

## Intensive Treatment of Specific Phobias in Children and Adolescents

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*One-session treatment (OST), a variant of cognitive-behavioral therapy, combines graduated in vivo exposure, participant modeling, reinforcement, psychoeducation, cognitive challenges, and skills training in an intensive treatment model. Treatment is maximized to one 3-hour session. In this paper, we review the application of OST for specific phobia in youth and highlight practical matters related to OST and its use in a clinical setting. We also briefly review results of treatment outcome studies and suggest future directions for clinical research and practice. We conclude that OST is an efficient and efficacious treatment.*

IT has been suggested that if a clinician is thinking about using cognitive-behavioral therapy (CBT) with anxious youth the clinician should “think exposures” (Kendall et al., 2005). Beyond this initial advice, however, conducting exposure therapy with children and adolescents is more complicated than one might “think.” Many questions are evident. What kind of exposure should be used (in vivo, in imagination, on audio/video tape, or in virtual reality)? Precisely what materials and stimuli will be needed? How will they be obtained? Where will they be kept? Can I do it myself or do I need an assistant? What length of exposure (i.e., brief or prolonged) should I use? At what dose (spaced or massed)? How does one plan and conduct an exposure? Does one need to get specialized training or supervision to ensure competence? As a result, “thinking exposure” with anxious youth is complicated and requires a rich understanding of developmental psychopathology and familiarity with increasingly intensive and efficacious treatment formats (cf. Davis, 2009; Ollendick, Davis, & Sirbu, in press).

In this paper, we will focus on a host of practical issues associated with using exposure therapy for the treatment of specific phobia in children and adolescents. In doing so, we briefly review the literature, which has brought exposure therapy for child phobia from a multi-session downward extension of adult therapy to a more developmentally informed, intensive, single session of cognitive-behavioral therapy (CBT) termed “One-Session Treatment” (OST; cf. Öst, 1987a, 1989, 1997; Ollendick et al., in press). In addition, in as much as a systematic

review of the conceptual underpinnings of OST and its treatment efficacy has recently been published (Zlomke & Davis, 2008), we will focus more on the actual implementation of OST with children in this paper and on extending the techniques described in the unpublished OST manual for children (Öst & Ollendick, 2001).

### Specific Phobias in Children

Experiencing fear and anxiety is normal and healthy in the course of child development and emotional growth. These emotions can even be looked upon as adaptive and, more importantly, as impressive markers of increasingly complex cognition and abstract thought processes (Muris, Merckelbach, Meesters, & van den Brand, 2002; Ollendick, Hagopian, & King, 1997). The evolution from transient, concrete fears of animals to more elaborate fears of supernatural phenomena (e.g., the “Boogeyman”) in children signals a welcome progression in the capability for abstract thought. However, when these fears linger and become more intense, a different type of developmental event may be signaled—the development of a specific phobia. In particular, strong, persistent, specific fears lasting more than 6 months and accompanied by intense physiological symptoms and avoidance or distress typify the presence of a specific phobia (*Diagnostic and Statistical Manual of Mental Disorders—4<sup>th</sup> edition, text revision; DSM-IV-TR*; American Psychiatric Association, 2000). Such fears have been shown to exist in 5% of children in community samples and up to 10% of children in mental health settings (Ollendick et al., 1997). Other research based on parental reports has suggested, however, that as many as 17.6% of children with “childhood fears” may meet criteria for specific phobia (Muris & Merckelbach, 2000) and, based on child report, that 22.8% of children who report

specific fears may meet criteria for an actual phobic disorder (Muris, Merckelbach, Mayer, & Prins, 2000). Moreover, although the average age of onset of specific phobia is between 9 and 10 years of age (although a wide range has been reported that varies by type of fear; cf. Öst, 1987b), fewer than 10% of adults report ever seeking treatment for their phobias and that the average duration of their phobias is 20 years (Stinson et al., 2007). The developmental, psychological, and medical impact of these phobias is significant, with sufferers accessing medical care at a rate higher than those with obsessive-compulsive disorder and second only to panic disorder (Deacon, Lickel, & Abramowitz, 2008). This plight is especially distressing given the efficacious child treatments that may offset such developmental impacts.

Clinicians treating child phobias are able to choose from several evidence-based treatment options that focus on exposure: for example, reinforced practice (i.e., contingency management), participant modeling, systematic desensitization (though historically efficacious, it has not received widespread use or study with children in recent decades), and CBT. Interestingly, however, with few notable exceptions most of the research on these efficacious treatment modalities with children is decades old (Davis & Ollendick, 2005; Ollendick, King, & Chorpita, 2006). Innovation in treating child phobias in recent years has come less from reinventing the wheel than from engineering how the wheels can move together to be more efficient: newer treatment alternatives have typically represented innovative ways of combining older, established techniques into a single therapy. It is this transformation,

combination, and adaptation of treatments provided over the course of several sessions into a well-tolerated, single massed session of exposure to which we now turn.

### Details About Applying the Treatment to Children Overview

Treatments for child anxiety have been suggested to work through diverse processes such as counterconditioning, extinction, habituation, change in catastrophic cognitions, development of coping skills, increased self-efficacy, emotional processing, and changes in expectancies and perceptions of dangerousness (Bouchard, Mendlowitz, Coles, & Franklin, 2004; Kendall et al., 2005). While one, some, or all of these processes may be implicated as mechanisms of change, what are really being proposed are alterations in one or more of the components of the tripartite phobic emotional response—physiology, behavior, and cognition. OST theoretically excels at targeting all three components of the phobic response (Davis & Ollendick, 2005). OST combines graduated in vivo exposure, participant modeling, reinforcement, psychoeducation, cognitive challenges, and skills training (Öst, 1997; Zlomke & Davis, 2008). The use of these techniques may seem a daunting and draining exercise to most clinicians unfamiliar with exposure therapy; however, we believe it is most beneficial to view the various techniques as tools in a clinician's toolkit specifically designed to address different aspects of the problematic fear. Hierarchical exposure, then, serves to elicit the child's fear and allows the clinician to implement one or more techniques to address the nuances of a child's phobic

Table 1  
Parting thoughts and reminders for conducting One-Session Treatment

- Expose and prepare yourself in advance—be sure you are comfortable with the stimulus yourself. You need to be able to model approach behaviors calmly and effectively.
- Know your stimuli—be familiar with the animals, insects, elevator, setting, etc. you are using and any quirks inherent to them. For example, does that dog have a tender spot or ailment; will that type of lizard drop its tail if distressed?
- Plan where you can safely and ethically house stimuli until they are needed (e.g., who will walk the dog? Does it have water? etc.).
- Consider the time of year and/or where to get stimuli before agreeing to treatment. For example, where do you get bees/wasps in the winter; do you know anyone with a pet snake?
- As best as possible, prepare what to say to an inquisitive stranger (or a familiar face) if you conduct exposure in a public place.
- Know what is safe for the people involved and the stimuli—do you know if the spider you are planning to use is poisonous? Better yet, does your patient have an allergy that you need to know about (e.g., to even nonpoisonous spider venom, bee stings, animal dander, etc.)? Is the dog you are using on a special diet and cannot be fed regular dog biscuits during a behavioral experiment (this actually occurred during a session—he vomited—but it was actually useful to the exposure and the dog was unharmed; i.e., “See, dogs get sick too.”)?
- Do not be afraid to get supervision or to consult. What is the best recipe for fake vomit? How do you work with bees/wasps and not get stung? How do you adapt a session to a child's developmental level? For most clinicians inexperienced with children, anxiety, or exposure therapy, OST involves more than reading the manual (Öst & Ollendick, 2001) or watching a demonstration video.
- Be prepared if the unexpected should happen, and if possible use it to your advantage in treatment. For example, as best you can, prepare yourself mentally for what you will do if the snake/dog/etc., bites you during the exposure.\*

Note: \* After you are collected, usually it is something like, “So, was that as bad as you thought it would be?” “Did [insert catastrophic cognition] happen?”

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