

Cognitive-Behavioral Therapy for Children and Adolescents with Obsessive-Compulsive Disorder

Aureen Pinto Wagner, PhD

Selected by experts as the treatment of choice for youngsters, cognitive-behavioral therapy (CBT) has emerged as a safe, viable, and effective treatment for obsessive-compulsive disorder (OCD) among children and adolescents. Yet, most children with OCD do not receive CBT, at least in part due to the shortage of clinicians who are well versed in managing the unique challenges that arise in the treatment of children. This paper reviews developmental factors that complicate the diagnosis and treatment of OCD in youngsters; it discusses appropriate adaptations of CBT protocols for children; and it presents the application of CBT for children and adolescents, using a developmentally sensitive protocol that is flexible and feasible in clinical settings: RIDE Up and Down the Worry Hill. Illustrated is the use of this protocol with a 15-year-old girl with forbidden thoughts and praying rituals, and a 6-year-old boy with fears of harm and reassurance-seeking rituals. Future directions for making CBT available and accessible to children with OCD are discussed. [*Brief Treatment and Crisis Intervention* 3:291–306 (2003)]

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Obsessive-compulsive disorder (OCD) is more common in children and adolescents than once believed, with a lifetime prevalence estimated at 2% to 3% (Zohar, 1999). Childhood OCD is often associated with severe disruption in social and academic functioning, comorbid emotional and

behavioral problems, and family dysfunction (Albano, March, & Piacentini, 1999).

A substantial body of literature supports cognitive-behavioral therapy (CBT), specifically exposure plus response prevention (ERP), as the key therapy for OCD among adults (see Marks, 1997, for a review). Exposure involves purposeful and conscious confrontation of objects or situations that trigger obsessive fears; response prevention involves refraining from the rituals that relieve the anxiety generated by obsessions. Exposure and response prevention must occur simultaneously for maximum

From the Division of Cognitive and Behavioral Neurology, Department of Neurology, University of Rochester School of Medicine and Dentistry.

Contact author: Aureen P. Wagner, OCD and Anxiety Disorder Consultancy, 35 Ryans Run, Rochester, NY 14624-1160. E-mail: awagner5@rochester.rr.com.

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benefit. The most commonly proposed mechanism for the effectiveness of ERP is that the process of habituation leads to the dissipation of anxiety when exposure is sustained and frequent. Additionally, the realization that obsessive fears do not materialize during ERP appears to reduce the potency of the obsessions.

ERP for OCD was developed for adults and initially considered neither possible nor desirable for children and adolescents. Since the mid-1990s, several open-trial and single-case studies have led to the emergence of CBT as a viable, safe, and effective treatment for OCD in children and adolescents (see March, Franklin, Nelson, & Foa, 2001, for a review). These studies have yielded impressive and durable response rates, ranging from 60 to 100%; mean symptom reduction rates of 50 to 67%; and maintenance of treatment benefits for up to 18 months.

Although the results of rigorous controlled studies are awaited, empirical and clinical reports thus far indicate that children and adolescents can utilize CBT as successfully as adults. Based on these findings, CBT is recommended by experts as the first-line treatment of choice for OCD in children and adolescents (March, Frances, Kahn, & Carpenter, 1997). However, it is believed that many, if not most, children and adolescents with OCD do not receive CBT for a variety of reasons. Many clinicians are not trained in CBT for OCD and may not be familiar with the unique developmental challenges that arise in the treatment of children. In addition, clinicians often find that research-driven treatment protocols are neither practical nor realistic in clinical settings.

Although OCD in children is quite similar in presentation to OCD in adults, developmental differences between children and adults arising from age, maturity, conceptual ability, and language development may complicate the application of CBT for children. First, OCD in children may be difficult to detect and diagnose for a variety of reasons. Children may not be able to recognize, label, or articulate their obsessions or fear triggers.

A typical response of "I just have to do it" or "I don't know" may mislead uninformed adults into believing the child's behaviors are willful. Primary presenting complaints of irritability, agitation, aggression, withdrawal, or decline in school functioning may mask OCD and may be mistaken for depression, other anxiety disorders, or even attention deficit/hyperactivity disorders. Children may keep their OCD a secret, and parents may be unaware of the presence or severity of OCD (Rapoport et al., 2000). Sensitive but direct interviewing by the clinician may be necessary to uncover obsessions and rituals that may underlie initial complaints. True OCD must also be differentiated from normal developmental rituals and fears that are commonplace in childhood. The child's lack of ability to introspect or give specific examples of symptoms or triggers also limits the therapist's ability to design effective treatment.

Diagnosis is also confounded by the fact that OCD in children is a highly comorbid condition. Up to 80% of youngsters meet criteria for an additional *DSM-IV* disorder, and up to 50% display multiple comorbidities, most commonly in the form of other anxiety disorders (26%–75%), depressive disorders (25%–62%), behavioral disorders (18%–33%), and tic disorders (20%–30%; Rapoport, et al., 2000; Zohar, 1999). Differentiation of tics from rituals can be surprisingly difficult. Depression is more common among adolescents with OCD than in children, and it may be reactive because it often occurs after the onset of OCD. Comorbidity complicates course of illness in OCD, as well as treatment outcome (Albano, March, & Piacentini, 1999).

Second, regarding what they bring to CBT, children and adolescents vary tremendously in their level of future orientation, ability to delay gratification, self-reliance, maturity, and internal motivation. Children rarely seek treatment for themselves and are usually in the clinician's office at the behest of a parent. In fact, they may

be more motivated to get help to avoid their fears than to overcome them. Young children are generally present-oriented and therefore less likely to appreciate the prospect of future improvement. Consequently, they may be reluctant to tolerate the potential anxiety of ERP to achieve future rewards. Compliance with ERP homework exercises can be particularly challenging because, naturally, most children dislike and avoid homework. As a result, children may require substantial structure, supervision, and assistance from the therapist and parents to participate effectively in CBT.

Other issues that affect accurate diagnosis and motivation for treatment include the fact that children often do not understand the nature of OCD and have misconceptions or worries about being “crazy.” They are less likely than adults to realize that their symptoms are senseless and excessive. Although older children may have good insight, their shame may lead them to minimize their symptoms. Children are more likely to passively succumb to obsessions and rituals, and may fear treatment because ERP can be counterintuitive and daunting at first glance.

Third, children live in the context of a family, and parents are an integral part of their lives. OCD can quickly become a “family illness” because children commonly involve family members in their OCD through participation in rituals, provision of reassurance, and assistance in avoiding fear triggers. Rage attacks may ensue if family members fail to comply. Families of children with OCD may exhibit more criticism, parent–child conflict, and parental OCD, which may predict a worse outcome (Hibbs, Hamburger, & Lenane, 1991).

Clinicians who do not recognize and address these developmental issues may make the mistake of rushing into treatment precipitously in response to the sense of urgency elicited by the child’s symptoms. Children, parents, and even clinicians may abandon treatment prematurely when lack of progress from hastily applied treat-

ment leads them to doubt its efficacy. Carefully assessing developmental issues, devising appropriate adaptations, and building a child and family’s “treatment readiness” prior to the initiation of treatment are therefore vital to success.

Recent manualized CBT protocols for children have included developmental adaptations such as psychoeducation, age-appropriate language, cognitive strategies for dealing with anxiety, use of graded exposure, rewards, and family involvement in treatment (March, Mulle, & Herbel, 1994; Piacentini, Gitow, Jaffer, Graae, & Whitaker, 1994). Clinical experience and recent studies indicate that active parent involvement in the child’s treatment may increase efficacy and long-term gains from treatment (Piacentini, et al., 1994; Waters, Barrett, & March, 2001).

The purpose of this paper is to describe the application of CBT for childhood OCD using a developmentally sensitive protocol that is flexible and feasible for clinicians in primarily clinical settings: RIDE Up and Down the Worry Hill (Wagner, 2002; 2003). The steps of the RIDE protocol are described as follows and illustrated via a 15-year-old girl with forbidden thoughts and mental rituals. A comprehensive assessment and treatment strategy for childhood OCD that involves four phases, including the RIDE protocol, is described later in this paper, along with its application for a 6-year-old boy with fears of harm and reassurance-seeking rituals.

RIDE Up and Down the Worry Hill: A CBT Treatment Protocol for Children and Adolescents

Understanding and accepting the vital concepts of exposure, habituation, and anticipatory anxiety, as well as the ability to tolerate anxiety during ERP, may be crucial to motivation and compliance. A child’s success in treatment might hinge on this understanding; yet these are not intuitive concepts. The RIDE acronym and the

metaphor of riding a bicycle Up and Down the Worry Hill were developed to explain CBT in child-friendly language (Wagner, 2000; Wagner, 2002).

The “Worry Hill” depicts the relationship between exposure and habituation. The bell-shaped curve of the Worry Hill (see Figure 1) illustrates the rise in anxiety when exposure to a feared situation takes place. Anxiety increases steadily as exposure continues and may reach a peak. If the child persists with exposure, automatic habituation sets in, and anxiety automatically begins to decline. If, on the other hand, the child succumbs to rituals or avoids the fear trigger, habituation is interrupted, and obsessions are inadvertently strengthened by negative reinforcement (i.e., escape from an aversive situation). The Worry Hill is explained to children as follows:

Learning how to stop OCD is like riding your bicycle up and down a hill. At first, facing your fears and stopping your rituals feels like riding up a big “Worry Hill,” because it’s tough and you have to work very hard. If you keep going and don’t give up, you get to the top of the Worry Hill. Once you get to the top, it’s easy to coast down the hill. But you can only coast down the hill if you first get to the top.

The four-step RIDE acronym (Rename, Insist, Defy, Enjoy) encompasses the steps that the child or adolescent must take to successfully tackle the Worry Hill. A step-by-step description of this treatment protocol is available in Wagner (2003). The RIDE was designed to simplify ERP for children and adolescents, enhance preparedness for treatment, and foster endurance of anxiety until habituation takes place. It includes both cognitive and behavioral techniques, such as externalizing; distancing; and taking control of OCD thoughts, exposure, and self-reinforcement. Coaching or instruction in each of the four steps is followed by therapist

modeling, behavioral rehearsal, frequent practice, and reinforcement, until the child masters the steps. In addition to the auditory mnemonic aid of the RIDE acronym, the *Worry Hill Memory Card* (see Figure 1) provides a visual mnemonic aid to the child. In essence, the RIDE teaches youngsters to stop, think, take control, and respond assertively to OCD, rather than default to an automatic reflexive compliance with obsessions and rituals.

The RIDE steps, as applied to 15-year-old Maria’s uncontrollable images of dying babies and her prayer rituals, are described as follows. Maria had begun to experience intrusive images when she was 13. A soft-spoken teenager, she recounted with anguish that she had seen a pregnant woman walk past her at the mall and that she suddenly “wished” that the woman’s baby would die. Horrified by the repugnant thought, Maria attempted to cleanse the image out of her mind by conjuring up the image of the pregnant woman walking by again and “canceling” the intrusive thought by fervently praying that the baby would be healthy. On another occasion, Maria was baby-sitting and suddenly had the urge to put the baby in the microwave along with his bottle. Panic-stricken, she checked the microwave and the baby’s crib repeatedly to ensure that she had not carried out the urge. Although she was relieved each time to find the baby sleeping contentedly, the doubt was relentless and tormenting. Maria was so distraught by the episode that she stopped baby-sitting altogether. By the time she sought treatment, Maria went to inordinate lengths to avoid eye contact or interaction with pregnant women and babies. On some days, she refused to leave the house. The four steps of the RIDE are as follows.

R: Rename the Thought

The first step involves recognizing OCD thoughts as unrealistic and distinct from the child’s rational self. Young children may find it

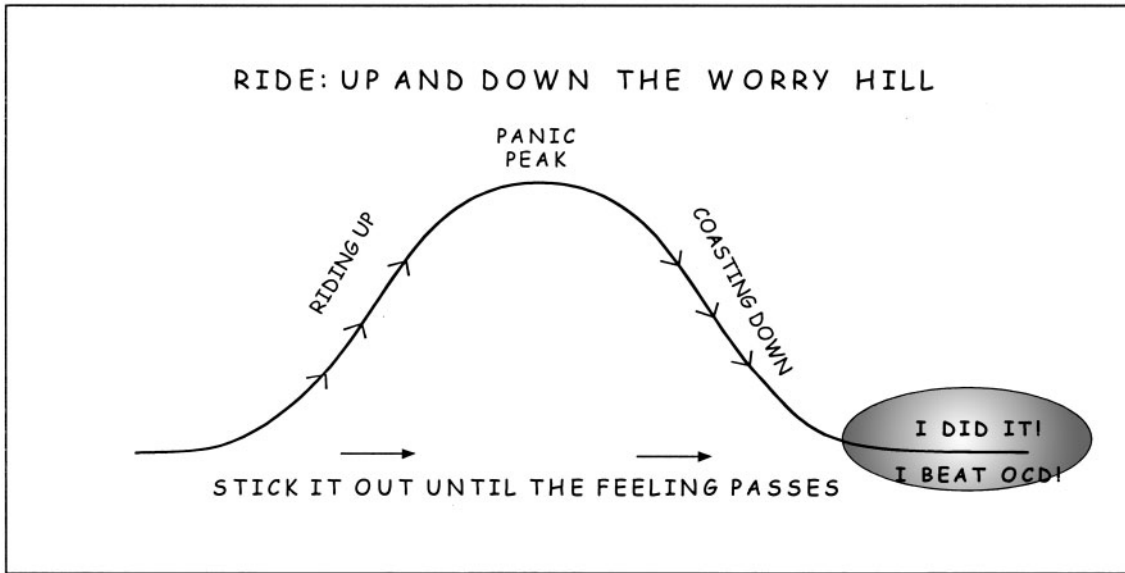


FIGURE 1

The Worry Hill. ©2002 Aureen P. Wagner, PhD. Reprinted with permission. From Wagner (2002).

R: Rename the thought. *That's OCD talking, not me.*

I: Insist that YOU are in charge! *I'm in charge. I choose not to believe OCD.*

D: Defy OCD. *I will ride up the Worry Hill and stick it out until I can coast down.*

E: Enjoy your success, reward yourself. *I did it! I beat OCD. I can do it again.*

helpful to personify OCD as the “Worry Monster” or “Mr. Right,” whereas adolescents usually prefer to refer to OCD by its name. The technique of externalizing OCD has been used by Schwartz (1996) with adults and March et al. (1994) with children. When Maria recognized and accepted that her obsessive thoughts were not volitional or enjoyable, she distanced herself from them by saying, “That’s OCD talking, not me.” In doing so, she felt absolved of deep shame and guilt.

I: Insist That YOU Are in Charge!

The second step fosters a shift in attitude from passive acquiescence to active assertion. It helps the child recognize and utilize the power of choice. Instead of readily succumbing to OCD’s injunctions, Maria chose to take active control over her thoughts and actions. Statements such as “I am in charge, not OCD” and “I’m going to choose not to believe the tricks that OCD plays

on my mind” helped Maria build the self-confidence and endurance she needed to embark on exposure.

D: Defy OCD—Do the OPPOSITE of What It Wants

The third step involves ERP, which requires a change in behavior. Exposures in Maria’s case entailed purposefully encountering pregnant women and babies by going to public places such as the mall and by taking on baby-sitting assignments. Response prevention involved refraining from “canceling” bad thoughts or saying prayers when intrusive images of dying babies assailed her. Maria talked herself through ERP by saying, “I’m going to ride up the Worry Hill now. It’s going to be tough going up the hill, but if I stick it out, I’ll get to the top of the hill. Once I’m at the top, it will be easy to coast down the hill. I won’t quit until the bad feeling passes. I won’t give in to the rituals.” As Maria encoun-

tered pregnant women and babies, her anxiety escalated and peaked, then automatically began to decline because habituation set in. Maria rode to the top of the Worry Hill and enjoyed the coast down the other side. The thoughts of dying babies seemed meaningless and eventually faded away. She was surprised that exposure wasn't as upsetting as she had expected. Maria's thoughts were far less troublesome with repeated exposures, and her anxiety habituated faster with practice.

E: Enjoy Your Success—Reward Yourself

The final step allows the child to review her success and take due credit for effort and courage. Maria learned to give herself positive feedback and internalize success. "I did it! I can do it again. Now I deserve to be good to myself."

The Worry Hill represents a universal metaphor because children as young as four, adolescents, and even adults can relate to the idea of riding a bicycle up a hill. Parents, siblings, and teachers find the metaphor equally helpful in understanding how CBT works. The easy acronym, logical steps, and visual features of the Worry Hill, as well as the RIDE acronym, are simple to grasp, remember, and recall, even in the midst of anxiety, thereby reducing chances of premature termination of exposure and habituation. Moreover, the metaphor is comprehensive and readily lends itself to a description of most elements of treatment and recovery. For example, graded exposure is described as "riding up little hills before tackling the big one"; preparation for treatment is similar to "finding a good helmet, the right pair of sneakers and having a bottle of water on hand"; the use of medication is portrayed as "training wheels on the bicycle"; and relapse is depicted as "you may fall off your bicycle even after you've learned how to ride."

Systematic and thorough assessment and

preparation for treatment, as described in the following section, must precede the implementation of the RIDE.

Four Phases in the Implementation of CBT for Children and Adolescents

The overall treatment strategy for children and adolescents may be conceptualized as occurring in four sequential phases. Each phase is focused on completing specific goals or building on skills that have been mastered in the previous phase. The number of sessions in each phase is flexible to allow customization to the child's and family's unique needs. The average treatment extends from 10 to 20 sessions, depending on the severity and complexity of the case. Straightforward cases of OCD may be treated in as few as 6 sessions.

Phase 1: Biopsychosocial Assessment and Treatment Plan

Phase 1 lays the essential foundation for successful treatment and may extend from one to three sessions (one session equals the 50-minute hour typical of clinical practice). A biopsychosocial assessment focuses on a complete and sensitive understanding of the child's OCD symptoms in the context of the child's personal attributes, physical health, family, social, and school functioning. Rather than merely assess OCD, it is geared toward the larger issue of the child's overall health, adaptation, strengths and limitations; and it allows for customized treatment that may help avert treatment failures. Biopsychosocial evaluation involves collaboration among physician, therapist, parent, child, school, and other relevant players. In addition, it utilizes a variety of methods: clinical interviews; clinician, parent, and child ratings; self-report inventories; and behavioral observations.

Initial diagnosis is followed by OCD symptom analysis and a treatment plan.

Initial Evaluation and Diagnosis The first step in the evaluation is to establish a diagnosis of OCD, assess baseline severity and impairment, and identify potentially difficult areas for treatment. The assessment should target current and past fears; rituals and triggers; events surrounding the onset of symptoms; frequency and context of symptoms; degree of distress and impairment; comorbid conditions; medical and developmental history; family history; social relationships; and functioning at home and school (Pinto & Francis, 1993). Although several structured diagnostic interviews for children are available, time and resource constraints make them infeasible in most clinical settings.

Interview with the Child. Although the child may not be the best historian, it is important for the clinician to gauge the child's insight and experience of symptoms, level of distress, and motivation for treatment. The clinician must be empathic and resourceful in order to engage children of various ages and levels of maturity; elicit trust; and query thoughts and rituals with the level of detail necessary for effective treatment. Interview of the child is geared toward obtaining answers to many questions:

- Does the child perform rituals to relieve anxiety or prevent bad outcomes?
- How is each fear connected with each ritual?
- What would happen if he did not do a ritual?
- How does the child know when he's done enough?
- What makes him feel better, and what makes the thoughts dissipate?
- Does she believe she can overcome her fears?
- Is she hopeful and optimistic, or does she feel defeated and dispirited?
- How does she feel about herself as a person?

Clinical Interview of Parent(s). Interviewing parents is very important because children may not be reliable informants. In addition to describing the child's symptoms, parents are valuable in providing a chronology of events, developmental history, comorbid symptoms, family history, and functioning, of which children might not be aware.

Self-Report and Parent Ratings. In addition to the clinical interview, several other measures with established psychometric properties yield clinically useful pre- and posttreatment data and can be efficient and time-saving in the clinical setting. They can be administered, scored, and reviewed prior to the first appointment, thereby allowing the clinician to target areas for closer assessment during the initial visits. The Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1991), an 118-item parent-report measure, allows clinicians to assess a broad range of symptoms that may be clues to both OCD and comorbid conditions. The child's overall anxiety can be assessed on the Multidimensional Anxiety Scale for Children (MASC; March, Parker, Sullivan, Stallings, & Conners, 1997). The Child OCD Impact Scale (COIS; Piacentini, Jaffer, Bergman, McCracken, & Keller, 2001), completed by parent and child, provides information on the impact of OCD on the child's school, social, and family/home functioning.

Clinician Ratings. Several single-item clinician rating scales, which take about a minute each to complete, are highly practical in clinical settings. The NIMH Global OCD Scale rates OCD severity and impairment. A score of 7 indicates clinically meaningful OCD symptoms, and scores of 13 to 15 indicate very severe symptoms. The NIMH Clinical Global Impairment Scale provides an overall judgment of impairment from 1 (not ill) to 7 (extremely ill). The NIMH Clinical Global Improvement Scale allows ratings of improvement during and after treat-

ment on a scale of 1 (very much improved) to 7 (very much worse).

OCD Symptom Analysis A close examination of specific obsessions, compulsions, triggers, the nature and frequency of parental participation, and assistance with rituals helps the clinician design targeted and effective exposures. The Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS; Scahill et al., 1997) is often the starting point for this information. The CY-BOCS assesses obsessions and compulsions in terms of time consumed, interference, distress, resistance, and control. Scores of 0–9 are considered subclinical, 10–18 mild, 18–29 moderate, and 30 or above indicative of severe OCD.

Biopsychosocial Treatment Plan The therapist must use the information derived from the assessment to develop a treatment plan that is designed to improve the well-being of the child, not just his obsessions and compulsions. The child may need treatment to help rebuild social skills and improve self-esteem, family relationships, and academic functioning. OCD symptoms should generally be treated first, unless other issues interfere with the treatment. For example, severe depression or family conflict may need to be treated before a child can engage in CBT.

Feedback and Education. The nature, course, prognosis, and contributing factors involved in OCD should be discussed with the child and parents. Blame and shame from misunderstanding OCD as a character weakness or the result of poor parenting should be eliminated. The child and parents should be offered all viable treatment options—including CBT, medication, or a combination of both (see March et al., 1997)—and assistance in making the optimal choices for the child. The therapist should explicitly discuss the pros and cons of each option, what each treatment involves, what sort of focus and

commitment will be required of parents and child, the possible duration of treatment, and when results may be expected. Families who opt for medication should be referred to a child psychiatrist.

Phase 2: Building Treatment Readiness

Phase 2 is focused on planned and active preparation for treatment. This phase is critical but often overlooked, which jeopardizes the chances of success in treatment. Devoting one to three sessions to cultivate treatment readiness in the child and parent is a worthwhile investment that enhances participation, compliance, and the ease of implementation of ERP. The four steps in building treatment readiness are *stabilization, communication, persuasion, and collaboration.*

Stabilization of the Child and Family Crisis

Families seeking help for a child's OCD frequently present in a state of crisis. They feel a sense of urgency for immediate relief, and parents may be at their wits' end. A child who is overwhelmed and struggling to function does not have the wherewithal to consider CBT. Overzealous implementation of CBT in these circumstances merely adds to the child's sense of burden and can therefore backfire. Stabilization involves providing the child with respite from the dual challenges of OCD and everyday living through flexible expectations and temporary accommodations at home and at school. In severe situations, the child may need medication to reduce the severity of symptoms prior to engaging in CBT. Parents who are highly distressed also need support, stress management, and conflict-resolution techniques to regain equilibrium before embarking on CBT with their child.

Effective Communication Perhaps the most critical part of treatment readiness is helping the child and parents understand the concepts

of exposure, habituation, and anticipatory anxiety. When children don't understand CBT, they are unnecessarily intimidated and consequently unmotivated. The language of CBT must be accessible to children. The metaphor of the Worry Hill was developed to communicate CBT concepts effectively in child-friendly language.

Most parents and children are not aware that habituation of anxiety is an automatic physiologic process and that it takes place naturally if anxiety is endured for a reasonable length of time. It is this lack of awareness and inability to tolerate increasing anxiety that leads them to give in to rituals to escape the anxiety. When a child understands the metaphor of the Worry Hill, it is often an *aha!* experience. Parents and children who are educated about the Worry Hill prior to beginning treatment appear to be less anxious and more motivated to engage in treatment. They are often surprised to find that the anxiety they feel during exposure is far less than anticipated.

Effective Persuasion Persuasion involves helping children see the necessity for change, the possibility for change, and the power to change. Children are more readily persuaded once they have an accurate understanding of OCD and CBT. The child must be helped to see the benefits of overcoming OCD; this convinces her of the necessity for change. When she learns that OCD can be successfully overcome and that many others have done it, she sees the possibility for change. The child must learn to rely on the therapists' word that confronting her fears will assuage them; she must believe in the RIDE for herself. She must experience no coercion and no surprises, because the child's trust in the therapist is imperative. Finally, the child must know that she has the power to change. She must understand that she herself can take charge and control of OCD, instead of letting it control her. The recognition that she

has the power to change is usually a liberating experience.

Collaboration between Parent, Child, and Therapist

The child, parent, and therapist have different but complementary roles to play in the child's treatment. Clearly defining each of these roles before treatment begins can expedite progress in treatment by preempting the conflict and frustration that can ensue from misunderstanding. The therapist's role is to guide the child's treatment; the child's role is to RIDE; and the parent's role is to RALLY for the child:

R: Recognize OCD episodes.

A: Ally with your child.

L: Lead your child to the RIDE.

L: Let go, so your child can RIDE on his own.

Y: Yes, you did it! Reward and praise.

The metaphor of the Worry Hill is extended to help children and parents clearly understand their respective roles in treatment. The child's role is described as follows:

No one else can ride a bicycle for you. You have to do it for yourself. In the same way, only you can face your fears and make them go away. No one else can do it for you.

The parents' role is conveyed as follows:

You can help your child get ready for the ride by selecting the right bicycle and gear and by holding on to the seat if he's unsteady. Eventually, you must let go and let your child ride by for himself. Your child cannot ride on his own until you let go of the seat.

With the therapist's guidance, the child must be involved in setting goals and deciding the pace of treatment, as is suitable to his age and maturity. The child is more likely to be invested

in his recovery when he perceives that he has control over it. It is a good rule of thumb not to begin ERP until the child voluntarily expresses willingness to proceed. Children rarely refuse to participate in treatment when they are well informed and given the choice. When a child declines to participate despite proper preparation, it may be a good indicator that the child is truly not ready for CBT and therefore unlikely to benefit from it. Additional preparation may be necessary, or other options such as medication may need to be considered. For some children, CBT may have to be deferred temporarily and attempted later when they are older, more mature, or more willing.

Treatment reluctance in a child is generally a perplexing and frustrating situation for parents and therapists alike, who either instinctively increase pressure on the child or abandon treatment prematurely. However, coercion and ultimatums do not address the underlying reasons for reluctance, which usually stem from misconceptions or misunderstanding of the treatment. Most children have the desire to be rid of OCD because OCD is not enjoyable; however, some children have difficulty in channeling the *desire* to get well into the *action* to get well. A thoughtful, sensitive approach is more likely to earn a child's participation than disapproval or pressure. As described in Wagner (2002; 2003), a strategic five-step plan for handling treatment reluctance recommends that parents and therapists slow down and "go through the PACES":

- P: Plan a strategy.
- A: Ascertain reasons for reluctance.
- C: Correct and remove obstacles to treatment.
- E: Empower to succeed.
- S: Stop assisting.

Phase 3: The RIDE Up and Down the Worry Hill

Phase 3 may extend between 4 to 15 sessions. It consists of separate plus joint sessions with the

child and parents. During this phase, the child participates in ERP.

Graded Exposure Graded exposure involves progressing in small sequential steps from the least feared to the most feared situations. It must be used with children almost without exception, as children may not be able to participate in ERP if they become overwhelmed by anxiety. The relatively easy success experienced during graded exposure provides positive reinforcement and boosts the child's self-confidence and willingness to attempt subsequent exposures. A graded exposure hierarchy must be constructed prior to beginning ERP.

Symptom Monitoring. Symptom monitoring provides targets for the graded exposure hierarchy, as well as data for ongoing evaluation of treatment response. The child and parents list all OCD symptoms and record their frequency on easy-to-use monitoring sheets known as the "OCD Tracking Diary" and "Tracking Diary for Parents." Parents may assist younger children or record for them.

"Fear Temperature." The Fear Temperature is analogous to the Subjective Units of Distress (SUDS) used in the treatment of adults, and it allows children to rank exposure targets from least to most difficult for graded exposure. Children rate their Fear Temperature on a Fear Thermometer, a graduated scale from 1 (no anxiety) to 10 ("out of control") that teaches children how to differentiate, quantify, and communicate levels of anxiety to the therapist and parents.

Cognitive Strategies The first two steps of the RIDE (Rename and Insist) are aimed at preparing the child's belief system in anticipation of exposure. They include perspective-taking, reframing, and distancing from OCD, as well as empowerment to take back control. The therapist may introduce other cognitive techniques as needed for each child.

Exposure and Response Prevention The Defy step of the RIDE signals the beginning of ERP. The therapist first instructs the child in the steps of the RIDE, then models the procedure and asks the child to follow suit. For instance, the therapist eats a snack with unwashed hands to model exposure to germs. Modeling allows the child to see that the therapist is willing to assume the same risks that are asked of her.

Rewards Rewards bridge the gap of delayed gain from treatment and provide children with the immediate incentive to participate and maintain motivation. The child must be rewarded for *effort*, rather than success, because effort reflects the desired behavior. Praise and attention are preferable to material rewards, although young children often need tangible rewards.

The Parents' Role to RALLY Specific parental behaviors that support and reinforce the child's RIDE are discussed in each session, along with instruction and the therapist's modeling of steps to eliminate participation in rituals. The RALLY steps are tailored and put into action as per the specific circumstances for each child and family, including the child's age, maturity, specific symptoms, degree of parental involvement in symptoms, and the nature of the parent-child relationship. Targets for working with parents include helping them take care of themselves so that they can take better care of their children; reducing parental assistance and participation in the child's symptoms; and increasing positive family interactions, communication, problem solving, and child management skills.

Frequent Practice Frequent and diligent practice of ERP is crucial for mastery of anxiety. Weekly graphs of progress and Fear Temperature ratings give the child and family tangible evidence of progress. The therapist assigns a daily "practice," in writing, after each session in

order to reduce the chances that assignments are forgotten or misunderstood. Incomplete assignments are usually a sign that there is some obstacle to the child's participation. Sometimes, the child is willing and enthusiastic in the therapists' office, but she gets cold feet when she gets home. Parents may not be able to provide the supervision or structure that allows the child to focus on completing ERP exercises. Exercises may not be working as expected because the child quits the RIDE prematurely before habituation has taken place, or she replaces overt rituals with silent mental rituals. Success in CBT will be severely limited until all barriers to full participation are removed. Maintaining daily phone contact with patients during the early stages of the RIDE can preempt many of these problems. Parents and children are asked to leave a message every day, letting the therapist know how the practice is proceeding. Doing so not only increases accountability but also allows the therapist to intervene quickly if things are not proceeding as expected.

Phase 4: After the RIDE

Phase 4 signals the end of treatment. It should begin when the child has mastered the RIDE, when parents RALLY effectively, and when the child's OCD symptoms have decreased.

Preparation for Slips and Relapses Parents and children need to be prepared for the reality that OCD "slips," or relapses, can happen either unexpectedly or at times of stress and transition. When prepared, they are more likely to have an organized and productive response, and less likely to become demoralized. Relapse recovery training involves having realistic expectations, recognizing the early signs of relapses, keeping things in perspective, and intervening immediately. The metaphor of falling off a bicycle is used to suggest that when a slip occurs, OCD should be confronted head on by doing

ERP exercises even more vigorously. “When you fall off your bicycle, you pick yourself up. If you made no attempt to get up, you wouldn’t get anywhere. If you want to move on, you get up, dust yourself off, survey the damage, attend to it, and get right back on that bicycle.” It is important that the child and parents not fall into the trap of avoiding the feared situation.

Treatment Completion and Booster Sessions When treatment is completed, the child must receive significant recognition for her efforts and success. Treatment outcome is assessed via CY-BOCS posttreatment scores, NIMH clinician ratings of improvement, changes in Fear Temperature, and parent and child ratings of percentage improvement. Periodic booster sessions after treatment enhance the maintenance of treatment gains. Booster sessions should be scheduled prior to completion of treatment to reduce the rate of attrition.

The RIDE Up and Down the Worry Hill CBT protocol shares many elements with March et al.’s (1994) groundbreaking CBT protocol for children entitled “How I Ran OCD off My Land.” Although no empirical data exists to compare these two protocols or their relative efficacy, they nevertheless share common features. Both protocols are grounded in ERP as the core technique for overcoming OCD, and both include developmental adaptations designed to optimize the child’s chances at success by making ERP child-friendly and less anxiety provoking. Other shared features include the use of metaphors, externalizing, and constructive self-talk strategies to help the child prepare for, and cope with, ERP, graded exposure, provision of rewards to reinforce effort, and structured parental involvement in treatment.

March et al.’s (1994) protocol focuses on cognitive resistance and constructive self-talk (such as “bossing back OCD”), otherwise known as the “tool kit” that children can use

to get through ERP. The RIDE protocol places greater emphasis on the child’s comprehension and acceptance of the key concepts of treatment—exposure, anticipatory anxiety, and habituation. It is the understanding of these concepts that makes ERP easier for the child. What is crucial is helping the child understand and experience the temporal relationship among these three critical elements in treatment. The child is trained to become acutely aware of and experience—on cognitive, behavioral, and physiological dimensions—the process whereby anxiety escalates during exposure and dissipates during habituation. This experiential learning, aided by the auditory and visual features of the Worry Hill, provides the child with powerful tangible feedback about the process, where fears can either be cemented or extinguished. The *aha!* experience that typically ensues allows the child to see the perfectly logical sense behind ERP. Clinical experience indicates that once children understand the metaphor of the Worry Hill, they often begin to view ERP as a stimulating challenge and are eager to rise to the occasion.

In addition, the Worry Hill protocol clearly and proactively delineates the roles of parent, child, and therapist in the treatment, and places strong emphasis on “treatment readiness” as a precursor to beginning ERP. It also offers a systematic step-by-step approach to dismantling the child’s treatment reluctance in order to reduce the chances of premature abandonment of treatment. The application of the four phases in the Worry Hill protocol is illustrated as follows.

Case Description

Daniel, a 6-year-old first grader who had been diagnosed with Tourette’s syndrome at the age of 4, was referred by his neurologist for incessant checking and reassurance seeking.

Phase 1: Biopsychosocial Assessment and Treatment Plan (Three Sessions)

Biopsychosocial assessment consisted of an interview with Daniel and his parents, a phone interview with his school teacher, a review of medical records, and administration of self-report measures and rating scales. Daniel had demonstrated many ritualistic behaviors since he was a toddler, including extremely rigid bedtime rituals and reassurance seeking. Six months prior to referral, Daniel's fears of harm and danger had escalated dramatically. He frequently checked for blood and "bugs" in his food, and he sought repeated reassurance from his parents that his food did not contain these substances. He refused to eat spaghetti sauce or ketchup for fear that they were blood. Family members were vigilant not to use the word "blood" in any conversation for fear of upsetting Daniel. Daniel made his parents check his closets and under his bed every night to make sure there were no "bad things and bad luck." When in bed, his toys and stuffed animals had to be arranged "just so," and his covers had to be tucked in tightly by his parents. Daniel repeated nonsense phrases such as "Pete teasing" and "how now" to avert bad luck. He checked his underwear at least 20 times a day to ensure that he had not accidentally soiled them, and he also asked his parents and teacher to check. He insisted on his parents' participation in "good-bye" rituals that involved saying a series of words in sequence and taking turns repeating them, as many as 10 times each day. At school, Daniel was noted to seek frequent reassurance from the teacher, to be highly distractible, and to need frequent redirection. Daniel reportedly had severe outbursts of anger if his parents or teacher did not comply with his demands. He had frequent nighttime awakenings and was unable to complete school work or homework. Daniel's tics, which consisted of sniffing, coughing, and shoulder

shrugs, reportedly caused minimal distress or interference.

Daniel's symptoms met criteria for a *DSM-IV* diagnosis of OCD as well as for Tourette's syndrome. His score on the CY-BOCS was 29, suggesting notable distress and functional impairment. Daniel's symptoms merited a score of 10 on the Global OCD Scale and a 5 on the Clinical Global Impairment Scale. Daniel was restless and hyperactive, and he had many negative attention-seeking behaviors, including frequent interruption of conversations. He acknowledged that he didn't like being afraid, and he expressed motivation to overcome his fears. With regard to family history, Daniel's mother had experienced anxious preoccupations and rituals as a child and suffered from panic attacks in her late teenage years.

Phase 2: Building Treatment Readiness (Two Sessions)

The diagnosis of OCD was described to the family, along with information about its course, risk factors, prognosis, and treatment options. Daniel's parents were reluctant to consider medication for him and opted for CBT. The metaphor of the Worry Hill was presented, and the roles of therapist, child, and parent were discussed at the outset. The importance of compliance and willingness to change were emphasized. Daniel clearly understood the Worry Hill and the RIDE, and was able to explain them to his parents. The realization that he could exercise control over his OCD appeared to increase his motivation. Daniel's parents were enthusiastic in their commitment to RALLY for him.

Phase 3: The RIDE Up and Down the Worry Hill (Six Sessions)

Daniel and his parents completed the daily diary and parent diary to monitor the nature, context, and frequency of obsessions and rituals. Daniel

was able to differentiate between realistic and “silly” obsessive worries and to rate his Fear Temperature on the Fear Thermometer. He joined the therapist in constructing an exposure hierarchy with the following items:

- 3: Having toys in disarray
- 5: Wearing damp underwear
- 6: Having bed covers “messed up”
- 7: Hearing the word “blood”
- 8: Saying “blood”
- 8: Eating spaghetti sauce or ketchup
- 10: Seeing blood

After coaching in the RIDE steps, gradual exposure to each situation on the hierarchy was conducted both in the office and at home with the parent’s help. Corresponding response prevention involved refraining from urges to rearrange his toys, say “Pete teasing,” check underwear, ask for reassurance, or have his parents “fix” his bed covers or check his closets and room for bad luck. Daniel used the Worry Hill Memory Card as a reminder of the RIDE steps, and the Fear Thermometer to rate changes in his anxiety from beginning to end of each exposure. As expected, his anxiety followed the curve of the Worry Hill, and habituation occurred within 2 to 10 minutes. Daniel received frequent praise and rewards for his effort.

Daniel’s parents learned how to RALLY for him by reinforcing the message of the Worry Hill and the steps of the RIDE, providing support during exposure exercises and gradually withdrawing participation in his rituals. They received guidance in child management strategies, such as consistent parental responses, structure, effective redirection, and differential reinforcement of positive behaviors. Strategies to help Daniel express frustration appropriately, contain angry outbursts, and channel negative attention seeking into positive behaviors were presented. Daniel’s parents learned stress management strategies for themselves. Reassurance

seeking was gradually weaned by preparing Daniel ahead of time for a change in parental response, by redirecting Daniel to consider if it was him or OCD asking for reassurance (and to answer the questions himself), and by gradually decreasing the number of reassurances down to one. These steps were role-played during the therapy session before the parents implemented them at home. Daily practice of ERP was assigned after each session and reviewed at the beginning of the following session.

Phase 4: After the RIDE (Four Sessions)

At the end of 6 sessions of ERP, Daniel and his parents reported 80% improvement in his symptoms and overall functioning. CY-BOCS score was 4; Global OCD Scale score was 2; and Clinical Global Improvement Scale score was 1. Bedtime, good-bye, and reassurance-seeking rituals were eliminated completely within three sessions. Fears of blood and soiling accidentally were eliminated by the end of six sessions of treatment. Daniel’s parents reported feeling more confident about helping him manage his OCD, and his teacher reported a significant decrease in reassurance seeking at school.

Booster sessions were scheduled at 4, 8, 14, and 22 weeks, and every 12 weeks thereafter for 2 years. They were focused on review of progress, identification of areas of difficulty, recapitulation of strategies, social skills training, and ongoing child management issues. Daniel experienced a minor relapse four months after treatment was completed, when the approach of Halloween triggered fears of blood and monsters. Relapse recovery steps were reviewed and implemented, and Daniel successfully overcame the resurgence of fears within two days. As Daniel got older, he was coached in cognitive strategies that allowed him to test the evidence for his fears, estimate the probability that his fears would come true, and develop problem-solving skills. At two years posttreatment,

Daniel's score on the CY-BOCS was 3, in the normal range. Other than occasional rituals that did not cause distress or interference, Daniel was reported to be doing very well at home and at school.

Summary and Future Directions

Knowledge about childhood OCD and its treatment has progressed in leaps and bounds in the last decade, thanks to significant research and clinical attention to the disorder. Clinicians are now better able to provide youngsters with symptom relief as well as the skills to manage OCD in the long-term and lead productive lives.

CBT, which was once considered neither feasible nor suitable for children, is now recommended by experts as the treatment of choice for OCD in youngsters. However, many obstacles need to be overcome before this recommendation translates to real benefit for children and families who struggle to cope with OCD. Parents, pediatricians, teachers, and school personnel, who function as gatekeepers for timely recognition and referral of children, often do not have the knowledge or tools to detect OCD until it is severe. Moreover, most children who are diagnosed still do not receive CBT as a result of the dearth of clinicians with the requisite skills. The application of CBT with children calls for expertise in treating children, familiarity with developmental and family issues, a sound therapeutic relationship with the child and the family, and facility in adapting and customizing standard treatment protocols.

Future directions in making CBT accessible and available for children include wider dissemination of accurate information about OCD and CBT to parents, school personnel, and health care professionals, as well as in-depth training opportunities for clinicians who treat children.

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