Anxiety in youth: A family-based treatment approach

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ROGERS Behavioral Health

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Disclosures

Stephanie C. Eken, MD, FAAP, and **David M. Jacobi, PhD,** have each declared that s/he does not, nor does his/her family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation. Drs. Eken and Jacobi have each declared that s/he does not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships.

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Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Describe three essential elements of exposure therapy
2. Describe at least two strategies to reduce symptom maintaining behaviors

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What we'll cover in this webinar

Essential elements

- Psychoeducation for patients and families
- Understanding the elements of exposure therapy
- Therapist beliefs and influence on providing exposure therapy

Compliance factors

- Comorbidity
- Managing noncompliance
- Functional assessment

Accommodation

- What is symptom accommodation in anxiety disorders?
- How does symptom accommodation interfere in the treatment of anxiety disorders?
- How to help families reduce accommodations

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A note about diversity

"Although considerable strides have been made in understanding, diagnosing, and treating obsessive-compulsive disorder (OCD), not all groups have benefited from these advances. OCD in ethnic and racial minority groups has been – and continues to be – a neglected area of study. The last 15 years of research has shed new light on OCD in African Americans, with some fascinating findings and new questions to answer."

(Williams, Debroux & Jahn 2016)

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Diversity, cont'd

Treatment programs: Under representation of minorities in specialized programs for OCD/anxiety

Prevalence: Prevalence of OCD in African American population similar to general population

Recruitment for research: efforts to recruit for research by using less technical descriptors, use of African American therapists to conduct the evaluations and advertising in traditionally African American institutions

Barriers to treatment: May include cost, transportation, stigma, fear of therapy, lack of awareness of anxiety symptoms and proven treatments for anxiety, lack of providers trained to treat OCD, cultural beliefs barring involvement in mental health treatment

Symptom dimensions: Misdiagnosis (more likely to be diagnosed as psychotic) and not receive appropriate care.

Comorbidity: Majority of those with OCD have co-occurring disorders (mood, anxiety, substance use) which can complicate diagnosis and treatment

(Williams, Debroux & Jahn 2016)

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Cross-cultural perspective

- Prevalence of OCD appears roughly consistent across ethnic groups in US (Himle et al., 2008)
  - African and Caribbean Americans showed an OCD lifetime prevalence of 1.6%
- Epidemiologic studies in other countries find similar rates cross nationally (Weismann et al., 1994)
  - Brazil lowest at 0.3%
  - Hungary highest at 2.7%
- Estimated to effect 112 million people worldwide during their lifetime

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Religious differences

- Christian samples reported symptoms were obsessions with contamination and thought control (Abramowitz et al., 2004)
- Catholic samples have an emphasis on perfectionism (Sica et al., 2002)
- Islamic samples centered on cleanliness, purity and religious themes (Saleem et al., 2009)
- Hindu samples show prevalence of obsessions with cleaning and contamination (Girishchandra et al., 2001)
- Jewish samples reported higher rates of scrupulosity (Huppert et al., 2007)

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Regional differences

- Latin American groups had themes of contamination and aggression (Williams et al., 2005)
- East Asian groups had greater concerns with symmetry and contamination (Matsunga et al., 2008)
- Indian samples emphasized themes concerning contamination & pathological doubt (Girishchandra et al., 2001)

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Essential elements

- Psychoeducation for patients and families
- Understanding the elements of exposure therapy
- Therapist beliefs and influence on providing exposure therapy

Q&A Please use the Q&A feature to send your questions to the moderator.

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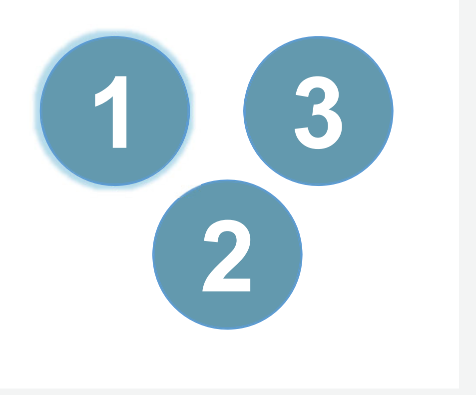
Element No. 1:

Psychoeducation for patients and families



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Anxiety vs. fear

- ***Anxiety –*** Apprehension about a future threat
- ***Fear –*** Response to an immediate threat
- Both involve physiological arousal
- Both can be ***adaptive***
  - Fear triggers “fight or flight”
  - Anxiety can increase preparedness
  - Yerkes-Dodson curve (next slide)

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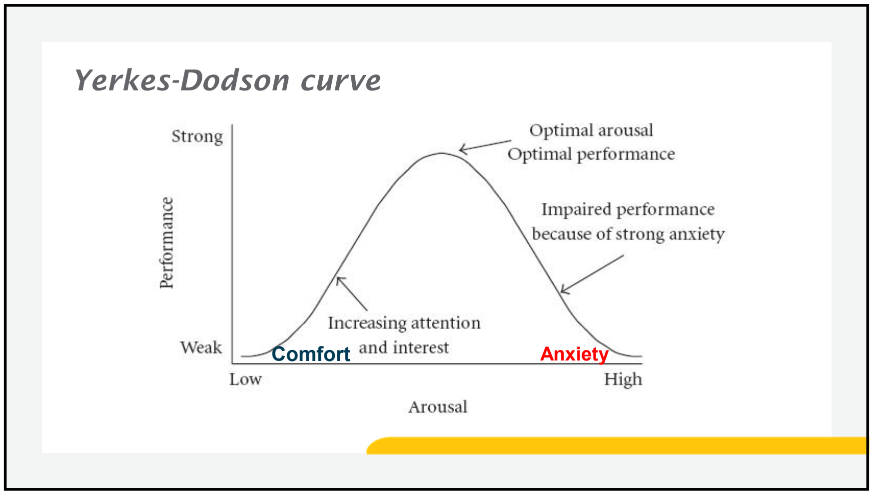

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Teaching a child (and caregivers) about anxiety

- ***Anxiety is normal.*** Everyone experiences anxiety at times. It's normal to feel anxiety before a big test or when trying a new activity.
- ***Anxiety is not dangerous.*** Although anxiety may feel uncomfortable it does not last long and will eventually decrease.
- ***Anxiety can be adaptive.*** Anxiety helps us prepare for real danger (fight/flight). We perform our best at moderate levels of anxiety (Yerkes-Dodson curve)
- Anxiety can become a problem when our bodies react to normal situations ***as if they were real dangers***

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Element No. 2:

Understanding the elements of exposure therapy

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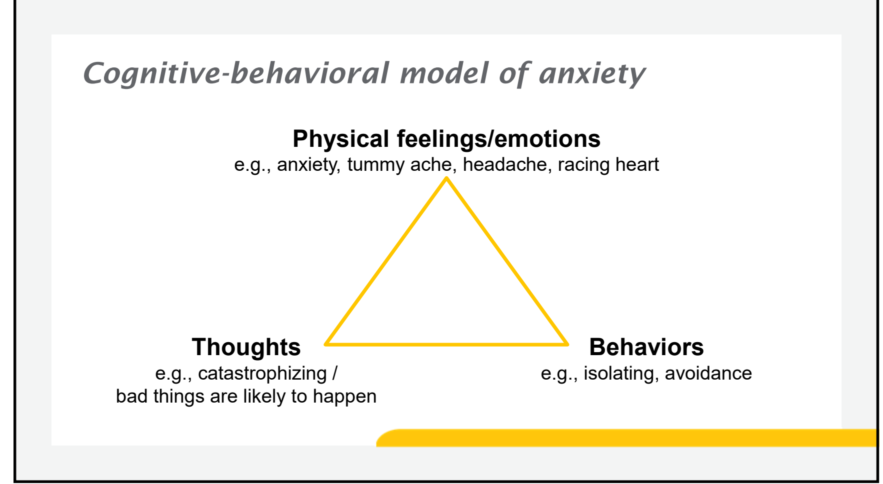

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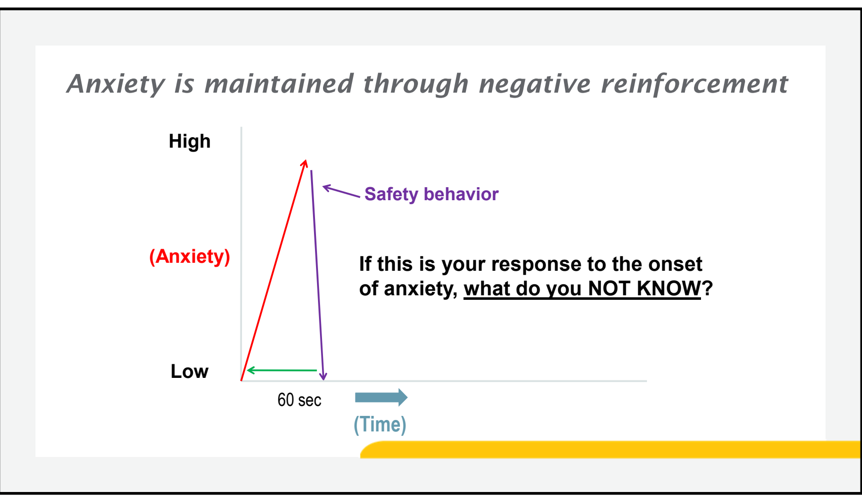

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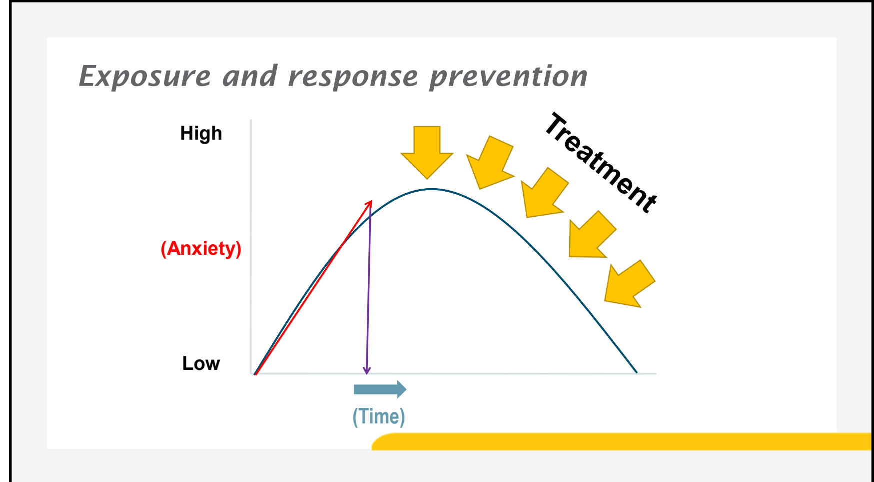

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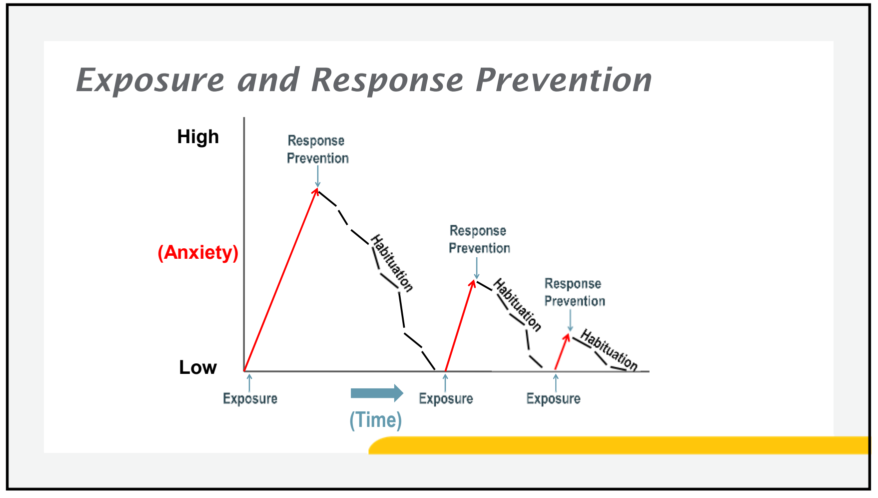

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Exposures = Confronting fears

GAD: worry exposure (imaginal exposure to feared outcomes), intolerance of uncertainty (raise hand in class when not confident, choose movie to watch, cold call a friend, spend X amount of time on homework)

Separation anxiety: Exposure to time away from parent or safe place, reducing access to phone to contact parent (also may have elements of GAD)

Panic/Agoraphobia: interoceptive exposures (hyperventilate, spin in chair), in vivo exposures to avoided situations (supermarket, theatres)

Social anxiety: social exposures (call a business, ask for time, wear conspicuous clothing, presentations)

Selective mutism: graded exposure involving interactions with others. Gradually work to increase social contact (e.g., increase voice volume, eye contact, initiating contact, etc)

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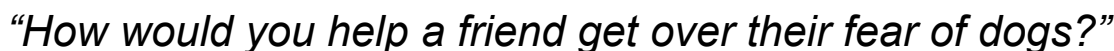
Explaining exposure to kids

Fear of dogs comparison:

- Most kids know instinctively how to get over a fear of animals



"How would you help a friend get over their fear of dogs?"

- Small steps, starting with easier exposures working into more challenging ones:

Small dogs ⇨ medium dogs ⇨ large dogs

Few feet away ⇨ foot away ⇨ petting the dog

Holding parents' hand ⇨ parent stands 6 ft away ⇨ being alone

Explaining exposure to kids

It' like riding the biggest roller coaster ***100 times in a row***

It's really scary at the start….

but then it becomes less scary, or even fun!

Modifying treatment for children

Child-friendly psychoeducation

- Emphasize externalization of the anxiety disorder
  - Worry Brain, Penelope, bully, pest
- Use metaphors that kids can relate to (false alarm, junk mail, spam mail, bully, false start/sports)
- *Ask "How has OCD/anxiety messed up your life?" "Does your OCD/anxiety make you have to do certain things you don't want to?"*
- Reduce stigma by doing prevalence exercises

Modifying treatment for children

Anxiety rating scales:

- Not all children can grasp 0-10, 0-100 scales
  - Worry thermometer
  - Faces
  - Colors (Red/Yellow/Green)
  - High/Medium/Low
  - Tallies: do exposure for 5 min, wait 1 min, repeat
- Have parents use the scale as well in conversation to normalize it

Modifying treatment: Kids are a tough audience!

- Find ways to make it fun first to engage them (finger painting with honey; bounce grape off the floor and eat, presentations on topics of interest; completing interoceptive exposures with child; scavenger hunt touch list)
- With younger kids, consider implementing a token economy system or other rewards for good effort
  - ***Coins in the pocket.*** Kids are given certain number of tokens at the beginning of the day. Have to give up tokens if they engage in "banned" behavior (e.g., reassurance seeking, apologizing, checking, retracing, avoiding, etc). Tokens remaining at end of the day can be cashed in for rewards.
  - Tokens can be something the child is interested in (sports teams, characters from movies, favorite activities, etc.)

Modifying treatment for children

Be very specific about response prevention guidelines

- Showering is limited to 15 minutes daily; handwashing is limited to only after bowel movements and before meals (or never)
- Washing body parts only once, refraining from counting, etc.
- No self-assurance, distraction, mental rituals during exposure

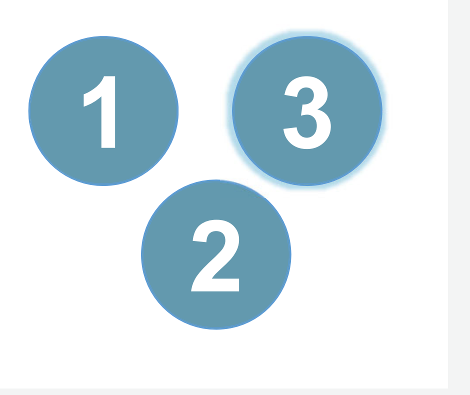
Need to track using <u>ban book</u>

- May need to find creative ways to increase compliance (e.g., wear ban book as necklace, include as part of goals list)

Remember: Response prevention is a limiting factor – if no RP then cannot move on to next exposure

Element No. 3:

Therapist beliefs



Background

Though efficacious, exposure therapy is <u>not</u> adopted well

- Majority of clinicians do not use exposure
- Cautious delivery style among users
- Not using session time effectively (not doing ERP in session) (Reid et al. 2017)
- Not having the proper education/training on how to utilize exposure-based interventions – ERP used only ***<u>30% of time</u>*** to treat kids with OCD (Reid et al. 2018)

What do therapists believe about exposure therapy?

Exposure therapy is unsafe
- Causes symptom exacerbation
- Can harm patients physically/emotionally

Exposure therapy is intolerable
- Patients perceive it as unacceptable
- Arousal reduction techniques are necessary

Exposure therapy is unethical
- Inhumane, cruel to patients
- Can lead to malpractice lawsuits

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Negative beliefs about exposure: A barrier to dissemination

These negative beliefs are associated with:
- Underutilization of exposure (e.g., van Minnen et al., 2010)
- *Overly cautious delivery of exposure*
  - Attempts to minimize patient anxiety (e.g., diaphragmatic breathing) (Freiheit et al., 2004)
  - Allowing patient safety behaviors (Deacon et al., 2013)
  - Reassuring patients of safety (Harned et al., 2013)
  - Shortened duration of exposure

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Involving the family

- Better treatment outcomes
- Have parents/caretakers do all sessions with kids up through age 12
- Teach the parents/caretakers how to do exposure work effectively, identify and reduce symptom accommodations, learn behavioral management skills, identify new obsessions/compulsions
- Allows you to catch mistakes early and role model managing difficult situations

Roger Behavioral Health's partial hospitalization programs require parents to be on site for the first five days. After that, attendance is decided on a case-by-case basis.

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Involving parents of adolescents

- Parents/caretakers must be present for assessment, and for the start/finish of each session
- Work with parents to establish goals list
  - May need to sign off on exposure and other goals
- Can provide rewards for successful completion of goals list work
- Participate in some sort of parent training-in intensive programs these are provided weekly
  - Can send handouts home for review

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Involving parents of adolescents

- For parents who nag or are over-involved: Use a fine system
- For parents who are burned out and do not want to be involved: Use empathy and cognitive reframing
- Always retain the right to discuss treatment with the parents
  - Note: teen may ask that they not be involved – you need to set limits of confidentiality up front

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Compliance factors

- Comorbidity
- Managing noncompliance
- Functional assessment

Please use the Q&A feature to send your questions to the moderator.

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Comorbidity

- Risk for developing other types of anxiety disorders/or psychiatric disorders
- Co-morbid psychiatric disorders:
  - Other anxiety disorders
  - ADHD
  - Autism Spectrum Disorder
  - Substance use in older teens
  - Depression (kids-somatic complaints, acting out, aggression)
  - Learning disabilities
  - Eating disorders
- Increased risk for adjustment difficulties in adulthood

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Rogers residential outcomes
Comorbidity is the norm

Children's Center	**Avg. no. Diagnoses / patient = 2.54**	**Adolescent Center**	**Avg. no. Diagnoses / patient = 3.38**
Diagnosis	***Frequency %***	***Diagnosis***	***Frequency %***
OCD	51.39	OCD	75.11
GAD	39.81	MDD, single episode	61.89
ADHD-Combined Type	24.54	ADHD-All	31.00
MDD, recurrent, severe, w/o psychotic features	15.28	GAD	29.96
Social Phobia	13.43	Social Phobia	27.97

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Managing noncompliance: Tantrums

Some kids show their fear by tantrumming and crying; some kids are professionals at avoidance behaviors

Biggest mistake:

Backing off when children cry or tantrum (in the context of doing exposure work)

- Best to show poker face, positive body posture, don't over talk
- Wait for child to be calm without letting them out of the situation or giving in
- Maintain safety

Managing noncompliance: Tantrums

- Sometimes rewards do not entice kids
- Start treatment in the parking lot or at the child's home
- Do not make treatment optional
- Tell them that they deserve to be happy and to have fun and do things like other kids
- Assume that they are anxious
- Find out what their parents told them…or didn't tell them!

Managing noncompliance: Tantrums

- Be matter of fact about the child hating therapy
- Suggest that their cooperation might be advantageous
- Act unconcerned and relabel their opposition as fear
- Keep the session going forward
- Be patient – it may take time for child to engage

Managing noncompliance: Tantrums

- Most kids hate being bored and having to sit outside during a session, or waiting in a parking lot
- Tantrums need an interested audience to stay alive….
  In the residential world, kids are removed from the room if a child is acting out. Staff are calm and offer the child options
- Use lots of cognitive reframing with the parents while the kid tantrums
- Keep an office full of candy, treats, soda pop, juice boxes, toys, and offer them for being cooperative

Managing noncompliance with teens

- Have to come to sessions unless you have a fever over 100.1°, repeated vomiting, or repeated diarrhea
- If medical issue exists (e.g., migraines, IBS) work with primary care provider to understand how child/teen is supposed to manage these and encourage they attend programming
- Work with parents to get teen to programming regardless of behavior and avoidance – may need to incorporate contingencies
- Therapist needs to talk freely with parents

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Functional behavior analysis / assessment

Antecedent	Behavior	Consequences
Other receiving attention	Kick / Hit peers / Look sad	Attention
Start of treatment block	Look sad / Act out	Get out of doing treatment
Check out line - See candy	Scream	Get candy

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Four functions of behavior

1. Attention seeking
2. Means of avoidance / escape
3. Control / Getting something
4. Self-regulation –
   - Can be normal healthy reaction to over-stimulation or emotions such as excitement or frustrations-may need to retreat.
   - Can also be ASD type behaviors such as self stimulation and stereotypic behaviors such as hand flapping or rocking

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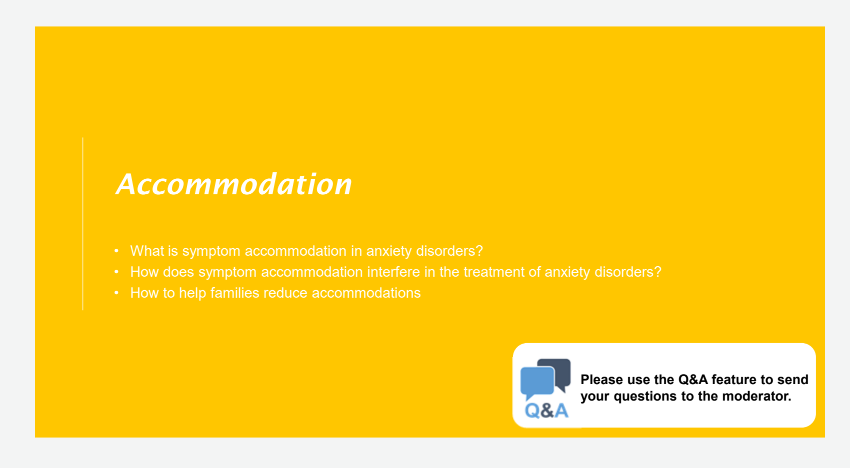

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Examples of family/symptom accommodation

- Assisting a teen to hand wash or complete shower rituals
- Accompanying teen to store due to panic
- Not calling on a child in the classroom
- Providing reassurance for worries
- Changing parental routine to be available to answer teen's calls or texts from school
- Buying items needed to complete rituals
- Speaking for a socially anxious child
- Allowing teen to "confess"
- Repeating phrases or actions (scripting)
- Having parent check the closets, electrical items, door locks, etc.
- Allowing teens to avoid certain activities, places, objects or persons because of anxiety

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Why some families accommodate

- It's easier in the beginning
- You think it is helpful
- It worked with your other children
- It's hard to tolerate your child's anxiety/distress
- You fear your child will feel unloved if you don't accommodate
- You fear your child's behavioral response

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Symptom accommodation in OCD: Frequency

- Most research completed with **parents or family members** of individuals with OCD
- Rates of accommodation very high (**approximately 60-97%)**
- High rates of accommodation also reported with siblings
- Most frequent types of accommodation:
  - Providing reassurance
  - Waiting for rituals to be completed
  - Assisting with avoidance of anxiety-provoking stimuli
  - Directly participating in rituals

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Symptom accommodation in OCD: Why is it problematic?

- Leads to more negative family dynamics
- Maintains or worsens OCD symptoms
  - Provides short-term relief – ***negatively reinforcing the behaviors*** – due to allowing the individual to avoid anxiety or other negative consequences of his/her symptoms
  - Prevents the individual from experiencing a reduction in anxiety after facing the feared situation without rituals/avoidance → ***prevents habituation***
- Reduces negative consequences of an individual's OCD symptoms/behaviors that may impact the individual's motivation for change or involvement in treatment

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Symptom accommodation in OCD: Impact on family

- Linked to more family dysfunction and stress
  - Ends up consuming increasing amounts of time for the family
  - Leads to unintended changes in the family routine
- Accommodation impacts marriages
  - Increases conflict
  - Reduces time available for parents to spend time together
- Accommodation impacts siblings
  - Worse mental health outcomes
- Accommodation reduces self-care

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Parental factors

Parental anxiety can lead to:

- Over-identifying with patient's anxiety
- Inability to tolerate child's distress

20% of parents of children with OCD, have OCD themselves

- Understanding the "need" to complete rituals

Overinvolved parenting

- If you have a history of rescuing your child from situations/consequences, this is a pattern likely to re-occur with anxiety

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What's the problem with accommodating?

Accommodation conflicts with goals of CBT

- Limits opportunities for child to learn that feared consequences don't happen
- Reduces child's motivation to change
- Prevents habituation

Associated with poorer treatment outcomes in children and adults with OCD

- Reduces effectiveness of CBT and long-term outcomes
- Numerous studies have demonstrated smaller reductions in CY-BOCS scores and worse functioning for children when families accommodate

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Treatment outcomes: Peris et al. 2012

- ***Family accommodation*** is a major predictor of treatment response and relapse in children and adults with anxiety or OCD
- Family ***conflict and blame*** typically increases with accommodation which also worsens outcomes
- Long-term outcomes in adulthood ***are worse*** in families with high levels of accommodation and intrusiveness
- However, families that can work together cooperatively (i.e., ***family cohesion***) tend to have kids that do better in treatment

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Family accommodation

Strategies to help parents become a parent-coach

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Strategies to help parents become a parent-coach

Mentally prepare yourself

- Your child will NOT thank you for removing accommodations
- It is likely that your child will initially get worse when you withdraw accommodations (extinction burst)
- Be aware of your body language and tone of voice when your child is anxious = put on your poker face!
- You can be empathetic without being accommodating (parallel with learning to be an exposure therapist)

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Strategies to help parents become a parent-coach

Reducing accommodations

- Needs to be in concert with the treatment team and the CBT goals
  - Important that your child knows we are working together and *are in agreement*
- Typically, accommodation reduction occurs gradually, but in a residential setting we tend to withdraw it more quickly
- You should prepare your child for accommodation reduction through good communication
  - Discuss working as a team to fight anxiety and OCD
  - Separate anxiety and OCD driven behaviors from child
  - Accommodation is allowing anxiety/OCD monster to "win"

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Reducing accommodations, cont'd

- Have a plan if your child becomes upset or overwhelmed
  - Timely disengagement if child is escalating or having only anxiety-driven conversations
- Do NOT over talk when your child is going into "meltdown mode"
- Feelings cannot always be controlled, but the ways feelings are managed can
  - Natural consequences to behaviors should be implemented
- Wait to process incidents when your child is calm

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Reassurance seeking – examples

Requests for reassurance

- "Are you sure you….locked all the doors?"
- "Did you touch my sheets?"
- "Did I hurt your feelings?"
- "Do you love me?"
- "I did a bad job."
- Calling parents repeatedly from school to make sure they are "okay"

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Information Seeking	Reassurance Seeking
Asks a question once	Repeatedly asks the same question
Asks a question to be informed	Asks questions to feel less anxious
Accepts the answer provided	Responds to the answer by challenging the answerer, arguing, or insisting the answer be repeated or rephrased
Asks people who are qualified to answer the question	Often asks people who are unqualified to answer the question
Asks questions that are unanswerable	Often asks questions that are unanswerable
Seeks the truth	Seeks a desired answer
Accepts relative, qualified or uncertain answers when appropriate	Insists on absolute, definitive answers whether appropriate or not
Pursues only the information necessary to form a conclusion or make a decision	Indefinitely pursues information without ever forming a conclusion or making a decision

Developed at the Anxiety Disorders Center, St. Louis Behavioral Medicine Institute

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How to reduce reassurance

- ***What do you think?/Maybe yes, maybe no/ I don't know.*** Give your child the opportunity to answer the question themselves.
- ***One worry question per hour/4 hours, etc.*** Limit the number of worry questions/day/hour.
- ***Delay reassurance.*** Insert a predetermined length of time before answering questions to increase tolerance for uncertainty.
- ***Coins in the pocket to use for reassurance.*** Use rewards to increase motivation to tolerate anxiety.
- ***Long-term vs short-term gain.*** With compliancy issues, perform a cost-benefit analysis to increase insight.
- ***Role play responses.*** Practice responding to reassurance questions in session.

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Reassurance vs. validation

Reassurance:

The act of removing doubt or fear; a verbal or nonverbal action that is done in an attempt **to reduce someone's doubt, fear, or distress** (e.g., anything that artificially reduces anxiety or attempts to **offer certainty** when certainty is not available).

Validation:

Verbal or nonverbal communication to another person that his or her emotions, thoughts, and behaviors **have causes and are understandable** given the situation or individual's learning history; verifying the facts of a situation.

Nonjudgmental; acknowledging someone else's point of view; conveying understanding and empathy without trying to fix things or challenge the person

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How to validate

Strategy	Validating	Invalidating
Actively listen	Providing your child undivided attention; looking at them while they talk	Checking your cell phone for messages while talking to your child; multitasking in any way
Be mindful of verbal and nonverbal reactions	Making eye contact; nodding; mirroring the child's affect	Rolling eyes, walking away, sighing; saying "you shouldn't feel that way"
Observe what the other person is feeling in the moment. Look for a word or words to describe the feeling.	"I want to make sure I understand. You're feeling anxious and worried because you have a test coming up, is that right?"	"I'm sure that's not it"; "that's no reason to be upset"; "I don't understand", "that doesn't make sense"
Reflect the feeling back without judgement.	"Not having certainty about the outcome of an exam is scary." "I can understand how much easier this would be to handle if we knew that everything is going to be alright."	"I get that you're anxious, but you have to get this work done." "If you don't get this under control, you're [insert consequence here]."
Show tolerance! Look for ways the emotions, thoughts and actions makes sense given the context of the situation and your child's previous experiences.	"I don't blame you for feeling hopeless about school; things keep piling up and you feel like you're drowning in expectations."	"This is just the way it is"; "You have to…"; "If you try harder, you can do this"; "You're too smart to let your emotions get in the way"

Accommodation: Case study

Robert is an 11-year-old with severe contamination fears of germs and toilet water. He avoids going into public restrooms, touching doorknobs, and shaking people's hands. He has hand washing and cleaning rituals that take him over 8 hours per day to reduce his fear that he will die if he is not "clean enough". He does not allow his family to touch him or sit in his two designated spots at home. There is special place in the laundry room where his clothes and school items are placed away from everything else. Robert will become verbally and, sometimes, physically aggressive if his younger sister who is "really gross" enters his room or touch his items.

About the presenters…

Stephanie Eken, MD, FAAP

Regional Medical Director

Dr. Eken is a board-certified child and adolescent psychiatrist, adult psychiatrist and pediatrician. She has lectured throughout the United States to professional, academic and lay audiences on a range of topics related to pediatric psychiatry. Her clinical interests include OCD and related disorders, anxiety disorders, eating disorders, ADHD, and depression. She is also interested in how the integration of technology can improve the quality of care.

David Jacobi, PhD

Lead Psychologist, Child and Adolescent CBT Services

Dr. Jacobi is a licensed clinical psychologist who specializes in using CBT for the treatment of OCD and anxiety disorders. He provides clinical consultation and supervision at the OCD and Anxiety Center Children's Residential Care as well as in the OCD partial hospitalization and intensive outpatient care at several Rogers locations in Wisconsin.

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