

Cognitive-behavioral treatment for specific phobias with a child demonstrating severe problem behavior and developmental delays[☆]

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Abstract

Cognitive-behavioral treatments (CBTs) are widely used for anxiety disorders in typically developing children; however, there has been no previous attempt to administer CBT for specific phobia (in this case study, one-session treatment) to developmentally or intellectually disabled children. This case study integrates both cognitive-behavioral and behavior analytic assessment techniques in the CBT of water and height phobia in a 7-year-old male with developmental delays and severe behavior problems. One-session treatment [Öst, L. G. (1989). One-session treatment for specific phobias. *Behaviour Research and Therapy*, 27, 1–7; Öst, L. G. (1997). Rapid treatment of specific phobias. In G. C. L. Davey (Ed.), *Phobias: A handbook of theory, research, and treatment* (pp. 227–247). New York: Wiley] was provided for water phobia and then 2 months later for height phobia. The massed exposure therapy sessions combined graduated in vivo exposure, participant modeling, cognitive challenges, reinforcement, and other techniques. Both indirect and direct observation measures were utilized to evaluate treatment efficacy. Results suggested CBT reduced or eliminated behavioral avoidance, specific phobia symptoms, and subjective fear. Negative vocalizations were reduced during height exposure following treatment. Vocalizations following treatment for water phobia were less clear and may have been indicative of typical 7-year-old protests during bath time. Findings indicate CBT can be effective for treating clinical fears in an individual with

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developmental disabilities and severe behavior. Future research in this population should examine CBT as an alternative to other techniques (e.g., forced exposure) for treating fears.

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The application of cognitive-behavioral therapies (CBT) to children with intellectual and developmental disabilities is a relatively new and emerging field of study. Recent studies and reviews highlight the need for further examination of these techniques with this special population (see the *Journal of Applied Research in Intellectual Disabilities*, vol. 19, 2006 for a special issue reviewing the use of CBT in the intellectually disabled). Moreover, there have been numerous calls for behavior analysts to investigate anxiety (e.g., Friman, Hayes, & Wilson, 1998) and, concomitantly, there has been a growing need for more precise and systematic behavioral measurement of anxiety by cognitive-behaviorists (Davis & Ollendick, 2005). Unfortunately, there has been little convergence between these two fields. The extant literature on anxiety and specific phobia within these two fields seem to have developed largely in isolation, with neither making use of the significant contributions of the other.

Specific phobias are intense, problematic fears of particular animals, objects, situations, or environments (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., text-revision, 2000; DSM-IV-TR). According to the DSM-IV-TR (pp. 443–450), to meet criteria for diagnosis there must be a specific cue which evokes a marked and persistent fear (criterion A), cue exposure must prompt an anxiety response (criterion B), the cue must be avoided or endured with distress (criterion D), and the fear or its consequences must interfere with the individual's typical functioning. Importantly, with children there are two distinct differences: there is no need for a child to report that fear is excessive (criterion C) and there must be a minimum of 6 months duration of the phobic symptoms (criterion F) to assure the fear is not developmentally appropriate and transient. These criteria, C and F, are likely of equal importance when treating those with intellectual or developmental disabilities of any age. Fears with this intensity and impairment occur in approximately 5% of typically functioning children in community samples and 15–20% of children presenting to anxiety disorder clinics (Ollendick, Hagopian, & King, 1997). Rough estimates have suggested specific phobia could affect as many as 350,000 children in communities across the United States (Davis & Ollendick, 2005).

Given the pervasiveness of the problem, a variety of exposure-based interventions have been created to treat specific phobia in children. The ongoing push to identify empirically supported treatments (ESTs) for childhood disorders (task force on promotion and dissemination of psychological procedures; Task Force, 1995; Chambless et al., 1996, 1998; Chambless & Ollendick, 2001) has resulted in the identification of several empirically supported treatments for specific phobias in typically developing children (Davis & Ollendick, 2005; Ollendick & King, 1998). These interventions are imaginal and in vivo systematic desensitization, reinforced practice, participant modeling, and CBT and its variants (Davis & Ollendick, 2005). Briefly, systematic desensitization involves counter-conditioning fear by pairing a hedonically incompatible response with exposure to the feared stimulus (e.g., relaxation). Reinforced practice simply involves shaping approach behavior to the feared stimulus through operant procedures, while participant modeling involves having the therapist model approach behavior toward and appropriate interactions with the feared stimulus while actively involving the

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