Intensive Treatment for OCD in Children and Teens

Stephen P. H. Whiteside, PhD, ABPP
Julie Dammann MA, LP
Michael Tiede MA, LP

Overview
- Introduction: Why intensive treatment is important
- Day 0: Pre-appointment preparation
- Day 1: Assessment and Education
- Day 2: Getting Started
- Day 3 and 4: Exposures and Parent Coaching
- Day 5: Wrapping up and post-treatment planning
- Conclusions: Future Directions and Questions

Introduction
Why Intensive Treatment is Important

Obsessive-Compulsive Disorder
- Symptoms highly heterogeneous
- Comprised of subtypes
  - Obsessions (sexual, aggressive, religious, somatic) & checking
  - Symmetry, ordering, counting, repeating
  - Contamination obsessions and cleaning compulsions
  - Hoarding (note: likely a separate disorder in DSM5)
- Severe disability associated with condition

OCD in children
- 1 in 200 children and adolescents
- Chronic 80% of adult cases develop in childhood
- Exposure and response prevention first-line treatment

Meta-Analysis: Effectiveness of Treatments for pediatric OCD

1 in 200 children and adolescents
(Franson, Whitaker, Rampton, Orme, & et al., 1998; Oxford Back et al., 1996)
Chronic 80% of adult cases develop in childhood
(Pauls, Alsobrook, Goodman, Rasmussen, & Leckman, 1995)
Exposure and response prevention first-line treatment
(Franson, Goodman, & Rasmussen, 1995)

(Abramowitz, Whiteside, & Deacon, 2005)
Effectiveness of Combined Treatment for Pediatric OCD

Franklin et al., 1998

Pediatric OCD Treatment Study
Randomized controlled trial

POTS, 2004

Obstacles to treatment

- Behavior therapy rarely available, especially ERP
  - Goisman, et al., 1993; Goisman, et al., 1999; Grabill et al., 2007; Kuehn, 2007
  - Even CBT practitioners rarely use exposure
    - Valderhaug, Gotestam, & Larsson, 2004
- Commute long distances to universities and research hospitals for weekly appointments
- Time and financial constraints
- Treatment refusal and drop-out

Intensive Treatments

- Adult panic disorder (Deacon & Abramowitz, 2006)
  - 2 days
- Childhood specific phobia (Ollendick, 2006)
  - 1 day
- Child panic (Pincus, Ehrenreich, Suarez, 2007)
  - 8 days
- Separation Anxiety (Source: Janda, 2007)
  - 1 week
- Pediatric OCD
  - Daily appointments over 3 to 4 weeks
  - Requires considerable time, money and travel

5-day Treatment Overview

- 10 appointments over 5 days
- Primary Component: ERP
- Inspired by PCIT methodology
- Goals:
  - Education on the CB conceptualization of OCD, its maintenance, and treatment through ERP
  - Initial symptom reduction through ERP
  - Build family confidence to continue ERP based on experiences during the treatment
Retrospective examination of 5-day

- 30 patients, Caucasian
- Age
  - Intensive 11 to 18, m = 13.4 (2.2)
  - TAU m = 6 to 16, 11.7 (3.2)
- Sex
  - Intensive 53.3% males
  - TAU m = 60% males
- Primarily intact families
  - Intensive parents partial post-secondary education
  - TAU m = Primarily intact families
- Primary diagnosis of OCD >= 1 year
- IQ > 85

Intensive data published in Whiteside and Brown (2010)

Obsessions and Compulsions

- Obsessions
  - Contamination 57%
  - Aggressive 21%
  - Sexual 14%
- Compulsions
  - Washing 71%
  - Checking 64%
  - Repeating 57%
  - Counting 36%
  - Ordering/arranging 57%
  - No hoarding

Outcome

Benchmarking

<table>
<thead>
<tr>
<th>Study</th>
<th>Pre-Tx M (SD)</th>
<th>Post-Tx M (SD)</th>
<th>F (1, 28)</th>
<th>% reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>POTS (2004)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT</td>
<td>26 (4.6)</td>
<td>14.0 (9.5)</td>
<td>-</td>
<td>46.1%</td>
</tr>
<tr>
<td>Combined</td>
<td>23.8 (3.0)</td>
<td>11.2 (8.6)</td>
<td>-</td>
<td>52.9%</td>
</tr>
<tr>
<td>Barret et al. (2004)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>23.6 (4.3)</td>
<td>8.36 (6.9)</td>
<td>-</td>
<td>64.6%</td>
</tr>
<tr>
<td>Storch et al. (2007)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive</td>
<td>25.9 (5.6)</td>
<td>9.5 (6.9)</td>
<td>16.2 (5.7)</td>
<td>40.6%</td>
</tr>
<tr>
<td>Weekly</td>
<td>25.4 (5.8)</td>
<td>12.8 (8.8)</td>
<td>9.8 (7.6)</td>
<td>44.2%</td>
</tr>
<tr>
<td>Current Study</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TAU</td>
<td>17.51 (5.5)</td>
<td>10.01 (5.2)</td>
<td></td>
<td>46.7%</td>
</tr>
<tr>
<td>Intensive</td>
<td>22.07 (5.5)</td>
<td>12.10 (5.6)</td>
<td>13.51 (5.7)</td>
<td>43.5%</td>
</tr>
</tbody>
</table>

Infrastructure Considerations

- Screening process
- Dedicated time in calendars
- Places patients to stay
- Willingness to work with parents
- Psychiatry available
- Inpatient options

Day 0
Pre-appointment preparation
Patient phone triage

- Current obsession and compulsion
- Previous treatment and outcome
- Medication status
- Inclusion criteria:
  - Child motivation for treatment (particularly pre-teen and teen)
  - Parent willingness to be present for treatment and coach exposures when returning home
- Exclusion criteria:
  - Severe family conflict
  - Developmental issues that would interfere with treatment
  - DBT has been recommended
  - Psychotic disorder
  - Not alternative to inpatient/residential
- Case example: Tics and family conflict

Symptoms

- Obsessions that are clearly related to Obsessive Compulsive Disorder
  - Contamination
  - Responsible for harm
  - Unacceptable thoughts
  - Symmetry, completeness, just right
- Compulsions that are related to the obsessions and not other diagnoses (autism, tics)
  - Washing/Cleaning
  - Checking, repeating, re-writing, re-reading, seeking reassurance
  - Praying, confessing, reassurance seeking (self or with others)
  - Arranging, routines, repeating, making, tapping / touching, counting
- Ability to address symptoms on location

Therapist Qualities

- Adequate training in the knowledge and skills necessary to provide mental health services to children and their families
- Training in
  - Child development and psychopathology
  - Social learning and behavior modification
  - ERP
  - Other interventions
- Capitalize on nonspecific factors
  - Socratic method, avoid jargon, compassion, respect, confidence, etc.
  - Flexibility
  - Individual style

Billing

- Evaluation
  - Diagnostic interview: 90791
- Treatment
  - 9 sessions- typically 50 minutes
  - Individual Psychotherapy: 90834
- 59-distinctly different procedure

Day 1

Evaluation, education treatment planning
Assessment Clinic Structure

Psychology
- Questionnaires
- Description of problem
- Previous Interventions
- Structured interview:
  - Anxiety and common co-morbid conditions (Depression, ADHD, ODD)

Psychiatry
- Medications
- Medical conditions
- Family mental health history
- Developmental History
- Social History

Assessment Measures

- Interview methods
  - MINI-KIDS
  - Children Yale Brown Obsessive Compulsive Scale (CY-BOCS)
  - ADIS-IV (parent & child)

- Self-report methods
  - Spence Children's Anxiety Scale
  - CY-BOCS Checklist
  - Children's Obsessive-Compulsive Inventory (Foa et al., 2010)
  - Children's Florida Obsessive Compulsive Inventory (Storch et al., 2009)

Functional Assessment

- Antecedent
- Behavior
- Consequence

FA: Antecedent

- Fear evoking stimuli
  - External vs. internal
- What happens immediately before
  - Contact vs. spreading
  - Immediately before event vs. while preparing
- Situation
  - Home vs. school or work
  - Presentations vs. small talk
  - In bathroom vs. bedroom

FA: Behavior

- Erroneous beliefs and interpretations
  - Very bad things are likely to happen
  - E.g., "I'll get sick and die"
- Emotional reaction
- Rituals
  - All avoidance, escape, safety aids, and strategies used to endure exposure when escape is not possible
  - Frequency and Intensity
  - Washing hands for 5 minutes

FBA: Consequence

- What occurs immediately after the behavior?
  - Anxiety decreases
- What is sustaining the behavior?
- Other people’s reactions
  - Family accommodation
Psychoeducation
Tools for fighting OCD
- Exposures - Face your fears
- Response Prevention - Don’t do what OCD tells you to do
- Learn how OCD works
- Reminder that OCD is the enemy
- Teach Mom and Dad to be good teammates
- Measure anxiety so it is easier to handle
- Recognize the lies that OCD tells you
- Be your own cheerleader, don’t help OCD by getting down on yourself
- Take it one step at a time. Set goals you can reach
- Reward yourself because making changes is hard

Why doesn’t anxiety go away

Germs

What is exposure?

The role of Cognitive Restructuring

Purpose: To recognize the lies that OCD tells you and prove them wrong
Do not: Try to modify the obsession itself
Boost confidence for exposures
Learn from exposures

Yes, there are germs, we won’t argue that

Modify: I am going to get sick and I can’t handle not knowing whether I am safe (Bad things are going to happen and I have to know for certain)
Lies that OCD tells me

- You shouldn’t have bad thoughts
- Thoughts = actions
- You have to know for certain
- You can’t handle feeling upset
- You have to stop bad thoughts
- Bad things are going to happen
- You have to stop bad things from happening
- You have to do things “Just Right

Developing a hierarchy

- Need to address fear beliefs
  - Cover body in contamination
  - Eat while contaminated
  - Hold child while contaminated
  - Therapist needs to be comfortable with
  - Magnified everyday events
  - Not dangerous activities

Bathroom Fear Ladder

<table>
<thead>
<tr>
<th>Exposure</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eat food off bathroom floor</td>
<td>9</td>
</tr>
<tr>
<td>Touch toilet seat</td>
<td>9</td>
</tr>
<tr>
<td>Touch toilet flusher</td>
<td>8</td>
</tr>
<tr>
<td>Touch door of toilet stall</td>
<td>8</td>
</tr>
<tr>
<td>Touch sink faucet</td>
<td>7</td>
</tr>
<tr>
<td>Touch towel dispenser in the bathroom</td>
<td>6</td>
</tr>
<tr>
<td>Touch bathroom door handle/knob</td>
<td>3</td>
</tr>
</tbody>
</table>

Contaminating Others Fear Ladder

<table>
<thead>
<tr>
<th>Exposure</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Touch a source of contamination then prepare food for others</td>
<td>9</td>
</tr>
<tr>
<td>Touch a source of contamination then hug someone who is ill</td>
<td>8</td>
</tr>
<tr>
<td>Touch a source of contamination then touch a loved one</td>
<td>7</td>
</tr>
<tr>
<td>Touch a source of contamination then someone else’s possessions</td>
<td>7</td>
</tr>
<tr>
<td>Touch a source of contamination then give someone a hug</td>
<td>6</td>
</tr>
<tr>
<td>Touch a source of contamination then shake hands with someone</td>
<td>5</td>
</tr>
<tr>
<td>Touch a source of contamination and then touch public surfaces (door knobs, railings, etc.)</td>
<td>4</td>
</tr>
<tr>
<td>Touch a public surface and imagine that your hand has germs and other people will become contaminated</td>
<td>4</td>
</tr>
</tbody>
</table>

Intrusive Thoughts Fear Ladder

<table>
<thead>
<tr>
<th>Exposure</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Think about mother dying from not walking right</td>
<td>9</td>
</tr>
<tr>
<td>Think about father dying from not walking right</td>
<td>7</td>
</tr>
<tr>
<td>Think about family member getting sick from not walking right</td>
<td>6</td>
</tr>
<tr>
<td>Think about having a bad day from not walking right</td>
<td>5</td>
</tr>
<tr>
<td>Think about having therapist dying right now from not sitting right</td>
<td>4</td>
</tr>
<tr>
<td>Think about having a bad day from not sitting right</td>
<td>4</td>
</tr>
<tr>
<td>Think about having therapist falling down from not sitting right</td>
<td>2</td>
</tr>
</tbody>
</table>
Engaging Kids in Exposures

- Psychoeducation
- Therapeutic Relationship
  - Teammates
  - Humor
- Child friendly language and metaphors
- Motivators
- Games-limited use
  - Rapport Building
  - Reward
  - To make exposures more acceptable for younger children

Habituation

- Child-friendly language
  - Getting used to the cold water in the pool
  - Getting used to a dark room
  - Coasting down a hill
  - Scary movies
  - Roller coasters
- Disgust as well
  - Picking up after dog
  - Chores
  - Changing diapers

Wagner, 2002

Beginning exposure

- Exercises to demonstrate like "I can't walk" and throw paper weight
- The situation to practice
- Bottom hierarchy
- What is OCD telling you will happen
  - Threat and intolerance of anxiety
- What is OCD telling you to do to make yourself feel better
  - rituals
- Anxiety ratings
  - Distress vs. Urges vs. Dislike
  - What happened
  - Fear come true
  - Anxiety overtime
  - First without parents, review with parents, then with observing

Introducing parent coaching

- Be positive and supportive
- You are going to find yourself saying the same things over and over, that's okay
- Setting exposure
  - Planning and setting up learning
- During exposure
  - Approximately every 2 minutes record anxiety
  - Help your child realize anxiety is decreasing without rituals
  - Monitor for rituals
- After exposure
  - What learned about fears and anxiety

Exposure progression

- Setting goals
  - Address each type of symptom
  - How high up the hierarchy
  - Child vs. parent
- Practicing between sessions
  - Complete exercise sheets
  - Sticking to plan
- Pace
  - Follow the child's lead
  - Encourage to do the hard items while they are here
  - Balance encouraging vs. restraining

Day 3 and 4

Exposure and Parent Coaching


**In vivo exposures**

- Contamination
- Spreading
- Just-right/symmetry
- Tapping/touching
- Re-reading/re-writing
- Harming others/self
  - knife

**Types of Imaginal Exposure**

- Primary
  - Confrontation with unacceptable ideas, images, thoughts (e.g., blasphemous, sexual, violent)
- Secondary
  - Exposure to thoughts/doubts evoked by situational exposure (e.g., after situational exposure to being the last person to leave home)
- Preliminary
  - As an intermediate step to prepare for situational exposure (e.g., imagine touching the floor before actually touching the floor)

**Why use Imaginal Exposure?**

- Helps patients learn to confront instead of resist unpleasant intrusive thoughts and memories
  - By purposely imagining distressing scenes, the individual learns he/she can handle anxiety
  - They may experience relief of symptoms after listening repeatedly, reinforcing the notion that exposure leads to habituation and symptom reduction
  - Reduces the need for resistance to thoughts (rituals)
- Increases tolerance for uncertainty
  - Fears of long-term future consequences that cannot be detected immediately can be confronted (brain damage in 30 years)
  - Fears of not “knowing for sure” can be confronted (you don’t know whether someone repeated the dirty joke you told)

**Why use Imaginal Exposure?**

- Corrects mistaken beliefs about intrusive thoughts and memories
  - Beliefs about the importance of thoughts
  - Beliefs about the need to control thoughts and memories
  - Patient sees that just by allowing him/herself to think of bad things does not make them come true (death of others, sin, other unwanted things)
  - Patients often gain perspective and see that the ideas that seemed distressing are no longer, and the feared outcomes are unlikely or manageable

**Parent coaching**

- Transfer control from therapist to parent/child
  - Observe
  - Record
  - Set-up
  - Co-lead
  - Lead
- Generalizing coaching principles
  - differential attention
  - small steps
  - replace avoidance with approach
  - Meet with parents individually
  - Balance pushing vs. accommodating

**Obstacles**

- Wednesday slump
- Patient resistance
  - Reward system
  - Team collaboration plan
  - Cut-out accommodation
- Not anxiety provoking
  - Practice for game metaphor
- Parents factors
  - Anxiety and OCD
  - Parent exposure
Day 5
Wrapping up and Planning for post-treatment.

Progress review
- Progress up fear ladder
-Parents independence in last session
-Review treatment goals of treatment
- Education
- Symptom relief
- Confidence in coaching (parent/child)

Post treatment Planning
- Plan for next week
  - Two exposures daily
  - Written plan
  - Planned phone calls
  - Monday and Friday
  - Emails
  - 3 stages
    - At-home treatment
    - Working on the fly
    - Moving on
  - Relapse prevention

Post-tx Obstacles
- Child resistance
- Busy Schedules
- Exposures without parents
- Parent noncompliance
- Frequent phone calls
- Local providers
- New symptoms
- Other parent/separate households

Future Directions
- Pilot in other disorders
- Complete current research study
- Compare to alternative (care at home, weekly)
- Enhance with technology
- Mayo Clinic Anxiety Coach
- Shorter interventions
- Questions