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Current Educational Practices in Classifying and Serving Students with Obsessive-Compulsive Disorder

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Current educational practices for classifying and serving students with mental health disorders such as obsessive-compulsive disorder (OCD) have been associated with specific problems. These include the stigma of labeling, misalignment of school-based categories (e.g., E/BD, OHI) with clinical diagnoses, and concerns regarding the provision of appropriate services to these students. In the present study, Illinois school psychologists completed a survey on current practices for classifying and serving students with a primary diagnosis of OCD. The results indicated that 0.7% of the students served by school psychologists had a primary diagnosis of OCD. The majority of these students (74.5%) were served under IDEA. Of the students receiving services under IDEA, 51.4% were classified under E/BD and 31.8% under OHI. Approximately two-thirds of the students with OCD (67.1%) were educated in less restrictive settings (e.g., regular classroom with or without resource/part-time special class). School psychologists' comments suggested a pattern of ambiguity and uncertainty surrounding the appropriateness of IDEA categories for OCD, concerns regarding the stigma of labeling, and problems related to providing appropriate services to these students. Response-to-Intervention (RtI) as an alternative to current evaluation practices is proposed and recommendations for improving traditional categorical service delivery models when RtI is not implemented are provided.

Keywords: obsessive-compulsive disorder, mental disorders, emotional disturbance, behavioral disorders, other health impaired, labeling (of persons), school psychologists

Based on recent estimates, approximately one-fifth of all students have diagnosable mental disorders (Hoagwood & Johnson, 2003). One mental disorder that recently has appeared on the educational landscape is obsessive-compulsive disorder (OCD), an anxiety disorder characterized by the presence of obsessions and/or compulsions. *Obsessions* are recurring thoughts, ideas, images, or impulses that are inappropriate, intrusive, and produce considerable distress or anxiety. *Compulsions*, or rituals, are purposeful, repetitive, behaviors that individuals perform, either overtly or covertly (i.e., mentally), to relieve, prevent, or undo the anxiety or discomfort created by the obsessions, or to avert a feared situation. The obsessions or compulsions are time consuming, cause substantial distress, or disrupt the individual's academic, occupational, or social functioning (American Psychiatric Association [APA], 2000). Hence, a person with obsessions related to contamination may engage in washing and cleaning rituals for hours to reduce the anxiety precipitated by contamination fears. (The reader is referred to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision [DSM-IV-TR; APA, 2000] for more detailed information on OCD.)

National and international studies have yielded heterogeneous results with regard to prevalence

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estimates of OCD in children and adolescents. Fontenelle, Mendlowicz, and Versiani (2006) reviewed numerous studies of OCD prevalence rates, including 16 studies of childhood OCD conducted between 1987 and 2003. The reviewers reported a wide range of OCD prevalence rates in children and adolescents (0.0%-4.0%). Potential explanations for this diversity include such variables as the population studied (e.g., mean age of participants) and methodological decisions (e.g., instrument selected to diagnose OCD, parent vs. child report) (Fontenelle, et al.; Rapoport, Weissman, Narrow, Jensen, Lahey, & Canino, 2000). In half of these studies, however, reported prevalence rates ranged from 1.9% to 4.0%. Once thought to be rare, OCD now is considered "a common disorder in both adults and the young" (Riddle, 1998, p. 92). The prevalence of OCD and other clinical diagnoses among today's children demands that school psychologists put into place procedures that promote access to effective mental health services for these students. Moreover, the link between mental health and optimal student learning outcomes is strong (Becker & Luthar, 2002), further highlighting the need for school psychologists to implement measures that enhance mental health among students.

Categorizing Students with Mental Health Disorders

Under the current public education system, students with clinical diagnoses must undergo a separate educational evaluation process to determine whether they qualify for special education services due to their disabilities. This process can result in an educational disability category diagnosis that is much broader and less specific than the clinical diagnosis. For example, the DSM-IV-TR clearly articulates OCD as a disability category (APA, 2000); however, a student with OCD may qualify for educational services according to several broader categories such as emotional disorder, behavioral disorder, or other health impairment. Meeting the traditional legal requirements for proper educational identification and categorization of students tends to be a time-intensive process (Hosp & Reschly, 2002) and does not necessarily lead to improved intervention and outcomes among students (Carlburg & Kavale, 1980; Thurlow & Ysseldyke, 1982). Therefore, it remains questionable whether conventional school-based evaluation procedures enhance treatment selection and related outcomes among students with mental health problems. Because maladaptive behavior associated with OCD frequently occurs across a variety of settings (e.g., home, school, community) and involves clinical treatment (Piacentini, Bergman, Keller, & McCracken, 2003), collaboration between school psychologists and clinical psychologists may be particularly helpful in developing effective evaluation and treatment plans.

Another concern associated with categorical diagnoses is labeling, which may lead to a variety of negative outcomes. First, labels can create the perception that students within a given diagnostic category are more alike than different, causing those who work with them to neglect their individual needs and strengths (Bianco, 2005; Smith, 2003). Because students with clinical diagnoses exhibit an array of symptoms, as evidenced by the frequency with which comorbidity is present among these individuals (APA, 2000), they may require a wide variety of treatment options. Second, stigma often is associated with disability labels, which not only may have a negative impact on an individual's self-concept, but also may alter the responses of individuals who come into contact with a person who has a mental disability (Susman, 1994). Third, labels have been shown to reduce learning expectations for students with disabilities, which may have damaging effects on their actual achievement (Foster & Ysseldyke, 1976). Therefore, it is uncertain whether the perceived benefits of labels (e.g., facilitating efficient communication among individuals, providing services similar to those shown to be effective for students displaying comparable behavior; Gallagher, 1976) outweigh the potential drawbacks.

Categorizing Students with OCD

OCD can be an insidious disorder, interfering with all aspects of a young person's functioning – social, behavioral, and academic (Adams, 2004; Adams, Waas, March, & Smith, 1994; Clarizio, 1991). In a seminal study that made use of parent and self-report measures to examine the psychosocial functioning of children and adolescents with OCD, Piacentini et al. (2003) found that among 151 children and adolescents with a primary diagnosis of OCD, almost 90% reported a significant problem in at least one area of functioning (school/academic, home/family, or social); close to half reported at least one significant problem in each of these three areas. Furthermore, 47% of parents and 44% of children reported that OCD caused significant problems in school/academic functioning. Overall, the two most significant OCD problems reported by parents and children alike were difficulties with concentrating on schoolwork and doing homework. Similarly, Sukhodolsky, do Rosario-Campus, Scahill, Katsovich, & Pauls (2005) found that children and adolescents with OCD fared significantly more poorly than children in a control group on several measures of adaptive, family, and emotional functioning. In addition, youth with OCD performed significantly worse on the school competence scale of the Child Behavior Checklist than did comparison peers. Children and adolescents with OCD also are at risk for comorbid psychiatric disorders, including tic disorders, major depression, anxiety disorders (e.g., panic disorder), disruptive behavior disorders (attention-deficit/hyperactivity disorder [AD/HD] and oppositional defiant disorder), specific developmental disorders, and enuresis (Geller, 2006; Sukhodolsky et al., 2005; Zohar, 1999), further complicating the behavioral and academic functioning of these students.

Because of the difficulties they experience in school, many children and adolescents with OCD require school-based accommodations and modifications and/or special education and related services to facilitate their educational functioning. In the past, some students have received accommodations and modifications via Section 504 of the Rehabilitation Act of 1973; others have gone through the traditional educational evaluation process and obtained special education and related services through the Individuals with Disabilities Education Act (IDEA) (Adams, 2004). Students who have received services under IDEA frequently have been classified under the federal category of "Emotional Disturbance" (ED) (Adams, 2004). However, parents of children with OCD and other concerned individuals, including mental health professionals and educational experts in the field of OCD, increasingly have expressed serious reservations about the ED classification and concomitant label. Indeed, a number of researchers have advocated that children and adolescents with OCD be identified under the "Other Health Impaired" (OHI) category (Adams, 2004; Chansky, 2000; Dornbush & Pruitt, 1996).

Several arguments might be offered for such a reclassification. First, many are troubled by the stigma sometimes associated with the ED label (such terms as "Emotional/Behavioral Disorders," or E/BD, may be used within various state systems; Muller & Markowitz, 2004) and the connotations it may invoke (Tourette Syndrome Association, 2006b). Particularly in cases where the media describe perpetrators of criminal and/or violent behavior as "emotionally disturbed," parents or guardians of children with OCD may have serious and legitimate concerns when the same label is applied to their child. Second, OCD has a documented neurobiological basis, including a link to the neurotransmitter serotonin (APA, 2000; Blier, Habib, & Flament, 2006), suggesting that OCD has a physiological, rather than a behavioral or emotional, basis. Moreover, AD/HD and Tourette Syndrome (TS), two other neurobiologically based disorders, are conditions listed under the IDEA "Other Health Impaired" category (34 C.F.R.§ 300.8[c][9][i]). During the reauthorization of IDEA in 1997, many individuals and organizations (e.g., Children and Adults with Attention-Deficit/Hyperactivity Disorder, or CHADD) advocated vigorously that AD/HD be included under the Other Health Impaired category (CHADD of Alachua

County, n.d.). In the final regulations enforcing Part B of IDEA 2004, Tourette Syndrome was listed as a disability under OHI rather than ED. Immediately after the release of the final regulations, the Tourette Syndrome Association (TSA) issued a public announcement entitled *Major Victory for Children with Tourette Syndrome: Individuals with Disabilities Education Act to Classify Tourette Syndrome as Other Health Impaired* (2006a). In its announcement, the TSA stated that "many educators…erroneously see TS as a behavioral or conduct disorder because of the nature of its symptoms and therefore classify these children under the Emotionally Disturbed (ED) category" (para. 9).

Finally, some individuals may be apprehensive about the ED label for students with OCD because of its potential ramifications for educational placement. As indicated earlier, labeling may create the perception that a particular treatment will be effective for most, if not all, students with a given label, and may lead to inappropriate decisions about how to address their individual needs (Bianco, 2005; Smith, 2003). One psychiatrist known for his work in childhood OCD expressed concern regarding students with OCD who are classified under ED and placed in self-contained classrooms for students with behavioral disorders. He noted that in some cases, the students with behavior disorders who exhibit externalizing, aggressive, acting out behaviors "…have a feeding frenzy at the expense of the kids with OCD. It can result in either withdrawal – sometimes out of school – or lashing back (often futility)" (A. J. Allen, personal communication, September 30, 2002).

Similarly, in its public announcement regarding the inclusion of TS under OHI in IDEA 2004, the Tourette Syndrome Association stated that classifying students with TS under the ED category "frequently results in students being placed in programs that are designed for students with emotional disorders where bullying and teasing generally increase, as does the punishment for their symptoms" (2006a, para. 9). Although a review of the literature yielded no information regarding the extent to which this phenomenon occurs for students with OCD, the potential for its existence raises serious concerns.

In sum, many of the previously cited problems related to educational practices for classifying and labeling students with mental health disorders, in general, have been associated with students who have OCD. These include the stigma linked to attaching the ED label to students with OCD, difficulties aligning a school-based category with a clinical diagnosis, and concerns regarding the provision of services to students with OCD. An understanding of current practices in identifying and classifying students with obsessive-compulsive disorder is essential to inform and advance best practices for serving these students. School psychologists, who play a crucial role in the identification and classification process, represent a key source of information regarding these practices. Yet none of the research that has appeared in the school psychology literature on childhood OCD since 1991 (Adams et al., 1994; Clarizio, 1991; McGough, Speier, & Cantwell, 1993; Sabuncuoglu & Berkem, 2006) has examined school psychologists' experiences and perceptions related to school-based practices for identifying and categorizing students with a clinical diagnosis of OCD.

The purpose of the present investigation was to conduct descriptive research with school psychologists in the state of Illinois first to determine how commonly childhood OCD is seen in educational settings and current patterns related to serving these students in school (e.g., 504, IDEA). Second, this study explored how students with a primary diagnosis of OCD served under IDEA are identified and categorized as well as school psychologists' opinions of these practices. Finally, the types of educational placements in which these students receive instruction were examined. To that end, the following research questions were posed:

1. What percentage of students evaluated or served by school psychologists have a primary diagnosis of OCD?

2. Among students with a primary diagnosis of OCD, how many are served via 504 plans, and how many are served under IDEA?
3. Among students with a primary diagnosis of OCD who are served under IDEA, what is the disability category (e.g., E/BD, OHI) under which they are most frequently classified, and under which disability category do school psychologists believe these students should be classified?
4. Among students with a primary diagnosis of OCD who are served under IDEA, in which educational settings are they placed (e.g., general education class, resource room)?

METHOD

Participants

To facilitate the selection of a suitable sample, a listing of the names and addresses of all school psychologists in the state of Illinois was acquired from the Illinois State Board of Education. From this list, a random sample of 400 names was chosen, using a computer-generated list of random numbers. Of the 400 individuals randomly selected, 123 school psychologists responded, for a response rate of 31%. Participants were recruited in accordance with the Institutional Review Board (IRB) from the first two authors' institution, which approved the study as exempt from the Code of Federal Regulations for the protection of human subjects. All respondents were entered into a drawing for three U.S. Savings Bonds.

Instrumentation

To gather data relevant to the stated research questions, a survey was constructed that asked respondents to provide (1) numerical responses, e.g., "How many students have you evaluated and/or provided services for (including such services as consulting) this school year?"; (2) categorical responses, e.g., "In your opinion, students with a primary diagnosis of OCD should be served under…" (respondents marked one of several categories provided); and (3) short verbal responses, e.g., "If you marked 'Strongly Disagree' or 'Disagree' above, please explain." For several items, respondents were asked to indicate the number of students with OCD who fit into each of three different severity categories. The severity levels were defined as follows:

Mild OCD: Slight interference with performance, but overall performance is not impaired

Moderate OCD: Definite interference with performance, but still manageable

Severe OCD: Substantial impairment in performance

These definitions were adapted from the Yale-Brown Obsessive-Compulsive Scale (Goodman, Price, Rasmussen, Mazure, Fleischman, Hill, et al., 1989), a scale that measures the severity of classic OCD symptoms.

Procedures

In April, 2003, a copy of the survey, two copies of the cover letter, and a self-addressed, stamped envelope were sent to the 400 randomly chosen school psychologists. Participants were asked to sign and return one copy of the cover letter along with the completed survey to indicate consent to participate in the study. Follow-up surveys were sent to those psychologists who did not respond after the initial mailing, and follow-up calls were made to individuals who did not respond to either mailing. Data were compiled and then analyzed using descriptive statistics.

RESULTS AND DISCUSSION

Research Question 1

The first research question addressed the percentage of students evaluated or served by school psychologists who had a primary diagnosis of OCD. Of the 12,685 students reported as being evaluated or served, 94 (0.7%) had a primary diagnosis of OCD. While this figure does not necessarily represent the incidence of primary OCD in the population of students at large, it is interesting to note that this statistic is identical to the one-year incidence rate suggested by the APA (0.7%) and relatively close to the 1%, one-year incidence rate established by Flament, Whitaker, Rapoport, Davies, Berg, Kalikow, et al. (1988). The results appear to confirm the assertion by Riddle (1998) that OCD is not a rare disorder among young people.

Research Question 2

Research question two addressed the percentage of students with a primary diagnosis of OCD served via 504 plans and the percentage served under IDEA. School psychologists reported that of the 94 students with a primary diagnosis of OCD, 12 (12.8%) received services under Section 504, 70 (74.5%) were served under IDEA, and the remaining 12 students (12.8%) were receiving no services. Acknowledging the role of OCD severity level, some respondents reported that when OCD symptoms were mild or well controlled by medication, no services or modifications were considered necessary.

As a point of interest, the relationship between OCD severity level and the type of services received (i.e., 504 or IDEA) also was examined using a chi-square test of independence. No significant relationship between severity level and the type of service received was found (χ^2 (2, N = 82) = 4.38, p = .11), and the effect size for this relationship was small (Cramer's V = .23, with a small observed tendency for children with more severe OCD to be served under IDEA rather than 504). It is important to note, however, that because the large majority of students with a primary diagnosis of OCD in the current study were reported as being served under IDEA, it appears that the typical impact of OCD on educational performance was deemed serious enough to warrant special education and related services.

Research Question 3

The first part of research question three addressed the disability category under which students with a primary diagnosis of OCD served under IDEA were classified. The category school psychologists most frequently reported was "E/BD" (51.4%), followed by "Other Health Impaired" (31.8%). The combination category "E/BD or OHI" was less likely to be reported (10.3%), with "Other" and various combination categories comprising only 6.5% of the responses. Thus, E/BD was the IDEA category under which the majority of students with a primary diagnosis of OCD were reported as being classified in the present study (see Table 1).

The second part of research question three was addressed by the survey item, "In your opinion, students with a primary diagnosis of OCD should be identified under the following IDEA category for the OCD…" (five categories were provided: Emotional/Behavioral Disorders, Learning Disabilities, Other Health Impaired, Other, or Need to create a new category under IDEA for these students). The obtained frequencies indicate that there was strong consistency between the category under which students with OCD were reported to be classified (Table 1) and school psychologists' opinions of the most appropriate IDEA category for these students (Table 2). A small percentage of psychologists believed that fewer students should be classified under E/BD than actually were. Nonetheless, 47.7% of school psycholo-

TABLE 1. *Frequency Distribution of Responses: Reported IDEA Disability Categories for Students with a Primary Diagnosis of OCD*

Category	Frequency	Percent
E/BD	55	51.4%
LD	0	0.0
OHI	34	31.8
Other	2	1.9
E/BD or OHI	11	10.3
LD and OHI	1	0.9
E/BD and LD	3	2.8
E/BD, OHI, and Other	1	0.9
Total	107	100.0

Note. E/BD=Emotional/Behavioral Disorder, LD = Learning Disability, OHI = Other Health Impaired

TABLE 2. *Frequency Distribution of Responses: Psychologists' Opinions of Appropriate IDEA Category for Students with a Primary Diagnosis of OCD*

Category	Frequency	Percent
E/BD	52	47.7%
LD	0	0.0
OHI	35	32.1
Other	2	1.8
New category needed	6	5.5
E/BD or OHI	12	11.0
E/BD, OHI, and Other	1	0.9
Other/new category needed	1	0.9
Total	109	100.0

Note. E/BD=Emotional/Behavioral Disorder, LD = Learning Disability, OHI = Other Health Impaired

gists selected E/BD as the most appropriate category for students with a primary diagnosis of OCD. Approximately 5.5% of the respondents reported that a new category is needed to classify students with OCD.

As a follow up to this question, respondents were asked to explain why they chose a particular IDEA category. Overall, two patterns emerged from an analysis of the school psychologists' comments. First, psychologists expressed considerable disagreement as to which IDEA category was the most appropriate for these students. Those who viewed OCD as a social/emotional or behavior disorder chose the E/BD category for OCD. Others, who perceived OCD as medical/clinical in nature, believed OHI was the best fit. In certain cases, psychologists referred to the IDEA category definition to classify OCD. For example, some chose OHI on the basis of the "limited attention" component of the definition, while others chose E/BD because of the "inappropriate types of feelings or behavior under normal circumstances" clause of the ED definition. Still others referred to the relationship between OCD and the DSM-IV-TR. Ambiguity

and uncertainty surrounding the appropriate IDEA classification for OCD also appeared in the remarks of several respondents who chose "E/BD or OHI." One of these psychologists stated, "I do not define it as an emotionally based disorder, and although it may be physiologically based, I have a hard time saying it is a health impairment..."

Overall, the results of the current study indicate that there is a clear lack of agreement among school psychologists with regard to the most appropriate school-based disability category for OCD. It may be that the students with a primary diagnosis of OCD in the present study represented a wide range of difficulties and comorbid disorders. Nonetheless, the psychologists' varied responses to questions concerning the categorization of students with OCD seem to suggest that current training and guidance for evaluating and classifying OCD are inadequate.

A second pattern inherent in psychologists' remarks regarding the most suitable educational category for OCD was concern regarding the stigma that may be associated with the ED label. A number of psychologists specifically alluded to the potentially negative impact of the ED label and parent preference for the OHI label. These results thus suggest that many of the problems that have been cited in the literature regarding educational practices for classifying and labeling students with mental health disorders also apply to students with the specific diagnosis of OCD.

Research Question 4

The final research question addressed the types of educational settings in which students with a primary diagnosis of OCD served under IDEA are placed. In one of the survey items, respondents were presented with a variety of educational placements and asked to indicate the number of students served within each of those settings. As is evident in Table 3, placements for students with OCD represent almost the full continuum of IDEA services. Of the 70 students served under IDEA, 47 (67.1%) were reported as receiving their instruction in less restrictive environments. More specifically, 10.0% were placed in full-time regular classrooms only, 11.4% received instruction in the regular classroom and part-time special classes, and a sizeable percentage (45.7%) received instruction in the regular classroom with part-time resource assistance.

Approximately 29% of the students with a primary diagnosis of OCD served under IDEA were educated in more restrictive settings. Of these students, 4.3%, 7.2%, and 5.7% were placed in LD, ED, and E/BD self-contained classrooms, respectively. An additional 11.4% received instruction in special day schools, and no students were placed in residential settings. Because there was only one residential school in the state of Illinois known to treat students with OCD at the time the survey was administered, this finding was not unexpected. As indicated in Table 3, 4.3% of students were reported as being served in placements designated as "Other."

The results of this study indicate that the large majority of students with a primary diagnosis of OCD served under IDEA received instruction in regular classrooms, alone or in combination with resource services or part-time special classes. Hence, it appears that the IDEA provision of the least restrictive environment was a guiding principle in decisions related to educational placements for students with OCD.

Study Limitations and Future Directions

A limitation of this investigation was that the results were based upon school psychologists' reports of students on their caseloads who had a primary diagnosis of OCD. Formal clinical evaluations of the presence or absence of primary OCD among students using such standardized instruments as diagnostic

TABLE 3. *Frequency Distribution of Responses: Reported Educational Placements for Students with a Primary Diagnosis of OCD Served under IDEA*

Placement	Frequency	Percent
FT regular classroom	7	10.0%
Reg. class & PT resource rm	32	45.7
Reg. class & PT spec.class	8	11.4
(Total)	(47)	(67.1)
FT self-contained LD	3	4.3
FT self-contained ED	5	7.2
FT self-contained BD	0	0.0
FT self-contained E/BD	4	5.7
FT self-contained OHI	0	0.0
Special day school	8	11.4
Residential setting	0	0.0
(Total)	(20)	(28.6)
Other	3	4.3
Grand Total	70	100.0

Note. FT = Full time, PT = Part time, E/BD=Emotional/Behavioral Disorder, LD = Learning Disability, OHI = Other Health Impaired

interviews may have yielded different results. Also, due to the self-selection nature of the sample, it is possible that school psychologists with a greater number of students with OCD on their caseloads were more likely to respond (although the majority of respondents reported having no students with OCD on their current caseloads). Future research could expand upon the results of the present study by obtaining data from a national sample of school psychologists. Future studies also might collect data on students who have OCD as either a primary or secondary diagnosis (only students with a primary diagnosis of OCD were included in the present investigation). It is important to note that, as the first of its kind to be conducted, this study is exploratory in nature. Additional research is necessary not only to confirm or refute the findings of this investigation, but also to gather information in such areas as actual services provided to students with OCD.

CONCLUSIONS/IMPLICATIONS FOR SCHOOL PSYCHOLOGISTS

The results of this study strongly suggest that the difficulties encountered in current educational practices for classifying and serving students with OCD mirror those associated with classifying and serving students with mental disorders, in general. The traditional educational evaluation process requires the identification of a particular categorical diagnosis for students with OCD – a process that is characterized by ambiguity and lack of agreement. Additionally, concerns exist regarding the stigma of the ED label for children and adolescents with OCD. Furthermore, because comorbidity among students with OCD is very common, these students require many different levels of support.

Although evidence from the present study as well as the existing OCD literature provide support for identifying students with OCD under the IDEA category of OHI (e.g., Adams, 2004), an alternative approach might better ensure that these students receive appropriate services. More specifically, the time

currently spent evaluating students with OCD to meet traditional legal requirements for proper educational identification and categorization might be used more effectively to implement evaluation procedures to identify successful services and interventions for these students. Once such interventions are implemented, a heavy emphasis should be placed upon careful monitoring of service effectiveness over time to promote the most positive outcomes possible. Such procedures are beginning to be put into practice for students with learning disabilities as a result of the Response-to-Intervention (RtI) focus within IDEA 2004. A related non-categorical model for service delivery has been developed and implemented in Iowa over the past decade, in which educational services for students with social-emotional problems are provided through a Response-to-Intervention framework within the school setting (see Grimes & Kurns, 2003). Similarly, Gresham (2005) supports RtI as an alternative method for identifying students as having an emotional disturbance, stating that the RtI method is in direct contrast to current practice, which is based on a "refer-test-place model in which students are not exposed to systematic, evidence-based interventions to ameliorate behavior problems" (Gresham, p. 341).

Application of a three-tier RtI model might encourage school systems to conduct universal screening for emotional and behavioral difficulties and implement intervention strategies that show promise for alleviating learning and behavior problems students with OCD frequently experience. Screening tools for detecting emotional and behavioral disorders are available but very infrequently used in school settings (Forness, Serna, Nielsen, Lambros, Hale, & Kavale, 2000). Prevention techniques such as teaching all students strategies for coping with anxiety (Merrell, 2001) and creating a positive and calm classroom environment (Lehr & Christiansen, 2002) might be incorporated as part of a first tier level of service provided to all students.

At the second tier, students with OCD whose symptoms interfere with learning and/or behavior could be brought to the attention of a school psychologist. The psychologist might conduct further assessment and collaborate with families and professionals outside the school to implement such empirically based interventions as teaching more advanced coping strategies, cognitive-behavioral therapy (Freeman et al., 2007), and/or pharmacotherapy treatment (Franklin, March, & Garcia, 2007). A psychologist in a clinical rather than educational setting may play the major role in implementing certain interventions for OCD (e.g., pharmacotherapy). Educational professionals, however, are instrumental in supporting and monitoring the effects of clinical interventions. If these strategies prove ineffective or are highly resource intensive (e.g., additional funding is needed to ensure that the student receives ongoing services to facilitate appropriate progress), an evaluation might be conducted to determine whether the student qualifies for special education services. The evaluation process might be part of a third tier of support provided to students with substantial needs. This evaluation may involve the implementation of intervention strategies that are very resource intensive (e.g., frequent therapy sessions, comprehensive behavior intervention plan) to identify the conditions under which the student is successful. If it is determined that the student requires such intervention strategies in order to make sufficient progress, he or she eventually may be provided those strategies on an ongoing basis using funding available through special education. Monitoring of progress over time would be essential to verify the efficacy of these interventions.

Within the three-tiered RtI model described above, interventions that are effective for a given individual are identified via the evaluation process, placing the focus on instructional needs rather than disability categorization (Grimes and Kurns, 2003). Instead of having to fit a particular disability category, a student may receive special education services based on the conditions under which he or she was found to be successful.

Although the RtI school psychology service delivery model for students with or at-risk for OCD

may be ideal for some school systems, others may not be capable of facilitating such change in the near future. Therefore, traditional categorical service delivery models may continue in many locations. The clear lack of agreement among school psychologists regarding an appropriate category for students with OCD observed in the present study suggests that there is a need for training and guidance with regard to evaluating and classifying OCD. Such training would help ensure that services provided through categorical service delivery models are tailored to meet individual student needs. By acquiring a basic understanding of conditions that may affect the learning and behavior of students with OCD, school psychologists would be in a position to inform the IEP team about services and settings that would lead to student success.

To ensure that students with OCD receive appropriate services, the potential consequences of categorical diagnoses must be considered carefully. For example, a student with OCD may need substantial structure to avoid being overwhelmed by his or her thoughts and corresponding rituals. Such structure initially might be considered as being most easily facilitated in a self-contained setting. However, other students in that type of setting may engage in behaviors (e.g., teasing, joking) that have the potential to exacerbate the student's obsessions and compulsions. Additionally, care should be taken to place students with OCD in a setting that optimizes access to services that address their needs. Within the evaluation process, consideration should be given to the students' specific educational needs and how those can best be met within the existing categorical service delivery system.

In conclusion, the best treatment options and services for students with OCD might result when school psychologists, clinical psychologists, teachers, parents, and the students collaborate in the development of intervention and monitoring plans that can be carried out in clinical, home, and school settings. Additionally, these plans should be informed by research on effective services for students with OCD. To that end, the following recommendations for best practice with regard to OCD interventions are proposed:

(1) Focus on implementing preventative interventions prior to considering 504 or IDEA eligibility, which should include a heavy emphasis on educating teachers, psychologists, and other school personnel about OCD. Such strategies as teaching all students techniques for coping with anxiety, holding clear classroom structure and expectations, and creating a generally calm classroom climate may prevent OCD from inhibiting a student's learning in school (Paige, 2004);
(2) Collaborate with clinical psychologists, parents, teachers and students to design and implement interventions that are aligned across the settings in which a child is engaged;
(3) Collaborate with clinical psychologists to find and implement interventions with empirical support such as cognitive behavior therapy (Freeman et al., 2007) and pharmacotherapy, including selective serotonin reuptake inhibitors (Franklin et al., 2007), to address behaviors that interfere with academic achievement and/or social functioning;
(4) Emphasize program content and relevant goals, i.e., focus on identifying measurable, relevant goals; and
(5) Emphasize progress monitoring and evaluation of student outcomes, which may include assistance with monitoring a student's response to medication (Volpe, Heick, & Guerasko-Moore, 2005).

School psychologists can play a vital role in creating, implementing, and monitoring school-based interventions for children and adolescents with OCD that ultimately will promote mental health and learning outcomes for these students.

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