SPONSORED TOPICAL WEBINAR

An Educational Resource for APA members from McLean Hospital.

Assessment and Treatment of Pediatric Anxiety Disorders and OCD

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- The recording will include the presentation slides.

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SPONSORED TOPICAL WEBINAR

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PRESENTERS

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  Instructor of Psychology in the Department of Psychiatry, Harvard Medical School

Our Programs

MAMP

- McLean Child and Adolescent Outpatient Psychiatry Dept.
- Intensive, group-based outpatient program
- Emphasis on exposure with response prevention (ERP)
- Ages 6-19, child and adolescent tracks
- Psychologists, psychiatrists, doctoral student trainees
- ERP and psychoeducation groups, individual family meetings, caregiver guidance sessions, ongoing collateral support
- Minimum four weeks, avg. length of stay 6-8 weeks

OCDI-JR

- 16-bed residential program
- Insurance based
- Ages 12 - 18
- Average length of stay 2-3 months
- Psychologists, psychiatrists, social workers, nursing, and exposure coaches
- Individual therapy, group therapy, daily coaching, weekly family meetings
- Emphasis on ERP and engaging in values-based activities

Agenda

- Cognitive-behavioral conceptualization of anxiety disorders and OCD
- Assessment methods and diagnostic considerations
- Cognitive-behavioral treatment of anxiety disorders and OCD
- Family-based considerations
- Q&A

CASE PRESENTATIONS

Case Study #1

Seneca is a 14yo female who was referred for assessment and treatment by her pediatrician. She presented to her local ER three months prior with concerns that she was having a heart attack; physical workup attributed symptoms to anxiety. She has lost 10 pounds since that time.

Seneca reports nausea, headaches, dizziness, and difficulty breathing most mornings before school, with onset at the beginning of her current freshman year in high school. Seneca reports that she does not fit in at her new high school, and is concerned that other students are judging her. In addition, she witnessed another student vomit in the hallway, and now endorses fears that she will vomit in front of her classmates. She subsequently has restricted her eating behavior to avoid nausea and/or vomiting. Seneca misses 2-4 days of school per week. On days when she attends school, she often presents to the school nurse with her symptoms and is typically dismissed early. When she does not attend school, she reportedly sleeps, watches TV, or spends time on her phone. Seneca has quit the basketball team and parents report she rarely spends time with friends outside of school.

Case Study #2

Mary is a 15-year-old female initially presenting to an outpatient clinic for the assessment and treatment of anxiety. Her father reported she has “always” been an anxious child, but her anxiety significantly increased in the past year. He also reports a decline in her grades, that she has withdrawn from her friends, and that she experiences low mood.

While Mary initially felt she could not share her fears, she eventually reports worries around being responsible for something terrible happening. She holds her breath when her brother is near, avoids being in a room with him, won’t touch anything he might touch after her, and she feels like a terrible sister. Her father spends a significant amount of time helping her plan her day to avoid her brother, moves and holds things to help her, and reassures her that nothing bad will happen to her brother.

Mary reports no matter what she tries the intrusive thoughts of something bad happening occur multiple times an hour and she engages in protection rituals throughout her entire day.

Anxiety Disorders of the DSM-5

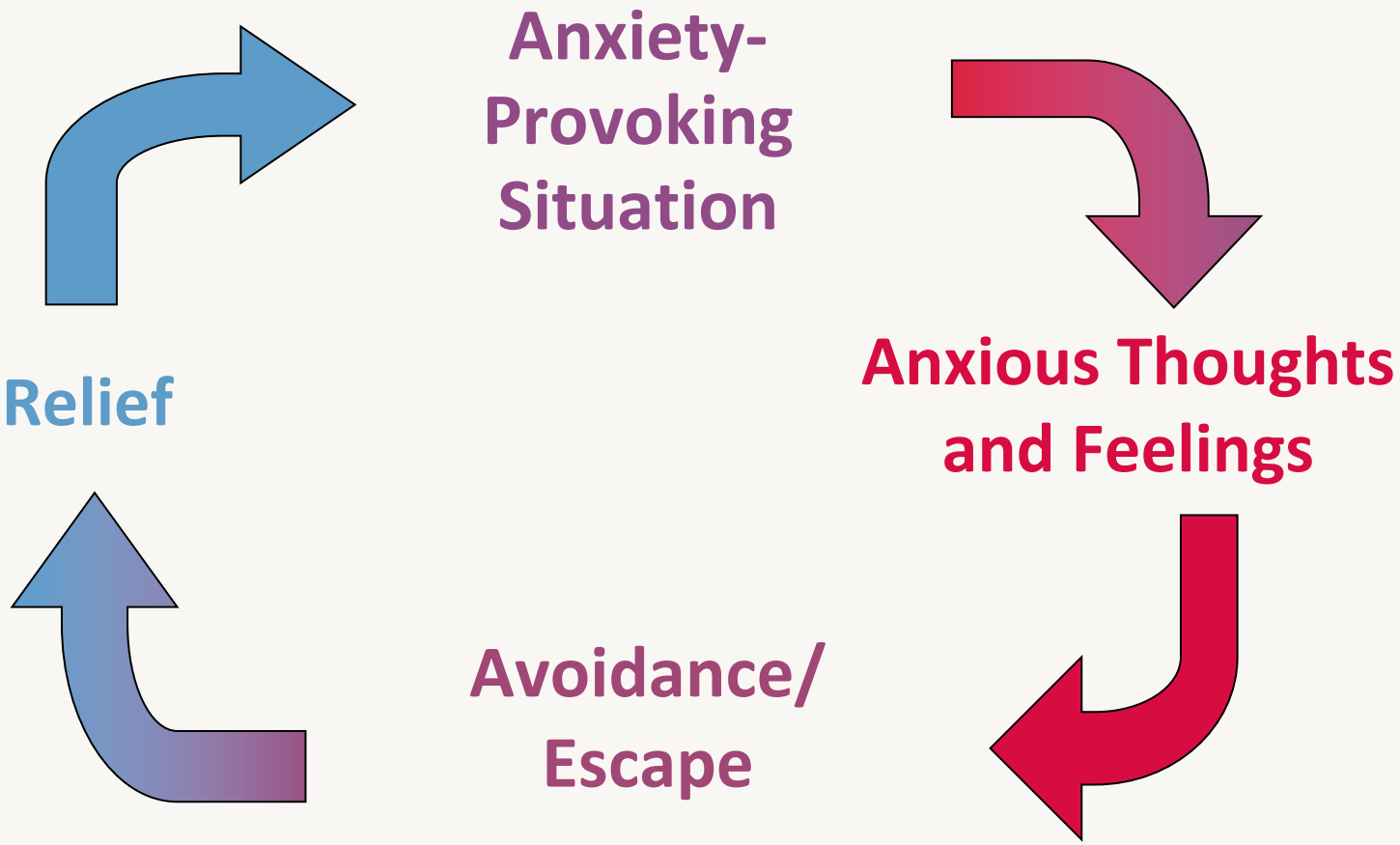
- Separation Anxiety Disorder
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder
- Panic Disorder
- Agoraphobia
- Generalized Anxiety Disorder
- Other Specified Anxiety Disorder
- Unspecified Anxiety Disorder

*Panic Attack Specifier

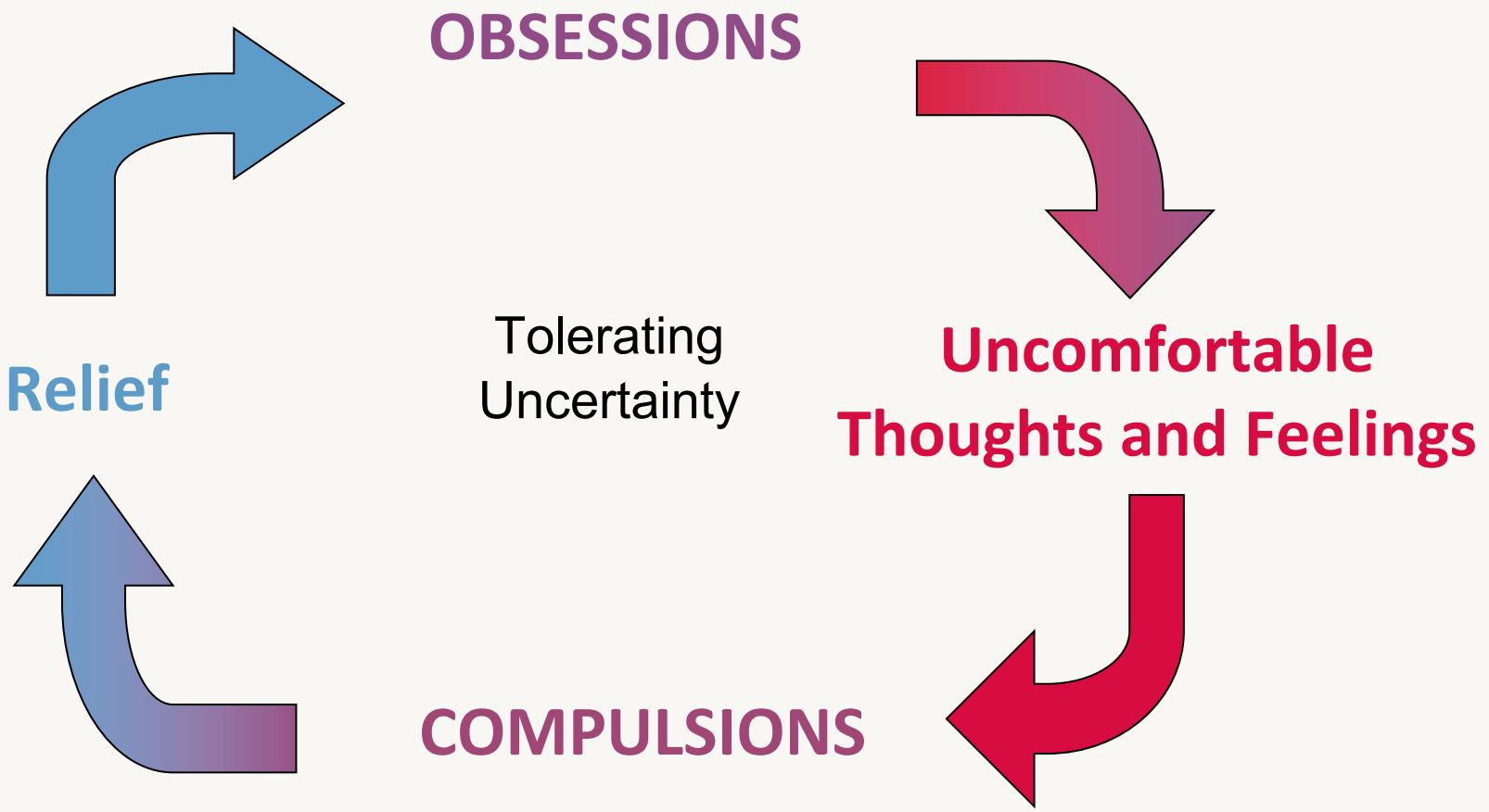
Shared features: excessive fear or anxiety and related behavioral disturbances, persisting beyond developmentally appropriate periods

Distinguishing features: types of objects or situations that induce fear or anxiety, avoidance behavior, associated thoughts or beliefs

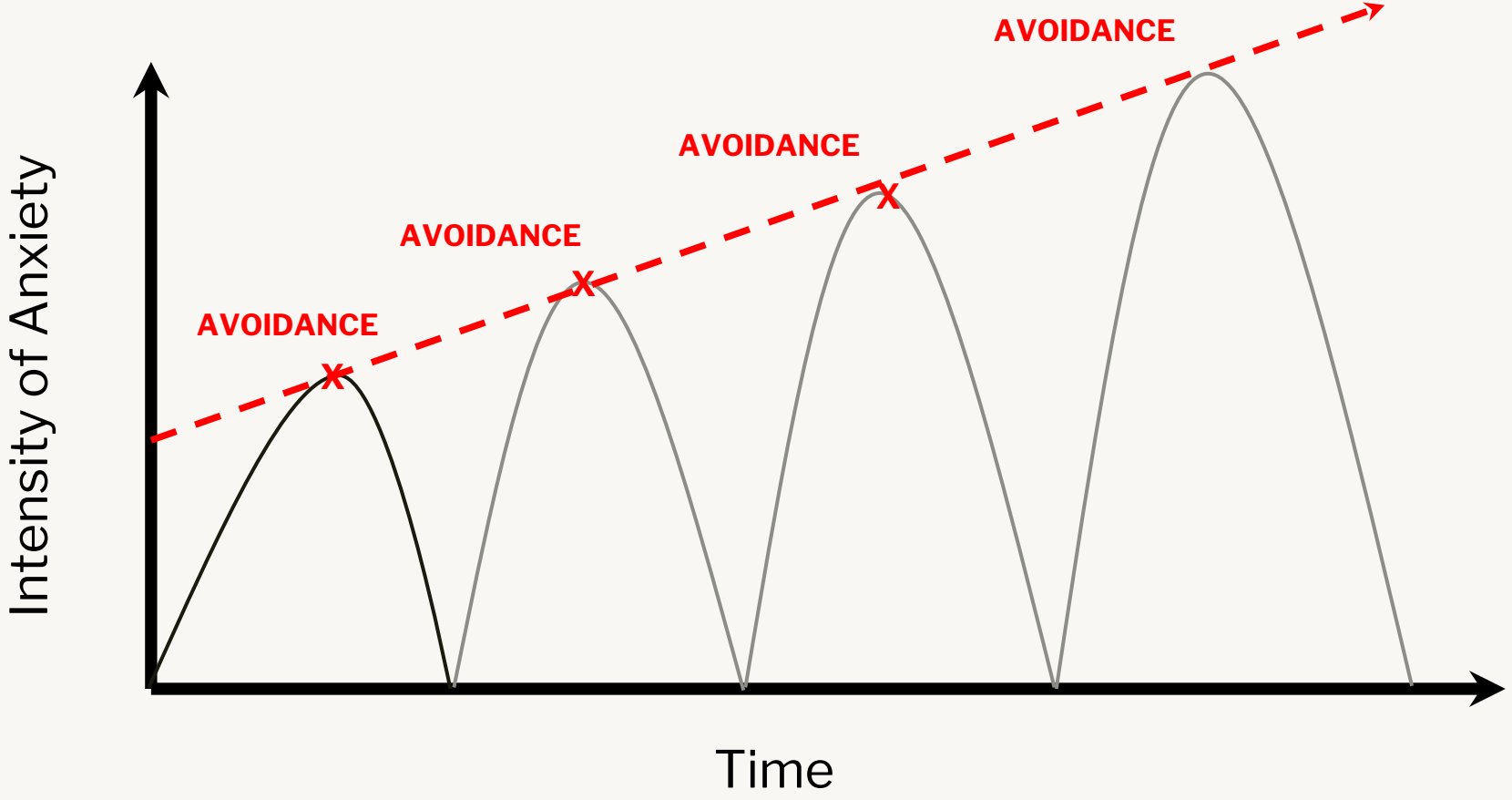
The Negative Reinforcement Cycle: Anxiety Disorders



The Negative Reinforcement Cycle: OCD



The Role of Avoidance



ASSESSMENT

General considerations for assessment

- Symptoms exist along a continuum
- Consider:
  - Stage of development
  - Life stressors
  - Substance/medication-induced symptoms
- Clinical diagnosis always determined based on:
  - Duration, Distress, Interference

Assessment of Anxiety Disorders

- Developmentally informed intake assessment
  - Consider who should be present for which part of intake, and for how long
  - Consider child's age, insight, etc.
  - Rapport-building
- Differential diagnosis amongst anxiety disorders
  - Structured or semi-structured assessment tools (e.g., K-SADS, ADIS-C/P)
  - Self- or parent-report measures (*MASC, SCARED*, etc)
  - Broadband self-report, parent report, or teacher report measures (*CBCL, BASC, etc)*
- Assigning and communicating diagnoses:
  - Consider symptom overlap: parsimony versus accuracy?
  - Patient/family experience or identification with disorder

Assessment of Anxiety Disorders

Behaviors:

- "What things are you doing, that you wouldn't ordinarily *do*, because of your anxiety?"
- "What things are you not doing, that you ordinarily would *do*, because of your anxiety?

Thoughts:

- "If I could hear your thoughts in the situation where you feel anxious, what would they be saying?"
- "What is the core fear that is driving this anxiety? What are you afraid will happen in this situation?"

Feelings:

- "What physical feelings do you notice in your body when you are anxious?"

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Case Study #1: Diagnostic Considerations

Panic Disorder; Social Anxiety Disorder; Specific Phobia: Other (vomiting)

Differential Diagnosis - Clarification Questions:

- Do panic symptoms always occur in response to a stressor (i.e., social situations, vomit), or can they occur unexpectedly?
- Is the fear of judgment by others excessive, compared to same-aged peers?
- What is the primary fear associated with vomiting? Judgment/ridicule by others? Fear of vomit/vomiting itself? Fear that nausea/vomiting will provoke additional panic symptoms?
- What is the belief driving the avoidance of school, basketball, friends? (*i.e., if I see my friends or play basketball, X will happen*)

Assessment: OCD

Children's Yale Brown Obsessive Compulsive Scale (CYBOCS)

- Current and past ratings for multiple categories of obsessions and compulsions
- Can either be child + parent combined or seperate
- Ages 6 - 17

Important to understand the intensity, duration, and frequency

Obsessive thinking alone is not enough to diagnose OCD

Assessment: OCD

- Functional analysis of the behaviors is important in order to develop appropriate treatment planning
  - What purpose are the behaviors or emotions serving?

- The connection between an obsession and a compulsion is not always obvious

- Assessment must include the ways the environment has adapted to child's OCD (e.g., family/school accommodations)

Dimensions of OCD

(Abromowitz, et al., 2010)

- Contamination obsessions (washing/cleaning compulsions)
- Responsibility for harm (checking/reassurance seeking compulsions)
- Intrusive/repugnant thoughts concerning sex, religion, and violence (mental rituals/neutralization compulsions)
- Order and symmetry (ordering/arranging and compulsions associated with “not just right” feelings)

Case Study #2

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While Mary initially felt she could not share her fears, she eventually reports worries around being responsible for something terrible happening. She holds her breath when her brother is near, avoids being in a room with him, won’t touch anything he might touch after her, and she feels like a terrible sister. Her father spends a significant amount of time helping her plan her day to avoid her brother, moves and holds things to help her, and reassures her that nothing bad will happen to her brother.

Mary reports no matter what she tries the intrusive thoughts of something bad happening occur multiple times an hour and she engages in protection rituals throughout her entire day.

Case Study #2: Diagnostic Considerations

Clarification questions:

Is the concern that harm will come to her or come to others? Both?

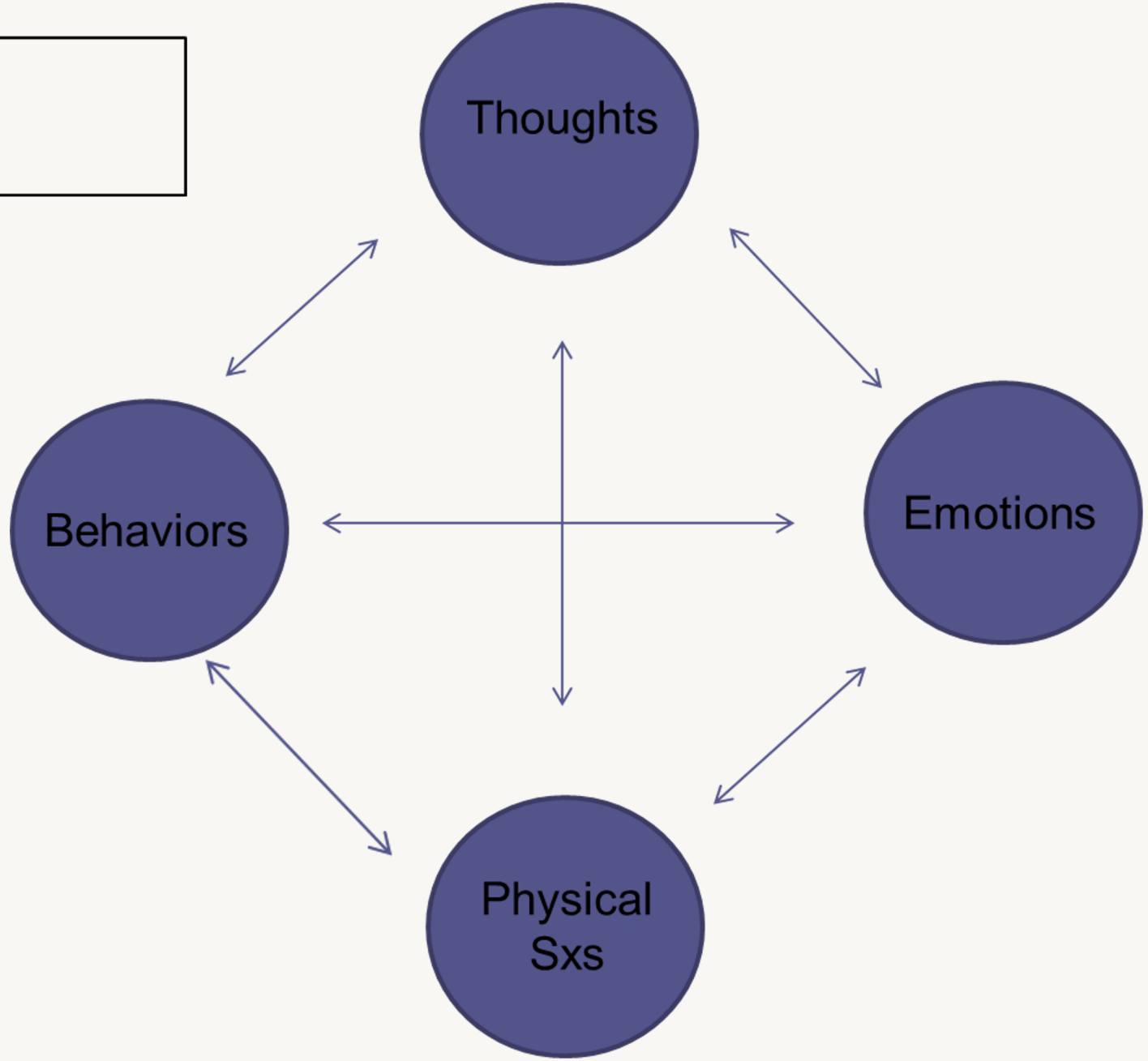
Is the brother contaminated or is she worried she will contaminate him?

Are there other or more subtle rituals present? Any mental rituals to consider?

Is she pulling for accommodations from her father or is he jumping in to avoid her distress?

TREATMENT

Situation:



Treatment Components: Emotions

Emotions

- Identifying and labeling emotions
- Identifying that emotions exist on a continuum
  - Use of thermometers, visuals
- Naming the emotions
- Helps externalize the issue and provides a language
  - Helps in identifying thoughts + actions
  - Gives parents a language when they are frustrated

Treatment Components: Cognitions

Thoughts

- Identifying thinking traps/common patterns
  - *Catastrophizing*
  - *Mind reading*
  - *Labeling*
  - *All or nothing (black and white)*
  - *Emotional reasoning*
  - *Jumping to conclusions*
  - *Disregarding the positive*
  - *Shoulds/Musts*
- Identifying patterns to *when* thinking traps are likely
  - *Before – anticipatory*
  - *In the moment*
  - *After – critical reflection*

Treatment Components: Cognitions

Cognitions

- Catching thought patterns, identifying the trap, challenging the thought
- Common ways to target thoughts:
  - *What is the evidence/proof for the thought?*
  - *What is another way to think about this?*
  - *What is the worst that could happen? Can I handle it?*
  - *What's the best that could happen?*
  - *What's the most likely to happen?*
  - *What would I say if a friend was saying this?*

Treatment Components: Behaviors

Behaviors

- Change behaviors
  - *Concrete action goals*
  - *Behavioral activation*
  - *Opposite actions*
  - *Exposures*
- Reinforcing behaviors
  - *Avoidance*
  - *Safety behaviors*

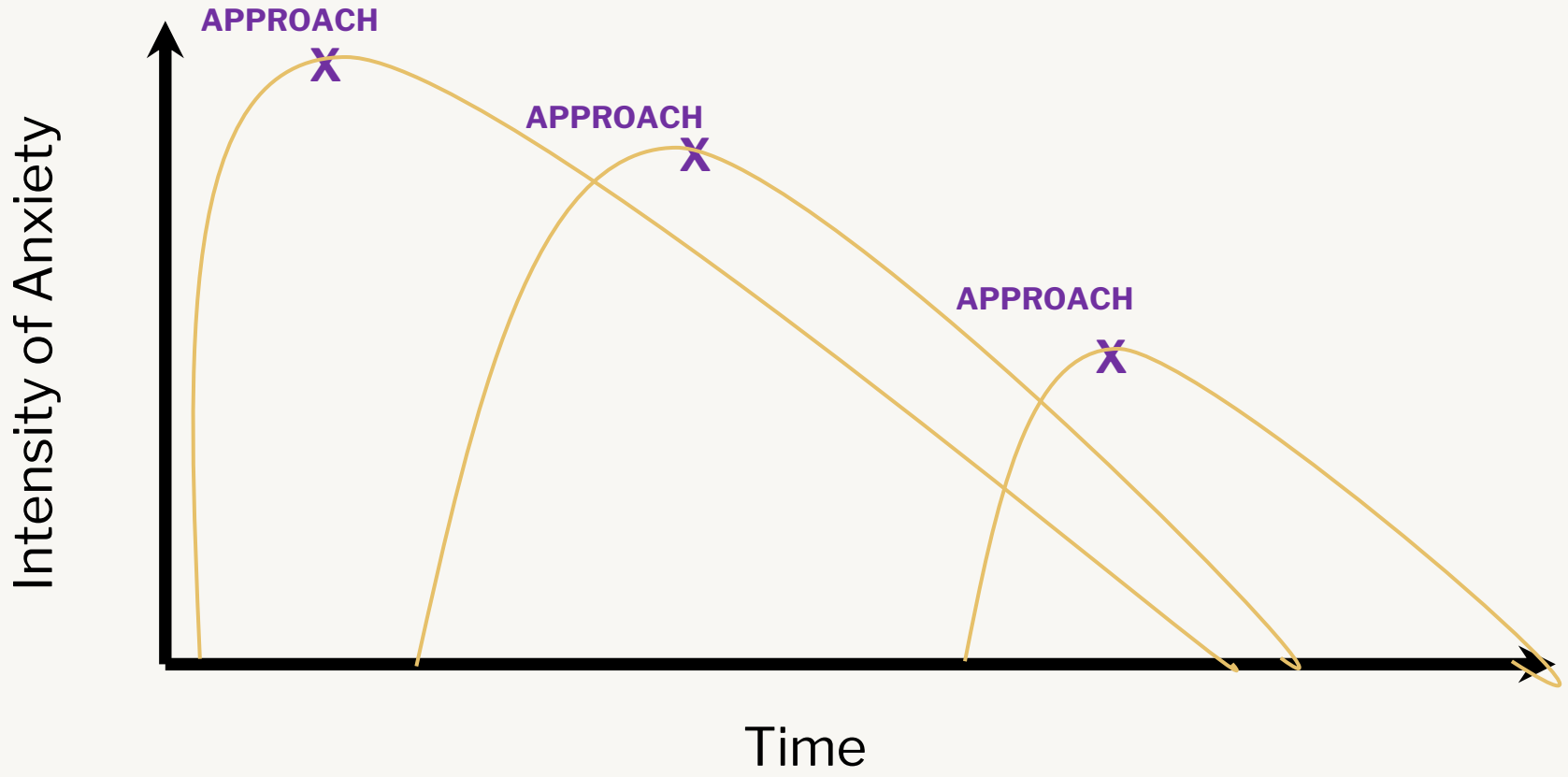
Exposures: The Prep

- Focus on therapeutic rapport
- Focus on developing willingness and “buy-in”
  - *Enhancing motivation (e.g., I want to be able to go on sleepovers, so I need to be able to use the bathroom at my friend’s house)*
- Formulating the fear and associated behaviors is key
- Define avoidance as a behavior
- Building a hierarchy/exposure menu – it evolves

Exposures

- You are not proving something is safe through ERP, instead you are helping clients tolerate uncertainty more effectively
- Teach how avoidance feels “safe” but actually increases anxiety
- Generalizing skills, teaching child how to design his/her own exposures
- Motivation & redefining life without anxiety

Graduated Exposure Practices



Inhibitory Learning

- Exposures allow the opportunity for new learning
  - Learn that anxiety can be tolerated, more manageable than assumed
  - Learn that rituals are not necessary to tolerate anxiety
  - Learn that feared outcomes do not necessarily occur (expectancy violation)
  - Important to combine fear cues and conduct exposures in different environments

(Craske et al., 2014; Abramowitz, 2018)

Troubleshooting Exposure Practice

- Set yourself up for success
- Developmentally appropriate rewards/contingencies
- Forced-choice options
- Roll back without backing down
- A note on coping skills/distress tolerance skills

Treatment: Case #1

Initial Sessions

- Rapport-building
- Determining level of parental/school involvement
- Consider psychiatric medication
- Clarifying motivators/rewards and contingencies

- Psychoeducation
- Introduction to mindfulness/present-focused emotional awareness
- Introduction to cognitive work

Ongoing Sessions

- Preparing for exposures
- Developing an Exposure Hierarchy
- Graduated exposure practices during and outside of sessions

Exposure Hierarchy: Case #1

SUDS	Target
10	Stay at school for the full day after eating
9	Eat full lunch in the cafeteria
8	Watch a vomit video while eating at home
7	Attend basketball practice
6	Eat a full breakfast before school
5	Spin in an office chair for 30s (interoceptive exposure)
4	Watch a vomit video
3	Eat a plain piece of toast before school
2	Text a friend to hang out

Treatment: Case #2

Initial Sessions

- Rapport building
- Psychoeducation around OCD, tolerance of uncertainty,emotions associated with OCD
- Functional analysis between obsessions and compulsions
- Clarifying values related to exposure work

Ongoing sessions

- Evolving exposure menu
- Shaping choice around selecting exposures
- Exposures in session and in-between sessions
- Reducing accommodations
- Focus on response prevention
- Relapse prevention

Exposure Menu: Case #2

Level	Targets
High	• Playing a video game with brother • Blowing bubbles with brother • Brother wearing the sweatshirt she contaminated • Eating next to brother at dinner table
Mid	• Using a video game controller after brother • Wearing brother's sweatshirt
Low	• Standing in view of brother, in a different room • Deep breathing while she can hear brother nearby

FAMILY CONSIDERATIONS

Parenting Dialectic

What is my job, as a parent, when my child is distressed?

Belief:
To Protect my Child

Belief:
To Promote Independence in my Child

Behavior:
Fragilize

Behavior:
Under-support

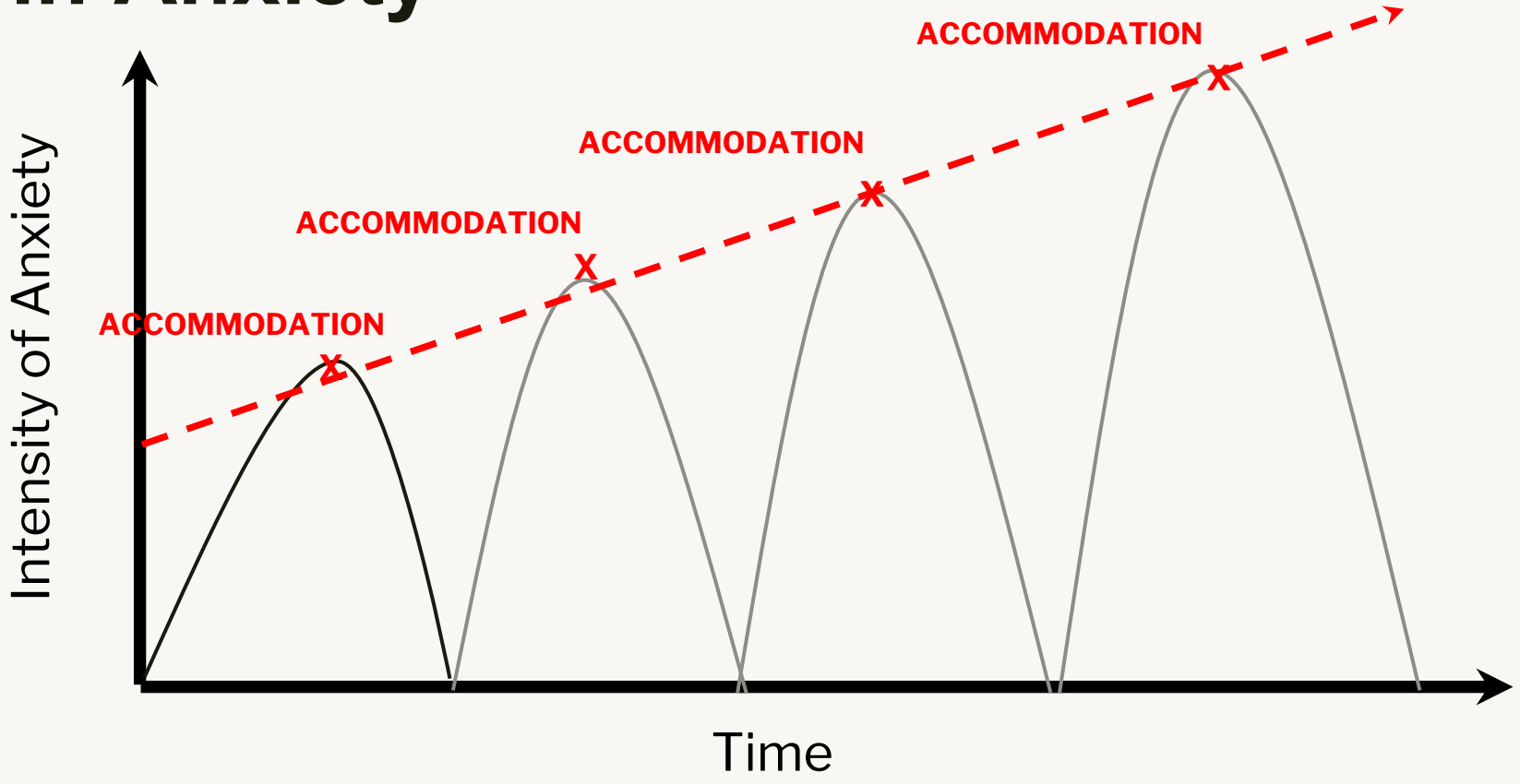
Caregiver Accommodation

Changes that caregivers make to their own behavior to help their children *avoid* or *lessen* feelings of anxiety.

Accommodation can involve:

- Participation in anxiety-driven behavior with the aim of avoiding or reducing child anxiety
- Modification of family routines and schedules

The Role of Accommodation in Anxiety



Is this Accommodation?

Is the parental response helping the child to gradually cope more effectively

Or

Is it helping the child to avoid distress?

Are the symptoms getting better over time as a consequence of the parental response

Or

Are the symptoms being maintained or worsening despite these efforts?

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Accommodation Reduction Plan

- **Parent Psychoeducation**
  - Role of accommodation in anxiety disorders
  - Basic behavioral principles, differential reinforcement of desired behaviors

- **Accommodation Targets:**
  - Gradually reduce accommodation around meal-prep/food choices
  - Gradually reduce responding to reassurance-seeking behaviors
  - Reinforce independent coping at home and school
  - Contingency-management around school avoidance
    - Remove access to reinforcers during the school day
    - Establish routine with minimal attention directed towards Seneca during school hours
    - Consult with guidance/school nurse to promote remaining onsite
    - Establish values-consistent rewards for Seneca to increasing school attendance

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Accommodation Reduction Plan

Disengage from following OCD's rules

- Psychoeducation for family around the role of accommodation, accommodation tracking
- Reduce reassurance answers
  - Limited number of reassurance questions that can be asked in a day
  - Answer once and not again within a certain period of time
  - Neutral responses only
- Reduce item holding
  - Over time reduce the number of times something can be held/moved
- Family event planning no longer involves OCD

AUDIENCE Q&A

FINAL THOUGHTS

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THANK YOU!

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