In this chapter we describe developmental and clinical characteristics of obsessionality and ritualistic behaviors, highlighting both pathologic and nonpathological expressions in childhood and adolescence. We define and discuss obsessional thoughts and compulsions, ritualistic behavior, and obsessive compulsive disorder (OCD) from a developmental perspective that places these behaviors in the familial context. With respect to OCD, we review empirical and theoretical literature that addresses clinical characteristics and phenomenology, observed age and gender effects in clinical populations, epidemiological studies, and issues of comorbidity. Finally, we propose a developmental model that begins with the emergence of early ritualistic behavior and suggests pathways to normative and maladaptive obsessional outcomes.

Despite the increased research attention on obsessionality in adult clinical populations (e.g., Jenike, 1989), we focus on studies that pertain to children and adolescents. Similar to the adult literature, the vast majority of information derives from research on the disordered state; however, we review the current knowledge about OCD in childhood and adolescence as well as the limited number of studies that address typical variation. Though obsessive compulsive personality disorder (OCPD) has often been described along a continuum of obsessionality, there is good evidence to suggest that OCD and OCPD are distinct clinical entities and that obsessionality is not a hallmark feature of OCPD (Carter, Pauls & Leckman, 1995). Moreover, given our focus on children and adolescents, and on the fact that personality disorders are not typically diagnosed in younger populations (DSM-IV; American Psychiatric Association, 1994), OCPD will not be discussed.
OBSESSIONS

Obsessions are repetitive, intrusive thoughts, images, and ideational impulses that can lead to significant subjective distress. Obsessions are typically experienced as uncontrollable. The content of obsessions may appear pointless, out of sync with day-to-day tasks, and/or bizarre, inappropriate, violent, repulsive, or obscene (Rachman, 1985). The obsessional thoughts are unwanted, and individuals with frequent obsessions commonly attempt to resist or dismiss the obsessions or to neutralize them with another thought or action (e.g., compulsion) (Hoogduin, 1986; Insel, 1984; Rachman, 1985).

Obsessions are not unique to individuals suffering from OCD. Rather, they are experienced by a majority of individuals in the general population and across numerous forms of psychopathology (March, Leonard, & Swedo, 1995a; Riddle et al., 1990; Turner, Beidel, & Stanley, 1992). Obsessional ideation can be distinguished from cognitions or cognitive styles that are characteristic of other psychiatric disorders. In contrast to unwanted and disturbing thoughts observed in psychotic processes (e.g., thought insertion), obsessions are understood and experienced as being internally produced rather than externally imposed. For example, in a psychotic process, an individual may experience distress from hearing “critical” voices and believing that the voices are emanating from real and outside sources. An obsessional thought about needing to confess any and every rule violation may also cause distress, though in this case, the individual is usually aware that the thought is a production of his or her own thinking. Obsessions are also distinct from the excessive worries that typify generalized anxiety disorder (GAD) (e.g., worry about finances, completing daily tasks, getting to appointments on time). The cognitions associated with GAD are future oriented and usually lack the stereotypical or ritualistic behaviors often complementing obsessions. Furthermore, obsessionality is often about feared consequences that are immediate and time-limited. It is not uncommon to observe both patterns of anxious cognitions in the same individual. As discussed later, OCD and other anxiety psychopathology often co-occur.

While the content of some obsessions may be extremely anxiety provoking (e.g., sexual or aggressive images involving loved ones), the content of obsessions does not appear to discriminate between pathological and nonpathological obsessions. In the adult literature, the major distinction between nonimpairing and pathological obsessions involves the degree of distress and amount of time that is associated with efforts to resist, regulate, neutralize, and/or suppress the intrusive thoughts (Rachman & Hodgson, 1978; Salkovskis & Harris, 1984). In nonpathological forms, an occasional disturbing thought may be intrusive or invasive, but it may be dismissed without lasting consequences and persistent anxiety. Similar findings have been reported for adolescents (Flament et al., 1990). There is some evidence that the degree of distress caused by intrusive thoughts is influenced by cognitive information processing, which includes attentional biases, appraisal processes, attributions about the content of the thoughts, and the role of the self in relation to these thoughts (Bolton, 1996; England & Dickerson, 1988; Leonard, Goldberger, Rapoport, Cheslow, & Swedo, 1990; Parkinson & Rachman, 1981; Salkovskis, 1985). For example, investigators have argued that perceived controllability, assumed (and overestimated) responsibility, self-criticism and blame for thought content, and the unacceptability of thoughts or images distinguish pathological and nonpathologic forms of obsessions (e.g., Rachman & Hodgson, 1978; Salkovskis, 1985; Turner, Beidel & Stanley, 1992). Thus, a better understanding of normative developmental processes regarding attributions of responsibility (i.e., internal–external), controllability, and stability should inform our understanding of a child’s or adolescent’s risk for specific maladaptive obsessions. Fearful and particularly salient attributions, such as potential harm to a family member, are likely to