Using Family-Based Exposure With Response Prevention to Treat Obsessive-Compulsive Disorder in Young Children: A Case Study

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Cognitive-behavioral therapy (CBT) using exposure with response prevention (ERP) is the treatment of choice for obsessive-compulsive disorder (OCD); however, developmental modifications should be considered when treating young children. This article presents a case study illustrating family-based CBT using ERP with a 7-year-old boy. The delivery of ERP for this case was guided by 3 main principles: (a) family involvement with a focus on reducing family accommodation, (b) understanding the functional relation between the client's obsessions and compulsions, and (c) creating conditions to facilitate habituation during exposure. Outcomes for this case indicate significant improvement in functioning and OCD symptoms. Results highlight the importance of family involvement and the applicability of using a function-based habituation framework when delivering ERP to this unique population. J. Clin. Psychol.: In Session 72:1152–1161, 2016.

Keywords: obsessive-compulsive disorder; young children; family-based cognitive behavioral therapy; exposure with response prevention; habituation

Obsessive-compulsive disorder (OCD) is a neurobehavioral disorder that affects individuals across the lifetime, including young children. Around 2%–4% of the pediatric population will have OCD at some point in life and an estimated .5% of this same group suffers from OCD at any given moment (Heyman et al., 2003; Valleni-Basile, Garrison, Jackson, & Waller, 1994); however, these numbers may underestimate the prevalence of OCD given young children may lack the ability to share their OCD symptoms with others (Freeman et al., 2012). Research shows that young children (defined as 8 years of age and younger) with OCD have a similar symptom presentation and severity level compared to later childhood onset OCD (Garcia et al., 2009). Appropriate assessment and treatment is crucial given that pediatric OCD has adverse developmental consequences and is associated with significant impairments and problems at home, at school, and with peers (Piacentini, Bergman, Keller, & McCracken, 2003).

Cognitive-behavioral therapy (CBT) using exposure with response prevention (ERP) has been identified as the first line treatment for children and adolescents with OCD (Geller & March, 2012; Freeman, Garcia, et al., 2014). For children with moderate to severe OCD, the combination of ERP and a selective serotonin reuptake inhibitor (SSRI) may be most beneficial. Treatment components of CBT for OCD typically include psychoeducation, symptom assessment and hierarchy building, ERP, and relapse prevention. Use of CBT has been shown to be effective in treating OCD for even the youngest patients aged 5–8 years (Freeman, Sapyta, et al., 2014). When treating young children with OCD, developmental modifications should be considered (see Choate-Summers et al., 2008). Most notably, parental involvement and use of parenting skills are crucial given developmental limitations of young children and the effect OCD can have on family functioning.

Research has shown that ERP is a critical ingredient in CBT treatments for OCD (Freeman, Garcia, et al., 2014). The process of ERP, however, may vary depending on the therapist's theoretical approach and the hypothesized mechanisms of change (see Conelea &

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Table 1
Functional Variations of Same Topographical Presentation of OCD Handwashing Symptom

	Example 1	Example 2	Example 3
Presenting concern	Child is washing hands 30 times per day	Child is washing hands 30 times per day	Child is washing hands 30 times per day
Specific fear/obsession	"I'm going to get sick because my hands are dirty"	"I'm a bad person because I said a swear word"	"I'm going to infect my parents and they will get sick"
Ritual	Wash hands to remove contaminant	Wash hands to neutralize thought and undo swear	Wash hands to prevent spread of germs
Core fear	Harm to self	Morality/scrupulosity	Harm to others
Example exposure	Touch bottom of shoe and resist washing hands	Write down a swear word and resist washing hands	Touch bottom of shoe and shake parent's hand without washing

Note. OCD = obsessive-compulsive disorder.

Freeman, 2015). The delivery of ERP for this case study was guided by three main principles: (a) family involvement with a focus on reducing family accommodation, (b) understanding the functional relation between the client's obsessions and compulsions, and (c) creating conditions to facilitate habituation during exposure. An overview of each of these principles is presented below.

Family accommodation refers to ways in which other family members assist or modify their own behaviors in response to client symptoms. Accommodation within the family is a common occurrence in pediatric OCD, adversely affects treatment outcome, and is positively related to symptom severity, behavior problems, and functional impairment (Lebowitz, Panza, Su, & Bloch, 2012; Storch et al., 2007). Childhood OCD can take many forms; common examples include providing reassurance, allowing avoidance, participating in rituals, and changing family routines. From a theoretical perspective, family accommodation serves as a reinforcement of the client's symptoms. Although family accommodation provides relief in the short term, it maintains symptoms over time. Therapist understanding of the family context, including patterns of accommodation, is a crucial adaptation of CBT when treating younger patients with OCD (Freeman et al., 2012).

To optimally deliver exposure, it is important to understand the relation between a client's obsessions and rituals (see Conelea, Freeman, & Garcia, 2012). Rituals that look similar topographically (e.g., handwashing) may serve different functions depending on the obsessions (e.g., fear of getting sick, neutralize intrusive thought). Table 1 illustrates how the same presenting concern may serve different functions and ERP should be approached differently for each case. Without this functional understanding, exposures may not activate the fear as intended, may be too easy, or may be too difficult. The process of hypothesis testing and understanding the relation between obsessions and compulsions should occur throughout treatment.

There are several different theoretical frameworks a therapist could use to approach exposure (see Conelea & Freeman, 2015). One of these frameworks is the habituation model, which proposes that exposure reduces anxiety through habituation to feared stimuli, and that the process of habituation is passive and internal (Benito & Walther, 2015). According to this theory, optimal exposure would involve activating the fear, minimizing behaviors that function to reduce anxiety (i.e., negative reinforcement via rituals, avoidance), and allowing time to pass so that anxiety will run its course and attenuate on its own (i.e., habituation). If the fear is activated and the child does not engage in behavior to actively reduce anxiety, then one would expect anxiety to naturally decrease within and across exposure trials. To facilitate these conditions, therapist behaviors during exposure should maintain or increase focus on the anxious trigger and associated obsessions, and therapist behaviors that actively reduce anxiety, such as making

the exposure easier once it has started, should be avoided. These parameters will allow for the client's distress to naturally reduce over time.

Presenting Problem and Client Description

The client, referred to as "Lyle," was a 7-year-old male presenting to outpatient therapy for concerns related to anxiety. The family described a gradual onset of obsessions starting approximately 6 months before the intake; however, the client only recently disclosed experiencing obsessions when his rituals became more interfering. He had no prior psychiatric history but was described as being temperamentally rigid and perfectionistic before the onset of these symptoms. At the time of intake, Lyle reported experiencing frequent obsessions related to contamination (e.g., germs), aggression (e.g., harm coming to self and others, violent images, fears about acting on an unwanted impulse such as cursing), sexual thoughts (he initially would not share specifics), and scrupulosity (e.g., making wrong decision, breaking rules).

The family described many compulsions including handwashing, toileting and other cleaning rituals, avoidance, checking, reassurance seeking, and confessing. These symptoms were described as frequent, distressing, and impairing. Consistent with the literature on the psychosocial effect of OCD (Piacentini et al., 2003; Piacentini, Peris, Bergman, Chang, & Jaffer, 2007), Lyle was having great difficulty completing his homework. He also had significant attentional difficulties that had worsened over the school year, which coincided with the onset of obsessional thoughts. The client was an only child living with both parents. Parents described increased strain in the parent–child relationship due to conflict around rituals. Parents also reported they must respond to his almost constant reassurance seeking because Lyle becomes distressed when they do not say what he wants.

Case Formulation

Lyle met criteria for OCD according to the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition* (American Psychiatric Association, 2013) criteria. The Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS; Scahill et al., 1997) was administered to assess the severity of his symptoms. Lyle and his parents endorsed items consistent with moderate OCD symptoms (score = 20). Most notably, his compulsions were described as "constant" and severe. Lyle also presented with symptoms consistent with attention-deficit/hyperactivity disorder (ADHD)–inattentive type; however, this diagnosis was provisional given the possibility that attention difficulties were secondary to his OCD symptoms. Ongoing monitoring of attention symptoms was conducted throughout treatment. Family accommodation and maintenance of Lyle's OCD was an important component of his case conceptualization. Parents were assisting with rituals, frequently providing reassurance, and had difficulty tolerating Lyle's distress when rituals were interrupted. Parents acknowledged their involvement in the client's symptom presentation and were focused on the relief Lyle experienced as a result of their reassurance.

To fully understand the relation between Lyle's rituals and obsessions, we conducted a functional assessment of symptoms using the protocol outlined by Conelea, Freeman, and Garcia (2012). This assessment was crucial in identifying several core obsessional themes: harm to self, harm to others, morality, and uncertainty/doubt. This assessment also clarified that specific rituals were related to different core obsessions depending on the context. Figure 1 is a selective portion of Lyle's functional symptoms assessment.

One of the barriers to this process was that Lyle was experiencing anxiety simply stating some of his obsessions aloud and initially refused to provide specifics around certain topics. To address this barrier, general names (e.g., "my worst thought") were used until we could do targeted exposure work around saying content aloud. Given that functional assessment can be difficult with this age group—because many youngsters have difficulty reporting their feared consequence behind a ritual–it is important to use different strategies to assess these relations such as using behavioral observation, reframing the question to be more developmentally appropriate, and using caregiver report.

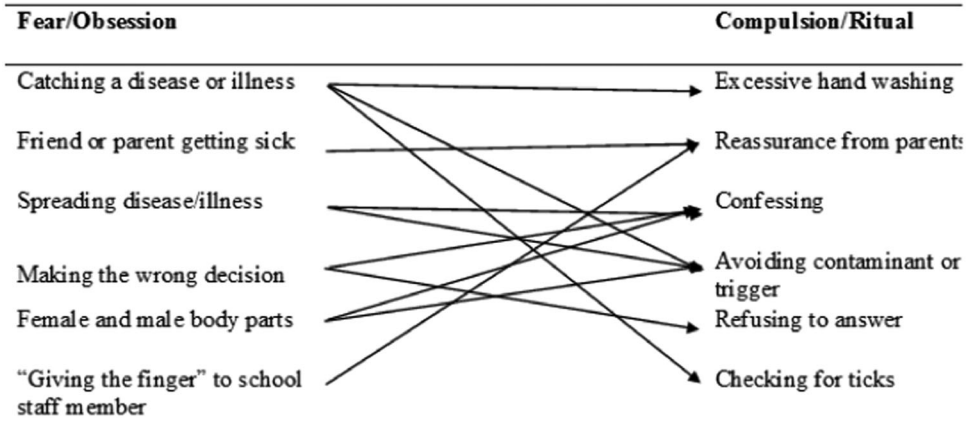

Figure 1. Selected sample of functional relationships between obsessions and compulsions.

Course of Treatment

Lyle received 24 sessions of family-based CBT, based on the manual *Family Based Treatment for Young Children with OCD: Therapist Guide* (Freeman & Garcia, 2008), over the course of 10 months. As previously described, the primary technique used was ERP and was approached using a habituation framework, emphasizing the natural reduction of anxiety without use of other approaches to reduce anxiety. Parents were involved in all treatment sessions with the goals of (a) reducing family accommodation of anxiety, (b) improving family problem-solving and positive communication around client symptoms, and (c) modeling of ERP for skill generalization to the home environment. A family-based approach was discussed at the outset of treatment to increase parental engagement in treatment.

Sessions 1–2

The first session was a psychoeducation session about OCD and the treatment approach. The family was somewhat naïve to OCD and ERP except for materials found through basic searches on the Internet. Given Lyle's age, it was important to meet with parents first to present a neurobehavioral framework, clearly explain ERP, ensure they understood the rationale for ERP, ensure they were supportive of the treatment, and address any concerns they might have. The parents were also educated on research regarding the effectiveness of CBT in combination with a SSRI for OCD. The option for a medication referral was discussed; however, the family opted to try an initial trial of ERP and defer a medication evaluation because of Lyle's age and because he had no previous trial of ERP. With Lyle, developmentally appropriate psychoeducation was used. OCD was presented as a "brain hiccup," with a focus on externalizing OCD and removing blame. Lyle was asked to name his OCD and draw a picture of it. He chose the name "OCD Vader."

A fear thermometer was introduced and practiced with a variety of scenarios. ERP was introduced as the way to "boss back" OCD. It was explained that we will do the opposite of what OCD Vader wants, and although it will make him uncomfortable at first, it will get easier over time. Lyle played soccer and his experience with learning soccer was used to illustrate how practice can help things get easier over time. A metaphor of going into the cold ocean and your body adjusting to the temperature was used to illustrate habituation. Additionally, discussion around pace of exposures emphasized the ideas that we would "start low and go slow" and that exposures would be done collaboratively. Lyle seemed to understand these basic principles and his parents were in agreement to continue treatment.

The second session focused on the functional assessment of symptoms and creating a fear hierarchy. The client was unable to discuss triggers or content related to sexual obsessions

but he did engage in hierarchy building around easier topics, such as contamination. Lyle identified contamination as the area he wanted to start "bossing back" OCD Vader. Parental monitoring of symptoms and practice externalizing OCD were the main areas of therapeutic homework.

Sessions 3–8

Exposures were introduced in session 3 and targeted contamination fears. Easier exposures were first identified from the hierarchy and ritual prevention was discussed before the onset of the exposure. Easier exposure items from the hierarchy were specifically chosen to set the stage for a successful exposure experience, increase Lyle's confidence and self-efficacy in using this approach, and gauge his ability to provide accurate fear ratings given his young age. Example contamination exposures during these sessions were (a) touching the inside of the trashcan without washing hands or asking for reassurance, (b) touching parents' food with "dirty" hands and not confessing, and (c) eating a piece of candy after it had touched something "dirty" and not confessing or seeking reassurance.

During these early exposures, ongoing case conceptualization and hypothesis testing of Lyle's core fears were especially important to better design and titrate exposure. For example, it became clear that some of Lyle's handwashing served the function to protect not only himself but also his parents from becoming ill. Having his parents touch or consume objects that he touched with dirty hands increased the difficulty of his exposures. Young children are often inaccurate raters of how difficult an exposure might be or unable to articulate the obsession driving their compulsion; therefore, hypothesis testing during exposure is especially important when treating younger children with OCD.

Reducing parent involvement in reassurance seeking and confessing was a key feature during these initial exposures. Parents were coached on how to respond to Lyle when he confessed or sought reassurance. Lyle's family also benefited from teaching about scaffolding exposures and how to handle unexpected triggers. For example, the parents were taught how to label OCD during unexpected exposures, validate Lyle's emotional experience, and encourage some degree of approach to the anxious trigger. Overall, Lyle did great with these initial exposures in the office. Though somewhat reluctant, he was always agreeable and engaged in an exposure of his choice. At times, Lyle would engage in distraction by talking about other topics of interest such as the toys in the office. When this occurred, Lyle was simply redirected back to the exposure task. Positive attention through praise, externalization of OCD, and positive self-talk (e.g., "I can do this") were used to support Lyle during his exposures.

Because Lyle had both some initial progress with contamination and spent an excessive amount of time doing homework nightly, exposures shifted to focus on his core fear of doubt. Lyle had great difficulty making decisions in general. Exposures, therefore, focused on Lyle making decisions and sitting with doubt without parents providing reassurance. In fact, parents were encouraged at times to increase Lyle's doubt during the exposure (e.g., "That answer could be wrong"). This treatment target was achieved initially through more contrived exposures, such as picking a favorite "toy" in office, and then through naturalistic opportunities with homework and making decisions at home (e.g., picking a movie during family movie night). A plan to reduce reassurance during homework was made collaboratively with the client and parent with good success. Over the course of a few weeks, Lyle was able to reduce the amount of time he spent on homework from approximately 3 hours per night to around 30 minutes.

Before session 7, Lyle reported to his mother that he did not want to continue treatment. Exposure, he said, was "hard." During the next session, his feelings were validated and processed. A rewards system was developed to enhance treatment engagement and provide motivation for participation in exposures. While Lyle agreed to continue treatment and was able to continue exposure that session, his reluctance highlights the importance of using a reinforcement system with young children engaging in exposure. Rewards were previously discussed with the parents but they did not want to use rewards at that time. Retrospectively, it would have been beneficial to have spent more time exploring the barriers to parents using rewards at the initiation of treatment.

Sessions 9–16

The next eight sessions primarily focused on addressing Lyle's intrusive worries and avoidance of sexual content. Two sessions were focused on reviewing the rationale and benefits of doing exposures with this content area and normalizing this OCD content for the client. Lyle continued to engage in other exposures. Because it was hypothesized that Lyle's core fear was related to morality and being "bad" for having such thoughts, other exposures in the same core fear area were conducted as a bridge to address these symptoms. For instance, the client wrote down and said swear words aloud without getting reassurance or confessing to the other parent.

Lyle was eventually able to build a hierarchy around sexual content with the highest trigger being "his worst thought." At this time, the client was unable to state the thought aloud. Example exposures used with Lyle were as follows: hearing the first author (JH) and parents say avoided words aloud (e.g., kiss, butt, penis); writing or saying the word; and watching cartoon characters kiss. Because Lyle was worried about being "bad," adding uncertainty around others seeing or hearing him engage in these actions increased the exposure difficulty. Therefore, we intensified such exposures by having him put his name on the index card with the word "butt" or have him place the card in a public recycle bin where someone might have seen him. Despite initial distress, Lyle habituated during each of these exposures. Short exposures were repeated in session to promote between trial habituation.

Given Lyle's age, exposure was also made more engaging while still focusing on the uncomfortable content. For instance, we played an alternate version of Go Fish, in which we wrote words on cards that were difficult for Lyle (e.g., boobs, butt, kiss). The client then had to ask other players, "Do you have a [boob]?" Lyle was consistently completing exposures at home and family noted progress. He also reported less frequent intrusive thoughts related to sexual content and a reduction in distress with such thoughts. He specifically reported at this time that the thoughts bothered him only a few times a week, whereas they used to bother him hourly. This was also evident in behavioral observation. For instance, the mother reported that Lyle was able to sit through a kissing scene on a TV show compared to his previous behavior of running out of the room or screaming to turn off the television. Because of Lyle's progress, we transitioned to meeting every other week during this middle part of treatment.

Sessions 17–24

During the final eight sessions, Lyle was able to complete more difficult exposures (e.g., client drawing female and male body parts, looking at nude artwork); thus, we were able to focus on maintaining gains and preventing relapse. The strategies for preventing relapse were educating the family about the chronicity of OCD, emphasizing the importance of continued exposure practice, and preparing the family to manage re-emergence of symptoms. Typical developmental stressors, such as starting a new school year, were identified and discussed as possible times OCD symptoms may increase.

In session 17, the client presented with a new OCD symptom: He was avoiding a particular set of toys because he associated the toys with a female body part. This was taken as an opportunity to help the family learn to deal with a new symptom. They created a fear hierarchy on their own and did a nice job of identifying exposures of various titrations for the fear hierarchy. Lyle was able to do an exposure related to the female body part in that session. Other developmental issues, such as peer conflict, also presented during this stage of treatment. Problem solving was introduced to help facilitate Lyle's ability to manage challenging situations.

In session 22, the client was able to write down his most difficult thought but not share it with his parent or JH. Though this had previously been identified as a 10 on a scale of 0–10, his actual anxiety was a 5. Lyle was able to sit with the thought and reported reduction in fear, and he was able to share his thought aloud in the following session. Even with decreased treatment frequency of once per month, Lyle was able to maintain gains. In the final session, a "graduation" meeting, we reviewed skills and celebrated Lyle's gains.

Outcome and Prognosis

OCD Severity

The CY-BOCS was used as the primary outcome measure for this case. The CY-BOCS is the "gold standard" for assessing OCD severity in a pediatric population and has been shown to have good psychometric properties (Scahill et al., 1997). Preliminary findings on the reliability and validity of the CY-BOCS among younger children (aged 5–8 years) demonstrated adequate psychometric properties, except for the Obsessions subscale, which should be interpreted with caution (Freeman, Flessner, & Garcia, 2011). The CY-BOCS includes a semistructured list of common OCD symptoms, including possible obsessive and compulsive symptoms. Following the checklist portion of the measure, the next sections inquire about the frequency, interference, distress, ability to resist, and perceived control of obsessive and compulsive symptoms. Each of these categories is rated on a 5-point Likert-type scale and total scores range from 0 (subclinical) to 40 (extreme). The CY-BOCS can be administered jointly with the child and parent, or separately, depending on the clinician's judgment of developmental appropriateness. Given Lyle's age, the CY-BOCS was administered to both the caregiver and the client at the same time.

Lyle's pretreatment CY-BOCS was a 20, which is in the moderate range. The CY-BOCS was readministered at session 23 and was an 8, which is in the lower end of the mild range and below the traditional clinical cutoff. These gains were maintained at a 1-month follow-up appointment (session 24) per the family report. Research suggests a decrease of 45%–50% in CY-BOCS scores is ideal to detect symptom remission (Storch, Lewin, De Nadai, & Murphy, 2010). Using this criterion, Lyle would be classified as being in symptom remission at posttreatment. Overall, Lyle's reduction in symptoms per the CY-BOCS change reflects a positive response to treatment and overall improvement.

Clinical Global Impressions (CGI)

The CGI is a well-established research and clinical rating tool that assesses illness severity (CGI-Severity) and change from the start of treatment (CGI-Improvement), rated on 7-point scales (Busner & Targum, 2007). Figure 2 shows Lyle's CGI over the duration of treatment. Lyle had a strong initial treatment response during the first 16 weeks of treatment and these gains were maintained over the next few months. As he completed more difficult exposures, we shifted our focus to relapse prevention and treatment frequency reduction. Lyle showed additional

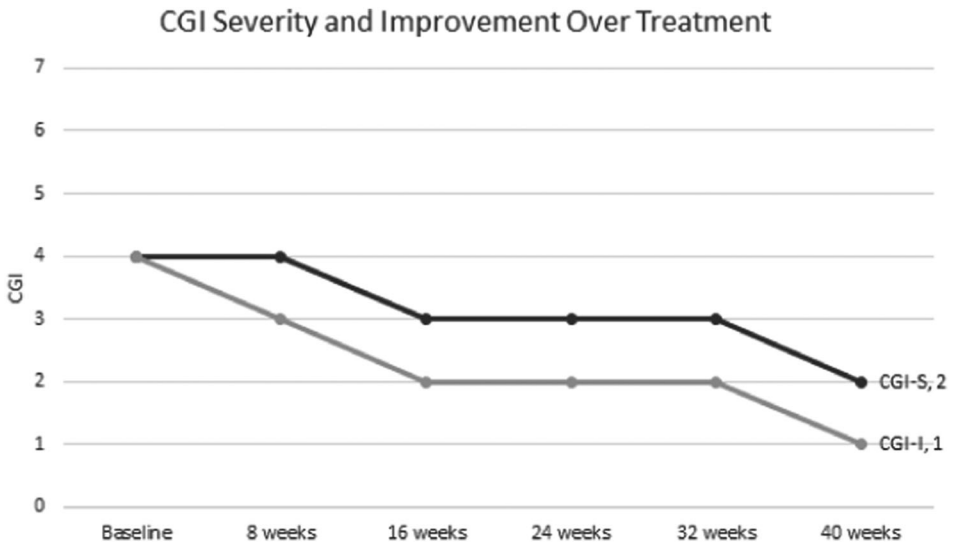

Figure 2. CGI ratings over course of treatment.

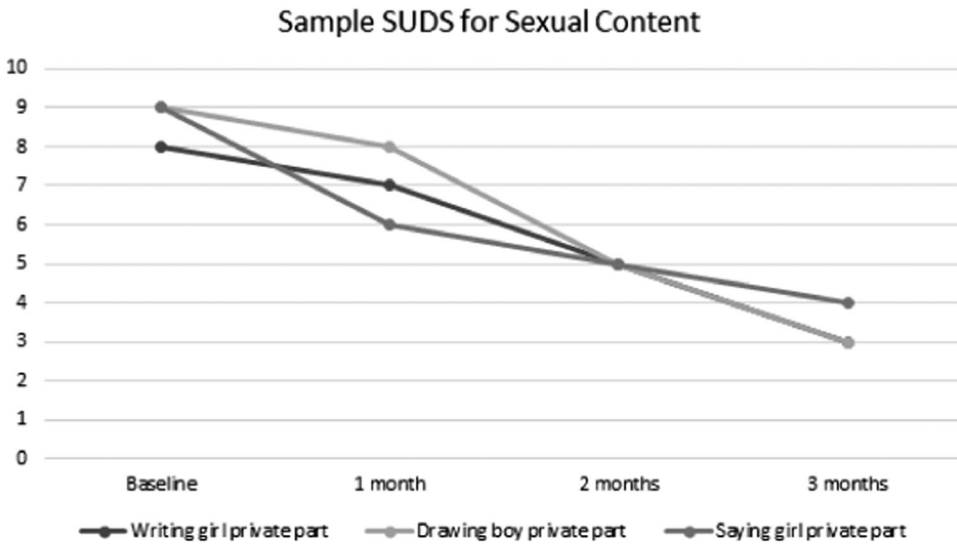

Figure 3. Ratings of SUDS for selected exposures.

improvement in the last 2 months, which is most likely attributable to his being able to complete exposures from the top of his hierarchy.

Subjective Units of Distress (SUDS)

We also used child-reported SUDS data obtained over time. According to habituation theory, one would expect not only within-trial habituation but also between-trial habituation. This particular client was able to use a rating scale of 0–10, though many patients in this young age group need a modified version of SUDS, such as using descriptors and hand gestures for "none," "a little," and "a lot" or a visual representation of anxiety, such as stacking cups, to show the amount of distress. Figure 3 shows Lyle's SUDS ratings for selected items on his fear hierarchy around sexual content across a portion of treatment.

As illustrated, Lyle's SUDS ratings decreased over time. Although his ratings never reached "0," this was not the ultimate goal or expected outcome. Most children find this type of content slightly uncomfortable. The goals were to reduce the intensity of distress associated with the content and increase his ability to handle his distress when confronted with uncomfortable stimuli. According to Lyle and his family, these goals were achieved. Lyle was reporting less distress with content related to body parts and intimacy (e.g., kissing) and showing improved ability to cope with more naturalistic exposures (e.g., seeing young couple hold hands and kiss on the beach).

Other Results of Clinical Significance

Functional impairment was also observed to improve greatly over the course of treatment. Piacentini and colleagues (2003, 2007) found homework and difficulties concentrating to be the commonly endorsed OCD-related impairments. This was true in Lyle's case. By the end of treatment, however, the time it took for Lyle to complete homework was dramatically reduced, from multiple hours to a half hour. His attentional difficulties noted in the initial evaluation also improved over the course of treatment, suggesting his inattention was mainly reflective of his obsessions. Thus, a diagnosis of ADHD–inattentive type was not assigned; however, his parents were encouraged to monitor his inattention given the rates of comorbidity between OCD and attention deficit hyperactivity disorders.

Clinical Practices and Summary

Overall, this case example highlights several important features with this unique population: (a) the importance of family involvement in the assessment and delivery of treatment, (b) the consideration of the functional relationship between symptoms, and (c) the application of ERP using a habituation theoretical framework. Previous research clearly suggests the need for family involvement when working with young kids with OCD. Family participation is crucial given that there is often family accommodation that maintains symptoms. When working with young children with OCD, therapists should be careful to adequately assess for and integrate family accommodation within the client's case presentation. This case also underscores the importance of reducing family accommodation as a treatment goal. Young children can be unreliable or inaccurate reporters; therefore, caregivers are a vital source of assessment information. Last, caregivers can serve as a "home coach" and play an important role to positively reinforce and be the driver in the delivery of exposure at home.

This case also provides further support for the importance of appropriate assessment of OCD in young children. Because young children often have ritualistic behavior, it is important to assess whether behavior is developmentally typical or beyond what is expected. The level of distress and interference around rituals are good indicators of whether it is atypical. This case also highlights the presence of multiple obsessional themes in a young child, such as scrupulosity and sexual obsessions. Previous research has suggested scrupulosity obsessions appear to be common in a sample regarding young childhood, which may be reflective of the developmental stage of young children being rule governed and having black and white definitions of right and wrong (Garcia et al., 2009).

Completing a functional assessment of symptoms enables therapists to treat a child's OCD more effectively through designing appropriate exposures. A therapist is able to use assessment data to determine what exposures "look like" (topographical information about obsessions and compulsions) and what "happens" during exposures (using functional information) to target fears and associated rituals to promote habituation (Conelea et al., 2012). This case study demonstrates that this model and theoretical approach to using ERP can be applied to young children. While challenging at times, exposures were designed to not only be fun and engaging for the young child but also activate and maintain his fear to ensure habituation. Thus, Lyle was not taught any anxiety management or reducing techniques, such as relaxation or changing anxious thoughts; he was encouraged to sit with the fear or uncomfortable experience. Positive attention through praise, externalization of OCD, and positive self-talk were integral to support Lyle during these exposures. Lyle experienced habituation both within and across exposures. His positive clinical outcomes suggest use of a function-based assessment and habituation-guided framework to delivering ERP is acceptable and relevant in young children.

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