Assessment and Treatment of Pediatric Anxiety Disorders and OCD
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Now, let me introduce our presenters. First. Dr. R. Meredith Elkins, a clinical psychologist specializing in the cognitive behavioral treatment of anxiety, mood, and related disorders in children, adolescents, and young adults. Dr. Maria G. Fraire, a licensed clinical psychologist who specializes in the treatment of severe anxiety, OCD, and co-occurring disorders, specifically utilizing cognitive behavior therapy and exposure and response prevention therapy. Welcome, Dr. Elkins and Dr. Fraire.

Dr. R. Meredith Elkins: Thank you so much. We're delighted to be here. Good morning or afternoon everybody, depending on where you're calling in from. Let me just start by telling you a little bit about the program that I co-direct alongside Jackie Sperling and Paulina Loo. The McLean Anxiety Mastery Program was designed to provide about a year's worth of outpatient CBT for kids with moderate to severe anxiety disorders in just a few weeks' time. We are a group-based intensive outpatient program with an emphasis on ERP or exposure and response prevention. Our kids ages 6 through 19 come to our program for afternoons a week for a minimum of four weeks.

We're an interdisciplinary team, including psychologists, psychiatrists, and doctoral student trainees. We are currently running in a hybrid format, so we have some in-person sessions and some virtual sessions. This was started during the pandemic, but we've retained the virtual aspect of our programming because we found that it has been so helpful to increase caregiver engagement and to be able to broaden our patient population. It's a lot easier to get people to come into the McLean area if they only have to do it a few times a week. I will pass it over to Maria.

Dr. Maria G. Fraire: Hello, everyone. Thank you for joining us today. I am the program director of our OCD Institute for Children and Adolescents, more fondly

referred to as OCDI Jr. We are a residential program with 16 beds. We're insurance-based. Kids come to us from all across the country and we have folks who also come internationally. The ages we see are 12 to 18. Most kids stay with us for about two to three months.

They really come to do intensive OCD and anxiety treatments. They work with a multidisciplinary team. We have psychologists, psychiatrists, social workers. We have a day nurse and an eve nurse. We have milieu staff that we trained to be exposure coaches. When kids and families come to work with us, the children and adolescents receive individual therapy and group therapy. We do at least one family meeting a week and we do daily exposure coaching.

We do a lot of prepping to help kids go back into their community. The main goal when they come to residential is to give them foundational skills to manage their OCD and anxiety and return to their outpatient teams to be supported in their homes. We are entirely in-person as a residential program. Our doors reopened here July 2020 and we've been operating ever since. We have, however, been able to capitalize on some of the virtual programming in terms of being able to have family meetings that are virtual.

It helps keep our parents more engaged, particularly if they're not local. With our residential program, we do our best to serve as many as we can. Our primary treatment modality is using exposure with response prevention, but we pull from a wide variety of evidence-based treatments, including acceptance and commitment therapy, dialectical behavior therapy, really depending on the individual and family needs. To give us a bit of a roadmap for our talk together, Meredith and I are both trained as cognitive behavioral therapists. That's our primary modality. As I mentioned, we pulled from other evidence-based treatments as well.

Today, we're going to be talking about anxiety disorders and OCD within a CBT conceptualizations framework. We're going to spend some time together talking really about assessment, how we understand anxiety disorders, how we elicit information from kids and families so that we can provide the best-tailored treatment possible. We'll talk a bit about treatment. We have two case studies that we'll be presenting to guide us through our presentation. We'll talk a fair amount about family-based considerations, really thinking about how we help kids and families really try their OCD and anxiety to give them a more fulfilling and value-based life. Of course, we'll leave time at the end for Q&A.

Dr. Elkins: All right, thanks, Maria. Again, as Maria said, we're going to present two case studies that we're going to refer to throughout the presentation. Our first case study would be Seneca. Seneca is a 14-year-old female who was referred for assessment and treatment by her pediatrician. She presented at her local emergency room three months prior with concerns that she was having a heart attack and physical workup attributed symptoms to anxiety.

She's lost 10 pounds since that time. She reports nausea, headaches, dizziness, and difficulty breathing most mornings before school with onset at the beginning of her current freshman year of high school. She reports that she doesn't feel like she fits in at her new school and she's 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 has subsequently restricted her eating behavior to avoid nausea and vomiting. Seneca misses two to four days of school per week. On days when she attends school, she often presents to the school nurse with symptoms and is typically dismissed early. When she does not attend school, she reportedly sleeps, watches TV, or spends time on her phone. She has quit the basketball team and her parents report that she rarely spends time with friends outside of school.

Dr. Fraire: The second case we'll be talking about is Mary. She's a 15-year-old female initially presenting to an outpatient clinic for the assessment and treatment of anxiety. Her father reported she's 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 friends, and she experiences low mood.

While Mary initially could not share her fears, had a hard time articulating her experience, she was eventually able to open up and reported worries about being responsible for something terrible happening. She holds her breath when her brother is near, she avoids being in a room with him, she 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, 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. She engages in protection rituals throughout her entire day.

Dr. Elkins: All right, so we're going to jump into talking about assessment and, again, keeping those case studies in mind, we'll refer back to them. It's beyond the scope of this presentation to go through each of these anxiety disorders that are in the DSM-5. We did want to note that these disturbances are all characterized by some shared features, really the excessive fear or anxiety, and related behavioral disturbances.

Where we see the distinguishing features between these disorders is, what is the source of the fear? It's going to range depending on whether the child is afraid of negative evaluation by peers, which is the source of the excessive fear for social anxiety, or whether it's really the fear of unpleasant internal sensations, again, characterized by panic disorder.

We also want to highlight that comorbidity is always going to be the norm rather than the exception when you're doing assessment around anxiety disorders. It's very rare to see a kiddo who just meets criteria for one anxiety disorder. Again, Maria, shared with us that we are all ascribing to a cognitive behavioral perspective, so we really wanted to highlight how we think about the development and maintenance of anxiety and OCD and the crucial role that negative reinforcement plays in these disorders.

Remember back to Psychology 101, where that negative reinforcement occurs when there's a behavior and a stimulus is then removed, which subsequently increases the

behavior in the future. That's like putting on that seatbelt removes that annoying beeping sound, and that reinforces us putting the seatbelt on next time. We see this with anxiety. A situation provokes a distressing, anxious response, anxious thoughts and feelings. The easiest way to get rid of that distress is to avoid or to escape the source of that distress.

This is a natural and normal and adaptive strategy when there is a legitimate danger to our life or well-being. The relief that comes from the avoidance makes it more likely that we're going to avoid the same situation in the future. When we see that the source of the distress isn't actually dangerous to the life or well-being, the cycle of negative reinforcement can become problematic. We see it with anxiety disorders. Maria is going to walk us through OCD.

Dr. Fraire: Very similarly, and you'll see, we really do like our visuals here in the CBT world. In OCD, anything about how obsessions or intrusive thoughts will show up for someone, it will lead to a very uncomfortable thought or feeling associated with it. Very often, that emotion can be anxiety, but it doesn't have to be. It could also elicit emotions of disgust or shame. Sometimes our kids experience what we call not just right experiences, where they can't really articulate it but just feels uncomfortable and incorrect.

This intrusive thought can trigger this response. What OCD has taught the child is that the ritual or the compulsion is the thing that brings them the relief. It makes them feel better. I have this thought. I have to do this behavior. I have to do this ritual. I have this thought. The ritual will get rid of the thought, negate it, or if I have this thought, I don't want it to come true, so I have to do the rituals so that it doesn't. As we go through the cycle, really, the thing that emerges for OCD that we talk a lot about with our kids and families is this difficulty in tolerating uncertainty.

In a bit, I'll talk a bit about the different dimensions of OCD. One of the common themes throughout OCD is that it takes things that are really important to someone and just makes them really, really fearful. That makes them very worried. Really, it's that uncertainty that something that could happen or that they did something terrible, but they're not sure. That is such a hallmark of OCD. We'll talk a bit more about that in a moment.

As we talk about our cycles and as we go through and talk about anxiety and OCD, you'll hear us repeatedly talk a lot about avoidance. We have this graph to simply demonstrate how avoidance can reinforce the anxiety. Anxiety becomes more intense over time the more that someone avoids something because what avoidance will teach them, whether they're anxious or they have OCD, is that it feels good.

It feels good to not do the things that make us uncomfortable and so we avoid it, but then it becomes even harder. We feel we can't manage something. We cannot tolerate the discomfort. We'll continue to avoid it. We'll see over and over again, families and kids get trapped in this cycle of avoiding more and more because it's just easier. It feels better, except over time, it simply becomes so much more challenging.

Dr. Elkins: We wanted to do a little disclaimer. Our slides are pretty content-heavy. Please understand that we may not cover everything that's written on the slides as we speak, but we know that you'll have access to these slides, so please feel free to refer back. Just briefly to set the stage regarding assessment. We do want to remember that anxiety is natural, normal, and harmless and that most of the population will experience a panic attack.

Most of the population will experience intrusive thoughts or obsessions, and then there are some periods across development where certain fears or anxieties or OC spectrum concerns may be more common and are likely transient. What we're really looking at as a determining factor for assigning a clinical diagnosis of an anxiety disorder or OCD are duration, distress, and interference.

How long have the symptoms been present? How distressing are they to the child or to the family unit? How much interference are they causing for the child? We set the stage for assessing anxiety in youth. We really just want to start with your excellent clinical skills, your excellent relational skills upfront to really develop rapport from the outset. We do recommend meeting with the child and caregivers together for the first intake appointment for introductions, for brief rapport-building, and it also gives time to consider who likely will be the best respondent, the best reporter.

Young kids will be more likely to get good, rich, clinically relevant information from the caregivers. For the older teenagers, they may have a better window into their symptoms and what's driving their symptoms. Of course, there's always the really precocious, insightful little one or the teenager who presents as younger or is more tangential. We like to start with parents and kids and then get a sense of who might be the best reporter.

There's really no hard and fast rule of how to do an unstructured or semi-structured assessment. That can be helpful also to make sure that we're reviewing confidentiality and its limits because we do want to make sure, especially for rapport-building early on, that if a teenager or a child inadvertent-- they share something with you that they feel is shared in private but then you have to tell family because of safety, we just really want to make sure that we're clarifying that ahead of time.

There are a number of avenues for assessment. We have some examples up here. In the interest of time, we're just going to move forward and talk a little bit about, again, from a cognitive behavioral perspective, mapping onto thoughts, feelings, behaviors, the things that we want to target in treatment. Here are some suggestions of ways that we like to get at what's going on for a kiddo.

Asking about their behaviors, so what things are you doing that you wouldn't ordinarily do because of your anxiety or the converse of that? What things are you not doing that you ordinarily would do because of your anxiety? This can help us to not only understand the interference associated with the anxiety but becomes a roadmap for treatment and for goal-setting. Really getting a handle on the thoughts is so important.

Asking questions like, "If I could hear your thoughts in the situation where you feel anxious, what would they be saying?" Because we're trying to get at, "What is the

core fear driving this anxiety? What are you afraid will happen in this situation?" We find that so diagnostically clarifying if it can be articulated. "I'm afraid that if I answer this question wrong that everyone's going to yell at me," is so much different than saying, "I'm afraid that I'm going to have a panic attack when I answer and I'm going to faint or pass out."

We really want to try to get a handle of the thoughts and that can really open up what's going on diagnostically. When we look at our first case study with Seneca, we've seen a number of different things that jump out that I would want to glom on to for assessment. We see there's concerns that she's having a heart attack. There are these other somatic symptoms going on. We see some areas of fear of negative evaluation by peers, fears that she's going to vomit, and then associated behavior restricting her eating.

If this is a case that was coming to us, we would, off the bat, be considering panic disorder, social anxiety disorder, specific phobia of vomiting. Those are the areas that we probably start with and dive into really assess and clarify, are these discrete diagnoses? Is one of them primary? Is there a rule out here? Some questions that I would be thinking of to clarify amongst these diagnoses regarding panic.

The panic symptoms occur in response to a stressor like a social situation or in the presence of vomit, or can they occur unexpectedly? Because for a diagnosis of panic disorder, the child needs to be experiencing unexpected, uncued panic attacks. It's not just, "I'm worried about something and then I have a panic attack." Asking about whether the fear of judgment is excessive.

I love the question of, "Compared to your peers, do you think you're worrying more about X, Y, or Z?" because, again, it is totally normal for young people but anybody to be concerned about how they're being viewed in a social situation or to be concerned about their academic performance, et cetera. Asking, "Compared to your friends, do you feel like you're worrying about this way more or is this way harder for you than other kids?" that can be clarifying.

I'd like to get more information about the vomiting. Is the fear of judgment, "I'm going to vomit and everyone's going to judge me," because then we could put this more with the social anxiety category? Is it a fear of vomiting itself? Then it would be more of a specific phobia presentation, or is it, "I feel nauseous and that accelerates my panic"? Then, again, trying to get at those core beliefs or those anxious thoughts. What belief is driving the avoidance of school, of basketball, of friends that can really help when you're trying to tease apart the diagnoses, especially knowing that anxiety disorders are often comorbid?

Dr. Fraire: Building off what Meredith said about the assessment for anxiety, we will use very similar approaches when we're assessing for OCD. A few slides earlier, we had the broadband, semi-structured, unstructured interviews like the K-SADS and the ADIS. They have OCD modules within them, so they can be part of your overarching assessment of anxiety and OCD.

As you want to become more fine-grained, if you feel like you're going down the path where OCD may be what's presenting for your client, then we often recommend

using the Children's Yale-Brown Obsessive-Compulsive Scale or the CYBOCS. There's actually two versions of this, but the original CYBOCS is very easy to find if you look it up online. It looks at past symptoms. It looks at current symptoms.

You can do it either separately between the child and the parent or you can do it combined. Overall, you would combine the scores clinically to look at which OCD categories may be presenting for the child, what sort of obsessions are showing up for them, what types of rituals are they engaging in. It can be used for a pretty wide age range of 6 to 17. As Meredith already mentioned, really what you're looking at is you're going through and asking about the different thoughts and behaviors that someone may be engaging in.

What you're also assessing for is, how intense are these thoughts? We can have intrusive thoughts that show up. About 90% of folks will have intrusive thoughts in general, but what we're looking for with OCD is, how much does it stick? How intense is it? How much do you keep coming back to it? How hard is it for you to disengage from this thought? We're looking at duration. How often is this happening? How frequently is it occurring?

This includes both the obsessions and the rituals. We're really looking at this because the combination of OCD is obsessions and rituals. Having obsessions in general is not enough to diagnose OCD. We'll sometimes see this in our clinic as well. We'll have parents call me like, "My child is obsessed with this one thing. They're just obsessed with it. They have OCD." As we're going through the assessment, there are other diagnostic considerations.

Are we talking about a kid who has a specific restrictive interest and they're on the autism spectrum? Are we talking about a kid who may be really, really into playing video games and parents are labeling that as an obsession and insists the rituals that they have to play video games? When we're looking at OCD, what we're really thinking about is intrusive, unwanted thoughts. These are thoughts that feel like they are not syntonic with who you are as a person.

This is really hard for kids to distinguish, particularly if they're experiencing OCD. If they had it at a young age, they're like, "I don't know if this is me or not, but if I'm having this thought, maybe it is," and so a lot of the assessment is helping sort through, "All right, what feels authentic to you and what feels like something that's almost outside and different and just not quite matching up with who you want to be?" and then we're looking at the intrusive nature of that.

When we're going through and doing the assessment, we're looking a lot about the functional analysis of the behaviors. Really, what we mean by that is, how are these thoughts and behaviors and emotions all connected? It's important in OCD to really think through and do this thorough assessment because it's not always obvious how the thought and the ritual may be connected. If you superimpose your own logic on it, you may actually miss some pretty critical components that you would need for your treatment planning.

For example, we had a kid who came into the clinic and they were doing a significant amount of hand washing. The clinician they were working with was a little newer to

OCD and heard hand washing and went through and asked all the germ questions, "Are you worried about getting sick?" The kid was like, "Yes, I'm worried about getting sick." They're like, "Great. Okay, so the thought must be that you're worried about getting sick. The ritual is you're doing all this hand washing. You started the exposures to the thoughts around getting sick."

Over time, what came out is the kid realized, "Yes, I'm worried about germs. I don't want to get sick, but that's not actually why I wash my hands. I wash my hands because I have had this thought that if I don't wash my hands, my grandmother will be very disappointed in me. When she's disappointed in me, that means she won't get into heaven. I wash my hands to protect my grandma so she can go to heaven."

So different than what you would've thought. Had the assessment not been done in a thorough way, they would've been really easy to miss, and the exposures would've been targeting the wrong thing. When we're doing assessment for OCD, we're really thinking a lot about what are the thoughts, what are the rituals, how are they connected. OCD is not logical, so we're on the lookout for that.

As we're going through doing our OCD assessment, we also are asking about, "Okay, how is OCD being maintained in the family and in the schools? How is OCD being reinforced? Where is it being accommodated?" because that will be such a big important part of the treatment planning we do. As we're going through in doing our OCD assessments, really OCD can target any sort of thing. Any fear you can come up with, any worry you might have, OCD can latch onto that.

We tend to see some overall dimensions that a lot of these things can fall into. The four dimensions we tend to see will be either on the contamination side. This can either be the child getting sick. It can be the parent worrying about someone else getting sick. It can be concerns that include causing this idea that they might take on the essence of someone else called "emotional contamination," which is a whole different part of OCD that's often overlooked.

We have that classic contamination one might think about for OCD, but that is actually only a fraction of the types of kids that we'll see. We'll see a lot of kids who come to us with this fear or responsibility of harm that they did something wrong, that something bad is going to happen to them, that they're responsible for something terrible happening in the world. They'll have these thoughts and it'll be tied to these rituals where they do a lot of checking, a lot of reassurance seeking.

Those are the kids who are googling what's going on in the world, "What accident did I cause?" In addition to that, we also see a lot of kids who have these intrusive, unwanted thoughts that are really uncomfortable. They can be uncomfortable topics for kids and parents to talk about. Unfortunately, our kids do experience these types of OCD. These can be OCD related to sex, kids who worry that they themselves are pedophiles and will do something terrible to younger children.

We'll have kids who worry a lot about heaven or hell, hyper-morality. They'll have violent intrusive thoughts. They'll have violent images. Again, these are all very unwanted thoughts for them. They make them very uncomfortable, causing a lot of

anxiety and discomfort, but they're engaging in compulsions to try to neutralize these thoughts because of the discomfort they're experiencing.

Then our fourth dimension is the order and symmetry. These are kids who need things in a specific way they feel very uncomfortable. This is the dimension that perfectionism falls under. Also, the OCD of "not just right" experiences fall within this dimension as well. This can often be an easy type of OCD to overlook because it's really hard for a kid and a family to articulate because it's not as obviously like I have this thought. I feel anxious that I do this thing.

It's like something just doesn't feel right, so I have to do it over and over again. I have to flick a light switch. It's not a certain number of times. It's not because I'm worried something bad will happen, but it's because it just doesn't feel right until I feel right. That can be pretty hard to target. These are just some examples of our OCD. If we think about Mary and what she's going through and we're thinking about our assessment questions, we started seeing it's impairing in her life.

Dad's identifying grades going down, withdrawing from friends. It's impacting her mood. It stands out to us that she's able to share that responsibility for something terrible happening. We start seeing, "Okay, here are some rituals that she may be engaging in. Holding her breath, avoiding being a room with brother, not touching things." She's identifying that it's happening pretty frequently. It's pretty intense and it's impacting her entire day.

It brings up a lot of questions of what we would wonder about and ask her more questions as we get to know her over time. We're trying to sort through. Is this a concern about harm coming to her? Is she worried the brother will do something for her? Is she worried about her brother that something will happen to him? Is it both going on? Is she worried a lot that something bad is going to happen that she's going to contribute to and the brother will be a part of it?

There's a bit to untangle there. We're also thinking, "Okay, if she's talking about it going on throughout the day, there's probably a lot more rituals that either she hasn't shared yet or that haven't been observed yet, or she doesn't quite realize her rituals." One of my notes here involves mental rituals. These are the things that kids are doing in their minds that aren't going to be obvious to any of the rest of us.

We want to make sure to talk to kids about the possibility of mental rituals that could be there because they're less likely to realize to report them. Something like this might be a neutralizing statement they say to themselves. Like in Mary's case, if she does happen to see brother, she'll have a neutralizing mental ritual that she can engage in that might be something along the lines of, "Okay, I see him, but I know he's safe. If I get out of here, he'll be safer."

She has to say that exact same thing over and over in her mind. It took a while for her to realize, that was a different type of ritual that was showing up. Then the other area particularly with kids, we're talking a lot with families about accommodations. We know that dad is really jumping in to help her out a lot. Is she pulling for that? Is he jumping in preemptively? Are they stuck in a cycle where accommodation is

becoming the norm? There's just a lot of things that we'll be sorting through as we get to know Mary better.

We're going to shift a bit and talk a bit about treatment. You all may be familiar with the CBT triangle. Some of you may be familiar with this graph that we have here. We consider it our CBT diamond. We'll, in the triangle, think about thoughts, emotions, behaviors, and particularly when working with kids, we really talk a lot about physical symptoms. You may have a kid who's pretty good about articulating their thoughts and sharing it.

You may have some kids who are pretty good at identifying their feelings but maybe don't realize how it's connected to their thoughts or behaviors. For a lot of the kids, what they are able to do is tell you, "I have a headache. I have a stomach ache. My body feels really tight. I feel very tired," and so we really think it's important to include those physical symptoms when you're conceptualizing the kid because for a lot of families, that's a good place to start.

When it comes to behaviors, parents can often identify different behaviors, and that's easier for them to explain all those different pieces. Then on the slide we had before, you notice we also have situations because the context matters in terms of what is going on for the kid. Here we have the thoughts, the emotions, the physical symptoms, behaviors, and they're all connected. They're all intertwined.

Through treatment, we identify, "All right, where might be the skills deficit?"

Are they better at identifying thoughts but not emotions, emotions but not thoughts? Are the kids not noticing how this is all connected to their behaviors? We're starting to build our treatment plan around, what skills do we want to shore up and what are we going to help them with? In the interest of time, as Meredith mentioned, we have a lot of content on these slides. We won't spend too much time on it in terms of the emotions or the thoughts, but we'll spend a fair amount of time talking about behaviors, particularly exposures, and avoidance.

As part of your treatment planning, you do want to be working with kids to identify emotions. It gives you a common language, it gives parents a common language to lose with their kids. We want to teach the kids what different emotions are, how they exist on a continuum. Often visuals are very helpful for this, and that emotions may happen in different ways. They can happen in a-- Well, you can talk about sad, happy, angry, but so much more nuanced than that. The more refined a child's language comes when it comes to emotions, the stronger they'll be able to be about noticing their own internal experience and being able to share it with you.

An important part of our treatment is also looking at the thoughts. A large part of CBT involves cognitive restructuring. That involves helping people recognize their clues of what kinds of thoughts they might be engaging in, catching the thoughts as they happen, and figuring out how to target the thoughts. On this slide, we have a lot of different types of thinking traps and the types of common patterns that may show up. Then on the next line, we'll have examples of what you do when you catch the thoughts. The first step is teaching kids to notice that they're falling into these

thinking traps. Then the next stage is, "Okay, they've had the thought, what do they do with it."

This is that cognitive restructuring piece of CBT, where we help kids sort it through right. You've had this thought, what's your proof for the thought? How likely is it to happen? You're helping them become critical thinkers around their thoughts. An important part of this work is helping them get a little distance from those spurs as well. This thought shows up, but that doesn't mean it's a fact. Let's look at it a little more objectively from other angles. That helps get a little distance, and will also help influence the emotions, their experiences, and the behaviors they're engaging in.

When I talk about behaviors, as I mentioned, we'll talk a fair amount about exposures, but there are other ways that you are targeting behaviors when it comes to treatment.

You're developing strong goals, goals that are achievable, goals that make sense. You're helping kids get reengaged in activities that OCD and anxiety may have taken from them. You're teaching them that even though they have the thought, they can't do anything, or they can't do anything while they're anxious, or they can't do anything while they're having this OCD thought. In fact, you can have the thought and still do the thing.

You can have the thought, and still engage in a values-based behavior that you want the kid moving towards. Of course, we're talking about our reinforcing behaviors as well, those avoidance and safety behaviors. All the ways that they're not engaging with the worlds because their anxiety and OCD is showing up, or the behaviors they're engaging in that they feel will keep them safer and will make it okay to go into the worlds. Those are all things that you'll be targeting. We really want to talk together about exposures because exposures is really the gold standard way that we're treating anxiety and particularly, OCD.

There's a lot of myths and confusion about what exposures are and what exposures are. We just want to spend a few minutes together talking about that. Exposures are only as good as the prep work you put into them. What I mean by that and it's like if the therapeutic rapport really matters. You're asking kids to face the fears that are the hardest thing for them, the scariest thing that their mind could think of. Then you're asking them to not engage in the one ritual they think is protecting them, or protecting their loved ones. In order to do that, you really need to have a strong therapeutic foundation.

We spend a lot of time talking with our kids about their willingness to leave their exposures and get their buy-in. We do our best to target exposures that are important to the kids. That's how we work on their motivation is figuring out what is it that anxiety has really taken from you? What would you like to get back to? Let's start there. Let's figure out how do we start chipping away at the things that anxiety and OCD has told you you can't do anymore, but you really miss. That's part of why we really emphasized early on how important the assessment is because you want to make sure you're targeting the right things.

It will help the child feel heard, that you understand them. You've defined avoidance as a behavior because that means it's something that can be changed. As we start talking more and more about the exposures, we'll use either hierarchies or exposure menus. We'll have examples of both in just a moment. I think it's important to consider that when you're doing an exposure, your goal is not to prove to the child that something is safe, that being byproduct of what they learn. They may learn, "Oh, I can actually do this thing," and that's what you want them to learn, but your underlying goal is not that it's safe.

Instead, what you're helping them to do is develop the skill that they can tolerate on uncertainty. They can tolerate doing this thing, they can tolerate the anxiety and discomfort without engaging in the ritual. When we're talking a lot about exposures and what we're doing, we really want the kids that become their own exposure coaches over time. We work really collaboratively with our kids to figure out, "Okay, this is how we're designing the exposures1 and this is how we're doing it together." You really want their input for that willingness. You also want it because you're not going to target every single anxious spot they have, every anxious behavior, every OCD thing that pops up.

We know that often OCD and anxiety can morph over time, but if you can teach those kids to design their own exposures so that they're really thinking about, "This is how I target this spot when it shows up," then you're giving them a tool that they'll be able to take with them. We'll spend a lot of time figuring out how to do the exposures, and different ways that works for the kid in front of us. We are able to do all of this tough work because we spend so much time working on their motivation, helping build their insight to how this is impairing for them and redefining their life without anxiety.

There's a few different ways in what we think about exposures and how they work. Exposures originally, you'll hear a lot combined with habituation. This is just a visual of habituation and what it could look like. The more that you repeat the exposure over time, the less the anxiety that you experience. It doesn't have this beautiful graph for everybody. Another way that we'll think about exposures is really, it's an opportunity for new learning. This is in the inhibitory learning model. Essentially, it's teaching that anxiety can be tolerated, that it's more manageable than one thought.

This is again, back to why that prep work and understanding the exposure is so important. Before we even do an exposure with the kid, we'll ask them, "Okay, what do you think is going to happen during this exposure? How much do you feel you'll be able to handle this experience?" Then when we go through the exposure, we'll have the experience. We'll ask them to report to us where their anxiety's at? What their experience is like? Then we'll be sure to debrief at the end of the exposure, "Okay, did the thing that you thought happened happen? Was the anxiety as hard as you thought it would be? Was it as high as you thought it would be?"

Sometimes it is, but what? Did you manage it in a way that felt a little different? Sometimes that is also true, and that is where that new learning comes in. We do exposure. It's important that we do it in all different places because that's how the learning will generalize. Not just in the office, but also in the community, in the home, in the schools. We're looking to find ways, how do we build on these exposures over

time because typically, as one becomes stronger and stronger in doing their exposures, we're mixing all sorts of cues together. We're doing multiple exposures at the same time because that's really how anxiety shows up in the real world.

Anxiety is never just like, here's the one thought that you get to deal with, all sorts of things show up. We want our kids to be able to have that experience of like, "Okay, I've had a lot thrown out at me. These exposures are really hard, but I've learned how to manage." Exposures are hard though, it's tough. As I said, you're asking kids to do really tough things. You're asking parents to tolerate their kids experiencing pretty significant anxiety. Would you just want to be thoughtful about doing that assessment? Set yourself self up to be successful.

You're getting a lot of data as you're doing the exposures to think through, "Okay, here's what's working, here's what's not working," and you're adjusting those exposures. You're not necessarily giving up an exposure, but that's what we mean by roll back without backing down. You can adjust it in time. Your assessment is throughout your entire process. When you're collaborating with the kid, and you can figure out the exposures together, that's when the most powerful thing happens.

We just have this one note on coping skills because we wanted to mention. You'll notice we don't talk specifically about coping skills in this talk at all. Coping skills definitely have their place. The coping skills, the stress tolerance skills are very useful. We'll often teach them to kids, particularly when there are safety concerns. It's a great time for distress tolerance skills, but one way to think about the coping skills is that's a way to manage anxiety and exposures are a way to treat anxiety. The coping skills on anything that can help you in the **[unintelligible 00:40:03]** when you're feeling very overwhelmed, but it's not to be combined with an exposure because it defeats the purpose of the learning that you're trying to teach.

Dr. Elkins: Thanks, Maria. I'm going to zip through how we would apply this treatment model to Seneca's case. Again, early sessions would really focus on rapport building, laying a foundation for treatment expectations, getting a sense of other folks in Seneca's life who are going to be important, who should be consulted, or who should be involved in treatment, and identifying goals and values and motivators. Again, as CBT is so collaborative, we would actually share our understanding of the development and maintenance of Seneca's anxiety through psychoeducation sessions. We would probably share our case conceptualization.

This is how we think this is playing out for you, what factors have contributed to your present concerns, and this is how we're going to tackle them. We would start to have Seneca start to track her anxiety-driven thoughts, behaviors, feelings, sensations outside of session so that we can identify and clarify some patterns that she experiences when she is anxious to increase awareness. We would provide some education about mindfulness, present focused emotional awareness, some cognitive work, but much of treatment is really going to be prepping for exposures, preparing for exposures, going through exposures ideally in session together and then between sessions.

We would develop an exposure hierarchy. This is an example of an exposure hierarchy that we could develop for Seneca. You'll notice that this includes situations

that are addressing vomit fears, social anxiety fears, and panic fears. You don't have to have a hierarchy that is targeting just one area then of interference or one diagnosis, you can really be flexible with this. Developing an exposure hierarchy can take several sessions, it can be done in one session.

One thing that I like to do is identify specific situations and put them on post-its, and then have the kid organize them, maybe put them on the wall from least anxiety-provoking to most anxiety-provoking. The aim, again with each of these is to challenge Seneca to test, "In this situation is my anxiety a true alarm here or is this a false alarm? What's my worst-case scenario? Can I handle it?" We would start low, we would work up, and this becomes a roadmap for treatment that can be modified, expanded upon over the course of treatment.

Dr. Fraire: Then similarly for Mary, you know what? We'll do the rapport-building. We did a lot of psychoed around OCD, we talked a lot about the prep work, really understanding the thoughts showing up for her, the ritual she was engaging in. What we use often with our kids with OCD is actually what we'll call an exposure menu. It's a little different than a hierarchy. It still serves the same purpose, and there's an example of it on the next slide. Basically, what we'll do is we'll break things into low, mid, and high. We do this because part of what we're also teaching our kids is the choice that they have, then they're choosing their exposures and what they want to do that day.

Some days you just have a day that you're just feeling really overwhelmed, your anxiety is really high. This might be a low day and that's okay. There's still exposures to do in that area. Some days you come in and you're a little more motivated, you're just feeling like you've got more energy. Great, we've got some exposures on the higher side that we can do. We does not do this intentionally because it does teach that flexibility also. Often in those with OCD, you'll see that rigidity shows up.

Then one of the things we saw over time when we were using hierarchy is some of our kids were getting stuck in, "Okay, I have to do this first, then I do this exposure, and then I do this exposure because that matches my son's rating." We wanted to move away from that. We use this more flexible, still serves the same purpose. You could argue that this still could lead to some inflexibility only if you make by what's person, not minding plans, but we have found it's given us just more opportunities. Just like how sometimes the OCD is louder, sometimes you can do your exposures in a way that you just feel more control of.

We've found this to be really powerful for our kids. Here are just some examples of what we did with Mary. As she moved through treatment, the other piece that we really emphasized with her is the exposure isn't just thinking about exposing yourself to the thought and just dealing with it, the response prevention is key. You have to make sure you're not engaging in some sort of neutralizing ritual, whether it's a behavioral or a mental ritual because that was showing up a lot for her.

Then relapse prevention was important also. Really talking about as she got better over time it's like, "Okay, how do we maintain this?" OCD is the type of diagnosis that will tend to live with you. It will latch onto new things, which is again, why we emphasize kids becoming their own exposure coaches. Because time and time

again, we were seeing kids who we've treated one area of OCD, and then they would come back later with a different area. We're like, "Okay, OCD is still there, but you already know how to target it, so let's break it down."

Dr. Elkins: Great. Let me see. It's 12:45, and I know we had wanted to do 20 minutes for questions, but this family consideration piece, this could be a talk in and of itself. We didn't want to neglect this. I will try to run through it. Over the past decade or so, I think our field has increasingly recognized that the old model of like, "My kid is anxious, I send them to a therapist, they do individual work and they come out fixed," is just insufficient. Involving caregivers in this work is so powerful. It's so powerful that we now actually have evidence-based treatments that are parent-only treatments.

The child is the patient, but the therapist does not meet with the child, they meet with the parent. By changing the parent's responses to the child anxiety, you can actually see clinically significant improvements in the child's anxiety. A lot of this work came out of the Yale Child Study Center, Eli Lebowitz and his team. It's so important we're increasingly using it in our programs. We didn't want to neglect it at **[unintelligible 00:46:14]**. Ultimately this starts from the dialectic of what is my job as a parent when my child is anxious or distressed? We know both of these are important.

On the one side, the belief is to protect my child. That's my number one job. On the other hand, the belief is, I need to promote independence, resilience in my child. These beliefs and wherever a parent may fall along this continuum at the extremes both fragilization and under support, which are the behavioral manifestations of these beliefs are both associated with elevated child anxiety. The parenting poll, frankly that is most associated with interfering child anxiety, and that we see so much clinically is on the left-hand side, so this fragilization. In the psychological literature, this is referred to as accommodation.

Accommodation or caregiver accommodation are changes that caregivers make to their own behavior to help their children avoid or lessen feelings of anxiety. These can range from very simple behaviors to very complex behaviors. It could be something like, "My kid is really, really stressed and anxious, they don't need to clean up after themselves at dinner. I'll do the dishes for them," to something incredibly complex like the entire family is co-opted into doing a ritual cleaning when they arrive home to prevent the contamination fears that are distressing one child.

We do want to stress this is not a parent blame game. That these behaviors in a vacuum are not bad. Everybody accommodates our loved ones. I accommodate my kid and my husband all the time. I'm sure everybody does it. These are not bad behaviors. These are gestures of caring and concern. We need to acknowledge that within a system where anxiety or OCD is a key player, these accommodations do have consequences. It's really important for clinicians to be aware of these issues and to be able to educate parents on them because we do see a similar role of accommodation as we do behavioral avoidance.

What you see, these well-attentioned attempts to decrease a child's distress may be helpful in the short term but over the long term, they can lead to more problems. Why is that? Well, because when we as parents accommodate, we don't give our kids the

chance to use their anxiety management skills to engage in exposures and to test their worst-case fears.

Also, when we accommodate, our behavior sends a message, "Oh, you're right, you can't handle this situation. This is too hard for you. This is dangerous," which then leads to greater dependence on caregivers and less independence over time.

We want to be mindful of this. As you, as a clinician, are educating parents about accommodation, and helping them to think through what behaviors they might be engaging in that might be inadvertently prolonging their child's anxious experience, they're going to start to come to you and say, "Okay, what about this behavior? Is this accommodation? What about this behavior? Is this accommodation?" It's really important to acknowledge that context matters. No one behavior is always accommodating. These are some questions that you as a clinician can ask yourself before responding.

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 even worsening despite these efforts? An example of a time when one behavior is accommodating in some capacity, but not in others, we had a kiddo in program who was struggling with school refusal. The parent was actually sitting in the lobby to help the child be in the school building. Yes, that is accommodating the anxious behavior. However, it became a good stepping stone to help the kid gradually be in school more often. If the parent was going to stay in there forever and the child thought that this was the status quo, that would be problematic. Frankly, the child might be more likely to have the parent sit closer and closer to the classroom rather than the lobby.

If the parent is in the lobby for a short period of time when the child is in school and we gradually remove the parent from the lobby, then that behavior actually becomes something that allows the child to engage in exposures more effectively over time. We really want to think about the context in which a parent behavior is happening. Let's just briefly refer back to our case study. We see that Seneca's missing many days of school week. She often gets picked up by her parents when she is feeling anxious at school, and that when she doesn't attend school, she sleeps or she watches TV or she spends time with her phone.

We can see that really in the absence of talking to parents about accommodation and having them be involved in treatment, it is a tall order to ask that Seneca's going to go to school and she's not going to ask to be picked up. We need actually parents to be on board to help Seneca understand, "We love you. This is important work. When we are on call for you to pick you up immediately, that's not helping you. That's not helping you. We are going to slowly and plan fully agree, do something. For example, if you text us, we are going to wait 20 minutes before you respond to give you the chance to use your skills," and gradually reduce that.

A lot of accommodation also means making home less cushy because I don't know about you guys, but if I could stay home from work, still get a paycheck and I could sleep and scroll on my phone all day, it would be a lot harder for me to do hard things. We also need to think about how can we change the home environment so

that we're helping Seneca to motivate to get to school. This can feel punishing for a kid. That's why it's really important that we are not ripping the rug out from underneath these kids.

We are engaging in an accommodation reduction plan that is planful, that is actually actively involving the child in the plan. We can say, "Starting today, if you do X when you're anxious, your parents are now going to do Y." We're going to build in motivators, rewards, and link these to values and goals, et cetera. This is something that is so key. We see that the neglect of this can actually prolong treatment and prolong suffering. We really want to be mindful of this aspect of treatment.

Dr. Fraire: Very similar. I don't have too much to add than what Meredith already said about accommodation. For Mary, we know that her dad is helping her a lot, and she's really helping her do a lot of the avoidance, and doing a lot for her, and giving her a lot of reassurance. Our accommodation plan, very similar to what Meredith outlined is collaborative with the kid and helps remove the accommodations in a gradual way.

We really do our best to help the family to learn a language where they externalize OCD, where it's basically like, "Well, I'm really angry at you Mary because you're making me do all these things." It's like, "Your OCD is making all these things harder in our family. How can we work together as a team against OCD." We'll start removing these accommodations and moving these back. Here's just some examples here of Mary, and how we started working through her accommodation.

Dr. Elkins: I think we have a few minutes [chuckles] for Q&A, but we're also happy to answer questions offline. Thank you all so much. Jodi, I just passed it back to you, so hopefully that worked.

Jodi: You did, thank you.

Dr. Elkins: Great.

Jodi: Deborah, would you like to read a few of the questions?

Speaker 4: We have a few questions to go over from our moderators. Let's see, is there an example of negative reinforcement cycling on complex tics for example, eye blinking?

Dr. Fraire: I'm just thinking about what the part of the question is. Is it that perhaps the question is asking if there's something about tics that can be reinforcing for someone before the engagement or Meredith, did you interpret the question a little differently?

Dr. Elkins: I apologize. I'm having a little bit of trouble understanding the question.

Dr. Fraire: I think if I'm following the question, one of the ways we could sometimes think about tics is there is that urge to engage in something, and engaging in the tic gives that release of that sense. For example, we'll see a number of kids who engage in hair pulling or trichotillomania here with us. How they'll describe it is that this urge builds up over time and the only relief they can get is from the pulling.

Similarly from tics, when we're working with someone who's experiencing tics, what we're teaching them is to notice that urge building because often initially it just feels like a behavior they engage in, but there is usually an urge behind it and the tic relieves that sensation. The better they get at being able to tolerate that urge, then the more control they'll feel like they have over not engaging in the tic.

Dr. Elkins: I think another thing to add and to take a little bit more of a broad-based approach, any of the exposures that we're talking about, really if you think about it, boils down to doing hard things and tolerating distress. In the tic situation, we would probably prompt a kiddo to bring on the urge to tic, and then to resist that urge to tic and to practice tolerating that distress, or to practice tolerating the distress that comes on from having the urge to engage in hair pulling. Really we want to focus on can you do hard things? Yes, you can. It doesn't feel good but these urges decrease over time if you don't give in to them.

Jodi: Wonderful, thank you both. Another question we have is what demographic or cultural adaptations should be considered when treating anxiety and OCD in youth?

Dr. Elkins: Great questions. There have been a number of published papers that formally evaluate evidence-based protocols that are adapted for certain demographic populations, different cultural adaptations. We do know that these methods can be applied cross-culturally across demographics, but there's no substitute for getting to know each individual patient and their family. In our program, we start off in our first family meeting asking about the family's emotion culture. How are emotions viewed and understood? What are cultural norms and expectations from the family's perspective around treatment or treatment seeking for mental health concerns?

Has the child or the family struggled with discrimination of any kind? I think this latter point is quite important, particularly when we're talking about exposures. For example, when we're doing social and anxiety exposures with kids, we often ask them to do what's called a social cost exposure. We're asking them to go into a social situation and do something that provokes anxiety in them because they're afraid they're going to be negatively evaluated by someone. For example, we're in Boston, right? Going into a Dunking Donuts and asking if they sell pizza.

Again, that brings this this sense of, "Oh I'm going to be viewed negatively, peer people are going to think I'm an idiot," and to help them learn that they can tolerate that discomfort. However, we want to be mindful if there's a child or a family who actually has experienced discrimination. There are very real fears or consequences that could come from engaging in a certain exposure out in the community or within their family unit or their community. We really want to be mindful of that. The short answer sorry, is that yes, there are many adaptations. It's really important not just to stick to a specific protocol or script, but to get to know the family and get to know more about their experience.

Jodi: Wonderful. Thank you both. Thank you so much for joining us, Dr. Elkins and Dr. Fraire. Thank you to all our listeners for your participation. We'd also like to thank McLean Hospital for making this webinar possible. A recording of this presentation will be emailed to everyone in two weeks time. The recording will include the presentation slides. As soon as the webinar has ended, a short survey will appear on

your screen. Please take the survey and give us your feedback. We thank you for your attention, and hope you have a great day.

[01:00:03] [END OF AUDIO]