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OCD and Exposure Response Prevention

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Abstract

"Obsessive-Compulsive Disorder (OCD) is a neuropsychiatric condition that ranges in severity, with the presence of obsessions or compulsions that are time-consuming…or cause marked distress or significant impairment" (Dyches et al., 2010, p. 35). It is the fourth most commonly diagnosed mental illness in the United States, affecting 1 in 200 children and adolescents (Bornheimer, 2014; Whiteside et al., 2014). Cognitive Behavioral Therapy (CBT) with Exposure Response Prevention (ERP) is the primary choice for treating youth diagnosed with OCD (Morgan et al., 2013). Due to the lack of research on the use of ERP in the treatment of children and adolescents suffering from OCD, this qualitative study will explore the effectiveness of ERP from the perspective of professionals working with this population. The main research question for this study was: *What are professionals' perceptions on the effectiveness of Exposure Response Prevention for children and adolescents diagnosed with Obsessive Compulsive Disorder?* Data were collected through face to face and phone interviews with four professionals that have experience utilizing ERP with this specific population. The interviews were transcribed and coded using a grounded theory approach. Within the findings the five major themes that emerged were 1) strengths of ERP, 2) education, 3) ethical concerns, 4) treatment interfering behaviors and 5) distress tolerance. These five themes were supported with seventeen subthemes. Data in this study supports the effectiveness of using ERP with children and adolescents diagnosed with OCD.

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OCD and Exposure Response Prevention

Obsessive Compulsive Disorder (OCD) occurs in nearly 1 in 200 children and adolescents (Whiteside et al., 2014). Since the 1960's, research on Cognitive Behavioral Therapy (CBT) involving Exposure Response Prevention (ERP) has shown to be an effective form of treatment for patients diagnosed with OCD (Strauss et al., 2015). Most studies, however, focus largely on adults. To date, there has not been significant research done on young children and adolescents. Previous research supports the effectiveness of ERP with adults experiencing OCD, whereas research into pediatric OCD focuses on case series and open trials of individual, family, or group-based treatments (Bolton & Perrin, 2006). ERP can also be used in non-traditional CBT format, but that is beyond the scope of this paper.

A diagnosis of OCD can be very debilitating for children and adolescents. "OCD is a neuropsychiatric condition that ranges in severity, with the presence of obsessions or compulsions that are "time-consuming (i.e., they take more than one hour a day) or cause marked distress or significant impairment" (Dyches et al., 2010, p. 35). OCD presents two primary clusters of features, which are obsessions and compulsions that are both distinct and correlated. Obsessions can be persistent ideas, thoughts, impulses or images (Dyches et al., 2010). Obsessions are intrusive and often dystonic in nature, resulting in underlying anxiety and distress. The obsessions are unwanted and usually irrational. The individual is not able to control their obsessions because their whole life consists of fear and doubt. Obsessions are often accompanied by compulsions; compulsions are also unwarranted or irrational repetitive behaviors or mental acts which individuals use to reduce the stress they experience from their obsessive thoughts (Dyches et al., 2010). An obsessive thought could be contamination based i.e. the fear of germs. The contaminant compulsive behavior/act might be the repetitively

washing of their hands. This behavior is not a separate or distinct choice for the client, it is an absolute. The severity of these symptoms can change over time. For instance, hand washing could go from multiple times a day to multiple times in an hour (Dyches et al., 2010). With OCD there is a vicious cycle that has to be performed. Abramowitz, Brigidi, Roche (2001) defined this cycle as:

> Obsessional thoughts are experienced as intrusive and repugnant and therefore cause increased distress and anxiety. Compulsive rituals, on the other hand, are performed with the aim of decreasing the discomfort associated with obsessions. Usually, the theme of a ritual is associated with that of the obsessional thoughts it is designed to neutralize. For example, someone with intrusive thoughts of contamination from urine would likely engage in repeated hand washing or cleaning rituals. Likewise, a person distressed over unwanted blasphemous thoughts might neutralize with repeated prayers or apologies to God. (p. 357-358)

Avoidance goes along with that cycle. If someone has an intrusive thought about getting into a car accident, they may avoid driving (Abramowitz, Brigidi, & Roche, 2001). Obsessions can cause fear, making the person become distressed. When this occurs, the compulsion is used in an attempt to relieve the distress that the obsession has caused. For someone dealing with OCD, cycle is being repeated over and over again. This shows their inability to deal with the obsession and how they are flooded with anticipatory fear.

OCD can cause a great deal of stress within an individual's life, making it difficult to navigate through basic day to day functions. The areas of impairment include: family, social, and academic performances (Torp et al., 2014). When children struggle within those areas, it can impact their psychosocial development (Torp et al., 2014). There are a variety of ways that

children and adolescents diagnosed with OCD are impacted on a daily basis.

Prevalence. Obsessive-Compulsive Disorder (OCD) is often viewed in chronic mental illness. OCD is the fourth most commonly diagnosed mental illness in the United States (Bornheimer, 2014). OCD affects 1 in 200 children and adolescents (Whiteside et al., 2014). When looking at the prevalence of OCD, comorbid diagnoses is another dimension to consider. Approximately 2% of children who are diagnosed with Autism Spectrum Disorders are also diagnosed with OCD (Lehmkuhl et al., 2007). According to Storch et al., (2007), comorbidity in child OCD is the rule rather than the expectation, "among children, high rates of comorbid major depression (10-73%), anxiety disorders (26-70%), tic disorders (17-59%), disruptive behavior (10-53%), attention deficit hyperactivity disorder (ADHD; 10-50%) and mania (27%) has been reported" (p. 111). Comorbid disorders need to be evaluated when determining the accurate route of treatment.

Treatment

There are a variety of treatments that can be used for OCD. Cognitive Behavioral Therapy (CBT) with Exposure Response Prevention (ERP) is an evidence-based practice that is the primary choice of treatment for youth diagnosed with OCD (Morgan et al., 2013). The International OCD Foundation (2015) disclosed that in the 1990's CBT with ERP was found to be useful for children and adolescents diagnosed with OCD, and had a 65-80% success rate. Although ERP is the principal choice for treatment, 20-40% of participants refuse treatment or drop out prematurely (Levy & Radomsky, 2013). Within pediatric OCD, up to 30% of children do not respond to treatment and 40% are partial responders (Morgan et al., 2013). Individuals may not want to participate in ERP due to their fear of exposure, and not wanting to directly face their obsessions. Parents of children diagnosed with OCD may be uncomfortable with the idea

of exposure evoking distress within their child; deterring them from having their child participate in ERP treatment.

ERP treatment provides exposure that is repeated and prolonged. It triggers the individual's obsession while helping them to resist their compulsive urges (Abramowitz et al., 2012). Exposure could be active (ex. touching a bathroom door or toilet) or imaginary (ex. confronting intrusive images of killing someone or unwanted sexual ideas) (Abramowitz et al., 2012). Using these techniques, it teaches the patient that obsessional fears are unrealistic, and eventually the anxiety they are feeling will decline even when they do not participate in avoidant or compulsive behaviors (Abramowitz et al., 2012).

There have been significant research supporting the use of ERP for OCD (Abramowitz, Bridgidi, & Roche, 2001; Morgan et al., 2013). There are a multitude of related interventions that have been found to be effective, including: family based approach, mindfulness-based CBT, OCD treatment with a Smartphone application, telephone CBT and metacognitive therapy (Choate-Summers et al., 2008; Abramowitz et al., 2012; Hertensein et al., 2012; Whiteside et al., 2014; Turner et al., 2014; Simons, Schneider & Herpertz-Dehlmann, 2006). Those will be explained in greater deal within the literature review.

Distress Tolerance: Clients and their Families

Another element that is vital in working with children and adolescents with OCD is distress tolerance. When someone is suffering from OCD, they are aware that their obsessional thoughts are intrusive and repulsive, which causes an increase in their distress and anxiety (Abramowitz, Bridgidi, & Roche, 2001). Compulsive rituals are used as an attempt to decrease the discomfort associated with their obsessions (Abramowitz, Bridgidi, & Roche, 2001). "Distress Tolerance... [is] the capacity to experience and withstand negative psychological

states" (Laposa et al., 2015, p. 8). Clients that are involved in ERP are learning about distress tolerance within their treatment. "The basic tenet of ERP is to expose clients to anxiety-producing situations while preventing them from ritualizing. As the exposure continues, anxiety intensity will decrease until the same stimuli no longer cause's anxiety" (Simpson, 2009. p.15-16). By using a symptom hierarchy, which is "a list of all anxiety-producing situations, arranged from least to most anxiety producing", the client will slowly be exposed to situations that bring on anxiety symptoms (Simpson, 2009, p. 16). The use of ERP is assisting clients in new strategies to manage distress and actively resisting the urge to participate in ritualistic behaviors (Simpson, 2009). Simpson (2009) further demonstrated how important it is for children and adolescents to strengthen their distress tolerance through the use of ERP.

Although ERP has shown to be an effective treatment for children and adolescents with OCD, but it can be challenging for them to be put into distress, also causing concern for the parents as well. Parents are usually involved within their child's treatment and because of that parental distress needs to be acknowledged and dealt with simultaneously (Lewin et al., 2014). When a child is participating in ERP, they are working with their therapist in being exposed from less distressing to more distressing symptoms throughout their sessions (Sukhodolsky et al., 2013). ERP directly focuses on the client, but parents also benefit from psychoeducation and are taught how to assist their children with implementing exposure practice assignments at home (Sukhodolsky et al., 2013). It is assumed that parents who are actively involved in their child's ERP treatment can then build their distress tolerance as well.

Distress Tolerance: Professionals

Therapists as well have to build their distress tolerance when it comes to using ERP. There are a variety of reasons why clinicians may be reluctant to provide exposure treatment to

their clients. There are negative beliefs associated with exposure therapy among clinicians that have created barriers within this treatment (Deacon et al., 2013). Therapists experience their own fears when it comes to implementing exposure therapy. These fears include: exposure will harm their clients, prolonged and intense exposure will cause panicked clients to decompensate, lose consciousness, their symptoms will worsen, or they will drop out of therapy (Deacon et al., 2013). In turn, therapists may come to believe that ERP is unethical. "The need to evoke distress in the client in order for new learning to take place may appear to contradict a clinician's ethical mandate to do no harm and the hope to ameliorate a client's distress" (Gola et al., 2015, p. 1). All of these concerns are valid, but if practitioners follow specific guidelines they can prevent and navigate through ethical dilemmas and can improve the delivery of ERP, ensuring ethically sound treatment (Gola et al., 2015).

Ethical Considerations

The literature presented ethical concerns with the use of Exposure Response Prevention, especially in treating children and adolescents. Gola et al., (2015) indicated that there are therapists that hold a negative view about implementing exposure therapy. They have a fear that by using exposure therapy they are going to cause damage toward their clients (Gola et al., 2015). Even practitioners who specialize in treating clients with anxiety have formed a negative view of ERP. Concerns therapists have with exposure seem to come from the fact that exposure evokes distress rather that soothing it (Olatunji et al., 2009). It is suggested, these beliefs come from a lack of adequate training and practitioners may not be utilizing exposure-based techniques within their work with anxiety disorders (Olatunji et al., 2009). "The need to train clinicians in the competent delivery of exposure has been identified [as] an important healthcare priority" (Deacon et. al., 2013, p. 772). Through clear guidelines, ethical concerns could be

reduced. Those guidelines would include the use of informed consent and assent, motivation for treatment, competence, beneficence and nonmaleficence, confidentiality and boundaries. If those are used correctly it can assist practitioners in preventing and navigating through ethical dilemmas within ERP (Gola et al., 2015).

There is limited qualitative research evaluating the effectiveness of ERP utilized for children and adolescents diagnosed with OCD. Therefore, this study will to explore *what are professionals' perceptions on the effectiveness of Exposure Response Prevention for children and adolescents diagnosed with Obsessive Compulsive Disorder?*

Literature Review

In the following literature review, Obsessive Compulsive Disorder (OCD) and Exposure Response Prevention (ERP) will first be defined and described in line with previous research specifically, focusing on children and adolescents. Next, research comparing ERP with alternative forms of treatment will be reviewed. Finally, research regarding ethical concerns in using ERP with children and adolescents will be explored (Gola et al., 2015).

Obsessive Compulsive Disorder

Description. In 1988, the prevalence of OCD in children and adolescents was 0.5% to 1% (March, 1995). OCD currently affects roughly 1-2% of the population (Levy & Radomsky, 2013). Whereas in children and adolescents OCD occurs in nearly 1 in 200 (Whiteside et al., 2014) and 1 to 4 percent of children under the age of 18 (Sukhodolsky et al., 2013). Fifty percent of individuals with OCD have symptom onset by the age of 15 (Nissen & Thomasen, 2008). Research has found that as many as 80% of adult OCD cases develop during childhood or adolescence (Whiteside et al., 2007). One of the top onset periods of OCD is in late childhood (Murray et al., 2015).

OCD is a neuropsychiatric condition with presences of obsessions and/or compulsions, this condition can range in level of severity (Dyches et al., 2010).

According to the DSM 5 (2013):

> Obsessions are recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted, whereas compulsions are repetitive behaviors or mental acts that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly. (p. 235)

Obsessions are involuntary and usually irrational, often causing the person to have feelings of fear and doubt associated with them (Dyches et al., 2010). They can lead to distress and impairment in everyday life, causing individuals to then attempt to ignore or suppress thoughts, images and impulses, in trying to neutralize the obsessions with compulsive thoughts or actions (Dyches et al., 2010). Compulsions are repetitive behaviors or mental acts that are used to prevent or reduce distress or perceived harm (Kircanski & Peris, 2014). The most common type of OCD is compulsive washing and contamination based OCD (Levy & Radomsky, 2013).

Impact. In order to explore the ramifications which OCD has on the individual, Whiteside et al., (2007) conducted a case study on a 14 year old female diagnosed with OCD. She presented with obsessional fear about gaining weight through contamination. This fear was expressed through ritualistic washing and avoidance. OCD can create impairments that interfere with a child's daily functioning, such as family, social and academic performance, which can have undesirable impact on the child's psychosocial development (Torp et al., 2014). To explore the impacts of OCD, Dysches et al., (2010) described in his research the consequence children and adolescents encounter. Those may involve OCD rituals that become time consuming and students may have difficulties with processing social-emotional information, which in turn can

affect their ability to initiate and maintain friendships. Students may experience bullying and be victimized because of their compulsive behaviors/actions; this can make the individual feel the need to hide their compulsions from their peers. In addition, pediatric OCD has been associated with substance abuse, and there can be an increase risk for suicidal ideation (Dysches et al., 2010). Lastly OCD can affect a student's academic performance. Student's full scale IQ is generally in the normal range, but OCD can radically impair their performance, creating difficulties with timed tasks (Dysches et al., 2010). Their OCD symptoms can interfere with their ability to listen in class, finish assignments, engage in conversation, getting to school, and they often have a high rate of truancy (Dysches et al., 2010).

Comorbidity

Comorbid disorders exist when medical conditions present themselves simultaneously in a patient, such as depression and phobias ("Comorbid," 2016). On average 86-90% of individuals with OCD meet criteria for at least one other diagnosis usually involving phobias and panic disorders (Bornheimer, 2014). When considering the use of ERP, which involves an increase in a patient's anxiety and distress levels, it is crucial to examine if exposure treatment is going to exacerbate symptoms of a comorbid disorder (Bornheimer, 2104). Children often experience high rates of comorbid major depression (10-73%), anxiety disorders (26-70%), tic disorders (17-59%), disruptive behavior (10-53%), attention deficit hyperactivity disorder (ADHD; 10-50%) and mania (27%) (Storch et al., 2007, p. 111). According to Ekers, Carman and Schlich (2004), "The prevalence of Obsessive Compulsive Disorder (OCD) in schizophrenia appears to be relatively common with OCD distinct from delusional presentations in 7.8% of cases" (p. 375). There can be clinical implications with clients that have a comorbid disorder. Storch et al., (2008) elaborates how these implications affect treatment for OCD with comorbid

diagnoses, and how these clinical implications should influence the different approaches recommended for OCD alone.

OCD Comorbidity with Autism. There are roughly 2% of children with Autism Spectrum Disorder (ASD) that also have OCD (Lehmkuhl et al., 2007). Evidence for Cognitive Behavioral Therapy (CBT) treatment in pediatric patients diagnosed with both disorders is limited (Murray et al., 2014). The symptoms/behaviors of OCD and ASD can appear similar (Lehmkul, Storch, Bodfish & Geffken, 2007) which can make it difficult to distinguish their symptoms from one another. Murray et al., (2015) and Lehmkuhl et al., (2007) suggested the importance of using CBT with modifications to meet the different needs of a patient diagnosed with OCD and ASD rather than just OCD alone. Research has suggested that the use of CBT, with normal protocols helped with reducing OCD symptoms. However CBT has not been proven as effective with individuals who have ASD (Murray et al., 2015). Therefore, modified CBT treatment should be utilized (Murray et al., 2015).

Treatment

CBT and ERP. Prior to the 1960's people with OCD were treated either with various forms of talk therapy, which focused on understanding the root cause of their problem, or relaxation therapy which aimed to provide immediate escape from their anxiety (Olatunji, Deacon & Abramowitz, 2009). In the 1960's Exposure Response Prevention (ERP) was first developed, and over the years a great deal of evidence supporting its effectiveness has been accumulated (Strauss et al., 2015). Throughout the literature, use of Cognitive Behavioral Therapy (CBT) with ERP has been shown to be an effective treatment technique for pediatric and adolescent OCD (Morgan et al., 2013). The process of exposure is conducted with the child through repeatedly replicating experiences that trigger a client's obsessions (Kireanski & Peris,

2015). Once clients have been exposed, they are encouraged to learn how to resist the associated compulsion or response prevention, through completing a series of exposure tasks or trials (Kireanski & Peris, 2015). The exposure process attempts to break the client's connection between obsessional thoughts and anxiety by weakening the pattern (Whiteside &Abramowitz, 2006). With ERP, obsessional fear will go away over time without rituals, which is known as habituation (Whiteside & Abramowitz, 2006). The clients are able to learn that compulsive rituals are not necessary to avoid or prevent disaster or to reduce their anxiety (Whiteside & Abramowitz, 2006).

According to the Introductory Textbook of Psychiatry (2014), exposure with response prevention for a client is done through the exposure to a feared situation, event, or stimulus. Exposure can be done through a variety of techniques such as imaginal exposure, systematic desensitization, or flooding (March, 1995). A compulsive hand washer may be exposed to contaminated objects by choosing to hold them, and then will resist the urge of washing their hands (Black & Andreasen, 2014). Graded exposure starts off at an easier end of the anxiety-provoking stimuli on a hierarchy order, where clients are able to rank their OCD symptoms from easiest to hardest to resist (March, 1995). This technique may be contrasted to flooding, that involves prolonged exposure to the highest level of anxiety-provoking stimuli. Flooding is believed to maximize treatment benefits with adults but it is not used in pediatric settings (March, 1995).

One underlying principle of ERP is to help the client face their fears without resisting or fighting against them (Wagner, 2002). Resisting and fighting OCD can increase an individual's level of distress and intensify their obsessions (Wagner, 2002). ERP should never be forced, the therapist providing treatment needs to have a balance between encouraging children and

adolescents to engage in exposure, but also sympathizing with their anxiety and distress (Bornheimer, 2014). ERP is a collaborative treatment where the clinician and the client are working together to develop the plan (Bornheimer, 2014). "The clinician must always ensure that the client agrees to the exposure and feels in control of his or her treatment plan" (Bornheimer, 2014, p. 42). As a result, ERP may help children and adolescents to confront their fears and take back control of their lives.

Effectiveness of Exposure Response Prevention

There is consistent empirical evidence suggesting that using exposure based cognitive behavioral treatments reduces anxiety disorder in children (Silverman et al., 2003). If premature termination of treatment occurs, than children are not receiving services that are beneficial to them (Silverman et al., 2003). ERP may be the first choice of treatment, however, up to 30% of children do not respond to treatment, and 40% only partially respond to treatment (Morgan et al., 2013). Researchers have found that 20-40% of treatment-seeking individuals refuse the treatment of ERP entirely or drop out prematurely (Levy & Radomsky, 2013). Professionals are continuing to research on ERP's effects on children and adolescent OCD in order to discover the reasons why individuals chose to complete or not complete treatment. Exposure can be very intimidating for a client, because triggering their obsessions and preventing their compulsions may cause them to experience high levels of anxiety.

With high rates of treatment rejection and drop out, research has suggested there is a need to explore alternatives to ERP (Simons, Schneider, & Herpertz-Dahlmann, 2006). Williams et al., (2014) indicated that the research is not clear as to whether ERP is equally effective for all types of OCD symptoms. When exploring the effectiveness of ERP there are factors to consider such as the OCD symptoms, comorbid disorders, and whether or not the treatment needs to be

altered to fit a client's needs.

Alternative Forms of Treatment. Although Cognitive Behavioral Therapy (CBT) with Exposure Response Prevention (ERP) are the recommended interventions for children and adolescent OCD, there is evidence indicating that alterations can be made to treatment to make it more effective. There were two studies conducted evaluating the use of CBT with ERP for clients diagnosed with OCD and schizophrenia, as well as OCD with Tourette's syndrome (Ekers et al., 2004; Woods et al., 2000). Both of those studies supported the use of CBT but also acknowledged limitations that may occur. The study conducted on OCD and schizophrenia reported that treatment of ERP was effective with specific considerations. CBT has been found to be the appropriate form of treatment when the individual with psychosis was stable; but if they were not stable, research has shown that treatment, should be reviewed (Carman & Schlich, 2004). Another important consideration when determining appropriate treatment is that the therapist is aware of their client's symptoms. There are a variety of factors to evaluate when deciding which treatment and interventions to use for clients with OCD, especially those with comorbid disorders. In these situations, different forms of treatment should be explored.

A quantitative study conducted by Simons, Schneider, and Herpertz-Dehlmann (2006), compared the effectiveness of metacognitive therapy versus exposure and response prevention for pediatric OCD. The research indicated that both MCT and ERP were successful in reducing obsessive compulsive symptom severity. The main difference noted between MCT and ERP is that MCT requires a higher level of self-reflection while ERP has a higher need for emotional regulation (Simons, Schneider & Herpertz-Dehlmann, 2006). With these results, it was suggested the MCT is a commendable alternative treatment to consider.

Research has found that using a family based approach with CBT treatment can be

beneficial (Choate-Summers et al., 2008). The family-based treatment program included psychoeducation, parent education, and exposure response prevention for young children and their parents (Choate-Summers et al., 2008). This program focused on the large role parents have, and how active they are in their child's treatment process. Sixty-two percent of children who completed their treatment were classified as attaining clinical remission of their symptoms (Choate-Summers et al., 2008). Using family-based approaches as alternatives to traditional ERP teaches parents how they can help facilitate their child's exposure therapy, and how couples can help each other within the treatment.

Mindfulness. Evidence presented by Strauss et al., (2015) asserts that 25% of people drop out of ERP treatment early, and those that continue with ERP treatment do not follow the essential elements involved in treatment. Mindfulness may help clients engage in treatment with accepting difficult thoughts, feelings, bodily sensations, and even becoming more aware of urges and learning not to automatically act on them (Strauss et al., 2015). Mindfulness is evaluating an experience in a non-judgmental way; Mindfulness-based Cognitive Behavioral Therapy (MCBT) combines mindfulness training with theoretical elements in CBT (Hertenstein et al., 2012). By incorporating MCBT with ERP patients have been able to experience a variety of benefits and reported that it did not involve harmful outcomes (Hertenstein et al., 2012). Mindfulness can assist clients in engaging in ERP, resulting in better therapeutic outcomes (Strauss et al., 2015).

Treatment and Technology. Clients may face barriers that hinder them from benefiting from CBT, which could require alterations be made to their treatment plan. Some of those barriers may be geographical or financial factors preventing them in receiving CBT (Turner et al., 2014). There are techniques that can be used to help those individuals overcome obstacles such as the use of Telephone Cognitive-Behavioral Therapy (TCBT) (Turner et al., 2014) and

OCD treatment with a Smartphone application (Whiteside et al., 2014). By using TCBT an individual simply needs telecommunication tools such as a telephone, Internet or video conferencing. This creates a more efficient way for professionals to provide treatment in spite of the distance (Turner et al., 2014). The Mayo Clinic developed a Smartphone application called the Anxiety Coach to improve the treatment of pediatric OCD patients (Whiteside et al., 2014). This application was created to support families in completing exposure assignments between sessions. It also provides a detailed examination of the patient's engagement in those assignments (Whiteside et al., 2014).

Exposure therapy is not always easily accessible, especially in community outpatient settings which can create a barrier for client's seeking treatment options. Using an application form called Information and Communication Technologies (ICT) can help (Whiteside et al., 2014). "ICT-based programs provide an appealing option for direct care and treatment dissemination because they are convenient, interactive, and can be individually tailored with little direct contact" (Whiteside et al., 2014, p. 81). The application focuses on three modules; assessment, psychoeducation and treatment. The assessment module helps with measuring the frequency of anxiety symptoms. The psychoeducation module explains the use of the application, the Cognitive-Behavioral (CB) conceptualization of anxiety, descriptions of anxiety disorders, explanations of CBT, and assistance for accessing other forms of treatment (Whiteside et al., 2014). With the use of this application, patients can receive additional help with exposure therapy without direct contact with their therapist.

Medication. The use of medication is also commonly utilized in clinical management for clients diagnosed with OCD (Black & Anderson, 2014). There are medications that have decreased anxiety and reduced OCD symptoms. These medications may reduce symptoms but

they are not a cure for the disorder (Dyches et al., 2010). Selective Serotonin Reuptake Inhibitors (SSRIs) approved by the U.S. Food and Drug Administration have been implemented in treatment of Obsessive Compulsive Disorder (Black & Anderson, 2014). There are a variety of medications that have been used for OCD those include sertraline (Zoloft), fluoxetine (Prozac), fluvoxamine (Luvox), and the tricylic antidepressant clomipramine (Anafranil) (Dyches et al., 2010). There has been a multitude of research supporting the efficacy of using SSRIs for older children and adolescents but there has not been as much empirical evidence supporting the efficacy of medication used in treating OCD in younger, mainly preschool children (Dyches et al., 2010).

Ethical Concerns

Despite the abundance of evidence supporting the use of exposure therapy for children and adolescents diagnosed with OCD, there are also ethical concerns coming from professionals and through public reaction (Gola et al., 2015; Olatunji et al., 2009). There are therapists that have negative views regarding exposure therapy, which may cause them to be hesitant to use it based on their ethical beliefs (Gola et al., 2015). The fact that exposure evokes distress rather than soothes may seem contradictory to clinicians mandate to do no harm (Gola et al., 2015; Olatunji et al., 2009). When dealing with a client that has schizophrenia and OCD, there are concerns that exposure-based interventions may increase stress and possibly enhance vulnerability to psychotic relapse (Ekers, Carman & Schlich, 2004). Gola et al., (2015) and Olatunji et al., (2009) both viewed similar items of importance such as, informed consent, assent, motivation for treatment, session management, managing negative outcomes, competence, beneficence, non-maleficence, confidentiality, and boundaries as all areas that need to be examined through appropriate ethical practice. Research has provided multiple ethical

considerations for exposure therapy with children, and strategies for preventing ethical dilemmas. With additional research it could facilitate better training at the graduate and postgraduate level.

It was evident within the literature that there is still a need for more research to be done on this topic. Most of the research was completed through quantitative studies, and even less research examined the perception of professionals who use ERP. Therefore, a qualitative study was conducted in order to provide descriptive information from professionals' perception of the effectiveness of Exposure Response Prevention for children and adolescents diagnosed with Obsessive Compulsive Disorder.

Theoretical Framework

Obsessive Compulsive Disorder is a debilitating disorder which can disrupt an individual's life immensely (Dyches et al., 2010). OCD is distinguished by unwanted intrusive thoughts, images or urges (obsessions) that are linked to repetitive or ritualistic behaviors (compulsions) (Murray et al., 2015). Individuals may be ashamed of the thoughts and/or behaviors that are related to the disorder (Abramowitz, Brigidi & Roche, 2001). This might cause them to hide their symptoms from friends, family members, peers and even treatment providers (Abramowitz et al., 2001).

An empowerment and strengths-based perspective will be used in the context of this paper, as ERP supports a child's ability to confront their fears and to gain control over their own lives (Wagner, 2002). A strengths perspective emphasizes people's abilities, values, interests, beliefs, resources, accomplishments, and desires (Zastrow, 2010). A strengths perspective is strongly related to the notion of empowerment (Zastrow, 2010). Empowerment can help individuals, families and groups to increase their personal, interpersonal, socioeconomic, and

political strength and work toward improving their circumstances (Zastrow, 2010). A combination of these two perspectives creates the lens through which ERP will be critically examined. From this point of view, this research project will explore specific benefits that ERP may offer to children and adolescents experiencing OCD.

As Wagner (2002) illustrated, clients who chose to participate in ERP and are successful in treatment are able to confront their fears, encouraging them to withstanding their distress until it dissipates. ERP clients, however, are not forced into participating in exposure; the role of the therapist is to have a balance between encouraging exposure and empathizing with their anxiety (Bornheimer, 2014). It is important for the child or adolescent to feel in control of their treatment. ERP can be described as a collaboration model between the therapist and the client (Bornheimer, 2014). ERP therapists support their clients in facing stimuli that are linked to significant fears. The process of understanding and confronting these fears within a supportive environment acts to empower the child or adolescent.

Methods

Research Design

The purpose of this study was to better understand the effectiveness of ERP for children and adolescents diagnosed with OCD from the perspective of professionals working in outpatient, inpatient, or residential treatment settings. This study utilized a descriptive qualitative design. Participants were recruited through convenience and snowball sampling, with a goal of eight to ten semi structured qualitative interviews. A qualitative design was chosen to bring forth insight from professionals' on the effectiveness of ERP with children and adolescents diagnosed with OCD. The final sample consisted of licensed psychologists from outpatient settings.

Participants

Participant recruitment was done through convenience and snowball sampling techniques. The convenience technique helped provide a sample for the researcher that was readily available (Monette et al., 2014). Snowball sampling is a nonprobability sampling technique where the researcher asks participants to refer more participants (Monette et al., 2014). In this study, participants were recruited from an independent boarding school/residential treatment center in Utah that is familiar with using ERP for young men (12-18 years old) with anxiety disorders. This agency was selected due to its use of ERP, and the fact that the researcher had professional contacts there. The researcher also used the International OCD Foundation website (iocdf.org) as part of the convenience sample to search for additional professionals to recruit. Once participants were recruited a snowball sample occurred where they suggested professionals who would be interested in participating in this study. By using those techniques, the goal was to identify eight to ten professionals willing to participate.

This study recruited four participants. All participants were Licensed Psychologists; and one was also a licensed marriage and family therapist. Three participants were male, and one was female. They all worked in outpatient settings. Three were from Minnesota and one was from North Dakota. Participants had extensive experience in working with ERP with a range from ten to thirty years. Participants received varying types of training on ERP such as participating in externships, local and national conferences, and training institutes.

Protection of Human Subjects

The researcher took part in the Collaborative Institution Training Initiative (CITI) prior to conducting the study. This training provided important information on history and ethical principles, research with human subjects, how to assess risk in social and behavioral sciences,

informed consent, privacy and confidentiality, and unanticipated problems and reporting requirements in social and behavioral research. To continue the protection of the participants in this study, the Institutional Review Board (IRB) approved it. Participants that were interested in being interviewed were provided a consent form. The form gave background information about the study, procedures, risk and benefits to participating in this study, confidentiality, the voluntary nature of the study, and contact information. It was emailed to the participant prior to the interview.

Participants had the option to be interviewed in person or by phone, depending on their convenience and location in relation to the researcher. Informed consents were reviewed with the participants before the beginning of the interview, allowing participants to ask any questions they had regarding the study before being interviewed. For interviews that were conducted over the phone, participants gave their consent verbally and emailed a signed copy of the form to the researcher. Interviews that were conducted in person, the consent form was signed before the interview began. In either scenario, participants were asked a series of questions in order to ensure they understood the details of the study, and that they were provided an informed consent. Participants were informed that if they did not want to answer any question they had the right to decline, and they could end the interview at any time with no consequences.

Participants' confidentiality was assured by conducting the interviews in a private setting. The face to face interviews were done at the professional's agency in a private room. If the interview was interrupted it was stopped and restarted once confidentiality could be secured. The researcher was in a private room when conducting interviews over the phone to reduce the chance of interruptions. All interviews were audio recorded for transcription purposes. Participants' confidentiality was protected by removing all identifying information from

interview recordings and transcripts. All voice recordings and transcripts were protected on the researcher's personal computer that was password protected. All recordings and transcriptions will be destroyed by May 16, 2016.

Procedure

Once the IRB approved the research study, the researcher was able to email professionals trained in ERP to see if they were interested in participating. Email addresses of potential participants were obtained through the snowball sample starting with the independent boarding school/residential treatment center in Utah and the International OCD Foundation website. Professionals that were interested were emailed a copy of the consent form. Non face to face interviewees were asked to send back the consent form to the researcher prior to the interview. Professionals interviewed in person could choose to email it back or sign it in person before the interview started. The researcher communicated to the participants through email to schedule a date, time and location of the interview.

Data was collected through four semi structured qualitative interviews either in person or over the phone. Interviews ranged from a minimum of 25 minutes to a maximum of 60 minutes. Phone interviews were recorded using the *Call Recorder* application on the researcher's phone. Face to face interviews were recorded using a basic *Smart Voice Recorder* application on the researcher's phone. All recordings were immediately transferred to a password protected computer and deleted from the researcher's phone. Face to face interviews were conducted at the professional's agency and phone interviews took place in a private setting. The semi-structured interview consisted of questions designed by the researcher in order to gain a better understanding in the effectiveness of ERP for children and adolescents diagnosed with OCD (see Appendix A for a list of questions). Once the interviews were completed, the researcher

provided contact information to the participants in case they had any questions or concerns.

Data Analysis

A grounded theory approach was used in order to uncover emergent themes and subthemes presented in the interviews (Bohm, 2004). Open coding was used first to analyze and break down the data line by line, while asking questions about the transcription such as; "What? What is the issue here? How? What aspects of the phenomenon are addressed or not addressed?" (Bohm, 2004, p. 271). This allowed the researcher to discover what concepts were important in answering the researcher's main question. The researcher read through the interview transcription once to allow themes to emerge while writing notes in the margins of the paper. Then axial coding was used to refine and differentiate concepts that were discovered (Bohm, 2004). Lastly, selective coding was used for the researcher to establish the main trend(s) that appeared within the data (Bohm, 2004). This was done through summarizing the notes and concepts that were discovered during open and axial coding. This helped develop the major themes, sub themes, and relationships between themes. The researcher was the only one that analyzed the data for this study.

Findings

This study explored professionals' perceptions on the effectiveness of Exposure Response Prevention for children and adolescents diagnosed with Obsessive Compulsive Disorder. Overall, professionals felt that ERP was an effective means of treatment when the proper guidelines were followed. This concept was explored in the five major themes that emerged during data analysis. Those five themes include: 1) strengths of ERP, 2) education, 3) ethical concerns, 4) treatment interfering behaviors, and 5) distress tolerance. Each of those themes included subthemes and quotes from the interviews that support them.

Strengths of ERP

Within the interviews, many comments were made in relation to the strengths of using ERP. ERP has been found to be an empowering approach when accompanied by a strengths-based model. There was vigor found within the interviews, in regard to the language used with clients and providing them with a sense of discovery and mastery. There were a variety of reasons why participants believed in the effectiveness of using ERP with children and adolescents suffering from OCD that resulted in the articulation of four subthemes, including: 1) effectiveness of ERP, 2) ERP is strength based, 3) language and 4) reward system with clients.

Effectiveness of ERP. The participants within this study all had great things to say about the effectiveness of Exposure Response Prevention. The common theme among them was, ERP is simply effective. One participant indicated:

> It is empowering, it puts people in the driver's seat throughout change…ERP brings people such a sense of mastery over a difficult internal experience.

Another participant stated:

> It is effective…in helping people get a life that they want to live and tolerate internal states that are unpleasant.

Participants were quick to state that they believe that ERP is valuable, and they all used the term "effective" to describe ERP.

ERP is Strengths Based. Participants also strongly suggested that using ERP with their clients brings a sense of empowerment. One participant commented:

> It is something that people can learn to do more and more of on their own and take with them and apply that strength to other areas of their life.

Another participant focused on how it is strengths based:

> …it is a very non-pathological approach I take with my kids, and so I don't ever want kids to feel like they are defective or something is wrong with them, so we always talk about OCD as kind of a superhero power, that they haven't learned how to control yet.

By focusing on strengths, the client is able to not get stuck thinking that there is something defective about them. This empowerment piece can continue through the language that the therapist integrates into therapy.

Language. Clients can be empowered by the language used by the therapist. Children and adolescents are not going to be able to understand clinical jargon. Using metaphors can help clients understand ERP and their OCD. One participant indicated:

> Well then of course the language, how we use it, language becomes very useful, with little kids. You want to use metaphors as much as possible and imagery and we will talk about standing up to a bully…externalizing OCD as a bully, fighting back, or other people will talk about stealing back what was taken from you.

This is empowering to clients and helps them understand what is taking place within their internal world, and creates a dialogue they can relate to. Another participant indicated:

> Kids understand the concept that they know this is a bully inside of my nervous system. The bully isn't going to leave me alone. The more I listen to the bully and do what the bully tells me the more it is going to control my life. So I do need to stand up to that and do the opposite. Have the bully loose it's power and kids tend to understand that and do really well at treatment.

By externalizing OCD as a bully, it can make it seem manageable for clients to understand and learn how they can fight back. Using metaphors can demonstrate to clients that OCD is not who they are, and that they can take back control over their life. This allows them to live the life they

want. Overall, when therapists use a strengths based approach and apply appropriate language while performing ERP, clients are empowered.

Reward System with Clients. Participants found that implementing a rewards system can be beneficial. Through a rewards system, clients are empowered within doing exposure and it indicates to them that they challenged themselves and did well. One participant stated:

> …we usually build in a reward system…I will use those incentives to help motivate them to do their ERP homework…I usually give stickers, like I was brave type of sticker or a fidget toy or something like that to keep, to kids that had a really successful session where they really pushed themselves.

Another participant indicated:

> Where there is some reluctance is where the reward can come in and that's where really structuring the exposure plan, manageable base, so it is appropriate for the child's situation helps too.

Providing a reward system can help a client feel empowered and believe that they have accomplished something within therapy. A reward system can also be applied with exposure assignments done at home, where parents can provide positive reinforcement for the child that completing their exposure homework.

Education

Within the interviews, the theme of education was stressed. In order to work effectively within ERP for children and adolescents with OCD, education is an important piece. There were three subthemes that emerged within education that included 1) alternative treatment, 2) self-directed care and 3) educating parents. The client, parent, and therapist all need to be involved in the education.

Alternative Treatment. Participants spoke about the importance of educating clients about other forms of treatment. This is important because it allows them to make an informed decision about whether they are interested and willing to participate in ERP. One participant indicated:

> …I am going to share with them alternatives to treatment. Not just ERP, I am going to share with them what I know about potential benefits, potential risks, potential costs, of any of the types of treatments I am aware of. All so they can make an informed decision.

Clients and their parents need to be well informed in order to decide if ERP treatment is the right fit for them. By providing extensive education, they will be better equipped to make that decision for themselves.

Self-Directed Care. Participants explained that an essential part of psychoeducation is teaching clients how to conduct exposure outside of the office. All of the participants interviewed stressed the importance of clients using self-directed care outside of their office. It is critical that clients choosing to participate in ERP learn how to implement the skills they have developed in the therapist's office and apply them into their daily lives. Participants indicated that they assign self-directed care assignments to their clients on a daily basis. One participant explained:

> I always tell them that they are coming here for a lesson about what to do and planning together about what to do. They agree they don't get better by coming here, but by doing the things between visits that we discuss here. So I view the vast majority of it is being self-directed, family directed outside of this setting.

Another participant gave an example of self-directed care with the involvement of parents, teaching both of them how to do exposure outside of the office.

> …So working up through exposures is usually there, resisting reassurance seeking if they are setting a limit to… ask mom and dad no more than this number of times. With night time rituals of having to say "I love you, I love you too, I love you" give a hug, "I love you" kiss on the cheek "I love you," I'll say ok let's set a goal of that and say no more than three I love you(s), let's do a pat on the back rather than a full hug. So we will build in the behavioral exposures as well as the thoughts exposure, and then response prevention.

This supports how clients and parents can work together through exposure at home and apply what they have learned from their therapy sessions. Another participant, being asked about self-directed care, stated:

> They are all going to do that, but we are going to plan it…parents will be in on that planning…for instance…show them how to keep a journal of their planned exposures…What do you want in your life, how is this bothering you, what do you want to steal back, what do you want to fight, what do you want to claim back? Let's talk about how we can do that…if someone is a germaphobe I would prefer they contaminate themselves and [name] never washes his hands…but if they feel they need to, same thing you do, let's see how long we can delay that. Or if we do decontaminate let's recontaminate as soon as we can… [assignments] have to be based off what is meaningful to them.

Self directed care was a common theme throughout the data. Professionals pointed out that self directed care to be an important element within the effectiveness of Exposure Response Prevention.

Educating Parents. Participants specified that it was vital for clinicians working with

children and adolescents with OCD to educate the parents about OCD, treatment options, and what to expect throughout the therapeutic process. According to a participant:

> I like parents in every session if possible. Sometimes when you get teens they don't want that, but we still get parent participation very much of the time. Because they are the best helpers, I want to train parents that are interested, willing and able to be behavioral therapists to be able to support their child because OCD episodes are pretty high, within about five years about half go back to having an OCD episode, so if the parents are involved and they understand the issue and what helped, they can remember longer.

This participant explained that when a child is young and involved in exposure exercises, they often remember the playing aspect of it. They were too young to recognize that they were doing exposure work to help them with their OCD. Parent involvement was stressed for many different reasons; one was to help children to remember the skills that had worked for them in the past.

Ethical Concerns

All participants expressed that they do not have ethical concerns about practicing ERP. They spoke about more ways professionals can ensure ethical practice. They included 1) proper training, 2) informed consent and clear boundaries and 3) ERP should never be forced.

Proper Training. Participants indicated that training was essential to ensure that ERP is done ethically, causing no harm to the client. Although participants indicated that they do not have ethical concerns directly with the practice of ERP, there are a variety of guidelines that have to be followed to ensure clinicians are conducting ERP ethically. One participant indicated:

> OCD is still one of the most misdiagnosed conditions and therapist who think they know Exposure Response Prevention and really don't is very dangerous…or they are tricking kids. I had a little girl that I worked with who is an elevator phobic and the therapist was

> like ‘oh come on sweetheart just get on the elevator, it is fine, I will not push the button.’ And they pushed the button and the doors closed and she had an absolute meltdown, panic attack.

Ethical concerns arise when professionals try to do exposure work with clients, but are not properly trained. There are a variety of ways that participants indicated clinicians can receive proper training. For instance, attending the International OCD Foundation conferences and going to the Behavioral Therapy Training Institute (BTTI).

Informed Consent/Clear Boundaries. Professionals agreed on how important it is to obtain informed consent from clients when practicing in ERP. The interviews also explained how important it is to maintain clear boundaries while doing this work. A participant said:

> Informed consent is critical and with everyone I have worked with…informed consent means I use language in a way that people can consume, they understand it…going to be about patient autonomy, the ability to choose, having information to make an informed decision that is critical.

If the child and their caregivers do not fully understand the treatment being suggested or available alternative treatments, they will not have the necessary tools to make an informed decision. Clients need to be able to understand the therapist’s expiation and comprehend what would be expected of them when participating in ERP. Another participant stated:

> I tend to not have very many ethical concerns about the treatment itself because this is something that if someone invites me to do with them and they are willing to partake, and we are not using punishment and we are not compelling, we are supporting, giving empirically supported treatment, I think that is all for the good…

One participate discussed how informing clients is empowering and allows for self-

determination.

> They are going to know they are going to choose, intentionally to let themselves be uncomfortable and how that might benefit them and they know they have complete say over it, and I am not going to have them do anything they are not willing to do and that I won't do first to model.

This further supports the following theme as to why ERP should never be forced.

ERP Should Never Be Forced. Professionals expressed in their interviews that clients should always have the choice to partake in ERP, and that no one should be forced to participate. It is always the client's choice in what they do and do not want to do within therapy.

> I never want anybody to do anything we discuss here unless they understand what I am asking them to do, why to do it, how to do it, and what they are likely to get as a result of doing it...I very much work in the spirit of attracting children to this change in behavior verses trying to force it or compel it. I don't recommend use of punishment as a strategy and I don't compel people to participate in this treatment.

Another respondent stated:

> And this is all collaboration, if someone is not interested in doing it we will not do that, no matter how much the parents or someone else wants, that is not therapy…that is not exposure.

One participant, highlighting how clients should never be forced into doing exposure, stated:

> By focusing more on the exposure, with my clients I will tell them like ok, I will touch the floor but I want to wash my hands after [speaking as the client], ok fine, I am ok with that, let's just focus in the moment, mindfulness, touch the floor, that is all we are going to do, I don't know what is going to happen in the future [talking as the therapist]. So

> let's just focus on touching the floor, we will cross that bridge with the response prevention when we get to it…And then a lot of times by the time we are done with the exposure, maybe you started at a four, now you are a two, so do you feel like you still need to wash your hands [talking as the therapist]? Well not really [talking as the client].

This showed how ERP is not being forced due to the fact that the therapist is working with the client and not compelling them to do anything they are not ready for.

Treatment Interfering Behaviors

A common theme that arose from the interviews was about Treatment Interfering Behaviors (TIBs). Three subthemes emerged; 1) family and parent involvement, 2) comorbid disorders effecting route of treatment and 3) the client. ERP has been found to be effective, but there are TIB's that can make treatment challenging. TIB's exist within the family, parent involvement and with comorbid diagnoses.

Family and Parent Involvement. Participants discussed that TIB's do not only occur with the client. There can be TIB's within the family structure and with the parents. The parent's anxiety may need to be address because it could be interfering with the client's treatment. One participant indicated:

> A very powerful challenge…when I am working with children [is] dealing with the parent's anxiety…so when you take a look at a family system, you have child's anxiety; you have parent's anxiety about the child's anxiety of the child becoming anxious seeing the parent's anxiety. [As] parents, we know what it is like to have someone we love in distress.

Another participant furthered the story by stating:

> I don't see too many treatment interfering behaviors in my kids. When I have in the past,

> it has been more family dynamic issues or parents that are having a messy divorce or things like that where I have had to scold parents to remind them that this isn't about them that it is about their child.

And yet another participant indicated:

> …child reluctance or parent…I don't see too much treatment interfering behavior…by the parents you know. Sometimes families are busy and not all families are equally able to follow plans directions. I could ask them to do a symptom monitoring sheet, sometimes it never comes back and it is kind of hard. I can't do any exposure hierarchy very easy, or I spend half of the session trying to get examples of symptoms and find appropriate starting places for exposure.

The dynamics within the family, and how that family system functions, have been found to play a large role in the client's success within treatment. Participants in this study provided supporting evidence that family dynamics can be considered TIB's.

Comorbid Disorders Effecting Route of Treatment. ERP treatment can become more difficult when dealing with comorbid disorders. When asked about comorbid disorders affecting the route of treatment, one participant stated:

> It absolutely does. Especially in regard to behavioral disorders, ADHD, oppositional defiant disorder, if those issues are present, there is some research evidence that suggests that can diminish the effectiveness of treatment. Sometimes you have to do parent management training or behavioral treatment, for behavioral disorders first, or get those issues identified and treated. Because those are both things that have to do with willingness to practice and follow directions.

And another participant indicated:

> Yep they can. When people unfortunately have obsessive compulsive personality disorder comorbid when they are all the sudden believe in the importance of their compulsions so their obsessions and compulsions, so they actually have to be willing to modify their beliefs in order to do exposure…comorbid ADHD with OCD in little kids can make it difficult…and they can lead to more power struggles, because parents are trying to get kids to focus on yet another thing.

When dealing with more than one diagnosis, the treatment route clinicians and clients decide to take can be changed. One respondent explained that when dealing with comorbid disorders, if she does not feel competent in those disorders, there will be a referral made to someone that works with those disorders. Then it will be decided if those disorders should be addressed first before ERP or at the same time, collaboration will be taking place between professionals.

The Client. Client's themselves might face TIB's directly in relation to themselves. A client's ambivalence for change and their reluctance or inability to start a difficult therapeutic process may disrupt progress. ERP is hard work and it is common for clients to experience TIB's. According to one participant:

> …low insight or organization, like the commitment to the organization of remembering to sit down every day…being willing to print out the sheet and write down the numbers and kind of just stay organized and complete the ERP in the way I have suggested…final one I would want to throw in is some people are not on board with the idea of tolerating distress, tolerating anxiety, and tolerating uncertainty. So if people are unwilling to do that, that can get in the way or they will get in the way.

Client's ability to stay organized while in treatment, being willing to do the hard work, tolerate distress, and feel anxious while sitting with uncertainty can affect treatment success. Those

things are viewed as TIB's. Another participant indicated:

> I don't see too much treatment interfering behaviors other than reluctance because of the young person's part, that it felt difficult. One of their fears is that if I start thinking and feeling that it is going to get worse and worse and worse and I won't be able to handle it.

ERP is difficult and can be scary, creating unpleasant internal experience. The client may experience uncertainty when participating in treatment, causing them to question if treatment is going to make them feel better or worse. Another participant stated:

> Just avoidance…a lot of research coming out, that common factors with neurotic disorders, meaning anxiety and depressive disorder is experiential avoidance. To me that often means emotional avoidance, I don't want to feel bad…we want to do anything we can to avoid internal distress.

Clients participating in exposure are going to experience different levels of distress. That is why building distress tolerance is a key factor within ERP. That can be hard which in turn can create a common TIB of avoidance. No one wants to feel bad, and dealing with uncertainty and uncomfortable internal states can make it challenging to be present within treatment.

Distress Tolerance

Distress tolerance was the fifth major theme that was evident within the qualitative data gathered. Distress tolerance is gaining the ability to withstand unpleasant internal experiences. Four subthemes emerged including 1) client: children and adolescents, 2) parents anxiety and distress, 3) mindfulness with distress tolerance and 4) therapist awareness of their distress. Distress tolerance was common in relation to the clients, parents, and professionals.

Client: Children and Adolescents. It was clear throughout the professionals' responses that distress tolerance is an important concept within ERP. Children and adolescents dealing

with OCD are often experiencing significant distress that at times exceeds their level of tolerance. Through ERP they are learning that that they can tolerate different levels of distress and internal discomfort. As one participant stated:

> …what's really transforming people, not that you habituate through anxiety but the brain learns that it can tolerate different levels of anxiety and function well…So what is more useful to use, to be able to habituate around something or being able to learn that we can tolerate internal states that are uncomfortable that you can apply over and over again to whatever comes up.

Another participant furthered this understanding by stating:

> …there is a distress tolerance kind of piece, teaches people what to do other than a compulsion, how to tolerate any discomfort they have in the middle of ERP and then working through gradual exposure, anxiety hierarchy or fear hierarchy and help people work their way through it with repeated gradual exposure and discontinuing the rituals.

By learning to tolerate different levels of distress, clients are able to apply that to different aspects of their lives. Professionals focused more on distress tolerance and helping clients learn that they can tolerate different levels of discomfort rather than habituate through anxiety. One participant indicated:

> …children managing their distress, well that is all teaching them what is going on and that there is hope and what can help. And then I do have a preset menu of things kids can do and things to remember when they are waiting for the distress feelings to fade on their own.

While they are participating in ERP, clients are able to learn how to tolerate their own distress with the help of their therapist. One participant indicated:

> If somebody is too distressed by something, I would allow them to ritualize. Well, first I would ask if they think they have a sense to keep pushing forward and keep trying, if not I will allow them to ritualize and then adjust the exposure so that it doesn't provoke as much distress in the future. A focus on anxiety reduction is not going to be part of what makes treatment better.

Professionals are focusing less on reducing anxiety and more on how clients can learn to tolerate their distress, as well as taking an acceptance and commitment focus on OCD.

Parent's Anxiety and Distress. A common theme that emerged was parent's anxiety and their distress. The therapist does not only help their clients with distress tolerance, they are teaching the parents how to handle their own anxiety. One participant demonstrated how this can be carried out:

> ...parents distress, I do a couple ways. One I suggest that they read a book for parents on helping kids overcome OCD…there is some good practical guidance in there about what to do and what not to do. Really I always teach and coach parents in detail about what to steer clear of, but what to aim to do instead. For example one of the biggest challenges for parents is when the young person is engaging in reassurance seeking. Parents of course do what all good parents do is try and provide reassurance which is a form of compulsion, interactive compulsion. I teach parents about why that perpetuates the problem and what to aim for instead and coach the child and parent together.

There are a variety of ways that parents can deal with their anxiety and in turn become better at assisting their child within their treatment for OCD.

Mindfulness with Distress Tolerance. Participants indicated that the use of mindfulness can be a beneficial skill in coordination with distress tolerance. One participant indicated:

> Well if people sit with it [the anxiety], I do a lot of mindfulness, lot of meditation, mindfulness meaning being in this experience. So if we take an experience of anxiety and we dissect it, what do we have? Unpleasant, physical sensations, paired with scary thoughts, not much else there. So if you sit with that and you change your relationship with those experiences, instead of being embedded in those experiences that you can start to pull back and become an observer…observe themselves. The sensations, the mental components maybe there but it is a different experience.

By pairing mindfulness with ERP, client's can learn how to create different experiences for themselves and not being embedded in their experiences of anxiety and fear. Another participant indicated:

> In addition to ERP I would say the next skill that I use most is relaxation with OCD, mindfulness training, sometimes thought challenging, not necessary for the OCD but more…depressive type symptoms, thinking like that might go along with it, or just as a reminder to go oh yeah that is right I need to be doing my ERP for my OCD, there is no way around this.

When clients are able to become mindful in therapy, they can step back remembering that although things are difficult and uncomfortable, that they still need to be aware of their exposure assignment that they are working on. One participant indicated:

> Sometimes I combined more of an acceptance commitment therapy slash mindfulness based approach to get people accepting of the chronic nature of OCD and to be accepting that ERP is a process to use on and off throughout life.

OCD is a difficult diagnosis to manage, but through building one's distress tolerance and using mindfulness it can be a very effective treatment for OCD.

Therapist Awareness of Their Distress. Lastly, it is extremely important for therapists to be aware of their own anxiety. When therapists themselves experience anxiety, they need to make sure that they are tending to their own anxiety and distress so that they do not negatively impact their clients. One participate explained:

> If I can't tolerate my own internal distress…what would I say about this uncertainty, if I can't tolerate that, how can I work with someone who their primary illness is about uncertainty…doing exposure with someone for their fear of suicide, they could suicide and that is on my watch. I probably have mid levels of anxiety about that, I trust my skills and my assessment skills but I could be wrong. I have lost patients to suicide before. I have to be willing to work within my own internal experience and be willing to have that there and to not push it away. If I am not willing to experience that distress then the patient is screwed because then therapy will become a different endeavor. I would collude with them in avoidance.

The interviews supported the concept that if a therapist is not able to deal with their own internal distress, then they cannot expect their clients to handle theirs. In acknowledging their own anxiety, the therapist can focus on their skills and assessments, finding confidence within the work they are providing. Another participant stated:

> When I am feeling distressed, I learned a long time ago if I feel bothered, rushed, or overwhelmed, that I just need to take my time, because I don't want to have my own sense of urgency…to cause me to change [the client's] treatment for the worse, to rush passed things or skip them...So I manage my distress by sticking with a plan and knowing that is the right thing.

Once again, the therapist's ability to trust their skills is important in managing their own distress.

By acknowledging their own distress they can use other skills they have learned such as slowing down and not rushing oneself in order to reduce their anxiety and be effective while working with their clients.

Discussion

This qualitative study presents a positive view on the effectiveness of using ERP for children and adolescents diagnosed with OCD. When ERP is utilized correctly, data suggest that it is an effective form of treatment. However, participants also indicate that treatment completion does not necessarily mean that clients are able to get rid of the symptoms of OCD indefinitely. In understanding the efficiency of ERP, data strongly support education as a significant component of long-term success. Ethical concerns were also noted throughout the interviews, but participants did not find these concerns to be deterrents to using ERP with children and adolescents suffering from OCD. Participants discussed the need to put safeguards in place that will promote success and minimize ethical concerns. For instance, ethical concerns can be minimized through the use of informed consents, and establishing clear boundaries.

Another component of long-term success is the acknowledgment of the role of Treatment Interfering Behaviors (TIB's). Although evidence supports the effectiveness of ERP, TIB's can derail clients during treatment. TIB's may exist within the client themselves, the parents, and within the family structure/system. Finally, professionals focused a great deal on the concept of distress tolerance. Therapists want to provide individuals with the tools they need to tolerate different levels of distress within a variety of aspects in their lives. The better professionals support clients with their distress tolerance, the more likely they are to have long term success.

Strengths of ERP

Findings were supported throughout the literature. Using exposure based cognitive

behavioral treatments have been shown to reduce anxiety disorders in children; this is proven through empirical evidence (Silverman et al., 2003). Literature supported ERP as the first choice of treatment, but also suggested that 30 % of children do not respond to treatment, and 40% are only partially respond (Morgan et al., 2013). The current study supported previous findings, as professionals indicated that clients who are reluctant and/or unwilling to do their ERP homework, frequently dropped out of treatment. Participants also indicated that clients taking part in ERP who follow their treatment plan show significant progress. If ERP is used correctly, and the client's are willing to participate, it is rare not to see progress within their treatment plan.

Education

Participants suggested that education is a vital piece with the client, parents, and therapist. It was supported within the literature that therapists need to be properly trained in ERP. "The need to train clinicians in the competent delivery of exposure has been identified as an important healthcare priority" (Deacon et. al., 2013, p. 772). As mentioned previously, one participant experienced the ramifications of a therapist not trained in ERP, and how it negatively affected a girl with elevator phobia. This young girl ended up having a panic attack and a melt down because the therapist tricked her into the elevator and then pushed the button when the therapist originally said they would not. It is evident that this therapist was not properly trained in ERP, and the client paid the consequences.

It is also crucial for the client and their parents to be educated about the ERP and alternative forms of treatment. Clients and their parents need to be well informed and educated about treatment options in order to make an informed decision. They must understand the potential benefits, risks and cost of ERP, potential alternative treatments before they can make well-informed decisions.

Ethical Concerns

Ethical concerns seemed to be present more in relation to clinician's not being proper trained in ERP. Olatunji (2009) proposed that negative views of ERP comes from lack of adequate training, and that maybe why practitioners may not be incorporating exposure-based techniques within their work with anxiety disorders. Participants in this study suggest that professionals not properly trained in ERP could create more ethical concerns than those fully trained. As mentioned above, when therapists are not trained within ERP and try doing exposure work it can become very dangerous. The use of informed consent was strongly focused on within this research, and was also found prevalent within the literature. Gola (2015) also stressed the importance of using guidelines within this practice such as informed consent and assent, motivation for treatment, competence, beneficence and nonmaleficence, confidentiality and boundaries. If those guidelines are used correctly it can support clinicians in preventing and guiding them through ethical dilemmas that may occur within ERP (Gola et al., 2015).

Treatment Interfering Behaviors

This study focused on how TIB's can affect the use of Exposure Response Prevention. Participants of this study clearly demonstrated how clients and their parents/family can create treatment interfering behaviors while participating in therapy. This research study identified comorbid diagnoses as potential TIB's. A respondent suggested that when working with children who have diagnoses of ADHD or oppositional defiant disorder and OCD "that there is some research evidence that suggests that can diminish the effectiveness of treatment." It is not uncommon for children and adolescents diagnosed with OCD to experience comorbid disorders. Literature suggested that there are high rates of comorbid major depression (10-73%), anxiety disorders (26-70%), tic disorders (17-59%, disruptive behavior (10-53%), attention deficit

hyperactivity disorder (ADHD; 10-50%) and mania (27%) (Storch et al., 2007). When looking at the effectiveness of ERP, it is significant to consider treatment interfering behaviors which can be presented through comorbid diagnoses.

Distress Tolerance

Distress tolerance was another main theme within this qualitative study. Distress tolerance can be evaluated within a client, parents/caregivers, and the therapist. According to Laposa et. al., (2015), it is the capacity to experience and withstand negative psychological states. Participants in this study focused on how ERP provides clients and parents with the tools needed to build their distress tolerance. Within therapy they are able to learn that they can handle different levels of distress, and that they can apply ERP skills within different aspects of their lives. While exploring professionals' perceptions of ERP, a big subtheme that emerged was the use of mindfulness in relation to distress tolerance. Literature provided evidence that mindfulness may help clients engage in treatment with accepting difficult thoughts, feelings, bodily sensations, even become more aware of urges and learning not to automatically act on them (Strauss et al., 2015). Children and adolescents participating in ERP are going to be exposed to a variety of levels of distress, by implementing a mindfulness component they maybe more equipped to tolerate these uncomfortable internal states and sit within their own uncertainty. Participants also suggested parents/caregivers can learn to tolerate their own distress as well. It can be difficult for parents to see their child in distress, but they have to learn that they can tolerate their anxiety and not become too avoidant with their child.

The findings from this qualitative research were helpful in supporting the main research question regarding professionals' perceptions of the effectiveness of ERP for children and adolescents diagnosed with OCD. While there were many strengths to this study, there were also

a number of limitations that will be discussed, below.

Strengths and Limitations

The main strength of this study was that it used a qualitative design that allowed for a depth of understanding on the topic. Four participants, with a combined total of 75 years of experience using ERP, took part in this study. They were able to present a comprehensive view of the use of ERP with children diagnosed with OCD. Although these four participants practiced in varying outpatient settings and across two states, there was a consistency in their responses that provided a great deal of support for the themes examined in this paper.

There were limitations presented within this qualitative study. Originally the research aimed to interview a variety of professionals such as licensed psychologists and licensed clinical social workers. The goal was to interview eight to ten professionals. Only licensed psychologists responded, resulting in four interviews. This low response rate does not allow for a board spectrum of viewpoints. For instance, perhaps clinical social workers might have a very different perspective on using ERP with children and adolescents diagnosed with OCD. This study aimed to reach professions within different treatment settings such as inpatient, outpatient and residential treatment settings. The professionals that participated were all from outpatient treatment offices. It is suggested that further research should be done with professionals from a variety of disciplines and settings discovering their perceptions on the effectiveness of Exposure Response Prevention for children and adolescents diagnosed with Obsessive Compulsive Disorder, in order to better explore differences by treatment setting and treatment provider.

Implications for Social Work Practice

There are many implications for social work practice resulting from this study. One thing that became apparent in the recruitment phase was it was difficult to find professionals

specializing in the use of ERP, especially with children and adolescent OCD. The participants involved in this research suggested that there is a need for more clinicians to be trained in this area so that children and families have more options available to them. There are short term care facilities available for these clients, but currently no residential treatment settings within the Twin Cities area capable of providing long term care for children and adolescents diagnosed with OCD. For social workers, there may need to be more education provided about ERP as an effective treatment. As a graduate student, for instance, there has not been a focus on ERP within my coursework or internships. By exposing students to this form of treatment, and supporting its benefits, could be a positive step towards breaking down these barriers for this population. That could create more urgency in providing properly trained clinicians and a variety of treatment settings using ERP for children and adolescent OCD.

Conclusion

This qualitative study provided professionals' perceptions of the effectiveness of Exposure Response Prevention for children and adolescents diagnosed with Obsessive Compulsive Disorder. It was clear within the major themes that emerged that there are many strengths related to the use of ERP. It has been found to be an effective form of treatment for children and adolescents struggling with OCD. Other themes supported its effectiveness. The proper educational component helps clients and their parents understand they have the right to self-determination, and they can make an informed decision on treatment options. If ERP is done correctly with properly trained professionals, there is little worry in relation to ethical concerns. It is important to remember, by following the correct guidelines, such as using an informed consent; clinicians can prevent and navigate through ethical dilemmas.

Despite the immense amount of evidence supporting the effectiveness of ERP it is

important to keep in mind that Treatment Interfering Behaviors and comorbid diagnoses can affect the route of treatment and its success rate. Distress tolerance is central to acknowledge with the client, parents/family, and the therapist. A client and their caregivers can learn that they can handle different levels of distress in relation to OCD through different experiences throughout their lives. Therapists need to be aware of their own distress, learn how to tolerate it, and accept and acknowledge that it exists. There were limitations to this study, but there was beneficial data collected. It is suggested that further research should be gathered in order to get a full understanding of the effectiveness of using ERP for children and adolescent OCD.

References

Abramowitz, J., Brigidi, B., & Roche, K. (2001). Cognitive behavioral therapy for obsessive compulsive disorder: A review of the treatment literature. *Research on Social Work Practice*, *11*(3), 357-372.

Black, D., & Andreasen, N. (2014). *Introductory Textbook of Psychiatry* (6th ed., pp. 227-228). Washington, DC: American Psychiatric Publishing.

Bohm, A. (2004). Theoretical coding: Text analysis in ground theory. In Flick, U., Kardoff E., & Steink I (Eds). *A Companion to Qualitative Research,* 270-275.

Bornheimer, L. (2014). Exposure and Response Prevention as an Evidence-Based Treatment for Obsessive–Compulsive Disorder: Considerations for Social Work Practice. *Clinical Social Work Journal Clin Soc Work J,* 38-49. doi:10.1007/s10615-014-0483-4

Bolton, D., & Perrin, S. (2006). Evaluation of exposure with response-prevention for obsessive compulsive disorder in childhood and adolescence. *Journal of Behavior Therapy and Experimental Psychiatry,* 11-22.

Choate-Summers, M., Freeman, J., Garcia, A., Coyne, L., Przeworski, A., & Leonard, H. (2008). Clinical Considerations When Tailoring Cognitive Behavioral Treatment For Young Children With Obsessive Compulsive Disorder. *Education and Treatment of Children, 31*(3), 395-416.

Comorbid. (n.d.). In Dictionary Online. Retrieved from http://www. Dictionary.com/browse/comorbid.

Diagnostic and statistical manual of mental disorders: DSM-5. (5th ed.). (2013). Washington, D.C.: American Psychiatric Association.

Deacon, B., Farrell, N., Kemp, J., Dixon, L., Sy, J., Zhang, A., & Mcgrath, P. (2013). Assessing

therapist reservations about exposure therapy for anxiety disorders: The therapist beliefs about exposure scale. *Journal of Anxiety Disorders,* 772-780.

Dyches, T., Leininger, M., Heath, M., & Prater, M. (2010). *Understanding Obsessive-Compulsive Disorder in Students: Symptoms and School-Based Interventions, 34,* 35-55.

Ekers, D., Carman, S., & Schlich, T. (2004). Successful Outcome Of Exposure And Response Prevention In The Treatment Of Obsessive Compulsive Disorder In A Patient With Schizophrenia. *Behavioural and Cognitive Psychotherapy Behav. Cognit. Psychother., 32,* 375-378. doi:10.1017/S135246580400147X

Gola, J.A., Beidas, R.S., Antinoro-Burke, D., Kratz H.E., & Fingerhut R. (2015). Ethical consideration in exposure therapy with children. *Cognitive and Behavioral Practice,* 1-10.

Hertenstein, E., Rose, N., Voderholzer, U., Heidenreich, T., Nissen, C., Thiel, N., . . . Külz, A. K. (2012). Mindfulness-based cognitive therapy in obsessive-compulsive disorder – A qualitative study on patients' experiences. *BMC Psychiatry, 12*(1). doi:10.1186/1471-244x-12-185

Kircanski, K., & Peris, T. (2014). Exposure and response prevention process predicts treatment outcome in youth with ocd. *J Abnorm Child Psychol, 43,* 543-552.

Laposa, J., Collimore, K., Hawley, L., & Rector, N. (2015). Distress tolerance in OCD and anxiety disorders, and its relationship with anxiety sensitivity and intolerance of uncertainty. *Journal of Anxiety Disorders,* 8-14.

Lehmkuhl, H., Storch, E., Bodfish, J., & Geffken, G. (2007). Brief Report: Exposure and Response Prevention for Obsessive Compulsive Disorder in a 12-year-old with Autism. *J Autism Dev Disord Journal of Autism and Developmental Disorders,* 977-981.

Levy, H., & Radomsky, A. (2013). Safety Behaviour Enhances the Acceptability of Exposure. *Cognitive Behaviour Therapy, 43*(1), 83-92.

Lewin, A., Park, J., Jones, A., Crawford, E., Nadai, A., Menzel, J., & Storch, E. (2014). Family-based exposure and response prevention therapy for preschool-aged children with obsessive-compulsive disorder: A pilot randomized controlled trial. *Behaviour Research and Therapy,* 30-38.

March, J. (1995). Cognitive-Behavioral Psychotherapy for Children and Adolescents with OCD: A Review and Recommendations for Treatment. *Journal of the American Academy of Child & Adolescent Psychiatry,* 7-18.

Monette, D., Sullivan, T., Dejong, C., & Hilton, T. (2014). *Applied Social Research* (9th ed., p. 147, 494). Belmont, CA: Brooks/Cole.

Morgan, J., Caporino, N.E., De Nadai, A.S., Truax, T., Lewin, A.B., Jung, L., Park, J.M., Khan, Y.A., Murphy, T.K., & Storch, E.A. (2013). Preliminary predictors of within-session adherence to exposure and response prevention in pediatric obsessive-compulsive disorder. *Child Youth Care Reform, 48*, 181-191.

Murray, K., Jassi, A., Mataix-Cols, D., Barrow, F., & Krebs, G. (2015). Outcomes of cognitive behaviour therapy for obsessive–compulsive disorder in young people with and without autism spectrum disorders: A case controlled study. *Psychiatry Research,* 8-13.

Nissen, J., & Thomsen, P. (2008). Clinicians' views on clinical examination and treatment of children and adolescents with obsessive–compulsive disorder (OCD). A Danish national survey study. *Nord J Psychiatry Nordic Journal of Psychiatry,* 309-314. doi:10.1080/08039480801984065

Olatunji, B., Deacon, B., & Abramowitz, J. (2009). The Cruelest Cure? Ethical Issues in the

Implementation of Exposure-Based Treatments. *Cognitive and Behavioral Practice,* 172-180.

Simpson, D. (2009). Adolescents with OCD: An integration of the transtheoretical model with exposure response prevention. *Best Practices in Mental Health,* 5(2), 14-26.

Simons, M., Schneider, S., & Herpertz-Dahlmann, B. (2006). Metacognitive Therapy versus Exposure and Response Prevention for Pediatric Obsessive-Compulsive Disorder. *Psychotherapy and Psychosomatics Psychother Psychosom,* 257-264. doi:10.1159/000092897

Storch, E., Larson, M., Merlo, L., Keeley, M., Jacob, M., Geffken, G., . . . Goodman, W. (2007). Comorbidity of Pediatric Obsessive–Compulsive Disorder and Anxiety Disorders: Impact on Symptom Severity and Impairment. *Journal of Psychopathology and Behavioral Assessment J Psychopathol Behav Assess,* 111-120.

Strauss, C., Rosten, C., Hayward, M., Lea, L., Forrester, E., & Jones, A. (2015). Mindfulness-based exposure and response prevention for obsessive compulsive disorder: Study protocol for a pilot randomised controlled trial. *Trials*. doi:10.1186/s13063-015-0664-7

Sukhodolsky, D., Gorman, B., Scahill, L., Findley, D., & Mcguire, J. (2013). Exposure and response prevention with or without parent management training for children with obsessive-compulsive disorder complicated by disruptive behavior: A multiple-baseline across-responses design study. *Journal of Anxiety Disorders,* 298-305.

Torp, N., Dahl, K., Skarphedinsson, G., Thomsen, P., Valderhaug, R., Weidle, B., . . . Ivarsson, T. (2014). Effectiveness of cognitive behavior treatment for pediatric obsessive-compulsive disorder: Acute outcomes from the Nordic Long-term OCD Treatment Study (NordLOTS). *Behaviour Research and Therapy,* 15-23.

Turner, C., Mataix-Cols, D., Lovell, K., Krebs, G., Lang, K., Byford, S., & Heyman, I. (2014). Telephone Cognitive-Behavioral Therapy for Adolescents With Obsessive-Compulsive Disorder: A Randomized Controlled Non-inferiority Trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 53*(12).

Wagner, A. P. (2002). *What to do when your child has obsessive-compulsive disorder: Strategies and solutions*. Rochester, NY: Lighthouse Press.

Whiteside, S. P., & Abramowitz, J. S. (2006). Relapse Following Successful Intensive Treatment of Pediatric Obsessive-Compulsive Disorder: A Case Study. *Clinical Case Studies, 5*(6), 522-540. doi:10.1177/1534650105278456

Whiteside, S., Ale, C., Douglas, K., Tiede, M., & Dammann, J. (2014). Case Examples of Enhancing Pediatric OCD Treatment With a Smartphone Application. *Clinical Case Studies, 13,* 80-94. doi:10.1177/1534650113504822

Whiteside, S., Brown, A., & Abramowitz, J. (2007). Five-day intensive treatment for adolescent OCD: A case series. *Journal of Anxiety Disorders,* 495-504. doi:10.1016/j.janxdis.2007.05.001

Williams, M., Farris, S., Turkheimer, E., Franklin, M., Simpson, H., Liebowitz, M., & Foa, E. (2014). The impact of symptom dimensions on outcome for exposure and ritual prevention therapy in obsessive-compulsive disorder. *Journal of Anxiety Disorders,* 553-558.

Woods D.W., Hook S.S., Spellman D.F., & Friman P.C. (2000). Case study: Exposure and response prevention for an adolescent with tourette's syndrome and ocd. *J. AM. ACAD. Child Adolescent Psychiatry, 39*, 904-907.

Zastrow, C. (2010). *Introduction to social work and social welfare: Empowering people* (10th

ed., p. 52). Belmont, CA: Brooks/Cole.

Appendix A

Interview Questions

Main Question: What are professionals perceptions of the effectiveness of Exposure Response Prevention for children and adolescents diagnosed with Obsessive Compulsive Disorder?

Interview Questions:

- **What is your licensure status and what is your experience with using Exposure Response Prevention (ERP) with children and adolescents that have been diagnosed with OCD?**
    - How long have you been using ERP?
    - Do you use ERP exclusively?
- Would you recommend ERP for children and adolescents with OCD? Why?
- **Can you tell me the process of using ERP for clients diagnosed with OCD?**
- What are the specific ways OCD symptoms changes while a client is involved in ERP?
- Would you be willing to share a case where you used ERP? (without sharing names)
    - Why do you think that approach was successful? Or why do you think it was not successful?
    - How have those experiences form your overall practice of ERP?
- **How do you manage distress in session to build distress tolerance?**
- **Do you have ethical concerns in relation to ERP?**
- **What are the strengths and limitation you have noticed with using ERP?**
- Do you use exposure assignments for your clients outside of therapy sessions? If so what kind of assignments are they?
    - Do you think they are effective?

  - How often do they complete the assignments?
  - Are the clients resistant to the assignments or open minded?

- Within the research it indicates that there is a significant percent of children and adolescent that don't response to treatment or that many clients drop out of ERP. Does that pertain to your experience with using ERP?
- **Is ERP more effective alone or with mix methods?**
- **Do you think that comorbid diagnoses affect the route of treatment?**
- Is relapse a concern when using ERP? If so how do you apply relapse prevention?
- Is there anything else that I haven't asked that you think would be helpful towards my research?