CHAPTER 1

Clinical Presentation and Comorbidity

CLINICAL DESCRIPTION/PHENOMENOLOGY

With a lifetime prevalence of 2–3%,OCD affects a significant number of children and adolescents, persists without effective treatment, and is associated with costly adult disability (e.g., Zohar, 2012). OCD is typically diagnosed in childhood or adolescence and proves to be impairing in family, social, and academic settings (Palermo et al., 2011; Piacentini, Bergman, Keller, & McCracken, 2003). According to DSM-5 (American Psychiatric Association, 2013), OCD is characterized by the presence of obsessions or compulsions, or both, although clinically it has been our experience that it is very rare to encounter patients with obsessions without compulsions. *Obsessions* are recurrent and intrusive thoughts, images, or impulses that cause elevated anxiety or distress (children may feel most comfortable calling them worries). These thoughts induce anxiety, discomfort, or distress regarding unlikely consequences (e.g., contracting a disease, hurting someone) and are not simply typical worries about real-life problems (e.g., friends, school). Common obsessions in children and teens include fear of contamination or disgust, fear of harm coming to oneself or others (often family or familiar people), aggressive sexual and religious themes (or "bad thoughts"), a need for symmetry or exactness, or a vague feeling of being "not just right" or incomplete. Although most obsessions can be grouped within these categories, the actual content of the specific obsessions is heterogeneous.

Compulsions (or rituals) are repetitive behaviors (e.g., reassurance seeking, checking, handwashing) or mental acts (e.g., praying, counting) that serve the purpose of reducing or controlling the anxiety associated with an obsessional thought or "not just right" feeling. Rituals

are aimed at preventing a feared outcome and/or neutralizing worry/discomfort and tend to be excessive. In OCD, rituals are performed intentionally and are goal-driven, but they also tend to be senseless (i.e., they defy conventional logic and are unwarranted). Common rituals include washing/cleaning, repeating, checking, touching/tapping, counting, ordering/arranging, hoarding, praying, and reassurance seeking/confessing. For example, children with obsessions about germs may wash their hand(s) for 20 minutes after touching a doorknob. However, other children might also lick their hands to get rid of germs, or they may feel fine about touching the doorknob as long as they don't have to touch their parents whom they are fearful of harming. (*Note:* This is why understanding the function of a child's fear is important; see below.)

Along with rituals, avoidance behavior is observed in OCD and serves the same purpose as compulsions. Youth with OCD engage in avoidance to prevent exposure to stimuli, places, or events that might induce obsessional thoughts and ritualizing. Additionally, children and teens may engage in avoidance behavior to avoid the compulsion to engage in time-consuming, uncomfortable, and/or embarrassing rituals. For example, someone with contamination obsessions may stay away from specific places and people in order to avoid having to perform her rituals. A child or teen may avoid brushing his teeth or showering to avoid getting stuck doing rituals. This kind of behavior can be confusing for parents who expect that a child with "OCD" would stay "clean" or "well groomed."

Young children with OCD may have a different pattern of symptom expression than adolescents and adults with OCD (Garcia et al., 2009; Geller, Biederman, Griffin, & Jones, 1996; Geller et al., 1998). In young children, compulsions without obsessions are common, as are sensory-related compulsions, such as tapping or touching until the child perceives that they feel "just right" (Rosario-Campos et al., 2001). In addition, compulsions in young children often involve another family member (e.g., reassurance seeking or verbal checking) (Rettew, Swedo, Leonard, Lenane, & Rapoport, 1992). These differences in symptom expression between young children and adolescents/adults may be largely due to developmental factors: for example, limitations in cognitive ability may be one reason why obsessions are endorsed less frequently and are less well articulated when present in young children. Young children may not be able to differentiate their obsessions from more normative thoughts or identify the connection between their obsessions and subsequent compulsions and express that connection to others. Young children also have greater dependence on their family for guidance and direction, which may be why many of their rituals involve other family members.

CORE OBSESSION THEMES

Though topographically distinct, research has shown that obsessions can be categorized within a few "core obsession themes" or core dimensions. These core dimensions are recognized as the motivations underlying an individual's OCD and have great importance in determining the functional relationship between obsessions and compulsions (Conelea, Freeman, & Garcia, 2012). While research suggests the existence of multiple specific core dimensions (e.g., disgust, guilt), *harm avoidance* and *incompleteness* are recognized as the two that are characteristic of most obsessions. Despite the heterogeneity associated with OCD, studies with clinical samples have shown that almost all of the participants endorsed feelings of either harm avoidance or incompleteness (Storch, Larson, et al., 2010). Understanding these two core dimensions provides insight on the functional relationship between obsessions and compulsions and proves to be beneficial in treatment settings.

Harm avoidance refers to symptoms that function to prevent injury or damage to oneself or others. Obsession content involves feared consequences, catastrophic interpretations, sensitivity to threat, and/or an inflated sense of responsibility for preventing harm. Compulsions associated with harm avoidance function to reduce the probability that a feared consequence will occur. Feared consequences are typically specific and easily articulated (e.g., "I will get sick"), although young children may describe harm in vaguer terms (e.g., "Something bad will happen").

Incompleteness refers to symptoms that are not associated with a specific threat but rather with "an inner sense of imperfection, connected with the perception that actions or intentions have been incompletely achieved" (Summerfeldt, 2004, p. 1156). Roughly synonymous terms in the literature include "not-just-right experiences" (Leckman, Walker, Goodman, Pauls, & Cohen, 1994), "feeling of knowing" (Rapoport, 1991), and "sensory phenomena" (Miguel et al., 2000). Obsessional content is difficult for patients to verbalize, but it typically involves a drive or sensory urge to repeat or continue a ritual until the action or perception feels "complete," "right," or "perfect." Distress is often described as the only feared consequence of ritual prevention. Associated compulsions function to achieve a sensation of completion or perfectionism. This includes sensory issues often exhibited in younger children.

ETIOLOGY

As described by Rosenberg, Russell, and Fougere (2005), a wide variety of biological findings implicating neuroanatomy, neurochemistry, and

neurocircuitry in OCD have been discovered, and collectively they suggest that specific brain regions and processes are implicated in OCD psychopathology. There is little controversy at this point that the brain is implicated in OCD; few psychopathological or even normative experiences or conditions would be thought to avoid brain-based neurobiological substrates entirely. What remains controversial about biological models is whether these collective observations are causes or consequences of OCD or entirely epiphenomenal. Psychological accounts of OCD's onset have also been proposed (for a review, see Shafran, 2005), and the integration of biological and psychological accounts has yet to provide any definitive information. Indeed, as these authors and others (e.g., Rasmussen & Eisen, 1992) have pointed out, the heterogeneity of OCD's presentation could obscure some of these pathways in that the flexibility of diagnosis itself in terms of symptom presentation may pave the way for multiple etiologies that do not map closely to the diagnostic entity currently known as OCD. Other ways to categorize OCD, such as by whether the symptoms are driven by harm avoidance or incompleteness, could be useful in generating a new set of biological hypotheses and studies that could allow for greater precision and convergence between OCD symptoms and underlying neurobiology. More research needs to be conducted to improve our understanding of OCD symptom presentation, neurobiology, and treatment response, which will lead to improvements in our understanding of each domain. In the meantime, however, there are patients to care for, and we must move forward with imperfect knowledge of etiology and instead focus on those maintaining factors that lie at the heart of CBT for pediatric OCD.

In our experience, families often ask about the origins of OCD at the beginning of the evaluation and treatment process. It is likely that these questions emerge early on because families have yet to participate in a comprehensive discussion of OCD and its treatment, and they continue to believe that knowledge of these etiological biological and psychological origins will dictate treatment decisions. Indeed, the increased recognition of the role of neurobiology in OCD has even reached popular literature, and accordingly many of our prospective families inquire about the "chemical imbalance" that they have heard might underlie the disorder. The etiology of OCD and the associated neurocircuitry, however, is far from definitive, with several neuroanatomical, neurochemical, and psychological theories proposed. That said, the neurobiology of the obsessional process and changes in glucose metabolism in implicated brain regions following CBT have been observed (e.g., Baxter et al., 1992). At the same time and as discussed below, the factors associated with OCD's etiology may or may not be the factors associated with its maintenance. Moreover, it is highly unlikely that a single cause,

biological or otherwise, will ever be found for a disorder as complex and heterogeneous as pediatric OCD.

In discussing these complex brain–behavior relationships and learning-based approaches to understanding the functional relationship between obsessions and compulsions, we usually begin by invoking Mowrer's two-factor theory (1939, 1960), which posits that intrusive, spontaneous, and involuntary obsessions give rise to anxiety and that compulsions are executed responses designed specifically to reduce it (see more about theory below). Thus, in order to connect this learning-based theory to the neurobiological evidence base, we cast the obsessions in OCD as unwanted, neurobiologically mediated events associated with negative affect or discomfort. However, completion of the compulsions can and, indeed, according to two-factor theory, should be considered to be semivolitional in that they are intentional responses that function to reduce obsessional distress or unpleasant emotional discomfort. Accordingly, exposure to situations that provoke obsessions or discomfort without engaging in compulsions to reduce that urge will eliminate the negative reinforcing effects of the intentional compulsive behavior and thus will eventually reduce the frequency and intensity of these thoughts or sensations.

Habituation to urges to engage in compulsions appears to develop over time, and subsequent reductions in the frequency and intensity of obsessions and urges to ritualize are consistently observed (Himle & Franklin, 2009). Medical metaphors may also help convey these relationships to patients and families, and the clinician may even inquire about whether the patient knows anyone with diabetes, for example. Usually, the patient and family can identify someone suffering from this condition, which then allows for a discussion of how, in the case of type I diabetes, the etiology is clearly biological—a pancreas that is not functioning to create insulin as it should, essentially. The course of the condition can clearly be influenced by changing certain behaviors such as improving diet and exercise, keeping track of symptoms, and following doctors' recommendations regarding medication and behavioral change strategies. We then weave that information back into a more detailed discussion of how this also applies in the case of OCD, which may allay initial concerns about not having a definitive etiology identified and specifically targeted. As H. L. Mencken once put it, "For every complex question there is a simple answer, and it is wrong."

With respect to the role of cognition in pediatric OCD, our clinical presentation and practice does include attention to OCD-relevant dysfunctional beliefs, but fundamentally it is our view that exposure provides the optimal context to change the mistaken beliefs of OCD. Thus, we emphasize this position throughout our work with patients

with OCD and in our discussions with patients and families about CBT and its rationale. As is explicated further in the chapter on presenting the rationale for treatment, efforts are made to "externalize" OCD and its fear messages and to encourage the patient to view OCD's threats as testable hypotheses rather than as facts. Such discussions are readily incorporated into exposures but can also precede exposures in order to set the stage for optimal outcomes.

A cogent discussion of theory also helps clinicians address the tendency for family members to blame one another, or perhaps even themselves, for the presence of OCD. Helping families to frame OCD in the proper neurobiological and learning context can help allay these concerns and is the very first step necessary to orient everyone in the process to focus on fighting against OCD instead of each other. In framing OCD in this manner, the clinician should describe and indeed embrace the neurobiological, cognitive, and behavioral literatures and synthesize these perspectives for patients. By doing so, clinicians also help dispel another inaccurate notion, which is that OCD is either biological or psychological, as if these levels of analysis are mutually exclusive. This position is perhaps best captured in the theory of mind–body dualism proposed by Descartes and other philosophers, who were, understandably, struggling to understand these complex relationships without access to the technology needed to examine them properly. When it comes to biology versus behavior, there is no either/or here: the brain is clearly implicated; emotion and its regulation is at the heart of the patient's efforts to reduce unwanted thoughts by engaging in compulsions; cognition may well play a key role; and behavior, especially avoidance behavior, matters. Each of these variables clearly interacts, and there is a role for various theoretical accounts to explain scientific observations at multiple levels of analysis. The clinician should be above guild issues and should instead integrate the various scientific literatures to promote patient understanding and treatment buy-in, since the road to follow next is almost always an arduous one.

As described earlier, the factors associated with OCD's etiology are complex, have yet to be pinned down definitively, and, most importantly, may or may not be the factors associated with symptom maintenance. CBT is decidedly a treatment that focuses on maintenance factors, and accordingly in our work we strongly emphasize these maintaining factors in our discussion with families. The most important ones to discuss are negative reinforcement and accommodation. Patients experience negative reinforcement when they engage in compulsions (they often report that the fear and discomfort they experience is relieved at least somewhat in the moment by performing compulsions), but the consequence of that experience of relief is a strengthening of the association

between compulsion and obsession. Accommodation, which we discuss in detail throughout the manual, is defined as efforts made by the patient and often by the family as well to avoid OCD triggers and keep the patient from becoming upset or stuck. These efforts, though logical and seemingly helpful in the presence of a distressed child who is functioning poorly, serve the same affective function as compulsions, and thus they trade off improvements in current functioning against confronting and ultimately mastering OCD. Accordingly, CBT therapists will discuss these etiological factors but will quickly emphasize the maintaining factors that will be targeted in treatment.

DIFFERENTIAL DIAGNOSIS/COMORBIDITY—DISORDERS THAT LOOK LIKE OCD AND DISORDERS THAT CO-OCCUR WITH OCD

Careful clinical assessment is an important step prior to beginning any treatment program for youth with OCD. Prior to specific evaluation of a child's OCD symptoms, it is important to complete a thorough clinical assessment of functioning across multiple domains. This evaluation is crucial in determining that OCD is in fact the child's primary disorder and in recognizing comorbid diagnoses. Clinicians should first consider whether recurrent thoughts or repetitive behaviors are developmentally appropriate. Developmental rituals of childhood are normal at certain ages, and they may be performed in a stereotypic or rule-bound fashion, which can make it difficult to differentiate them from OCD rituals. Most children exhibit ritualistic or superstitious behaviors at some point during their development. These behaviors also tend to worsen during times of transition or stress (e.g., going to school, the birth of a sibling). OCD rituals are usually more dramatic, persistent, and distressing than developmentally typical rituals (Evans et al., 1997; Leonard et al., 1990). For example, children with developmentally typical rituals are much more likely to "give up" or "go along" with breaking a ritual when pressed, in contrast to a child with OCD who is much less likely to give up without protest and more significant distress. However, it is not always easy to differentiate the two kinds of rituals, and sometimes normal ritualistic behavior can worsen over time and become more like OCD.

With regard to differential diagnosis, several other childhood disorders include obsessional features and compulsive behaviors. Stereotypies in youth with developmental delays including autistic spectrum disorders may resemble OCD rituals in that stereotypies are repetitive formalized behaviors. However, stereotypies are usually simple, do not appear to be preceded by an obsession, and are not egodystonic. The frequent

association of OCD and tic disorders (Holzer et al., 1994; Leckman et al., 1994) requires that rituals and tics be distinguished because each requires different treatments. Although motor tics can be preceded by a sensation or an "urge," they are typically not initiated by a thought or accompanied by anxiety (Leckman, Walker, & Cohen, 1993). The high rates of comorbidity between OCD and tic disorder further complicates this differential, as a given patient may exhibit both compulsions and tics. The prompt for those repetitive behaviors (thought vs. urge) will help clinicians to differentiate one from the other and to implement the proper behavioral interventions for each. Obsessions and rituals can also be seen in depressive and other anxiety disorders, eating disorders, body dysmorphia, and the various impulse-control disorders. Finally, if the obsessions or compulsions are particularly bizarre and are seen by the patient as reasonable, a diagnosis of psychosis may be considered (although such a diagnosis is extremely rare in children).

The creation of the "obsessive–compulsive and related disorders" (OCRD) classification in DSM-5 adds greater complexity to the task of differential diagnosis. These disorders, grouped on the basis of their topographically similar symptoms, include, in addition to OCD, body dysmorphic disorder (BDD), hoarding, excoriation, and trichotillomania and must be considered in terms of differential diagnosis as well as potential comorbidity. They are characterized by repetitive thoughts or behaviors that resemble the repetitive behaviors seen in those with OCD. However, the behaviors are not always performed in an attempt to combat anxiety-provoking internal or external cues as in OCD (Abramowitz & Jacoby, 2015). It is therefore important to identify the functional differences between OCD and the related disorders in this new class.

Excoriation and Trichotillomania

Excoriation is marked by recurrent skin picking, causing marks or lesions, and trichotillomania is characterized by recurrent hair pulling resulting in hair loss. Both disorders lead to distress and to the individual's attempts to stop engaging in the impulsive behavior (American Psychiatric Association, 2013). The disorders are similar to one another in that the impulsive behavior in both is preceded by an urge to engage in the behavior and is followed by a sense of relief or pleasure (Stanley, Bowers, Davis, & Taylor, 1992). The episodes of impulsive behavior often begin outside of the person's awareness and are performed to reduce physical discomfort rather than to prevent or avoid an undesirable outcome (Abramowitz & Jacoby, 2015). While these behaviors are similar to those in OCD in that they are difficult to stop, it is important

to draw a distinction between impulsive and compulsive behaviors. The impulsive behaviors seen in these two disorders can be described as pleasurable in that the behavior eliminates the physiological urge to pull or pick. Compulsive behaviors seen in OCD, however, are more often performed deliberately to respond to a feared outcome or sense of incompleteness (Summerfeldt, 2004).

Hoarding

Hoarding is characterized by excessively collecting items and/or difficulty discarding possessions to the point of distressing clutter (American Psychiatric Association, 2013). Hoarding was once viewed to be a symptom of OCD, but DSM-5 separated the two disorders. While hoarding behaviors are apparent in up to a third of patients with OCD, not all patients demonstrating hoarding behaviors meet the criteria for OCD (Wheaton, Abramowitz, Fabricant, Berman, & Franklin, 2011). This diagnostic distinction is further supported by the differences in symptom phenomenology. Unlike obsessional thoughts, the excessive desire to save and acquire possessions is typically egosyntonic and does not cause distress in those exhibiting the hoarding symptoms (Wheaton et al., 2011). The act of saving also does not provide the same respite from anxious thoughts, as compulsions do for those with OCD, and therefore the behaviors in the two disorders are functionally distinct (Abramowitz & Jacoby, 2015). Youth who engage in hoarding may be more likely to describe their belief that hoarding has a "magical" purpose or that objects may have feelings, which could be expected developmentally but manifest in keeping objects or items that others may well describe as useless.

Body Dysmorphic Disorder

BDD is marked by a preoccupation with perceived flaws in one's physical appearance and repeated behaviors in response to those perceptions (American Psychiatric Association, 2013). Much like obsessional anxiety in OCD, the recurring thoughts in BDD are egodystonic and cause marked distress. These thoughts are intrusive and obsessional by nature and often present for 3–8 hours a day (Phillips et al., 2010). BDD is both characteristically and functionally similar to OCD, as those with BDD often perform behaviors in direct response to their obsessive thoughts (e.g., checking the mirror for scars, wearing excessive makeup; Abramowitz & Jacoby, 2015). The distinction between the two disorders lies in the consequence of performing the ritual. Whereas individuals with OCD tend to experience a reduction in anxiety following their

ritual, those with BDD may find that their compulsive behavior maintains their anxiety (Phillips et al., 2010). In addition, it appears that people with BDD show generally poorer insight into their condition than those with OCD, which may also underlie relative differences between the two conditions in treatment outcome. Between-session noncompliance may well mediate poor insight as a moderator; that is, certainty about the veracity of the fear will lead to less effort to confront situations that are likely to provoke it.

Once the diagnosis of OCD is suspected and other differential diagnoses have been ruled out, it is not uncommon to observe significant comorbidity, even in younger children. Diagnoses that commonly occur with OCD include other anxiety disorders, tic disorders, disruptive behavior disorders (particularly attention-deficit/hyperactivity disorder [ADHD] and oppositional defiant disorder [ODD]), mood disorders (more often in older children and teens), and OCRDs. Research studies show that the task of differential diagnosis and establishing comorbid diagnoses is often accomplished via structured diagnostic interviews such as the Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS) and the Anxiety Disorders Interview Schedule (child version [ADIS-C] and parent version [ADIS-P]). However, in clinical practice, this is often not feasible (or necessary), and a thorough clinical interview is appropriate.

AN EMPHASIS ON FUNCTION OVER FORM: THE RELATIONSHIP BETWEEN OBSESSIONS AND COMPULSIONS

Successful treatment of OCD relies heavily on identifying and understanding the functional relationship between obsessive thoughts and compulsive behaviors. Compulsions observed in OCD are most often direct responses to obsessional anxiety or situations causing subjective distress and/or discomfort. OCD is heterogeneous, and therefore obsessional thought varies greatly depending on the interests and values of the individual (Abramowitz & Jacoby, 2015). When a patient with OCD experiences an intrusive thought, it becomes obsessive due to the interpretation and significance he or she imposes on it (O'Connor, 2002). A compulsion is then developed that aims to neutralize the anxiety and/or discomfort caused by the obsession. The behavior, whether observable or internal, is intended to reduce the anxiety associated with the idiosyncratic thought. The topography of compulsions may give insight into distress associated with the behavior; however, it is necessary to take contextual events into account when trying to understand the function of the behavior (Conelea et al., 2012).

Characterizing symptoms using the two core fear dimensions—harm avoidance or completeness—may give preliminary insight into how a patient's compulsions relate to her obsessions. For instance, two children who struggle with compulsive lock checking will neutralize for distinct reasons depending on the core fear dimension. The child with harm-avoidance obsessions will check the door to prevent some feared consequence (e.g., "I check to make sure an intruder doesn't enter"), whereas the child whose symptoms fall within incompleteness will check until he feels satisfied (e.g., "I check until it feels right").

Obsessions and compulsions do not exist independently. In the case of young children, sometimes obsessions will not be immediately apparent due to lack of insight or the shame of obsessive thoughts. It is also common to find children without obsessive thought who ritualize solely to minimize feelings of incompleteness (Walther, Josyula, Freeman, & Garcia, 2014). Despite this obstacle in identifying the source of anxiety, the function of the behaviors in those with OCD consistently serves to reduce obsessional anxiety (Walther et al., 2014).

THE IMPORTANCE OF IDENTIFYING THE CHILD'S CORE FEARS

One common pitfall for clinicians using ERP for OCD is having an inadequate understanding of the child's core fears. This task can be challenging, especially with younger children who may be unable to articulate their fears and/or the therapist may lack sufficient insight into their obsessions. From the start of the assessment and continuing into treatment, your goal should be to understand (and to help your patient and his or her family understand) the specific characteristics of OCD triggers and the feared consequences of not completing rituals. For example, children may avoid things that are perceived to be contaminated or "germy," but why? Do they fear getting sick themselves, or do they dread getting loved ones sick? If they get sick, do they fear they might die or experience an acute transient illness (headaches, sore throat, vomiting)? Or do fears of contamination have nothing to do with illness or death? Are the fears associated with a "not-just-right" or disgust feeling, or perhaps they signal a totally different type of feared outcome such as global warming or religious impurity. For a teen with scrupulosity obsessions, if she doesn't confess to her mother, does she fear only that Mom will be mad at her or that there is a chance she will go to hell for the offense? Or are these obsessions linked to what her peers will think of her or to whether she will get into the college of her choice? This task is not an easy one, and it is best thought of as an ongoing assessment process that will continue throughout the patient's care. The specific fears also may

be a blend of two or more of these themes. These crucial details will assist the therapist in developing a well-targeted fear hierarchy for ERP as treatment moves forward.

THE FUNCTIONAL ASSESSMENT

Structured interviews meant to characterize groups of symptoms may be flawed in that they often emphasize topographic features of behavior rather than the purpose behind the behavior (Summerfeldt, Kloosterman, Antony, & Swinson, 2014). The functional analysis helps to broadly assign behaviors to a diagnostic class, but it also guides treatment design by closely examining purpose. The aim of behavioral assessment is to gather contextual information about behaviors, understand how the context of the behavior is reinforcing, and integrate that knowledge into a treatment plan that is designed to alter that reinforcement. The analysis should work to find connections between internal events, observable environmental factors, and the target behaviors (O'Brien, Hayes, & Kaholokula, 2015).

Obsessions and compulsions are cyclical in that anxiety-provoking situations or thoughts trigger recurrent obsessions that the individual attempts to neutralize with ritualistic behaviors. If the anxiety is reduced after the individual engages in the behavior, he or she learns, through negative reinforcement, that the behavior will alleviate anxiety in the face of future feared situations (Himle & Franklin, 2009). By learning that the only way to reduce anxiety is through the performance of rituals or avoidance, the individual never learns to tolerate his anxiety and therefore fails to habituate (Conelea et al., 2012).

The goal of the functional assessment is to identify not only the thoughts or situations that may be causing or maintaining anxiety, but also the elements that are reinforcing the behavior (O'Brien et al., 2015). While overt neutralizing behaviors in response to physical events are easily observed, some compulsions result from purely internal events (O'Connor, 2002). Particularly in pediatric OCD, some obsessions or internal events may be difficult to identify because of lack of insight. In these cases, the therapist may have to use functional assessment to draw conclusions based on the likelihood and context of the behavior (Conelea & Freeman, 2015).

Given the fact that behaviors may vary across contexts, it is important to gather not only topographical information, but also information regarding the intensity of anxious feelings in the presence of different environmental events. Observing the varying frequency and duration of behaviors across contexts will help inform the conceptualization of the

functional relationship between the obsession and compulsion (O'Brien et al., 2015). For instance, a child who obsessively checks to make sure his pens are perfectly aligned may not experience the same anxiety if a classmate's pens are crooked on her desk. In this case, the obsession and subsequent compulsion are specific to his personal space, and therefore treatment would aim to closely mimic this particular experience.

Behaviors that seem similar on the surface may serve different functions depending on the nature of the obsession. The contextual information that is gathered about those behaviors will allow for more specific targets during treatment. For instance, two children with harm-avoidance obsessions may avoid social interaction, but one child may be responding to contamination obsessions (a fear that interacting with peers will lead to getting sick), whereas the other may be responding to sexually aggressive obsessions (a fear that he is a sexual perpetrator and may harm his peers). The nature of the obsession will help the therapist design an appropriate exposure treatment plan. All behaviors are related and reinforced by interacting environmental factors; treatment will focus on manipulating those factors to produce change (Miltenberger, 2008).

In general, detailed knowledge of OCD's presentation in a particular child provides a solid foundation on which a case formulation and a treatment plan can be developed. It cannot be emphasized strongly enough to therapists how important it is to develop expertise in how OCD symptoms relate to each other and to push beyond form and toward function. In our climbing metaphor, detailed knowledge of a mountain's topography, terrain, weather patterns, and prior challenges sets the stage for determining how a given climber will likely fare on the same climb under similar and different circumstances. It is also important to determine if a climber will be ready for the journey: a thorough review for comorbid psychiatric disorders may well reveal a constellation of symptoms that may make the effort to conquer OCD even more daunting. Therapists would be wise to flag such conditions when they can be uncovered. For example, patients who are so severely depressed that it would be difficult to motivate them to engage in a challenging, action-oriented treatment such as CBT for OCD should perhaps have the other symptoms targeted first, just as a climber with a persistent pulmonary infection should have that issue attended to prior to initiating an ambitious hike across rough terrain.

Guilford Publications
370 Seventh Avenue
New York, NY 10001
212-431-9800
800-365-7006
www.guilford.com