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Developmental Transformations and Pediatric OCD: A Review of the Literature and Proposal for Drama Therapy in Treatment

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Abstract

One to four percent of the population experiences obsessive-compulsive disorder (OCD), and the majority of cases of begin in childhood or adolescence (Agarwal et al., 2016). Youth with OCD may experience barriers to their personal, familial, social, and academic success. In this Capstone Thesis paper, a critical review of the literature is conducted about obsessive-compulsive disorder (OCD) in children and adolescents, standard treatment methods including cognitive behavioral therapy (CBT) with Exposure and Response Prevention (ERP), and Developmental Transformations (DvT). DvT is proposed as a supplemental treatment method for pediatric OCD to be combined with ERP to combat treatment resistance, address associated symptoms and comorbidities, and increase tolerance and flexibility.

Keywords: pediatric obsessive-compulsive disorder, drama therapy, developmental transformations, cognitive behavioral therapy, exposure and response prevention

Author Identity Statement: This Capstone Thesis was written from the perspective of a cisgender white female located in the northeastern United States.

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Introduction

Children and adolescents with obsessive-compulsive disorder (OCD) may face extensive challenges from their symptoms, comorbid conditions, or impairment to their family system or social well-being. Cognitive Behavioral Therapy (CBT), Exposure and Response Prevention (ERP), and medication are the first lines of treatment for pediatric OCD (Freeman et al., 2018). While these methods are well studied and effective, some children and adolescents do not respond to treatment or show improvement but have lingering subclinical symptoms (Kim et al., 2020; Law & Boisseau, 2019; Melin et al., 2018).

One treatment method that has potential to benefit this population by supplementing standard treatment is Developmental Transformations (DvT). DvT is a type of drama therapy based on the idea that rather than trying to control the inevitable chaos in the world around them, people benefit from learning to tolerate and adapt to that chaos (Johnson, 2013). DvT uses improvisational play with a trained facilitator (playor) and one or more participants (players) to expand the players' tolerance and complex understanding of their life experiences. This capstone thesis reviews the literature on pediatric OCD and standard treatment options available as well as the available literature on DvT with children and adolescents. This thesis 1) makes theoretical connections between OCD and DvT theory, 2) argues that DvT could be a viable supplemental treatment option for pediatric OCD, 3) identifies gaps in existing literature, and 4) proposes future research on the integration of DvT with standard treatment for children and adolescents with OCD.

Operationalizing the Terms

This thesis discusses several associated symptoms or qualities of children and adolescents with OCD. For the purposes of this thesis, intolerance of uncertainty refers to the fear of or inability to cope with a perceived lack of enough information (Carleton, 2016). Perfectionism refers to “the pursuit of high standards and self-criticism over not meeting standards”, including either perfectionistic strivings (reaching for perfectionism), perfectionistic concerns (self-doubt or anxiety about perfectionism), or both (Limburg et al., p 1301, 2017). Intrusive thoughts refer to unwanted distressing thoughts or images, differentiated from obsessions which are repetitive intrusive thoughts that hold disproportionate significance and which the individual attempts to mitigate (Rachman, 1997).

While the term "play" can encompass a broad range of experiences, this thesis—unless otherwise specified—uses the term according to the drama therapy core process known as dramatic play. Dramatic play is defined as, “Engagement in a co-created improvised relationship with reality, utilizing imagination and spontaneity. Typically, there is a sense of experimentation, and an engagement in experiential processes that are expressive and collaborative” (Frydman et al., p 8, 2022).

Literature Review

Obsessive-Compulsive Disorder

OCD can have a profound impact on a child or adolescent’s life. To be diagnosed with OCD, one must experience time-consuming and impairing obsessions, compulsions, or both (American Psychiatric Association [APA], 2022). The person can be specified as having good, poor, or no insight and as either having or not having current or previous tics (APA, 2022). While the average age of OCD onset in the United States is 19.5, 25% of people with OCD experience onset by 14 years, and almost 25% of men with OCD experience onset before the age

of 10 years old (APA, 2022). Without treatment, the majority of people with OCD in childhood will continue to have OCD throughout their lifetime (APA, 2022).

As defined by *The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition Text Revision* (DSM V TR), obsessions are "Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress," (APA, p 265, 2022). Compulsions are defined as "Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly" which are "aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation" and are "not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive" (APA, p 265, 2022).

Pediatric OCD

Obsessions can be difficult to diagnose in children because they are an internal thought process and cannot be directly observed, and compulsions can be difficult to diagnose because young children may have difficulty or be incapable of describing the intentions behind their behaviors (APA, 2022). Themes in the content of obsessions often differ across developmental stages, aligning with developmentally appropriate topics (APA, 2022).

Adolescents described the experience of having OCD as being burdensome, time-consuming, and constantly on their minds (Keys, Nolte, & Williams, 2018). Some described a constant feeling of needing things to be just-right but not being able to achieve that, and others described a feeling of being out of control (Keys, Nolte, & Williams, 2018). Most of the adolescents described isolating from others due to fear of triggers or shame about the disorder

(Keys, Nolte, & Williams, 2018). Children and adolescents with OCD may feel immense shame about their obsessions or compulsions, especially those deemed socially unacceptable (Keys, Nolte, & Williams, 2018). Adolescents with OCD described trying to hide their OCD symptoms, feeling different and isolated from others, and frequently facing stigma and misunderstandings about OCD and mental illness (Keys, Nolte, & Williams, 2018). A meta-analysis found that overall, worse OCD symptoms correlated to higher levels of shame (Laving et al., 2023). Shame about symptoms is important to address as it can be a large barrier to accessing treatment (Laving et al., 2023).

Associated Symptoms

In addition to obsessions and compulsions, there are some symptoms commonly associated with OCD that are not included in the diagnostic criteria. Up to 60% of individuals with OCD experience sensory phenomena including "physical sensations, just-right sensations, and feelings of incompleteness that precede compulsions," (APA, p 267, 2022). Strong emotional responses such as disgust, unease, anxiety, and panic attacks are associated with OCD, as are avoidant behaviors to evade discomfort and specific triggers and dysfunctional beliefs including "an inflated sense of responsibility and the tendency to overestimate threat; perfectionism and intolerance of uncertainty; and overimportance of thoughts (e.g., believing that having a forbidden thought is as bad as acting on it) and the need to control thoughts," APA, p 267, 2022). Many people with OCD experience varying degrees of suicidality, often impacted by comorbidities such as depression and anxiety (APA, 2022; Angelakis, 2015).

Intolerance of Uncertainty. Intolerance of uncertainty may play a major role in OCD (Fraire, 2023). The American Psychological Association (APA) published a commentary about the role IU plays in pediatric OCD, which noted that adolescents are at high vulnerability to IU

because of their stage of brain development and that rituals, reassurance seeking, avoidance, and safety behaviors present in OCD could be conceptualized as a way to seek certainty (Fraire, 2023). Fraire (2023) suggests that for children, parent training and ERP are current options to address intolerance of uncertainty in youth, but that more ways should be explored including finding ways to introduce exposure and build tolerance for uncertainty using different methods that do not necessarily start with the specific obsessions and compulsions present, which may be too intense for some clients in early treatment (Fraire, 2023).

Sperling (2023) measured the intolerance of uncertainty (IU) at the beginning and end of treatment of children and adolescents with anxiety or OCD aged 8-19 in an intensive outpatient program which included ERT and other treatment methods. At both intake and discharge, the researchers measured anxiety, the impact of anxiety on daily functioning across multiple domains of life, and IU as reported by the child and a caregiver. Participants engaged in an ERT group designed to target individual fears and avoidances, including exposures that specifically target IU. The study found that higher IU correlated with higher levels of anxiety and impairment, IU decreased by the end of treatment, and larger decreases in IU by the end of treatment were correlated with larger decreases in anxiety and impairment by the end of treatment (Sperling, 2023). This study's generalizability to OCD treatment was limited in that OCD symptoms were not measured and diagnostic information about the severity of the OCD cases was not included. Further research is necessary to better understand the role IU plays in OCD relative to other disorders, create IU assessment scales, and study treatment options (Fraire, 2023).

Intrusive Thoughts. Intrusive thoughts, a transdiagnostic symptom and common occurrence even in healthy individuals, are often associated with OCD (Barrera & Norton, 2011).

Intrusive thoughts in children and adolescents with OCD are understudied, but still widely understood to be relevant to treatment (Berman, Wilver & Wilhelm, 2018). Rachman (1997) distinguished intrusive thoughts as unwanted distressing thoughts or images from OCD obsessions as the overestimation of how significant, important, or true those thoughts are. Barrera and Norton (2011) supported this in their study that concluded intrusive thoughts themselves do not predict OCD symptoms, but attitudes about the intrusive thoughts do. The study was limited in that the population was not clinical and was only looking at intrusive thoughts and OCD symptoms in healthy individuals, and findings were mixed depending on which diagnostic tool was used (Barrera & Norton, 2011). Still, this provides a starting point for future research about whether the intrusive thoughts themselves or the reaction to the intrusive thought is more relevant to the development and treatment of OCD.

Berman, Wilver, and Wilhelm (2018) studied how parents of children with OCD viewed and responded to their children's intrusive thoughts and how that impacted the family system. The researchers surveyed parents on their attitudes towards their children's intrusive thoughts and on the adaptive, maladaptive, and neutral suggestions to their children to respond to the thoughts. Parents who viewed intrusive thoughts as overly significant corresponded to more severe OCD symptoms in their children. While their emotional response to the intrusive thoughts of their children had a significant correlation to the severity of symptoms, whether they provided adaptive or maladaptive suggestions to their children did not (Berman, Wilver & Wilhelm, 2018). Even unintentionally, parents may pass down maladaptive attitudes about intrusive thoughts to their children with OCD who in turn could view their unwanted thoughts as more significant, and thereby make the thoughts more impairing (Berman, Wilver & Wilhelm, 2018).

Perfectionism. Perfectionism is closely associated with obsessive-compulsive disorders, depressive disorders, and eating disorders (Cludius et al., 2022). A meta-analysis looking at perfectionism across diagnoses found that in OCD and other disorders, perfectionistic concerns (fears about not achieving perfection) are more closely associated with psychopathology than perfectionistic strivings (ambitions to reach perfection) (Limburg et al., 2017). A German study of perfectionism in adults with OCD or Major Depressive Disorder (MDD) found that in both OCD and MDD, perfectionistic tendencies were much higher than in control groups. Perfectionism did not differ significantly between OCD and MDD. However, the study was limited in that many individuals in the OCD group also had depressive symptoms and many individuals in the MDD group also had obsessive/compulsive symptoms (Cludius et al., 2022). Though frequently discussed in the literature as a symptom closely tied to OCD, perfectionism does not have adequate research in the population partially due to the limited valid and reliable perfectionism assessment tools (Cludius et al., 2022).

Cognitive Distortions and Dysfunctional Beliefs. Miegal et al. (2023) found that people with OCD tended to have cognitive distortions such as overestimating threats. The researchers predicted that cognitive distortions in people with OCD would be related to common obsessions and compulsions, but instead found a wide range of dysfunctional beliefs, regardless of specific obsessions and compulsions (Meigal et al., 2023). Children and adolescents with OCD may also experience significant cognitive rigidity, struggling to change perspectives and thinking patterns (Karimi, Roudsari & Heydari Yazdi, 2021). This lack of flexible thinking may impact the ability to see perspectives apart from their distorted thoughts and dysfunctional beliefs.

A common cognitive distortion among children and adolescents with OCD is responsibility belief, the perception of having more control than one genuinely has over a

situation, especially in preventing harm (Collins & Coles, 2018). Heightened responsibility in children could be a precursor to the development of OCD (Collins & Coles, 2018), and some adolescents with OCD have reported developing OCD symptoms after a trauma they associated with responsibility beliefs, such as a tragic event they believed they caused (Keyes, Nolte, & Williams, 2018).

Comorbidities

In a 2021 meta-analysis, 63.6% of children and adolescents with OCD had at least one comorbid disorder. Anxiety was the most common comorbidity in pediatric OCD, but depression, tic disorders, attention deficit hyperactivity disorder (ADHD), panic disorder, specific phobias, and autism spectrum disorder (ASD) were also common (Sharma et al., 2021). In addition to the comorbidities found in youth with OCD, eating disorders, substance use disorders, personality disorders, and mood disorders were found in OCD in adulthood (Sharma et al., 2021). Due to the high likelihood of comorbid anxiety, mood, tic, or neurodevelopmental disorders in children and adolescents with OCD, individuals should be screened for these comorbidities and treatment should reflect the complexities of each case (Sharma et al., 2021).

Immune-Mediated OCD

Many cases of OCD symptomatology in childhood are caused by Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcus (PANDAS) or Pediatric Acute Onset Neuropsychiatric Syndrome (PANS) (Wald et al., 2023; O'Dor et al., 2022). In these cases, rapid onset of OCD, tics, and other symptoms occur due to a Group A Streptococcus (strep) infection in the case of PANDAS or another infection in PANS (Wald et al., 2023; O'Dor et al., 2022). The COVID-19 pandemic has shed new light on the prevalence and impact of PANS (Pallanti & Di Ponzio, 2023). In some cases, COVID-19 in youth has led to the sudden onset or worsening

of neuropsychiatric symptoms, including depression, anxiety, and OCD (Pallanti & Di Ponzio, 2023). Though the exact prevalence is unknown, PANDAS/PANS in OCD patients is significant enough that some researchers have proposed adding a subtype of autoimmune-related OCD to OCD diagnostics (Endres, 2021).

PANDAS/PANS is often an explanation for treatment-resistant OCD in children and adolescents, and it requires both medical and behavioral health interventions to treat (Endres et al., 2021; O'Dor et al., 2022). PANDAS/PANS can cause other symptoms that complicate OCD treatment such as rapid cognitive changes and physical health concerns (Endres et al., 2021; O'Dor et al., 2022). PANDAS/PANS cases tend to have more thought compulsions and can be extremely difficult to address using only standard OCD treatment methods (Endres et al., 2021; O'Dor et al., 2022).

Standard Treatment for Pediatric OCD

Standard treatment for OCD in children and adolescents includes medication, family interventions, and cognitive behavioral therapy (CBT) often including exposure and response prevention (ERP) (Law & Boisseau, 2019; McGuire et al., 2015; Kim et al., 2020). ERP is a type of exposure therapy within CBT in which clients are encouraged to endure increasingly feared triggers until stress levels subside without engaging in a compulsion (Law & Boisseau, 2019). A meta-analysis found that 68% of children with OCD responded to CBT treatment (McGuire et al., 2015). Melin et al. (2018) found that two-thirds of participants who had gone through CBT for pediatric OCD were still in remission three years later.

Bolton and Perrin (2008) sought to isolate the effects of ERP from other treatment methods in pediatric OCD and found that four of the eight participants no longer met diagnostic criteria after completing approximately five weeks of ERP treatment. Though the study was

limited in its small sample size and its inability to have the OCD assessor be blinded to who was in the treatment group versus the waitlist control group, it provided evidence that ERP is worth continuing to study in youth and that it could be an option for manualized, short-term, and simple to administer treatment for pediatric OCD (Bolton & Perrin, 2008).

While the CBT with ERP approach tends to be effective, it has limitations. Children with less severe symptoms or with specific and easily observable triggers and compulsions tend to respond very well to ERP, but others with more severe symptoms or less identifiable fears do not benefit as much from this approach (Law & Boisseau, 2019). Morgan et al. (2013) found children with more severe symptoms to be less likely to comply with treatment in sessions, as were children with families who were more accommodating of their symptoms. Additionally, certain comorbidities can impact the efficacy of standard treatment for OCD (Kim et al., 2020; Law & Boisseau, 2019). Law & Boisseau (2019) concluded in a literature review that comorbid depression or personality disorders correlated with worse treatment outcomes.

Family Involvement in OCD Treatment. Pediatric OCD can impact the entire family system, and one factor that contributes to the severity of OCD in children and adolescents is family accommodation (Brezinka, Mailänder & Walitza, 2020). Because of this and the difficulties of performing cognitive therapy with very young children, pediatric OCD treatment often focuses on addressing the family rather than the individual (Brezinka, Mailänder & Walitza, 2020). A case series of five children aged four to five years old with severely impairing OCD demonstrated success in CBT treatment focused on the family system. The children attended only the first session, and the parents attended between four and ten sessions which focused on reducing family accommodation of the child's compulsions. At the six-month follow-up, all five children had a significant decrease in OCD symptoms (Brezinka, Mailänder &

Walitza, 2020). Some of this success was attributed to the early intervention once symptoms were noted in each of these cases (Brezinka, Mailänder & Walitza, 2020).

Chessell (2023) studied a similar approach with ten children with OCD aged five to twelve years old. Half of the children responded at least somewhat to CBT treatment administered by their parents who were being guided and supported by a therapist (Chessell, 2023). Both studies had small sample sizes and relied on self-reported data from parents, but the results of each suggested that parents or home environment have an impact on pediatric OCD and that including families in treatment is sensible.

Play in OCD Treatment. Though little research has been done on the use of play therapy to treat pediatric OCD, Myrick & Green (2012) suggested play therapy methods integrated with CBT and ERP or alongside medication could be beneficial for children to clarify and integrate difficult CBT concepts and externalize symptoms. Play therapy may also be able to help increase flexible thinking, tolerance of change and uncertainty, self-confidence, and adaptability as well as prime a child to do better with cognitive and behavioral OCD treatments (Gold-Steinberg & Logan, 1999). Van Bennekom et al. (2021) studied a virtual reality game as a tool to assess OCD symptoms. Despite being cognitively aware that all triggers were in-game and there were no real dangers, individuals with OCD completed significantly more in-game compulsions than those without OCD and experienced significantly more stress in response to triggers and steep relief from stress after completing compulsions measured by both subjective report and physiological changes (van Bennekom et al., 2021). Though this study was designed to test tools for assessment, the results suggested future research is warranted to explore play and imagination-based methods for treatment involving exposure to triggers because it could allow for location-specific triggers and compulsions to be worked through at a treatment office or

facility and could scaffold the intensity by starting with the imaginal and moving into the tangible (van Bennekom et al., 2021).

Drama Therapy

Drama therapy is the use of dramatic techniques such as improvisation, play, storytelling, or design to elicit transformation or other therapeutic value (North American Drama Therapy Association (NADTA), 2021). Drama therapy is a broad term encompassing many practices and can be used as a stand-alone practice or alongside or incorporated with other therapeutic practices (NADTA, 2021).

Drama Therapy with Children and Adolescents

Drama therapy with children and adolescents has been used in outpatient settings, inpatient settings, schools, hospitals, community centers, and more (Berghs et al., 2022). Drama therapy has been shown to help children and adolescents with depression, anxiety, stress, responses to trauma, social anxiety, inattention, hyperactivity, impulsivity, risk-taking, and aggression (Berghs et al., 2022). Drama therapy has also helped children and adolescents develop social skills, regulate emotions, cope with distress, and explore identity (Berghs et al., 2022). In reviewing the literature about drama therapy with children and adolescents, Berghs et al. (2022) identified several commonly found mechanisms of change including self-expression and creativity, sharing personal experiences and emotions, identifying with others, enjoying playfulness and role play, developing self-awareness and identity, reflecting on oneself and others, embodying new experiences and emotions, and gaining a sense of power and agency.

Developmental Transformations

The second edition of the Developmental Transformations Text for Practitioners defined DvT as “The transformation of embodied encounters in the playspace” (Johnson, p. 38, 2013).

Embodiment is the presence in and awareness of one's body, and in DvT is required for encounter with another (Cooley, 2021). DvT has been widely applied across populations since its conception in the 1980s and has evolved to include a range of cognitive, social, behavioral, and emotional benefits (Sajnani, Willemsen & Butler, 2023). A 2023 scoping review of articles about DvT across populations identified categories of observed benefits across studies: "*increased tolerance, increased playfulness, increased self-acceptance, increased self-regulation, increased agency, increased flexibility, increased dimensionalisation, symptom reduction, increased presence, increased quality of life* and *benefits to others*" (Sajnani, Willemsen & Butler, p 298, 2023). Conclusions about the extent to which these benefits are measurable are limited by the lack of intentionally designed research, as all but one of the studies in the scoping review were case vignettes. Additionally, there is limited consistency in and measurement of variables such as style of the practitioner within the practice of DvT (Sajnani, Willemsen & Butler, 2023).

Play. At the heart of DvT is the intentional use of play for therapeutic transformation. Play allows for an exploration of whatever themes are currently most personally relevant to the client in a world that is cocreated and mutually agreed upon to be safe from real harm and separate from reality (Dintino et al., 2015). DvT practitioners do not analyze the specific images that come up in the play and search for concrete meaning. Rather, they explore with ongoing curiosity and collaboration with participants the themes and patterns, as well as diversions from those patterns, that emerge over time (Johnson & Pitre, 2021).

DvT practitioners use specific strategies to find aesthetic distance, the balance between being close enough to the material to be engaged but not too close to become overly activated or shut down, within the play (Dintino et al., 2015). Aesthetic distance balances one's ability to engage both cognitively and affectively (Dintino et al., 2015). If someone is brought out of the

play by being too activated by the subject material or unable to fully engage because the material becomes too real, the practitioner can remind the participant that they are in play together with strategies such as creating a larger-than-life character, adding absurd elements to the scene, or bracketing the scene with commentary about the scene itself (Dintino et al., 2015).

DvT practitioners (playors) invite one or more participants (players), into the playspace, "a particular state of play, being a mutual agreement among the participants that everything that goes on between them is a *representation* or *portrayal*." (Johnson & Pitre, p 130, 2021). The playspace is a non-physical place of relationship and mutuality, separate from reality, where the participants and their relationships all influence one another (Johnson & Pitre, 2021). Because the playspace requires mutual agreement and is separate from reality, it can bend time, space, and power. Actions can be changed, roles can be reversed, and power dynamics can be deconstructed (Johnson & Pitre, 2021). Additionally, the agreement includes restraint from and relative safety from harm. Someone can be harmed within the play, but harming them in reality takes them out of the playspace (Johnson & Pitre, 2021). Nevertheless, the playspace cannot ever be fully safe from harm because the experience of harm even within play can be very real and no encounter with another is without risk (Johnson, 2013).

Instability Theory. Instability theory, the postmodern idea that "experience is nonrepeating", informs the fundamentals of DvT (Johnson & Pitre, p 125, 2021). The core of instability theory is that no single moment is the same as another and cannot be controlled or predicted, so one must be able to adapt to the world around them from moment to moment (Johnson & Pitre, 2021; Johnson, 2013). Despite the instability of the world, individuals need some level of stability, or equilibrium, to be able to function. Instability theory names static equilibrium the controlling of the chaos and dynamic equilibrium as the tolerating and navigating

of the chaos (Johnson & Pitre, 2021; Johnson, 2013). While both are necessary, DvT attempts to help people find dynamic equilibrium, an adaptability to the world around them and embracing of instability (Johnson & Pitre, 2021; Johnson, 2013). An individual who only looks for static equilibrium will have a difficult time tolerating the instability of other people and the world when they cannot have the control they need, while a person with dynamic equilibrium will be able to navigate the things that cannot be controlled, including other people (Johnson & Pitre, 2021). As stated by Johnson and Pitre (2021), "DvT attempts to lower the fear of the instability of Being, rather than lowering the instability of Being," (p 136).

Varielation. DvT practitioners use specific play-based techniques as interventions. To find static equilibrium, players enact repeating forms, patterns in the play that often reflect patterns in life in some way (Johnson, 2013). Varielation is the practice of intentionally breaking a player away from their repeating forms, moving toward dynamic rather than static equilibrium (Johnson, 2013). DvT practitioners do this by noticing and responding to repeating forms and any subtle or major changes in those forms that occur (Johnson, 2013). Varielation moves the play toward transformation by following changes that arise from the player(s) or by adding or changing unexpected elements that break the expected patterns (Cooley, 2021). The fluidity in using varielation to try new things, break patterns, and push tolerance can create change in personal attitudes and habits (Cooley, 2021). A DvT practitioner described her own experience of becoming not only more comfortable with but fully embracing eye contact after playing with eye contact in DvT over time (Cooley, 2021).

Dimensionalization. Dimensionalization is the process of creating a more complex understanding of experience by adding perspective and nuance (Johnson, 2013). The aim of dimensionalization in DvT is to help people move toward dynamic equilibrium by adding these

complexities to understanding and enhancing strict black-and-white categorical schemas (Johnson, 2013). Adding more complex perspectives within play gives people the opportunity to take these nuances with them into real life (Cooley, 2021). Cooley (2021) described an experience as a DvT player in which she was able to add hope and levity to a circumstance that was previously only dark, heavy, fearful, and hopeless.

Part of dimensionalization is building the distinguishing of what is play and what is real, allowing for the acknowledgment that in DvT one exists in both (Johnson, 2013). DvT has been shown to help children and adults differentiate between what is real and what is imagined in individuals with trauma symptoms or schizophrenia (Butler, 2012; Pitre, 2014; Dintino et al., 2015; Pitre, Sajnani & Johnson, 2015; Domikles, 2016; Willemsen, 2020). Butler (2012) suggested that the mutual agreement that what happens in the playspace is separate from reality could help individuals with schizophrenia better differentiate psychosis from reality, noting that while data is currently limited, field observations indicate that this concept is worth researching.

DvT as Exposure

DvT offers play as a form of exposure to what is otherwise too intense to face directly (Dintino et al., 2015; Pitre, Sajnani, and Johnson, 2015). Trauma-Centered DvT (TC-DvT) was designed to target trauma by taking advantage of this ability of play. It uses principles of exposure, which closely align with the goal of DvT to increase tolerance of the instability of Being (Johnson & Pitre, 2021).

Pitre, Sajnani, and Johnson (2015) wrote about a case of TC-DvT being used with a five-year-old boy with an extensive trauma history. The practitioner utilized the principles of exposure therapy within DvT and was able to start playing with highly distanced material and move into material closer and closer to the child's actual trauma history. This exposed him to his

triggers without going too quickly and dysregulating him and correlated to an improvement in behavioral, emotional, and physical symptoms outside of sessions (Pitre, Sajnani & Johnson, 2015). Though this study is limited in that it is a case study of one child, it provides a field example of a practitioner bringing a client in and out of play and closer to the subject material using dimensionalization and varielation and seeing observable progress in and outside of sessions over time.

DvT with Children and Adolescents

Though DvT can be practiced individually or with groups, research about DvT with children and adolescents in groups is primarily focused on individual DvT, which impacts the recorded benefits in children compared to adults (Sajnani, Willemsen & Butler, 2023). DvT with children and adolescents has a wide range of studied applications from single, brief sessions for stress reduction to long-term, deep work to address trauma.

DvT has been used with children and adolescents in inpatient settings (Reynolds, 2011). A DvT facilitator in a children's psychiatric inpatient unit used DvT to delve into difficult topics and feelings, explore group dynamics of the residents, play with the power dynamics in the room, and regulate emotion by titrating in and out of high emotions in the play (Reynolds, 2011).

One school-based program successfully used short-form (ten- to twenty-minute) DvT sessions to reduce stress of students without keeping them out of the classroom for too long (Pitre, Mayor & Johnson, 2016). Another school-based program in 2019 used spontaneous moments of DvT style play as an intervention for students in the milieu of an elementary school (Webb, 2019). By observing the needs of individual students and creatively responding in the moment with connection and small bits of play, practitioners helped the students manage their

stress enough to get back into the classroom and work towards more academic success (Webb, 2019).

Discussion

An abundance of literature supports the use of CBT, ERP, and/or medication as treatment for OCD in children and adolescents. The field lacks adequate exploration into how to support those who do not respond to treatment at all, or who do respond but without full remission. Youth with OCD are highly likely to have comorbidities that add emotional, medical, or cognitive barriers to the standard treatment methods available. Given the many barriers to remission for children and adolescents with OCD, options for alternative or supplemental therapy need to be researched and offered to youth. Drama therapy, specifically DvT, could be a useful option for pediatric OCD because of its theoretical connection to OCD symptoms, its specific interventions, and its accessibility.

Instability theory posits that individuals who seek static equilibrium will be unable to achieve it, but those who strive for dynamic equilibrium will be able to adapt to their surroundings and tolerate the world around them. Through a DvT lens, individuals with OCD could be conceptualized as seeking static equilibrium. Compulsions are used as an attempt to exert control over the world around them, whether based in rationality or not. Individuals with OCD experience relief only after feeling some level of static equilibrium, reinforcing the compulsion. However, because the static equilibrium is temporary if not an illusion, the distress returns as an obsession and/or urge for a compulsion. Intolerance of uncertainty and a need for perfection and order fall into instability theory as a desire for static equilibrium. DvT would help children and adolescents strive instead for dynamic equilibrium, coping with the chaos and uncertainty of the world and giving up the desperation for unobtainable control.

Interventions

Though research is limited, DvT-style improvisational play could itself be a useful practice for children and adolescents with OCD. Versluys (2017) found that people with OCD were less playful than those without OCD and suggested that while there is no known causal relationship between OCD and lower playfulness, the correlation is enough to consider studying whether interventions to increase playfulness would also help alleviate symptoms. Play therapy, using similar approaches to DvT, has been successfully used alongside CBT to support children with OCD (Gold-Steinberg & Logan, 1999; Myrick & Green, 2012). In nonclinical populations, improvisational play helped people break rigid thought patterns and think more flexibly (Lewis & Levatt, 2013). Improvisation also helped nonclinical populations improve quality of life and increase tolerance of uncertainty (Felsman, Gunawardena & Seifert, 2020). While play itself could help lay the groundwork for change, specific interventions by DvT practitioners could more directly target OCD symptoms and related experiences.

DvT interventions provide exposure to instability by practicing what it feels like to break repeating forms. TB-DvT is based on and aligned with exposure therapy principles. A core component of DvT is being in relation to another. The DvT playspace is made of at least two people, constantly influencing one another. Because people are unpredictable and irrational, being in relationship with others is a state of instability (Johnson, 2013). The playor can use the instability of relationship within the microcosm of the playspace to prepare the player for instability in real life. As the player seeks static equilibrium through repeating forms, the playor can help the player deviate from these forms through varielation and gradually expand the player's window of tolerance.

DvT practitioners can also help children and adolescents separate what is imagined from what is real through dimensionalization. In an obsession, the feelings are real even if the thought is untrue or disproportionate to reality. The imagined risk of not performing a compulsion is not the same as a true risk, nor is the imagined control that comes from completing a compulsion the same as true control. Part of DvT is separating real and not real through dimensionalization. To enter the Playspace, the players and playor must all agree that what occurs is not real, even though the emotions are completely real and fully felt (Dintino et al., 2015). The skill of differentiating between fiction and reality despite the very real feelings present in both could translate from DvT play to obsessions and compulsions in daily life, especially alongside CBT which would help target the specific thoughts and behaviors.

A child with a fear that a natural disaster will happen if they do not perform a specific bedtime ritual does not separate the prediction of a future event (imaginal) from the actual future (reality). For this child, a DvT practitioner could explore in session what it feels like to break away from ritual or could play out natural disasters, starting with something more absurd and distant from the child's fear and moving toward something that is more grounded in the child's obsession using varielation. Through dimensionalization, this child may begin to tolerate the discomfort and differentiate their fear from reality. In concurrent or subsequent CBT/ ERP sessions, the therapist can then support the child and family in breaking these rituals in real life, challenging distorted thinking, and intentionally framing intrusive thinking as a passing thought rather than an accurate portrayal of reality.

DvT could provide a space to resist compulsions contained within the safety of play before doing so in the real world. For example, a child with contamination fears who needs to wash their hands after touching a surface in public places would in ERP work to reduce

handwashing in these circumstances. However, there is a real risk in ERP - though disproportionate to the imagined risk - that illness could occur after touching a contaminated surface and not washing their hands. For a child who is initially unable to endure that small risk, the playspace offers an even more scaffolded version of this exposure within the containment of DvT play, which includes an agreed-upon restraint from harm and distinction from reality. There could be an imagined doorknob, imagined contamination, and imagined worst- or best-case outcomes that the child can experience before building up to touching a doorknob without handwashing in real life using ERP.

Many children and adolescents may experience intense shame regarding obsessions related to taboo topics (Laving et al., 2023). The playspace can offer non-judgmental containment for dangerous or taboo thoughts or impulses. A person could also play out acting on impulses or leaning into intrusive thoughts. An adolescent with OCD who has recurrent intrusive disturbing images and urges for self-harm and a fear they might act on these images could use CBT and ERP-based approaches to reframe their attitudes about their intrusive thoughts to be more adaptive and develop skills to resist self-harm urges. Alongside CBT, the adolescent could use DvT to engage with these intrusive images in play and address any related shame. As the adolescent explores these images and impulses within the safety of play, the playor can offer containment and acceptance by collaborating and engaging in images that the adolescent would initially think are unplayable. This would allow the adolescent to begin changing their attitudes toward the intrusive images and decrease their perceived significance and impairment. It would give the adolescent a space of acceptance to contrast the out casting and shame from social stigma.

DvT enables the therapist to support the client through exposure, regardless of location or practicality, by working alongside them in the playspace. While an ERP therapist can practice resisting some compulsions in therapy and can give clients skills to resist responding to a trigger at home, a DvT practitioner could use the playspace to enact the trigger and toleration of resisting a compulsion, even in situations where doing so in ERP would be impractical because of safety or logistics. People with OCD have been observed having an emotional and physiological response to virtual triggers for obsessions and compulsions, even when the participant was fully aware they were not real (van Bennekom et al., 2021). Thus, working through this real emotional response within the relative safety of the playspace and support of the playor could be a good way to use the guiding principles of exposure therapy without needing to visit every location where an obsession or compulsion is likely to occur or leaving the child or adolescent to do it on their own or with caregivers for the first time without having practiced surviving that experience.

DvT can support children and adolescents with OCD by focusing on their overall experience including their intersecting identities, personal interests, relationships, and other mental health challenges or trauma. Someone may use DvT to explore the impact their OCD has had on their family system, as was done with young children whose experiences of trauma impacted their roles within the family (Martinez, 2018). Someone else may explore the experience of stigma and misconceptions about OCD, a widely misunderstood disorder. DvT has been used as a tool to explore nuances within the experience of social rejection, isolation, and loneliness (Fried & Zahavi, 2023). A child or adolescent experiencing disconnection from peers due to OCD symptoms could benefit from targeting symptoms using ERP while addressing their social identity in the Playspace. For some, DvT could delve into what it is like to have comorbid

disorders such as anxiety, depression, or restrictive eating. It could help someone solidify and expand salient identities or roles outside of the sick one to allow more room for growth.

Mental health practitioners have a responsibility to consider the impact power, privilege, and oppression have on the experiences of individuals and the role healthcare fields have played in furthering social disparities and to include a social justice lens in providing care. DvT can play with the impact society has on an individual's OCD because of the reversibility and ability to deconstruct or alter power dynamics within the play. In the playspace, the child can hold the power and openly express what it is like to not hold the power. Even in lighthearted play, and despite the fact that in reality the practitioner does still hold the power, players have the opportunity to explore the power dynamics that impact their everyday lives and work through breaking repeating forms in the play to be able to do so in real life as well.

Accessibility

OCD has high levels of comorbidity with other disorders, which can include mobility limitations and cognitive deficits. In those with PANDAS/PANS, cognition and mobility may vary drastically from one week to the next. This requires treatment to be not only adaptive to an individual's needs but adaptable from one minute to the next. DvT practitioners, embracing dynamic equilibrium, regularly modulate across developmental stages of play and can continually reshape the play to fit where the participant is in that moment.

Omens (2014) wrote about working with medically compromised children in a hospital setting where Omens was able to both adapt to the mobility needs of clients and play with the trauma their bodies have endured and the medical challenges they face. Similarly, Johnson (1986) described using DvT with older adults who used wheelchairs and found that the participants were able to play with their experience of aging and mobility restrictions. DvT is set

up to work with a wide range of physical and cognitive abilities and has been researched in young children, teenagers, adults, people with schizophrenia, people with substance use, people with Alzheimer's or dementia, and many other populations with widely varying degrees of cognitive functioning (Sajnani, Willemsen & Butler, 2023). DvT offers adaptability and embraces the unique and nuanced experiences of each individual.

Currently, the best option offered to very young children with OCD is a family-orientated approach, which may or may not include a direct intervention for the child depending on their cognitive capability of engaging with CBT. Incorporating DvT into treatment could empower the child with a more active role in treatment even at a young age. In the DvT playspace, the child could build a tolerance to instability through gradual exposure and play with their fears while building differentiation between fiction and reality. Meanwhile, caregivers could engage in parent training or CBT to receive psychoeducation and support in reducing accommodations at home for their child's OCD.

Limitations

CBT and ERP for pediatric OCD are well studied, but the field still has limitations. The majority of studies on children with OCD rely on reports from caregivers, who can only measure changes in visible behaviors, not the subjective internal experience of the individuals with OCD. Just because someone stops performing certain behavioral compulsions does not mean they have decreased their obsessive thoughts or thought compulsions. Little research attempts to study treatment in very young children and most of the existing research attempts to exclude youth with comorbid mental health conditions or with autoimmune-influenced OCD (Freeman et al., 2018). While this helps simplify and clarify the data, it decreases the transferability to the majority of youth with OCD, who are more likely to have a comorbid condition than not.

Research is severely lacking on the practice of DvT. The vast majority of published DvT research articles are qualitative case studies written by DvT practitioners. Instability theory lacks rigorous literature supporting it, and there are no standardized measurements of static or dynamic equilibrium to test. Much more empirical data is needed to determine efficacy and mechanisms of change in DvT. No research currently exists that examines DvT with OCD, and it is currently not recommended as a treatment for OCD because CBT and medication are well studied and effective (Johnson & Pitre, 2021). Considering this, DvT should not be the primary treatment offered to this population due to ethical concerns. However, it could serve as a supplemental treatment method or an alternative option for those not fully benefiting from standard treatment methods.

While in theory a combined DvT and ERP could be a viable treatment option for children and adolescents with OCD, DvT is currently inaccessible to much of the population. Few locations in the United States have DvT practitioners at all, and even in these locations there are a limited number of clinicians. This makes the cost of DvT unreachable for the majority of the population, especially when including cost of travel and considering that DvT is currently unlikely to be covered by health insurance. To make DvT more accessible to the population, training needs to be more widely available to clinicians and awareness should be brought to clinicians who may be interested in this type of treatment that it exists. On top of having more clinicians trained in DvT available, DvT could become more accessible by being covered by insurance. For this to happen, more thorough research must be conducted to allow for confidence by both providers and insurance agencies that DvT is an effective practice.

Conclusion

While more research is needed to determine efficacy, DvT alongside other treatment methods has the potential to provide enormous support for youth with OCD. With further research, DvT could become more available to those who would benefit from it with increased referrals from mental health care providers, coverage from insurance companies, and new practitioners. A mixed methods study of randomized groups of children and adolescents who receive standard treatment alone or standard treatment with DvT that measures symptoms by both a well-established qualitative measure such as the CY-BOCS and qualitative interviews of the participants, practitioners, and caregivers could establish whether DvT is a viable option as a supplemental treatment method. Further studies could look into the specific mechanisms of change, whether group or individual DvT is more appropriate for this population, and who would be most likely to benefit from DvT supplementing standard treatment.

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: Laura L. Wood