Introduction

Obsessive–compulsive disorder (OCD) affects an estimated one of every 200 children in the United States, and as many as 50% to 60% of the youth diagnosed with OCD experience severe impairment in their personal, social, and academic life. Although researchers and clinicians have recognized for many years that cognitive behavior therapy (CBT) is an effective treatment for adults with OCD, the application of this treatment to youth lagged until 1989, when John March and his colleagues developed a CBT protocol specifically for the unique needs of youth with this debilitating disorder. In 1998, March (with Karen Mulle) published the treatment protocol and his findings from the research study in the book titled *OCD in Children and Adolescents: A Cognitive-Behavioral Treatment Manual*. The book is a landmark in the treatment of pediatric OCD and is responsible for introducing clinicians around the world to the power and benefits of this approach.

However, treatment protocols, such as the one designed by John March and his colleagues, are primarily for researchers, not necessarily for clinicians. To test the efficacy of a psychological treatment, researchers ensure that all subjects in a study receive the psychological interventions at the same intensity, in the same order, and in the same manner. The process of standardizing treatment results in protocols that limit to some degree the clinician's flexibility and creativity. The view of many clinicians that they must "follow the book" to provide evidence-based treatment often prevents them from accepting these treatments into their clinical practice. At the same time, although many clinicians hold this view, we know that this view is not quite accurate.

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Cognitive Behavior Therapy for OCD in Youth: A Step-by-Step Guide, by M. A. Tompkins, D. J. Owen, N. H. Shiloff, and L. R. Tanner

Our experience is that clinicians (outside of standardized treatment studies) who provide evidence-based treatments rarely follow the book and instead flexibly and creatively apply the components or interventions within the treatment approach based on a comprehensive case conceptualization. In other words, flexibility and creativity are between the lines of every treatment protocol, but most clinicians are not aware of this. We have written this book to reach these clinicians and to describe explicitly the flexibility and creativity inherent in CBT for pediatric OCD.

What do we mean by *flexibility* and *creativity*? By *flexibility*, we mean the thoughtful selection and application of the core strategies that are part of CBT for pediatric OCD. These evidence-based core strategies include prolonged exposure and response prevention primarily, but also other strategies such as engagement, decreasing family accommodation behaviors, and relapse prevention. At the same time, most treatment protocols do not, in our opinion, provide clinicians with sufficient guidance to understand when and how to apply these core strategies. This is the job of case conceptualization. A comprehensive case conceptualization enables the clinician to pick and choose, in a thoughtful and flexible manner, what to include in the treatment and to what degree. Most protocols or treatment manuals assume clinicians have a firmer and more comprehensive understanding of CBT and cognitive behavior conceptualization than many clinicians do. We have written this book not only to underscore the importance of a case conceptualization-driven modular approach and the value it brings to the treatment of pediatric OCD, but also to explain how to do it, particularly across a range of symptoms, co-occurring conditions, and developmental ages of youth.

By *creativity*, we mean the ability to think on ones' feet, that is, to creatively apply the core evidence-based strategies to the unique strengths and weakness of a particular youth while engaging the youth in the active application of these strategies to the problem at hand. Many clinicians believe that a treatment protocol limits their creativity with youth. They believe a treatment protocol boxes them into thinking about OCD in a certain way and doing CBT for it in a lockstep fashion. However, we know that to be effective, clinicians need to feel free to think outside the protocol box and to do what they love to do—to be creative and do what makes clinical sense while at the same time applying the evidence-based core strategies. We want clinicians to focus less on doing the steps of the treatment "right," and instead focus on engaging the child in a treatment approach we are confident can help. Above all, we want clinicians to feel as if they can still have fun with the child while using an evidence-based approach.

ORGANIZATION OF THE BOOK

We have divided the book into three parts. This is a nuts-and-bolts book, and the parts mirror our clinical approach to the problem of pediatric OCD. We diagnose and assess the condition, develop a case conceptualization that results in a treatment plan, then apply the core strategies based on that plan.

In Chapter 1, we review the nature of pediatric OCD and review the efficacy of CBT and medications for the condition in youth. In Chapter 2, we summarize the treatment plan described in this book, describe key intervention modules and the empirical evidence that supports them, and describe case conceptualization and the structure of sessions. We intentionally separated Chapters 1 and 2 from Parts I through III that focus on assessment and treatment of the condition. Although it is important that clinicians understand the nature of OCD, we also recognize that busy clinicians may have little time to read information about the phenomenon of pediatric OCD (and there is a great deal of it). Fortunately, it is not necessary for clinicians to know all of the research literature on pediatric OCD to treat the condition effectively. Therefore, we limit the information to what we believe is necessary to answer the typical questions that youth and parents ask regarding the condition and its treatment.

In Parts I and II, we walk clinicians through the diagnostic and assessment processes and describe how to implement the core strategies for a wide range of symptoms and with a variety of youth and their families. In Chapters 3 to 9, we introduce the core strategies in a manner that builds on skills and concepts. Although engagement is crucial early in treatment, engagement is an ongoing process that is sensitive to the ups and downs of motivation on the part of both youth and parents as well as to the developmental age of youth.

In Part III, starting with Chapter 10, we present three cases to illustrate the evaluation and treatment process, from assessment, case formulation, and treatment planning, and from the beginning to the end of treatment. We have selected these cases to illustrate the flexible and creative application of the approach across a range of symptoms, and developmental, cultural, and family factors. In Chapter 11, we describe the commonly prescribed medications for pediatric OCD and how clinicians can include medications in CBT for the condition. Again, we present only the information we believe is necessary to answer the typical questions that youth and parents ask regarding medications for the condition and guidelines for clinicians who wish to include medications within CBT for pediatric OCD. Last, in Chapter 12, we describe typical problems that arise when providing CBT for pediatric OCD and offer ways to overcome them.

The descriptions of youth and parents in this book are composites or contrived and do not describe any particular real-life youth, parent, or particular circumstance. Throughout the book, we refer to materials that we have found helpful in our own clinical practice. They are available for download at http://pubs.apa.org/books/supp/tompkins.

CONCLUSION

The American Academy of Child and Adolescent Psychiatry recommends CBT as the first-line treatment for youth with OCD, whether alone or in combination with medications for the condition (Geller, March, & AACAP Committee on Quality Issues, CQI, 2012). At the same time, parents can search

many years before they find a clinician with sufficient experience and training to provide CBT for the condition. Why is that? The answer to this question is complicated, as are most questions about mental health and mental health services, but part of the answer may be that more clinicians would learn CBT for pediatric OCD if it were a better fit for the way they work. In this book, we describe a treatment approach for pediatric OCD that is effective yet flexible, fun yet focused, and based on solid clinical science yet speaks to the innate creativity, genuineness, and personal style of clinicians. In describing this approach, we hope to encourage more clinicians to treat pediatric OCD and thereby help more kids.

We now move to the first chapter of the book, in which we present the epidemiology and phenomenology of the disorder in youth, including the range of symptoms, typical co-occurring conditions, and the developmental and cultural factors that influence the expression of OCD in a pediatric population. We believe clinicians who have a basic understanding of the condition can more effectively diagnose and treat it.