

## Conceptualizing and Managing Risk in Pediatric OCD: Case Examples

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### **Abstract**

A subset of patients with obsessive-compulsive disorder (OCD) present with symptoms that indicate risk. In some cases of OCD, risk is only apparent, merely reflecting the content of obsessional fears which are never acted upon (e.g. intrusive thoughts of harming others). In contrast, genuine risk can arise in OCD as an unintended consequence of engaging in compulsions or avoidance (e.g. skin damage caused by washing with bleach). In both situations, risk can cause confusion among clinicians regarding diagnosis and /or hinder access to appropriate treatment. The current article adds to the small existing literature on risk in OCD by presenting case examples illustrating different types of risk in the context of pediatric OCD, along with a discussion of their implications for management. The cases highlight that it is crucial that risk in OCD is considered carefully within the context of the phenomenology of the disorder. In many cases, treatment should follow the usual OCD treatment protocols and both apparent and genuine risk resolve with successful treatment of the OCD. In some cases, there may be a need to actively manage genuine risk. In these instances, it is essential that risk management is carefully integrated into a program of evidence-based treatment for OCD.

**Keywords:** Obsessive-compulsive disorder, risk, cognitive-behavior therapy, pediatric.

Obsessive-compulsive disorder (OCD) is a debilitating disorder affecting approximately 1-2% of young people (Heyman et al., 2001; Douglass et al., 1995). The disorder is characterized by the presence of recurrent, unwanted and distressing intrusive thoughts (obsessions) and/or repetitive acts that are performed in order to alleviate anxiety or prevent a feared outcome from occurring (compulsions) (American Psychiatric Association, 2013; World Health Organization, 2018). Over the last two decades, a strong evidence-base has emerged for the treatment of pediatric OCD. Cognitive-behavior therapy (CBT) has been shown to be efficacious, both alone and in conjunction with serotonin reuptake inhibitors (SRIs) (e.g. Watson & Rees, 2008; Öst et al, 2016, Nair et al, in press). Despite its efficacy, approximately 30% of young people fail to respond to CBT for OCD and nearly half of all patients are left with clinically significant symptoms (Ost et al., 2016). Various factors have been identified as potential barriers to successful treatment, including certain comorbidities and family factors (Ginsburg, Kingery, Drake & Grados, 2008; Krebs & Heyman, 2010; Torp et al., 2015; Garcia et al., 2010). However, one potential barrier to change that has received little empirical attention is risk associated with OCD.

When considering risk in OCD, it is important to distinguish genuine risk from risk that is only apparent. Veale and colleagues (2009) defined primary risk as apparent risk that arises directly from an obsession. The apparent risk is that the patients will act on intrusive and unwanted thoughts and impulses, such as stabbing somebody or engaging in inappropriate sexual behavior. This “risk” is only apparent, not genuine, because patients with OCD do not act on obsessions. On the contrary, the content of the obsession is abhorrent to the sufferer, and the rituals or avoidance which form core symptoms of the OCD are carried out in the belief that this will prevent the obsessions from being realized (Veale et al., 2009).

Secondary risk is defined as genuine risk arising as a direct consequence of performing compulsions or avoiding feared situations (Veale et al., 2009). For example, in the case of contamination fears, an OCD sufferer may avoid eating, resulting in malnourishment. Such risk is unintended by the sufferer, but nevertheless has real potential for harm. There is limited literature on secondary risk in OCD, but previous case reports have highlighted some specific examples. For example, Hood, Bapista-Neto, Beasley, Lobis, and Pravdova (2004) describe a case of self-injurious behavior in an adolescent with OCD who repeatedly bit her tongue, resulting in bleeding and significant lacerations. After some initial confusion over the cause of this behavior, it was eventually formulated as a compulsion in the context of OCD. In another example, Storch et al. (2004a) describe a child with OCD who reported fears of choking and contamination. As a result of these fears, the child stopped eating solid food, lost 10% of his body weight and required hospitalization. Similarly, Jassi and colleagues described cases of young people with ritualized eating in the context of OCD, some of whom restricted their eating and became significantly underweight (Jassi, Patel, Lang, Heyman & Krebs, 2016). Ion, Hameed, Pillay, and Drummond (2009) examined a sample of consecutive admissions to a specialist adult OCD service and found that approximately 58% of patients had clinical evidence of severe dehydration, which was most commonly a consequence of difficulties in preparing drinks due to compulsive behaviors or avoiding drinking in an attempt to reduce the need to urinate.

Although these case reports highlight the potential for adverse consequences arising from OCD, the majority do not offer guidance on how to manage risk while at the same time treating OCD effectively. This is an important issue because both primary and secondary risk associated with OCD in youth can impede successful treatment outcome for several reasons. First, therapists can become distracted from the OCD, focusing instead on extensive risk assessment, managing the risk itself or potentially mis-conceptualizing the risk as a separate

or comorbid problem. Second, in cases of primary risk, therapists can misguidedly take measures to reduce the apparent threat. This is not only unnecessary, but it can also be counterproductive, fueling obsessional worries and exacerbating symptoms. For example, in a case of aggressive obsessions, extensive risk assessments could reinforce the patient's belief that they are dangerous and may act on their obsessions. Third, therapists may refrain from encouraging patients to engage in ERP tasks for fear of increasing risk or even actively encourage avoidance of situations that trigger OCD symptoms. These issues may be particularly pertinent when working with young people, when more stringent safeguarding legislation typically means more cautious management of risk. Additionally, children may be less able to articulate their symptoms compared to adults, making it harder for clinicians to accurately formulate the risk.

The current study describes four clinical case examples of young people with OCD and the associated primary (apparent) or secondary (genuine) risk. We aim to draw out the similarities and differences across a range of risk issues, highlighting the ways in which they might impede treatment, in order to give a comprehensive account of risk within the context of OCD and provide guidance on its management.

## **Methods**

### **Cases**

Four cases highlighting risk in pediatric OCD are described here. Patients were identified from the register of a National and Specialist OCD and Related Disorders Clinic in the United Kingdom. All cases presented met ICD-10 diagnostic criteria for OCD as their primary diagnosis, as confirmed by the specialist multidisciplinary team during a detailed assessment (described below). Cases have been anonymized and the descriptions are

presented in a truncated form, focusing specifically on the risk issues, in order to omit identifying information.

### **Assessment and Treatment**

The specialist multidisciplinary team assessment included an interview with parents to obtain a developmental history and an account of presenting difficulties, including evaluation of diagnostic criteria. A semi-structured interview (Children's Yale-Brown Obsessive-Compulsive Scale; CY-BOCS; Scahill, Riddle, & McSwiggin-Hardin, 1997) with the young person was conducted to obtain a detailed account of OCD symptoms.

All patients received CBT through the specialist clinic, comprising of 12–22 weekly sessions which were protocol-driven (Turner, Krebs & Volz, 2018) and delivered by experienced therapists who received regular supervision. CBT included psychoeducation about OCD and anxiety, exposure with response prevention (ERP) and relapse prevention. Parents were included in sessions as appropriate, depending on a range of factors including the extent to which they were involved in rituals and the age of the young person. The use of concomitant SSRI medication was also considered at assessment (further details provided in case descriptions).

### **Measurement**

All cases completed the CY-BOCS at baseline and post-treatment. The CY-BOCS is a clinician-administered measure that assesses the frequency, interference, levels of resistance and control, and distress associated with obsessions and compulsive behaviors experienced by the young person. It yields a total score ranging from 0-40, which indicates the overall level of current OCD symptom severity. The CY-BOCS has been shown to have good reliability and validity (Scahill et al., 1997; Storch et al., 2004b).

## Results

### Case 1: Primary risk in a Case Presenting with Pedophilic Obsessions

Michael was a 15-year-old boy who presented with an 18-month history of severe OCD. He had previously received several trials of selective serotonin reuptake inhibitor (SSRI) medication and CBT without improvement. Michael presented with a range of obsessions and compulsions, but his primary symptoms comprised abhorrent and intrusive sexual thoughts about babies and children. These thoughts gave rise to acute distress, marked avoidance of children, compulsive urges to confess the content of his thoughts to his mother, reassurance seeking, and rumination about his sexual orientation and risk to children. At assessment, Michael obtained a total CY-BOCS score of 32, indicating severe OCD.

Prior to assessment at the OCD Clinic, Michael's obsessions had caused concern among family members and clinicians. This concern was exacerbated by Michael reporting that he might be enjoying his intrusive sexual thoughts. He described feeling sexually aroused when he experienced sexual thoughts about children. He also reported that he thought about children while masturbating and was uncertain as to whether he was purposefully bringing these thoughts to mind. Thus, although Michael had been diagnosed with OCD, previous clinicians had been uncertain as to whether his sexual thoughts about children were an OCD symptom and so he had never been assured that they were part of his OCD. Furthermore, his previous treatment had not incorporated exposure to these thoughts.

Pedophilic obsessions are common in young people with OCD (Fernandez de la Cruz et al., 2013). Furthermore, it is not unusual for OCD patients to report physiological signs of sexual arousal when they experience sexual obsessions, even though the thoughts are unwanted (Warwick & Salkovskis, 1990). Sexual arousal as a physiological response can be triggered in people even when the stimulus is not welcomed by the person or is perceived as

threatening (Levin & van Berlo, 2004). Physiological symptoms of anxiety can be difficult to differentiate from some of the sensations associated with sexual arousal. Selective attention to the genitalia, as might occur when ‘checking’ for arousal, can increase blood flow to the genital area (Veale et al., 2009), triggering sensations that are indistinguishable from sexual arousal. Many young people with sexual obsessions experience inappropriate sexual intrusions during masturbation and interpret this as meaning that they must find the thoughts pleasurable. However, this can be understood as a classic example of the paradoxical effects of thought suppression (Wegner, Schneider, Carter & White, 1987).

It was clear at assessment that Michael was suffering from OCD and that he presented no risk to children for a number of reasons. First, Michael described the intrusive thoughts about children as distressing and ego-dystonic. Although Michael reported being confused about whether he had occasionally found the thoughts enjoyable, this was formulated as occurring within the context of the conditioned physiological response to sexual thoughts, the overlap between anxiety and sexual arousal, and the role of thought suppression during masturbation. Second, he had no history of acting on these thoughts, and third, he was in fact going to extreme lengths to ensure that he could never act on his thoughts (e.g. avoidance of children).

The formulation was shared with Michael and his family at the end of his assessment. The family were informed that all symptoms could be understood within the context of OCD and that pedophilic obsessions are common in OCD. The family were given a clear and confident message that Michael was not a danger to young people, and that treatment would involve exposure to children rather than any attempts to keep him away from children. Michael received 22 sessions of CBT for his OCD, along with medication (fluoxetine 20mg, augmented with 0.5mg risperidone). Psychoeducation was adapted to include information regarding the normality of unwanted sexual intrusive thoughts, the inherent problems in

differentiating arousal from anxiety, how selective attention can impact sensations in the body and the role of thought suppression. Michael and his therapist devised a hierarchy in order to tackle previously avoided situations involving children, beginning with exposure to pictures of babies and children. The final step in his hierarchy was to have physical contact with a baby or child, and the therapist was able to arrange for Michael to hold and feed a colleague's baby. By the end of therapy, Michael experienced occasional intrusive thoughts of a sexual nature, but was no longer engaging in avoidance of babies and children. At the end of treatment, Michael's total CY-BOCS score was 18. The remaining OCD symptoms comprised of more classical contamination fears surrounding dirt and germs, and Michael and his family were encouraged to continue to work on these using the knowledge they had gained throughout therapy.

### **Case 2: Primary Risk in a Case presenting with Obsessional Thoughts of Self-Harm**

Laura was a 16-year-old girl with an eighteen-month history of OCD, initially presenting as contamination obsessions with associated washing rituals. Laura also presented with a history of significant deliberate self-harm, which had resulted in a three-month inpatient admission following an episode of cutting her wrists and legs with a razor blade. During this admission, Laura was placed on one-to-one observation after disclosing intrusive and persistent thoughts about harming herself.

Laura's assessment at the specialist OCD clinic took place three months after she had been discharged from the inpatient unit. Laura and her parents reported that she had not engaged in any further self-harm whilst on the ward or since her discharge. However, since her discharge, Laura had become highly distressed by intrusive thoughts of cutting herself and as a consequence had begun to avoid knives and other sharp objects including drawing pins, paperclips and staples. Laura described spending large amounts of time checking for

sharp objects and asking her parents to check whether she was carrying anything sharp. If her family inadvertently exposed her to a sharp object (e.g. her mother wearing a brooch), Laura would become highly distressed and violent towards them.

Following her discharge from the inpatient unit, Laura had received three outpatient appointments with another service. Laura's reports of intrusive thoughts and worries about harming herself had been interpreted as being self-harm threats rather than a symptom of her OCD. As a result, exposure to sharp objects had not been encouraged and instead her parents had been advised to remove or hide sharp objects at home. Her therapist had stated that her "behavioral difficulties", including threats of self-harm and her tendency to become angry towards her family, would need addressing separately to OCD.

At the specialist OCD assessment, a number of factors were considered when formulating Laura's symptoms. First, people with OCD do not have a history of acting on their intrusive thoughts. Although Laura had harmed herself in the past (to the extent of requiring inpatient treatment), during the assessment it became clear Laura no longer had any desire to harm herself and in fact was now terrified of doing so. Thus, the thoughts of self-harm that Laura was currently experiencing were wholly ego-dystonic in nature, in stark contrast to how she had presented in the past, when she had deliberately entertained thoughts of self-harm without any attempt to resist them. Second, at assessment, a clear link was established between Laura's ego-dystonic thoughts and her repetitive behaviors (e.g. checking), which were compulsive in nature (i.e. acts that she did not want to perform but felt she had to in order to prevent self-harming). Specifically, she felt compelled to carry out such behaviors in order to prevent self-harming. Laura's fear of harming herself had generalized to a range of objects, including objects that would not typically be used for self-harm (e.g. drawing pins), and her attempts to remove these objects from her vicinity were clearly excessive. Her compulsions were far beyond the reasonable precautions which a person

might take to resist the urge to self-harm, to the point where they were having a significant impact on her functioning. Third, Laura's behaviors clearly fell within the recognized OCD symptom domains of checking, avoidance and reassurance seeking. For these reasons, Laura was diagnosed with OCD, with her primary obsession being a fear of harming herself.

Laura's total CY-BOCS score prior to specialist treatment was 26, indicating moderately severe OCD. Her medication was increased from 150mg to 200mg sertraline and she received 14 sessions of CBT. These sessions incorporated graded exposure to sharp objects, starting with exposure to drawing pins and progressing to knives, which were at the top of her hierarchy. As well as carrying out these tasks with her therapist, her parents were encouraged to gradually reintroduce sharp objects to the home. Laura was also helped to reduce checking and reassurance seeking. By the end of treatment, she was no longer distressed by intrusive thoughts of self-harm and no longer avoided knives or other sharp items. Her post-treatment CY-BOCS score was 10.

### **Case 3: Secondary Risk in a Case of Self-Neglect Arising from Avoidance**

Lisa was a 17-year-old girl who presented with a 3-year history of OCD and a diagnosis of high functioning autism. Lisa's parents first noticed that she was taking longer than usual to carry out self-care activities, with rituals such as standing on one foot when washing. As Lisa's symptoms worsened, she eventually became wholly dependent on her parents for basic self-care such as washing and dressing. Lisa began to avoid showering and going to the toilet, as a way of circumventing her rituals. She was eventually admitted to hospital for three months due to the severity of her symptoms and lack of self-care. Following this admission, Lisa developed a fear of being poisoned and consequently stopped eating and drinking. She experienced significant weight loss with amenorrhea and was involuntarily readmitted to hospital, where she required nasogastric feeding.

During her second admission, the inpatient team established that she did not present with anorexic cognitions and that her dietary restriction was exclusively associated with her obsessional fear of being poisoned. Lisa received CBT for OCD and commenced fluoxetine 60mg in conjunction with risperidone 0.25mg, with some benefit. Her weight increased and she started to menstruate again. However, overall her OCD remained severe and she was therefore referred for specialist OCD treatment.

At the specialist OCD assessment, Lisa scored 30 on the CY-BOCS and her weight for height percentage was 85.5%. Since the acute risk of dehydration and malnourishment had resolved, it was recommended that she be discharged and continue with outpatient treatment. However, a key issue was ensuring that her fluid and dietary intake was maintained, not only to protect her physical health but also to optimize her response to CBT. Research in eating disorders suggests that being underweight can impact on cognitive functions that are required for CBT, such as flexibility and global integration (Tchanturia et al., 2011, 2012; Lang, Lopez, Stahl, Tchanturia & Treasure, 2014). Furthermore, young people who are low in weight due to OCD-related dietary restriction have been shown to have a significantly poorer response to CBT for OCD, compared to patients of a healthy weight (Jassi et al., 2016). Therefore, Lisa and her family were informed that she needed to maintain a minimum 85% weight for height, in order to continue with CBT through the specialist clinic. Lisa agreed to have her weight continually monitored on a weekly basis throughout the course of her outpatient treatment.

Lisa continued to gain weight in outpatient care and engaged fully in a 20-session course of CBT for OCD. Treatment included exposure to eating a range of previously avoided foods without engaging in rituals such as examining the food. Her score on the CY-BOCS reduced to 15 by the end of treatment. She was able to carry out all self-care activities independently and was no longer restricting her dietary intake.

**Case 4: Secondary Risk in a Case of Self-Injurious Compulsions**

Alex was an eight-year-old boy who presented with a six-month history of OCD. At assessment, Alex's CY-BOCS score was 19, indicating mild to moderate OCD symptoms. Alex reported "hearing voices" that told him to stick pencils, pens, and spoons down his throat and gouge out his eyes. This was in response to the intrusive thought that his family would be killed if he did not perform these compulsions. Thus, Alex presented with secondary risk of self-harm through performing unusual and potentially extremely harmful compulsions in an attempt to neutralize his obsessions. Prior to attending the specialist OCD assessment, Alex had presented to his GP on several occasions and had attended his local Accident and Emergency (A&E) department after an incident of poking his eyes. Throughout this time, Alex's OCD remained undiagnosed. Following his A&E presentation he was prescribed 0.25mg risperidone in an attempt to reduce his agitation, with no effect.

Upon assessment at the specialist clinic, Alex presented with a range of more common OCD symptoms (e.g. counting and ordering). However, because Alex's OCD included compulsions which involved causing harm to himself, it was necessary to prioritize managing this risk in parallel with planning OCD treatment. Alex's parents were advised to ensure that cutlery, pens and other potential implements were not easily accessible to him. It was emphasized that this would be a short-term measure, not a long-term solution. It was explained that CBT would include exposing Alex to these implements in a graded way so that Alex could practice resisting the urge to perform self-harming compulsions. He was also prescribed 50mg sertraline following assessment.

Alex received 12 sessions of CBT incorporating ERP which included gradually exposing himself to sharp objects and statements and images of his family being killed, without ritualizing. As Alex progressed through CBT and his urge to carry out compulsions

reduced, sharp objects were gradually reintroduced into his home environment. Alex responded well to treatment and his self-injurious behavior completely resolved. His post-treatment CY-BOCS score was nine.

### **Discussion**

The young people described here all presented with symptoms that had previously caused their treating clinicians alarm by virtue of their risky, or apparently risky, phenomenology. Encouragingly, in all cases clinicians considered OCD as a differential diagnosis and ultimately referred the young people to a specialist OCD clinic due to diagnostic uncertainty or treatment-resistance.

The first two cases are examples of primary risk arising from obsessions. This risk is only apparent and once correctly formulated as a symptom of OCD, should be no cause for alarm since patients do *not* act on their obsessions. Other examples of primary risk include intrusive thoughts of harming others, which can cause particular concern in young people with a history of conduct problems, and obsessional thoughts about theft and arson. The latter two cases presented here highlight types of secondary risk arising as an unintended consequence of engaging in compulsions. There are many and varied examples of secondary risk in young people with OCD, some of which include developing urinary tract infections due to avoidance of passing urine, damaging skin as a result of using bleach to clean hands, and developing rectal prolapse as a consequence of excessing straining to eliminate feces.

The cases described here highlight the importance of carefully considering the appropriateness of standard risk protocols prior to implementation in cases of OCD. Risk assessment and management is unnecessary in cases of primary risk and can be

counterproductive. This is clearly demonstrated in the case of Michael, where standard risk protocols fueled his obsessional fears of being a pedophile and exacerbated his symptoms. In contrast, risk assessment and management are necessary and beneficial in cases of secondary risk. Alex's self-injurious compulsions meant that it was imperative that he was not left unsupervised with sharp objects at the start of treatment. Similarly, in the case of Lisa, it was essential that her food and fluid restriction be managed effectively so that her physical health could be maintained at a level which would enable her to engage with CBT.

### **Implications for Practice**

The current review has clear implications for the management of risk in pediatric OCD. At assessment, cognitions and behaviors pertaining to risk should be assessed carefully and considered within the context of OCD, including differentiating whether the risk is genuine or apparent. As described in the above case examples, a number of questions can be posed at the point of assessment to help clinicians confidently determine whether a young person is presenting with primary or secondary risk in the context of OCD. Guiding principles for assessing and formulating risk in OCD are shown in Table 1.

Where young people present with seemingly dangerous intrusive thoughts, clinicians should assess for ego-dystonia of thoughts, history of acting on thoughts, compulsions linked to these thoughts, and presence of other OCD symptoms (see Table 1). Consideration of these features *in combination* can enable clinicians to determine whether the risk is genuine or only apparent. Once formulated as OCD, primary risk should be managed by normalizing symptoms within the context of OCD and proceeding as usual with ERP-based CBT, with or without concomitant pharmacotherapy. A lengthy risk assessment, placing the patient on one-to-one observation or ensuring that the patient does not come into contact with the object of his or her obsessions should be avoided. As highlighted in these case examples, such

measures can be counterproductive in that they may serve to exacerbate the patient's fear that he or she may act on their obsessions, thus making both obsessions and compulsions worse. In order to avoid this, both therapist and patient should be confident in their diagnosis of OCD and in their knowledge that patients with OCD do not act on their compulsions. For this to be achieved it is essential that the network surrounding the young person share in this understanding so that they are able to respond to OCD in a coherent and supportive way. Families will need to help sustain the therapeutic work in the home environment and professionals across different agencies must form part of a consistent and unambiguous approach. For patients presenting with obsessions that pose a primary risk, exposing themselves to their fears can seem dangerous and therefore the psychoeducation phase of treatment may need to be extended and must include core family members. It is particularly important to spend time ensuring that patients presenting with primary risk and their families are engaged with the CBT model, and that they fully understand the rationale for conducting ERP. Psychoeducation about OCD and the role of anxiety can be helpful in illustrating the reasons for exposure to feared stimuli and the need to refrain from engaging in compulsions. The OCD formulation offers a clear framework to demonstrate why the feared stimulus should be approached rather than avoided and why intrusive thoughts should be tolerated rather than feared. It is important that intrusive thoughts are understood as uncontrollable, meaningless and completely normal.

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Cases of secondary risk should be managed by formulating the risk clearly within the context of OCD and proceeding as normal using standard evidence-based ERP protocols (see Table 1). Although it may be necessary to take practical steps to manage or minimize risk

before commencing CBT (for example refeeding in the case of someone who has stopped eating as a result of contamination fears and is dangerously underweight), therapists should not be distracted in the overall management plan from treating OCD as the primary problem. In most cases it is both possible and necessary to manage risk and treat OCD in parallel in order to achieve recovery. Treating the OCD is essential for the long-term reduction of such a risk, as illustrated in the cases presented here, and successful treatment should result in risk resolving. In cases of secondary risk, it is essential that all professionals involved in the care of the young person with OCD are clear on the rationale driving the treatment plan. Any lack of clarity could lead those less familiar with OCD to assume that risk should always be assertively ‘managed’, without first establishing whether it is primary or secondary. The care plan should outline without ambiguity why the chosen risk management procedure will be followed and how this ties into the CBT protocol.

In summary, OCD in young people that is associated with either primary or secondary risk can be effectively treated with CBT incorporating ERP, and risk resolves with successful treatment. Exposure tasks can be particularly challenging for clinicians in the context of risky behavior, whether real or apparent, and it is therefore essential that they are well supported by a robust network of professionals with a solid understanding of OCD.

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Table 1

*Guiding principles for assessing primary and secondary risk*

	Guiding principle	Considerations
Primary risk	Thoughts are ego-dystonic.	This can be difficult to establish, particularly in the case of sexual or aggressive obsessions. Sexual arousal can be experienced even when sexual thoughts are unwanted. Anxiety can be confused with arousal. Thought may be experienced at inappropriate times (e.g. during masturbation).
	There is no history of acting on thoughts.	There may be rare occasions of acting to ‘test out’ an obsession (e.g. seeking out inappropriate pornography to an attempt to reassure self that he/she does not enjoy deviant sexual material). There may be a history of appearing to act on an obsession due to another comorbidity (e.g. young person with aggressive obsessions may have a history of violence related to comorbid conduct disorder).
	Other obsessions are present.	Most, but not all, young people present with a range of obsessional fears, which may help to inform diagnosis of OCD.

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	<p>Obsessions will be linked to compulsions.</p>	<p>Some compulsions may be covert (e.g. mental rituals) and/or behaviors that are not recognized by the young person as compulsions (e.g. reassurance seeking). The association between obsession and compulsion is not always obvious. Some compulsions involve magical thinking, whereby there is no logical, direct link between the intrusive thought and the compulsive behavior (e.g. fear that a loved one will die, and a compulsion of repeatedly walking up and down stairs).</p>
<p>Secondary risk</p>	<p>If the risk will impede CBT then this may need to be managed first (e.g. significant low weight).</p> <p>If the risk will not impede CBT but needs active management, this should be carried out in parallel to CBT.</p>	<p>Ensure the treatment plan clearly indicates that CBT (with or without SSRI medication) is the intended intervention once the young person is able to engage.</p> <p>Be clear about the rationale behind any management plan and review as the young person progresses through treatment. Risk management is intended as a short-term intervention (e.g. temporary removal of sharp objects). Clinicians should be careful to ensure that risk management strategies do not become compulsions (e.g. fueling avoidance of sharp objects). If relevant, this should be addressed using graded ERP.</p>

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