Intensive Cognitive Behavioral Therapy for Pediatric Obsessive–Compulsive Disorder: A Treatment Protocol for Mental Health Providers

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The authors describe a protocol for intensive cognitive behavioral therapy (I-CBT) for children and adolescents with obsessive–compulsive disorder (OCD). After a review of pediatric OCD and efficacious treatments, the rationale for an intensive approach to treatment is provided along with findings in the extant literature. Subsequently, a session by session outline of I-CBT for pediatric OCD is provided. Finally, a case example of this treatment approach is discussed.

Keywords: obsessive–compulsive disorder (OCD), intensive cognitive–behavioral therapy (CBT), treatment manual, children, exposure and response prevention

Obsessive–compulsive disorder (OCD) occurs more commonly among children and adolescents than previously believed, with point prevalence rates between 1% and 4% (Douglass, Moffitt, Dar, McGee, & Silva, 1995; Flamant et al., 1988; Zohar, 1999). Pediatric OCD is associated with pervasive impairments in children’s familial, academic, and social functioning (Koran, Thienemann, & Davenport, 1996; Piacentini, Bergman, Keller, & McCracken, 2003). If untreated, pediatric OCD tends to persist into adulthood (Thomsen & Mikkelsen, 1995) and is associated with long-term negative outcomes, such as socially avoidant behaviors and reduced social functioning (Thomsen, 1994).

As in adults, pediatric OCD is characterized by recurrent thoughts and/or repetitive behaviors that result in significant distress and impaired functioning (American Psychiatric Association, 2000). Obsessions are persistent and intrusive thoughts, ideas, impulses, or images that result in anxiety. Compulsions are repetitive behaviors or mental acts that typically function to reduce or prevent anxiety, often in response to an obsessive thought. The presentation of pediatric OCD is heterogeneous, with common obsessions including fears of contamination (e.g., dirt, germs); fears of harm caused to oneself or others; a need for symmetry, exactness, or order; and religious fears (Swedo, Rapoport, Leonard, Lenane, & Cheslow, 1989). Common rituals and compulsive behaviors include decontamination (e.g., washing, cleaning, bathing); repetition of routines; order seeking (e.g., arranging, checking); confessing, praying, and seeking reassurance; touching, tapping, or rubbing; and compulsive avoidance (Scahill et al., 2003; Swedo et al., 1989). Children are likely to endorse multiple symptoms (Flament et al., 1988) yet may not recognize their obsessions and compulsions as bizarre or excessive (American Academy of Child and Adolescent Psychiatry [AACAP], 1998).

Efficacious Treatments

Cognitive–behavioral therapy (CBT) and pharmacotherapy with serotonin reuptake inhibitors (SRIs) have emerged as first-line interventions for pediatric OCD (see Lewin, Storch, Adkins, Murphy, & Geffken, 2005, for a re-
Clinically significant reductions in pediatric OCD have been documented in randomized controlled trials of SRIs (see Geller et al., 2003, for a review). Likewise, the efficacy of CBT (with exposure and response prevention [E/RP]) has been demonstrated in numerous open trials (Benazon, Ager, & Rosenberg, 2002; Franklin et al., 1998; March, Mülle, & Herbel, 1994; Piacentini, Bergman, Jacobs, McCracken, & Kretchman, 2002; Scahill, Vitulano, Brenner, Lynch, & King, 1996; Thienemann, Martin, Cregger, Thompson, & Dyer-Friedman, 2001) and three controlled trials (Barrett, Healy-Farrell, & March, 2004; de Haan, Hoogduin, Buitelaar, & Keijsers, 1998; Pediatric OCD Treatment Study Team [POTS], 2004). Results from a recent multisite, randomized, placebo-controlled trial indicate that pediatric OCD patients treated with CBT alone or CBT with concomitant sertraline showed significantly more improvement than those taking sertraline or placebo alone (POTS, 2004). In a second comparative randomized trial, de Hann et al. (1998) found CBT to be superior to clomipramine in children ages 8–18 years.

### Barriers to Treatment

Although a recent meta-analysis of 521 pediatric OCD patients found lower rates of chronic OCD than previously estimated (M = 41%; range 13%–87%), these data suggest that pediatric OCD is not transient (Stewart et al., 2004). Further, data from both psychopharmacological treatments and CBT suggest that many patients do not demonstrate a clinically significant response to treatment. For example, the treatment response rate in the extant CBT trials ranged from 57% to 88% (Barrett et al., 2004; Benazon et al., 2002; Bolton, Luckie, & Steinberg, 1995; Franklin et al., 1998; Piacentini et al., 2002). Similarly, data from recent pharmacological trials have reported response rates ranging from 30% to 74% (Cook et al., 2001; DeVeaugh-Geiss, Moroz, Biederman, & Cantwell, 1992; Geller et al., 2003; Grados, Scahill, & Riddle, 1999; Liebowitz et al., 2002). Given that between 12% and 70% of patients apparently fail to benefit from these therapies, interventions suitable for pediatric patients with treatment-refractory OCD must be identified (Storch & Geffken, 2004).

Aside from patients who do not benefit maximally from existing therapies, a separate cohort of youth never receive appropriate treatment (Flament et al., 1988; Heyman et al., 2001). Jenike (1989, p. 539) described OCD as a “hidden epidemic” because of the underdiagnosis and undertreatment resulting from patients’ lack of access to treatment, health care providers’ lack of familiarity with efficacious treatments, and patient secrecy. Although the POTS team reported that the initial treatment of pediatric OCD should be CBT alone or CBT with concurrent selective serotonin reuptake inhibitor (SSRI) therapy, most youth with OCD receive only SRI monotherapy or SRI with concurrent atypical neuroleptic medications (POTS, 2004). The lack of professionals trained in CBT for OCD has been identified as among the greatest barriers to successful treatment (AACAP, 1998). Limited access to specialists familiar with empirically supported treatments (e.g., CBT with E/RP) may result in the prescription of pharmacotherapy alone and/or other psychotherapies that have not been demonstrated as efficacious (e.g., play therapy, psychoanalytic therapy, insight-oriented therapy). In fact, fewer than 33% of clinicians participating in a national survey of 79 clinicians treating pediatric OCD reported using E/RP (or similar techniques), despite rating CBT as a favorable approach to treatment (Valderhaug, Gunnar Gøtestam, & Larsson, 2004). Additionally, Flament et al. (1988) found that only 20% of children with OCD were receiving mental health services, and Heyman et al. (2001) reported than only 36% of the families of children with OCD had consulted their general practitioner. Further, only 12% of these children were referred for specialized mental health services for OCD.

### Overcoming Treatment Limitations

Medication augmentation (e.g., with dopamine antagonists and benzodiazepines) has been suggested as one option for pediatric cases that are unresponsive to CBT and conventional trials of SRIs (Grados & Riddle, 2001; Dougherty, Rauch, & Jenike, 2002). Unlike in the adult literature, however, there are few data supporting augmentation strategies for pediatric OCD.
Intensive CBT (I-CBT) offers another option for treatment-refractory pediatric OCD. I-CBT techniques are similar to traditional CBT with E/RP. However, the frequency and duration of the sessions are increased (i.e., from weekly 50-min sessions to daily 90-min sessions) to allow for extended E/RP. Research suggests that prolonged, continuous exposures are superior to shorter, intermittent exposures (Rabavilas, Boulougouris, & Stefanis, 1976). I-CBT sessions are held daily on weekdays for approximately 3 to 4 weeks. Kozak and Foa (1997) hypothesized that although weekly sessions might be adequate for patients with mild OCD symptoms, patients with severe OCD might benefit from daily CBT sessions to quickly target problem areas and result in relatively rapid improvements. In addition to patients with refractory OCD, patients without local access to mental health professionals who are trained in empirically grounded OCD treatment would likely benefit from this program (Storch, Gelfand, Geffken, & Goodman, 2003). Finally, the succinct, focused, directive approach of an intensive CBT program may enhance the child’s motivation by serving as the primary focus for several weeks, unlike in standard weekly treatment (Foa & Steketee, 1987). In addition, Franklin, Tolin, March, and Foa (2001) speculated that the intensive approach to OCD treatment may be better suited for children with severe symptoms or significant functional impairments (e.g., not going to school).

Research has supported the use of I-CBT as an effective treatment for refractory OCD. In one open trial of I-CBT for refractory pediatric OCD, all five children who participated were treatment responders and showed significant decreases in OCD symptomatology (Storch & Geffken, 2004). Similarly, three case reports have documented reductions in OCD symptomatology in youth (Fernandez, Storch, Lewin, Murphy, & Geffken, in press; Franklin et al., 2001; Storch et al., 2004). Franklin et al. (1998) examined the outcomes of seven youths who received 1 month of intensive treatment and seven youths who received 4 months of weekly treatment. Results indicated that both approaches were associated with children’s Yale–Brown Obsessive Compulsive Scale (Scahill et al., 1997) reductions of 70% and 64% at post-treatment and reductions of 58% and 67% at a 9-month follow-up. However, participants were not randomly assigned to treatment group, and inferential tests were not conducted to examine group differences. In a randomized, controlled study in adults, patients in the intensive therapy group were significantly more likely to reach recovery statutes (85%) than those receiving twice-weekly treatment (55%; Abramowitz, Foa, & Franklin, 2003). Although preliminary data support the potential efficacy of an intensive approach, the literature has been hindered in that no comprehensive treatment guidelines have been reported for youth. Thus, our aim is to describe the intensive treatment model used in our clinic.

Intensive Pediatric OCD Treatment Program

First Meeting: Assessment and Orientation to Treatment (90–120 Min)

Diagnostic assessment. Prior to beginning treatment, a clinical assessment with the child and family is conducted. Goals of this initial session include information gathering and family psychoeducation. Although most patients referred for I-CBT for OCD have been previously diagnosed with OCD, diagnostic criteria should be verified. In addition, the child is screened for common comorbid conditions, as these co-occurring conditions may relate to treatment resistance (March & Mulle, 1998) and suggest the need for ancillary treatment (e.g., parent behavioral training) concurrent to the I-CBT protocol. Further, patients are screened for severe psychopathology, such as thought disorder, that would contraindicate CBT for OCD. The use of a structured interview for OCD and other psychiatric disorders (e.g., Anxiety Disorders Interview Schedule for Children; Silverman & Albano, 1996; or Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children—Present and Lifetime Version; Kaufman et al., 1997) is recommended.

Initial education. After the diagnosis is confirmed, pertinent terminology regarding OCD is reviewed with the child and family. In particular, the distinction between obsessions and compulsions is described at a developmentally appropriate level. For example, obsessions can be described to a child as “thoughts or feelings that are unpleasant and hard to keep out of your mind; they can make you feel worried,
upset or nervous—you might not understand why these thoughts happen.” Compulsions or rituals can be explained as

things you can do to make yourself less worried when you have obsessive thoughts; you might feel a need to do something over and over again until you feel better or it seems “just right”: if you don’t do the compulsion or ritual (sometimes more than once), you feel as though your worry will get worse and worse.

Including examples based on the child’s specific symptoms is helpful with making the distinction between obsessions and compulsions. The patient then reviews the definitions in his or her own words and provides his or her own examples. The use of metaphors or nicknames may be helpful in educating younger children about OCD (March & Mulle, 1998).

Next, obtain information about specific obsessions and rituals (e.g., context, triggers, frequency, consequences of not completing rituals, and avoidance). Parents should be involved in this process, because children (especially those who are aware of the bizarre nature of their obsessive thinking and rituals) may attempt to minimize or neglect to disclose OCD symptoms. Avoidance patterns that maintain the child’s OCD are also assessed. For example, children may avoid stimuli that elicit obsessive thoughts, which, in turn, maintain the child’s avoidance via negative reinforcement. This information-gathering process also includes obtaining a history of previous treatment (e.g., behavioral therapy, medication) and family psychiatric history.

Developmental considerations. Throughout the assessment session, child developmental characteristics are assessed. In particular, knowledge of a child’s age and cognitive functioning and insight into the nature of his or her OCD are paramount in determining the direction of treatment, as introduction of cognitive components of therapy depends on the child’s developmental level and insight. Younger children and those with impaired cognitive functioning receive fewer and less sophisticated cognitive components to treatment. Additionally, these patients require more parental involvement for maximal success with behavioral interventions (Geller, 1998).

The child’s degree of insight into his or her condition, distress, history of resistance to obsessions and compulsions, and willingness to participate in therapy must also be assessed. Children who are not distressed by their OCD and/or do not view their symptoms as bizarre or unusual may be less motivated to participate in E/RP. Further, younger children (who are more often present oriented) may not tolerate well the short-term distress and anxiety of E/RP treatment exercises, which are necessary to achieve future reduction of OCD symptoms (Piacentini, 1999). A child’s motivation to participate in treatment and willingness to resist rituals may determine whether contingency management strategies (e.g., rewards for participation in E/RP) are necessary.

Evaluating symptom severity. The therapist should assess symptom severity at pretreatment and throughout the intervention to evaluate the efficacy of the program and the necessity of protocol adjustments. The Children’s Yale–Brown Obsessive Compulsive Scale (CY-BOCS; Scahill et al., 1997) is a 10-item clinician-rated inventory of obsession and compulsion severity. The National Institute of Mental Health Global Obsessive–Compulsive Scale (Goodman & Price, 1992) and the Clinical Global Improvement Scale (Guy, 1976) provide other mechanisms for rating the severity and improvement of OCD symptoms. The Children’s Depression Inventory (Kovacs, 1992), the Multidimensional Anxiety Scale for Children (March, Parker, Sullivan, Stallings, & Conners, 1997), and the Child Behavior Checklist (Achenbach, 1991) can also be used to assess co-occurring depression, anxiety, and externalizing disorders.

Providing an outline and rationale for treatment. At the conclusion of the initial evaluation, the child and his or her family are provided with an overview of the I-CBT protocol and procedures. Providing a session schedule with space for recording future homework assignments is often helpful. Practitioners emphasize the importance (and requirement) of family participation in the intensive treatment process, both inside and outside of therapy sessions (Barrett et al., 2004; Knox, Albano, & Barlow, 1996). In addition, general education about CBT for OCD is provided to the family. Anxiety can be normalized as an integral part of human existence (e.g., through an example of an anxious caveman hiding from a saber-toothed tiger to save his life). Subsequently, explain to the patient that sometimes anxiety and worries do not make sense and are unhelp-
ful (as is the case with the child’s obsessions; provide pertinent examples). The family is told that compulsions and rituals serve to reduce anxiety in the short term and make the child feel better, albeit temporarily. The crux of this explanation is describing rituals and avoidance as (a) ineffective at reducing anxiety in the long term, (b) interfering with normal functioning, and (c) preventing the child from developing more effective strategies for coping with anxiety. For example, because compulsive behaviors and rituals actually function to reduce anxiety in the short term, these behaviors are more likely to be used the next time an obsessive thought occurs (Franklin & Foa, 2002). Therefore, engaging in compulsions actually increases the future likelihood of compulsive behavior and inhibits the child from learning other ways of managing anxiety.

Finally, a brief overview of the upcoming treatment sessions is provided. The therapist addresses expectations for treatment and reminds the family that CBT has been demonstrated as effective in extensive research with both adults and children who suffer from OCD. However, the family is also informed that I-CBT is not the “magic bullet” and that successful treatment does not necessarily equate to the elimination of all OCD symptoms. Rather, successful treatment results in significantly decreased distress and interference from distressing thoughts and behaviors associated with OCD as well as the development of skills to eliminate or reduce compulsive and ritualistic behaviors. Remind the family that this therapy focuses on training a set of skills for treating OCD and that an important part of this treatment is learning to independently implement the treatment (e.g., “be your own therapist”) if future obsessions or compulsions develop. Explain to the family that supplementary “booster” sessions of CBT may be necessary, even after successful treatment. However, the result obtained from therapy is typically associated with the effort the family invests—the patients who do the best tend to put forth 150% effort during session and homework exercises.

Session 1: Development of a Fear Hierarchy (90 Min)

At the beginning of the first treatment session, review the child’s and parents’ understanding of the previous meeting. This may best be achieved through an interactive process in which the child is asked to define obsessions and compulsions and the parent is asked to review how they are related. Subsequently, instruct the patient and family to rate anxiety on the Subjective Units of Distress Scale (SUDS; March & Mulle, 1998). On the basis of information obtained in the assessment, the therapist assists the family in developing a list of stimuli and situations that would elicit a range of symptoms, from mild discomfort to incapacitating anxiety, in the child (if compensatory compulsions or rituals are prevented) and rate how anxiety provoking, on a scale of 0 (no anxiety) to 100 (extreme anxiety), approaching each situation would be. The child should be encouraged to use the entire range of the SUDS in development of a fear hierarchy; if clusters of rating develop, the child can be asked to rank order his or her anxiety associated with situations with similar or identical SUDS ratings. The hierarchy should consist of concrete situations the patient avoids or for which the patient would find it difficult to inhibit compensatory overt or mental rituals (Lewin et al., 2005).

The utility of the hierarchy is explained in the context of E/RP, which involves gradually exposing patients to anxiety-provoking situations while they refrain from engagement in compulsions or ritualistic behaviors (Meyer, 1966). This results in habituation to anxiety, as the individual’s anxiety attenuates without reliance on compensatory ritualistic behavior. Further, E/RP provides the patient with objective experiences to contradict the inaccurate expectations that motivate rituals (Foa & Kozak, 1996). Accordingly, the therapist describes hierarchy-based E/RP. Typically, the patient starts at a minimally to moderately distressing situation and progresses up the hierarchy during subsequent exposures. The analogy of climbing a ladder or staircase may be helpful: starting at the bottom rung and working to the top. It is also helpful to advise patients that overcoming lower rated anxiety-provoking steps or rungs on their fear hierarchy often results in decreased difficulties with situations described as more fearful.

During the first session, an in vivo exposure exercise is conducted. The therapist identifies a situation with a low SUDS rating to provide the child with maximal opportunities for success.
Prior to beginning, the therapist should prepare the family for the expected result. For example, one might say,

At first, you might feel very worried. However, if you stop yourself from doing a ritual, your anxiety will start to decrease by itself. In fact, the next time you encounter [the feared stimulus], your anxiety might be a little less intense and will go away faster. Eventually, you might not be bothered at all by [the feared stimulus].

Although the patient will likely be anxious, therapists should disclose exactly what will be done in each E/RP exercise to build trust. Further, they should remind the child that the E/RP makes each successive exposure less difficult. Graphical representations (e.g., graphical plotting of anxiety vs. time) may be helpful. During the exercise, the child is exposed to the anxiety-provoking situation, and SUDS ratings are obtained throughout the exposure in frequent intervals. The child remains in the exposure, refraining from any compulsive behaviors, until anxiety decreases to minimal (SUDS scores less than 20 can serve as a guideline, but 60%–80% reduction is usually sufficient). Repeat the exposure as many times as feasible or until the initial anxiety level remains consistently low; this repetition functions both (a) as a model for homework exercises and (b) to illustrate the relative reduction in anxiety over successive exposures. It is important that the first exposure exercise result positively. Even if the child participates in the exercise but fails to inhibit all compulsions, provide praise for successive approximations of the desired behavior while continuing to assert the need for inhibiting all rituals. All exposures are repeated until response prevention is maintained.

Prior to ending the session, review the child’s and parents’ understanding of E/RP and its application. Using the hierarchy as a guide, assign approximately 1 to 2 hr of homework for the family to complete prior to the next session. Again, it is important to choose assignments with which the child is likely to be successful, and specific exposures should be repeated multiple times successively to facilitate both (a) habituation to feared stimuli and (b) more rapid attenuation of distress. The I-CBT therapist is directive and explains assignments explicitly. For example, the therapist may insist that certain rituals be abstained from completely (e.g., reassurance seeking, multiple hand washes). Parents should be reminded that they are active participants in the treatment and should be present as coaches during the homework. Additionally, parents can model therapist behaviors from in-session E/RP exercises (e.g., asking the child for SUDS ratings, monitoring the duration of each exposure). All in-session E/RP exercises are repeated as part of the homework.

Sessions 2 Through 4: E/RP

From this session forward, commence with a comprehensive review of homework from the preceding session, which reiterates the importance of homework exercises in the I-CBT protocol. Specifically, verify that the homework exposures were completed and ascertain the duration of the exercises and SUDS ratings for each completed assignment. Additionally, assess whether the child experienced habituation to anxiety during assignments (e.g., decreased SUDS ratings, more rapid attenuation of distress over successive exposures). If diminished anxiety during homework is reported, reinforce that the reduction in distress was due to the prolonged exposure. However, regardless of SUDS ratings, praise the child for participating in the difficult, anxiety-provoking procedure. Continue to encourage future participation in E/RP exercises, reminding the child that overt reductions in anxiety may take several exposures. Also, review the child’s understanding of the rationale for the E/RP procedure if necessary and reiterate that behavioral tasks conducted outside of session are the impetus for psychological change. Specifically, participation in assigned homework (and, at best, additional E/RP exercises) drives the reduction of OCD symptoms—significant improvement is highly unlikely on the basis of participation during in-session E/RP exercises alone.

Stekette, Shapiro, and Van Noppen (1999) instructed therapists to address failure to complete homework assignments. This is especially important in the I-CBT protocol because of the short duration of therapy and high frequency of sessions—it is necessary to ascend the patient’s fear hierarchy more rapidly in I-CBT as compared with a weekly session. If the patient does not appear to have participated maximally in the assigned exercises, identify barriers to homework completion (Stekette et al., 1999). For example, identify whether poor compliance with homework was due to high anxiety, low
motivation, suboptimal parental involvement, or a combination of these and other factors. If high anxiety is suspected, begin with stimuli lower on the patient’s fear hierarchy and/or commence with the problematic stimuli in the current session. Nevertheless, emphasize that the exercise will not be avoided; the feared stimuli must be confronted for improvement in OCD to occur. If the homework was not completed because of poor planning or organization by the patient or family, discuss concrete details for implementing assignments outside of sessions (e.g., plan locations and times for therapeutic exercises). Instruct the parents to maintain a more involved role in organizing and encouraging the child. Finally, reiterate the importance of homework completion.

In subsequent sessions, in vivo E/RP exercises should be continued on the basis of the patient’s hierarchy. By the second session, actively involve the parent in the process of identifying appropriate exposure exercises and leading E/RP in session. Depending on the child’s age and developmental level, it may also be appropriate to involve the patient in developing E/RP procedures. By the third session, have the family model how they conduct E/RP exercises outside of session. The short duration of the I-CBT program necessitates that homework procedures are done correctly—frequent checks on E/RP integrity are paramount. Finally, by the third or fourth session, the therapist should identify a tentative schedule of E/RP exercises based on SUDS ratings and the child and guardian’s mastery of prior assignments. At the conclusion of each I-CBT session, develop additional E/RP assignments for homework. In addition, each exposure session completed in session should be assigned as part of the homework assignment. Ensure that the homework exercises are clearly understood and written down by the family.

**Sessions 5 Through 13: Introduce Cognitive Interventions and Continue With E/RP**

The remaining I-CBT sessions emulate the prior sessions: Homework is reviewed, in-session E/RP exercises are conducted (items of increasing difficulty on the fear hierarchy are attempted), and out-of-session exposures are assigned. The therapist continues to direct the parents and patient to identify and design E/RP procedures to prepare them for continued treatment following I-CBT. Additionally, the therapist ensures that the child maintains adherence to past directives. For example, if a child was told to discontinue all checking of locks in Session 1, he or she should continue to abstain from this behavior as well as similar behaviors with the same function (e.g., asking the parent whether the door is locked).

Typically, in the fifth session, cognitive coping strategies for obsessive thinking are introduced. This treatment approach is tailored to the child’s developmental level. For example, for young children, March and Mulle (1998) described the training of constructive self-talk. This strategy involves helping the child to change his or her way of thinking and talking about OCD. For example, children with OCD often present with thoughts of being powerless against their OCD symptoms, are pessimistic that improvement can occur, and are self-critical. The March and Mulle (1998) procedure involves teaching children to externalize and blame the OCD (not themselves) and bolstering their self-efficacy via supportive and empowering self-statements such as, “I can handle this fear; I’m going to fight and beat my OCD; go away, OCD.” Assisting the child to develop a nickname for OCD may facilitate some of these elementary cognitive coping skills (March & Mulle, 1998). Another basic cognitive skill is assisting the child to appropriately label feelings such as anxiety. When the child is able to recognize distressing times, he or she can then be instructed to use cognitive interventions such as the aforementioned self-statements. For older children, a greater emphasis is placed on cognitive restructuring of obsessive thinking. Assist the child to identify inappropriate thoughts. Next, assist the child to label obsessive thoughts as unrealistic products of his or her OCD, to realize the inaccuracy of obsessive thinking, and to develop rational self-statements to challenge faulty assumptions.

Cognitive restructuring techniques are adjunctive to the E/RP exercises in the I-CBT protocol. For example, a child could be instructed to restructure common OCD-related concerns, such as overestimation of responsibility, in the context of refraining from all compulsive safety-checking rituals. Remind patients that cognitive restructuring skills take time to
develop and that practice is required to reattribute and replace obsessive thinking with rational statements. The goal is not for obsessive thinking to disappear but rather for the child to learn how to cope with (e.g., dismiss, restructure) intrusive thoughts. Supplementary strategies are discussed in the section regarding covert rituals.

As before, continue to assign E/RP and cognitive homework exercises, building on the present session and previous assignments. Over successive sessions, the family and child should be increasingly involved in developing E/RP exercises. Finally, if the client completes the hierarchy, demonstrates mastery of E/RP exercises (including abstinence from all rituals), and shows a comprehensive understanding of cognitive interventions, termination of I-CBT can occur early (although it is uncommon, I-CBT can be completed in as few as five or six sessions). In these cases, proceed to the concluding sessions outline (below). Conversely, if progress is being achieved but at a slow rate, consider extending the I-CBT protocol by several days.

Sessions 14 and 15: Concluding I-CBT, Review, and Generalization

The emphasis of the final I-CBT sessions is review of treatment strategies and preparation to generalize treatment to the child’s home environment. Engage the family in identifying possible areas of future difficulty and strategies to apply therapeutic principles to these problems. Remind the family that the E/RP exercises can be applied to any future occurrences of OCD and that intensive, repeated E/RP exercises will likely be necessary.

It is also important to discuss the progress achieved during I-CBT. For example, when children first construct a hierarchy, they often perceive many items as impossible to achieve. Nevertheless, during I-CBT, the children typically master these fears within 2–3 weeks and dramatically improve daily functioning. Emphasize the significance of each accomplishment with the family, highlighting that if the child can master OCD once, he or she possesses the skills to overcome residual symptoms and address new obsessions appropriately. Finally, review the family’s understanding of the treatment principles. Discuss proper application of cognitive restructuring techniques as adjuncts to E/RP exercises. For example, restructuring obsessive thoughts should become more automatic for the child as OCD-related distress and impairment decrease via E/RP. Finally, obtain clinician-rated and patient-rated measures of current symptom severity. Often, it is helpful to discuss significant improvements on these ratings with the family to highlight treatment gains.

Follow-Up

After the I-CBT program is completed, booster sessions of CBT are typically arranged via several different mechanisms, depending on symptom severity at discharge and proximity to trained care. For the majority of clients, a local psychologist trained in CBT is identified as a resource for the clients as they generalize the treatment strategies into their home environment. Our clinic often provides clinical supervision if the practitioner is unfamiliar with CBT for OCD. Even for clients with minimal symptoms after I-CBT, an initial contact session with a local provider is recommended in case of relapse. For clients with minimal to mild symptoms at discharge who have no CBT professionals in their area, weekly telephone contacts with the I-CBT program are prescribed. At times, clients complete I-CBT having made substantial improvements in functioning and reductions in severity of OCD. Nevertheless, moderate symptoms of OCD may persist. For these patients, more intensive follow-up is required following I-CBT. Weekly sessions at the I-CBT program are recommended if the distance is manageable. Alternatively, weekly sessions with a local CBT provider are arranged.

Troubleshooting/Frequent Errors

Child refusal. Child refusal of E/RP assignments may occur because of intense distress. Therefore, beginning with a lower step on the fear hierarchy may be indicated. However, if refusal persists (because of either continued distress or noncompliance), behavior modification procedures can be used in conjunction with E/RP. For example, rewards or tokens can be earned for participation in E/RP exercises (or abstinence from rituals). Response costs can also be used, contingent on ritualization.
Covert rituals only. Children with covert rituals only (i.e., obsessive-type OCD) present special challenges to treatment. Salkovskis (1999) outlined an OCD-specific form of cognitive therapy with adults that may be applied to children. However, it is our experience that younger children have less success with this form of cognitive therapy because of developmental and cognitive limitations. Obsessions and covert rituals are viewed as cognitive distortions that are approached by cognitive restructuring. For example, many obsessions can be inductively reduced to an overvalued sense of responsibility for causing or failing to prevent harm to oneself and others (Salkovskis, 1999). Overall, six central OCD-related belief domains have been identified as important targets of restructuring: (a) exaggerated sense of responsibility, (b) overvalued importance of thoughts, (c) inflated concern about the importance of controlling one’s thoughts, (d) overestimation of threat, (e) intolerance of ambiguity and uncertainty, and (f) perfectionism (Obsessive Compulsive Cognitions Working Group, 1997). Therapy should emphasize constructing and validating alternative, less threatening explanations for intrusive thoughts, images, and doubts rather than focusing on disconfirming negative beliefs (Salkovskis, 1999). If intrusive thoughts are not negatively interpreted, they are less likely to be viewed as significant. Further, Salkovskis (1999) suggested that the patient be encouraged to view his or her obsessional thoughts will never come true (e.g., contracting HIV), the therapist can guarantee that the client will continue to suffer from obsessions if he or she continues ritualistic thinking and behaviors (Salkovskis, 1999).

In addition, children and adolescents with obsessive-type OCD sometimes deny distress or impairment, despite parental reports of OCD-related difficulties (Storch et al., 2005). In these situations, it is often useful to implement a brief motivational intervention (e.g., Miller & Rollnick, 2002) to encourage active participation in treatment before continuing with the I-CBT protocol. Referring to symptoms of OCD as annoying or bothersome rather than impairing or problematic may also promote more active involvement of the patient and encourage his or her desire to be in charge. Finally, enlisting the support of parents to explain how the child’s OCD symptoms negatively affect the family may serve to motivate patients who do not otherwise admit consequences of their symptoms.

Reassurance seeking. The E/RP procedure is designed to force patients to abandon problematic strategies for managing anxiety and consequently adopt more adaptive methods. Nevertheless, patients will attempt to engage in other means for resolving distress. For example, children often attempt to elicit reassurance from the parent or therapist. It is important for the therapist not to fall into this “trap.” Repeatedly providing reassurance to a child with OCD can function to reduce anxiety without allowing for the E/RP procedure to attenuate distress. The therapist should remind the child no more than once, “I am your doctor [therapist, health care provider] and will not let you be harmed. I know this is scary, but nothing bad will happen to you.” No future reassurance should be provided by the I-CBT therapist or the parents. The therapist should label client attempts at reassurance seeking while giving minimal attention (e.g., “That’s reassurance seeking, so I will not answer your question”). Attempts at reassurance are conceptualized to be maintained by social positive reinforcement (e.g., parental attention; Fernandez et al., in press). Therefore, a critical treatment mechanism for reducing reassurance-seeking behaviors is via extinction. Differential reinforcement of other behaviors is implemented instead (Salkovskis, 1999).

Therapist Characteristics

In addition to a strong knowledge of the empirical literature and efficacious treatment protocols, there are several characteristics necessary to be an effective I-CBT therapist for OCD. First, the therapist must ensure that treatment is consistent with the initial description of the procedures (i.e., the client should develop expectations for the therapeutic procedures and anticipate subsequent portions of the protocol; Kozak & Foa, 1997). Unlike therapists for mood disorders or generalized anxiety disorder, whose the objectives for the session typically
include reducing distress, the I-CBT therapist for OCD must derive antecedents that systematically elicit anxiety in his or her patients. Further, the therapist must convince the patient to repetitively endure exposure to these feared situations (without attempting to intervene to attenuate the patient’s distress). This is particularly difficult when one is working with children and their parents. Accordingly, the therapist must establish rapport, with appropriate empathy for the patient’s distress, while firmly asserting the need for the E/RP exercises. If a therapist tolerates a client’s rituals in session, it is doubtful that a patient will be inclined to reframe for compulsions outside of the therapy. Patients and parents are often skeptical of E/RP. Perhaps more than with any other theoretical orientation of psychotherapy, OCD therapists must exhibit expertise and confidence: The therapist must assure families that he or she is an expert and will not assign exercises that risk the client’s safety at any point throughout the treatment. Kozak and Foa (1997) asserted that the therapist must be an “expert coach,” not a “punitive parent”—indecision or extreme rigidity on the part of the therapist can damage credibility of the treatment. Nevertheless, the therapist must be aware of compulsive reassurance-seeking behaviors surrounding treatment exercises that function to reduce the client’s anxiety. Relatedly, the I-CBT therapist for OCD must continuously assess the function of the client’s verbal and nonverbal behaviors (including parent–child interactions).

Case Example

Joey was a 12-year-old Caucasian boy who lived 6 hr from the I-CBT program, in a rural community, with no access to CBT providers. He was referred for I-CBT because of treatment-refractory OCD and major depressive disorder (MDD). Treatment in the previous year included pharmacotherapy (fluoxetine,quetiapine, and aripiprazole), weekly individual and family counseling, and a 12-day stay in a pediatric psychiatric inpatient unit. During the I-CBT program, Joey and his mother were seen for 90-min daily during the regular work week. The family resided in an extended stay hotel near the clinic throughout treatment.

First Meeting

Administration of the Anxiety Disorders Interview Schedule, Child and Parent Versions (ADIS-C/P; Silverman & Albano, 1996) confirmed diagnoses of OCD and MDD. Joey and his mother participated in psychoeducation related to OCD, and Joey spoke openly about his obsessions (primarily religious, morality, afterlife; perfectionistic; and contamination themes) and compulsions (primarily reassurance seeking, questioning, confessing, and hand washing). He obtained a score of 31 on the CY-BOCS (Obsession score = 14, Compulsion score = 17), which indicated severe impairment. We discussed the design and rationale for I-CBT, focusing on the importance of breaking the obsession–compulsion cycle and allowing anxiety to decrease naturally over time. Joey was introduced to a roller-coaster metaphor, in which each hill becomes gradually smaller and less anxiety provoking.

Session 1

The SUDS rating scale was introduced, and Joey participated fully in the construction of a fear hierarchy. Joey participated in an exposure exercise (digging in the dirt) without being allowed to engage in hand washing. For homework, Joey was instructed to refrain from hand washing, except during daily bathing, and his mother was instructed to refrain from reassuring Joey. She was told to label the request as an OCD symptom and refuse to respond.

Sessions 2–4

Joey reported increasing success with his homework over the course of the three sessions. He described “catching himself” when beginning to engage in compulsive behaviors and stopping himself. In-session exposures focused on increasingly difficult contamination exercises (e.g., touching garbage, toilets), as well as talking about anxiety-provoking topics (e.g., sin, morality, the afterlife) without engaging in reassurance seeking.

Sessions 5–10

Joey and his mother reported significant decreases in reassurance seeking and questioning
compulsions but noted that he had begun to apologize excessively. Joey’s mother later noted that he generally changed clothing approximately three to five times per day. Thus, these behaviors were added to Joey’s list of prohibited activities. Sessions involved increasingly cognitive interventions, including the introduction of a boxing match metaphor. I-CBT was conceptualized as a fight against OCD that lasts several rounds, with each attempt to resist compulsive behaviors serving as a punch in the nose of OCD and each failure to resist serving as a punch in Joey’s nose. We also discussed the importance of fighting new symptoms as soon as they appear (e.g., the apologizing) to prevent the symptoms from gaining strength. Homework remained an important focus, and Joey and his mother were praised for their effort in this arena. Homework failures were evaluated through cognitive restructuring, and plans were installed to prevent future slips.

Sessions 11–13

Joey reported improved mood and increased confidence related to his success in fighting the OCD. Despite occasional setbacks, he described feeling 90% better. Joey and his mother noted that reassurance seeking and questioning compulsions had generally disappeared, that Joey was wearing only one outfit per day, and that obsessions had decreased substantially. Joey continued to experience infrequent slips related to apologizing and hand washing, though these behaviors had also markedly decreased. We discussed the importance of continuing to fight the OCD, even under difficult conditions. Joey identified with several role models who continued fighting when they felt like giving up.

Sessions 14–15

We reviewed progress over the course of treatment and praised Joey for reaching the top of his hierarchy. Joey was able to explain treatment methods and rationale as well as identify the gains he had made. After reiterating the importance of Joey continuing to “act as his own therapist” in the future, we explored various possibilities when OCD might “reappear” or become more problematic and brainstormed methods to manage such situations. At termination, Joey’s CY-BOCS score had decreased to 14. Arrangements were made for Joey to continue weekly outpatient therapy with a local treatment provider, whom we supervised by phone.

Summary

As described in the case example above, the fundamental aspects of the I-CBT program involve training in behavioral principles (e.g., exposure, response prevention, extinction), parent training, and cognitive restructuring (when appropriate). The I-CBT program involves 90-min psychotherapy sessions held on consecutive weekdays for approximately 3 weeks. The intensive protocol offers an alternative approach to treating children with OCD who do not adequately respond to conventional medication or psychotherapy protocols. In addition to serving as an alternative approach for treatment-refractory patients, I-CBT may be well suited for children who have significant functional impairments, exhibit severe symptomatology, or do not have access to mental health professionals who are trained in empirically supported therapies for OCD treatment. As the lack of trained mental health providers is cited as a significant treatment barrier to children with OCD, the I-CBT protocol provides a feasible alternative to families residing in areas distant from treatment centers specializing in OCD. Overall, research findings in adults substantiate the use of intensive CBT as an alternative to once-weekly therapy sessions. However, there are no controlled treatment outcome studies of weekly versus intensive sessions in children. Currently, a randomized clinical trial is being conducted at our treatment center, comparing intensive and weekly sessions in pediatric OCD patients. Future directions dictate a need for further controlled studies of I-CBT and other first line treatments of pediatric OCD (e.g., CBT and SSRIs; Lewin et al., 2005).

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