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Cognitive-Behavioral Treatment For Anxiety and OCD in Children
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Neurobehavioral Framework

Overview

The current scientific understanding of OCD (Obsessive-Compulsive Disorder) places the disorder in a neurobehavioral framework i.e. neuro, neurological; behavioral, manifested in thoughts, feelings, and behaviors. OCD is not a bad habit. It is a neurological problem that cannot, in any way, be viewed as the child's fault or as something the child could stop if he or she just tried harder. An easy way to think of OCD is that it is a short circuit, brain hiccup, and/or as a volume control problem in the brain. The brain is like a worry computer that inappropriately sends fear cues when no threat is present or turns up the volume on fear cues that do not deserve so much attention.

OCD is an illness distinct from the child as a person and does not affect the ability of the rest of the brain and child to function normally. Just as children with asthma or diabetes have symptoms that are not willful misbehavior, children with OCD also do not willfully misbehave.

In the approach we are going to use, the child, family members and therapist will be allies against OCD. I will act as "coach" to the child and family.

Externalizing OCD

One key to the success of this approach is the way we will externalize the problem and separate OCD from the child. We describe OCD as an unpleasant neurobehavioral illness in which both the child and family already have some influence over. Our goal is to increase the influence we have over OCD. The first way we do this is by giving that part of the child that has OCD a nasty name. For example, some children choose to call it "the enemy", "the beast", "old friend", or "Bossy." You can be creative with this as long as the name is not too scary or too friendly.

The second way we increase our influence over OCD is by expanding the "transition or work zone". To do this we look for situations in which the child is successful in resisting OCD. We can do this by asking the child "when did OCD (or the name you have given it) not boss you around." We are looking for the times, however small they might appear, that the child wins over OCD. From this information the child is helping spell out the stimulus hierarchy where he or she wins. We will also include on the hierarchy where the child currently looses to OCD. The transition zone defines the transition between the territory controlled by the child and territory controlled by OCD and where the child will work to boss back OCD by selecting the Exposure/Response Prevention (E/RP) tasks. Describing this as a "work zone" also communicates an expectation that the child must do the work to get better.

Gradual exposure

Children who have anxiety disorders typically like treatment to be predictable and controllable. The ways we can help them is by scheduling weekly appointments on the same day and time if possible. We also will use graded exposure where the child has explicit control over the selection of exposure targets, which are addressed in the homework assignments. We need to make sure the treatment is predictable, controllable and successful. The child may want to choose a higher-level exposure task early on and we may have to hold back their enthusiasm to ensure success. We do not want to turn the graded exposure into "flooding" which will reduce compliance with treatment.

Client control and perspective

It is crucial that the treatment not appear as punishment to the child. We tell the child that we will not ask them to do anything that they are not ready for. Our focus is on progress, not the speed of progress.

Obsessions and Compulsions

Obsessions are unwanted thoughts, urges, or images that are accompanied by negative feelings. Compulsions are actions designed to make these thoughts go away and to relieve the negative affects that come along with the obsessions.

A child's view

OCD is a problem in the brain. If the brain were a computer, OCD would be one small chip that kept sending out the wrong message, loudly, to the rest of the computer. One part of the brain sends thoughts, urges, or feeling of fear to the child and to the rest of his or her body when it's not suppose to. It is like the brain gets the hiccups, which the child experiences as OCD. In the child's case, OCD gives them a big fear message about normal every-day experiences. For example, children might go into the bathroom and their brain might tell them to be extra, extra careful and wash their hands many times, instead of gently reminding them to wash before they leave. These fear messages are called obsessions. The second part of OCD is the action the child takes to make the fear message go away, such as washing their hands over and over again. These actions are called compulsions, and they make OCD stronger because the child is doing what OCD wants them to do.

Treatment Process

Psychoeducation

We must remember that OCD is a problem in the brain. If the brain were a computer, OCD would be one small chip that kept sending out the wrong message, loudly, to the rest of the computer, as we discussed in the previous paragraph.

1. Bossing back OCD: The first thing we will do is give OCD a nasty nickname.
2. To boss back OCD we need to know what OCD looks like and how much of the child's life is under the control of OCD. We want to find out what part of his or her life OCD controls, what part the child controls, and what part is half and half.

Cognitive training

In cognitive training (CT) we train the child in cognitive tactics for resisting OCD. The goals are to increase a sense of personal efficacy, predictability, controllability, and self attributed likelihood of a positive outcome for the E/RP tasks. We do this by reinforcing accurate information regarding OCD and its treatment, cognitive resistance and self-administered positive reinforcement and encouragement (positive self-talk). To help the child feel things are more predictable and controllable we frame the E/RP as a strategy and the therapist and parents are allies in the child's battle against OCD. Constructive self-talk (bossing back OCD) and the use of positive coping strategies provide the child with a cognitive "tool kit" to use during exposure and response prevention tasks.

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Mapping OCD

This step maps the child's experience with OCD, including specific obsessions, compulsions, triggers, avoidance behaviors, and consequences. This process generates a "stimulus hierarchy." We will use pictures to visually identify what portion of the child is "OCD" and what portion the child is successfully "bossing back." The section where the child sometimes wins and sometimes loses in the picture demonstrates the "transition zone" or "work zone" where the graded exposure tasks will occur. The thermometer is also useful to help the child create the hierarchy in terms of when OCD really wins (10) and where OCD loses (1).

Graded Exposure and Response Prevention

"Exposure" occurs when the child exposes herself/himself to the feared object, action, or thought. "Response prevention" is the process of blocking rituals and/or minimizing avoidance behaviors. Response prevention takes place when the child refuses to perform the usual anxiety-driven compulsion. A visual metaphor, created by Dr. Aureen Wagner, is found in her book "Up and Down the Worry Hill." Dr. Wagner describes the exposure takes, as the portion of the hill the child has to ride up. It is a hard process, but once at the top of the hill, the child will sail down and be rid of the OCD.

Sources:

March, J. S. & Mulle, K. (1998). *OCD in Children and Adolescents.*

Wagner, A.P. (2004). *Up and Down the Worry Hill.*