Chapter 8
Playful CBT with Children Diagnosed with OCD

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8.1 Introduction

Obsessive-compulsive disorder (OCD) is a heterogeneous psychiatric condition characterized by unwanted, intrusive thoughts (obsessions) and repetitive or ritualized behaviors (compulsions) aimed to reduce distress associated with obsessions (American Psychiatric Association, 2013). OCD impacts individuals across development, including young children and adolescents. Pediatric OCD is often

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associated with functional impairment, disruption to developmental gains, and chronicity, making early intervention key (Albert et al., 2019; Fineberg et al., 2019). Family-based cognitive behavioral therapy (CBT) using exposure and response prevention (ERP) is a well-established and efficacious behavioral treatment for pediatric OCD with treatment response rates ranging between 64.7 and 100% in clinical trials (Freeman et al., 2018). Efficacy for family-based CBT using ERP extends to young children, ages 3–8 (Freeman et al., 2014; Lewin et al., 2014), and exposure-based CBT for OCD has been found to be effective when transported into community settings (Torp et al., 2015). ERP involves actively approaching anxiety-provoking stimuli while not engaging in any rituals or safety behaviors. Exposures may include facing actual in vivo situations, imaginal content, or distressing physical sensations (interoceptive exposures). For example, if a client with OCD experiences contamination-related obsessions and performs mental counting rituals, an effective exposure might involve the client touching a surface perceived to be contaminated (i.e., doorknob), focusing on the distress caused by that activity, and resisting the urge to count.

ERP is rooted in behavioral theory of both classical and operant conditioning. OCD symptoms are thought to be maintained through a negative reinforcement cycle, with rituals or avoidance behaviors being reinforced by providing temporary relief from distress. ERP aims to disrupt this cycle by eliminating avoidance and escape behaviors (e.g., rituals). Two main theories have emerged to explain the effectiveness of ERP: inhibitory learning (Craske et al., 2008; Craske et al., 2014) and habituation (Foa & Kozak, 1986; Benito & Walther, 2015). In both models, exposure to anxiety-provoking stimuli is necessary and is believed to directly facilitate a corrective experience through extinction learning; however, the processes thought to promote learning differs between the two models (Himle, 2015). The habituation model emphasizes exposure procedures that facilitate a natural decrease in anxiety over time (Foa & Kozak, 1986; Benito & Walther, 2015). The inhibitory model focuses on exposure procedures that create new expectations about what will happen when the feared stimulus is encountered such as a feared outcome not occurring or the ability to tolerate one's distress (Craske et al., 2008). Clinical applications discussed in this chapter are based upon the tenets of extinction learning that are broadly relevant to both theoretical models.

This chapter has a special emphasis on integrating play when delivering ERP. Integrating play into exposures can make them more tolerable and fun, which in turn may increase a child's engagement. More specifically, play is used strategically to foster a child's: (a) willingness to complete exposures, (b) engagement throughout exposures, and (c) favorable perception of treatment. Additionally, creating space for silliness and humor allows the child to have a different experience with a feared stimulus than they might have anticipated, which is a key tenet of the inhibitory learning approach (Craske et al., 2014). As a child's sustained engagement with exposure stimuli is essential to learning from an exposure, the benefits of play are particularly powerful to a child's treatment gains. It is important to be mindful of the *function* play has on an exposure. Depending on how play is used, it may detract from exposure (e.g., distract the child from the worries or distress the

child is meant to face in the exposure) or enhance it (e.g., facilitate the child's engagement with their worries or distress). For example, simply playing a card game likely distracts from the targeted fear (i.e., detracts from the exposure) if the game does not relate to or trigger the core fear. Simple and quick modifications (e.g., contaminating the game, changing the rules of the game), however, changes the card game to target a fear. Examples of play-based exposures will be discussed with an emphasis on engaging a target fear.

Techniques in this chapter are described generally for a pediatric population but therapists should consider the developmental level of their own clients and tailor the intervention accordingly. For more detailed information on delivering CBT for pediatric OCD, consider reviewing *Treating OCD in Children and Adolescents* (Franklin et al., 2019).

8.2   Clinical Applications for Pediatric OCD

8.2.1   Providing Psychoeducation

Psychoeducation is an important foundation of treatment and is used throughout the course of treatment as needed. This early stage of therapy is a great opportunity for therapists to illustrate key concepts in a playful, engaging, and relatable manner. Primary components of psychoeducation outlined below typically include information about OCD, orientation to and rationale for ERP, and externalizing of OCD. General information about OCD (e.g., prevalence rates, nature of OCD) can be individually tailored based on a family's understanding of OCD. It is important to clarify any misconceptions during this part of treatment and to make clear that OCD is not the child or family's fault. The International OCD Foundation (2020) provides helpful online resources, including brochures and fact sheets that can be used to guide this discussion with families.

8.2.1.1   Our Body's Alarm System

Describing the body's innate fear response as a natural alarm system is a helpful metaphor for explaining how OCD functions in the brain and why ERP works. Below is an example of how this could be explained to a family.

Example: Explaining the Alarm "Many people think of anxiety as bad, but anxiety is meant to be a helpful emotion. Anxiety is our body's natural alarm system. Just like a smoke detector would go off if there was a fire, our body's anxiety alarm alerts us when there is danger. For instance, if a tiger walked into the room right now our anxiety alarm would go off telling us to get away

instead of trying to pet the tiger! This is called a 'true alarm' and it keeps us safe from danger. Sometimes, however, people's alarms can become very sensitive—the volume is turned way up—and their alarm goes off when it doesn't need to. For example, this would be the case if after a kitten walked into the room your anxiety alarm went off telling you to run away or if a smoke detector went off when toast was burnt but there was no fire. These are called 'false alarms.' They feel just like true alarms even though there isn't any danger. Essentially, OCD takes over this alarm system. Rituals or compulsions can be thought of as specific ways you've learned to turn off this alarm. The ritual makes you feel better in the moment but leads to more rituals in the future. We want to help you turn down the volume of your alarm with a special treatment that we know helps kids with OCD called exposure and response prevention. Our job is to work as a team to help you 'boss back' OCD by facing these false alarms in small steps without doing your rituals."

Make this concept more interactive by asking the child how they might react if a kitten walked into the room, then ask how they might react if a tiger walked in the room or even make it playful by acting out the scene. Try providing other examples of helpful anxiety that are relevant to youth, such as studying when one is nervous about a test or jumping out of the way of an oncoming car. With children, we often talk about ERP as *bossing back* OCD. At the most basic level of explanation, bossing back is doing the opposite of what OCD wants you to do.

8.2.1.2   Goals of ERP

After building the rationale and orienting the family to how ERP works, introduce the goals of ERP. Exposure-based CBT aims to build tolerance for distress and to decrease anxious distress through repeated practice. One helpful way of explaining ERP is to compare it with learning a new skill that is relevant and interesting to the child (e.g., musical instrument, a sport, dance). For example, for a child who loves baseball, draw the comparison that when they first began playing, they likely could not throw a fastball or strike out their opponent. With persistence and practice, however, they learned new skills and became better at the sport "the more you practice, the better you get at the activity!" The same is true for ERP. Explain that confronting a feared situation will become easier over time as the child repeatedly practices being brave in that situation.

Similarly, the feeling of warming up after entering a cold swimming pool or the ocean is a helpful metaphor to explain a body's natural decrease in anxiety over time. Use Socratic questioning to illustrate on how the water feels really cold at first but if you stay in the water, it feels warmer over time. Prompt the child to reflect on the fact that the temperature does not actually change; instead, their body adjusts to

being in the water, causing the water to feel warmer. Other ways to illustrate this point are by prompting the child to think about their fear the first time they rode a roller coaster or watched a scary movie and comparing the experience to how they might feel after doing the activity many times.

8.2.1.3 Normalizing Intrusive Thoughts

Intrusive thoughts are unwanted thoughts or images that enter an individual's consciousness. For children with OCD, however, some of these intrusive thoughts become salient and intensely distressing. Some children have a difficult time understanding these experiences and feel too embarrassed to verbalize the thoughts and associated distress. Psychoeducation regarding the nature of intrusive thoughts normalizes these experiences and sets the stage for doing ERP, during which children focus on these thoughts. Tompkins et al. (2020) suggest that labeling a thought as *bad* or *scary* makes us think it is important, which causes the mind to think about it more, thereby making the thoughts more frequent and/or distressing. When individuals with OCD try to push away the obsession, the thought only becomes stronger. There are several well-known prompts that demonstrate this concept. *Purple Elephant* is a version of this technique that includes the therapist prompting the child and family to imagine anything, except a purple elephant (Storch & Lewin, 2016). Use some of your engagement tools to be creative! Does your client enjoy playing a sport? Prompt them to think of anything in the world except their favorite athlete in a clown suit, for example. Processing this activity with the child and family highlights that pushing away thoughts tends to make them stronger and tougher to not think about. This technique can add to the child and family's understanding of how OCD, specifically intrusive thoughts, has become powerful.

8.2.1.4 Externalizing OCD

Externalizing OCD is an engaging strategy used with the child and family early in treatment. Personifying OCD as a separate entity removes self-blame both from the child and the caregiver, giving them an opportunity to unite together against a common enemy (Myrick & Green, 2012). Families often relate to this concept when comparing OCD to a bully who will not go away.

Externalizing OCD includes asking the child to name OCD and create an illustration of their OCD. If you or another family member is particularly skilled in drawing, you could ask the child to close their eyes and describe what OCD looks like and then draw the visual of it! Some children prefer to personify OCD with a familiar character, such as a villain from a movie or video game. Another idea is to use a photo or to print a coloring page of this character. For young children, choosing a tangible object, such as a stuffed animal, is often helpful to represent OCD.

8.2.2 Building a Fear Hierarchy

To optimally deliver ERP and create a hierarchy for OCD, it is crucial to understand the relation between obsessions and compulsions (Abramowitz et al., 2019; Conelea et al., 2012). Compulsions that look similar topographically (e.g., what the behavior looks like when observed) may serve different functions depending on the underlying obsession or fear. Function represents the *purpose* of the behavior and draws links between the action and associated antecedents and consequences.

Figure 8.1 depicts how the same ritual may be associated with a number of different obsessions. In this example, a handwashing ritual may *look* the same when observed topographically, but may reflect different functions, such as responding to a disgust feeling, trying to neutralize a harm obsession (e.g., getting sick, someone getting hurt), or achieving a feeling of symmetry. Understanding these connections will help a therapist select exposures appropriately.

The process of hypothesis testing and understanding the relation between obsessions and compulsions should start before initiating ERP and occur throughout treatment. Conelea et al. (2012) present a helpful framework for organizing and understanding function using a visual map to link obsessions with compulsions. A thorough functional assessment will prepare a therapist to make a hierarchy with the family. Next, general principles for building a hierarchy are described, followed by modifications to make this process more playful and engaging.

8.2.2.1 The Fear Thermometer

Prior to building a hierarchy, a scale measuring distress should be introduced to the child and family (e.g., 0–10 scale, stoplight, faces). The scale serves as a communication tool around a child's distress both within and outside of exposure. A common example is a *fear thermometer* with numbered anchors relative to an individual child's distress. One way to engage the child is to have them draw their own thermometer as an art project. They can create their own version by picking representations for different levels of distress, such as faces, colors, types of animals, or cartoon characters. Choose a range that meets the child's developmental level. Consider practicing using the scale with non-OCD situations (e.g., going to a new playground, riding a roller coaster) before using it for hierarchy items.

8.2.2.2 Creating and Climbing the Fear Ladder

A fear ladder (i.e., a fear hierarchy using a ladder metaphor) is an exposure treatment plan that lists out specific situations or feared stimuli that the client will gradually face without engaging in rituals or avoidance behaviors (Abramowitz et al., 2019). To introduce this concept to a child, you might say the following:
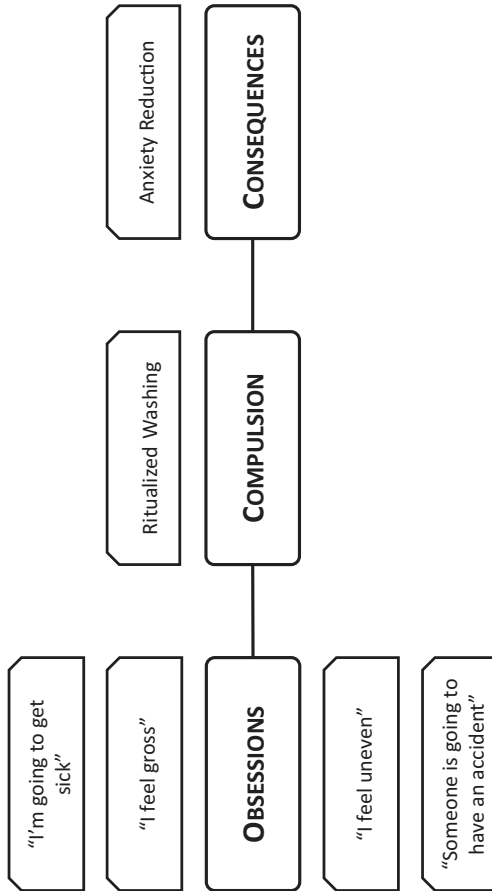
Fig. 8.1 Functional link between obsessions and compulsions

Example: Introducing the "Now we are going to focus on creating a plan together for how you are going to OCD. Today, we are making a fear ladder, which means we are going to talk about different situations that you might practice without doing any rituals or compulsions. I want you to use the fear thermometer to tell me how difficult something would be for you. Just like climbing a ladder, we don't start at the top or with the hardest practice first, we begin at the bottom of the ladder with something that feels like a small step."*boss back*

The next step is to identify specific situations that trigger the child's anxiety. Choose items that the child will practice in different contexts (e.g., office, home, community). Include situations, places, or things that are avoided or result in ritualizing on the hierarchy. When creating fear hierarchies for OCD, identify the obsession or fear the child is to focus on during the exposure, as well as any avoidances or ritualized behaviors the child should not engage in during or after the exposure. Ask the child and caregiver to rate items using the scale (e.g., fear thermometer) you introduced to the family. The goal is to identify items that represent low, middle, and high ranges of distress for a particular fear or target area. When trying to find ways to make an exposure easier or more difficult, consider changing the proximity of the stimulus, altering the amount of contact with the stimulus, combining more than one stimulus, having the caregiver present or not, or increasing or decreasing uncertainty around the task. It is important to note that sometimes building the hierarchy may be an exposure itself and a therapist needs to work towards the child sharing specific obsessions. Notably, caregiver perspective is especially important when creating hierarchies with younger children or children whose report is less reliable. Hierarchies for children should include specific items around reducing family accommodation as needed.

Hierarchies will constantly evolve throughout treatment and the initial hierarchy is meant to serve as a starting point for exposure work. To help facilitate engagement in hierarchy building, consider these options:

Create a *Sticky Note* Ladder

Write hierarchy items on sticky notes and ask the child to put them on the wall to create a sticky note ladder. The child can move around items as you build the hierarchy together. Figure 8.2 is an example of hierarchy items for a child who is fearful of bleach contamination and has compulsions of washing and counting.
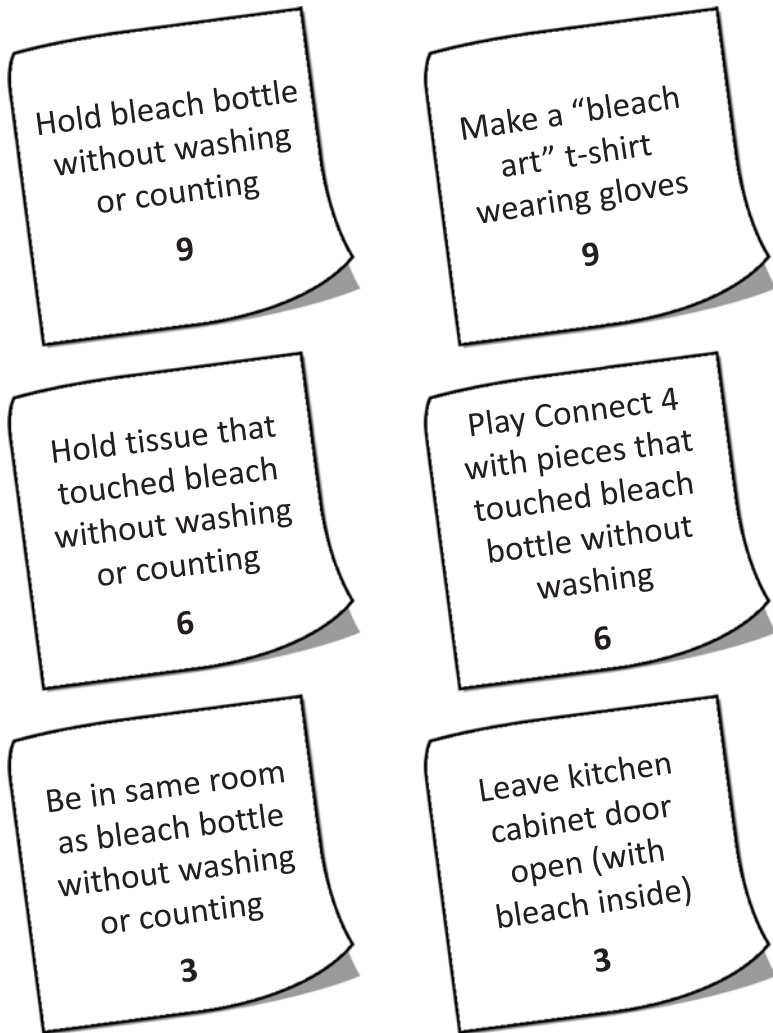
Fig. 8.2 Example of a *Sticky Note* Fear Hierarchy

Make a Bucket Game

Set up buckets on the other side of the room representing varying levels of difficulty (e.g., easy, medium, hard) or child's level of anxiety (e.g., a little, some, a lot). Write hierarchy items on pieces of paper. Ask the child to put cards into the bucket or even make it a basketball game by tossing the paper into the bucket.

Create Videogame Levels

Organize different hierarchy items into levels from easier to more difficult tasks. The child could design their own version or model the levels after their favorite game. For extra fun, create a hierarchy with a special or bonus challenge at the end of each level that they must complete before moving onto the next level.

8.2.3 Exposure and Response Prevention (ERP)

ERP is the main treatment ingredient in CBT packages for OCD treatment; therefore, it is imperative that ERP be part of your clinical intervention. This section will first focus on how to select an exposure with the family and general guidelines for delivering ERP. We will then discuss specific ways to use play to engage youth in exposure work.

8.2.3.1 Exposure Selection

The process of selecting an exposure should always be carried out collaboratively with the family. We have identified three steps for selecting engaging exposures for youth with OCD, detailed and summarized in Table 8.1.

The first step is to identify the current exposure goal and revisit the hierarchy. This goal is what you, the child, and/or their caregiver hope to achieve in completing an exposure during this session. Goals can be specific (e.g., eat more protein despite OCD food rules, wear a winter jacket the child believes is contaminated, tolerate uncertainty of what time mom will return from work) or broad (i.e., break food rules more generally, face contamination fears, tolerate uncertainty). Once you have identified the exposure goal, refer to the relevant hierarchy for exposure ideas for the session. Search for items in the hierarchy that relate to the exposure goal. In some cases, exposures listed in the hierarchy would achieve the identified goal in step one. In other cases, modifications to the exposure in the hierarchy would be necessary to achieve the goal. Aside from relevance to the identified goal, therapists

Table 8.1 Overview of how to select an exposure

Steps for exposure selection	Brief description
1. Identify current exposure goal	With family, identify the current exposure goal—whether specific or broad. Refer to fear hierarchy for exposure ideas related to the identified exposure goal
2. Integrate play (as appropriate)	Consider ways to integrate play into the exposure
3. Finalize exposure expectations	Conduct a *mini hierarchy* to titrate difficulty of exposure, clarify expectations, and finalize exposure before starting

should also consider selecting an exposure that is at the appropriate level of difficulty for the child, is engaging, and is one the child would be willing to attempt. Regarding exposure difficulty, it is better to pick an exposure on the easier side of the spectrum and later increase the difficulty than to start with an exposure that is too difficult and later attempt to reduce its difficulty. Think about exposure choice using the *Goldilocks principle*, meaning the goal is to find a task that is challenging yet doable (i.e., not too easy, but not too hard).

The second step is to brainstorm ways to integrate play into the exposure. As previously established, consider tailoring the exposure using activities (e.g., chess), franchises (e.g., Star Wars), and other things the child enjoys (e.g., cats). For further guidance on how to do so, refer to the section *Approaches to Integrating Play into Exposures*. In many cases, play can be integrated in some fashion. Once you have decided how to integrate play into the exposure, if applicable, finalize details of the exposure.

The last step is to conduct "mini" hierarchy building to clarify and finalize the exposure. "Mini" hierarchy building prior to the start of the exposure can be helpful to ensure the exposure task is clear, appropriately challenging, and engaging (e.g., playful enough to facilitate child's motivation). For example, a child with contamination fears may have "touch sink" as an item on their hierarchy. In presenting exposure options to the family and before agreeing upon an exposure, the therapist should try to be as specific as possible around the expected exposure task. In this example, further assessment might include specifying which sink the child would be touching (as child may perceive different sinks to have varied levels of contamination), whether the child will have direct or indirect contact (i.e., child touching the sink itself or an object that touched the sink), what part of the sink the child will touch directly or indirectly (e.g., faucet handle, side of the basin, drainage hole), what part(s) of their body will touch the contaminated item (e.g., elbow, one finger, two fingers, entire palm). Additionally, response prevention should be discussed and agreed upon prior to the exposure. For instance, this child may be asked to resist checking their hands to determine how contaminated they look; wiping, rinsing, or washing hands; or seeking reassurance from the caregiver.

8.2.3.2   Therapist Delivery of ERP

Prior to starting the exposure, clear instructions should be given about the expectations for the child, caregiver, and therapist. For younger children, coach caregivers on how to support the child during the exposure, such as how to respond if the child makes requests around ritualizing. Next, ask the child to approach the exposure stimulus. Once the exposure begins, try to help the child maintain contact with the exposure task. Examples include providing descriptive statements about the exposure itself (e.g., "Nice job being brave by breaking a rule with this game"), encouraging the child to decrease avoidance (e.g., "I want to focus on that incomplete feeling"), or increasing the difficulty of the exposure task itself (e.g., "Now touch it with your other hand, too"; Benito et al. 2020; Benito & Walther, 2015).

Given the goal of exposure is to create a new learning experience through building distress tolerance, attempt to avoid using strategies that purposefully reduce anxiety during exposure, such as using relaxation, providing accommodation, or distracting the child from the exposure. Additionally, there is no set length or rule for ending an exposure. While the inhibitory learning theory suggests that subjective reports of distress do not need to be reduced for exposure to end (Craske et al., 2014), an essential goal for OCD treatment is to ensure that children will continue to resist rituals related to the exposure after the session. If a child seems to be engaging in more approach behaviors and less avoidance, this is a good indicator that the exposure task is getting easier or they are tolerating their distress better. Natural reduction in fear (e.g., habituation) may occur within an exposure or through repeated practices though the habituation process is not necessary to end the exposure.

One engagement strategy that is especially helpful for younger children is for the therapist to play the role of OCD. You can either pretend to be OCD or use an object (e.g., puppet, stuffed animal) to represent OCD during the exposure. Playing OCD encourages the child to focus on the exposure task while also being silly and humorous. For instance, you could pretend to shrink in size as the child approaches the exposure task or "bosses back" OCD by doing the opposite of their rituals or saying things like "I don't have to listen to you."

8.2.3.3   Approaches to Integrating Play into ERP

This section details strategies for integrating play into exposures using games and creative arts. Examples for how to apply the approaches are provided. Some techniques lend themselves particularly well to certain core fears, while others have such varied applications that they span all core fears. Most, if not all, of these approaches can be used across several core fears. We strongly encourage you to be creative with application of these strategies.

Creating New Exposure Games

One way to integrate play into exposure is to create a new game. This gives you the ability to highly specialize a game towards a child's specific obsessions and associated triggers. The process of making a game with the child may be part of the exposure if constructing the game pieces is anxiety-provoking. The following are examples of different games that can be used in ERP.

Word Games Some children with OCD may avoid certain words or phrases associated with obsessional content. Constructing a word game is a fun way for kids to gradually approach this content by either first seeing the content, writing the content, or saying it aloud. These games can be particularly helpful for youth with illness worries, specific fears (e.g., ticks, severe weather, vomit), sexual obsessions, or morality concerns. A number of these games (e.g., Build a Flower, Word

Association) can also be used interactively during telehealth if you have a shared whiteboard.

Memory Game Build your own version of a memory game with "tiles" (e.g., paper cut into squares) featuring pairs of words related to the core fear you intend to target. The goal of this game is to have the child look at and think about content on the tiles. For example, for a child with obsessions about getting ill, create memory tiles with names of different illnesses (e.g., the flu, pneumonia, diarrhea). The exposure can simply consist of playing the game and thinking about the illnesses listed on the tiles. Alternatively, ways to increase difficulty might be to combine the game with other triggers (e.g., touching a germy surface before playing), having the child say the words aloud during the game, including pictures, or sharing facts or a story for each match made.

Go Feel Uncomfortable This game is based on Go Fish with cards involving avoided words or phrases. Make your own version of Go Fish "cards" with whatever materials you have on hand (e.g., paper cut into rectangles) featuring pairs of words or images related to the core fear you intend to target. Memory cards can also be used to play this game. For example, if a child worries about using "bad" words, make cards with the avoided content. The child then verbally asks, "Do you have a [avoided word]?" as part of the game. In this example, selection of words should be collaboratively decided with the child and caregiver. For an easier version, consider words that rhyme with or sound like the "bad" words. The exposure can consist of playing the game and thinking about if the child did something immoral by reading or saying the words written on the cards. Ensure the child resists any rituals, such as confessing.

Word Association Competition Compete to see who can think of the most words related to a word central to the core fear one would like to target. If your client has an unlucky color of red, take turns saying different words that are associated with that color (e.g., stop sign, cardinal, autumn leaves) to see who can come up with the most words. The goal would be for the child to engage in the game and resist any rituals. In this example, you could write the words with a red marker to make the task more challenging.

Build a Flower/Build a Snowman This game involves having a secret word or phrase that the other player must guess by giving letters. The secret word should be related to obsessional content that you are trying to target. If the child misses the letter, you draw one part of a flower or snowman until the child either guesses the word/phrase or the full picture is drawn. For example, for an illness related exposure, the therapist may make the secret word be "cancer" and the child guesses letters until they identify the word or lose when the flower or snowman is fully drawn.

Spin the *Exposure Wheel* This game is a fun way to introduce playfulness around choosing different aspects of an exposure by "spinning a wheel." To complete this game, identify different potential aspects of exposure and put them into a randomizer (e.g., a virtual wheel to spin, write them on slips of paper and place in a bowl). "Spin the wheel" to randomly choose aspects of exposure. For example, if a child is fearful of cartoons and fantastical media, collaboratively write down names of characters from cartoons and fantasy films on slips of paper and put them into a

bowl. Take turns reading names on slips of paper and pulling up images of the characters. If a child habituates to the images, increase the exposure difficulty by watching videos of the characters instead. This particular approach also introduces more uncertainty, which may be another exposure target. To add even more uncertainty (as appropriate), the therapist could choose the characters without child input.

Secret Mission: Code Brave Design an adventure or special mission for the client that is relevant to their core fear. This game is especially helpful for children with morality concerns around breaking rules or doing something "wrong." For example, a Code Brave assignment might be to put an item in the grocery store back in the "wrong" spot without confessing. It is important to discuss these types of exposures with caregivers separately to provide the rationale and secure their agreement. Another Code Brave example is completing a scavenger hunt to search for feared stimuli or associated items. For instance, a child who is afraid of spiders might have scavenger hunt items including going to a spot they previously saw a spider, going to the basement, finding an outside spider web, or finding a real spider. Additionally, Code Brave can be used to target evenness/symmetry urges by moving personal items around or throwing away items to target hoarding.

Modifying Existing Games

Another way to use games is to make quick modifications to existing games to activate the child's core fear. Modifications can include changing or adding rules to gameplay or altering the physical pieces of the game (e.g., contaminating game pieces). Many of these approaches require owning board games although the specific board game is often flexible**.**

Change or Create New Rules Changing or creating new rules of board games may serve as an exposure for youth with rigidity, *not just right* (NJR) feelings, perfectionism, or morality concerns as part of their OCD. This approach often requires hierarchy building to identify what specific rule changes would activate or increase the anxiety you wish to target. For instance, an exposure task in a Monopoly game might include one or more of the following: the child moving pieces in the opposite direction, paying the *wrong* owner of space they land on, not collecting $200 when they pass go, or not going to jail when they get a *go to jail* card.

Contaminate Games Contaminate a preferred game or toy (e.g., board game, Legos, stuffed animals) with the goal of the child playing with the contaminated object. For example, a child who considers his younger sister to be highly contaminated given that she crawls on the floors of public places can play Scrabble with pieces touched by the child's younger sister before playing. During the Scrabble game, encourage the child to focus on the contaminated tiles and resist related rituals. Contaminating game pieces may be modified using sticky substances as well (e.g., small amounts of soda or honey).

Operation The game of Operation is useful to target health related fears or disgust. For example, each player describes an illness related to the body part where

the item was removed. When the child removes the ankle bone, they share or read a story about bone cancer.

Pictionary Similar to word games, Pictionary is easily adapted across a wide range of core fears and helps a child approach feared content in a fun way. For example, if a child is fearful of bugs, a therapist and child can take turns drawing and guessing different items associated with insects. Pictionary is a game that is applicable for telehealth by using a shared whiteboard screen or holding up pieces of paper to the screen.

Simon Says Use Simon Says to encourage movement while activating a relevant core fear. For example, this game is helpful to target asymmetry or unevenness in body movements (e.g., tap your left hand but not the right). For children with sensory intolerance or NJR feelings with clothing, playing Simon Says while wearing clothes that do not feel right promotes distress tolerance while engaging in activities.

Creative Arts

Using art as a medium to complete exposures is very effective across a number of core fears. Below are some examples of ways to use integrate arts into ERP when treating pediatric OCD.

Baking/Cooking For contamination fears, bake and eat a preferred treat in the presence of a contaminant or with "contaminated" hands. For example, if a child is afraid of coming in contact with cleaners, a family may bake brownies with disinfectant wipes on the counter while resisting rituals. Cooking or baking using knives, if developmentally and clinically appropriate, can be an engaging exposure for youth who may avoid sharp objects due to self-harm obsessions. Changing proximity to the knife or altering the type of knife (e.g., plastic, butter, bread knife) are ways to make the exposure easier or harder. For perfectionism obsessions, purposefully altering a recipe, such as putting in too much or little of an ingredient, might be distressing for the child and can build tolerance for making small mistakes.

Artwork Using art across many different mediums is a creative and fun way to engage children in exposures. For children with NJR or incompleteness symptoms, consider asking the child to color outside of the lines, choose *incorrect* colors for objects (e.g., blue sun, red grass), and/or leave portions of the drawing incomplete without correcting. Art projects are useful for targeting avoidance related to sticky substances or disgust. Completing art projects using glue, finger painting, or shaving cream may target these feelings. Given these projects can become quite messy, be mindful of slowly approaching the task to ensure the exposure is manageable and not too difficult. Similar to using knives with baking, some children may avoid using scissors for fear of harming themselves or others. Art projects incorporating scissors can be utilized to help them approach the stimulus. To target hoarding, purposefully create a drawing or complete a coloring page to recycle. The child would *boss back* OCD by resisting the urge to save it or take it out of the recycling bin. To add some extra fun, consider making paper airplanes to fly into the recycling bin!

Media While not necessarily play, using media (e.g., video games, movie clips) can make exposures more engaging given these are typically preferred activities. For example, there are scenes from TV shows and movies appropriate for different ages that feature vomiting (e.g., Dora the Explorer, Arthur, Pitch Perfect 2, Cheaper by the Dozen). For intrusive images or thoughts, consider watching or reading the scene from Harry Potter and the Prisoner of Azkaban when Harry casts the Riddikulus spell to banish the Boggart. In the scene, the spell turns a Boggart, who feeds on fear, into something silly, taking away its power. Rather than avoiding scary thoughts, encourage children to use their own Riddikulus spell and imagination to change the distressing image/thought into something silly. One could sit with the funny version of the intrusive image or even draw a picture of it as an exposure.

Songs and Storytelling Another fun way to help youth approach feared content is for them to create a silly song or story. Change the information and level of detail of the story or song make it more or less difficult. For stories, use a *Roll-a-Story* format with dice to turn this activity into a game. Collaboratively identify and assign a character, setting, and problem that are related to obsessional content to each dice number (e.g., 1–6). The child then rolls the dice for each category to select prompts to be used in a story. For instance, a child with obsessions related to choking might roll the dice and be asked to produce a story involving a sibling (character), the bus (setting), and gagging (problem). Read the story as an exposure. Encourage details to create a vivid imaginal exposure as a way to increase the difficulty.

8.2.4   Family Involvement

Family involvement in pediatric OCD treatment is important and targeting family accommodation (e.g., family involvement in rituals, changes in routine in response to OCD) is associated with positive treatment responses (Anderson et al., 2015; Lewin et al., 2014). Since children spend the majority of their time outside of therapy, it is critical that families continue incorporating and reinforcing strategies or techniques learned in treatment (e.g., reducing accommodation, encouraging children to approach feared stimuli without ritualizing). The amount therapists use these strategies will depend on a child's presentation, motivation, and interactions within the family. Repeating play-based exposures completed during the therapy session at home is one helpful strategy to promote ERP at home. Encourage caregivers to participate in your session exposures to help build their confidence in completing similar exposures in the home environment.

Using positive reinforcement strategies is strongly encouraged, including verbal praise for brave behavior. Many children also benefit from a rewards system. Utilization of rewards to encourage children to complete between-session homework is an important way for caregivers to reinforce treatment strategies. Rewards can be tangible items (e.g., stickers, small toys) or privileges (e.g., staying up 30 minutes past bedtime, making a preferred treat, family movie night, having special time with a caregiver). As an example, create a *Bingo* chart filled with exposure

practices that the child can earn a sticker or checkmark for completion. Once they have a bingo, the child can earn a reward. Most importantly, be creative and identify rewards that are reinforcing for the child.

Other helpful strategies for caregivers when doing ERP with children include modeling and scaffolding (Freeman & Garcia, 2008). One way children learn is by observing adults. Encourage parent modeling of brave behavior by demonstrating approach to uncomfortable situations and by calmly encouraging children to do the same. Other family members can model brave behavior by participating in exposures both in session and at home. Scaffolding supports a gradual approach to help the child face challenging situations, especially with unexpected triggers. To scaffold approaching an anxiety-provoking situation, a caregiver should first identify the child's emotion and empathize with their feelings. Second, brainstorm options to limit avoidance and help the child approach the situation in some way. Lastly, encourage the child to approach and praise them for brave behavior.

8.2.5 Relapse Prevention

Relapse prevention is typically incorporated towards the end of treatment and includes educating the family about the chronicity of OCD, possible reemergence of symptoms, and value of continued exposure practice. It is important for families to know that exposure does not end with treatment but should become part of a new lifestyle. Comparing OCD to a weed in a garden exemplifies how anxiety returns if you do not keep engaging in exposure. To help the child practice managing new or reemerging symptoms, ask them to pretend to be the therapist and help you with an OCD symptom. Children often find this to be a fun way to practice applying these skills to new situations.

Lastly, another part of relapse prevention is to focus on the child's progress and skill acquisition. Making a project, such as a video or book, promotes self-efficacy by reviewing ways in which a child has progressed and it documents skills the child has learned. This final project can be a helpful resource for families after treatment to review skills.

8.3 Conclusion

Cognitive behavioral therapy using ERP is a well-established and effective treatment for pediatric OCD. Integrating play and using playful approaches when delivering ERP for OCD can help promote treatment engagement and increase tolerability of exposures for youth. When using play in ERP, it is important to be mindful of the function of play with the primary goal to increase engagement and willingness rather than serving as a distraction. By being creative and playful with CBT for

OCD, children not only create new and helpful learning experiences but they can have a little fun too!

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