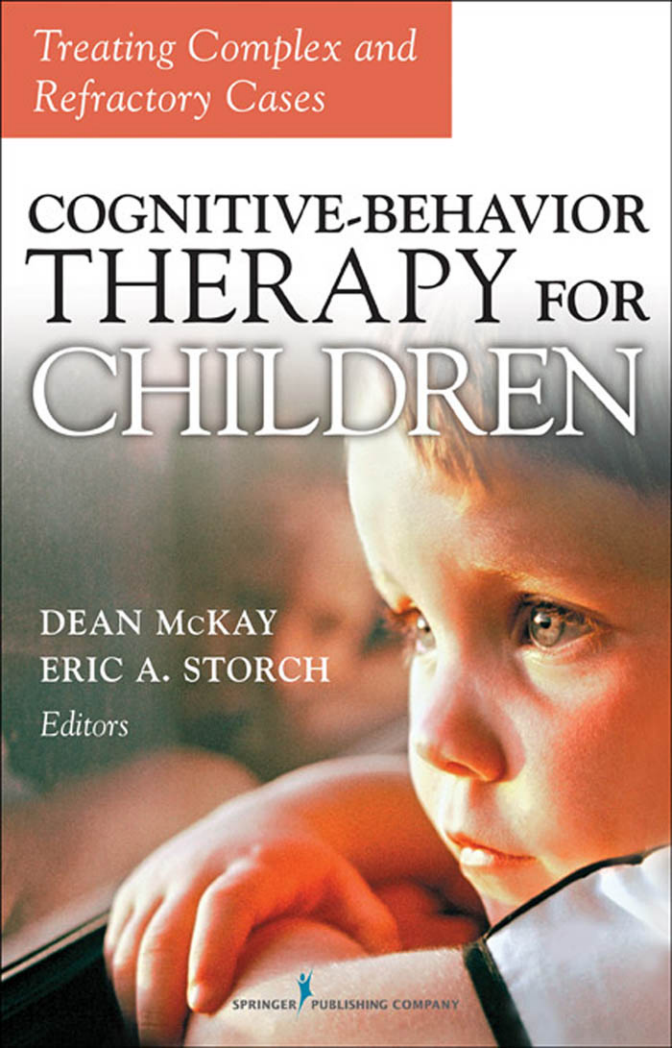
*Treating Complex and Refractory Cases*

# COGNITIVE-BEHAVIOR THERAPY FOR CHILDREN



DEAN McKAY
ERIC A. STORCH
*Editors*

SPRINGER PUBLISHING COMPANY

# Cognitive-Behavior Therapy for Children

## *Treating Complex and Refractory Cases*

**DEAN McKAY, PhD, ABPP**

**ERIC A. STORCH, PhD**

**Editors**

SPRINGER PUBLISHING COMPANY
New York

**Dean McKay, PhD, ABPP,** is Associate Professor, Department of Psychology, Fordham University. He currently serves on the editorial boards of *Behaviour Research and Therapy*, *Journal of Clinical Psychology,* and *Journal of Anxiety Disorders,* and is Associate Editor of *Journal of Cognitive Psychotherapy*. He has published over 120 journal articles and book chapters, is editor or co-editor of 8 published or forthcoming books, and has given over 150 conference presentations. Dr. McKay has been a member of the Obsessive Compulsive Cognitions Working Group since 1995. He is Board Certified in Behavioral and Clinical Psychology by the American Board of Professional Psychology (ABPP), is a Fellow of the American Board of Behavioral Psychology and the Academy of Clinical Psychology as well as a Clinical Fellow of the Behavior Research and Therapy Society. His research has focused primarily on obsessive-compulsive disorder (OCD), body dysmorphic disorder, and health anxiety and their link to OCD and the role of disgust in psychopathology. His research has also focused on mechanisms of information-processing bias for anxiety states. Dr. McKay is also director and founder of the Institute for Cognitive Behavior Therapy and Research, a private treatment and research center in Westchester County, New York. He resides in Port Washington, New York, with his wife, Dawn, and daughter, Rebecca.

**Eric A. Storch, PhD,** earned his BA in Psychology from Binghamton University in 1997, followed by his MS, MPhil, and PhD degrees in Child-Clinical Psychology from Teachers College, Columbia University. At the University of South Florida, he is currently an Associate Professor of Clinical Psychology in the Department of Pediatrics and holds joint appointments in the Departments of Psychiatry and Psychology. Dr. Storch is a licensed clinical psychologist and serves as the Director of the University of South Florida Obsessive Compulsive Disorder Program.

Dr. Storch specializes in the cognitive behavioral treatment of adult and childhood obsessive-compulsive disorder (OCD), as well as other obsessive-compulsive spectrum disorders (e.g., trichotillomania, tic disorders, body dysmorphic disorder, skin picking) and anxiety disorders. He is highly regarded for the psychological treatment of OCD, particularly with regard to treatment-refractory cases. He also has a special interest in the dissemination of effective psychological treatment approaches for OCD and tics as well as in the development and validation of OCD assessment measures. Dr. Storch has published over 150 peer-reviewed articles. He is the lead editor on a text entitled *Handbook of Child and Adolescent Obsessive-Compulsive Disorder*. Dr. Storch has received grant funding from the National Institute of Mental Health, Obsessive Compulsive Foundation, National Alliance for Research on Schizophrenia and Depression (NARSAD), Foundation for Prader-Willi Research, and numerous other foundations for his research on OCD and related topics. He resides in Tampa, Florida, with his wife, Jill, and their daughter, Maya.

Springer Publishing Company, LLC
11 West 42nd Street
New York, NY 10036
www.springerpub.com

*Acquisitions Editor: Sheri W. Sussman*
*Production Editor: Pamela Lankas*
*Cover design: Mimi Flow*
*Composition: International Graphic Services*

Ebook ISBN: 978-0-8261-1687-1

09 10 11 12 / 5 4 3 2 1

Printed in the United States of America by Hamilton Printing.



**Library of Congress Cataloging-in-Publication Data**

Cognitive-behavior therapy for children : treating complex and refractory cases / Dean McKay, Eric A. Storch, editors.
p. ; cm.
Includes bibliographical references and index.
ISBN 978-0-8261-1686-4 (alk. paper)
1. Cognitive therapy for children. 2. Cognitive therapy for teenagers. 3. Child psychotherapy. I. McKay, Dean, 1966. II. Storch, Eric A.
[DNLM: 1. Cognitive Therapy—methods. 2. Adolescent. 3. Child. 4. Mental Disorders—therapy. WS 350.6 C67625 2009]
RJ505.C63C646 2009
618.92'891425—dc22
2009017312

*This book is dedicated to my family, Dawn and Rebecca, for their support and encouragement and for being such fun travel partners, both on vacation and in life. And for the children whom I have worked with, for creating a sense of importance in determining effective means of alleviating distress.*

**—Dean McKay**

*With much love this book is dedicated to my mother and father, who instilled in me both the joy of learning and the importance of helping others. And to my daughter, Maya—thank you for being the perfect reason to come home from work early.*

**—Eric Storch**

# Contents

# Contributors

**Anne Marie Albano, PhD**, Department of Psychiatry, Columbia University College of Physicians and Surgeons, New York, New York

**Renae Beaumont, BSc (Hons), PhD**, School of Psychology, University of Queensland, Brisbane, Australia

**Sara J. Becker, MA**, Department of Psychology and Neuroscience, Duke University, Durham, North Carolina

**Elissa J. Brown, PhD**, Department of Psychology, St. John's University, Queens, New York

**Tymesha Buckner, MA**, Applewood Centers, Elyria, Ohio

**Carole L. Campbell, PhD**, Department of Psychiatry, Children's Hospital of the King's Daughters, Norfolk, Virginia

**Bruce F. Chorpita, PhD**, Department of Psychology, University of California–Los Angeles, Los Angeles, California

**Christine A. Conelea, MS**, Department of Psychology, University of Wisconsin–Milwaukee, Milwaukee, Wisconsin

**John F. Curry, PhD**, Professor and Director of Clinical Psychology, Department of Psychology and Neuroscience, Duke University, Durham, North Carolina

**Carla Kmett Danielson, PhD**, Assistant Professor, Department of Psychiatry, Medical University of South Carolina, Charleston, South Carolina

**Thompson E. Davis III, PhD**, Department of Psychology, Louisiana State University, Baton Rouge, Louisiana

**Angela Celio Doyle, PhD**, Department of Psychiatry, University of Chicago, Chicago, Illinois

**Norah Feeny, PhD**, Associate Professor, Department of Psychiatry, Case Western Reserve University, Cleveland, Ohio

**Clint E. Field, PhD**, Director, Psychology Community Clinic, Department of Psychology, Utah State University, Logan, Utah

**Sarah Fischer, PhD**, Assistant Professor, Department of Psychology, University of Georgia, Athens, Georgia

**Gary R. Geffken, PhD**, Department of Psychiatry, University of Florida, Gainesville, Florida

**Erin L. Girio, MA**, Department of Psychology, Ohio University, Athens, Ohio

**Daniel le Grange, PhD**, Department of Psychiatry, University of Chicago, Chicago, Illinois

**Paulo Graziano, MA**, Department of Clinical and Health Psychology, University of Florida Health Center and Department of Psychology, University of North Carolina at Greensboro, Greensboro, North Carolina

**Wendy N. Gray, MS**, Department of Clinical and Health Psychology, University of South Florida, Gainesville, Florida

**David M. Janicke, PhD**, Department of Clinical and Health Psychology, University of South Florida, Gainesville, Florida

**Mary L. Keeley, MS**, Department of Clinical and Health Psychology, University of Florida Health Center and Department of Psychiatry and Behavioral Sciences, Emory University, Atlanta, Georgia

**Alyssa M. Marder, PhD**, Department of Psychology, University of California–Los Angeles, Los Angeles, California

**Lisa J. Merlo, PhD**, Assistant Professor, Department of Psychiatry, University of Florida, Gainesville, Florida

**Miguel Morales, MD**, Child Psychiatrist, Departments of Pediatrics and Psychiatry, University of South Florida, Gainesville, Florida

**Melanie W. Moretz, PhD**, Department of Psychology, Fordham University, Bronx, New York

**Brett Nelson, MD**, Departments of Pediatrics and Psychiatry, University of South Florida, Gainesville, Florida

**Thomas H. Ollendick, PhD**, Department of Psychology, Child Study Center, Virginia Polytechnic Institute and State University, Blacksburg, Virginia

**Julie Sarno Owens, PhD**, Department of Psychology, Ohio University, Athens, Ohio

**Tara Peris, PhD**, Department of Psychiatry, University of California–Los Angeles School of Medicine, Los Angeles, California

**John Piacentini, PhD**, Department of Psychiatry, University of California–Los Angeles School of Medicine, Los Angeles, California

**Jennifer Regan, BA**, Department of Psychiatry, Columbia University College of Physicians and Surgeons, New York, New York

**Thomas M. Reimers, PhD**, Clinic Director, Boys Town Pediatric and Family Services Clinic, Clinical Associate Professor, Creighton University School of Medicine, Omaha, Nebraska

**Lauren Richerson, PhD**, Department of Psychology, Ohio University, Athens, Ohio

**Connie J. Schnoes, PhD**, Boys Town Pediatric and Family Services Clinic, Boys Town, Nebraska

**Cristian Sirbu, MD, PhD**, Charleston Area Medical Center Health Education and Research Institute and West Virginia University School of Medicine–Charleston Division, Charleston, South Carolina

**Heather L. Smith, PhD**, Department of Psychiatry, Montefiore Hospital and Albert Einstein School of Medicine, Bronx, New York

**Kate Sofronoff, PhD**, School of Psychology, University of Queensland, Brisbane, Australia

**Amanda M. Stone, MA**, Department of Psychiatry, University of Florida, Gainesville, Florida

**Sharon C. Sung, PhD**, Department of Psychiatry, Montefiore Hospital and Albert Einstein School of Medicine, Bronx, New York

**Cydney J. Van Dyke, MA**, Department of Psychology, Fordham University, Bronx, New York

**Michael R. Walther, BS**, Department of Psychology, University of Wisconsin-Milwaukee, Milwaukee, Wisconsin

**Douglas W. Woods, PhD**, Department of Psychology, University of Wisconsin-Milwaukee, Milwaukee, Wisconsin

**Eric A. Youngstrom, PhD**, Department of Psychology, University of North Carolina–Chapel Hill, Chapel Hill, North Carolina

**Jen Kogos Youngstrom, PhD**, Department of Psychology, University of North Carolina–Chapel Hill, Chapel Hill, North Carolina, and Applewood Centers, Elyria, Ohio

# Foreword

Readers of *Cognitive-Behavior Therapy for Children: Treating Complex and Refractory Cases* are likely drawn to this book to learn more about how to alleviate most effectively the distress of children and adolescents who suffer from psychiatric disorders. The development and evaluation of psychological treatments has yielded an array of interventions with scientific documentation to help affected youth. Mental health professionals, as a consequence, have at their disposal many available methods by which to reduce child and adolescent disorders. Most of these methods rely on cognitive-behavioral treatment procedures. Although the probability is high that other treatments currently in use in the field, as well as treatments under development or interventions yet to be developed, are also effective, one cannot deny that cognitive-behavioral therapy (CBT) has advanced most significantly over the past decades.

In this context, the current volume is significant because it addresses head-on an issue that has been generally neglected in the literature. Namely, despite the availability of effective CBTs to address key child and adolescent disorders, including those that are covered in this book (e.g., depression, separation anxiety disorder), substantial proportions of youth treated with evidence-based CBT protocols fail to show symptomatic improvement at posttreatment evaluations. This book does not sweep this fact under the rug, neither does it transmit a sense of hopelessness and helplessness to a subset of child and adolescent clients. Instead, the editors have brought together leading experts to synthesize and analyze a body of research on treatment outcome predictors and barriers of treatment for the different disorders. Chapter authors cogently describe barriers to treatment implementation and recommend systematic adjustments to help improve the outcomes of formerly refractory child and adolescent clients.

The current volume is significant on another level. This book highlights the fact that the sharp distinctions often drawn in the literature

between efficacy and effectiveness can be misleading. "Efficacy" refers to whether a particular CBT has been found to "work" by means of experimental procedures. "Effectiveness" refers to whether a particular CBT has been found to "work" in settings and under conditions in which the treatment will typically be delivered, such as in private practice and community mental health clinics. The chapters contained herein highlight the notion that the child and adolescent psychological treatment research literature is better characterized as falling along a continuum with respect to efficacy and effectiveness. Many so-called efficacy studies are high in external validity and many so-called effectiveness studies use rigorous internal validity or controls. It is this continuum between efficacy and effectiveness that made it possible for the chapters' authors to blend lessons learned from both areas to formulate recommendations about the handling of complex and refractory cases. These recommendations are not only empirically informed but are also richly illustrated through case examples that showcase the authors' clinical acumen and skills.

*Cognitive-Behavior Therapy for Children: Treating Complex and Refractory Cases* thus represents an important effort in narrowing the gap between research and practice. The reluctance of many clinicians to adopt evidence-based treatments in their practices often occurs because they have found that these treatments may help some of their clients, but, for other clients, the treatments did not help or helped only partially. Families dropped out, children could not become engaged, debilitating comorbid symptoms interfered with the CBT procedures, and other extant factors were operating. The chapters in hand delineate these factors for each of the disorders covered. Clinicians can turn to these chapters when faced with the challenge of treating clients whose manifestations do not permit application of evidence-based CBT protocols as described in the literature. Having an understanding of these issues provides the clinician in practice with the flexibility to be adaptable to variations in problem, context, or condition.

The chapters also provide a valuable guide that researchers can turn to in their efforts to expand the current evidence base for child and adolescent psychological treatments. The chapters' coverage of which subgroups of child and adolescent patients show optimal response to current intervention strategies, and which subgroups do not, is essential to "get at" moderators of treatment outcome. The chapters' coverage

of how treatments need to be adjusted for certain cases is also essential to get at mediators of treatment outcome.

Consequently, the chapters suggest avenues for future study designs that might include comprehensive and systematic assessments to measure hypothesized moderating and mediating variables. Such designs might also include the assessment of why child and adolescent clients do not adhere to CBT protocols. Such designs, which move beyond the "basic" pre–post randomized clinical trial design, will ultimately lead to significant theoretical advances about child and adolescent psychosocial treatments and, concomitantly, lead to more effective and better treatments for these debilitating child and adolescent disorders.

The result, I hope, of *Cognitive-Behavior Therapy for Children: Treating Complex and Refractory Cases* is that it will help to optimize the mental health interventions that children and adolescents deserve to receive—treatments that have, at their core, the theory and methods of CBT. It is also my hope that this important volume will reduce the barriers that currently exist in the implementation of evidence-based CBTs in clinical and community practice settings.

Wendy K. Silverman, PhD, ABPP
*Professor of Psychology*
*Florida International University*
*Miami, Florida*

# General Issues in Refractory Cases

PART I

# 1 The Challenge of Difficult Cases

DEAN McKAY AND ERIC A. STORCH

At the present time, there are empirically supported treatments for most of the major psychiatric diagnoses that may be identified in children and adolescents. The advent of these empirically supported approaches has been critical in providing a heuristic for developing treatment plans for affected youth. No client neatly fits into the ideal template for any empirically supported treatment program, however. There are innumerable client-specific factors that may alter the nature and outcome of even the most carefully conducted therapy program.

A sign of maturity for any treatment research program is the ability to move beyond interventions for specific diagnoses and address, systematically, prognostic limitations that might interfere with standard delivery of care. Cognitive-behavioral therapy (CBT) has advanced significantly over the past quarter century. When refractory cases were first systematically discussed for adult clients, there were two important distinctions that occurred. First, many clinicians were resigned to the notion that nonresponders were "treatment failures" often directly or indirectly conveying a sense of hopelessness to a subset of clients (Foa & Emmelkamp, 1983). Second, 25 years ago there was a limited body of literature on empirically supported treatment and virtually no data available on outcome predictors. Instead, CBT-oriented clinicians were

refining individual techniques and only beginning to see CBT's widespread applicability to diagnoses (Franks & Wilson, 1973).

As is so often the case, many of the empirically supported approaches for major psychiatric diagnoses were developed with adults in mind. To this end, the ability to describe barriers to treatment implementation and the inclusion of empirically supported modification to these therapies has progressed faster for adults and has recently been summarized (McKay, Abramowitz, & Taylor, in press). Nonetheless, there appears a widespread reluctance to consider refractory cases, perhaps because of the inherent difficulty associated with the term. Fortunately, as more researchers endeavor to address poor prognostic signs, the ability to address these problems will help move formerly refractory clients into a different category, perhaps merely referenced by the diagnosis with special modifiers.

Whereas there are now two texts that deal directly with refractory cases in adult disorders (Foa & Emmelkamp, 1983; McKay et al., in press), this book is the first to cover this topic in children and adolescents. The importance of addressing such cases may serve the purpose of bridging the gap between laboratory and controlled treatment outcome results and applicability in the clinic. For example, Weisz and colleagues (Weisz, Donenberg, Han, & Weiss, 1995) found that outcomes with children and adolescents were generally poorer for specific diagnoses when treated in community clinic settings when compared with protocols for empirically supported treatments. On the one hand, this may simply reflect the variations and unreliability of uncontrolled treatment implementation. On the other hand, it also likely reflects the variety of known complicating factors that often lead to exclusion from clinical trials, particularly in the early stages of treatment development.

## EMPIRICALLY SUPPORTED TREATMENTS VERSUS EMPIRICALLY SUPPORTED PRACTICE

In some respects, the movement to identify factors that may interfere with standard delivery of empirically supported treatment packages is a movement back to the early days of behavior therapy. At that time, there was limited reliance on diagnosis, and instead a focus on functional analyses of behavior that allowed for identification of theory-driven empirically supported techniques. The approach of empirically supported practice (McKay & Tryon, 2002) or, in a nod to classification,

the transdiagnostic approach (Harvey, Watkins, Mansell, & Shafran, 2004), is consistent with the broader approach to training clinicians based on principles of psychological clinical science (for a historical perspective, see Bootzin, 2007). A comparison that summarizes this distinction is in order. Engineers building a bridge do not rely on a manual for bridge building, but are daunted by limitations such as variations in river width or tidal changes that deviate from the originally empirically supported approach to building a bridge. Instead, there are a set of theoretically derived principles that guide bridge building, with limitations coming also from that same theory (i.e., water depth combined with width of expanse). Psychological science may be entering a similar phase of treatment development.

With respect to childhood disorders, we are perhaps better positioned to use previously empirical support than for adult disorders. Many empirically supported treatments for children are age-downward extensions of the same protocol for adults. A notable example is the treatment of childhood obsessive-compulsive disorder (OCD). The early empirically supported treatment involves exposure with response prevention. This approach, even with modifications drawn from cognitive therapy, remains the key therapeutic element in treatment for adults with the disorder (Abramowitz, Taylor, & McKay, 2005). However, in the case of children with OCD, it is not necessarily the case that there will be good insight into the disorder. In adults, poor insight is also a poor prognostic indicator for the disorder (McKay & McKiernan, 2005). In such instances, exposure-based treatments are not necessarily advised. This would suggest a modified approach, or one that does not rely at all on previously successful approaches used with adults. In the case of diagnoses first identified in childhood (e.g., attention-deficit/hyperactivity disorder [ADHD]; separation anxiety disorder), treatments may be developed specifically with children in mind, an unusual scenario in psychological interventions. In fact, it is in this arena that there may be age-upward extensions to adult presentations of similar problems. Such is the case with ADHD, where at least in the case of psychopharmacological management, there are now numerous trials of stimulant medication for attention problems in adults (Davidson, 2008).

## SCOPE OF THIS VOLUME

This book has been developed with both researchers and clinicians in mind. We considered researchers as we sought to identify prognostic

signs that would be the source of future research into developing and refining treatment for a wide range of childhood disorders. We bore clinicians in mind as they face the challenge of treating clients who present with what immediately may fit neatly into a diagnostic category, but whose specific manifestation of the condition does not permit application of the standard protocols as described in the published literature.

The book is organized into three major sections. The first provides an overview of general considerations that may lead to barriers in treatment for children and adolescents. As noted earlier, many empirically supported approaches are age-downward extensions of previously validated approaches for adults. However, childhood and adolescence are complex developmental periods. When psychopathology intrudes on youth, there are specific considerations in developing treatments, and special barriers to implementation that must be addressed. Should one fail to contend with these special considerations, treatment may fail before one even reaches a prognostic barrier that is unique to the diagnosis in question.

The second section deals with issues involving internalizing disorders, or those related to inner emotional disturbance. Oftentimes, these children present with problems that are a source of disturbance for parents and child alike, but do not necessarily rise to the attention of school personnel. Many of the disorders in this section conform to the age-downward extension model of treatment development. The final section addresses externalizing disorders. Most of these conditions are ones initially identified in childhood. Clinicians treating these disorders must often devote significant energy working with other personnel (i.e., school personnel, other providers) as well as parents, and perhaps spend more time with these individuals than with the identified child client. In both sections on internalizing and externalizing disorders, case illustrations are provided detailing ways in which treatment was modified from the original approach to address complicating factors.

It is our hope that this text will inform researchers and clinicians alike as they provide services to children and adolescents with a wide range of psychopathology. In light of the advances in the delivery of CBT, we feel that this is a timely occasion to consider the wide range of psychotherapy modifications available to address factors that may negatively impact outcome.

## REFERENCES

Abramowitz, J. S., Taylor, S., & McKay, D. (2005). Potentials and limitations of cognitive treatments for obsessive-compulsive disorder. *Cognitive Behaviour Therapy, 34*, 140–147.

Bootzin, R. R. (2007). Psychological clinical science: Why and how we got to where we are. In T. A. Treat, R. R. Bootzin, & T. B. Baker (Eds.), *Psychological clinical science: Papers in honor of Richard M. McFall* (pp. 1–28). New York: Taylor & Francis.

Davidson, M. (2008). ADHD in adults: A review of the literature. *Journal of Attention Disorders, 11*, 628–641.

Foa, E. B., & Emmelkamp, P. M. G. (1983). *Failures in behavior therapy*. New York: Wiley.

Franks, C. M., & Wilson, G. T. (1973). *Annual review of behavior therapy*. Oxford, UK: Brunner/Mazel.

Harvey, A., Watkins, E., Mansell, W., & Shafran, R. (2004). *Cognitive behavioural processes across psychological disorders: A transdiagnostic approach to research and treatment*. Oxford, UK: Oxford University Press.

McKay, D., Abramowitz, J.S., & Taylor, S. (in press). *Cognitive behavior therapy for refractory cases: Turning failure into success*. Washington, DC: American Psychological Association.

McKay, D., & McKiernan, K. (2005). Information processing and cognitive behavior therapy for obsessive-compulsive disorder: Comorbidity of delusions, overvalued ideas, and schizophrenia. *Cognitive and Behavioral Practice, 12*, 390–394.

McKay, D., & Tryon, W.W. (2002). Behavior therapy: Theoretical bases. In W. Sledge & M. Hersen (Eds.), *Encyclopedia of psychotherapy* (Vol. 1, pp. 277–291). San Diego, CA: Academic Press.

Weisz, J. R., Donenberg, G. R., Han, S. S., & Weiss, B. (1995). Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. *Journal of Consulting and Clinical Psychology, 63*, 688–701.