetings with parent groups. Let them know about your experiences.

13. Use a lawyer, if necessary. Learn about the local legal resources. Find out which lawyers in your community are familiar with educational and mental health issues. Talk to your local Protection and Advocacy agency or American Civil Liberties Union for suggestions. Call the State Bar Association. Talk to other parents who are lawyers or who have used lawyers. Consider a legal consultation to make sure you are pursuing all appropriate avenues and options regarding services for your child.
14. Become politically active. Meet with state senators and representatives. Question candidates about their positions on access to necessary and appropriate mental health services for children and families. Testify at hearings on state legislation and budgets. Legislators are more likely to be influenced and persuaded by personal stories than by data, statistics or the opinions of professionals.

15. Build coalitions and work with local advocacy and parent organizations such as NAMI, NMHA and the Federation of Families. Develop and publicize a common “Agenda for Children’s Mental Health”.

16. Teach children about advocacy. Invite them to become involved in advocacy activities, where appropriate, but don’t force them to participate.

17. Develop a legislative strategy. If your state does not yet have parity legislation, put this at the top of the agenda. Other “family protection” initiatives include:
   - access to an independent panel to review and potentially reverse insurance company denials
   - consumer representation on community mental health center boards
   - adequate network provisions, which mandate timely and appropriate access to specialists
   - adequate funding for school and community based mental health services.

18. Seek bipartisan support. Mental illness effects families of all political persuasions. Building a broad base of support has been a key to successful legislative initiatives, both at the State and Federal levels.

19. Fight stigma. Develop an ongoing local education campaign that reiterates the key messages:
   - child psychiatric disorders are very real illnesses
   - they effect lots of kids and adolescents
   - fortunately, they are also quite treatable, especially if treatment begins early and is individualized to the needs of each child and family.

20. Become involved with medical education. Meet with local medical students and residents. Sensitize them to the issues and challenges families face when caring for a child with emotional and behavioral problems.

21. Use the media. Write letters to the editor and/or op-ed pieces on child mental health issues. Meet with local reporters covering health care topics. Suggest story ideas to local TV stations.

22. Work with local professional organizations. Psychiatrists, psychologists, social workers, psychiatric nurses, and mental health counselors are natural allies with a common advocacy agenda. Coordinate efforts on issues such as parity, funding for mental health services, managed care oversight, etc. Professional organizations may also have access to resources, including funds for lobbying and/or public education initiatives, from their national associations.
23. Talk to other parents. Seek out and join local parent support groups. If none exist, consider starting one. Develop an email “listserv” to facilitate communication. Circulate articles, information and suggestions about local resources.

24. Attend regional and national conferences of parent and advocacy organizations. Such meetings provide information, ideas, camaraderie and support. Sharing experiences with other parents is both helpful and empowering.

25. Don’t give up. Aim for and celebrate incremental victories and accomplishments. Remember, advocacy is an ongoing process!

There’s no right or wrong way to be an advocate for your child. Advocacy efforts and initiatives should be individualized to your state, community and the particular issues, circumstances and needs within your family. Advocacy is also hard work. Even when people want to help, and are willing to listen, it takes lots of time and energy to change the system. But when it works, and it often does, the outcome is clearly worthwhile. You really can make a difference, both for your own child, and ultimately for all children who need and deserve access to appropriate and effective mental health treatment services.

Resources

The following organizations are excellent resources regarding advocacy on behalf of children’s mental health:

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue, NW
Washington, DC  20016
(202) 966-7300
www.aacap.org

American Psychiatric Association
Division of Public Affairs
1400 K Street, NW
Washington, DC  20005
(202) 682-6140
www.psych.org

Federation of Families for Children’s Mental Health
1101 King Street, Suite 420
Alexandria, VA  22314
(703) 684-7710
www.ffcmh.org

National Alliance for the Mentally Ill
Colonial Place Three
2107 Wilson Blvd., Suite 300
Arlington, VA  22201-3042
(703) 524-7600
www.nami.org

National Mental Health Association
1021 Prince Street
Alexandria, VA  22314-2971
1-800-969-6642
www.nmha.org

The Children’s Defense Fund
25 E Street NW
Washington, DC  20001
(202) 628-8787
www.childrensdefense.org

Bazelon Center for Mental Health Law
1101 15th Street NW, Suite 1212
Washington, DC  20005-5002
(202) 467-5730
www.bazelon.org
Dr. Fassler is a Board Certified Child and Adolescent Psychiatrist practicing in Burlington, Vermont. He is a Clinical Associate Professor in the Department of Psychiatry at the University of Vermont College of Medicine. Dr. Fassler is also a Trustee of the American Psychiatric Association (www.psych.org), a Fellow of the American Academy of Child and Adolescent Psychiatry (www.aacap.org), and a member of the Board of the Federation of Families for Children’s Mental Health (www.ffcmh.org).
Resources

National Institute of Mental Health Information Center (NIMH)
Office of Communications
6001 Executive Boulevard, Room 8184, MSC 9663
Bethesda, MD 20892-9663
nimhinfo@nih.gov
1-866-615-6464

Obsessive Compulsive Anonymous
PO Box 215
New Hyde Park, NY 11040, USA
516-739-0662
http://www.obsessivecompulsiveanonymous.org

Obsessive Compulsive Foundation
P.O. Box 70
Milford, CT 06460
(203) 878-5669
http://www.ocfoundation.org

Understanding Obsessive Compulsive Disorder
http://understanding_ocd.tripod.com/index.html

OCD online
http://www.ocdonline.com

Mental Help

http://www.mentalhelp.net/

Anxiety Disorders Association of America
http://www.adaa.org

National Eating Disorders Association
http://www.nationaleatingdisorders.org

U.S. Dept. of Health & Human Services
http://www.healthfinder.gov

Internet Mental Health
http://www.mentalhealth.com

Freedom From Fear
http://www.freedomfromfear.org

Medline Plus (National Library of Medicine & National Institutes of Health)
http://www.nlm.nih.gov/medlineplus

Medscape
http://www.medscape.com/psychiatryhome
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<thead>
<tr>
<th>Organization</th>
<th>Web Site</th>
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<td>American Academy of Child and Adolescent Psychiatry</td>
<td><a href="http://www.aacap.org">http://www.aacap.org</a></td>
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<td>Web site on Eating Disorders</td>
<td><a href="http://www.something-fishy.org">http://www.something-fishy.org</a></td>
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<td>National Alliance for the Mentally Ill</td>
<td><a href="http://www.nami.org">http://www.nami.org</a></td>
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<td>Depression and Bipolar Support Alliance</td>
<td><a href="http://www.dbsalliance.org">http://www.dbsalliance.org</a></td>
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<td>National Mental Health Association</td>
<td><a href="http://www.nmha.org">http://www.nmha.org</a></td>
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<tr>
<td>American Psychiatric Association</td>
<td><a href="http://www.psych.org">http://www.psych.org</a></td>
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</table>
OCD Book List

General

Compulsive Acts: A Psychiatrist's Tales of Rituals and Obsessions
by Elias Aboujaoude, M.D.

The Anti-Anxiety Workbook: Proven Strategies to Overcome Worry, Phobias, Panic, and Obsessions (The Guilford Self-Help Workbook Series)
by Martin M. Antony, Ph.D. and Peter J. Norton, Ph.D.

The Imp of the Mind: Exploring the Silent Epidemic of Obsessive Bad Thoughts
by Lee Baer, Ph.D.

Getting Control: Overcoming Your Obsessions and Compulsions
by Lee Baer, Ph.D., with a foreword by Judith Rapoport, M.D.

Obsessive-Compulsive Disorder Demystified: An Essential Guide for Understanding and Living with OCD
by Cheryl Carmin, Ph.D.

The Obsessive-Compulsive Trap: Real Help for a Real Struggle
by Mark Crawford, Ph.D.

Obsessive-Compulsive Disorder: The Facts
by Padmal de Silva and Stanley Rachman

The Sky is Falling: Understanding and Coping with Phobias, Panic and Obsessive-Compulsive Disorder
by Raeann Dumont

Obsessive-Compulsive Disorder For Dummies
by Charles H. Elliott, Ph.D., and Laura L. Smith, Ph.D.

Stop Obsessing!: How to Overcome Your Obsessions and Compulsions
by Edna B. Foa, Ph.D., and Reid Wilson, Ph.D.

Freedom From Obsessive-Compulsive Disorder: A Personalized Recovery Program for Living with Uncertainty
by Jonathan Grayson, Ph.D.

Coping With OCD: Practical Strategies for Living Well With Obsessive-Compulsive Disorder
by Bruce Hyman, Ph.D., with Troy Dufrene

The OCD Workbook: Your Guide to Breaking Free from Obsessive Compulsive Disorder
by Bruce M. Hyman, Ph.D. and Cherry Pedrick, R.N.

The OCD Answer Book: Professional Answers to More Than 250 Top Questions About Obsessive-Compulsive Disorder
by Patrick B. McGrath, Ph.D.

Overcoming Compulsive Checking
by Paul R. Munford, Ph.D.

Overcoming Compulsive Washing
by Paul R. Munford, Ph.D.

Over and Over Again: Understanding Obsessive Compulsive Disorder, Revised Edition
by Fugen Neziroglu, Ph.D., and Jose Yaryura-Tobias, M.D.
Tormenting Thoughts and Secret Rituals: The Hidden Epidemic of Obsessive-Compulsive Disorder
by Ian Osborn, M.D.

Obsessive-Compulsive Disorders: A Complete Guide to Getting Well and Staying Well
by Fred Penzel, Ph.D.

Overcoming Obsessive Thoughts
by Christine Purdon, Ph.D., C.Psych., and David A. Clark, Ph.D., L.Psych.

The Boy Who Couldn't Stop Washing: The Experience and Treatment of Obsessive-Compulsive Disorder
by Judith L. Rapoport, M.D.

Brain Lock: Free Yourself from Obsessive-Compulsive Behavior
by Jeffrey M. Schwartz, M.D., with Beverly Beyette

Deep Brain Stimulation: A New Treatment Shows Promise in the Most Difficult Cases
by Jamie Talan

Personal Memoirs

The Boy Who Finally Stopped Washing: OCD From Both Sides of the Couch
by John B.

Rewind, Replay, Repeat: A Memoir of Obsessive-Compulsive Disorder
by Jeff Bell

Obsessive-Compulsive Anonymous: Recovering from Obsessive-Compulsive Disorder
by Roy C.

The Thing Inside My Head: A Family's Journey Through Mental Illness
by Lois Chaber

Memoirs of a Born Shlepper: Never Give OCD a Third Thought
by Rod Fadem

Living With Severe Obsessive Compulsive Disorder
by Marie Gius

The Thought that Counts: A Firsthand Account of One Teenager's Experience with Obsessive-Compulsive Disorder
by Jared Kant

Fixation Pains: ...A True Struggle for Survival
by John Michael Molinari Ill

Life in Rewind: The Story of a Young Courageous Man Who Persevered Over OCD and the Harvard Doctor Who Broke All the Rules to Help Him
by Terry Weible Murphy, Michael A. Jenike, and Edward E. Zine

Desert Lily
by Peter A. Pascaris

Contaminated: My Journey Out of Obsessive Compulsive Disorder
by Gerry Radano, MSW
Trichotillomania

Help for Hair Pullers: Understanding and Coping with Trichotillomania
by Nancy J. Keuthen, Ph.D., Dan J. Stein, M.D., and Gary A. Christenson, M.D.

The Hair-Pulling Problem: A Complete Guide to Trichotillomania
by Fred Penzel, Ph.D.

Impulse Control

The Habit Change Workbook: How to Break Bad Habits and Form Good Ones
by James Claiborn, Ph.D., ABPP, and Cherry Pedrick, R.N.

Stop Me Because I Can't Stop Myself: Taking Control of Impulsive Behavior
by Jon E. Grant, J.D., M.D., and S.W. Kim, M.D.

Body Dysmorphic Disorder

The BDD Workbook
by James Claiborn, Ph.D., ABPP, and Cherry Pedrick, R.N.

The Broken Mirror: Understanding and Treating Body Dysmorphic Disorder
by Katharine A. Phillips, M.D.

Feeling Good About the Way You Look: A Program for Overcoming Body Image Problems
by Sabine Wilhelm, Ph.D.

Perfectionism

When Perfect Isn't Good Enough: Strategies for Coping with Perfectionism
by Martin M. Antony, Ph.D. and Richard P. Swinson, M.D.

Why Does Everything Have to be Perfect?
by Lynn Schackman, M.D., and Shelagh Ryan Masline

Scrupulosity

The Doubting Disease: Help for Scrupulosity and Religious Compulsions
by Joseph W. Ciarrocchi, Ph.D.

Hoarding

Overcoming Compulsive Hoarding
by Fugen Neziroglu, Ph.D., ABPP, Jerome Bubrick, Ph.D., and Jose Yaryura-Tobias, M.D.

Buried in Treasures: Help for Compulsive Acquiring, Saving, and Hoarding
by David F. Tolin, Ph.D., Randy O. Frost, Ph.D., and Gail S. Steketee, Ph.D.
Family

Freeing your Child from Obsessive-Compulsive Disorder
by Tamar E. Chansky, Ph.D.

Helping Your Child With OCD
by Lee Fitzgibbons, Ph.D., and Cherry Pedrick, R.N.

Talking Back to OCD: The Program That Helps Kids and Teens Say "No Way" - and Parents Say "Way to Go."
by John S. March, M.D.

What to do When Your Child Has Obsessive-Compulsive Disorder: Strategies and Solutions
by Aureen Pinto Wagner, Ph.D.

Obsessive-Compulsive Disorder: Help for Children and Adolescents
by Mitzi Waltz

For Family Members of Adults with OCD

by Robert Collie, Th.D.

Obsessive-Compulsive Disorder: New Help for the Family
by Herbert L. Gravitz, Ph.D.

Loving Someone with OCD: Help for You and Your Family
by Karen J. Landsman, Ph.D., Kathleen M. Rupertus, M.A., M.S., and Cherry Pedrick, R.N.

Children and Adolescents

You Do That Too? Adolescents and OCD
by Jose Arturo and Rena Benson

Repetitive Rhonda
by Jan Evans, MA

Not As Crazy As I Seem
by George Harrar

No One is Perfect and YOU Are a Great Kid
by Kim Hix

What to do When Your Brain Gets Stuck: A Kid's Guide to Overcoming OCD
by Dawn Huebner, Ph.D.

Blink, Blink, Clop, Clop: Why Do We Do Things We Can't Stop? An OCD Storybook
by E. Katia Moritz, Ph.D., and Jennifer Jablonsky

Mr. Worry: A Story About OCD
by Holly L. Niner

A Thought is Just a Thought: A Story of Living with OCD
by Leslie Talley
Up & Down the Worry Hill: A Children's Book about Obsessive-Compulsive Disorder and its Treatment
by Aureen P. Wagner, Ph.D.

Professionals

General

Clinical Handbook of Obsessive-Compulsive Disorder and Related Problems
Edited by Jonathan S. Abramowitz, Ph.D., Dean McKay, and Steven Taylor

Obsessive-Compulsive Disorder: Advances in Psychotherapy (An Evidence-Based Practice Book)
by Jonathon S. Abramowitz, Ph.D.

Concepts and Controversies in Obsessive Compulsive Disorder
Edited by Jonathon S. Abramowitz, Ph.D., and Arthur C. Houts

Cognitive-Behavior Therapy for OCD
by David A. Clark

The Obsessive-Compulsive Disorder: Pastoral Care for the Road to Change
by Robert M. Collie, Th.D.

by Edna Foa, Ph.D., and Michael J. Kozak, Ph.D.

Mastery of Obsessive-Compulsive Disorder: A Cognitive-Behavioral Approach (Client Workbook)
by Edna Foa, Ph.D., and Michael J. Kozak, Ph.D.

Mindfulness- and Acceptance-Based Behavioral Therapies in Practice (Guides to Individualized Evidence-Based Treatment)
by Lizabeth Roemer and Susan M. Orsillo

Treatment of Obsessive-Compulsive Disorder
by Gail S. Steketee, Ph.D.

by Gail S. Steketee, Ph.D.

by Gail S. Steketee, Ph.D.

Obsessive Compulsive Disorder: The Latest Assessment and Treatment Strategies
Edited by Gail S. Steketee, Ph.D., Teresa Pigott, M.D., and Todd Schemmel, Ph.D. candidate

Obsessive-Compulsive Disorder: Theory, Research and Treatment
Edited by Richard P. Swinson, M.D., Martin M. Antony, Ph.D., Stanley Rachman, Ph.D., and Margaret A. Richter, M.D.

by Sabine Wilhelm, Ph.D., and Gail S. Steketee, Ph.D.

Biobehavioral Treatment of Obsessive-Compulsive Spectrum Disorders
by Jose A. Yaryura-Tobias, M.D., and Fugen Neziroglu, Ph.D.
For Teachers

Teaching Kids With Mental Health and Learning Disorders in the Regular Classroom: How to Recognize, Understand, and Help Challenged (And Challenging) Students Succeed
by Myles L. Cooley, Ph.D.

Teaching the Tiger: A Handbook for Individuals Involved in the Education of Students with Attention Deficit Disorders, Tourette Syndrome or Obsessive-Compulsive Disorder
by Marilyn P. Dornbush, Ph.D. and Sheryl K. Pruitt, M.Ed.

For Professional Organizers

What Every Professional Organizer Needs To Know About Hoarding
by Judith Kolberg

Treatment of OCD in Children & Adolescents

by John S. March, M.D., M.P.H., and Karen Mulle, B.S.N., M.T.S., M.S.W.

Cognitive Behavioral Treatment of Childhood OCD: It's Only a False Alarm (Therapist Guide)
by John Piacentini, Audra Langley, and Tami Roblek

Handbook of Child and Adolescent Obsessive-Compulsive Disorder
Edited by Eric A. Storch, Ph.D., Gary R. Geffken, Ph.D., and Tanya K. Murphy, M.D.

by Aureen Pinto Wagner, Ph.D.

Worried No More: Help and Hope for Anxious Children
by Aureen Pinto Wagner, Ph.D.

Treatment of Hoarding

Compulsive Hoarding and Acquiring (Therapist Guide)
by Gail S. Steketee, Ph.D., and Randy O. Frost, Ph.D.

Compulsive Hoarding and Acquiring (Client Workbook)
by Gail S. Steketee, Ph.D., and Randy O. Frost, Ph.D.

Treatment of Body Dysmorphic Disorder

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by Joseph W. Ciarrocchi, Ph.D.
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