Research on Child and Adolescent Psychopathology
https://doi.org/10.1007/s10802-024-01258-x

Potential for Harm in the Treatment of Pediatric Obsessive-Compulsive Disorder: Pitfalls and Best Practices

Erika S. Trent[1,2] · Elizabeth C. Lanzillo[1,3] · Andrew D. Wiese[1] · Samuel D. Spencer[1,4] · Dean McKay[5] · Eric A. Storch[1]

Accepted: 7 October 2024

Abstract

Pediatric obsessive-compulsive disorder (OCD) can be debilitating and chronic unless treated early with efficacious intervention. The past several decades of intervention research have identified cognitive-behavioral therapy (CBT) with exposure and response/ritual prevention (ERP) as the first-line, evidence-based psychological intervention for pediatric OCD. Yet, many youths with OCD unfortunately remain inadequately treated. In well-meaning but misguided efforts to treat this complex disorder, clinicians holding misconceptions about ERP may fail to apply evidence-based treatments, misapply generic CBT techniques and ERP principles, or turn to non-evidence-based interventions. Potentially harmful treatments may worsen symptoms, while ineffective treatments can waste resources, impede patient access to efficacious treatment, and weaken public confidence in psychotherapy. The overarching goals of this review paper are to describe potentially harmful and ineffective practices in the treatment of pediatric OCD and to offer recommendations aligned with evidence-based practice. First, we dispel common misconceptions about ERP that may underlie its underuse among clinicians. We then describe potentially harmful and ineffective interventions for pediatric OCD, starting with misapplication of generic CBT techniques and ERP principles. We also identify non-evidence-based treatments for pediatric OCD that have limited conceptual or empirical foundations. Finally, we conclude with recommendations for clinicians who treat pediatric OCD, intervention researchers, training programs across mental health-related disciplines, and policymakers.

Keywords Exposure and response prevention · Cognitive-behavioral therapy · Evidence-based practice · Child and adolescent · Parents · Education and training

* This work was completed while Elizabeth Lanzillo was affiliated with Baylor College of Medicine and the Catholic University of America. Elizabeth Lanzillo is currently affiliated with Old Town Psychology, Alexandria, VA, United States.

✉ Erika S. Trent
erika.trent@bcm.edu

Elizabeth C. Lanzillo
lanzillo@cua.edu

Andrew D. Wiese
andrew.wiese@bcm.edu

Samuel D. Spencer
samuel.spencer@unt.edu

Dean McKay
mckay@fordham.edu

Eric A. Storch
eric.storch@bcm.edu

[1] Menninger Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine, Houston, TX, USA

[2] Department of Psychology, University of Houston, Houston, TX, USA

[3] Department of Psychology, The Catholic University of America, Washington, DC, USA

[4] Department of Psychology, University of North Texas, Denton, TX, USA

[5] Department of Psychology, Fordham University, Bronx, NY, USA

Published online: 23 October 2024

Introduction & Background

Pediatric obsessive-compulsive disorder (OCD) is a debilitating psychiatric condition affecting 1–2% of youth (Geller & March, 2012). It is characterized by intrusive, repetitive, and distressing thoughts (i.e., obsessions) and behaviors or mental acts that are intended to alleviate this distress (i.e., compulsions), both of which can occupy significant time and cause clinically significant distress and impairment (American Psychiatric Association, 2022). Although compulsions are designed to alleviate obsessional distress, these behaviors often paradoxically strengthen obsessions (Rachman, 1998). Children and adolescents (hereafter "youth") with OCD often experience functional impairment in academics, family activities, social relationships, and overall quality of life (Storch et al., 2018). OCD typically follows a chronic course, placing affected youth at risk for further functional disability in adulthood (Micali et al., 2010). Fortunately, the past several decades of intervention research have identified efficacious psychological interventions for pediatric OCD; yet, many youths with OCD remain inadequately treated (Marien et al., 2009).

In a recent literature review, McKay et al. (2021) described the potential for harm in OCD treatment in adults. They identified a range of misguided or inappropriate interventions for adult OCD across several theoretical approaches, including misapplication of cognitive-behavioral interventions and use of treatments with limited empirical support. Building on this discussion, Spencer et al. (2023) highlighted that many clinicians shy away from using exposure and response/ritual prevention (ERP)—an evidence-based intervention for OCD (Cervin et al., 2024; McGuire et al., 2015)—due to concerns about harming patients, and proceeded to debunk common misconceptions about ERP. In failing to apply potentially helpful treatments due to unfounded *concerns* of doing harm, clinicians may instead turn to inappropriate interventions that *actually* risk harm. Identifying and minimizing potential harm in OCD treatment has important implications for clinical work, intervention research, clinical training, and policy.

Despite recent literature addressing the potential for harm when treating adults with OCD (McKay et al., 2021), little attention has been given to this topic in youth. Examining the potential for harm in the treatment of pediatric OCD is necessary for several reasons. For one, early and effective intervention is linked to improved treatment outcomes and reduced burden of illness (Liu et al., 2021). As such, inappropriate treatment during this crucial developmental window may have longstanding implications for youths' wellbeing. Moreover, when well-meaning but misinformed clinicians or parents erroneously perceive harm related to implementing ERP, they may turn to non-evidence-based practices that can exacerbate OCD symptoms. Indeed, as discussed in further detail below, various treatments without empirical support (e.g., energy therapies) have been packaged for children with OCD and advertised to parents (Hupp & Santa Maria, 2023; Pignotti & Thyer, 2019). Thus, clinicians should be aware of such pseudoscientific interventions and educate youth and families on iatrogenic practices that should be avoided. Additionally, treatment for pediatric OCD has several differences from adult OCD treatment, such as a greater emphasis on family involvement and weaker emphasis on cognitive techniques. Overlooking such differences can result in suboptimal treatment and continuation of OCD pathology.

The aims of this conceptual review are threefold. First, we shed light on common misconceptions about ERP for pediatric OCD, as such misconceptions likely hinder widespread dissemination and uptake of ERP (Storch et al., 2020). Second, we identify several potentially harmful and ineffective interventions for pediatric OCD, including misapplication of cognitive and behavioral techniques and use of non-evidence-based approaches. Third, we provide recommendations regarding best practices for clinicians, researchers, training programs, and policymakers. By understanding why clinicians may fail to employ potentially helpful interventions, misapply evidence-based techniques, or rely on non-evidence-based interventions, we can improve dissemination of efficacious psychological intervention for pediatric OCD.

Defining "Harm" in the Treatment of Pediatric OCD

Borrowing from previously established frameworks (Dimidjian & Hollon, 2010; McKay et al., 2021), we delineate between "harmful" and "ineffective" interventions. The American Psychological Association (APA) Ethical Principle A (2017) states that psychologists "strive to benefit those with whom they work and take care to *do no harm*" (p. 3; emphasis added). Although the Ethical Code does not elaborate on the definition of "harm," Dimidjian and Hollon (2010) define harmful treatment as "a causal effect, producing outcomes that are worse than they would have been in the absence of treatment" (p. 21). In the context of pediatric OCD, harmful treatment may inadvertently encourage compulsions, introduce new compulsions, or strengthen a youth's obsessional beliefs, which collectively contribute to increased frequency or duration of symptomology.

Ineffective treatments do not cause direct harm and have no significant effect on symptoms of interest (McKay et al., 2021). Despite this seemingly innocuous definition, the use of ineffective treatments is concerning for several

reasons. Ineffective treatments waste time, money, and other resources, and may contribute to decreased willingness to engage in future treatment, ultimately delaying access to evidence-based treatment (Dimidjian & Hollon, 2010). It often takes up to 10 years from OCD symptom onset for individuals to seek treatment, and there is typically an additional several year delay until they receive an accurate diagnosis and proper treatment (Moritz et al., 2013). Over 40% of adults with OCD reported that previous experiences with ineffective interventions prevented them from seeking further treatment (García-Soriano et al., 2014). Similarly, parents of youth with OCD report that their lack of trust in mental health treatment hindered them from seeking help for their child (Kolvenbach et al., 2018). As such, ineffective treatments may cause families to disengage from the mental health system. This is problematic given that early intervention is key for positive treatment outcomes (Liu et al., 2021) and non-treatment leads to worsened symptoms (Micali et al., 2010). Finally, ineffective treatment reduces public confidence in the field of psychotherapy, which already suffers from an "image problem" owing to popular misrepresentations in the public (Gaudiano & Ellenberg, 2014). Thus, even if not actively harmful, ineffective treatments are still deeply problematic and warrant attention.

Potential for Harm Due to Misconceptions About ERP

Cognitive-behavioral therapy (CBT) with ERP has been identified as a gold-standard psychotherapeutic treatment for pediatric OCD (Cervin et al., 2024; Kircanski & Peris, 2015; McGuire et al., 2015; Rosa-Alcázar et al., 2015). ERP involves systematically approaching stimuli or triggers that elicit obsessions (i.e., exposure) with therapist guidance, while resisting urges to engage in associated compulsions or avoidance strategies (i.e., response/ritual prevention). One of the goals of ERP is to help patients become more flexible in how they respond to their OCD triggers. Through graded exposures, patients learn that they can tolerate anxiety without giving in to compulsions, that feeling anxiety does not necessarily mean feared outcomes occur, and that they can handle the feared outcome if it does occur. By developing the confidence that they can manage anxiety-provoking situations without relying on compulsions, youth are able to navigate their day-to-day lives more effectively. Despite ample empirical support for the efficacy of ERP for youth (Cervin et al., 2024), research exploring misconceptions about ERP have primarily focused on adult populations (Deacon et al., 2013; Spencer et al., 2023), with such work in youth remaining comparatively limited.

Misconception #1: ERP Presents a Significant Risk of Harm

Ill-founded beliefs that ERP presents a significant risk of harm are a major impediment to effective OCD treatment for youth (Blakey et al., 2018; Deacon et al., 2013). More specifically, clinicians and adult OCD patients sometimes express unfounded concerns that ERP may lead to serious negative outcomes such as a medical emergency (e.g., loss of consciousness) or illness (e.g., contracting pathogens from a public trash can; Blakey et al., 2018). While research has not directly examined the misconception that ERP risks harm among pediatric patients, many therapists are reluctant to practice ERP with youth because they are a vulnerable population (APA, 2017; Franklin et al., 2015). Youth and family members may also share this belief (Blakey et al., 2018). Relatedly, youths undergoing ERP treatment face unique challenges related to their developmental context. For example, peers or teachers may notice if a child practices exposures in school contexts (e.g., not washing hands before or after eating lunch, submitting an assignment after checking their work only once instead of three times). Navigating judgment or misunderstandings in such contexts may be daunting for clinicians who are less experienced in ERP.

Provided the accuracy of diagnosis, extensive literature reveals a lack of empirical support for perceived adverse outcomes associated with ERP (Deacon et al., 2013). To illustrate, Schneider et al. (2020) conducted a survey of clinicians to investigate the frequency and nature of serious negative outcomes due to ERP. Of the 230 clinicians surveyed with experience treating pediatric OCD, only one provider (0.4%) reported a patient-related adverse outcome. Moreover, the nature of the outcome (i.e., educational disruption and poor grades due to patient maladaptively using ERP to avoid engaging in schoolwork) did not pose a threat to the patient's safety.

Despite the absence of evidence for serious negative outcomes, it is worth noting that the nature of exposure can involve some, albeit minimal and normative, risk for harm (Blakey et al., 2018). For example, when treating a child with contamination-themed OCD who avoids using public restrooms due to fears of contracting an untreatable illness, ERP tasks may include touching a public toilet seat and resisting handwashing. While this exposure involves some risk (i.e., it is *possible* that touching a toilet seat will result in exposure to a pathogen), the level of risk is largely reasonable in relation to the child's degree of impairment and/or distress. If an undesired outcome does occur, it provides an opportunity for the child to learn that they can tolerate their discomfort and manage the negative outcome, ultimately recognizing that continuing to engage in compulsions and avoidance strategies is not "worth it" in the long-term. It

is also possible for youth to experience disappointment or frustration after an "unsuccessful" exposure that was beyond their current capabilities early in treatment (e.g., a child agrees to touch a toilet seat early on in treatment but finds out it was more difficult than he thought). However, this does not seem likely to cause long-term harm; in fact, clinicians can transform such moments into learning experiences by commending the youth's bravery and collaboratively calibrating their exposure hierarchy.

Moreover, family accommodation (i.e., behaviors intended to reduce the child's OCD-related distress that inadvertently contribute to OCD symptomology; Lebowitz et al., 2016) and OCD-driven avoidance can also potentially contribute to harm (e.g., risk of developing a urinary tract infection due to holding urine to avoid public restroom use). Despite the understandable desire to alleviate a child's distress, family accommodation has been shown to perpetuate OCD symptomology and can result in disruptions in social and educational experiences (Lebowitz et al., 2012). For example, providing reassurance throughout the school day to a child via text messaging could impact a child's ability to engage in their coursework and reinforce their belief that they managed the situation only because their parents assured them that "it will be okay."

Misconception #2: ERP Elicits Extreme Distress Which Results in Premature Termination

Concern that ERP will lead to extreme distress among youth, ultimately resulting in treatment termination, has also been documented (Blakey et al., 2018; Johnco et al., 2020; Reid et al., 2017). For example, a survey of clinicians treating youth with anxiety and related disorders revealed that clinicians were likely to use cognitive restructuring and relaxation strategies more frequently than exposure techniques due to negative beliefs about ERP and a lack of training in ERP (Reid et al., 2018). More recently, Keleher et al. (2020) examined clinician-reported barriers to using ERP when treating pediatric OCD. Findings from their anonymous survey completed by clinicians in the United Kingdom ($n = 107$) identified concern for patient intolerability as the most common negative belief (Keleher et al., 2020).

Research examining distress among patients receiving ERP reflects the expected trajectory of discomfort according to theoretical models (Craske et al., 2014). A short-term increase in distress is common and expected during exposures; however, patients engaging in ERP generally demonstrate a decline in distress across subsequent exposure tasks (Chu et al., 2015; McGuire et al., 2015). Further, contrary to some clinicians' perceptions, ERP does not involve "flooding" in the classic sense (i.e., immediate, intensive exposure to a strong magnitude of a feared stimuli). Instead, best practices suggest guiding patients through exposures in a graded manner (Foa et al., 2012). Starting with easier exposure tasks provides youth a mastery experience, before moving on to more challenging exposure tasks. Relatedly, if eliminating compulsions is too difficult at the beginning of treatment, clinicians can grade exposures by delaying (e.g., delay washing hands for 10 min. after touching a handrail instead of washing immediately) or diminishing compulsions (e.g., wash hands for 20 s. after touching a handrail instead of 1 min.).

Moreover, despite significant clinician-reported concern about youths' ability to tolerate distress while engaging in exposures, youths themselves have reported minimal concern about ERP tolerability (Riemann et al., 2014). These findings are further supported by recent meta-analytic data showing attrition rates for ERP are lower compared to alternative psychotherapeutic interventions and pharmacological treatments for children (Johnco et al., 2020). Additionally, in a study of youth with OCD undergoing ERP, participants with higher (vs. lower) treatment expectancy at baseline were less likely to drop out and showed greater symptom improvement (Lewin et al., 2011). Taken together, these findings highlight the importance of increasing awareness about the efficacy of evidence-based treatments for OCD.

Misconception #3: Exposure Tasks are Inappropriate for Youth, Particularly for Youth Experiencing Taboo Obsessions

In the previously described study by Keleher et al. (2020), findings revealed that clinicians were less likely to utilize ERP when treating youth with taboo obsessions (e.g., sexual, harm, and religious obsessions) compared to other OCD symptom dimensions (e.g., contamination). Nearly 50% of clinicians reported reluctance to address taboo obsessions with ERP due to their belief that "exposure tasks feel inappropriate" (Keleher et al., 2020, p. 5). Reservations about conducting exposures focused on sexual content with youth were also identified in a thematic analysis of clinicians' attitudes toward ERP (Schneider et al., 2020). Our own clinical experiences have provided anecdotal evidence that this concern is shared by parents of pediatric patients. For example, one parent of an adolescent with intrusive thoughts of suicide consistent with OCD (e.g., "What if I jump in front of car?") expressed their concern that ERP would increase the likelihood of their daughter acting on these thoughts.

Importantly, research examining the prevalence of adverse outcomes for patients engaging in ERP for taboo obsessions has demonstrated that serious negative outcomes during and following ERP tasks are rare (Schneider et al., 2020). Further, by recognizing intrusive thoughts as normative mental content that does not automatically entail

action (Radomsky et al., 2014), youth will likely experience a decrease in the intensity and frequency of their intrusive thoughts. In fact, labeling common experiences with specific ERP-based terminology can be helpful. In the example of the adolescent with suicide-themed obsessions, labeling this phenomenon as "thought-action fusion" (i.e., the belief that thinking something makes it true) and providing relevant psychoeducation would help the adolescent dispel this erroneous belief. Accordingly, ERP does not increase the likelihood of acting on intrusive thoughts or introduce new thoughts; rather, engagement in ERP supports youth to confront their existing thoughts, leading to a reduction in associated distress. Avoidance of exposures targeting potentially taboo—yet common—obsessions and failure to normalize intrusive thoughts may prevent youth from receiving effective treatment and reinforce experiences of shame.

Done correctly, ERP considers the patient's developmental age when determining specific exposure tasks. Thus, exposure tasks that are effective for an older adolescent may be iatrogenic for a younger child. For instance, with an older adolescent experiencing fears of impulsively hurting his family members, holding a knife in their presence may be an appropriate exposure. It is normative for an adolescent to use a knife in daily living (e.g., preparing food), and learning that he can hold a knife near his family members without stabbing them will decrease long-term distress and improve his functioning. However, for a young child with similar harm obsessions, this exposure would be developmentally inappropriate and likely to cause undue distress without long-term benefit. A more developmentally appropriate exposure task for a young child with a similar core fear may involve using scissors near family members for a craft project. When developmentally informed, ERP for taboo/harm-related obsessions is unlikely to cause harm.

Implications of Misconceptions in Relation to Harm

Mistaken beliefs about ERP hinder the application of evidence-based treatment, which can result in the delivery of treatment that is either harmful or ineffective (McKay et al., 2021). For example, a clinician who believes ERP is inappropriate for youth experiencing taboo obsessions may respond to a patient's intrusive doubt (e.g., "What if I stab my little sister with scissors?") with reassurance (e.g., "You would never do that."). Such reassurance only provides temporary relief without allowing for the new learning that is critical for effectively treating OCD. Relatedly, mistaken beliefs about ERP influence parents' and patients' willingness to participate in treatment. Misconceptions, including the belief that ERP poses a significant risk of harm, may lead families to seek alternative non-evidence-based intervention, or perhaps, no treatment at all. In such cases, youth are more likely to experience greater impairment and potentially chronic OCD symptoms into adulthood (Micali et al., 2010).

Potential for Harm in Cognitive-Behavioral Interventions for OCD

Misapplications of General Cognitive-Behavioral Techniques for Pediatric OCD

CBT refers to an umbrella of interventions that target maladaptive cognitive or behavioral problems underlying a range of psychological difficulties (Hofmann et al., 2014). While CBT has a strong evidence base in treating many disorders of childhood including pediatric OCD (Cervin et al., 2024), not all generic CBT techniques are necessarily appropriate for treating pediatric OCD.

Potentially Harmful Applications of Generic Cognitive-Behavioral Techniques

Thought Stopping Thought stopping involves pairing an intrusive thought with an aversive stimulus (e.g., painful slap on wrist) combined with a variant of the command, "stop!" Among community providers treating pediatric anxiety disorders including OCD, over 60% reported using thought stopping "often" or "always" (Whiteside et al., 2016). Therapists who used thought stopping endorsed more negative beliefs about exposure and reported that therapists' role during exposure is to decrease the child's anxiety (c.f., facilitate habituation; Whiteside, 2023). While there is little-to-no research on the use of thought stopping in the treatment of pediatric OCD specifically, its use has been documented in a handful of cases with only anecdotal findings (Wolff & Rapoport, 1988). Generally speaking, researchers and clinicians purport that thought stopping possesses questionable utility and should be avoided when treating OCD (Abramowitz, 2021; McKay et al., 2021; Reddy et al., 2020; Whiteside et al., 2016). Thought stopping can interfere with ERP for OCD because of its potential to function as cognitive avoidance, or a mental compulsion designed to temporarily neutralize an intrusive thought but paradoxically increase the salience of such mental content (Tolin et al., 2002). For example, a teenager who experiences intrusive thoughts about impulsively hurting his family members may develop a habit of mentally repeating "No!" until the intrusive thought and associated distress recede. He may then come to believe that this mental compulsion prevents him from acting on his intrusive thought. Engaging in this compulsion during ERP would interfere with the process of

learning that simply having an intrusive thought does not make it true.

Cognitive Restructuring Cognitive restructuring involves identifying negative and distorted thought patterns and modifying them to include a focus on more positive and balanced thoughts (Beck & Beck, 2011). Identifying and challenging cognitive distortions is common in treatment manuals for pediatric anxiety disorders and pediatric OCD (e.g., March & Mulle, 1998). The ubiquity of cognitive restructuring likely originates from its inclusion in adult OCD treatment manuals, which is founded in empirical research supporting cognitive conceptualizations of OCD (Wilhelm & Steketee, 2006). However, in comparison to adult OCD, the role of cognitive distortions may be less central in the conceptualization of pediatric OCD. For example, cognitive distortions commonly observed in adult OCD (e.g., perfectionism, overestimation of threat) do not consistently distinguish children with OCD from children with other anxiety disorders or non-clinical samples (Barrett & Healy, 2003; Ye et al., 2008). Indeed, a meta-analysis of clinical trials for pediatric OCD found that the presence of cognitive restructuring techniques did not predict treatment outcomes (Rosa-Alcázar et al., 2015). If misused, cognitive disputations of obsessions can perniciously function as self-reassurance. Similar to thought suppression, self-reassurance can function as a mental compulsion to the extent that it neutralizes or attenuates an intrusive thought (Neal et al., 2017). For example, a child with contamination OCD has an intrusive thought, "I'll get sick from the germs on my classroom's doorknobs," and disputes this thought by telling himself, "No, I won't get sick because the janitor sanitizes these doorknobs every day." This self-reassurance attenuates his anxiety momentarily, yet strengthens his beliefs that germs will make him sick.

While cognitive restructuring (i.e., "challenging" obsessions) specifically can interfere with ERP, not *all* cognitive therapy techniques are necessarily harmful. For example, externalizing OCD by assigning it a "nickname" and practicing encouraging self-talk (e.g., "The OCD Monster is telling me to wash my hands, but I don't have to listen to him because I'm the boss!") are cognitive techniques commonly included in earlier stages of ERP protocols for youth with OCD (e.g., The Pediatric OCD Treatment Study Team, 2004). Such cognitive techniques are useful insofar as they help children engage successfully in ERP.

Potentially Ineffective Applications of Generic Cognitive-Behavioral Techniques

Poor contingency management Effective contingency management, which involves systematically rewarding treatment engagement (e.g., exposure completion), is a key component of cognitive-behavioral interventions for children (Gosch et al., 2006). However, this approach can become ineffective if parents are not coached in developing a sustainable reward system with sufficiently motivating rewards. While adolescents may be motivated by delayed rewards (e.g., additional screen time later that week), young children may benefit from more immediate and physically tangible rewards (e.g., a small toy from a prize box). Having a strong contingency management system is especially relevant to ERP for OCD because daily exposure "homework" is critical to its success. Unlike homework tasks in other cognitive-behavioral interventions (e.g., worksheets, relaxation techniques), exposure homework requires youth to confront feared stimuli without engaging in their habitual compulsions that make them feel better. Intrinsic motivation tends to develop as youth start to make enough progress to see positive differences in their day-to-day life, but until then, extrinsic motivation is cultivated through contingency management.

Relaxation Techniques Relaxation training, such as progressive muscle relaxation or diaphragmatic breathing, is commonly utilized in pediatric anxiety disorder treatment (Whiteside et al., 2016). However, empirical studies generally reveal that relaxation techniques alone are ineffective in the treatment of OCD (Abramowitz, 2021; Reddy et al., 2020). Randomized controlled trials with samples of OCD youth demonstrate the superiority of ERP-focused CBT over relaxation training, with response rates of 57–72% for ERP-focused CBT vs. 20–41% for relaxation training (Freeman et al., 2014; Piacentini et al., 2011). In the context of pediatric OCD treatment, relaxation training is theoretically incongruent with the objective of evidence-based exposure methods. That is, one of the goals of ERP is to help patients develop a healthier relationship with anxiety by learning that they can tolerate anxiety without giving in to compulsions and that feeling anxiety does not necessarily mean feared outcomes occur. On the other hand, relaxation training aims to decrease anxiety at will, which can reinforce problematic beliefs that sustain OCD. In other words, relaxation techniques can serve as a substitute for compulsions. If misused, these coping strategies may function as compul-

sions to remove unwanted anxiety rather than helping youth learn how to tolerate anxiety.

Misapplications of ERP for Pediatric OCD

Potentially Harmful Applications of ERP

When an exposure task aligns with the underlying theoretical model, the short-term distress experienced is minimal relative to the therapeutic benefits of learning and consequent long-term symptom improvement. For an exposure to be conceptually driven, it should carry *perceived* risk but *not actual* risk. Identifying a patient's specific "core fear" (i.e., the worst-case scenario outcome if the content of obsessions manifested) is central to developing an exposure that carries only perceived risk. If an exposure task is not conceptually driven, the therapeutic benefits of the exposure task no longer outweigh the distress or potential harm it incurs. For example, for a child who fears vomiting from eating "dirty" food, rubbing a cracker on the floor and eating it would be an appropriate exposure because it targets this child's core fear. The therapeutic benefit (i.e., the child learning that they can eat a cracker off the floor, which helps them eat other foods in more normative situations in their day-to-day life) outweighs potential discomfort during the exposure. Even in the unlikely event that they *do* vomit, the child would learn that they were able to handle this outcome better than they expected, further diminishing their fear of eating potentially dirty food (e.g., Guzick et al., 2020). However, for a child who fears vomiting from someone poisoning her food, this same exposure would not target the core fear and thus any distress during the exposure would not be outweighed by therapeutic benefit. A more appropriate exposure for this core fear could involve having an unfamiliar person (e.g., confederate) handle their food before eating it. Thus, to avoid undue harm, clinicians should tailor exposures to the patient's idiosyncratic core fear.

Potentially Ineffective Applications of ERP

Failure to Incorporate Contemporary Models of ERP ERP was originally founded on the theoretical framework of emotion processing theory (Foa & Kozak, 1986), which proposed that exposure activates a patient's pathological cognitive fear structure (i.e., inappropriate associations between stimuli, responses, and their meanings) while subsequently providing corrective information about the nonthreatening nature of the stimuli, responses, and their meanings. The behavioral process of habituation is theorized to attenuate the association between the stimuli and the increased anxiety response, as well as the link between the compulsion and decreased anxiety response. Within this framework, it is necessary to elicit anxiety via exposure to a feared stimulus and continue until habituation occurs (i.e., until the pathological fear structure has been corrected).

Craske et al. (2014) proposed the inhibitory learning model as an alternative framework that can complement emotion processing theory. Within this framework, habituation is not the sole emphasis of exposure; rather, exposure is conceptualized as an opportunity for the patient to encounter previously feared stimuli in a diverse range of contexts/settings with a flexible response style emphasizing expectancy violations and distress tolerance. Specifically, a child may learn during the exposure that they experienced less distress than anticipated, they coped with the distress better than anticipated, and that their feared outcome did not occur (McGuire & Storch, 2019).

Rigid adherence to a habituation-focused framework can be iatrogenic for youth whose distress habituates slowly or minimally due to the nature of their OCD presentation. In particular, patients who experience "disgust" in response to OCD triggers tend to habituate less than do patients who experience typical fear responses (Mitchell et al., 2024). In such cases, repeatedly insisting a patient continue an exposure until habituation occurs may result in prolonged frustration that is not outweighed by therapeutic benefit. Incorporating the inhibitory learning model would de-emphasize short-term distress reduction and instead prioritize flexible behavioral responding in response to triggers, learning via expectancy violations, and bolstering distress tolerance. For example, for the teenager with fears of harming family members, an inhibitory learning-informed exposure may ask the teenager to chop vegetables with a large kitchen knife for 5 min. while his parent sits next to him. The goal is not necessarily for his distress to decrease during those 5 min., but rather for him to test his OCD fears and learn new information when his expectancy is violated (i.e., "I *can* use a knife near my parents without stabbing them"). When working with youth and their families, clinicians can present the inhibitory learning model as conducting "experiments" to test out OCD fears, as well as empowering youth to build distress tolerance and behavioral flexibility in response to OCD triggers.

Failure to Modify Family Accommodation Practices Therapists commonly treat pediatric anxiety disorders by working with the child individually and interacting with parents in the form of brief updates, check-ins, or occasional parent-focused sessions. Given that poor family functioning can attenuate youth treatment outcomes (e.g., accommodation, family conflict, child blame; Peris & Piacentini, 2014), parental involvement in pediatric OCD treatment is crucial.

For example, in a meta-analysis of pediatric OCD treatment studies, higher parental involvement was associated with greater treatment effect sizes (Rosa-Alcázar et al., 2015). To enhance treatment outcomes, it is important that parental involvement targets specific mechanisms of change.

Effective parental involvement requires clinicians to consider the role of family accommodation. Although family members have a well-meaning desire to reduce the child's OCD-related distress, family accommodation can inadvertently function to perpetuate youth OCD symptomology (Lebowitz et al., 2016). Common family accommodation behaviors include assisting the child in rituals, providing reassurance, participating in rituals, and facilitating child avoidance of triggers. For example, the parents of a child with obsessions about harming family members may discard their steak knives and use only butter knives at the dining table, reassure the child he has not harmed anyone, or exempt him from chores such as helping with dinner preparation. Family accommodation is associated with worse OCD symptoms and poorer treatment outcomes (Lebowitz et al., 2016; Merlo et al., 2009). Family accommodation is counter to the goals of ERP, which is for youth to learn to confront and cope with triggers independently without reliance on compulsions. As such, family accommodation may "undo" the progress a child makes in ERP treatment. In fact, parent-only treatment targeting family accommodation is a promising treatment for pediatric anxiety disorders, including OCD (Lebowitz et al., 2020; Storch et al., 2024). Just as clinicians and youth develop an exposure hierarchy, clinicians and parents can also develop an "accommodation reduction hierarchy." For instance, a child's parents recognize that they accommodate their child's fears about family members getting hurt: they avoid driving on highways, they respond to his daytime texts reassuring him they are "okay," and they patrol the perimeter of the house on his behalf before going to bed. The child reports how distressing it would be if his parents were to remove each accommodation, which allows the parents to arrange these accommodations into a hierarchy and gradually work from the easier ones to the harder ones.

Insufficient Parental Involvement in Treatment It is important that parents are actively involved in their child's treatment. Involving parents in psychoeducation helps parents understand the nature of OCD and ERP. Parents also serve as "co-therapists" who facilitate exposures with their child in between sessions (e.g., monitoring anxiety ratings, catching subtle compulsions, helping the child resist discontinuation until habituation or violation expectancy has occurred) until the child can do them more independently. By fully understanding the rationale of ERP and their role in it, parents are more likely to comply with treatment, which predicts more successful treatment outcomes (Kircanski & Peris, 2015). While parental involvement is especially critical for younger children to ensure treatment compliance, it is also valuable for adolescents in terms of bolstering familial relationships. Unless there are specific contraindications (e.g., significant adolescent–parent conflict interfering with treatment, adolescent unwilling to discuss taboo obsessions in parent's presence), parents should be involved in treatment as much as possible (Taboas et al., 2015). Not actively involving parents in psychoeducation and ERP may render treatment ineffective.

Underutilization of Exposures Exposures are unlikely to be effective if they are not delivered with sufficient intensity (Farrell et al., 2013). Common mistakes that result in ineffective outcomes include not doing in-session exposures, not assigning regular exposure homework, and not addressing the child's core fear (Farrell et al., 2016). Patient-led exposures alone (i.e., carried out independently outside therapy sessions) in the absence of therapist-guided in-session exposures have not been shown to consistently yield sufficient improvements (Franklin et al., 2011). Yet, 54% of clinicians who treat pediatric anxiety disorders including OCD reported that they use in-session, clinician-guided exposures "rarely" or "never" (Whiteside et al., 2016). Relying on children and parents to conduct exposures without first practicing them in-session can result in behaviors that inadvertently spoil exposures, such as allowing mental compulsions or prematurely discontinuing the exposure. Another common mistake is not assigning regular exposure homework in between sessions. A clinical trial found that children completing intensive, daily ERP sessions showed quicker decreases in symptoms compared to children completing spaced out, weekly ERP sessions (Storch et al., 2007), highlighting the importance of frequent exposure practice.

Furthermore, ERP is unlikely to be effective unless it properly targets the patient's idiosyncratic core fear. This is especially important for exposures targeting taboo OCD topics (e.g., sex, pedophilia, violence), which clinicians often avoid or "water down" to the point that they do not sufficiently address the core fear. While it is good practice to *begin* treatment with easier exposures that are peripheral to the core fear, clinicians should recognize that is not the "endpoint" of treatment. Rather, it is important to incrementally proceed to more challenging exposures that are more closely related to the core fear. For example, for an adolescent with scrupulosity OCD who fears angering God and going to Hell, an appropriate *initial* exposure may be simply

walking by a church without compulsively praying. A more challenging exposure later in treatment could involve actions that may "upset" God, such as ripping pages out of a bible containing text about Hell without engaging in compulsive prayer or confession. Only using weak exposures—whether due to insufficient intensity, low frequency, or inappropriate focus—will likely attenuate treatment effectiveness.

Use of Telehealth When in-Person ERP is Indicated With the onset of the COVID-19 pandemic, telehealth has proliferated and is now widely accepted (Maye et al., 2022). Generally, ERP for pediatric OCD delivered over telehealth is comparably efficacious to that delivered in-person (Franklin et al., 2024). Telehealth ERP also confers benefits such as making treatment more accessible to families who live in areas without trained providers, providing a first line of treatment for youth whose symptoms prohibit them from attending appointments in person (e.g., severe contamination OCD, comorbid agoraphobia), and enabling clinicians to conduct in-session exposures in children's natural environments (e.g., house, school). However, clinicians should engage in collaborative decision-making with youth and families, as in-person delivery may be more beneficial than telehealth in some cases. In particular, OCD therapists have expressed concerns about using telehealth to treat patients under 13 years of age due to difficulties building rapport (e.g., inability to play in-person games), engaging them in treatment, addressing limited insight, and addressing factors that interfere with ERP (Wiese et al., 2022). Treatment resistance and attentional difficulties may be especially salient when working with youth with comorbid externalizing concerns (Storch et al., 2008). Additionally, patients with especially severe OCD symptoms may struggle to resist compulsive urges more during telehealth-delivered exposures than in-person exposures. Clinicians are also less able to detect and correct compulsions over telehealth (e.g., tapping rituals that are not visible on camera). Clinicians treating pediatric OCD via telehealth should consider factors that may interfere with ERP, inform patients of the risks and benefits of treatment options, and provide recommendations where indicated. For more extensive guidelines on shared decision-making surrounding telehealth for pediatric anxiety and OCD, see Islam et al. (2023).

Insufficient Considerations of Comorbidities Youth with OCD and psychiatric comorbidities—particularly, depression, externalizing disorders, and neurodevelopmental disorders—show poorer treatment response to ERP than those without comorbidities (Farrell et al., 2023). Thus, not thoroughly assessing and accounting for comorbidities may result in suboptimal treatment outcomes. Farrel et al. (2023) proposed a clinical decision-making algorithm for stepped-care ERP that includes structured assessment of comorbidities and recommends higher intensity treatment for youth with complex comorbidities (i.e., disruptive behavioral disorder, attention-deficit disorder, depression, or autism spectrum disorder). However, less is known about the role of other psychiatric comorbidities, such as posttraumatic stress disorder (PTSD), in pediatric OCD. Although traumatic experiences and rates of PTSD are higher in youth with (vs. without) OCD (Lafleur et al., 2011), the literature on this topic is currently limited by the absence of longitudinal data (Wislocki et al., 2023). Moreover, no trials have examined how to optimize treatment for youth with co-occurring OCD and PTSD, which highlights an important area for future research.

Potential for Harm Through Non-Evidence-Based Psychological Interventions

Use of non-evidence-based psychological treatments for pediatric OCD may result in harm or non-beneficence for patients and their families. Below, we review interventions that do not appear to possess a plausible mechanism of action, are not supported by a theoretical or conceptual foundation, or are not empirically supported by methodologically rigorous clinical research. We also specify what components of these treatments are potentially iatrogenic (i.e., exacerbate symptoms) for pediatric OCD and thus should be avoided until empirical evidence provides support for these.

Energy Therapies

Energy therapies (also known as "tapping therapy") encompass a collection of intervention approaches based on energy psychology, a branch of alternative medicine based on the belief that "healing energy" can be channeled into patients. Energy therapies—such as thought field therapy (TFT) and energy freedom techniques (EFT)—claim to release energy blockages that cause negative emotions by tapping on "meridian points" (i.e., specific points along the body such as the face, torso, hands, or feet that are derived from traditional Chinese acupuncture) while the patient focuses on their distress (Gallo & Vincenzi, 2008) throughout one session lasting up to 15 min (Callahan, 2001). Variants of energy therapies differ in the specific types of sequences of tapping utilized (Callahan, 2001; Craig, n.d.). Websites promoting energy therapies for the treatment of pediatric OCD and related disorders claim that these therapies are effective in treating these conditions (Paton & Alex, 2019; Ray,

2018). Such websites sell EFT manuals, recordings, and a "Tappy Bear"—a stuffed bear used to teach children tapping spots (Carrington, 2008).

Yet, the claim that OCD is caused by energy blockages has not been empirically supported or even evaluated to our knowledge. Perhaps ironically, considering that some presentations of OCD involve repetitive actions (including tapping) as a compulsion, the tapping component of energy therapies have considerable potential to promote tapping rituals and aggravate OCD symptoms. Additionally, TFT encourages patients to check for and eliminate "individual energy toxins"—i.e., any substance that purportedly prevents TFT from working and can include common foods such as wheat, milk, and eggs (Callahan Techniques, Ltd., 2011). Not only can this practice aggravate obsessions about food or toxins and reinforce checking compulsions, but it also has potential to restrict a patient's diet. To date, there is no research supporting claims that energy therapies are efficacious for children with OCD.

Hypnotherapy

Hypnotherapy involves the use of hypnosis—a state of focused concentration, decreased peripheral awareness, and increased suggestibility—by a licensed professional to address medical or psychological disorders. While the specific length of treatment depends on an individual's presenting concerns, 5–12-week protocols of weekly hour-long sessions have been reported (Elkins et al., 2013; Gonsalkorale et al., 2003). Case studies have documented the use of hypnotherapy for pediatric OCD (Huynh et al., 2008). The framework of hypnotherapy conceptualizes the etiology of OCD as hidden intrapsychic conflicts (Meyerson & Konichezky, 2011). Conceptualizing OCD from this treatment perspective suggests that symptoms are maintained in a cycle between anxiety caused by subconscious intrapsychic conflict, which manifests as OCD symptoms, which in turn worsen anxiety. The premise of hypnotherapy for OCD treatment is that hypnotically inducing temporary dissociation breaks this cycle by uncovering intrapsychic conflict (Meyerson & Konichezky, 2011).

There is limited empirical evidence supporting an intrapsychic etiology underlying pediatric OCD, however. A meta-analysis on hypnotherapy in children and adults found no studies on OCD that met the criteria of having a randomized design and between-group comparisons (Flammer & Bongartz, 2003). Some case studies on hypnotherapy for pediatric OCD describe the use of potentially harmful cognitive-behavioral techniques described above (e.g., thought stopping; Kraft & Kraft, 2006). Additionally, adolescents with OCD have been shown to endorse higher levels of dissociative symptoms compared to non-clinical samples, and OCD symptom severity correlates with dissociative symptoms (Sideli et al., 2023). Encouraging dissociation in a population that already endorses higher-than-average levels of dissociation carries the risk of aggravating symptoms. While hypnotherapy advocates recognize this association and argue that hypnotically-induced dissociation can help regulate pathological dissociation (Meyerson & Konichezky, 2011), the mechanisms of this have not yet been identified.

Psychodynamic Therapy

Psychodynamic therapy integrates psychoanalytic techniques (e.g., exploration of past experiences, attention to the patient–therapist relationship, interpretation) and other therapeutic techniques (e.g., supportive interventions) with the goal of improving patient self-understanding and interpersonal patterns (Summers et al., 2024). Compared to psychoanalytic therapy, psychodynamic therapy involves less frequent sessions (once or twice weekly) and tends to be shorter (8–50 + sessions; Fonagy, 2015). The psychodynamic formulation of OCD purports that obsessions are manifestations of unresolved intrapsychic conflicts of a poorly integrated self, and compulsions are defense mechanisms against such anxiety-provoking internal conflicts (McKay, 2023). Psychodynamic therapy therefore aims to make the unconscious elements of obsessions and compulsions conscious through therapist interpretations (Chlebowski & Gregory, 2009). Nearly 16% of clinicians endorse applying psychodynamic approaches to pediatric OCD (Valderhaug et al., 2004).

There is limited evidence to date supporting the use of psychodynamic therapy for pediatric OCD, however (Midgley et al., 2021). Conceptualizing obsessions as intrapsychic conflicts may be harmful because it leads youth with OCD to misinterpret their obsessions as unconscious desires, rather than seeing them accurately as ego-dystonic thoughts (McKay et al., 2021). For example, a psychodynamic approach may suggest that sexual taboo OCD thoughts reflect sexual fantasies, rather than conceptualizing these as intrusive thoughts. Such a misconception may have iatrogenic effects for youth with OCD as it encourages over-importance of thought—i.e., a cognitive distortion that thoughts carry significant meaning about oneself, which is linked to more severe OCD symptoms in youth (Borda et al., 2017). Therefore, until psychodynamic treatment for pediatric OCD is supported by empirical evidence, this approach is not recommended.

Recommendations

Considering the phenomena that contribute to potentially harmful or ineffective treatment, we offer the following recommendations for best practices for clinicians who treat pediatric OCD, researchers who study pediatric OCD intervention, training programs, and policymakers.

Recommendations for Clinicians

It is imperative that clinicians who treat pediatric OCD use evidence-based practice. The only psychosocial intervention for pediatric OCD that meets the *Journal of Clinical Child and Adolescent Psychology* evidence-based evaluation criteria for *well-established* intervention is family-based, ERP-focused CBT (Freeman et al., 2018). At this time, other interventions have not demonstrated sufficient evidence to be classified as well-established. Clinicians who treat pediatric OCD should also tailor ERP *for youth* specifically (Freeman et al., 2018). Competence in providing ERP to adults with OCD does not automatically translate to competence in providing ERP to youth with OCD. Clinicians must self-assess their boundaries of competence (APA, 2017) and know when to consult or seek supervision, when to refer out, and to whom. Clinicians wishing to develop competence in ERP for pediatric OCD are directed to resources such as the Behavioral Therapy Training Institute, which offers self-assessment tools, workshops, and online consultation groups (IOCDF, 2024).

Furthermore, we recommend clinicians to provide patients and their families psychoeducation about evidence-based treatments for pediatric OCD. It is understandable for families of pediatric OCD patients to be drawn to non-evidence-based approaches which make grandiose claims, use pseudoscientific jargon, or offer the allure of a "quick and easy" cure (Lilienfeld et al., 2014; Pignotti & Thyer, 2019). If patients or their families express interest in alternative approaches, clinicians should be prepared to provide psychoeducation about treatment options, the evidence (or lack thereof) supporting each, and risks of benefits of each, in a nonjudgmental manner. Clinicians can also share free online resources such as the International OCD Foundation's website (https://iocdf.org), which provides family-friendly educational materials that are evidence-based, as well as a directory of ERP-trained providers.

Recommendations for Researchers

It is important that intervention researchers make concerted efforts to systematically assess for adverse events and attrition. As discussed by Uhre et al. (2020), insufficient focus on these two areas is arguably a relative weakness in the literature on ERP for pediatric OCD. On balance, however, when adverse events are evaluated, these rates appear to be extremely low (Storch et al., 2013, 2016; The Pediatric OCD Treatment Study Team, 2004). Regarding the systematic assessment of adverse events, Dimidjian and Hollon (2010) proposed methods such as having patients complete a self-report measure for the target problem at each session, monitoring a range of adverse events with potential relevance to psychotherapy (e.g., suicide, hospitalizations, serious medical illness), and having impartial observers monitor patient safety (e.g., data safety and monitoring boards). Monitoring adverse events in randomized controlled trials, and reporting these in a centralized database, could help the field draw conclusions on whether certain adverse events are more likely in each intervention. Regarding attrition, if possible, it is important to learn *why* patients prematurely terminated treatment. Qualitative research studies, including those grounded in community-based participatory research approaches (Wallerstein et al., 2020), may be helpful in this vein.

Research that debunks pseudoscientific interventions for pediatric OCD would also be informative (see McKay, 2023 for a preliminary example of this). Although we can infer the likely inefficacy of the non-evidence-based methods described above based on the lack of plausible mechanisms of action, there is a paucity of empirical evidence evaluating the aforementioned claims. While the absence of evidence does not necessarily mean that untested interventions are inherently harmful, the burden of proof for such interventions as "evidence-based" rests on the proponents of such approaches (Lilienfeld, 2007). Without systematic data, it is easy for uninformed therapists or consumers to rely on anecdotal "evidence" supporting non-evidence-based approaches.

While outside the scope of the present article, a critical area for further research is optimal medication management in treating pediatric OCD. Even though selective serotonin reuptake inhibitors (SSRIs) in combination with ERP is recommended for moderate-to-severe cases of pediatric OCD (Geller & March, 2012), pharmacotherapy may come with drawbacks such as side effects and high attrition rates. Indeed, the most common reasons for attrition from SSRIs in pediatric OCD clinical trials were lack of efficacy or adverse reactions (Johnco et al., 2020). In the case of treatment-resistant pediatric OCD, SSRIs are often augmented with clomipramine or an antipsychotic, but these medications have poor side effect profiles and need to be studied in children further before widespread use (Bloch & Storch, 2015). Moreover, there is no empirical data to guide SSRI discontinuation for pediatric OCD. A randomized controlled non-inferiority trial, which examines whether youth with OCD on a serotonin reuptake inhibitor can safely

discontinue their medication after successful ERP augmentation, is currently underway (Leuchter et al., 2023).

Another area warranting further research is the treatment of pediatric OCD symptoms secondary to pediatric autoimmune neuropsychiatric disorder associated with streptococcus (PANDAS) or pediatric acute-onset neuropsychiatric syndrome (PANS). The recommended treatment for PANDAS/PANS is to treat active infections and address the OCD symptoms with ERP, reduction of family accommodation, or pharmacotherapy (Franklin et al., 2023; Thienemann et al., 2017). While these interventions appear effective in alleviating OCD symptoms regardless of the etiology of their onset (Franklin et al., 2023), controlled trials are needed to determine best practices.

Recommendations for Training Programs Across Disciplines

Given that most children with suspected OCD are initially seen in pediatrician offices, hospitals, and school settings before seeing an OCD specialist (Jacob & Storch, 2013), training across mental health-related disciplines (e.g., psychology, social work, medical residencies) is crucial. Therefore, we recommend educators include a primer on the diagnosis and treatment of OCD in medical or clinical training programs. Overall rates of misdiagnosis of adult OCD among physicians, psychologists, and psychology doctoral students range from 18.5 to 50.5%, with higher rates of misdiagnosis in taboo thought presentations than in contamination or symmetry-related obsessions (Glazier et al., 2013, 2015; Glazier & McGinn, 2015). Misdiagnosis has detrimental consequences, from delayed treatment to inappropriate intervention (Stahnke, 2021). To minimize gaps in care, it is important that trainees receive adequate training to recognize OCD and provide appropriate referrals. After viewing a video-based intervention, psychology doctoral students' misidentification rates decreased from 18.5 to 5.4% (Glazier & McGinn, 2015), suggesting that educational efforts improve diagnostic accuracy. We also recommend that foundational intervention courses in training programs preemptively dispel the myths about ERP discussed earlier in this article. This could involve assigning readings (such as Reid et al., 2017) and facilitating group discussions. By developing an accurate understanding of ERP, trainees will be able to better educate parents, provide appropriate referrals, and correct other clinicians' misconceptions.

Given misapplications of generic CBT techniques and ERP principles in the treatment of pediatric OCD, we also recommend expanding the availability of clinical training opportunities focused on treating OCD. Currently, there are limited opportunities in OCD-specialized predoctoral practica and internship training sites. Given the heterogeneity of OCD presentations, and the nuances involved in OCD treatment in youth and families, expanding opportunities for hands-on clinical training will lead to a greater number of highly competent pediatric OCD providers in the future.

We also recommend that training programs provide a solid foundation in research methods and evidence-based practice. To be able to detect pseudoscientific claims and select evidence-based interventions, clinicians-in-training must be equipped with an understanding of the scientific method, the importance of evidence-based practice, and how to critically consume research literature. When evaluating a treatment option, trainees should be encouraged to consider questions such as: *Is this treatment supported by theory? Is this treatment supported by empirical evidence (i.e., clinical trials)? If so, how strong is the quality of the clinical trial? Are these trials published in reputable, peer-reviewed journals? Have trials demonstrating efficacy been replicated, and if so, by whom?*

Recommendations for Policymakers

Policies targeting mental health literacy can help children access evidence-based care instead of ineffective and potentially iatrogenic treatments. Parents who receive education about treatment options for pediatric OCD express preference for ERP (Lewin et al., 2014), and youth with higher expectations for ERP respond better to treatment (Lewin et al., 2011). Preliminary studies have shown that hosting informational events in communities and schools effectively increases youths' and parents' understanding of OCD and its treatment (Jassi et al., 2016; Jones et al., 2020). Thus, policies that fund schools to develop and deliver such programs would be beneficial. Another impactful avenue could be policies that provide stronger incentives for clinicians to use evidence-based interventions in treating pediatric OCD. For example, insurance reimbursement models that reimburse evidence-based practices (i.e., ERP) at higher rates than non-evidence-based methods could encourage more clinicians to adopt ERP to treat pediatric OCD. Not only is ERP effective in treating pediatric OCD with a 68% response rate (McGuire et al., 2015), but it is also efficient, with one study showing that 38% of youth responded in as few as seven sessions (Torp et al., 2019). As such, by paying for treatment that works, insurance companies may incur fewer costs in the long run, in addition to incentivizing better clinical care.

Summary and Future Directions

Pediatric OCD has potential to be debilitating and chronic unless treated early with efficacious intervention. A substantive body of research has identified ERP as a gold-standard psychological intervention for pediatric OCD (Cervin et al., 2024). However, many youths remain inadequately treated because of limited availability of ERP and because of many providers' reliance on non-evidence-based treatments. In well-meaning but misguided efforts to treat this complex disorder, clinicians with misconceptions about ERP may fail to apply evidence-based treatments, misapply generic CBT techniques and ERP principles, or turn to non-evidence-based interventions. To minimize potential harm in the treatment of pediatric OCD, it is crucial that clinicians use evidence-based practice, which at this time, is ERP with family involvement (Freeman et al., 2018). Clinicians are also encouraged to know their boundaries of competence, refer out when appropriate, and provide psychoeducation to patients and families about evidence-based practice. Recommended future research directions include collecting systematic data comparing the efficacy of non-evidence-based approaches to waitlist control or evidence-based interventions. Finally, training programs are encouraged to incorporate education on pediatric OCD and research methods, and policymakers may consider initiatives to help improve mental health literacy and incentive evidence-based practice. With our collective efforts, we can minimize potential harm upon youths with OCD and instead provide timely and effective treatment that promotes positive long-term outcomes.

Author Contributions All authors contributed to the conceptualization of this paper. The first draft of the manuscript was written by Erika S. Trent and Elizabeth C. Lanzillo, and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Data Availability No data was used in the preparation of this review article.

Compliance with Ethical Standards

Funding This work was supported in part by funding of The Baylor College of Medicine Intellectual and Developmental Disabilities Research Center (P50HD103555) from the Eunice Kennedy Shriver NICHD, the International OCD Foundation (IOCDF), and the Texas Child Mental Health Care Consortium (TCMHCC). The contents of this publication do not necessarily reflect the views or policies of the NIH, IOCDF, or TCMHCC. The mention of trade names, commercial products, or organizations do not imply endorsement by the US Government.

Competing Interests Dr. Eric Storch reports receiving research funding to his institution from the Ream Foundation, International OCD Foundation, and NIH. He is a consultant for Brainsway and Biohaven Pharmaceuticals. He owns stock less than $5000 in Niew. He receives book royalties from Elsevier, Wiley, Oxford, American Psychological Association, Guildford, Springer, and Jessica Kingsley. Dr. Dean McKay receives royalties from the following book companies: Elsevier; Springer Science + Nature; Guilford Press; American Psychological Association; Cambridge University Press; Oxford University Press; and Wiley. The remaining authors have no relevant financial or non-financial interests to disclose.

Ethical Approval Since no data was collected for this review article, no ethics approval was sought.

Informed Consent Since no participant data was collected for this review article, no informed consent was necessary.

References

Abramowitz, J. S. (2021). *The family guide to getting over OCD: Reclaim your life and help your loved one*. Guilford.

American Psychiatric Association (2022). *Diagnostic and statistical manual of mental disorders (5th ed., text rev.)*. https://doi.org/10.1176/appi.books.9780890425787

American Psychological Association (2017). *Ethical Principles of Psychologists and Code of Conduct*.

Barrett, P. M., & Healy, L. J. (2003). An examination of the cognitive processes involved in childhood obsessive–compulsive disorder. *Behaviour Research and Therapy*, *41*(3), 285–299.

Beck, J. S., & Beck, A. T. (2011). *Cognitive behavior therapy: Basics and beyond*. Guilford.

Blakey, S. M., Thomas, B. E., & Farrell, N. R. (2018). Addressing common myths and mistaken beliefs in the treatment of Youth with OCD. In E. A. Storch, J. F. McGuire, & D. McKay (Eds.), *The Clinician's guide to cognitive-behavioral therapy for childhood obsessive-compulsive disorder* (pp. 203–223). Elsevier.

Bloch, M. H., & Storch, E. A. (2015). Assessment and management of treatment-refractory obsessive-compulsive disorder in children. *Journal of the American Academy of Child & Adolescent Psychiatry*, *54*(4), 251–262.

Borda, T., Neziroglu, F., Taboas, W., McKay, D., & Frenkiel, L. (2017). Overvalued ideation in adolescents with obsessive-compulsive disorder. *Psychiatry Research*, *255*, 66–71.

Callahan, R. J. (2001). The impact of thought field therapy on heart rate variability. *Journal of Clinical Psychology*, *57*(10), 1153–1170.

Callahan Techniques, L. (2011). *Callahan Techniques: Thought Field Therapy Algorithm Level Training Manual*. http://www.tapping-therapy.com/elearning/pdf/TFT-Algorithm-Manual.pdf

Carrington, P. (2008). *Guide to Tappy Bear: Happy to Use Tappy Bear for your child and yourself*. Pace Educational Systems, Inc.

Cervin, M., McGuire, J. F., D'Souza, J. M., De Nadai, A. S., Aspvall, K., Goodman, W. K., Andrén, P., Schneider, S. C., Geller, D. A., & Mataix-Cols, D. (2024). & others. Efficacy and acceptability of cognitive-behavioral therapy and serotonin reuptake inhibitors for pediatric obsessive-compulsive disorder: A network meta-analysis. *Journal of Child Psychology and Psychiatry*.

Chlebowski, S., & Gregory, R. J. (2009). Is a psychodynamic perspective relevant to the clinical management of obsessive–compulsive disorder? *American Journal of Psychotherapy*, *63*(3), 245–256.

Chu, B. C., Colognori, D. B., Yang, G., Xie, M., Bergman, R. L., & Piacentini, J. (2015). Mediators of exposure therapy for youth obsessive-compulsive disorder: Specificity and temporal sequence of client and treatment factors. *Behavior Therapy*, *46*(3), 395–408.

Craig, G. (n.d.). *The Palace of Possibilities™: The Gold Standard (Official) EFT Tapping Tutorial*. https://www.palaceofpossibilities.com/tutorial

Craske, M. G., Treanor, M., Conway, C. C., Zbozinek, T., & Vervliet, B. (2014). Maximizing exposure therapy: An inhibitory learning approach. *Behaviour Research and Therapy*, *58*, 10–23.

Deacon, B. J., Farrell, N. R., Kemp, J. J., Dixon, L. J., Sy, J. T., Zhang, A. R., & McGrath, P. B. (2013). Assessing therapist reservations about exposure therapy for anxiety disorders: The therapist beliefs about exposure scale. *Journal of Anxiety Disorders*, *27*(8), 772–780.

Dimidjian, S., & Hollon, S. D. (2010). How would we know if psychotherapy were harmful? *American Psychologist*, *65*(1), 21.

Elkins, G. R., Fisher, W. I., Johnson, A. K., Carpenter, J. S., & Keith, T. Z. (2013). Clinical hypnosis in the treatment of postmenopausal hot flashes: A randomized controlled trial. *Menopause (New York, N.Y.)*, *20*(3), 291–298.

Farrell, N. R., Deacon, B. J., Dixon, L. J., & Lickel, J. J. (2013). Theory-based training strategies for modifying practitioner concerns about exposure therapy. *Journal of Anxiety Disorders*, *27*(8), 781–787.

Farrell, L. J., Sluis, R., & Waters, A. M. (2016). Intensive treatment of pediatric OCD: The case of Sarah. *Journal of Clinical Psychology*, *72*(11), 1174–1190.

Farrell, L. J., Waters, A. M., Storch, E. A., Simcock, G., Perkes, I. E., Grisham, J. R., Dyason, K. M., & Ollendick, T. H. (2023). Closing the gap for children with OCD: A staged-care model of cognitive behavioural therapy with exposure and response Prevention. *Clinical Child and Family Psychology Review*, *26*(3), 642–664.

Flammer, E., & Bongartz, W. (2003). On the efficacy of hypnosis: A meta-analytic study. *Contemporary Hypnosis*, *20*(4), 179–197.

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*, *99*(1), 20.

Foa, E. B., Yadin, E., & Lichner, T. K. (2012). *Exposure and response (ritual) prevention for obsessive compulsive disorder: Therapist guide*. Oxford University Press.

Fonagy, P. (2015). The effectiveness of psychodynamic psychotherapies: An update. *World Psychiatry*, *14*(2), 137–150.

Franklin, M. E., Sapyta, J., Freeman, J. B., Khanna, M., Compton, S., Almirall, D., Moore, P., Choate-Summers, M., Garcia, A., & Edson, A. L. (2011). & others. Cognitive behavior therapy augmentation of pharmacotherapy in pediatric obsessive-compulsive disorder: The Pediatric OCD Treatment Study II (POTS II) randomized controlled trial. *Jama*, *306*(11), 1224–1232.

Franklin, M. E., Kratz, H. E., Freeman, J. B., Ivarsson, T., Heyman, I., Sookman, D., McKay, D., Storch, E. A., & March, J. (2015). Cognitive-behavioral therapy for pediatric obsessive-compulsive disorder: Empirical review and clinical recommendations. *Psychiatry Research*, *227*(1), 78–92.

Franklin, M. E., Eken, S., & Osterlund, E. (2023). Current Research Updates on PANDAS and PANS. *Current Developmental Disorders Reports*, *10*(4), 264–273.

Franklin, M. E., Engelmann, J. M., Bulkes, N. Z., Horvath, G., Piacsek, K., Osterlund, E., Freeman, J. B., Schwartz, R. A., Himle, M. B., & Riemann, B. C. (2024). Intensive cognitive-behavioral Therapy Telehealth for Pediatric Obsessive-compulsive disorder during the COVID-19 pandemic: Comparison with a matched sample treated in person. *JAACAP Open*, *2*(1), 26–35.

Freeman, J. B., Sapyta, J., Garcia, A., Compton, S., Khanna, M., Flessner, C., FitzGerald, D., Mauro, C., Dingfelder, R., & Benito, K. (2014). & others. Family-based treatment of early childhood obsessive-compulsive disorder: The Pediatric Obsessive-Compulsive Disorder Treatment Study for Young Children (POTS Jr)—A randomized clinical trial. *JAMA Psychiatry*, *71*(6), 689–698.

Freeman, J. B., Benito, K., Herren, J., Kemp, J., Sung, J., Georgiadis, C., Arora, A., Walther, M., & Garcia, A. (2018). Evidence base update of psychosocial treatments for pediatric obsessive-compulsive disorder: Evaluating, improving, and transporting what works. *Journal of Clinical Child & Adolescent Psychology*, *47*(5), 669–698.

Gallo, F., & Vincenzi, H. (2008). *Energy tapping: How to rapidly eliminate anxiety, depression, cravings, and more using energy psychology*. New Harbinger.

García-Soriano, G., Rufer, M., Delsignore, A., & Weidt, S. (2014). Factors associated with non-treatment or delayed treatment seeking in OCD sufferers: A review of the literature. *Psychiatry Research*, *220*(1–2), 1–10.

Gaudiano, B. A., & Ellenberg, S. (2014). Psychotherapy in decline: What steps are needed to promote evidence-based practice? *Clinical Practice*, *11*(4), 385–389.

Geller, D. A., & March, J. (2012). Practice parameter for the assessment and treatment of children and adolescents with obsessive-compulsive disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, *51*(1), 98–113.

Glazier, K., & McGinn, L. (2015). Non-contamination and non-symmetry OCD obsessions are commonly not recognized by clinical, counseling and school psychology doctoral students. *Journal of Depression and Anxiety*, *4*(3), 10–4172.

Glazier, K., Calixte, R. M., Rothschild, R., & Pinto, A. (2013). High rates of OCD symptom misidentification by mental health professionals. *Annals of Clinical Psychiatry*, *25*(3), 201–209.

Glazier, K., Swing, M., & McGinn, L. K. (2015). Half of obsessive-compulsive disorder cases misdiagnosed: Vignette-based survey of primary care physicians. *The Journal of Clinical Psychiatry*, *76*(6), 7995.

Gonsalkorale, W., Miller, V., Afzal, A., & Whorwell, P. (2003). Long term benefits of hypnotherapy for irritable bowel syndrome. *Gut*, *52*(11), 1623–1629.

Gosch, E. A., Flannery-Schroeder, E., Mauro, C. F., & Compton, S. N. (2006). Principles of cognitive-behavioral therapy for anxiety disorders in children. *Journal of Cognitive Psychotherapy*, *20*(3), 247–262.

Guzick, A. G., Reid, A. M., Balkhi, A. M., Geffken, G. R., & McNamara, J. P. (2020). That was easy! Expectancy violations during exposure and response prevention for childhood obsessive-compulsive disorder. *Behavior Modification*, *44*(3), 319–342.

Hofmann, S. G., Dozois, D. J., Rief, W. E., & Smits, J. A. (2014). *The Wiley handbook of cognitive behavioral therapy*. Wiley Blackwell.

Hupp, S., & Santa Maria, C. L. (2023). *Pseudoscience in therapy: A skeptical field guide*. Cambridge University Press.

Huynh, M. E., Vandvik, I. H., & Diseth, T. H. (2008). Hypnotherapy in child psychiatry: The state of the art. *Clinical Child Psychology and Psychiatry*, *13*(3), 377–393.

International Obsessive-Compulsive Disorder Foundation (2024). *Behavior Therapy Training Institute (BTTI)*. https://iocdf.org/professionals/training-institute/btti/

Islam, S., Sanchez, A. L., McDermott, C. L., Clapp, D., Worley, J., & Becker-Haimes, E. M. (2023). To proceed via telehealth or not? Considerations for pediatric anxiety and related disorders beyond COVID-19. *Cognitive and Behavioral Practice*. https://doi.org/10.1016/j.cbpra.2023.01.004

Jacob, M. L., & Storch, E. A. (2013). Pediatric Obsessive–compulsive disorder: A review for nursing professionals. *Journal of Child and Adolescent Psychiatric Nursing*, *26*(2), 138–148.

Jassi, A. D., Kolvenbach, S., Heyman, I., Macleod, T., Rose, J., & Diamond, H. (2016). Increasing knowledge about obsessive compulsive disorder and support for parents and schools: Evaluation of initiatives. *Health Education Journal*, *75*(5), 600–609.

Johnco, C., McGuire, J. F., Roper, T., & Storch, E. A. (2020). A meta-analysis of dropout rates from exposure with response prevention and pharmacological treatment for youth with obsessive compulsive disorder. *Depression and Anxiety*, *37*(5), 407–417. https://doi.org/10.1002/da.22978

Jones, G., Jassi, A., & Thomas-Smith, K. (2020). *Improving awareness and help seeking for obsessive compulsive disorder in ethnic minority youth*. https://doi.org/10.21203/rs.3.rs-32169/v1

Keleher, J., Jassi, A., & Krebs, G. (2020). Clinician-reported barriers to using exposure with response prevention in the treatment of paediatric obsessive-compulsive disorder. *Journal of Obsessive-Compulsive and Related Disorders*, *24*, 100498.

Kircanski, K., & Peris, T. S. (2015). Exposure and response prevention process predicts treatment outcome in youth with OCD. *Journal of Abnormal Child Psychology*, *43*, 543–552.

Kolvenbach, S., Fernández de la Cruz, L., Mataix-Cols, D., Patel, N., & Jassi, A. (2018). Perceived treatment barriers and experiences in the use of services for obsessive–compulsive disorder across different ethnic groups: A thematic analysis. *Child and Adolescent Mental Health*, *23*(2), 99–106.

Kraft, T., & Kraft, D. (2006). The place of hypnosis in psychiatry: Its applications in treating anxiety disorders and sleep disturbances. *Australian Journal of Clinical and Experimental Hypnosis*, *34*(2), 187–203.

Lafleur, D. L., Petty, C., Mancuso, E., McCarthy, K., Biederman, J., Faro, A., Levy, H. C., & Geller, D. A. (2011). Traumatic events and obsessive compulsive disorder in children and adolescents: Is there a link? *Journal of Anxiety Disorders*, *25*(4), 513–519.

Lebowitz, E. R., Panza, K. E., Su, J., & Bloch, M. H. (2012). Family accommodation in obsessive–compulsive disorder. *Expert Review of Neurotherapeutics*, *12*(2), 229–238.

Lebowitz, E. R., Panza, K. E., & Bloch, M. H. (2016). Family accommodation in obsessive-compulsive and anxiety disorders: A five-year update. *Expert Review of Neurotherapeutics*, *16*(1), 45–53.

Lebowitz, E. R., Marin, C., Martino, A., Shimshoni, Y., & Silverman, W. K. (2020). Parent-based treatment as efficacious as cognitive behavioral therapy for childhood anxiety: A randomized noninferiority study of supportive parenting for anxious childhood emotions. *Journal of the American Academy of Child & Adolescent Psychiatry*, *59*(3), 362–372. https://doi.org/10.1016/j.jaac.2019.02.014

Leuchter, J. D., Kook, M., Geller, D. A., Hertz, A. G., Garcia, J., Trent, E. S., Dibbs, T., Onyeka, O., Goodman, W. K., & Guzick, A. G. (2023). & others. Promoting OCD WEllness and resilience (POWER) study: Rationale, design, and methods. *Psychiatry Research Communications*, *3*(2), 100111.

Lewin, A. B., Peris, T. S., Bergman, R. L., McCracken, J. T., & Piacentini, J. (2011). The role of treatment expectancy in youth receiving exposure-based CBT for obsessive compulsive disorder. *Behaviour Research and Therapy*, *49*(9), 536–543.

Lewin, A. B., McGuire, J. F., Murphy, T. K., & Storch, E. A. (2014). Editorial Perspective: The importance of considering parent's preferences when planning treatment for their children–the case of childhood obsessive-compulsive disorder. In *Journal of Child Psychology and Psychiatry* (Vol. 55, Issue 12, pp. 1314–1316). Wiley Online Library.

Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science*, *2*(1), 53–70.

Lilienfeld, S. O., Lynn, S. J., & Lohr, J. M. (Eds.). (2014). *Science and pseudoscience in clinical psychology*. Guilford.

Liu, J., Cui, Y., Yu, L., Wen, F., Wang, F., Yan, J., Yan, C., & Li, Y. (2021). Long-term outcome of pediatric obsessive-compulsive disorder: A meta-analysis. *Journal of Child and Adolescent Psychopharmacology*, *31*(2), 95–101.

March, J. S., & Mulle, K. (1998). *OCD in children and adolescents: A cognitive-behavioral treatment manual*. Guilford Press.

Marien, W. E., Storch, E. A., Geffken, G. R., & Murphy, T. K. (2009). Intensive family-based cognitive-behavioral therapy for pediatric obsessive-compulsive disorder: Applications for treatment of medication partial-or nonresponders. *Cognitive and Behavioral Practice*, *16*(3), 304–316.

Maye, C. E., Wojcik, K. D., Candelari, A. E., Goodman, W. K., & Storch, E. A. (2022). Obsessive compulsive disorder during the COVID-19 pandemic: A brief review of course, psychological assessment and treatment considerations. *Journal of Obsessive-Compulsive and Related Disorders*, *33*, 100722.

McGuire, J. F., & Storch, E. A. (2019). An inhibitory learning approach to cognitive-behavioral therapy for children and adolescents. *Cognitive and Behavioral Practice*, *26*(1), 214–224.

McGuire, J. F., Piacentini, J., Lewin, A. B., Brennan, E. A., Murphy, T. K., & Storch, E. A. (2015). A meta-analysis of cognitive behavior therapy and medication for child obsessive-compulsive disorder: Moderators of treatment efficacy, response, and remission. *Depression and Anxiety*, *32*(8), 580–593. https://doi.org/10.1002/da.22389

McKay, D. (2023). 5. Obsessions and compulsions. In S. Hupp, C. L. Santa, & Maria (Eds.), *Pseudoscience in therapy: A skeptical field guide* (pp. 53–68). Cambridge University Press.

McKay, D., Abramowitz, J. S., & Storch, E. A. (2021). Mechanisms of harmful treatments for obsessive–compulsive disorder. *Clinical Psychology: Science and Practice*, *28*(1), 52.

Merlo, L. J., Lehmkuhl, H. D., Geffken, G. R., & Storch, E. A. (2009). Decreased family accommodation associated with improved therapy outcome in pediatric obsessive–compulsive disorder. *Journal of Consulting and Clinical Psychology*, *77*(2), 355.

Meyerson, J., & Konichezky, A. (2011). Hypnotically induced dissociation (HID) as a strategic intervention for enhancing OCD treatment. *American Journal of Clinical Hypnosis*, *53*(3), 169–181.

Micali, N., Heyman, I., Perez, M., Hilton, K., Nakatani, E., Turner, C., & Mataix-Cols, D. (2010). Long-term outcomes of obsessive–compulsive disorder: Follow-up of 142 children and adolescents. *The British Journal of Psychiatry*, *197*(2), 128–134.

Midgley, N., Mortimer, R., Cirasola, A., Batra, P., & Kennedy, E. (2021). The evidence-base for psychodynamic psychotherapy with children and adolescents: A narrative synthesis. *Frontiers in Psychology*, *12*, 662671.

Mitchell, B. J., Coifman, K. G., & Olatunji, B. O. (2024). Is disgust more resistant to extinction than fear? A meta-analytic review of laboratory paradigms. *Behaviour Research and Therapy, 174*, 104479.

Moritz, S., Timpano, K. R., Wittekind, C. E., & Knaevelsrud, C. (2013). Harnessing the Web: Internet and Self-Help Therapy for People with Obsessive–Compulsive Disorder and Posttraumatic Stress Disorder. *Handbook of Treating Variants and Complications in Anxiety Disorders*, 375–397.

Neal, R. L., Alcolado, G. M., & Radomsky, A. S. (2017). Responsibility, checking, and reassurance-seeking in OCD. *The Wiley Handbook of Obsessive Compulsive Disorders*, *1*, 361–376.

Paton, S., & Alex, S. (2019). *EFT for Parents of Children who Pull Hair and Pick Skin*. https://www.udemy.com/course/eft-for-parents-pick-pulling/?kw=eft+for+parents&src=sac&couponCode=LETSLEARNNOWPP

Peris, T. S., & Piacentini, J. (2014). Addressing barriers to change in the treatment of childhood obsessive compulsive disorder. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, *32*, 31–43.

Piacentini, J., Bergman, R. L., Chang, S., Langley, A., Peris, T., Wood, J. J., & McCracken, J. (2011). Controlled comparison of family cognitive behavioral therapy and psychoeducation/relaxation training for child obsessive-compulsive disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, *50*(11), 1149–1161.

Pignotti, M., & Thyer, B. A. (2019). Obsessions and compulsions. In *Pseudoscience in child and adolescent psychotherapy: A skeptical field guide* (pp. 159–171).

Rachman, S. (1998). A cognitive theory of obsessions. In E. Sanavio (Ed.), *Behavior and cognitive therapy today* (pp. 209–222). Elsevier.

Radomsky, A. S., Alcolado, G. M., Abramowitz, J. S., Alonso, P., Belloch, A., Bouvard, M., Clark, D. A., Coles, M. E., Doron, G., & Fernández-Álvarez, H.& others. (2014). Part 1—You can run but you can't hide: Intrusive thoughts on six continents. *Journal of Obsessive-Compulsive and Related Disorders*, *3*(3), 269–279.

Ray, R. L. B. (2018). *Manage Childhood OCD Naturally With This Little Known Method*. https://rlbray.com/2018/04/12/manage-childhood-ocd/

Reddy, Y. J., Sudhir, P. M., Manjula, M., Arumugham, S. S., & Narayanaswamy, J. C. (2020). Clinical practice guidelines for cognitive-behavioral therapies in anxiety disorders and obsessive-compulsive and related disorders. *Indian Journal of Psychiatry*, *62*(Suppl 2), S230.

Reid, A. M., Bolshakova, M. I., Guzick, A. G., Fernandez, A. G., Striley, C. W., Geffken, G. R., & McNamara, J. P. (2017). Common barriers to the dissemination of exposure therapy for youth with anxiety disorders. *Community Mental Health Journal*, *53*, 432–437.

Reid, A. M., Guzick, A. G., Fernandez, A. G., Deacon, B., McNamara, J. P., Geffken, G. R., McCarty, R., & Striley, C. W. (2018). Exposure therapy for youth with anxiety: Utilization rates and predictors of implementation in a sample of practicing clinicians from across the United States. *Journal of Anxiety Disorders*, *58*, 8–17.

Riemann, B. C., Deacon, B. J., Farrell, N. R., & Kinnear, K. (2014). *Myth #4: Patients participating in exposure perceive treatment as unethical, intolerable, and harmful. In N.R. Farrell & J.J. Kemp (Chairs), Myth-busting exposure therapy for anxiety.* Annual Meeting of the Association for Behavioral and Cognitive Therapies, Nashville, TN.

Rosa-Alcázar, A. I., Sánchez-Meca, J., Rosa-Alcázar, Á., Iniesta-Sepúlveda, M., Olivares-Rodríguez, J., & Parada-Navas, J. L. (2015). Psychological treatment of obsessive-compulsive disorder in children and adolescents: A meta-analysis. *The Spanish Journal of Psychology*, *18*, E20.

Schneider, S. C., Knott, L., Cepeda, S. L., Hana, L. M., McIngvale, E., Goodman, W. K., & Storch, E. A. (2020). Serious negative consequences associated with exposure and response prevention for obsessive-compulsive disorder: A survey of therapist attitudes and experiences. *Depression and Anxiety*, *37*(5), 418–428.

Sideli, L., Santoro, G., Fontana, A., Guglielmucci, F., Caretti, V., & Schimmenti, A. (2023). The relationship between obsessive-compulsive symptoms and dissociation: A systematic review and Meta-analysis. *Journal of Trauma & Dissociation*, *24*(3), 362–379.

Spencer, S. D., Stiede, J. T., Wiese, A. D., Guzick, A. G., Cervin, M., McKay, D., & Storch, E. A. (2023). Things that make you go hmm: Myths and misconceptions within cognitive-behavioral treatment of obsessive-compulsive disorder. *Journal of Obsessive-Compulsive and Related Disorders, 37*, 100805.

Stahnke, B. (2021). A systematic review of misdiagnosis in those with obsessive-compulsive disorder. *Journal of Affective Disorders Reports*, *6*, 100231.

Storch, E. A., Geffken, G. R., Merlo, L. J., Mann, G., Duke, D., Munson, M., Adkins, J., Grabill, K. M., Murphy, T. K., & Goodman, W. K. (2007). Family-based cognitive-behavioral therapy for pediatric obsessive-compulsive disorder: Comparison of intensive and weekly approaches. *Journal of the American Academy of Child & Adolescent Psychiatry*, *46*(4), 469–478.

Storch, E. A., Merlo, L. J., Larson, M. J., Geffken, G. R., Lehmkuhl, H. D., Jacob, M. L., Murphy, T. K., & Goodman, W. K. (2008). Impact of comorbidity on cognitive-behavioral therapy response in pediatric obsessive-compulsive disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, *47*(5), 583–592.

Storch, E. A., Bussing, R., Small, B. J., Geffken, G. R., McNamara, J. P., Rahman, O., Lewin, A. B., Garvan, C. S., Goodman, W. K., & Murphy, T. K. (2013). Randomized, placebo-controlled trial of cognitive-behavioral therapy alone or combined with sertraline in the treatment of pediatric obsessive-compulsive disorder. *Behaviour Research and Therapy*, *51*(12), 823–829. https://doi.org/10.1016/j.brat.2013.09.007

Storch, E. A., Wilhelm, S., Sprich, S., Henin, A., Micco, J., Small, B. J., McGuire, J., Mutch, P. J., Lewin, A. B., & Murphy, T. K.& others. (2016). Efficacy of augmentation of cognitive behavior therapy with weight-adjusted d-cycloserine vs placebo in pediatric obsessive-compulsive disorder: A randomized clinical trial. *JAMA Psychiatry*, *73*(8), 779–788.

Storch, E. A., Small, B. J., McGuire, J. F., Murphy, T. K., Wilhelm, S., & Geller, D. A. (2018). Quality of life in children and youth with obsessive-compulsive disorder. *Journal of Child and Adolescent Psychopharmacology*, *28*(2), 104–110.

Storch, E. A., Peris, T. S., De Nadai, A., Piacentini, J., Bloch, M., Cervin, M., McGuire, J., Farrell, L. J., McCracken, J. T., & McKay, D.& others. (2020). Little doubt that CBT Works for Pediatric OCD. *Journal of the American Academy of Child and Adolescent Psychiatry*, *59*(7), 785–787.

Storch, E. A., Guzick, A. G., Ayton, D. M., Palo, A. D., Kook, M., Candelari, A. E., Maye, C. E., McNeel, M., Trent, E. S., Garcia, J. L., Onyeka, O. C., Rast, C. E., Shimshoni, Y., Lebowitz, E. R., & Goodman, W. K. (2024). Randomized trial comparing standard versus light intensity parent training for anxious youth. *Behaviour Research and Therapy*, *173*, 104451.

Summers, R. F., Barber, J. P., & Zilcha-Mano, S. (2024). *Psychodynamic therapy*. Guilford.

Taboas, W. R., Mckay, D., Whiteside, S. P. H., & Storch, E. A. (2015). Parental involvement in youth anxiety treatment: Conceptual bases, controversies, and recommendations for intervention. *Journal of Anxiety Disorders*, *30*, 16–18.

The Pediatric OCD Treatment Study Team. (2004). Cognitive-behavior therapy, Sertraline, and their combination for children and adolescents with obsessive-compulsive disorder. *Journal of the American Medical Association*, *292*(16), 1969–1976.

Thienemann, M., Murphy, T., Leckman, J., Shaw, R., Williams, K., Kapphahn, C., Frankovich, J., Geller, D., Bernstein, G., Chang, K., & others (2017). Clinical management of pediatric acute-onset neuropsychiatric syndrome: Part I—psychiatric and behavioral interventions. *Journal of Child and Adolescent Psychopharmacology*, *27*(7), 566–573.

Tolin, D. F., Abramowitz, J. S., Przeworski, A., & Foa, E. B. (2002). Thought suppression in obsessive-compulsive disorder. *Behaviour Research and Therapy*, *40*(11), 1255–1274.

Torp, N. C., Weidle, B., Thomsen, P. H., Skarphedinsson, G., Aalberg, M., Nissen, J. B., Melin, K. H., Dahl, K., Valderhaug, R., & Ivarsson, T. (2019). Is it time to rethink standard dosage of exposure-based cognitive behavioral therapy for pediatric obsessive-compulsive disorder? *Psychiatry Research*, *281*, 112600.

Uhre, C. F., Uhre, V. F., Lønfeldt, N. N., Pretzmann, L., Vangkilde, S., Plessen, K. J., Gluud, C., Jakobsen, J. C., & Pagsberg, A. K. (2020). Systematic review and meta-analysis: Cognitive-behavioral therapy for obsessive-compulsive disorder in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *59*(1), 64–77.

Valderhaug, R., Götestam, G., K., & Larsson, B. (2004). Clinicians' views on management of obsessive–compulsive disorders in children and adolescents. *Nordic Journal of Psychiatry*, *58*(2), 125–132.

Wallerstein, N., Oetzel, J. G., Sanchez-Youngman, S., Boursaw, B., Dickson, E., Kastelic, S., Koegel, P., Lucero, J. E., Magarati, M., Ortiz, K., & others (2020). Engage for equity: A long-term study of community-based participatory research and community-engaged research practices and outcomes. *Health Education & Behavior*, *47*(3), 380–390.

Whiteside, S. P. (2023). Examining Community clinicians Use of Imaginal exposure with childhood anxiety disorders. *Child Psychiatry & Human Development*. https://doi.org/10.1007/s10578-023-01556-3

Whiteside, S. P., Deacon, B. J., Benito, K., & Stewart, E. (2016). Factors associated with practitioners' use of exposure therapy for childhood anxiety disorders. *Journal of Anxiety Disorders*, *40*, 29–36.

Wiese, A. D., Drummond, K. N., Fuselier, M. N., Sheu, J. C., Liu, G., Guzick, A. G., Goodman, W. K., & Storch, E. A. (2022). Provider perceptions of telehealth and in-person exposure and response prevention for obsessive–compulsive disorder. *Psychiatry Research*, *313*, 114610.

Wilhelm, S., & Steketee, G. S. (2006). *Cognitive therapy for obsessive compulsive disorder: A guide for professionals*. New Harbinger.

Wislocki, K., Kratz, H. E., Martin, G., & Becker-Haimes, E. M. (2023). The relationship between trauma exposure and obsessive–compulsive disorder in Youth: A systematic review. *Child Psychiatry & Human Development*, *54*(6), 1624–1652.

Wolff, R., & Rapoport, J. (1988). Behavioral treatment of childhood obsessive-compulsive disorder. *Behavior Modification*, *12*(2), 252–266.

Ye, H. J., Rice, K. G., & Storch, E. A. (2008). Perfectionism and peer relations among children with obsessive-compulsive disorder. *Child Psychiatry and Human Development*, *39*, 415–426.