

**CLINICAL EXOTICA:**  
TREATMENTS FOR USE IN  
SCHOOL SETTINGS

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Children who only poop outside the toilet

Adolescents refusing to speak at school



Teens refusing to touch doorknobs

Kids who repeatedly shout out curse words for no apparent reason

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### What Are Clinically Exotic Problems?

- Low frequency mental health disorders
- Habit Disorders
  - Tic disorders
  - Tourette's Disorder
  - Trichotillomania
  - Stuttering
- Elimination Disorders
  - Enuresis
  - Encopresis
- Selective Mutism
- Obsessive Compulsive Disorder

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## The Importance of Awareness of Clinical Exotica for Schools

- Understanding possible causes of rare or odd behaviors
- Effective responses to these behaviors
- Prevention of negative long-term consequences of failure to address the disorders
- Awareness of evidence-based alternatives to medically-based treatment
  
- **So as to not be speechless and unable to find and/or deliver help to the student!**

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### HABIT DISORDERS: TREATING REPETITIVE SELF-SOOTING BEHAVIORS

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## Habit Disorders

- Repetitive involuntary behaviors that **apparently** serve no purpose
  
- Actually help people self-soothe, especially during times of stress, anxiety, or nothingness
  
- Although tics are experienced as irresistible, they can be suppressed for varying lengths of time
  - Playing the piano, singing, running, playing a game, etc.

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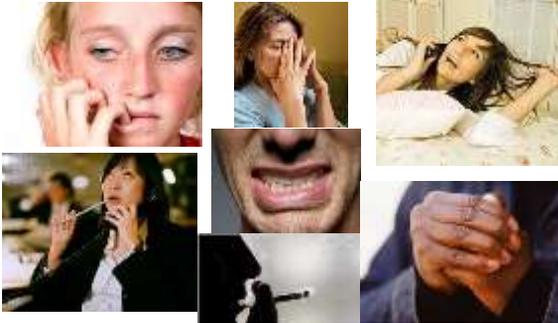
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We all have habits to self soothe, what are yours?




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### Defining Habits

- **Maladaptive habits** are stereotyped, repetitive behaviors that create negative physical or social effects for the individual
  - **Physical effects:** tissue damage, alopecia
  - **Social effects:** embarrassment, social stigma, rejection, victimization
- Nervous habits are relatively common
  - Hand to head: nail biting (10%), hair pulling/twirling (1.5%)
  - Oral: lip/cheek/tongue biting (22%), teeth grinding (5%)
  - Other: object manipulation (22%)
    - Woods, Miltenberger, & Flach, 1996

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### Types of Habits

- Nail biting
- Skin picking
- Thumb sucking
- Mouth biting
- Hair pulling
- Motor tics
- Vocal tics
- Smoking

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## Self-Soothing Mechanism

- Socially acceptable vs. unacceptable
- Distinction between “normal” & “disordered”



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## Tic Disorders

- **Definition:** Vocal, motor, or vocal + motor (i.e., Tourette s)
- **Vocal tics:** Rapid, recurrent, non-rhythmic stereotyped vocalizations that do not serve a communicative functioning
  - Usually grunting, throat clearing not due to illness, coughing and sometimes saying words
- **Motor tics:** Rapid, repetitive jerking movements of muscle groups that are not the result of spasms, chorea, or tremors Usually in head/neck region, but can also occur in arms/legs
  - Can be simple or complex
- **Prevalence:** 1% of children experience ongoing tics lasting more than one year

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## Premonitory Sensation or Urge to Engage in the Habit or Tic



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## Tension Reduction or Relief

- Many individuals report a feeling of relief or tension reduction following the involuntary movement



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## Factors Associated with Increased Habits



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## Tourette's Syndrome

- **Definition:** Individual experiences multiple motor tics &  $\geq 1$  vocal tic
- **Prevalence:** More common in children (5-10/10,000) than adults (1-2/10,000)



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## So...what is a tic?

- Involuntary, rapid, recurrent, non-rhythmic motor or vocal action
- Sudden and seemingly purposeless
- Useful to make a distinction between Simple vs. Complex tics

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## Simple versus Complex Tics

Motor Tics		Vocal Tics	
Simple	Complex	Simple	Complex
Eye blinking	Hopping	Throat clearing	Phases:
Eye rolling	Jumping	Coughing	"oh boy"
Facial grimacing	Touching objects	Spitting	"Shut up"
Nose twitching	Twirling	Sniffing	Animal noises
Arm jerking	Gyrating	Snorting	Muttering under breath
Head nodding	Bending	Screeching	Complex breathing
Finger movements	Biting lip	Barking	Stuttering
Teeth clicking	Head banging	Grunting	Speech atypicalities:
Shoulder shrug	Kissing	Whistling	Accents
Lip pouting	Licking	Sucking sounds	Loudness
Abdominal tensing	Coprophaxia	Clacking	Coprolalia
Rapid leg jerks	Echopraxia	Syllable sounds, "eee"	Echolalia

\*Adapted from U. Chowdry's (2004) *Tics and Tourette's Syndrome*

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## Tics continued.....

- Echophenomena
  - Echolalia- repetition of words or parts of words that others say.
  - Echopraxia- repetition of actions of others.
- Coprophenomena
  - Coprolalia- utterance of obscene, aggressive or socially inappropriate words or phrases (10%)
    - Behavior laypersons associate as defining feature of TS
  - Copropraxia- obscene or lewd gestures or movements

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## Trichotillomania

- **Definition:** Recurrent hair pulling resulting in noticeable hair loss. Individual notices an increasing sense of tension prior to or when resisting pulling and pleasure or relief when pulling out hair.
- **Prevalence:** 0.6%




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## Habit Reversal Training (HRT)

- Multicomponent procedure developed by Azrin & Nunn (1973, 1974)
- Used to treat nervous habits, tics, stuttering
- HRT has been shown to be effective & replicable across 25 years of training & for a spectrum of habits/related behaviors (Cook et al., 2005; Peterson, Campise, & Azrin, 1994; Woods & Miltenberger, 1995; 1996)

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## Habit Reversal Training (HRT)

- 5 phases
  - Awareness training
    - Response description, response detection, early warning signs, antecedent identification
  - Competing response training
    - Using incompatible behavior prior to or following occurrence of habit
  - Relaxation training
    - Given the relationship between habits and stress/downtime, relaxation techniques are emphasized before entering habit-prone situations
  - Motivation/Social Support procedures
    - Identify drawbacks of habit, elicit support from significant others to perform competing response, practice in situations in which the habit is likely to occur with reinforcement for competing response
  - Generalization procedures

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## Awareness Training

- Introduce purpose of awareness – so that child is aware of when the habit will occur or is occurring
- Four awareness techniques included (1) response description, (2) response detection, (3) early warning, and (4) situation awareness




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## Awareness Training

- **Response description:** the client describes in detail each occurrence of the behavior while looking in a mirror.
- **Response detection:** the therapist informs the client when he or she engages in the behavior until the client can detect each occurrence without assistance.
- **Early warning procedure:** the client practices identifying the earliest signs of the target behavior.
- **Situation awareness training:** the client describes all of the persons around when the behavior occurs, and the places and situations in which it occurs.

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## Competing Response Training

- Competing response is implemented when the client first becomes aware that the habit or tic is occurring
- Contingent on the behavior, the client practices the competing response for 3 minutes




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## Finding the Right Competing Response

- A competing response (CR) had to meet five criteria.
  - (1) be opposite to the nervous movement;
  - (2) be capable of being maintained for several minutes;
  - (3) produce isometric tensing of muscles involved in the movement;
  - (4) be socially inconspicuous and easily compatible with normal, ongoing activities, but still incompatible with the habit; and
  - (5) for muscle tics, the behavior must strengthen the muscles antagonistic to the tic movement

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## Motivation & Social Support Techniques

- **Habit inconvenience review:** the client reviews all of the problems and discomforts that are caused by the habit or tic.
- **Social support procedure:** the client's family and friends are asked to praise the client for the nonoccurrence of the behavior, and to prompt the client to practice the CR when they notice an occurrence of the habit or tic.
- **Public display:** the client demonstrates to others that he/she can control the target behavior.

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## Gradual Generalization

- The last component of HRT stresses generalization
- **Exposing** the client to increasingly more anxiety-provoking situations and **coaching** them to be aware and use competing response

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## Simplified Regulated Breathing HRT for Stuttering

- Simplified and specialized version of HRT
  - Awareness Training
  - Competing Response Training
  - Motivation
    - Wagaman, Miltenberger & Woods (1995); Freeman & Friman (2004)

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**ELIMINATION DISORDERS:**  
THINKING OUTSIDE THE  
TOILET BOWL

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## Elimination Disorders



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DO YOU HAVE TO GO  
TO THE BATHROOM  
YET?

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## Enuresis



### Definition:

- Repeated voiding of urine into bed or clothes (whether involuntary or intentional).
- 2 X/week for at least 3 consecutive months OR clinically significant distress/impairment in social, academic, or other areas of functioning.
- Chronological age  $\geq$  5 years.
- Not due to direct physiological effects of a substance or a general medical condition

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## Enuresis

**Prevalence:** 5-10% of children at age five; decreases approximately 15% per year; 1% in ages > 15

### Types:

- Nocturnal, diurnal, or both
- Primary (continence never achieved) or secondary (continence achieved)

### Gender Differences:

- Boys > girls (2-3:1)
- Diurnal enuresis more common in females than males

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## Simplified Physiology of the Bladder



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## Evaluation

- Medical evaluation to rule out disease
- History to assess diagnostic criteria, etiological factors, mental health screening
- Identify & eliminate sources of punishment for urinary accidents
- Assess treatment motivation of parent(s) & child

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## Unrecommended Methods of Responding to Enuresis



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## Empirically Supported Treatments for Enuresis

- Pharmacological
  - Desmopressin (DDAVP)
  - Imipramine (Tofranil)
    - High Relapse Rates / \$\$ / Risks?
- Behavioral
  - Urine alarm
  - Responsibility training, self-monitoring, positive reinforcement, retention control training
- Combined pharmacological & behavioral
  - No difference in frequency of dry nights compared to behavioral intervention alone during treatment + higher rates of relapse during post treatment

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## Urine Alarms



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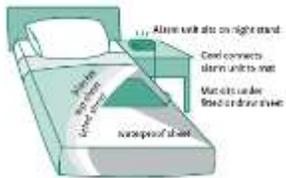
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## Behavioral Intervention for Enuresis: Urine Alarms



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## How Does the Urine Alarm Protocol Work?

- Alarm alerts youth at onset of urination
- Alarm = aversive stimuli to be avoided
- Teaching retention control strategies plus providing aversive stimuli at onset of undesired behavior leads to development of bladder control

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## Example Case

- “Sara”
- 13-year-old, multi-racial female
- 8th grade
- High average IQ
- Developmental/Medical History: Unremarkable
- Placed in a residential treatment facility due to an escalating pattern of defiance toward authority figures and unsafe behavior

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## Urine Alarm Protocol



- Self-monitoring of nocturnal enuresis
  - Interrater agreement checks w/ + reinforcement for agreement
- Urine alarm to be worn nightly
- Responsibility training
- + reinforcement each morning for following protocol
- Additional + reinforcement for dry nights

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## Urine Alarm Protocol



- Daily practice using pelvic floor muscles to start & stop flow during daytime urination
- Retention control/increase functional bladder capacity
- No restriction of fluids prior to bedtime
- No waking by others to use restroom
- After 7 dry nights, 1 night off of alarm
- After 7 more dry nights, 2 nights off...etc.
- Overcorrection procedures

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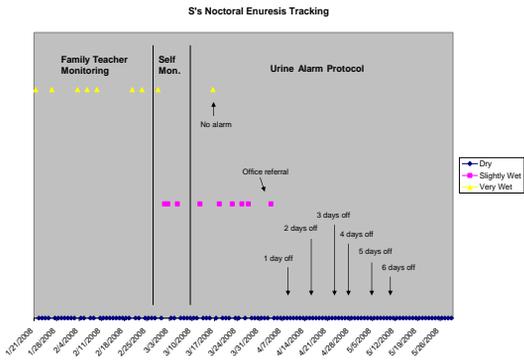
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### Urine Alarm Protocol for Daytime Enuresis

- Self-monitoring of daytime enuresis
  - When is the wetting happening?
  - Do I have an urge to go?
- Responsibility training
  - Setting up a toileting schedule
  - Begin with prompts, transfer responsibility for following schedule to child
- + reinforcement for following protocol & dry days
- Daily practice using pelvic floor muscles to start & stop flow during daytime urination
- Retention control/increase functional bladder capacity
- No restriction of fluids
- Overcorrection – increase fluid consumption

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### Encopresis

- Definition:**
- Repeated passage of feces into inappropriate places (voluntary or intentional)
  - ≥ 1x/month for 3 months.
  - Chronological age ≥ 4 years.
  - Not due to direct physiological effects of a substance or a general medical condition
- Prevalence:**
- 1% of 5 year olds
- Gender Differences:**
- More common in males than females

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## Etiology

- Majority of cases have physiological etiology & associated behavioral/dietary problems
  - Physiological: reduced colonic motility, constipation, fecal retention
  - Dietary: insufficient roughage/bulk/fluids, irregular diet, medications
  - Behavioral: Unstructured, inconsistent, &/or punitive toilet training, toileting avoidance
- Small minority of cases do not involve physiological problems & are more treatment resistant

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## Empirically-Supported Treatment of Encopresis

- **Multi-component behavioral treatment**
  - Responsibility training
    - Scheduled toilet sits & Child cleans up after him/herself
  - Tracking of successful/unsuccessful toilets
  - Reinforcement for days without accidents
  - Raising the child's awareness that it is a problem
  - Diet high in fiber
- **Primarily medical focus**
  - Full bowel evacuation
  - Medication
  - Dietary recommendations
  - Scheduled toilet sitting

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## Summary of Recommendations for Diagnosis & Treatment of E & E

- Make sure physician has seen child for evaluation & treatment
- Learn about physiological processes
- Eliminate punishment for accidents
  - Instead discipline the child when s/he is not being truthful and teach responsibility for cleaning up the mess
- Establish instructional control prior to treatment
- Expect reoccurrence of accidents when schedules disrupted
- Be an active participant in child's successes

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# SELECTIVE MUTISM



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Can you identify the child with selective mutism?



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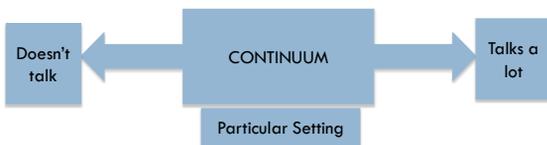
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## Continuum of talkativeness

- Some people are slow to warm up when thrust into a group
  - Temporarily mute to chronically mute



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## Selective Mutism Defined

- A consistent failure to speak in specific social situations (in which there is an expectation for speaking, e.g., at school) despite speaking in other situations.
- It interferes with educational or occupational achievement or with social communication.
- The duration of the disturbance is at least 1 month (not limited to the first month of school).
- The failure to speak is not due to a lack of knowledge of spoken language or not better accounted for by a communication disorder (e.g., stuttering)

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## Selective Mutism

- SM is a rare disorder with estimates from 0.03 to 0.2% of K-12 population (Sharp, Sherman, & Gross, 2007)
- School is typically the setting in which children first experience impairment as a result of SM (Giddan, Ross, Sechler, & Becker, 1997; Kehle, Bray, & Theodore, 2006)
- More prevalent in girls than boys - 3:1

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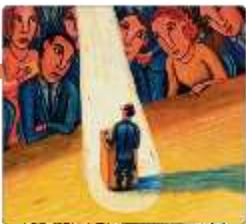
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## Nature of SM

- Child does not talk at anyone in the setting
- Child only talks to family members in presence of others in the setting
- Child talks to some people (e.g., whispers to teacher) in the setting outside of home but not others (e.g., peers)

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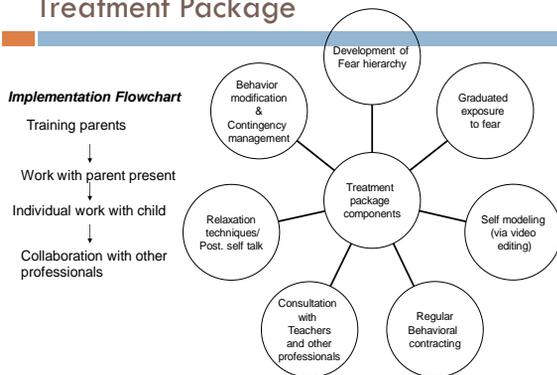
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## Treatment Package




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## Selective Mutism

- Behavior treatment
  - ▣ Shaping, goal setting and reinforcement
  - ▣ Stimulus fading
  - ▣ FBA – what is predicting & maintaining the student not speaking in the setting?
- Systematic Desensitization (Gold standard)
  - ▣ Step by step approach

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## Psycho-education of Child

- Bibliotherapy
- Cat's Got Your Tongue: A Story for Children Afraid to Speak
  - Written by Charles Schaefer
  - Published by Magination Press in 1992
- Treatment is explained in age-appropriate language to child
- Child is assured that the therapist will practice with them in becoming braver and stronger.

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## Psycho-education of Parents

- Selective mutism is conceptualized as a social anxiety disorder
- Discussed as a problem that can and should be overcome
- Cognitive-behavioral techniques are explained
- Describe ways parents could prevent inadvertently reinforcing mutism

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## Function of Selective Mutism

- Selective mutism can start out as anxiety-based avoidance but end up being maintained by other factors
  - Attention from others
  - Avoidance of academic work
- Adults allow the student to avoid verbal responses by:
  - Asking the child questions that do not require verbal replies
  - Allowing the child to respond by other means
    - Gestures (pointing, nodding head)
    - Written responses

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## Behavior Treatment – Shaping, Goal Setting, and Contingency Management

- The first step in developing a shaping program is to identify and operationally define the student’s current level of performance and the goal level of performance on the target behavior (e.g., frequency of verbal responses)
- Next, establish expectations for speaking (do not allow the child to easily avoid, but don’t pressure too hard), and when the student meets the goal, he or she is provided with a reward.
- It is important that school personnel or a parent collaborate with the child to identify potential rewards

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## Stimulus Control




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## Behavior Treatment - Stimulus Fading

1. Assess where and to whom the student with SM speaks
2. Assess with whom the student is motivated to talk
  1. This can be done by developing a list of peers, school personnel, family, and any other individuals central to the student’s life.
3. Based on the student’s responses, create a list of potential individuals to whom we want to transfer stimulus control
  1. Often in school settings, the student’s teacher is the primary person to whom we want to transfer control;
4. Have a person who is a stimulus for talking (e.g., parent) come into the setting that is a stimulus for mutism (e.g., school)

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## IMPORTANT – Make Speech Predictable

- Not knowing what to say (performance anxiety) can be scary for the child and part of the reason the child remains silent
- Whatever speech is required should be predictable.
  - When it is your turn, say the color and number of your card. For example, 'Red three,' and then place your card on the pile
- You may need to have the words written down so he or she can read them
  - This allows the student to focus on speaking instead of focusing on both formulating an answer and speaking

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**TREATING OCD:  
PERFECTIONISM,  
CONTAMINATION, AND  
PERCEIVED DANGER**

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## Obsessive Compulsive Disorder (OCD)

- **Definitions:**
  - **Obsessions** are recurrent, intrusive thoughts, images, or urges that are not consistent with the individual's self-perception & are often accompanied by distressing negative affects;
  - **Compulsions** are repetitive, purposeful behaviors (observable or covert) that are often performed according to certain rules or in a stereotyped fashion in order to make obsessions & negative affects go away
- **Neurobehavioral Framework:** OCD symptoms are caused by short circuits in the brain that inappropriately send fear cues when no threat is present

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## OCD

- Prevalence: 1/200 children & adolescents
- Gender Differences:
  - ▣ Boys more likely to have prepubertal onset & to have a family member with OCD or Tourette Syndrome
  - ▣ Girls more likely to have onset during adolescence & to have more phobic symptoms

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## Normal vs. OCD

- It's developmentally appropriate and common for young children to like things done "just so" or insist on elaborate bedtime rituals – associated with mastery & control




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## Normal vs. OCD

- It's atypical when the thoughts and rituals disrupt **occupy a significant amount of time and are chronically disruptive to normal life functions, relationships, and academics**




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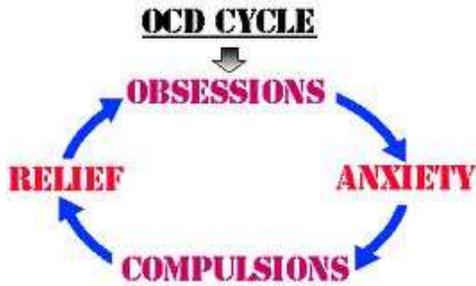
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### Typical OCD Symptoms

- | <u>Obsessions</u>                                   | <u>Compulsions</u>                          |
|---|---|
| <input type="checkbox"/> Contamination themes       | <input type="checkbox"/> Washing            |
| <input type="checkbox"/> Harm to self/others        | <input type="checkbox"/> Repeating          |
| <input type="checkbox"/> Aggressive themes          | <input type="checkbox"/> Checking           |
| <input type="checkbox"/> Sexual themes              | <input type="checkbox"/> Touching           |
| <input type="checkbox"/> Scrupulosity/religiosity   | <input type="checkbox"/> Counting           |
| <input type="checkbox"/> Forbidden thoughts         | <input type="checkbox"/> Ordering/arranging |
| <input type="checkbox"/> Symmetry urges             | <input type="checkbox"/> Hoarding           |
| <input type="checkbox"/> Need to tell, ask, confess | <input type="checkbox"/> Praying            |

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### Expert Consensus Treatment Guidelines for OCD

- Age specific considerations:
  - Prepubescent children: CBT first for milder or more severe OCD
  - Adolescents: CBT first for milder OCD; CBT plus SRI for more severe OCD
- Overall efficacy, speed, & durability of treatment:
  - Milder OCD: CBT alone; or CBT + SRI
  - More severe OCD: CBT + SRI

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March, Frances, Carpenter, & Kahn (2006)

## Steps of CBT for OCD

- 1) Psychoeducation about neurobehavioral framework of OCD & externalize OCD from child as an enemy to fight
- 2) Awareness training
- 3) Relaxation training
- 4) Cognitive training to increase constructive and resistant self-talk, positive coping skills, controllability, & self-reward for exposure/response prevention (E/RP) tasks
- 5) Mapping child's experience of OCD including obsessions, compulsions, triggers, avoidance behaviors, & consequences to develop exposure hierarchy
- 6) Graded exposure & response prevention (E/RP): therapist assisted imaginal & in-vivo practice linked to weekly out of session practice

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## E/RP Tasks for Jack

Obsession/Compulsion	Exposure/Response Prevention
Must count while walking	Walk up stairs while having a conversation with therapist or saying alphabet backwards
Avoid touching doorknobs in public	Deliberately touch doorknobs in clinic without washing hands immediately afterwards; repeat at school & other public bathrooms
Avoid emotional expression with family members	Express feelings to mom with prompt from her; express without prompt; receive hug from mom; initiate hug with mom
Need to make lists to identify priorities	Boss back urge, remind self to think about topic only during scheduled worry time, & engage in distracting pleasant events
I think I might be a Nazi. I think I might be gay.	Identify thought as OCD's not Jack's; ignore & engage in distracting pleasant events until the thought goes away

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## Resources

- Habit disorders
  - Managing Tourette Syndrome: A Behavioral Intervention Workbook
    - Woods and Piacentini
  - Tic Disorders, Trichotillomania, and Other Repetitive Behavior Disorders: Behavioral Approaches to Analysis and Treatment
    - Woods and Miltenberger
- Elimination
  - Elimination Disorders in Children and Adolescents (Advances in Psychotherapy: Evidence-Based Practice)
    - Christophersen and Friman

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## Resources

- Selective Mutism

- Helping Children with Selective Mutism and Their Parents: A Guide for School-Based Professionals
  - Kearney

- OCD

- Talking Back to OCD: The Program That Helps Kids and Teens Say "No Way" -- and Parents Say "Way to Go"
  - March
- Family-Based Treatment for Young Children with OCD Workbook (Programs That Work)
  - Freeman and Garcia

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