Chapter 5
One-Session Treatment: Principles and Procedures with Children and Adolescents

Thompson E. Davis III, Thomas H. Ollendick, Erin T. Reuther, and Melissa S. Munson

Introduction

One-Session Treatment (OST) is a massed, cognitive-behavioral exposure therapy that progresses over the course of a single, 3-hour session and was developed by Öst (1987, 1989, 1997). Though originally developed as an intervention with adults, the adaptation and use of OST with children and adolescents have progressed substantially in the last decade or so. To date, six studies have examined the use of OST with children (Muris et al. 1997; Muris et al. 1998; Öst et al. 2001; Davis et al. 2007; Ollendick et al. 2009; Flatt and King 2010). In particular, the two larger randomized controlled trials of OST with children by Öst et al. (2001) and Ollendick et al. (2009) led to the developmentally informed format that is currently practiced (Öst and Ollendick 2001). Though this intensive 3-hour format may seem too brief or insufficient to address long-standing specific phobias, the research conducted to date has indicated strong support for its being an empirically supported treatment for both adults (Zlomke and Davis 2008) and children and adolescents (Davis et al. 2011a; see Chap. 11 for a review of the evidence for both). Although OST with children and adolescents is firmly grounded in the work preceding it with adults, it is a developmentally sensitive adaptation of its adult counterpart and has many unique features that make it more suitable for youth and their families. Over the past few years, we and our students have been refining the procedures with children and adolescents and have several studies underway to examine critical elements of it. This chapter will focus on the clinical application of OST with children and adolescents with an

T. E. Davis III (✉)
Department of Psychology, Louisiana State University, Baton Rouge, LA, USA
e-mail: ted@lsu.edu

E. T. Reuther · M. S. Munson
Laboratory for Anxiety, Phobia, & Internalizing Disorder Studies (LAPIS),
Department of Psychology, Louisiana State University, Baton Rouge, LA, USA

T. H. Ollendick
Child Study Center, Department of Psychology,
Virginia Polytechnic Institute and State University, Blacksburg, VA, USA

T. E. Davis III et al. (eds.), *Intensive One-Session Treatment of Specific Phobias,*
Autism and Child Psychopathology Series,
DOI 10.1007/978-1-4614-3253-1_5, © Springer Science+Business Media, LLC 2012

emphasis on the principles and procedures commonly used with this age range. This chapter will cover a variety of applied issues: a) conducting the functional assessment with children, b) providing a developmentally appropriate rationale for treatment, c) preparing for and conducting the massed session, and d) addressing posttreatment issues including followup and client setbacks.

Conducting the Functional Assessment with Children

Conducting a successful OST with children depends on the clinician's ability to adequately plan for the massed session and secure the stimuli needed for each step of the graduated hierarchy of exposure therapy. It is necessary for the clinician to be able to judge and anticipate the intensity of exposure for the client throughout a session—a sort of Goldilocks approach of not making exposure steps too easy or too difficult, but rather getting the exposure just right (i.e., challenging but negotiable). As a result, a functional assessment is a crucial initial step in preparing for the massed OST (Davis et al. 2009; Öst and Ollendick 2001; Zlomke and Davis 2008). It is during this 45- to 60-minute session that a clinician fleshes out information obtained during the initial diagnostic intake sessions (see Chaps. 2 and 3 for details), elicits the child's catastrophic cognitions, creates a detailed fear hierarchy to be used in treatment, and, to the extent possible, determines the maintaining variables and functions of the phobic response (Öst and Ollendick 2001).

Clinicians have typically used open-ended or loosely semistructured clinical interviews to determine the functions of anxious behaviors (see Ollendick et al. 2004). Along with this, behaviorally and cognitive-behaviorally oriented practitioners have a longstanding history of integrating less formal clinical observations into determinations of functional behavior. It is this type of functional assessment that is used prior to OST: a loosely semistructured interview that "detail[s] the origins of the phobia, cognitions about the phobia, and the behaviors that come about in response to the phobic stimulus" (Ollendick et al. 2004, p. 284) and that also attempts to discern the maintaining factors of the fear.

It is generally advisable to schedule this session approximately one week before the OST session, if at all possible (Davis et al. 2009). This is to ensure there is adequate time between the two appointments for the clinician to plan treatment and obtain the necessary exposure materials or make arrangements for travel to specific exposure sites (see Chap. 6 for additional suggestions and details). Even so, we have occasionally done both the functional assessment and OST within a one-day or two-day period for individuals traveling from far away (Note: This usually involved some screening and preparation to allow us to generally have the exposure stimuli and materials we would need in advance). Overall, the functional assessment session serves to transition from the assessment phase to the treatment phase, allows the clinician to prepare for the OST session, and gives the clinician an opportunity to describe and discuss the rationale for OST and answer questions the family might have about the treatment (Davis et al. 2009; Öst and Ollendick 2001). As part of this transition from assessment to treatment, the functional assessment session provides

an ideal opportunity to provide assessment feedback and diagnostic conclusions to the family. This feedback serves two purposes: (1) it summarizes the results of the assessment and informs the child and family of the concerns identified by the clinician, and (2) it provides a fluid and easy transition into the functional assessment proper by priming the family to discuss even more details about the child's specific phobia.

The functional assessment itself should largely follow a style somewhere between an open-ended clinical interview and a semistructured interview. In other words, the clinician's goal is to have a detailed conversation with the child about his or her fear that will inform treatment and cover certain predetermined topics (but also be sensitive to the possibility that discussing the phobic stimulus itself may be evocative and even constitute exposure). As a result, the clinician should generally maintain a supportive, caring style while he or she attempts to seamlessly discuss all the various topics which must be addressed during the functional assessment.

The goal during this session is to evoke the catastrophic cognitions and expectations about the feared stimulus, create a graduated fear hierarchy, and cover several other tasks necessary to plan for OST (e.g., determine maintaining factors, the child's previous experiences and exposures, important qualities of the stimuli that impact the severity of the fear) all at a developmentally appropriate level without unnecessarily straining the conversation or being too structured in its approach (Öst and Ollendick 2001). Given all that a clinician needs to discern and record during this session, we have included our overall guide for the clinician in conducting the functional assessment: the *Functional Assessment Worksheet for OST* (Davis 2006). This worksheet assists in focusing the functional assessment and offers a variety of prompts to help ensure the clinician covers all of the necessary topics to plan an OST individually tailored to the child's fear. The worksheet was developed by the first author following his work with Ollendick and Öst on the largest major treatment outcome study conducted to date. Descriptions of these topics are given below.

Though some clinicians may view working with children as more difficult than working with adults given their cognitive and developmental limitations associated with their young age, the child clinician actually has several advantages (and, unfortunately, disadvantages) over the clinician interviewing an adult. Most importantly, the child clinician has the luxury of multiinformant input (e.g., parents, caregivers). When conducting a functional assessment with a child, it is best to begin and end with the parent in the session (Davis et al. 2009; Öst and Ollendick 2001). At least initially, having the parent in the functional assessment session can help the clinician build rapport with the family and, hopefully, put the child more at ease. If feedback from the assessment session has not already been given to the parent, this is also a good opportunity to do that as well. After an initial orientation to the functional assessment session, however, it is generally recommended that the clinician work with the child alone if the child is old and mature enough to do so (Davis et al. 2009; Öst and Ollendick 2001). Finally, at the end of the functional assessment and with the child's assent, the parent or caregiver can be brought back into the session and the details of the functional assessment can be reviewed with input from the adult.

Of necessity, however, working with children requires some alteration to the methodology of the traditional functional assessment (see Chap. 4 and Öst 1997 for more on traditional OST functional assessments with adults). Creating a fear hierarchy with children may be impacted by their developmental level, and this may prevent them from thinking in abstract ways necessary to differentiate how they would feel in different situations (Holmbeck et al. 2004). One way to combat cognitive limitations in younger children is to make the development of the fear hierarchy as concrete as possible (Davis et al. 2009). For example, it is often useful with younger children to use flashcards to list the different situations involving the feared stimulus (Chorpita 2007). Once all of the situations are listed on separate cards, the child can order the situations from the easiest to the hardest to handle. This method allows the child to compare each situation to another, one at a time, rather than trying to make more abstract evaluations. Once the situations are rank-ordered, the child can then assign fear ratings to each situation and the clinician can use that information to create a more traditional fear hierarchy.

Evoking catastrophic cognitions in young children can be even more difficult than developing the fear hierarchy, as the development of metacognition does not fully occur until early adolescence (Holmbeck et al. 2004). Because of this, it is important to ask the child about concrete examples of situations in which he or she encountered the phobic object and then ask what thoughts he or she had at that time. It is often helpful to ask the child to discuss the first encounter he or she had with the phobic object, the most recent encounter, and the worst encounter (Öst and Ollendick 2001). For each of these, the child can be probed as to what thoughts he or she was having at the time of the encounter using specific and directed questions (e.g., What were you afraid might happen? What were you thinking about at that time?), which can help the clinician get an idea of the catastrophic cognitions. Another helpful experience for the child is to have the child complete a behavioral approach test (BAT) during the initial assessment (which is highly recommended if possible). The BAT offers a specific and recent exposure to the phobic object that the child can easily call to mind and that the clinician can corroborate. At other times, it can be helpful to ask the child to imagine being in the presence of the phobic object, to recreate the sights, sounds, and smells and then to elicit the cognitions (e.g. Tell me then what you would be thinking).

Overall, it is important to remember that children's development ranges from concrete thought to increasingly complex levels of abstract thinking as they age and negotiate developmental milestones (Davis 2009). As a result, it is important to be patient with children and appreciate they are working within the capacities of their own development. For example, when asked about cognitions or abstract concepts, many children will relay concrete stories about interactions they had with the feared stimulus (Davis et al. 2009). This should not be viewed as evasiveness by the child, but rather cooperation from a child who is hampered by limited cognitive resources at these early stages of development.

Evoking Catastrophic Cognitions

One-Session Treatment is set up to allow exposure to be conducted in a way that facilitates the challenging of a client's catastrophic cognitions (Öst 1997; Öst and Ollendick 2001). In order to do this, it is important to be sure the clinician has a clear understanding of what the child's catastrophic cognitions are. This is partly premised on the idea that it is an individual's catastrophic cognitions and preconceived expectancies that maintain the avoidance behavior (Davis et al. 2009; Öst 1997; Öst and Ollendick 2001; Zlomke and Davis 2008). As a result, evoking catastrophic cognitions is one of the major tasks of the functional assessment session. It is also helpful to view the entire functional assessment as flowing between the topics to be covered, rather than fixating on the separate components individually and then moving to the next one and so forth (Davis et al. 2009). By doing this, the clinician can feel free to try and evoke catastrophic cognitions while building the fear hierarchy (described in the next section) and then allow catastrophic thoughts to inform steps on the hierarchy and vice versa. For example, if the child indicates that overly active, fast dogs are more problematic than calm dogs, the clinician can use that information to probe about why that is so. Perhaps the child has cognitions that relate to being knocked over, jumped on, or scratched whereas calm dogs are viewed as less of a threat. As a result, the clinician can use behavior to inform cognition and cognition to inform other probes about behavior and so forth. This is often helpful as children frequently have difficulty expressing exactly what they fear will happen without drawing upon previous experiences. In addition, it is advisable to inquire about several aspects of each catastrophic cognition. In particular, a clinician should note the strength of the child's belief that the catastrophe will occur, how well the child believes he or she is able to cope should it occur, and how bad she or he believes it would be if it occurred (Öst and Ollendick 2001; see Ollendick et al. 2009). A rating scale is provided on the *Functional Assessment Worksheet* (Davis 2006) to facilitate the collection of these beliefs based on Ollendick et al. (2009). This information will help the clinician judge how to handle particular challenges during the OST and also assist in letting the clinician know how far he or she can "push" or motivate the child to do more during a particular step.

Building a Fear Hierarchy

Building a fear hierarchy is an important component of the functional assessment session. This component involves having the child (possibly with the parent's help if need be) identify different aspects of the feared stimulus and different situations involving the stimulus that evoke fear, and then rank them from the easiest to the most difficult (Öst and Ollendick 2001). Many cognitive-behavioral treatments (CBT) for adult and childhood anxiety involve building a fear hierarchy as part of treatment

(e.g., see Chaps. 2 and 3). While the construction of the fear hierarchy in OST is similar to these other approaches, considerations for specific phobias are addressed below. Please refer to the *Functional Assessment Worksheet* (Davis 2006) for a graduated fear hierarchy that we have found to be particularly helpful.

The main purpose of the fear hierarchy is to guide exposure and allow the clinician to be sure that he or she has the appropriate stimuli to generate and gradate the feared response (Öst and Ollendick 2001). The first thing that the clinician must be certain to get information on is the specific aspects of the stimuli that evoke the fear response. Two separate individuals can have a phobia of the same stimulus, but very different and unique aspects of the stimulus may trigger their respective fears. In the instance of dog phobia, for example, the clinician would need to get specific information about the characteristics of dogs that are associated with the fear. Is it harder for the client to be around big dogs or little dogs? Are dogs that bark harder than overly active dogs that move around a lot? Are dogs that jump a problem, or are dogs that lick worse? Does the color of the dog's coat make a difference? What about if the dog's teeth are showing or if it is wagging its tail? Answers to these questions will help the clinician be sure that he or she has an appropriate variety of stimuli to address the child's specific concerns.

Another area that should be explored when developing the fear hierarchy is the various types of situations that the child may be in involving the phobic stimulus and how much fear each situation would evoke. Looking again at a phobia of dogs, it would be important to have the child rate the fear he or she believes would be felt across a variety of situations. For example, how much fear would pictures of a dog evoke? Would movies involving dogs cause anxiety? How about seeing a dog through a window, watching someone else interact with a dog, having a dog in the room in a cage, or on a leash, or roaming free? All of these situations may evoke different levels of fear and should be explored to determine the easiest and most difficult situations.

Using the *Functional Assessment Worksheet* (Davis 2006), we have found it works well to ask children what is the easiest thing they can do involving their feared stimuli (e.g., using the ADIS-C/P fear thermometer, what would be a 1?) and what is the hardest or scariest thing they can think of involving their feared stimuli (e.g., what would be an 8?). Following the establishment of opposing poles within which to work from, it is then easy to ask what would be something half-way in between a one and an eight and so forth. Prompting the child with possible situations may be helpful if he or she struggles to identify different scenarios; however, it is advisable to be open-ended in questioning if at all possible to ensure the responses are truly the child's (Davis et al. 2009; Öst and Ollendick 2001). The fear hierarchy on the worksheet is laid out with space to write details about each step to be placed on the hierarchy on the left; however, it is quite common that in the process of discussing other cognitions or steps, the clients will identify other steps to be included. As a result, there are spaces on the right of the hierarchy to include additional steps occurring between previously indentified steps. It is advisable to distinguish roughly eight to ten steps in the hierarchy. Finally, while the clinician's job is to develop the hierarchy to the extent possible, inevitably some steps need to be rearranged and new

steps may need to be included during the actual OST session. The clinician should also keep in mind that steps in the hierarchy that were rated low by the child may actually end up being more difficult than the child expected and vice versa (i.e., hard steps may be easy). This is likely due to the accommodation and avoidance of the feared stimulus interfering with the child's ability to accurately judge just how he or she would respond, particularly in more longstanding and severe instances. As a result, it is important for the clinician to gather as much ancillary information about the phobia as possible during the functional assessment session.

Additional Information to Gather During the Functional Assessment

Though mentioned briefly throughout the preceding sections, there are also several other categories of information which should be covered during the functional assessment. For ease, these will be briefly reviewed in the order in which they appear on the *Functional Assessment Worksheet* (Davis 2006): etiology/maintaining variables, previous exposures and experience, the client's typical response when afraid, and important stimulus characteristics. Though possible, it is unlikely that a single causal experience will lead to a specific phobia (for reviews see Chap. 1 and Nebel-Schwalm and Davis in press) or that a client can even accurately tie his or her fear back to a particular etiological event. More likely, a specific phobia results from a combination of experiences accruing over time (Davis 2009; Nebel-Schwalm and Davis in press; Ollendick et al. 2004). For example, a phobia may result from the interaction of several mild to moderate, directly conditioned negative experiences with a parent that modeled fear to particular stimuli with a child's own overall tendency toward behavioral inhibition and internalization. If applicable, however, the clinician should have the goal of collecting as much of this information as possible to be able to anticipate steps in the OST that might be particularly evocative based on a past, etiological flash-bulb event (e.g., a dog attack). Even so, determining a particular etiological event or path from a child's history is not as important as having a clear understanding of the variables that are currently maintaining the phobia (Davis et al. 2009; Öst and Ollendick 2001), including who is accommodating and how they are accommodating a child's fears. Even though it is ideal that such information be obtained from children, it is not always possible. Still, when it can be obtained it is helpful in planning treatment.

Along these lines, a clinician should discuss the child's previous exposures and experiences with his or her feared stimulus. It is advisable to inquire about the client's "worst" experience with the stimulus and the client's "most recent" experiences. No client comes to treatment without his or her own history of "exposure." Whether it was a well-intentioned parent trying to help a child "just get over it because there's nothing to be afraid of" or possibly an older sibling who thought it was (and maybe thinks it still is) "funny" or "cool" to surprise a child with a feared stimulus, children will present for treatment with their own unique exposure histories. Additionally, children

inevitably have "accidental" exposures, in which they unexpectedly encounter the stimulus during their daily activities. These experiences are important for the clinician to note for later to address the child's concerns that that kind of harsh experience will be exactly what OST will be like, and to *gradually* test those experiences through supportive exposure and cognitive challenges during the actual OST. This is also a good time to obtain information about the measures taken to avoid the feared stimulus. Understanding how the child and his or her family have altered his or her life because of anxiety can add to the information used to challenge negative thoughts during the treatment session.

During the functional assessment, the clinician should also determine what a client's "typical" fear response is or looks like. Lang (1977, 1979) described fear as a response that encompasses physiology, behavior, and cognition. Given this conceptualization, it behooves the clinician to have the client describe his or her "typical" experience of fear. It can also be helpful to have clients describe their responses to "accidental" exposures or conditioning events. Care should be taken to have the client detail avoidance behaviors (e.g., running away or possibly even aggression), describe physiological symptoms throughout the body (e.g., sweating, racing heart, maybe even full panic attacks), and catalog cognitions (as described in preceding sections). This information is especially helpful in allowing the clinician to prepare for the extent of the child's avoidance, but also for the clinician to better identify and gauge how scared a client may be during a particular part of the actual exposure session based on the descriptions obtained beforehand. Finally, an important part of the functional assessment is clearly differentiating the qualities and characteristics of feared stimuli that make the fear more or less intense. During OST, these details help to create minor augmentations of steps for new tasks that can be attempted.

The Rationale for One-Session Treatment

Providing a rationale for treatment is customary with cognitive-behavioral practice and OST is no exception (Öst and Ollendick 2001). At the conclusion of the functional assessment, the clinician should provide a rationale for choosing OST for this particular child and family. We have included a "Rationale for One-Session Treatment for Specific Phobia" that we have found particularly helpful for clients. The rationale is adapted from several sources on OST. This handout is typically given to the clients to review while the treatment is being described and they are allowed to take it home with them. It also has the benefit of having a place for appointment information for the OST. Much of the information from the rationale handout is straightforward; however, a few noteworthy points will be reviewed below.

The presentation of the rationale for OST provides an important opportunity for the clinician to describe what supportive, controlled exposure will be like and to assuage any fears or correct any misconceptions about what OST will be like (Davis et al. 2009; Öst and Ollendick 2001). When presenting the rationale for OST, the

clinician should use frequent examples from the child's own history to describe what the treatment will be like, but as importantly what it will not be like (i.e., OST will not be like their worst experiences and the fear will not be like the uncontrolled, traumatizing experiences they may have had in the past). Additionally, it is important to emphasize three additional points in conducting OST. First, it is important to emphasize that the child and clinician will be working together as a team to treat the child's fear. In this way, exposure will occur in a supportive, controlled environment and the child will not have to face his or her fears alone. This idea can be instantiated in the functional assessment, with the child as the expert on his or her fear and the clinician as the expert on how to help alleviate it. It may be helpful to describe their roles together as a team—the clinician as someone to encourage and prompt the child to push himself or herself, but not force him into something he is not prepared to do, and the child as the one who tries to do his very best. Also, clinicians should be honest in describing that the child will have to experience some fear to improve—the difference is that a moderate level of fear is usually the goal and that the clinician is not somehow attempting to traumatize or flood the child or repeat or beat his or her worst personal experience (Davis et al. 2009; Öst and Ollendick 2001; Zlomke and Davis 2008). Moreover, the levels of fear the child experiences will eventually decrease if the child remains in the step. Second, the clinician should emphasize that a 3-step process will be used for exposures. The clinician will discuss a possible step or behavioral experiment with the child to test a particular cognition or expectancy, then the clinician will demonstrate or model the step, and, lastly, the child will be encouraged to do the step. Third, and finally, it is important for the clinician to emphasize that a great deal of improvement usually occurs with OST during the actual session, but that OST should be seen as the *start* of treatment (Davis et al. 2009; Öst and Ollendick 2001; Zlomke and Davis 2008). Several months of self-exposures and practices by the client may be necessary to solidify treatment gains.

During and following the presentation of the rationale for OST, it is also an excellent opportunity for the clinician to attempt to gauge the child's motivation for treatment. Treatment motivation in OST is important as it requires a child with at least some motivation to work toward getting better. Basically in the case of OST, enough motivation is needed to deal with his or her fear and to confront increasingly higher steps on his or her fear hierarchy. The child needs to be motivated enough to eventually stand fairly high levels of anxiety during a prolonged session. This is particularly an issue with child and adolescent therapy in general as it is usually the parents or caregivers who bring a child in for treatment and not necessarily at the urging of the child himself or herself. Finally, it is important to use the remaining moments of the session to discuss possible concerns and questions families may have and remove any impediments to their attendance at the next session. It is helpful to plan for how the child and family should handle anxiety about the appointment or catastrophic cognitions about the OST session itself. It can also be helpful to normalize anticipatory anxiety the children may feel prior to the OST session, and to encourage them to motivate themselves to come using examples from information gained in the interview.

Set-Up and Preparation

The process of planning exposures should begin when building the hierarchy in the functional assessment. As the child relays what features make a certain stimulus more or less anxiety-provoking, the clinician can be thinking of how that might be incorporated into the session. For instance, if a child describes that large or hairy spiders are more difficult to encounter, then those types of spiders will need to be located. While it is not necessary to have every characteristic of the stimuli mentioned in the functional assessment present at treatment, it is important to be able to both address the highest levels of the fear ladder as well as having a starting place for exposure. Stimuli for certain types of phobia, such as dogs, or many situational phobia types, such as enclosed spaces, will need to be planned more carefully. To conduct OST for a specific phobia of dogs, the clinician will need to plan on having multiple dogs available and kept in an accessible area. The care of animals also needs to be considered, such as having someone available to watch the dogs, get them water, and take them on walks. Additionally, the clinician should be familiar with any animals used in therapy and should be prepared for any unexpected circumstances (e.g., a dog being sick or scared or a bug getting lose). If a clinician has not worked with a particular type of animal, such as a snake, he or she should practice handling the animal first to become familiar with how to anticipate the animal's motions to keep the exposure session in control. For a situational phobia, such as enclosed spaces or elevators, the clinician will need to carefully plan where appropriate places will be and need to ensure that they will be available on the day of treatment. Finally, time of year may need to be taken into account when planning treatment. If the stimuli associated with a phobia are only available during a certain time of day or time of year, it may require careful planning of when the treatment takes place. For example, if a child has a phobia of bees or caterpillars, the treatment may need to occur in the summertime or springtime or special arrangements to obtain the stimuli via internet or a pet store may need to be made. The clinician will also need to plan how to access bees in order to bring them into the therapy session, and the clinician should consider the opportunities available for practice after the session (e.g., if insects are ordered from the internet during the winter, will there be opportunities to practice outside of the session?).

Additionally, the clinician is responsible for a fair amount of psychoeducation about the stimulus during the therapy session. While it is not necessary to educate the client on the intricate details of the stimulus or situation, the clinician should be able to provide basic information about the stimulus being treated. This may include the basic anatomy, life cycle, and typical behavior of an animal. It may also include information about how elevators, escalators, or airplanes "work." In any case, the clinician will likely have to plan on preparing for the session by using reliable and child-friendly resources. It may also be helpful to bring diagrams or pictures from textbooks or the internet to aid in explanations. This is an important part of the preparation process and some time should be devoted toward it. Adequately answering the child's questions about the feared stimulus not only informs the child but also gives the clinician added credibility. The preparation for the session may

require additional planning and arrangements on the part of the clinician to ensure that the stimuli necessary for a successful and effective exposure are available and accessible during the treatment session. For a full review and discussion of this topic, see Chap. 6.

Using the Functional Assessment to Inform Case Conceptualization

The functional assessment can be used to synthesize information and refine the case conceptualization. "A basic conceptualization that fear maintains the avoidance is of little therapeutic use (Öst and Ollendick 2001); instead, to the extent possible understanding the specific functions of the behavior will better support a formulation for the phobia and inform treatment (e.g., attention, tangible objects, escape, etc.)" (Davis et al. 2009, p. 297). Information obtained, such as catastrophic cognitions, characteristics that make stimuli more difficult or anxiety-provoking, and current avoidance can help to identify factors that maintain the phobia. Avoidance of activities, people, or places related to the phobia can especially serve as a specific guide to what is maintaining the phobia and where it will be important to target exposure in treatment. All of this information can also be used to inform treatment planning for the exposure session as well as to identify potential practice exercises the child may benefit from completing.

Information obtained while making the hierarchy and probing for catastrophic cognitions can prove to be valuable in determining maintaining factors of a specific phobia (Öst and Ollendick 2001). Avoidance of situations that involve the phobic stimulus is one of the key factors that maintain the specific phobias in children. While constructing the hierarchy, the clinician should keep in mind and probe about current situations the child and family are avoiding. Any situations the child is currently avoiding are likely serving to maintain the phobia, and realistic ways of recreating those situations in session should be considered during the construction of the hierarchy. Likewise, catastrophic cognitions typically serve to maintain phobias (Öst 1997). Overestimations of danger or negative consequences such as believing one will have a panic attack in a public place and not be able to deal with the consequences of the attack are some examples of cognitions that will drive avoidance of situations. Also, information obtained in a parent or caregiver interview can yield particularly relevant information when working with children. Mostly, children will not be able to provide detailed information about their maintaining factors. Caregivers, however, can give information about accommodation at home, at school, and in other environments. They can also give information about situations the child avoids, which children often have a difficult time describing or recalling. Additionally, it is important to ask parents about other possible maintaining factors, particularly modeling of fearful or avoidant behavior by a sibling or parent or other family member such as a grandparent or cousin. If modeling is a significant issue, this will need to be addressed

as it could limit the feasibility of practicing approach behavior following treatment (e.g., if a parent is uncomfortable or unwilling to be around the phobic stimulus).

Learning about and conceptualizing the maintaining factors will help to inform and plan for treatment. In the treatment session, the hierarchy will serve as a guide for gradually exposing the client to situations which involve varying degrees and variations of the phobic stimulus. It is also important for these situations to mimic situations the child is currently avoiding to increase the likelihood for generalization after the treatment session. It is beneficial to practice skills in session that the child can begin to use in everyday settings, such as catching and releasing insects or petting dogs and feeding them treats. Catastrophic cognitions will also need to be carefully challenged in session, which can be done through the aid of setting up situations (i.e., behavioral experiments) in which they can be tested (Davis et al. 2009; Öst and Ollendick 2001). For example, if a child has an unrealistic expectation that a spider will run up his arm if his hand is within a few inches, then that cognition can be challenged by putting the clinician's and child's hands near the spider and observing its behavior. By observing the spider withdraw rather than approach, this can likely be disproved. By setting up similar situations, overestimations of negative consequences can be tested in session based on what was garnered from the elicited cognitions and beliefs. While parents are typically not included in the treatment session itself, information obtained from parents can be used to inform treatment for youths regarding appropriate stimuli and setting up situations to test cognitions. Just as parents often provide information about avoidance and environmental factors that maintain the phobia, taking their information into account when planning treatment can lead to a more effective treatment. This will likely include reconfiguring the hierarchy based on this information to make it more inclusive of situations currently avoided in the child's everyday life. Finally, because family accommodation and modeling of fearful behavior is common in the maintenance of specific phobia, this will need to be addressed with the children (and their parents).

Conducting One-Session Treatment with Children and Adolescents

Overview

As noted, OST is conducted over a massed session that is maximized to 3-hour in duration. Typically, it is conducted about one week following the functional assessment. During the session, the clinician combines several empirically supported treatment methods together into the unique OST format including exposure, cognitive challenges, participant modeling, and reinforcement, as well as the provision of psychoeducation and skills acquisition (Davis and Ollendick 2005; Davis et al. 2009; Öst and Ollendick 2001; Zlomke and Davis 2008). Quite frequently, the combination of these methods can even be used with children in a fun turn-taking approach—as both clinician and child take turns suggesting behavioral experiment ideas once the

overall treatment format and pace are established (Davis et al. 2009). In the following sections, we will review the various components of OST separately and then cover their integration into the massed session. In general, the session begins with a review of the rationale for treatment and a description of the process to be used for conducting behavioral experiments with children. Pretreatment instructions should also be given and the clinician should emphasize that nothing will be done to surprise or shock the child, rather the clinician explains that the session will be completed with the child and clinician working as a team with the goal of overcoming the child's phobia.

Exposure

The most noticeable method in OST is gradual exposure to the feared stimulus or situation over the course of up to 3-hour (Öst and Ollendick 2001). Exposure is thought to serve three main purposes in OST (Davis et al. 2009; Zlomke and Davis 2008). First, it provides a framework in which to allow fear to habituate and avoidance to extinguish. Second, the direct, prolonged in vivo exposure prevents cognitive and behavioral avoidance in a controlled and safe environment; the clinician should actively work to avoid discussions, unnecessary breaks, etc. that would distract from the exposure and allow avoidance. Finally, and potentially most importantly, the exposure adds a mechanism by which fear can be elicited to activate and address faulty or problematic catastrophic cognitions and expectancies (Öst 1997; Öst and Ollendick 2001). As a result, OST has been discussed in terms of addressing all three components of the fear response: psychophysiology, avoidance behavior, and catastrophic cognition (Davis and Ollendick 2005). Beyond this, the massed exposure itself is also thought to facilitate the treatment gains brought about by OST (Zlomke & Davis). Recent research has even begun to investigate the claim that massed OST is superior to spaced 1-hour weekly sessions for three weeks (Davis et al. 2011b).

The actual exposure during OST takes the form of behavioral experiments that are intended to test the child's catastrophic thoughts and expectations regarding interaction with the feared stimulus or situation (Öst and Ollendick 2001). The overall act of designing a behavioral experiment in-session utilizes a 4-step process: proposing and discussing a possible step, having the clinician model that step if necessary, encouraging the child to perform the modeled behavior, and reinforcing the child for the attempted or successful approach (Note: Additional cognitive steps are discussed in the following section). For example, a clinician may create a behavioral experiment for a dog using the following steps: Discussing and describing the situation to be tested (e.g., petting a leashed dog), obtaining the child's prediction of what will happen (e.g., the dog will bite me), formulating the child's catastrophic belief (e.g., I will get hurt badly or even die), having the child participate in the behavioral experiment (i.e., petting the dog with the help of modeling from the clinician), and having the child say out loud what the dog actually did (e.g., the dog waved its tail and seemed to enjoy it) and how convinced he or she is of the catastrophic belief

(e.g., does not believe it at all). Of course, the clinician should also reinforce the child with praise for completion of the behavioral experiment.

The clinician makes the child aware of the first three steps as part of the overall process or scheme they will use as a team to treat the child's fear. As a result of this teamwork, negotiation is usually a very important part of setting up behavioral experiments (Davis et al. 2009). The child agrees to remain in the situation and experience the fear until his or her subjective units of distress (SUDs) rating has reduced by approximately 50% or more, or the clinician has determined the fear has sufficiently subsided to proceed (Davis et al. 2009; Öst and Ollendick 2001; Zlomke and Davis 2008). Negotiating which tasks the team may try next can be difficult as initially the steps proposed are usually too low on the fear hierarchy to impart much benefit. Even so, we have found these initial "easy" behavioral experiments to be positive in helping the child learn the overall format for OST and gain initial confidence and self-efficacy. In particular, Davis et al. (2009) have described the use of "foot in the door" and "door in the face" techniques to move the session along and gain the child's willingness to continually try increasingly difficult steps. Initially, the clinician suggests and negotiates very simple, easy interactions ("foot in the door") to build rapport, trust, and behavioral momentum. As the session progresses, however, it can be useful to use "door in the face" techniques at points where the treatment seems to stonewall. The clinician will suggest a step far beyond what the child might be ready to complete with the expectation that the subsequent negotiation will lead to an intermediate step that is still a progression up the hierarchy. For example, a child and clinician may be several feet away from a leashed dog and the clinician may suggest going over and either petting or unleashing the dog as the next step. If the child agrees to proceed, then there is progress; however, if the child disagrees, then he or she will likely agree to the suggestion of only moving several feet closer—still notable treatment progress. While we have found this adaptation to be useful with children, it may not be necessary for adults. We suggest using it with children, however, as it addresses important developmental limitations.

Finally, overlearning is also a component of exposure when doing OST, both in the traditional sense of repetitive interactions with the stimulus at a given step in order to achieve mastery, but also in the sense of completing steps which usually exceed what a child would experience in the "real world" (Davis et al. 2009; Öst and Ollendick 2001; Zlomke and Davis 2008). For example, behavioral experiments of this nature may work up to involving the placement of a spider in a child's hair, having the child put his hand in a dog's mouth (Note: only with a dog that has been trained to safely do so), or safely looking over the highest point in a stadium. The expected result is that mastery of these more intense situations will make more normative interactions outside of therapy easier and less evocative by comparison (Davis et al. 2009).

Cognitive Challenges

Actual cognitive restructuring in the traditional, Socratic cognitive-behavioral sense as recommended by Beck and others is not routinely done during OST. Instead,

clinicians present behavioral challenges to the child that cause the child to rethink expectancies and outcomes (e.g., instead of coming up with alternate cognitions or countering automatic thoughts; Öst and Ollendick 2001). Behavioral experiments, then, serve in part as opportunities to safely test out catastrophic cognitions and expectations about interactions with the feared stimuli or situations. Having gained an idea of the child's catastrophic thoughts from the functional assessment, the clinician will ask the child to make a prediction about performing a proposed behavioral experiment. Once the step is completed, the clinician will then revisit the catastrophic thought and remind the child of his or her expectation about what would happen during the step compared to what actually did happen during the behavioral experiment. This allows the clinician to challenge the child's maladaptive or distorted cognitions and expectations and allows the child to correct these preconceptions by drawing their own conclusions based on their experiences in session (Davis et al. 2009; Öst and Ollendick 2001). As a result, Socratic cognitive restructuring is not used, but cognitive structures and processes are thought to change based on the confirmation or disconfirmation of the child's expectations during the session. In addition, the frequent discussion of the child's predictions, catastrophic cognitions, and fearful memories serves to prevent cognitive avoidance during the session.

Participant Modeling

Participant modeling is a technique whereby the model demonstrates a behavior and then incorporates the observer into the modeled action (Ollendick et al 2004). This method is also integrated into the OST procedure. During OST, participant modeling is used to further break down complex or difficult steps where the child may otherwise begin to lose momentum or progress (Zlomke and Davis 2008). Essentially, more difficult steps like actually touching a dog or actually looking over a railing can be graded even further by implementing participant modeling. In these examples, the clinician or model, can demonstrate the behavioral experiment to be completed and then assist the child in completing the step (Öst and Ollendick 2001). With the dog, the clinician may demonstrate petting the dog (while testing out the child's expectations about what might happen), and then use participant modeling by having the child place his hand on the back of the clinician's hand while they pet the dog in tandem. Eventually, clinician contact can be faded out as the hands are reversed (i.e., child's hand on bottom petting the dog with the clinician's on top), the child pets the dog with the clinician only offering a supportive hand on his shoulder, and so forth. Participant modeling is also potentially important for other types of phobias (i.e., not just animal type phobias). With the example of heights, a clinician may demonstrate holding on to a railing and safely looking over a balcony, have the child then do the same with the clinician offering a hand on his shoulder, and so on. In this case, there may be more of a skill-building component to the modeling; however, with other phobias, modeling may be a way to further treat the fear through observational learning (i.e., social learning and Bandura; see Davis and Ollendick

2005 for a review). For example, a child with an injection phobia may benefit by seeing the clinician receive an injection even there is no "skill" to be learned per se. As a result, participant modeling can be used for a variety of phobias and work both with deficient skills and the actual fear. Either way, however, the goal is to eventually fade out the model until only verbal instructions and support are offered by the clinician (Davis et al. 2009).

Reinforcement

Reinforcement in the form of attention, praise, and social support are always a part of OST and an important component at the end of behavioral experiments (Davis et al. 2009; Öst and Ollendick 2001; Zlomke and Davis 2008). While tangible reinforcers are not typically used (e.g., stickers, food items, toys; see Chap. 9 for a modified OST using reinforcement and other techniques), the provision of social reinforcers are key to encouraging approach behavior. Moreover, the selective use of attention during the session might serve to positively reinforce approach behavior or, in a way, punish avoidance behavior (e.g., addressing a child's avoidance behaviors directly and decreasing the amount of attention provided to the child until approach is again reinitiated). Although firm support for this selective attention is currently lacking, it is recommended that the clinician use attention selectively as a reinforcer contingent on the child's approach behavior (Davis et al. 2007). Most importantly, however, the clinician should be careful not to reinforce avoidance behavior by allowing escape from the situation, providing praise for a failed attempt, or unnecessarily attempting to reassure or console a fearful child beyond what is absolutely necessary (though obviously the goal is not to present a harsh or uncaring persona).

Psychoeducation and Skills Training

Psychoeducation and skills training are the remaining components added to OST and are common among other cognitive-behavioral interventions as well. In OST, however, these tools serve dual roles both as methods which add to the OST and as opportunities to keep the exposures fresh, interesting, and informative (Davis and Ollendick 2005; Davis et al. 2009; Zlomke and Davis 2008). Psychoeducation serves to keep the lulls between exposures or during exposures focused on the actual exposure and assists with "correcting myths, false assumptions, and catastrophic expectancies as well as address[ing] the lack of a needed skill set (e.g., how to pet a dog without scaring it)" (Davis et al. 2009, p. 6). The psychoeducation and skills training provided during OST also helps to encourage the safe interaction with stimuli and situations during and after the OST. For example, topics covered include how to safely interact with a new dog or, more importantly *if* one should approach an unfamiliar dog; also, for example, children are informed about how to handle unexpected encounters with "wild" snakes and the differences between snakes

Table 5.1 Parting thoughts and reminders for conducting OST. (Reproduced with permission from Davis et al. 2009)

- 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.[a]

[a]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?"

kept as pets and those they may encounter accidently. Safety overall is important in OST and similar information should also be shared with the parents or caregivers (Öst and Ollendick 2001). Taken as a whole then, the clinician is responsible for learning a great deal about each feared stimulus or situation prior to the session so that he or she can answer questions, provide corrective information and dissuade misconceptions, and educate the child about the actual properties, behavior, nature, etc. of the feared stimulus. The knowledge to be learned should include everything from the simple names of body parts to explanations for certain behaviors to be able to offer information and answer a variety of questions (e.g., Is the snake cold and slimy? Why do dogs pant? Why do roaches run away when the lights are turned on? What does this button do on the elevator?).

Implementation

The implementation of OST involves the combined use of the previously discussed methods (Öst 1987, 1989, 1997; Öst and Ollendick 2001). Preparation for the session will be important and particular points to consider are included in Table 5.1. Based on

our experience, progress is typically uneven through the 3-hour session and children typically advance in one of three ways: 1) a child proceeds quickly through behavioral experiments throughout the session, 2) a child proceeds slowly initially and then progresses more rapidly as the session continues, and 3) a child proceeds well only to become "stuck" at a particular point in the session (Davis et al. 2009). The first two instances rely on the preparation and patience of the clinician to successfully guide the child through the intervention. The third case, however, highlights the fact that children (and their parents) who avoid approaching and thinking about a feared stimulus may not fully appreciate what aspects of an exposure may prove evocative. Clinicians should be prepared for unexpected problems or fears during the session as it is common that many of these characteristics will not come out until the OST and the child has an opportunity to actually come into prolonged contact with the feared stimulus or situation. As a result, the fear hierarchy and the functional assessment should serve as a rough guide for the session, but the clinician should also be prepared for behavioral experiments that were not necessarily based on the information obtained prior to treatment, but were made possible through the child's verbalization of catastrophic beliefs during the session. Progress may also vary from child to child with the same phobic stimulus or between children the same age. This is, in fact, a strength of OST—the implementation of OST is flexible enough to accommodate the various differences and nuances between children and their fears during the session (Öst and Ollendick 2001). While a specific guide for each possible stimulus may seem applicable, it is actually limiting in the sense that each treatment to varying extents is planned around a particular child with a particular fear (Davis et al. 2009). Even so, a rough example of a portion of an OST for dog phobia is presented in Table 5.2. The primary guide for conducting a successful OST is patience: when conducting OST the child's fear will subside as long as the child remains in the situation and avoidance is prevented (Davis et al. 2009).

After the One-Session Treatment

Toward the end of the massed session and immediately after it finishes, there are several steps we recommend. As with the functional assessment, it can be beneficial to bring the parent or caregiver in and have the child quickly demonstrate his or her new-found skills and abilities (Davis et al. 2009; Öst and Ollendick 2001). This gives the child a chance to proudly exhibit his or her newly acquired skills and abilities, and it is also an opportunity to show the parents how behavioral experiments are carried out and to provide instructions for future self-exposures on their own. Generally, several months of continued practice are recommended to cement gains (Davis et al. 2009; Öst and Ollendick 2001). Parents are briefly instructed in how to safely carry out exposure with their children and encouraged to schedule numerous opportunities for their children to practice their new-found skills (e.g., trips to local dog parks for

Table 5.2 Hypothetical example of the progression of treatment for a child with a dog phobia. (Reproduced with permission from Davis et al 2009)

A. First Dog (approximately 1–1.5 hours of the massed session)

1. Talk about dogs; introduce idea of bringing a dog into the room; negotiate details of first exposure and assess the child's predictions of what will happen
2. A small dog is brought into the room (e.g., a West Highland Terrier) leashed by an assistant who holds the leash close and tight at the opposite end of the room from the child and clinician. The clinician praises progress and encourages the child to watch the dog. They discuss how the dog's behavior is similar or dissimilar to expectations and cognitions discussed earlier
3. The clinician suggests moving closer. The child declines and details are discussed. The interim is used to discuss educational elements regarding dogs (e.g., Do you know how to tell a mean dog from a nice dog? How can we tell if that is a mean or nice dog?). The clinician again suggests moving closer. The child and clinician move 3 feet closer to the dog and discuss/challenge cognitions and predictions
4. The clinician again suggests moving closer; however, before details can be negotiated the child simply begins moving forward and the therapist replies, "I'll just stop when you do then; you're doing great!" The child and clinician move four more feet closer to the dog and discuss/challenge cognitions and predictions
5. The child agrees to allow the dog two more feet of freedom on its retractable leash
6. The child agrees to allow the clinician to touch the dog. Predictions of what will happen are assessed before and discussed following
7. The clinician uses participant modeling to have the child in closer proximity while the clinician pets the dog
8. The clinician shapes the response with praise and participant modeling until the child is independently petting the leashed dog
9. The child realizes how close she is to the dog's teeth and recoils slightly
10. The clinician assesses the catastrophic thought (i.e., "it will bite me"), asks the child for a prediction of what will happen if she pets the dog's head, and with permission demonstrates how the dog dislikes having the clinician's hand in its mouth. The child is then encouraged to do the same and performance is discussed
11. Etc

B. Similar procedures would occur with the second and third dogs (a medium and large dog respectively) taking up the remaining 1.5 hours or until sufficient behavioral experiments have been conducted and over learned until the child exhibits little or no fear

Treatment occurs at an uneven pace and differs considerably from child to child, even for the same phobic stimulus. This example was constructed with the catastrophic fear being associated with the size of the dog and it knocking the child over and biting him or her.

dog phobia or arranging to meet a neighbor's well-trained dog). Additional follow-up appointments should be scheduled if necessary and a quick, tentative plan for additional booster sessions can be discussed (Davis et al. 2009; Öst and Ollendick 2001)—this may involve scheduling an additional session for a refractory case (see Chap. 7), but more than likely only involves putting a brief plan in place for how to deal with possible set-backs and ways to contact the therapist should it be necessary.

At this stage the clinician should also explain the difference between a set-back and a possible treatment failure or relapse (Öst and Ollendick, 2001). A set-back is not uncommon and usually involves a child briefly experiencing a return of fear in

Table 5.3 Instructions on what to do when a setback occurs. (Reproduced with permission from Öst and Ollendick 2001)

1. Tell yourself that this is what the therapist said would occur sooner or later, and it is not a catastrophe. It is not a relapse, but a temporary failure to manage a situation that you have managed before
2. Restrict the setback (i.e., do not let it spread to similar situations)
3. Rehearse the coping-skill you acquired during therapy in a non-stressful situation
4. Enter the setback situation as soon as possible, and focus your attention on the very first signs of anxiety coming on
5. Apply your coping-skill as soon as you feel the first anxiety signals. Keep applying it and stay in the situation until the anxiety reactions dissipate
6. Leave the situation when the anxiety is reduced, and when you have finished your business there
7. If this does not work, plan to try a somewhat easier situation by thinking back on what happened during the treatment
8. If it works, go back to the setback situation and repeat steps 4–6
9. If this still does not work, call the therapist as soon as possible to discuss the problem or to arrange for an extra therapy session

a certain situation. Usually, a set-back occurs when the child fails to implement the techniques learned during OST (i.e., to remain in the situation until the fear subsides and then, possibly, even test out the catastrophic thought or conviction that triggered the fear; Öst and Ollendick 2001). A number of options for addressing treatment set-backs are described in Chaps. 4 and 7; however, a few issues that particularly pertain to children and adolescents will be reviewed here and are included in Table 5.3 which is reproduced from the unpublished child OST manual (Öst and Ollendick 2001). In our clinical experiences, four of the more common sources of set-backs are 1) the child encountering the feared stimuli in an unexpected situation that he or she was not prepared for, 2) the child and parents not conducting self-exposure practices, 3) the parents or caregivers continuing to reinforce and accommodate avoidance behaviors, and 4) a primary parent or caregiver having a similar phobia himself or herself and continuing to model phobic behavior and provide negative information about the child interacting with the feared stimulus. The way these various set-backs may be handled varies by the client's unique circumstances. For example, in the first instance the child may simply return to the problematic situation (or a similar safe situation) with the parents and conduct a self-exposure; while in the second and third situations, the clinician may simply be able to emphasize the need for the family to practice the skills learned during the OST or, possibly, try a brief parent-training intervention. We have encountered the fourth situation less frequently than the other three; however, having a parent or other family member with the same phobia has been one of the more difficult circumstances to correct. In our experience, a phobic parent usually presents two issues—continued modeling of the phobia to the child and frequent discouragement of self-exposures (as they might be "dangerous" but would also involve the parent having to expose himself or herself as well). Ideally, this type of set-back can be addressed by having the parent see the initial success by the child and opt for scheduling his or her own OST as well.

Overall, the clinician should emphasize that a set-back is not unexpected and not an overall failure on either the child or the parent's part (Öst and Ollendick 2001). Less than ideal outcomes and repeated problems with the fear returning or perhaps never having been alleviated may be indicators of a poorer outcome, however. The reader is referred to Chap. 7 for additional details and plans for handling such cases.

Summary and Conclusions

OST with children is a well-established empirically-supported treatment for childhood-specific phobias (Davis et al. 2011a). The treatment is the result of careful assessment, interview, and planning. To begin, a clinician should conduct a functional assessment approximately 1 hour in length to learn more about a particular child's fear. In particular, the child's catastrophic cognitions should be obtained and explored and a fear hierarchy should be constructed. Remember too that even the functional assessment and simply discussing the client's fear may be evocative, and so this session gives the clinician an opportunity to build rapport by being supportive, probing, and empathetic. Next, the clinician integrates all of this information into a cohesive rationale as to why OST will be a good treatment choice for a particular child. Approximately one week later, the actual OST session occurs during which the clinician uses several evidence-based treatment methods to work with the child as a team to confront the child's feared stimuli. Overall, support for the use of OST with children is quite strong and most children have found the process goes per their expectations (Svensson et al. 2002).

FUNCTIONAL ASSESSMENT WORKSHEET FOR ONE-SESSION TREATMENT

Thompson E. Davis III, Ph.D.

CLIENT'S NAME: _____ TODAY'S DATE: _____/_____/_____

THERAPIST'S NAME: _____ DATE FOR OST:_____/_____/_____

INTERVIEW STIMULUS (E.G., DOGS): _____ PARTICIPANT/CLIENT #: _____

OVERALL DIRECTIONS: The following worksheet is designed to assist in obtaining and recording information in preparation for the massed, exposure therapy session. Sections are included for eliciting and rating catastrophic cognitions, creating a fear hierarchy, recording important causal and maintaining variables, recording a client's previous exposures and the client's reactions to exposure, and recording various stimulus characteristics important for planning the exposure session. Specific goals and instructions follow in each individual section; however, ideally the overall session should flow similar to an interview or conversation (i.e., not necessarily going from section to section in order).

CATASTROPHIC COGNITIONS (adapted from cognitive scales used in Ollendick et al., 2009)**:**
Directions—Elicit at least 2 catastrophic cognitions from the client. Concrete and specific cognitions are preferred to broad thoughts or worries (e.g., "the dog will bite me and I'll bleed" vs. "I will get hurt"). Subsequently, help the client rate each cognition for certainty, coping, and catastrophic outcome.

1) _____

How certain are you that _____ will happen? 0 1 2 3 4 5 6 7 8 (Not at all — Very Certain)

How certain are you that you could handle _____? 0 1 2 3 4 5 6 7 8 (Not at all — Very Certain)

How bad would it be if _____? 0 1 2 3 4 5 6 7 8 (Not at all — Very Bad)

2) _____

How certain are you that _____ will happen? 0 1 2 3 4 5 6 7 8 (Not at all — Very Certain)

How certain are you that you could handle _____? 0 1 2 3 4 5 6 7 8 (Not at all — Very Certain)

How bad would it be if _____? 0 1 2 3 4 5 6 7 8 (Not at all — Very Bad)

3) _____

How certain are you that _____ will happen? 0 1 2 3 4 5 6 7 8 (Not at all — Very Certain)

How certain are you that you could handle _____? 0 1 2 3 4 5 6 7 8 (Not at all — Very Certain)

How bad would it be if _____? 0 1 2 3 4 5 6 7 8 (Not at all — Very Bad)

FEAR HIERARCHY:

Directions—The following page is designed to assist in the creation of the fear hierarchy. The goal is to generate approximately 8-10 steps of gradually increasing difficulty. In the left column, 8 spaces are allotted (based on the recommended use of and familiarity with the ADIS interviews); similarly, in the right column 9 spaces are provided for any intermediate steps uncovered (e.g., a step between steps 2 and 3, or a step determined to be easier than 1). It is frequently easiest to establish the poles first (e.g., What is easiest? What is hardest?) and then continue by splitting the differences (e.g., What would be something in the middle between 1 and 8? …between 5 and 8?).

EASIEST

1.) _____

2.) _____

3.) _____

4.) _____

5.) _____

6.) _____

7.) _____

8.) _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

HARDEST

ETIOLOGY / MAINTAINING VARIABLES:
Directions—Attempt to determine the variables that are maintaining the fear or at least contributing to it (e.g., family factors, the fear and avoidance allow escape from demands made on the client). Obtaining a specific etiological event or history is desirable, but rare and not necessary.

CLIENT'S PREVIOUS EXPOSURES (e.g., most recent encounter, worst encounter):
Directions—Attempt to determine how the client reacts when exposed to the feared stimulus. If a behavioral avoidance task (BAT) was conducted during assessment, also inquire about that experience.

CLIENT'S RESPONSE WHEN EXPOSED (e.g., physiological, cognitive, behavior):
Directions—Attempt to determine how the client will react when exposed (e.g., Panic attacks? Aggression? Elopement? Freezing? Crying or clinging?).

IMPORTANT STIMULUS CHARACTERISTICS (e.g., size, color, setting, environment):
Directions—Attempt to determine various stimulus characteristics that will be important for planning and gradating the exposure (e.g., is a smaller dog easier or harder, do certain breeds make a difference).

- End -

Rationale for One-Session Treatment (OST) for Specific Phobia[1]

Your clinician has determined that you have a specific phobia. A specific phobia is a strong, persistent fear of a particular thing, place, or situation that causes problems or distress for you. Also, for many people, the fear from their phobia makes them avoid places, people, or situations that they would either like to go to or need to go to. The good news is that there are many excellent and effective therapies to treat specific phobia. One of the most effective treatments for specific phobia is called OST. This is the treatment that your clinician is recommending for you. OST has been in use for more than 30 years, since a Swedish psychologist and anxiety expert named Lars-Göran Öst, Ph.D. developed it. OST is described as a brief, cognitive-behavioral, exposure therapy. This means that our treatment will work both with your scary thoughts (cognitions) and avoidance behaviors. Also, a big part of what we believe makes phobias worse for people is avoidance. When you avoid what it is you're afraid of, then you're keeping yourself from having positive experiences which might change your behavior and thoughts for the better. Over time, we have learned that many people with phobias become more and more avoidant—a process we call generalization. For example, you may have initially only been afraid of a certain animal or place in particular, but over time, many people with phobias find that their fear has grown to include most or all animals of a certain type or most situations that are similar.

One concern many people have with OST and other exposure therapies involves what they should expect. In our experience, when many people see "exposure," they think of reality TV game shows or bad experiences they may have had before. *This is not the type of "exposure" done during OST. Our goal is to create a safe, controlled setting in which you can learn to overcome your fear at your own pace*.

During treatment, you and your clinician will work as a team. Your clinician will use a 3-step process to help you overcome your fear. *First*, you and your clinician will discuss a "behavioral experiment" or exposure step you might try. *Second*, after you and your clinician have agreed on a step, the clinician will do the step first to show you how it is done and what you can expect. *Third*, your clinician will encourage you to do the step yourself. Also, an important rule to remember is that your clinician will NEVER try to surprise you, shock you, or expose you to more than you are able to handle. Experiences like that are not helpful and are just another bad experience with your fear. Our goal is not to scare you, but you will need to experience some fear in order to get better. The job of the clinician is to make sure the steps you discuss and try are only in your "middle range" of fear or less. The goal is NOT to have you experience the most fear you've ever felt or beat or recreate your worst experience. At other times, some people are afraid their fear will just go up and up and won't stop. This doesn't happen; actually if you work with your clinician and stay in

Fig. 5.1 Many people think that their fear will just keep going up and up. . . . Actually, that does not happen

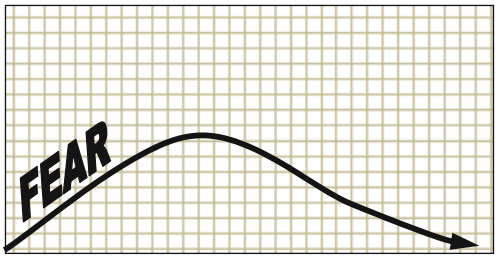

Fig. 5.2 The exposures we do help you experience some fear and learn that you can overcome it

the step, your fear will eventually go back down. At the same time, you'll be teaching your body how to handle that type of fear in the future! For example, think back to something scary you may have done in the past, like riding a bike. The first time you tried to ride it, you may have been scared.

However, after keeping at it and practicing you eventually learned how to ride it and are not scared of it anymore. This overall process is very similar to what you will be doing in your OST session with your clinician—just at a structured and safe pace (Figs. 5.1 and 5.2).

During the OST session, the clinician's job will be to motivate you to do your best and to gauge each step to make sure it is not more than you can handle. Your job will be to work with the clinician to come up with steps you might try, to stay in the situation/step until the fear has gone down, and do your best. Again, you will experience some fear during OST—this is necessary to teach you and your body that the scary things you are expecting either don't occur or, if they do, they are not as bad as you might have thought. It is important to remember, though, that the clinician will use all the information you have provided to make sure each step only causes a "medium" level of fear—the goal is not to have you be at your most fearful or highest fear level.

Also, please remember that your 3-hour session is only the beginning. While we can do a great deal to help you with your phobia in a short period of time using OST, a large part of your success will be up to you and your practicing what you learned. Your clinician will go over some practices you should try. Generally, it is thought that about 6 months of practice should be enough to see if your improvement during treatment will last (or even continue to get better!).

[1]Rationale adapted from those used in or described by Öst (1997), Öst and Ollendick (2001), Ollendick et al. (2009), Zlomke and Davis (2008), and Davis et al. (2009).

Your Clinician for OST is_____.

Your Appointment for OST is at___:___ on __/__/__.

Sometimes illness, emergencies, or other events beyond your control may mean you need to reschedule your appointment. If you need to cancel and reschedule your appointment, please call us at (_____)____ -_____. Other times, it is common for people to become anxious before their appointment and have thoughts about cancelling to avoid their fears. Remember that avoiding positive experiences only prolongs the fear and can make it worse over time. If you are nervous about the upcoming session and thinking about cancelling or have questions about OST, please do call your clinician at (_____)____ -_____ to discuss your concerns about the session. Our goal is to make the treatment as painless and easy as possible, and the available research tells us that most people find the session goes just as we have described it here and that they felt they were in control during the treatment.

References

Chorpita, B. (2007). *Modular cognitive-behavioral therapy for childhood anxiety disorders*. New York: Guilford Press.

Davis III, T. E. (2006). Functional assessment worksheet for one-session treatment. Baton Rouge: Louisiana State University. (Unpublished manuscript).

Davis III, T. E. (2009). PTSD, anxiety, and phobias. In J. Matson, F. Andrasik, & M. Matson (Eds.), *Treating childhood psychopathology and developmental disorders* (pp. 183–220). New York: Springer.

Davis III, T. E., & Ollendick, T. H. (2005). A critical review of empirically supported treatments for specific phobia in children: Do efficacious treatments address the components of a phobic response? *Clinical Psychology: Science and Practice, 12,* 144–160.

Davis III, T. E., Kurtz, P., Gardner, A., & Carman, N. (2007). Cognitive-behavioral treatment for specific phobias with a child demonstrating severe problem behavior and developmental delays. *Research in Developmental Disabilities, 28,* 546–558.

Davis III, T. E., Ollendick, T. H., & Öst, L. -G. (2009). Intensive treatment of specific phobia in children and adolescents. *Cognitive and Behavioral Practice, 16,* 294–303.

Davis III, T. E., May, A. C., & Whiting, S. E. (2011a). Evidence-based treatment of anxiety and phobia in children and adolescents: Current status and effects on the emotional response. *Clinical Psychology Review, 31,* 592–602.

Davis III, T. E., Reuther, E. T., Munson, M. S., Rudy, B. M., May, A., & Jenkins, W. S. (2011b). One-session treatment of specific phobias: A preliminary investigation of massed vs. spaced formats in adults. Manuscript in preparation.

Flatt, N., & King, N. (2010). Brief psycho-social interventions in the treatment of specific childhood phobias: A controlled trial and 1-year follow-up. *Behavior Change, 27,* 130–153.

Holmbeck, G. N., Greenley, R. N., & Franks, E. A. (2004). Developmental issues in evidence-based practice. In P. M. Barrett & T. H. Ollendick (Eds.), *The handbook of interventions that work with children and adolescents-from prevention to treatment* (pp. 27–48). West Sussex: Wiley.

Lang, P. J. (1977). Imagery in therapy: An information processing analysis of fear. *Behavior Therapy, 8,* 862–886.

Lang, P. J. (1979). A bio-informational theory of emotional imagery. *Psychophysiology, 16,* 495–512.

Muris, P., Merckelbach, H., Van Haaften, H., & Mayer, B. (1997). Eye movement desensitisation and reprocessing versus exposure in vivo: A single-session crossover study of spider-phobic children. *British Journal of Psychiatry, 171,* 82–86.

Muris, P., Merckelbach, H., Holdrinet, I., & Sijsenaar, M. (1998). Treating phobic children: Effects of EMDR versus exposure. *Journal of Consulting and Clinical Psychology, 66,* 193–198.

Nebel-Schwalm, M., & Davis III, T. E. (in press). Nature and etiological models of anxiety disorders. In E. Storch & D. McKay (Eds.), *Handbook of treating variants and complications in anxiety disorders*. New York: Springer.

Ollendick, T. H., Davis III, T. E., & Muris, P. (2004). Treatment of specific phobia in children and adolescents. In P. Barrett & T. H. Ollendick (Eds.), *The handbook of interventions that work with children and adolescents—from prevention to treatment* (pp. 273–299). West Sussex: Wiley.

Ollendick, T. H., Öst, L. G., Reuterskiöld, L., Costa, N., Cederlund, R., Sirbu, C., Davis III, T. E., & Jarrett, M. (2009). One-session treatment of specific phobias in youth: A randomized clinical trial in the USA and Sweden. *Journal of Consulting and Clinical Psychology, 77,* 504–516.

Öst, L. -G.,(1987). One-session treatments for a case of multiple simple phobias. *Scandinavian Journal of Behavior Therapy, 16,* 175–184.

Öst, L. -G. (1989). One-session treatment for specific phobias. *Behavior 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.

Öst, L. -G., & Ollendick, T. H. (2001). Manual for the one-session treatment of specific phobias in children and adolescents. Unpublished manuscript available from authors.

Öst, L. -G., Svensson, L., Hellström, K., & Lindwall, R. (2001). One-session treatment of specific phobias in youths: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 69,* 814–824.

Svensson, L., Larsson, A., & Öst, L. G. (2002). How children experience brief exposure treatment of specific phobias. *Journal of Clinical Child and Adolescent Psychology, 31,* 80–89.

Zlomke, K., & Davis III, T. E. (2008). One-session treatment of specific phobias: A detailed description and review of treatment efficacy. *Behavior Therapy, 39,* 207–223.