

Assessment and Treatment of Aggressive, Sexual, and Religious Symptoms in Pediatric Obsessive-Compulsive Disorder

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Abstract

Intrusive aggressive, sexual, and religious symptoms are common in pediatric obsessive-compulsive disorder (OCD) and may cause significant impairment and distress. However, practitioners may not accurately identify these symptoms as OCD due to limited awareness of the ways OCD symptoms present themselves. Further, development of appropriate treatment strategies may prove challenging depending on a clinician's experience with these content domains, as there is a paucity of literature that guides clinicians on how to approach these symptoms when treating youth. The present article provides recommendations to address these taboo symptoms effectively based on current literature and clinical experience. Recommendations for assessment and treatment of these symptoms are provided.

Keywords:

Obsessive-compulsive disorder, Taboo obsessions, Children, Treatment, Scrupulosity

Target Audience:

Psychologists

Program Level:

Intermediate

Learning Objectives

1. To increase clinicians' awareness of aggressive, sexual, and religious symptoms in pediatric obsessive-compulsive disorder (OCD)
2. To facilitate accurate assessment of taboo symptoms in pediatric OCD
3. To provide recommendations to effectively treat taboo symptoms in pediatric OCD

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is a common and distressing disorder characterized by obsessions and/or compulsive behaviors. Obsessions are intrusive thoughts, images, or impulses associated with significant anxiety or distress, and compulsions are behaviors or mental acts that a person with OCD performs to reduce anxiety. Approximately 1-2% of youth are estimated to be affected by pediatric OCD (Maina, Giuseppe, Bogetto, & Ravizza, 1999; Rapoport et al., 2000; Zohar, 1999), with even more children potentially going undetected or misdiagnosed (Heyman, Fombonne, Simmons, Ford, Meltzer, & Goodman, 2003) and/or experiencing subclinical symptoms (Douglass, Moffitt, Dar, McGee, & Silva, 1995). In youth, OCD is often associated with significant impairment academically, socially, and in the home (Piacentini, Bergman, Keller, & McCracken, 2003), as well as reduced quality of life (Lack et al., 2009). Accordingly, given the potential burden that pediatric OCD may present, it is important for clinicians to be knowledgeable of effective treatment strategies.

Cognitive-behavioral therapy (CBT) with exposure and response prevention (ERP) is commonly recognized as the most effective psychosocial treatment for adults (Foa et al., 2005) and youth with OCD (see Freeman et al., 2014 for a review). Treatment recognizes that behavioral models of OCD focus on principles of learning related to Mowrer's (1960) two-factor theory of the acquisition and maintenance of fear and the process of negative reinforcement. Specifically, a neutral stimulus elicits anxiety-provoking thoughts and distress, and the individual engages in compulsions or avoidance in an effort to reduce his or her anxiety. Thus, through the cycle of negative reinforcement, the individual learns to rely on compulsions or avoidant behaviors to decrease anxiety when confronted with similar stimuli (Abramowitz, Taylor, & McKay, 2007). Exposure and response prevention treatment is therefore based on these principles of learning. A hierarchy of potential exposures (i.e., situations that elicit anxiety) is collaboratively created by the therapist and patient and organized based on the level of anxiety associated with each exposure. Exposures are then completed in a gradual manner from

those that are least threatening to most anxiety-provoking, and the patient is encouraged to resist engaging in compulsive behaviors in response. Over time, the individual with OCD learns that his or her distress will decrease on its own, through a process called habituation, without engaging in compulsive behaviors. The process of ERP requires the patient to remain in contact with the feared stimulus until the anxiety diminishes. This process weakens the connection between the feared stimulus and the anxiety reaction.

Despite the evidence that supports the use of ERP, the literature does not fully address the intricacies of implementing effective ERP in pediatric OCD, particularly when the nature of symptoms includes more taboo themes such as aggressive, sexual, or religious/blasphemous content. These types of symptoms tend to be particularly aversive and ego-dystonic for the affected individual (Abramowitz, Franklin, Schwartz, & Furr, 2003). Nevertheless, such symptoms are commonplace in pediatric OCD, with studies showing a significant number of youth exhibiting such symptoms (e.g., Geller et al., 2001; Masi, Millepiedi, Mucci, Bertini, Milantoni, & Arcangeli, 2005). Patient access to effective treatment is also limited by the availability of trained therapists (see Larson, Storch, Lewin, Geffken, Murphy, & Goodman, 2005 and Freeman et al., 2014 for reviews). Additionally, these particular symptoms may not be identified accurately as OCD due to practitioners' limited awareness of OCD symptom presentations. For instance, Glazier, Calixte, Rothschild, and Pinto (2013) assessed mental health professionals' abilities to identify taboo thoughts as manifestations of OCD versus non-OCD, based on vignettes of common symptoms. Rates of incorrect identification were significantly higher for vignettes including sexual, aggressive, and religious content, compared to the contamination symptoms vignette. Karadag et al. (2006) found that patients with religious and sexual obsessions were not diagnosed as having OCD for over seven years since disorder onset, despite having visited several health care settings. A misdiagnosis of OCD may result in a number of negative outcomes including improper case conceptualization, inappropriate treatment, or erroneous reporting with the potential for serious consequences. An individual who seeks treatment for obsessions about homosexuality may be inaccurately considered to be struggling with sexual identity, rather than OCD. Intrusive thoughts of

self-harm or harm-to-others might be incorrectly perceived as suicidal or homicidal ideation, resulting in hospitalization that might serve to reinforce the child's perception that s/he is dangerous. Clinicians might erroneously assume that a child with intrusive sexual thoughts has been abused, leading to excessive interrogation. In the case of child molestation and pedophilia, clinicians unaware of the presence of intrusive sexual thoughts as OCD may report individuals to authorities out of concern that they might harm a child (Glazier et al., 2013). This highlights the need for greater training of these content domains in OCD. Accordingly, the present article provides recommendations to address these taboo symptoms, based on current literature and clinical experience.

Commonality of Aggressive, Sexual, and Religious Themes in Pediatric OCD

Increasing research examines symptom dimensions in pediatric OCD, with studies generally showing a high frequency of "taboo" symptom content and therefore conveying the commonality of such symptoms. Most of this literature stems from factor analytic studies of OCD that indicate that aggressive, sexual, and religious obsessions commonly occur together in adults (Bloch, Landeros-Weisenberger, Rosario, Pittenger, & Leckman, 2008) and children and adolescents with OCD (Delorme et al., 2006; Masi et al., 2005; Mataix-Cols, Nakatani, Micali, & Heyman, 2008; McKay, Piacentini, Greisberg, Graae, Jaffer, & Miller, 2006; Stewart et al., 2007; Stewart et al., 2008; Storch et al., 2008). In an attempt to summarize the prevalence of such symptoms, Geller et al. (1998) reviews studies examining OCD symptoms in children and adolescents, and he indicates that studies reported prevalence rates of 12.5-81% for concerns about causing/receiving harm to the self or loved ones, 4-27% for sexual concerns, and 4.2-29% for religious concerns. In more recent studies on children and adolescents with OCD, rates have ranged from 32.6%-75% for aggressive symptoms, 11%-36% for sexual symptoms, and 4.6%-38% for religious symptoms (Delorme et al., 2006; Geller et al., 2001; Stewart et al., 2007; Stewart et al., 2008; Storch et al., 2008). Geller et al. (2001) found that adolescents evidenced significantly higher rates of sexual and religious preoccupations than children, with Geller et al. (2001) noting that this occurrence may follow themes and conflicts appropriate to developmental stages. Notably, the occurrence

of such symptoms in pediatric OCD may also be somewhat higher than published studies report given child secrecy in reporting embarrassing obsessive thoughts and compulsive behaviors, particularly those involving aggressive, sexual, and religious themes (Storch, Bjorgvinsson, Riemann, Lewin, Morales, & Murphy, 2010). Accordingly, the regularity with which these symptoms occur warrants efforts to facilitate treatment for such symptoms. Further, such symptoms may be particularly distressing, with some studies showing that youth with these symptoms exhibit greater severity and impairment. For instance, Storch et al. (2010) found greater impairment in youth with aggressive/checking symptoms when compared to other symptoms. Similar findings have been reported in adults, in that patients with aggressive and unacceptable obsessions were found to exhibit the greatest symptom severity when compared to individuals with contamination, symmetry, or hoarding obsessions (Abramowitz et al., 2003), and the authors suggest that such symptoms may be particularly distressing, interfering, and difficult to challenge.

Recommendations for Assessment

Effective CBT with ERP in youth must be preceded by a thorough assessment of obsessive content and compulsive behaviors, which may be particularly challenging when symptom content involves forbidden themes. Youth with OCD may be hesitant to disclose their OCD symptoms due to embarrassment and/or concerns that others will judge them negatively. This occurs due to the often taboo content of obsessions and compulsions that may involve thoughts of engaging in violent or harmful behaviors, "forbidden" sexual activities, or immoral acts. Accordingly, these symptoms may be concealed by the child for fear of the reaction by parents/guardians, or even the therapist. Though exact prevalence rates of these types of intrusive thoughts in youth are unclear, the aforementioned studies along with clinical experience suggest that they occur frequently and are often associated with significant distress. Normalizing these thoughts can encourage youth to disclose these concerns. In Rachman and De Silva (1978), non-clinical adults identified experiencing a variety of intrusive thoughts and impulses

including thoughts of harm coming to a close friend or family member, thoughts of acts of violence in sex, thoughts of physically punishing a loved one, and thoughts that one might do something dramatic like rob a bank. These non-clinical adults also reported impulses to hurt or harm someone, to say something nasty or verbally attack someone, to jump in front of a train or bus, to be violent towards children, or to engage in aggressive sexual behaviors. This study demonstrated that even individuals without OCD experience taboo intrusive thoughts, yet the difference is suggested to be that those with OCD tend to place a heightened significance on these thoughts. Theories of OCD (Rachman, 1998; Salkovskis, 1999) indicate that although most people experience intrusive thoughts, people with OCD misappraise these thoughts to have catastrophic or unacceptable consequences (e.g., “my perverted thoughts mean I’m a pervert,” or “thoughts of harming people with sharp objects means I’m dangerous”), and thus they experience increased preoccupation with and difficulty controlling the thought (Schwartz & Abramowitz, 2003; Siev, Steketee, Fama, & Wilhelm, 2011). Rachman (1998) discusses that if a person perceives himself to be dangerous, he may view sharp objects as threatening and may determine that such objects are therefore best avoided. Such avoidance then leaves the person’s view of himself as dangerous to be unchallenged. Yet if the individual repetitively exposes himself to situations that increase the risk of the feared consequence coming true (e.g., being around sharp objects), then the individual’s belief will usually be weakened after repetitive exposures in which they obtain disconfirming evidence (e.g., they see that they do not act on the impulse). In Wheaton et al.’s (2010) study of treatment-seeking adults with OCD, unacceptable thoughts (comprised of religious, sexual, and violent obsessions along with neutralizing strategies) were predicted by beliefs about the importance of and need to control thoughts, emphasizing that those with taboo obsessions reported placing greater importance upon such thoughts along with a greater need to control such thoughts. In treating patients whose primary concerns are unacceptable aggressive, sexual, and/or religious obsessions, clinicians might therefore focus on identifying and correcting erroneous beliefs about the meaning of and need to control intrusive thoughts (Wheaton et al., 2010). Essentially, treatment aims to help the patient determine that obsessional thoughts are irrelevant and do not require further action (Salkovskis, 1999).

Accordingly, it is helpful to convey to patients that the goal of CBT with ERP is not the complete elimination of all intrusive thoughts, but instead to have patients learn to tolerate such thoughts without the associated distress and impairment. Once that occurs, patients often simultaneously report a reduction in the frequency of obsessions.

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To facilitate a thorough assessment, it can be helpful to describe themes commonly present in OCD. This can often be achieved by administration of the Children’s Yale-Brown Obsessive-Compulsive Scale (CY-BOCS; Scahill et al., 1997), which includes a comprehensive checklist. Before administration, it is helpful to let the youth know that you are going to go through a list of common obsessions and compulsions that many children experience, as this normalization will likely make youth more open to discussing symptoms. Other brief checklists, such as the Children’s Florida Obsessive Compulsive Inventory (C-FOCI; Storch et al., 2009) and the Obsessive-Compulsive Inventory – Child Version (OCI-CV; Foa, Coles, Huppert, Pasupuleti, Franklin, & March, 2010) include brief screener questions that assess the presence of these types of intrusive thoughts (e.g., death, horrible events, harm coming to a loved one). When possible, if the youth is still hesitant to disclose symptoms, it may be helpful for the clinician to provide examples of symptoms, with developmental context in mind (for example, asking youth if they have thoughts that involve themselves or other people getting hurt, whether they experience intrusive thoughts or images when they are around certain people, or whether they have any bothersome thoughts related to religion). Further, youth may benefit from spending some time individually with the therapist to discuss content they are hesitant to discuss in front of parents (e.g., sexual obsessions; Franklin, Dingfelder, Coogan, Garcia, Sapyta, & Freeman, 2013). In such situations, it is important for the parents and teens to be aware that assessment will be most effective if the teen can speak openly about symptoms without concerns about the symptoms being revealed to the parent(s), as long as there are no imminent safety concerns identified (Franklin et al., 2013).

Current Literature on Treatment of Aggressive, Sexual, and Religious Themes in Pediatric OCD

Literature on the treatment of aggressive, sexual, and religious themes in pediatric OCD is limited, with most guidance coming from case studies. Some literature discusses addressing forbidden thoughts in therapy (e.g., Purdon; 2004) with some work focusing specifically on aggressive obsessions (Cassano, Nangle, & Grady, 2009), sexual obsessions (O'Neil, Cather, Fishel, & Kafka, 2005), and religious/scrupulosity symptoms (Abramowitz, 2001; Ciarrocchi, 1995; Huppert & Siev, 2010; Huppert, Siev, & Kushner, 2007; Paradis, Cukor, & Friedman, 2006; Siev, Baer, & Minichiello, 2011). Storch et al. (2008) found that youth, aged 7-19, with primary aggressive/checking symptoms or sexual/religious symptoms at baseline responded positively to CBT. Essentially, results of that study showed that youth benefited positively from CBT regardless of symptom subtype. Cassano et al. (2009) found CBT with ERP to be effective for a 10-year-old boy with aggressive obsessions, with gains maintained 3 months post-treatment. More recently, de la Cruz et al. (2013) compared 50 youth with sexual obsessions to 103 youth without sexual obsessions treated with CBT at a specialty pediatric OCD clinic. Results demonstrated that both groups improved significantly after CBT, and the researchers found no significant differences between groups in terms of treatment outcome, which provides support for the use of CBT with youth who present with sexual obsessions. Some adult studies indicate that patients with aggressive, sexual, and/or religious obsessions may experience poorer response to CBT and pharmacotherapy compared to those with other primary symptoms (Alonso et al., 2001; Ferrao et al. 2006; Rufer, Fricke, Moritz, Kloss, & Hand, 2006; Mataix-Cols, Marks, Greist, Kobak, & Baer, 2002), yet other studies do not support such findings (Abramowitz et al., 2003; Fallon et al., 1990). Williams, Farris, Turkheimer et al. (2011) highlight that it is unclear why some studies have shown CBT to be less effective for taboo thoughts, indicating that this could be due to practitioners neglecting the associated compulsions or because these types of obsessions require more intense treatment. Or, it could be that clinicians are uncertain how best to proceed when faced with taboo obsessions in youth with OCD. Thus, the development of

treatment recommendations may be helpful in guiding clinicians on how to implement CBT with ERP with such symptoms in youth.

General Treatment Recommendations

To effectively engage in treatment, it is important to educate parents and patients about the CBT model of OCD so they understand the rationale for exposure tasks. Still, clinicians may find it challenging to identify appropriate, beneficial ERP tasks to address these symptoms while simultaneously being cognizant of developmental considerations and parental concerns about exposure tasks. Given these obstacles, many mental health professionals may shy away from using ERP for these symptoms, possibility due to their own discomfort with engagement in exposure tasks. In a survey of clinicians treating pediatric OCD, while cognitive-behavioral therapy was a preferred approach, only 1/3 of clinicians reported frequently using anxiety-provoking methods (e.g., ERP) in treatment (Valderhaug, Gotestam, Gunnar, & Larsson, 2004). Accordingly, a common dilemma facing clinicians is the process of choosing appropriate exposures to utilize in treatment. In many situations, this task may appear relatively easy; the exposure task would be eliciting the obsession and having the individual refrain from engaging in the associated compulsion. An example would be that a child with OCD may feel that he or she has to dress themselves in a ritualized manner (i.e., compulsion) or else something bad would happen to his or her family (i.e., obsession). In this case, the therapist might encourage the child to get dressed in a non-ritualized manner and wait until the anxiety about something bad happening dissipated via habituation. However, this task can prove more difficult depending on the content and nature of the person's symptoms. With intrusive thoughts of a sexual or violent nature, however, the child would clearly not be encouraged to act the feared scenario out in order to confront the fear. In OCD, obsessions tend to occur in the form of doubts or uncertainty about whether or not one will actually commit the act. Purdon (2004) discusses that a general rule of thumb is to expose patients to what they fear. This can be achieved by encouraging them to write out a narrative of the thought in as much

detail as possible, and then encouraging them to review this over and over again until they habituate to the thought. Similarly, this narrative could be audiotaped and then played over and over for the patient.

Treatment of Intrusive Aggressive Thoughts

Common aggressive thoughts in pediatric OCD include intrusive thoughts of harm to self, others, or animals, destroying objects, and thoughts of doing something harmful either accidentally or intentionally. Youth may also experience thoughts of unacceptable words (e.g., “hate”), thoughts or impulses to use profanity towards others, violent images, or thoughts of fantastical creatures harming them like monsters, zombies, and vampires. Often, these symptoms can be identified as they frequently manifest as “what if” thoughts (e.g., “what if I hit my mother” or “what if I stab someone”). Given these concerns, youth may engage in significant avoidant behavior, such as avoiding sharp objects (e.g., scissors, knives) or things that they view as dangerous, in an effort to decrease the likelihood or risk of engaging in those harmful acts. Accordingly, treatment would consist of decreasing avoidance and increasing contact with feared objects. Purdon (2004) describes that a patient afraid of acting impulsively should be exposed to the situation in which he or she thinks the impulse will occur. Accordingly, if the child is avoiding sitting in the front seat of a car due to fears that he will impulsively grab the wheel and swerve while driving, then he should be exposed to that situation. If a child is avoiding use of scissors or knives due to fear that he will impulsively stab himself or others, then the child should use these objects more frequently. Patients with these types of intrusive thoughts often seek significant reassurance because they have difficulty tolerating the doubt and uncertainty that occurs with the obsession. In these cases, the patient should continue to be exposed to that uncertainty without doing anything about it (Purdon, 2004). These symptoms may also be associated with confessing behavior, apologizing, attempts to neutralize the obsessive thought through a corresponding ritual (e.g., pinching one’s self for having an intrusive thought), and reassurance-seeking if the youth feels guilty for having such thoughts.

One challenge of addressing aggressive thoughts in pediatric OCD is determining whether the thoughts are in fact OCD symptoms, or if they are driven by actual urges to engage in the aggressive act. As safety of the patient and others is of primary importance, assessment of these symptoms can prove challenging. To make this determination, the clinician must be thorough in the assessment process. A developmental history of the youth should be taken, and it should be noted whether the youth has a previous history of aggressive behavior towards himself or others. Youth who present with aggressive fears rarely have a history of harmful acts or impulsive behavior. It is also important to assess depressive symptoms, as well as suicidal and homicidal ideation, intent, or plan. What is generally found is that youth with aggressive obsessions usually describe obsessive thoughts of harm, and those often include thoughts of hurting someone as well as how they could harm someone (e.g., hitting, stabbing). However, patients with OCD generally deny having any actual intent to commit the acts of harm. Usually they will say they do not want to harm anyone, yet they cannot seem to stop the intrusive thoughts of doing so. Thus, youth with OCD generally describe these thoughts as ego-dystonic, indicating that they do not want any harm to occur and reporting significant distress when having the thoughts.

Treatment of Intrusive Sexual Thoughts

Developmental considerations are important in regard to intrusive sexual thoughts in OCD. Through the course of our clinical experience, we are often surprised by the detailed and graphic nature of the sexual thoughts present in children, which often seem particularly mature for many youth. Parents may have misconceptions about what their child has already been exposed to, so this can be relevant in treatment. However, the goal of assessment is certainly not to put new thoughts into children’s heads, but to encourage them to disclose what they are already thinking about so that these obsessions can be effectively addressed in treatment. Sexual thoughts that commonly occur in youth with OCD include intrusive thoughts of sexual activities, which may involve friends, family members, children, and animals. Content involving homosexuality,

incest, aggressive sexual activities (e.g., thoughts of being raped or raping others), using inappropriate objects sexually, and molestation of younger children are common. Adolescents and teenagers may experience intrusive thoughts about whether or not they would be sexually aroused by the sexually inappropriate behavior. In regard to intrusive thoughts about homosexuality, youth may engage in behaviors to obtain reassurance associated with their sexual orientation (e.g., reading material on the internet about how to tell if one is homosexual, questioning others or seeking reassurance about sexual orientation) (Williams & Farris, 2011). Youth may also experience intrusive thoughts related to their own or others' genitals, sexually transmitted diseases, or becoming pregnant or getting someone else pregnant, with these latter symptoms more common in adolescents than younger children.

Given the “forbidden” nature of these thoughts, a common concern endorsed by youth with OCD and/or their parents or caregivers is uncertainty regarding whether these thoughts are due to OCD, or whether the children might in fact have genuine interest in such sexual behaviors. One main determinant in attempting to answer this question is the response that children have to these thoughts, such as whether the thoughts cause distress or excitement/arousal. Research on adults with OCD may shed light on this issue. One study compared adults with OCD to adults without OCD who exhibit nonparaphilic sexual addictions; those with OCD reported significantly more fear and avoidance related to their sexual thoughts (Schwartz & Abramowitz, 2003). Compared to adults with OCD, those with nonparaphilic sexual addictions reported higher levels of sexual arousal associated with their thoughts, and a greater degree of sexual pleasure from performing their compulsive behaviors. Adults with OCD also reported greater levels of distress than those with nonparaphilic sex addiction. In line with these results, clinical experience suggests that most youth with OCD experience intrusive sexual thoughts as unwanted, repugnant, and threatening. They also experience a variety of negative emotions, such as shame, guilt, embarrassment, and disgust when having intrusive sexual thoughts, whereas someone with a true interest in committing these acts would likely not experience the same degree of negative emotions and instead experience them as erotic, wanted, and not too distressing. Further, with sex addictions, compulsions

often involve performing the sexual activity that is thought about, whereas in OCD, compulsive rituals often do not involve sexual behavior at all and the individual instead seeks to neutralize sexual obsessions (e.g., via avoidance, praying). Confessing is also a frequent compulsion associated with intrusive sexual thoughts. Children often feel they have to confess these thoughts to their parents so as to be told such thoughts are “okay” or that they are not perverts. Individuals may mentally review sexual scenarios in their heads and compulsively check their bodies to ensure they are not sexually aroused. However, arousal does not seem to be the best indicator of disorder status, as individuals with OCD may experience doubt and uncertainty about whether or not they are aroused in the first place, making this challenging to assess. Further, O’Neil et al. (2005) discusses how someone may misinterpret as sexual arousal what are instead physiological manifestations of anxiety in the presence of children. Penzel (2012) also emphasizes that people may simply react sexually to sexual content. If individuals exhibit stimulation or arousal in response to forbidden sexual content, the person may then think such behavior reflects an inner desire that they in fact want to participate in such forbidden activities, when in fact the arousal is just a physiological symptom that is not necessarily predictive of sexual status (Ogas & Gaddam, 2011). For instance, Adams, Wright, and Lohr (1996) found self-reported heterosexual men endorsing homophobia to demonstrate significantly greater arousal to male homosexual erotica, measured via penile tumescence, than heterosexual men without homophobia. However, it is challenging to assess physiological arousal, as self-report measures of sexual arousal may reflect social desirability biases (Zeichner & Reidy, 2009) or hesitancy to disclose true inner desires. Further, if arousal does occur, it may be challenging to determine whether physiological arousal is affective or sexual in nature. Nevertheless, it is relevant to conduct a thorough assessment as sexual obsessions (e.g., obsessions about homosexuality) can also be associated with delayed treatment if symptoms are mistakenly considered part of normative pubertal development (de la Cruz et al., 2013). Overall, the presence of avoidance, confessing, reassurance-seeking, excessive checking behaviors or other OCD symptoms can also suggest that symptoms are likely OCD.

After obtaining an accurate understanding of the youth's intrusive sexual thoughts, cognitive-behavioral techniques can be used. As indicated, the treatment of intrusive sexual thoughts is best treated by exposure to the feared thoughts and images as well as decreased avoidance. When treating sexual thoughts, the therapist would not have the youth engage in in-vivo exposures in which they actually commit the feared act. However, clinicians would expose the youth to stimuli that trigger the intrusive thoughts as well as situations that increase the risk of the act occurring. Developmental considerations and parental concerns are important when devising exposures. Obviously, clinicians should not engage in exposures that violate any laws or interpersonal rights, but developmentally appropriate exposures can be used in conjunction with conveying clear rationale to parents and youth about ERP, and obtaining consent for participation. For exposures targeting fears of homosexuality, clinicians can use sexy pictures of models and pictures of people in bathing suits. If obsessions center around particular people in their lives (e.g., family members, friends), exposures may involve looking at pictures of those people and increasing their contact with them. If obsessions involve fears of molesting younger children, the patient may be encouraged to go with his or her parents to pick up the younger sibling at school, to look at a parenting magazine to see pictures of young children, to change a baby's diaper, or to go to a playground. Aside from decreasing avoidance, since actual exposure to the act is not appropriate, treatment often involves conducting imaginal exposure or writing narratives of what would happen if in fact the actual fear did occur. Then, repetition of imaginal exposure or reviewing narratives of the fear serves to desensitize the youth to these types of thoughts.

Treatment of Religiosity/Scrupulosity

Scrupulosity is when an individual's obsessions and compulsions center on religious or moral fears. Obsessive-compulsive symptoms often develop around religious themes, cultural or religious practices, or themes of morality. Youth may exhibit fears of dying and not going to heaven, having blasphemous or immoral thoughts, engaging in immoral behavior,

thoughts of disobeying or offending a religious figure, or not being forgiven for sins. Youth may also exhibit religiously-motivated concerns about morality. A child may perceive himself to be immoral due to being bad and not recycling a soda can (Siev, Steketee, Fama, & Wilhelm, 2011). In Christianity, thoughts may include fears associated with the devil, Satan, or with going to hell (Huppert & Siev, 2010). In Judaism, symptoms may relate to "dietary restrictions," family purity, praying correctly, observing the Sabbath, following commandments, religious observance of holidays, or studying correctly (Cohen & Rozin, 2001; Greenberg & Shefler, 2002; Hermesh, Masser-Kavitzky, Gross-Isseroff, 2003; Paradis et al., 2006). In Islam, symptoms may manifest in regard to cleanliness, fears of impurity, strict rules, and doubts about proper engagement in prayers (Ghassemzadeh, Mojtabai, Khamseh, Ebrahimkhani, Issazadegan, & Saif-Nobakht, 2002). Scrupulous themes in Muslims may include concerns about cleanliness, purity, dietary laws, prayer, repeating behaviors that involve religious practice, and other religious behaviors (Huppert & Siev, 2010; Karadag et al., 2006). Additionally, fears can be both sexual and religious (e.g., an intrusive sexual image of Jesus; Siev, Steketee, Fama, & Wilhelm, 2011). Interestingly, Karadag et al. (2006) found that patients with religious obsessions had longer delays in seeking professional help compared to other patients with OCD. One reason for this may be the person's own uncertainty about whether his or her symptoms are simply efforts to follow religious practices or if they are better conceptualized as OCD.

Hence, it is important for the clinician to become familiar with religious teachings and customs to differentiate religious laws from OCD-motivated rituals (e.g., dietary behavior, cleansing rituals, praying). As this may sometimes prove challenging and overwhelming, it may often be necessary for the clinician to consult with a religious leader (e.g., priest, rabbi, monks), or have the youth talk to the religious leader. However, the clinician should ensure that the religious leader has an understanding of the youth's symptoms and hold beliefs that will be consistent with the aims of treatment (Himle, Chatters, Taylor, & Nguyen, 2013). Scrupulosity may be more challenging to treat if patients view their symptoms in the domain of religion rather than OCD (Huppert & Siev, 2010). Huppert et al. (2007) describe that it is important that clinicians do not blame religion

for OCD symptoms, citing the lack of conclusive research directly linking religiosity and the development of OCD. For instance, using a Jewish Israeli sample, Hermesh et al. (2003) found no significant differences in degree of religiosity between patients with OCD, panic disorder, or healthy controls (e.g., Hermesh et al., 2003; see Himle et al., 2013 for a review of the current literature on religiosity and OCD). However, religiosity may influence the form or manifestation of OCD (Abramowitz, Deacon, Woods, & Tolin, 2004). It may be helpful to tell youth that OCD likes to sneakily attack people by targeting things that are particularly important to them (e.g., values), making it even more challenging to fight symptoms. Accordingly, a child who highly values religion may experience OCD symptoms of a religious nature. Huppert indicates, “Understanding that OCD is not caused by religious adherence, but rather that such adherence can influence how OCD manifests in religious patients (i.e., in religious obsessions and compulsions) enables the clinician to use the patient’s religious beliefs as a framework to treat the disorder more effectively” (Huppert et al., 2007, pg. 928). Clinicians should be respectful of the individual’s religious values and laws to establish rapport and facilitate treatment participation, rather than conveying that religious values be reduced in treatment (Huppert et al., 2007).

In order to address these symptoms, exposures can be informed by the nature of the symptoms. If symptoms involve excessive praying or other compulsions, treatment should include exposure to stimuli that elicit urges to do compulsions while encouraging the youth to resist engagement in compulsions. Accordingly, if fears involve blasphemous content, treatment should increase the child’s exposure to the feared content (e.g., profanity) without the engagement in rituals (e.g., apologizing, confessing) to neutralize fears. To target morality-based symptoms, exposure exercises may involve slightly breaching moral standards, such as saying something offensive, “contaminating” fruit in a grocery store by touching it without purchasing it, not engaging in a socially acceptable behavior (e.g., holding the door open or saying thank you), or taking more than one free brochure (Himle et al., 2013). Creativity and consultation with other clinicians and/or clergy members can be used to develop exposure exercises that elicit anxiety and obsessions without stretching moral standards too far (Himle et al., 2013).

Nevertheless, these types of symptoms can prove challenging in developing exposures that target the OCD while not simultaneously offending the patient’s religion or culture. Huppert et al. (2007) discusses the challenge of addressing symptoms when engagement in in-vivo exposures would violate religious law. They discuss the importance of working together, creatively, to develop situations that violate OCD law but not religious law. Huppert et al. (2007) indicate that it is not necessary to expose religious patients to actual sin consistent with religious doctrine. They discuss that effective ERP encourages patients to expose themselves to actions that increase the risk of their feared consequences, rather than engagement in actions that actually cause the feared consequence to come true, indicating that exposures do not require individuals to experience the feared consequence, but rather, to tolerate risk and uncertainty. They mention that scrupulous patients therefore do not need to actually sin, but instead should allow for slightly greater risk than others normally would, without intentionally following through with the violation. Normative behavior in that individual’s religious community can serve as a reference point (Huppert et al., 2007). Whereas many individuals may think that their adherence to religious practices is in service of God, in fact their behavior from OCD causes them to ritualize in service of OCD (Huppert et al., 2007). Clinicians might focus less on whether thoughts matter and more on convincing patients that the achievement of immediate perfection is a goal demanded by OCD, not religion (Siev & Cohen, 2007). Siev, Baer, & Minichiello (2011) found that 70% of adults with scrupulosity reported that their symptoms have significantly interfered with their relationships with God or religious observances. Thus, the rationale for treatment can be presented as a way to remove OCD as a barrier to spiritual connection with God. Huppert et al. (2007) discusses that for ultra-religious individuals whose goal is subservience to God rather than individual fulfillment, one motivation is that treatment should enable the individual to serve God more completely (without interference due to OCD). As youth may express a concern that God will be offended or disappointed if the youth engages in exposure exercises, the clinician could ask the youth if he or she believes in God, and if so, whether God is all-knowing. If that is the case, then God will likely know that the youth has OCD and will be aware that the intent of exposures is to treat OCD, not offend God.

However, it is recognized that the youth would still be faced with tolerating uncertainty. Youth may seek perfection in following religious rules and adhering to moral standards in an effort to obtain certainty about salvation (e.g., “I’ll definitely go to heaven”), when in fact this certainty cannot be achieved and therefore efforts should encourage the youth to learn to tolerate uncertainty. Of note, clinicians should also be cognizant of any efforts from youth to seek reassurance (Huppert et al., 2007), as this often comes up during exposure exercises and may also occur if the youth interacts with clergy members or participates in religious practices such as confessionals.

Conclusion

This article sought to review the literature and provide recommendations for the assessment and treatment of aggressive, sexual, and religious/scrupulous thoughts in pediatric OCD. As indicated, a thorough

assessment of the undesirable thoughts and distressing behaviors (e.g., compulsions, avoidance) is essential so that cognitive-behavioral strategies can be utilized effectively in treatment (Schwartz and Abramowitz, 2003). Because many clinicians have difficulty identifying appropriate, beneficial ERP tasks to address these symptoms, it is hoped that this article provides some guidance about potential strategies to consider. Youth and parents should have a clear understanding of the rationale for exposure exercises prior to engaging in them. Also, since youth may be particularly nervous about exposures to taboo symptoms, it is often helpful for exposures to be modeled by the clinician and/or the youth’s parent(s). Clinicians should also have developmental context in mind throughout treatment and also use methods that have shown to be beneficial with youth to encourage motivation and treatment (e.g., positive reinforcement). Consultation with other experienced CBT practitioners is also highly recommended, as consultation will help clinicians maintain the ethics of our profession along with using effective treatment strategies.

Summary of Recommendations

1. Clinicians should be aware of the commonness of symptoms with taboo themes in pediatric OCD and be able to assess these symptoms accurately. Assessment should include youths' appraisal of these thoughts, as well as whether thoughts are ego-dystonic.
2. Clinicians should assess the nature of compulsions or avoidant behaviors associated with these thoughts. In particular, clinicians should inquire about mental rituals (e.g., praying, neutralizing thoughts), confessing, and reassurance-seeking behavior, as well as other symptom domains.
3. Describing themes commonly present in OCD and normalizing taboo symptoms may be an effective strategy to get youth to disclose these symptoms.
4. It may be helpful to meet individually with youth if s/he is hesitant to disclose symptoms in front of parents(s)/caregiver(s). In such cases, it is important to clearly review limits of confidentiality prior to this discussion. However, very often the child has already disclosed such symptoms and is seeking reassurance from the parent(s).
5. In the context of assessing intrusive thoughts of harm, a thorough developmental history should be taken in the assessment process to determine whether the youth has a history of aggressive behavior and/or impulse control.
6. Given the embarrassment, guilt, and shame often associated with these thoughts, it is particularly important to assess depressive symptoms and suicidality.
7. Cognitive-behavioral treatment with exposure and response prevention is a first-line treatment for pediatric OCD. Accordingly, clinicians should educate parents and youth about the cognitive-behavioral model of OCD so that all parties understand the rationale for exposure tasks, and obtain parental consent for participation.
8. It is important to eliminate engagement in any compulsions and eliminate avoidant behavior.

Summary of Recommendations

9. Systematically and gradually expose patients to what they fear. Exposure to the content of the intrusive thoughts is often necessary in treatment. Further, a patient who is afraid of acting impulsively should be exposed to a situation in which s/he thinks the impulse will occur.
10. Clinicians should consult with other experienced CBT practitioners if there are questions about assessment or use of therapy strategies.

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