OCD in Children

Recognising Obsessive-Compulsive Disorder in children and young people

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Can a young child develop OCD?

Yes. OCD is thought to occur in between 1% and 4% of the child and adolescent population — meaning that in an average primary school of 500 pupils, between 5 and 20 young people could be struggling with it. OCD tends not to go away on its own, and without treatment is likely to persist into adulthood. Many adults diagnosed with OCD report that symptoms began during childhood.

Normal worries vs OCD

OCD involves intrusive thoughts (obsessions) and repetitive behaviours (compulsions). Everyone experiences intrusive thoughts about topics that people with OCD worry about — germs, harm to loved ones, and so on. What differentiates normal worries from OCD obsessions is the amount of time spent on them, the level of distress they cause, and the compulsion to "get rid of" the thought.

Ritualistic behaviours are also common in young children aged 3–7 — lining up toys, needing routines to be the same, distress around dirt or sticky substances. What distinguishes these developmental behaviours from OCD is the time spent on rituals, the degree to which they interfere with daily life, and the distress caused when the child is prevented from completing them. A period of watchful waiting is appropriate for younger children.

Common obsessions

Obsessions are intrusive thoughts, worries, or mental images. Common themes include:

- **Germs and contamination:** concern about becoming ill or passing germs to others.
- **Harm:** fear of harm coming to oneself or others through assault, fire, burglary, or death.
- **Symmetry and order:** fear of something bad happening or a sense of unease if things are not arranged "correctly".
- **Health:** excessive concern about illness or body appearance.
- **Hoarding:** excessive worry about losing things.
- **Religious:** preoccupation with morality, god, or going to hell.
- **Aggressive:** fear of physically harming someone.
- **Sexual:** unwanted intrusive thoughts of a sexual nature. In younger children this may involve intrusive thoughts about body parts.
- **Transformation:** fear of taking on undesirable characteristics or losing one's identity.

Common compulsions

Compulsions are repetitive behaviours or mental acts performed to reduce distress. They include:

- **Washing and cleaning:** ritualised or excessive handwashing; extensive shower routines; excessive time spent on the toilet.
- **Checking:** repeatedly checking locks, switches, taps, school bags, or the safety of others.
- **Reassurance seeking:** repeatedly asking parents or teachers questions linked to the core fear.
- **Ordering and symmetry:** needing items placed in exactly the right position.
- **Religious rituals:** praying a certain number of times or apologising to avoid punishment.
- **Hoarding:** collecting items others would discard; inability to throw things away.
- **Avoidance:** avoiding places or situations that might trigger anxiety or the need to perform rituals.
- **Confessing:** feeling compelled to confess every detail of behaviour to check nothing harmful has been done.
- **Repeating:** re-entering rooms, rewriting homework, or repeating phrases until it "feels right".
- **Touching, tapping, counting:** touching items a set number of times, or counting to a particular number while completing activities.

"Magical thinking" — the belief that a ritual can prevent something bad from happening — is common in young people with OCD, particularly younger children.

OCD in younger children

OCD presents similarly in children and adults, but with some differences. Younger children are less likely to recognise the irrationality of their obsessions and may only be able to describe a vague fear of "something bad happening" or a need to act until it "feels right." Compulsions may be driven by a sense of disgust or discomfort rather than a specific fear. This should not be taken to mean the problem is not OCD.

As children approach puberty, obsessions may shift to mirror developmental changes, including sexual and aggressive themes. The most common obsessions across childhood are contamination and germs, followed by harm to self or others, and morality or religion.

Risk factors

Individual factors:

- Biological factors, including differences in serotonin processing in the brain.
- An inflated sense of personal responsibility — feeling overly responsible for preventing bad things happening.
- Being a worrier; intolerance of uncertainty and a strong need to feel in control.
- Heightened perfectionism, which can make it hard to start or complete tasks.
- Being thoughtful and sensitive, with a strong awareness of others' feelings.

Environmental and systemic factors:

- Bullying, which can reinforce negative beliefs about oneself.
- Heightened stress, particularly in situations where the child has limited control.
- Taking on excessive responsibility at home — for example, emotionally supporting a parent.
- Bereavement or serious illness of someone close to the family.
- Parental mental health difficulties, including OCD, anxiety, or depression.

Watchful waiting

It is not always necessary to refer immediately at the first signs of OCD. Some children go through phases of repetitive behaviour that they outgrow. However, if obsessions and/or compulsions are causing significant distress or interfering with daily life, the family should seek support — starting with the GP.

How to help

- Talk with the young person about their worries and anything they are struggling with — exam stress, bullying, bereavement, changes at home.
- Explain anxiety in simple terms: how it can be helpful but sometimes becomes over-sensitive, like a faulty car alarm. Importantly, anxiety does lessen over time, even without doing anything to change the situation.
- Encourage Exposure and Response Prevention (ERP) — facing feared situations in small, manageable ways, and resisting the urge to complete compulsions until the anxiety reduces on its own.

Helpful self-help books:

- *Breaking Free from OCD* — Jo Derisley, Isobel Heyman, Sarah Robinson & Cynthia Turner (2008)
- *What to do When Your Brain Gets Stuck: A Kids' Guide to Overcoming OCD* — Dawn Huebner (2007)

When and where to refer

A referral should be made when the young person and/or their family are experiencing significant distress, or when compulsions are interfering with daily life — getting to school on time, completing schoolwork, seeing friends, or managing basic self-care routines.

The first point of contact is the GP, who can assess and refer to the local CAMHS. The school SENCO or school nurse may also be able to initiate a referral and will often have observed the OCD affecting school performance.

Treatment

The NICE-recommended treatment is Cognitive Behavioural Therapy (CBT) with Exposure and Response Prevention (ERP), offered over up to 14 weekly sessions initially. Between 70% and 80% of young people achieve symptom remission with effective treatment. Medication (SSRIs) can be used alongside CBT in some cases.

In serious cases where OCD has caused substantial impairment and community-based treatment has not been sufficient, referral to a specialist service is possible. This may involve intensive CBT with ERP, and in the most serious cases, inpatient admission to a child and adolescent hospital.