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Evidence-Based treatment of pediatric treatment-resistant OCD:

Maximizing outcomes with intensive, multisystemic outpatient treatment

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Presentation Outline

Describe evidence-based treatment across multiple settings to enhance pediatric OCD treatment compliance and response

1. Describe fundamental information regarding the nature and treatment of pediatric treatment-resistant OCD and tailor evidence-based interventions to incorporate patient-specific factors.
2. Intervene with parents, family, school, and community to treat factors that function to maintain treatment-resistant pediatric OCD.
3. Design and deliver intensive, multi system evidence-based treatment within an outpatient setting to maximize outcomes among youth with treatment-resistant OCD.

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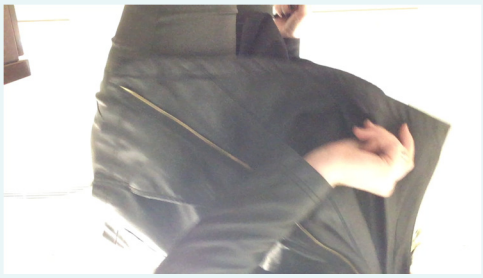
The Case of Claire

Claire: A Patient's Perspective



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Case of Claire: Background

- Currently: 14-year old freshman in high school and lives with her parents, brother, and sister
- Intake on April 27th, 2017 and in 8th grade
- Previously treated for Generalized Anxiety Disorder with "CBT" for about 6 months
  - Reported was not very helpful
  - Primary strategy she was taught was "fact checking" but that seemed to increase symptoms
- No medication prior to her treatment at our center
- Symptoms/worries were very much based on fears about being negatively evaluated by peers and teachers
- Perfectionism
- Skin picking was significant and occurring on a daily basis
  - Legs, hands, and arms
  - She had never received treatment for skin picking

Case of Claire: Background

- Symptoms Claire reported at intake were more characteristic of Social Anxiety Disorder and Excoriation Disorder
- However shortly after intake it became clear that Claire was actually struggling with Obsessive Compulsive Disorder
- Claire had a tendency to under-report the intensity and severity of her symptoms
- Parents also seemed unaware of the degree to which Claire's symptoms were affecting her
- Began treatment twice per week in the office

Case of Claire: Case Conceptualization and Multisystemic Treatment

- During the beginning of treatment Claire was resistant to sharing the severity of her symptoms with treatment providers, family, and friends
  - Symptoms were getting worse
  - Claire under-responds to symptoms (suffers in silence) until they are very interfering
  - Does not want to look as if she is "complaining" or being a burden or essentially being imperfect to anyone
  - Avoidance of sharing her symptoms with those that can help seemed to serve as a ritual fueled by perfectionism

Case of Claire: Case Conceptualization and Multisystemic Treatment

- Claire's parents were much more focused on her brother who also had OCD and was exhibiting externalizing behaviors
  - Under-responders "She is fine"
  - Holding off on psychiatrist; delayed finding a psychiatrist that has experience with OCD even after multiple recommendations
  - Not really engaged at home with exposures and helping support ritual prevention
- For a few months Claire flew under the radar at school despite her debilitating symptoms
  - School under-accommodation – "Grades are fine we don't notice anything wrong with her"
  - Perfectionism had her up until 2 AM or 3 AM making sure she completed work and studied

Case of Claire: Case Conceptualization and Multisystemic Treatment

- Triggers:
  - School work (tests; reading, writing, homework)
  - Social interactions especially with unfamiliar peers and teachers
  - Wet drains/plumbing
  - Music
  - Eating utensils plates and cups
- Primary Obsessions and Compulsions
  - Violent, intrusive images and obsessions related to harming herself or others
  - Hours of mentally reviewing previous or future social interactions preventing her from sleeping
  - Images and feelings of disgust when looking at drains and down toilets resulting in avoidance
  - Song lyrics playing in her head constantly sometimes multiple songs at once
  - Re-reading and rewriting due to perfectionism to the point she could no longer read or write
  - Skin picking especially when doing school work
  - Praying her "thankful" prayer

Case of Claire: Case Conceptualization and Multisystemic Treatment

- The "content" of Claire's OCD was not very distressing for her but the fact that it interfered with her ability to focus and attend was intolerable and made her extremely anxious
- Core Fears
  - I must show perfect attention and have the perfect responses when in social interactions
  - I must have the perfect grades and perfect academic performance
  - I must be the perfect student, friend, daughter, patient, etc.
    - **If I am not perfect** in these areas I could be thought of as mean, disrespectful, stupid, unreliable, irresponsible, or disinterested
    - No one would want to be around me or interact with me
      - I would be considered a **bad person and would be alone**

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Case of Claire: Case Conceptualization and Multisystemic Treatment

- School Treatment Goals and Interventions
  - **Goal:** Provide appropriate accommodations vs. under accommodate
    - "Things will snowball if we provide extended time on assignments"
    - "Wouldn't that be encouraging her perfectionistic tendencies to allow her more time"
    - "This material is hard to understand maybe she has to accept that it is difficult material"
    - "We should take her out of honors because the material is too challenging"
    - "Mom is an alarmist. Do you see her that way?"
    - "Her grades are fine"
  - **Interventions**: Working with school to educate them about her OCD and the treatment hierarchy
  - Identified appropriate accommodations in a 504 plan that align with treatment goals

Case of Claire: Case Conceptualization and Multisystemic Treatment

- Parent Treatment Goals and Interventions
  - **Goal**: Unified parenting
  - Increase their tolerance of Claire's distress rather than avoiding/under-responding
  - **Interventions**: Parent sessions and family sessions teaching them how to be more involved in treatment and how to advocate for their daughter
- Psychiatry
  - **Goal**: Identify effective medication regimen
  - **Interventions**: Collaboration with neurologist to determine the best medication regimen because they had little experience in the treatment of OCD
  - Providing recommendations and encouraging family to see a pediatric psychiatrist specializing in OCD

Case of Claire: Case Conceptualization and Multisystemic Treatment

- Claire Treatment Goals and Interventions
  - **Goal**: Function despite obsessional thinking
  - **Interventions**: Externalize OCD; Practicing thoughts playing like background noise
  - Exposures/Ritual prevention in session trying to complete school work despite intrusive thoughts and images
  - Basic strategies and problem solving to help her get through school work when she could no longer read
  - **Goal**: Reduce/eliminate picking
  - **Interventions**: Improving distress tolerance and implementing Habit Reversal Training/Competing Response
  - **Goal**: Increase tolerance of imperfection
  - **Intervention**: Identify ways she can begin to tolerate being imperfect – in the family, as a student, a patient, and friend
  - Exposures to the possibility that she is a "bad" person (saying the unthankful prayer)
  - Imperfect exposures especially with reading and writing

Case of Claire: Case Conceptualization and Multisystemic Treatment

- Claire Treatment Goals and Interventions
  - **Goal:** Increase tolerance of uncertainty
  - **Interventions**: Learning to resist mentally reviewing social interactions for hours and tolerate the uncertainty of how she is being perceived by others
  - Imaginal exposures geared at her social retracing introducing the uncertainty of what people are thinking of her and that they could think she is "mean, disrespectful, stupid, unreliable, irresponsible"
  - **Goal**: Increase assertive behaviors
  - **Interventions**: Attending her 504 meeting, taking advantage of the 504 accommodations provided during trial period, confronting teachers about what accommodations she is entitled to

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Pediatric Treatment Resistance

Pediatric Treatment Resistance

Characteristics of treatment-resistant youth

- Very young children
  - Treatment is frequently targeted at the parents
- Adolescents
  - Connecting with the teen is important but can be difficult
  - Teens can vary in maturity
  - Teens can exert a tremendous amount of control
  - Parents can be intimidated especially when the teens grow quickly in size

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Pediatric Treatment Resistance

Characteristics of treatment-resistant youth

- Youth exhibit a high need for control
  - In treatment, the need for control has to be met appropriately
  - Otherwise it turns into a battle of the wills
- Control is used to manage anxiety and situations in general
  - The youth change the parameters of the situations
  - There is control of parents, siblings, school, and treatment providers
  - Verbal threats & physical aggression are used to control
  - Withdraw/shutting down, and selective mutism are used to control
- There is impatience and intolerance
  - of distress, emotion, and anxiety
  - of other people, especially family members

Pediatric Treatment Resistance

Characteristics of treatment-resistant youth

- Diminished motivation due to:
  - High anxiety within the youth and the family
  - High expectations and perfectionism within the family
  - High levels of accommodation from the family or school
  - Failed courses of past treatment
- Secondary gain
  - Attention; being left alone; staying home vs. going to school

Pediatric Treatment Resistance

Characteristics of treatment-resistant youth

- Co-morbid disorders
  - Can be sensory sensitive or have misophonia
- Perfectionism
- Rigidity and unrealistic beliefs and treatment expectations
  - E.g., Just fix this anxiety
- A strong belief in their obsessions
  - Eg., The kitchen counter should be perfectly clean
  - Eg., I don't want to take medication because I'm afraid medication will take away how much I care about my obsessions

Pediatric Treatment Resistance

Treatment resistant behaviors

- Escape into the world of immersive video games or YouTube videos
  - Create very reinforcing fantasy existence for themselves
  - Perceive all their needs met
  - Have CONTROL at all times
  - Identify as having friends
  - Feel successful
  - No wrong choices or real consequences
  - ALL PLEASURE
- They are willing to go to any length to maintain control and they know what will work with their parents
  - Threaten harm to self or others; not eating; not sleeping
  - Damaging property at home or in the therapist's office
  - Refusing to get into the car; Jumping out of the car

Pediatric Treatment Resistance

Highly Emotionally Reactive Child	Low Emotionally Reactive Child
Thoughts: Perfectionist; Everything needs to be perfect; if something feels weird then something is wrong, and if something is wrong we need to fix it right away. I'm going to die. I'm not going to change; I'm going to threaten you; make it stop.	Thoughts: They adopt the role of "the failure". I will never be good enough, I can't handle this.
Feelings: Anxiety and frustration	Feelings: Malaise, hopeless
Actions: Verbal and physical aggression, emotional threats, pestering, badgering, negotiation, reassurance seeking, refusal	Actions: Avoidant; Hopeless; Procrastinating; Low motivation; Manipulative; passively controlling

Pediatric Treatment Resistance

It is important to address environmental factors that maintain the disorder

Family Patterns associated with treatment resistance

- Parenting approaches are not unified
- One parent is more all-or-nothing and is sometimes the 'bad parent'
- The other parent is overly accommodating and is sometimes pushed around, threatened, or abused
- One parent has no credibility
  - The accommodating parent 'holds back' the 'bad parent', who then has no credibility
  - The all-or-nothing parent makes all the rules and the accommodating parent has no credibility

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Pediatric Treatment Resistance

It is important to address environmental factors that maintain the disorder

School Patterns associated with treatment resistance

- Schools can be:
  - Not accommodating enough
  - Overly accommodating
  - Accommodating using boiler plate accommodations that do not meet the individual needs of the child

Pediatric Treatment Resistance

Reverberations of the child's OCD are invariably observed across settings

- Symptoms start in the child
- Are reinforced in the family
- Are echoed in the school
- Are attempted in the treatment provider's office

Because there is treatment resistance and a lack of compliance, treatment needs to broaden its scope to include family and school

Pediatric Treatment Resistance

It is important to address cultural factors

School Patterns associated with treatment resistance

- Schools can be:
  - Not accommodating enough
  - Overly accommodating
  - Accommodating using boiler plate accommodations that do not meet the individual needs of the child

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Obsessive Compulsive Disorder

The Nature of OCD

Popular culture presents a narrow perception of OCD
OCD presents clinically as:

- Contamination
- Perfectionism
- Fear of harm to self or others
- Aggressive obsessions
- Religious obsessions and scrupulosity
- Intrusive sexual or inappropriate thoughts
- Not quite right OCD

The Nature of OCD

All the anxiety disorders, including OCD, function similarly

- Trigger/Obsession: Any thought or action that is intrusive, inappropriate, or causes anxiety to increase
- Response/Ritual/Compulsion: Any thought or action that a person feels driven to perform and which causes anxiety to suddenly decrease

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The Nature of OCD

- When anxiety is triggered, the person engages in an unhelpful avoidance response to alleviate the anxiety
- These unhelpful avoidance responses are called 'rituals' or 'compulsions'

The Nature of OCD

- Rituals do reduce anxiety in the short-term
- We are biologically wired to alleviate discomfort
- Rituals are therefore used repeatedly to alleviate anxiety
- Rituals become less effective and need to be relied upon more as the disorder progresses

The Nature of OCD

Behaviors used in rituals are not always wrong in other contexts

The repetitive use of behaviors to avoid an emotional experience is maladaptive

- Hand washing is not inherently bad
- Many hours of repetitive hand washing done for the purpose of avoiding anxiety and providing reassurance about a feared consequence is maladaptive

The Nature of OCD

- Using rituals to respond to anxiety contrasts with how we handle normal human emotion with which we allow an emotional experience
- With normal emotion, the emotion comes and goes on its own and may resurface again in the future. We do not consistently intervene to make the emotion stop right now
  - For instance, ideally with anxiety and grief, the emotion is allowed to run its course without our consistent attempts to avoid that emotion

The Course of OCD

- OCD waxes and wanes over the course of a person's life
- OCD often plays whack-a-mole

The Course of OCD

- When rituals are relied upon to escape the experience of anxiety several things happen:
  - Anxiety increases over time
  - Anxiety spreads to new situations and the overall number of areas affected by anxiety increases
  - Rituals become less effective and are used more frequently

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The Course of Anxiety

Every time a child reacts to anxiety with a ritual, the child doesn't learn

- Anxiety comes and goes on its own
- Feared consequences are highly unlikely, but if they happen, you can handle it

The Nature of OCD

Obsessions and Compulsions are Functionally Related But Not Always Logical:
Determine the Function of the Behavior

Obsession	Compulsion/Ritual
1. What if I make a mistake	1. Erase or start over
2. What if I spread germs and kill someone	2. Avoid and wash
3. What if I have a bad thought	3. Ask for reassurance; go to sleep with the Netflix/music on
4. What if need this important thing again; it is sentimental to me	4. Hoarding: Don't throw much away
5. What if I sin and go to hell	5. Tap 3 times; undo and redo actions

The Nature of OCD

Always ask, "What are your feared consequences if you did not perform the ritual or if you did not avoid?"

Obsession	Core Feared Consequence (without rituals or avoidance)
1. What if my mom leaves me at school	1. Then I will panic uncontrollably
2. What if I look bad at school or get a bad grade	2. Then I won't be perfect
	3. Then I will feel bad

The Course of OCD

Risk Tolerance

Tolerance of uncertainty
Tolerance of anxiety

→ Lack of tolerance of uncertainty
Lack of tolerance of anxiety
Futile search for certainty

Greater anxiety
Greater avoidance

The Course of OCD

Risk Tolerance

0 rituals
Uncertainty
Unimpaired
More risk of feared consequence

In order for anxiety to improve, we need to accept in thought and action the truth, which is that in uncertainty and doubt we should trust and not try to control the outcome with rituals

24 hours of rituals
Futile search for certainty
Very anxious and impaired
Still there are risks of feared consequences

Why Does Emotion Cause Pain?

Chronic Sympathetic Nervous System Activation
- Physical symptoms of anxiety
  - Muscle tension and pain, heart rate and pulse
- Narrow Attentional Focus on the threat
  - Can't concentrate
- Deactivation of digestion and sleep
  - Causing sleep and gastrointestinal problems

Parasympathetic Nervous System Activation
- Physical calm
- Broad concentration
- Activation of digestion and sleep

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Why Does Emotion Cause Pain?

Chronic Sympathetic Nervous System Activation
- The part of your brain that turns flight or flight on is not the smart part of your brain
- It treats OCD, a 50 yard dash, a test, and a tiger the same

Kids react to danger that isn't there
- And parents react too because their kids are so anxious and insistent

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Evidence-Based Treatment of Pediatric OCD
Empirical Support for Exposure with Response Prevention

Empirical Support

- There is extensive literature supporting Exposure with Response Prevention as a first-line treatment in adults (e.g., Abramowitz et al., 2003, Foa et al., 2005; Tolin et al., in press)
- There are several published randomized trials supporting CBT, especially Exposure with Response Prevention, as a first-line treatment in children (e.g., Barrett et al., 2004; Stourch et al. ,2007; Pediatric OCD Treatment Study I, POTS, 2004)

Empirical Support

- There is extensive literature supporting combined Exposure with Response Prevention and medication treatment over medication alone and possibly over CBT alone in adults (e.g., Foa et al., 2002).
- Only one Radomized Controlled Trial examined combined treatment versus monotherapy in children.
  - Pediatric OCD Treatment Study I, POTS, 2004

Empirical Support

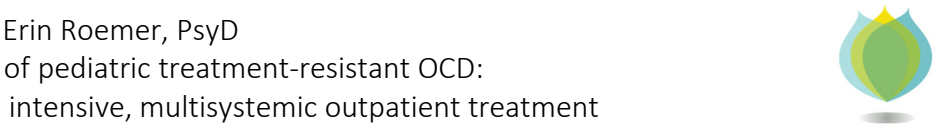
Pediatric OCD Treatment Study I, POTS, 2004 Summary
- Medication alone is helpful but few patients remit
- CBT alone produces a greater chance of remission than medication alone
- CBT and medication combined produces the best chance of remission

POTS Team (2004). "Cognitive-behavioral therapy, sertraline, and their combination for children and adolescents with obsessive-compulsive disorder: the Pediatric OCD Treatment Study (POTS) randomized controlled trial." JAMA 292 (16): 1969-1976.

Empirical Support

Pediatric OCD Treatment Study I, POTS, 2004 Recommendations
- Children and adolescents with OCD should start with either CBT alone, or the combination of CBT and medication
- Family involvement in the treatment of pediatric OCD is necessary
- Therapist experience matters

POTS Team (2004). "Cognitive-behavioral therapy, sertraline, and their combination for children and adolescents with obsessive-compulsive disorder: the Pediatric OCD Treatment Study (POTS) randomized controlled trial." JAMA 292 (16): 1969-1976.



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Direct Treatment of the Child

Exposure with Response Prevention

- The first line treatment of anxiety is a specific form of CBT called Exposure with Response Prevention (ERP)
- The goals of ERP are to:
  - Activate anxiety to promote habituation
  - Activate feared consequences to promote cognitive acceptance

Jonathan Abramowitz NJ-ACT 21st Master Lecture New Concepts in Exposure for Anxiety Disorders

Exposure with Response Prevention

There are three kinds of exposure:

- In-Vivo Exposure: confronting fears in real life, touching objects that might be contaminated, imperfection, dogs, etc.
- Imaginal Exposure: confronting individual fears and overall feared consequences in imagination
- Interoceptive Exposure: intentionally provoking feared physical sensations such as a pounding heart or dizziness

Jonathan Abramowitz NJ-ACT 21st Master Lecture New Concepts in Exposure for Anxiety Disorders

Exposure with Response Prevention

Emotional processing theory (Foa and Kozak, 1985)

- underscores the importance of activating the emotional experience of anxiety in order to change the emotional experience of anxiety

Exposure with Response Prevention

Inhibitory learning theory

- Fears are never extinguished or unlearned
- A new, non-fear response inhibits, but does not eliminate, the original fear response
- Habituation is not necessary
- The treatment goal is to learn to accept fear and tolerate it instead of fearing it
- The old fear may return in time in new contexts

Exposure with Response Prevention

Acceptance and commitment therapy and mindfulness may encourage exposure

- Mindfulness metaphors can be used to supplement exposure to promote compliance

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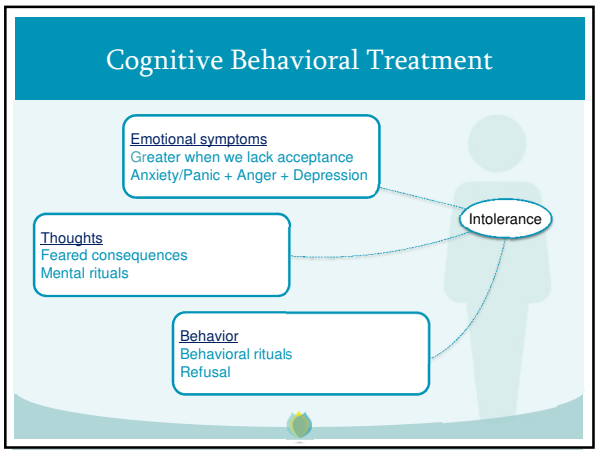

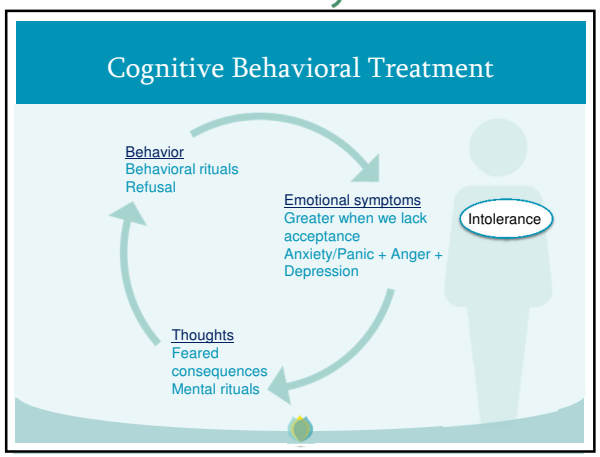

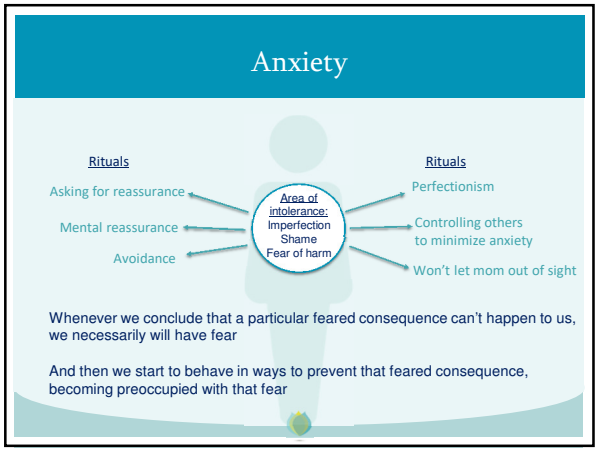

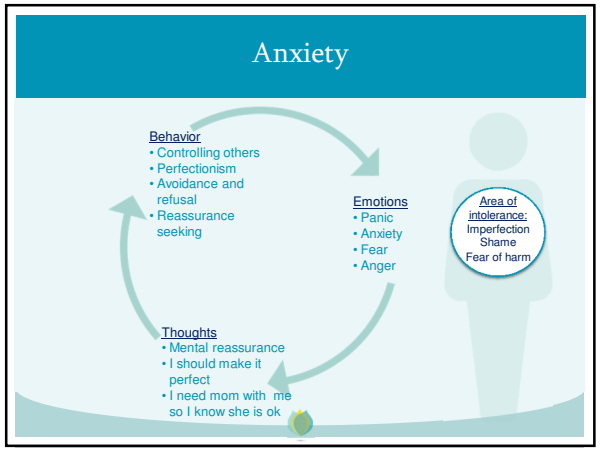

Exposure with Response Prevention

It is not normal to have chronic negative emotions

Whenever emotions are more extreme than they should be:

- Thoughts and beliefs are more inaccurate than they should be
- Behavior is more maladaptive than it should be

Exposure with Response Prevention

Exposure with response prevention targets the cognitive and behavioral components of the problem:

- To create tolerance of the feared consequence
- To correct the maladaptive behavior, which reinforces and increases the chronic emotion

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Exposure with Response Prevention

Exposure with response prevention gradually:

- Results in lower and more tolerable emotion
- Changes intolerant and distorted thinking and beliefs
- Teaches adaptive behavior
- Creates insight and self-awareness

Exposure with Response Prevention

Insight and self-awareness are initially limited:

- There is a lack of self-awareness of all the components of the diagram
- We get used to thoughts and behavior, even if they're incredibly maladaptive, in much the same way that we get used to cold water

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Cultural Factors to Consider in the Design and Implementation of Effective Treatment

ADDRESSING MODEL

Age and generational influences	Children, elders
Developmental Disabilities	People with developmental disabilities
Disabilities acquired later in life	People with disabilities acquired later in life
Religion and spiritual orientation	People of muslim, jewish, buddhist, hindu and other minority religions and faiths
Ethnic and racial identity	People of Asian, South Asian, Pacific Island, Latino, Africa, African American, Arab, Middle Eastern heritage
Socioeconomic Status	People of lower status because of occupation, education, income or rural habitat
Sexual Orientation	Gay, lesbian, bisexual
Indigenous heritage	American Indian, Alaska Natives, FirstNations, Inuits, Metis, Native Hawaiians
National origin	Immigrants, refugees, international students
Gender	Women, transgender people

Hayes, 2008

Things to Consider

- Therapist's awareness of their values, privilege, biases, and world views
- Be aware of different meanings for nonverbal communication
- Be aware of differences in preferences for physical space
- Stay aware of changing conceptualization
- Look for culturally related strengths and supports
- Consultation, supervision and on-going self-assessment

Hayes, 2008

Culturally Responsive CBT

- Be aware of different cultural expectations and beliefs regarding treatment
- Recognize cultural influences on the client's cognitions, emotions, and behaviors, and physical symptoms.
- Set goals, develop treatment plans, and choose interventions in collaboration with clients
- Adapt therapy to the cultural context of the client
- When using family interventions, conceptualize family in a broad sense
- Consider religion as a potential source of strength and support

Hayes, 2008

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How to Design and Implement Effective Treatment

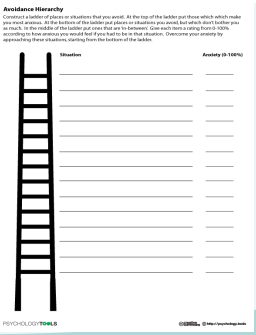
Exposure with Response Prevention

- Create a hierarchy of treatment goals that is conceptually consistent with the core obsession or area of intolerance
  - One of the ways in which exposure with response prevention is carried out ineffectively is that the hierarchy is just a collection of feared situations, lacking any conceptual understanding
- Identify feared consequences in relevant high emotion situations
- Identify mental and behavioral rituals that come from core areas of intolerance
- Practice both situation specific and harder, more core exposures to the core obsession or area of intolerance

Hierarchy of Anxiety Treatment Goals

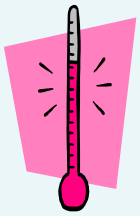
Develop a hierarchy of anxiety
- "What brings on anxiety?"
- "What would you do if you were to try to make yourself anxious:
- Easy, Medium, Hard"

It is important to start with something manageable
- Avoid starting with something too difficult or moving too quickly



Hierarchy of Anxiety Treatment Goals

FEAR THERMOMETER



10
NO WAY
THE WORRY WINS ALL THE TIME

5
MAYBE I CAN; MAYBE I CAN'T
I WIN SOMETIMES AND THE WORRY WINS SOMETIMES

0
NO PROBLEM
I WIN ALL THE TIME

MY GOALS

Parents go out together

Imperfect appearance
Imperfect homework

Going to school

Going to lacrosse practice with mom there

Mom and dad have a conversation

Exposure with Response Prevention

- Ritual prevention means that we need to prevent the reliance upon maladaptive rituals
- Either:
  - Gradually
  - Or, Not Gradually
- Practicing exposure without reliance upon maladaptive rituals fosters acceptance and tolerance

The Struggle to Accept

Lack of acceptance causes distress

Effective treatment fosters acceptance of anxiety and uncertainty, and of the reality of the situation that causes distress
- People with anxiety tolerate uncertainty all the time in areas of their life unaffected by anxiety
- They have a very difficult time tolerating uncertainty in the areas affected by anxiety
- People who struggle with depression and anger frequently may have a difficult time accepting the reality of loss and suffering

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The Struggle to Accept

Whenever we isolate any possibility and state that _____ can't happen to us, we necessarily have fear

- Life is full of surprises
- However they are surprises only to us, simply because we expected otherwise
- We adjust to little surprises more easily
- Bigger surprises we call traumas and have a more difficult time accepting

The Struggle to Accept

Difficulty accepting causes us to fear these larger surprises

Treatment always focuses on the truth

- There is uncertainty about whether our feared consequence will happen
- The course of our life is largely out of our hands

The Struggle to Accept

- Anxiety overestimates the probability that the feared consequence will happen and leads us to believe that it could happen soon
- Treatment asks the client to gradually accept with their actions what we are asking them to accept intellectually at the outset

Questions to Facilitate Acceptance

- What is the purpose of my suffering?
- What purpose would my life have if I suffered my feared consequence?

Questions to Facilitate Acceptance

Imagine experiencing your feared consequence and answer these questions:

- Why did this happen to me?
- How has it affected me physically and emotionally?
- How have my loved ones and I responded?
- What can I do and no longer do?
- What is the quality of my life?
- How am I coping?
- What decisions might I be confronted with?
- What decisions might I make?

Imaginal Exposure

Describe the current and long-term fears

Situation specific fears always emanate from core areas of intolerance

- I'm afraid my mom will die
- I'm with my friends and risking that I might say something stupid
- I am risking losing all my friends
- I am risking shame, guilt, rejection, and isolation
- I am risking that I might panic or continue to have uncontrollable anxious thoughts

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Imaginal Exposure

- Accept intellectually that my feared consequence could happen and is out of my control
  - The first step is to accept this intellectually
  - Exposures should always tell the truth
- Intellectual acceptance relates directly to acceptance of the entire treatment goal

Imaginal Exposure

- Describe why one would accept this truth
  - My rituals don't perfectly prevent my fear, even if I ritualize more and function less
  - My loved ones and I suffer greatly as a result of my anxiety
- Real life and imaginal exposures are acceptance of these possibilities through action
- Freedom from anxiety occurs through acceptance

Therapeutic Relationship

- This is all fine and good, but let's get back to the fact that this kid won't even talk to us
- Treatment resistant youth can be difficult & demanding
- Control emanates from the child to the parents, school, and therapeutic relationship:
  - The clinician-child interactions parallel the parent-child interaction
  - Threats are used to refuse and control
    - "I'm going to sue you;" "I'm going to get you fired;" "This will be the last time we work together"
  - Physical aggression can be used
    - Damaging property; threatening body language

Therapeutic Relationship

- It is important to:
  - Develop Rapport
  - Give the child choices
  - Predict and label refusal for parents
  - Not reinforce behavior designed to control
  - Set appropriate boundaries with youth & parents
  - You might need a "good cop" and a "bad cop"

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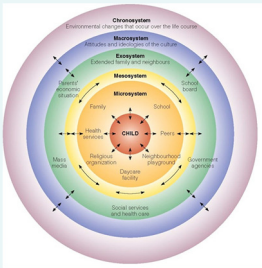
Treatment Targeting the Parents and Family

Intervening with Parents and Family

- The conceptualization of the anxiety disorder has *reverberations throughout the parents and the family*
- Necessary to treat family factors that function to maintain the anxiety disorder



Bronfenbrenner, 1979

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Parental Psychopathology

- Up to 80% of parents of children with anxiety also meet criteria for an anxiety disorder (Ginsberg & Schlossber,2002)
- Maternal anxiety was associated with:(Drake & Ginsberg, 2011; Ginsberg & Schlossber,2002)
  - More catastrophizing
  - More anxious modeling based on maternal report
  - Less warmth
  - More disengaged and withdrawn when solving problems

Parental Psychopathology

- Parental perfectionism and overcontrol are linked to the development of anxiety in childhood (Affrunit & Woodruff-Borden, 2015; Greblo & Bratko, 2014)
  - Overly critical and demanding
  - Rigid adherence to strict and high standards of behavior and performance
  - Permissiveness
- Parental overcontrol and anxiety interact to increase developmental impairment (Soenens & Vansteenkiste, 2010)

Parental Psychopathology

- Greater levels of psychopathology in parents of children with OCD as compared to parents of pediatric and non-psychiatric patients(Calvo, Lázaro, Castro, Morer, &Toro, 2007)
  - Higher prevalence of anxiety disorders, depression, OCD (Liakopoulou et al., 2010)
    - Fathers were found to have greater severity levels of OCD
- Parental OCD and anxiety symptoms are associated with increased family accommodation (Leibowitz, Panza, Su, & Bloch, 2014)

Parental & Family Accommodations

Common Family Accommodations

- Provision of reassurance
- Help with anxiety rituals
- Help with avoidance
- Decreased behavioral expectations of the child
- Modification of family routine and activities

Parental & Family Accommodations

- Accommodation is common in OCD
  - strongly and consistently correlated with OCD symptom severity and impairment (Storch et al., 2015)
- Family accommodation is greater with contamination OCD and with internalizing or externalizing problems (Leibowitz, Panza, Su, & Bloch, 2012)

Parental & Family Accommodations

- Levels of accommodation are associated with treatment outcomes
  - Decreases in family accommodations in treatment of OCD predicted treatment outcome when controlling for pretreatment severity and impairment (Merlo et al., 2009)
  - Targeting family accommodation in treatment may improve OCD treatment outcomes (Leibowitz, Panza, Su, & Bloch, 2012; Merlo et al., 2009)

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Intervening with Parents and Family

- Treatment intervention goals:

1. Conceptualize and treat the child's anxiety disorder
2. Identify and treat patterns of triggers and behavior among the parents
3. Identify and treat patterns of triggers and behavior among the family system

Conceptualize the OCD within the Child-Parent Relationship

- There is a core belief and areas of distress tolerance that maintains the child's anxiety disorder that also apply to the parents.
- Dysfunctional interactions between the child and the parents are the result of a negative feedback loop in which the child and the parents are alternatively triggered.

Conceptualize the OCD within the Child-Parent Relationship

- From an assessment perspective, use data collected from the child to assess and develop a hypothesis about the functional relationship between the child and the parent
- Identify roles each parent takes when interacting with the child around the topic of anxiety
- Domains to assess among the parents include:
  - Expectations of treatment
  - Anxiety triggers
  - Areas of frustration intolerance, especially when the child is the one triggering the parent
  - The parents' behavioral response to the child's dysregulation and accommodation

Conceptualize the OCD within the Child-Parent Relationship

Highly Emotionally Reactive Child	Conceptualization of patient's mother
Thoughts: Perfectionist; Everything needs to be perfect; if something feels weird then something is wrong, and if something is wrong we need to fix it right away. If I feel weird, I'm going to die. I can't deal with physical symptoms. I need to feel right. I'm not going to change; Feelings: Anxiety, frustration Actions: Verbal and physical aggression, emotional threats, pestering, badgering, negotiation, reassurance seeking, refusal	Thoughts: Perfectionist; everything needs to be perfect with my child. If something is wrong it needs to be fixed now, it needs to be done quickly; why isn't this working; She needs intensive treatment; do we have the wrong diagnosis because if so we are missing THE effective treatment. Feelings: Overwhelmed; Shame; Anxiety Actions: Accommodation, Multiple calls to providers; seeking second opinions or other medical interventions, video-taping outbursts,

Conceptualization of the Parents

- There is a push to divide the parents
- Typically, one parent triggers the child and is triggered by the child more easily; is overwhelmed, handling it all, and feeling burdened
- The other parent is rendered irrelevant and is pushed out by the child and by the first parent

Conceptualization of the Parents

Conceptualization of patient's mother	Conceptualization of patient's father
Thoughts: I don't want to be the primary person interacting with her; You don't have to deal with her. Do whatever it takes to calm her down. Feelings: Overwhelmed Actions: In an effort to mollify her daughter, mom pushes the dad out of interactions.	Thoughts: I'm ineffective; I'm the bad guy Feelings: Criticized Actions: Withdraws, walks on eggshells; Stays out of it; echoes mom's language and perspective to providers. OR Gets angry and when he gets angry is very all or nothing with expectations

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Treatment of the Family

- When we broaden our scope even more, there is a core belief and areas of distress tolerance that also apply to the family
- Use data collected from the child and parents to assess and develop a hypothesis about the ways in which anxiety functions within the family
- There are usually rigid roles that each family member assumes. These roles are more apparent when the child is emotionally reactive
  - Broaden the scope of understanding to include other children or individuals in the family

Parent and Family-Based Treatment Goals

Awareness of Triggers

- Create awareness of shared triggers and of the feedback loop in which the parent and child are alternatively triggered
  - "What brings on anxiety?"
  - "What can I tolerate?"
  - "What is difficult to manage?"
  - "How am I complicit in this and what makes me complicit in this?"

Parent and Family-Based Treatment Goals

Strong Behavior Management Plan

- Gradual application of behavior management strategies
  - Incentives for treatment related behaviors
  - Consequences for treatment interfering behaviors
  - Zero tolerance for some behaviors
- "How can I create a functional family life?"

Parent and Family-Based Treatment Goals

- **Exposure Hierarchy for the Parents**
  - Gradual tolerance of the child's emotion
- **Ritual Prevention for the Parents**
- Remove parents from the emotionally reactive feedback loop
- Introduce dad and mom into effective parenting and tolerance of the child's emotion

Parent and Family Treatment Plan

Behavior Plan Hierarchy	Exposure Hierarchy
High Emotion Crisis: the goal is damage control Contain and wait out outbursts; minimize conflict and attention given to behavior Be ready to go to the hospital	Hard More powerful incentives offered for achieving these goals
Low to Moderate Emotion Reward a few easy to achieve expectations Ignore mild behavior meant to obtain reassurance or to wear parents down Ask the child to correct misbehavior	Medium Incentives earned for treatment goals Use the disorder as an incentive Eg., The child earns time with mom
	Easy Easy to achieve exposure goals Functional behavior goals respectful tone; use emotion words Daily structure and chores

Parent and Family-Based Treatment Goals

Strengthen the Marriage

- Improve Communication
- Create Unified Values and Decisions Between Parents
  - Create the perception of unity between parents
  - Hierarchy: Communicate about and develop unified decisions in low emotion areas, and in areas unaffected by anxiety.

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Parent and Family-Based Treatment Goals

Strengthen the Marriage

- Forgiveness of and Compassion for your Spouse and Child
  - Encourage parents to consider, "what is the area of difficulty or intolerance that is causing such dysregulated behavior in my child, or that is causing frustration and upset in my spouse?"
- You as the Parents are the Example
  - As best you can, give your children the gift of the example of a good marriage.

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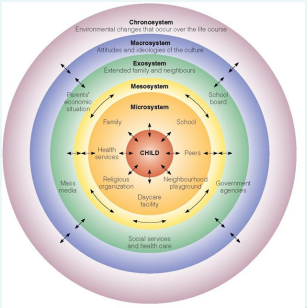
Treatment Targeting the School

School Factors
Bronfenbrenner's five environmental systems



Bronfenbrenner, 1979

School Factors for Treatment Resistance

- Assess the role of the school in the child's treatment resistance
  - The school is an important setting and usually needs to be included in treatment
  - There is either great dysfunction at school or the child looks perfect to school personnel
- Natural setting
  - Expect to see the same dysfunctional coping strategies mirrored in the school setting
- Treatment needs to include exposures to be performed at school and a behavior plan at school

Case Conceptualization in Schools

- Highly Emotionally Reactive Treatment-Resistant Behaviors at School:
  - School refusal
  - Frequent tardiness or unexcused absences
  - Absences on significant days
  - Frequent request to go to the nurse's office
  - Excessive worrying, temper tantrums, and crying
  - Frequent request to call or go home

Case Conceptualization in Schools

- Low Emotionally Reactive Treatment-Resistant Behaviors at School:
  - Taking excessive amount of time to complete work
  - Skipping lunch
  - Tend to be very quiet or remote
  - Holding onto items
  - Asks an excessive amount of questions
  - Perfectionism at school

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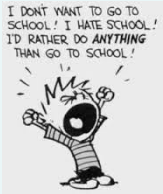
School Refusal

- School refusal
  - Refuses to attend school due to emotional distress
- Common characteristics
  - Common among both genders
  - Peaks at times of developmental transition
  - Tends to occur with greater frequency following vacations and weekends



Kearney, 2008

Why Students Refuse School

4 main reasons

1. **Receive attention from significant others outside of school**
   - Prefer to be at home with parents or other caregivers
2. **Avoid school-related objects or situations that cause general distress**
   - Experience general distress at school
   - Distress tends to be linked with
     - Transition between classes or teachers
     - Riding the school bus
     - Entering the school building

Kearney, 2008

Why Students Refuse School

4 main reasons

3. **Escape uncomfortable peer interactions and/or performance situations**
   - Difficulty in social and evaluation situations: Class participation, group or large projects, oral presentations, recitals, lunchtime, and extracurricular activities
4. **Pursue tangible reinforcement outside of school**
   - Videogames
   - Home alone all day

Kearney, 2008

School Refusal versus Truancy

School Refusal	Truancy
Feel fearful and anxious	Feel bored and angry
Are likely to tolerate small aspects of school day	Antisocial behaviors
Isolate at home	Do not stay at home
Likely to complete missed work	Not motivated to complete missed work
Parents call them in sick	Hide absences from parents

Kearney, 2008

Case Conceptualization in School

- The conceptualization of the anxiety disorder has reverberations that are observable in school
- The successful treatment of childhood anxiety disorders necessitates broadening treatment to include interventions at the school to treat factors that function to maintain the anxiety disorder

Case Conceptualization in School

➢ Treatment intervention goals:

1. Conceptualize and treat the child's anxiety disorder
2. Identify and treat patterns of triggers and behavior among the parents and family
3. Identify and treat patterns of triggers and behavior within the school

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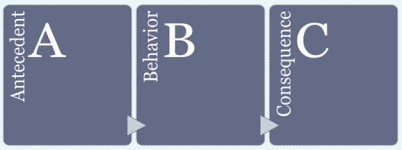
Case Conceptualization in School

Determine the function of treatment-resistant behaviors

- How does school staff respond to treatment-resistant behaviors?



Home:	Parents leave to go out	Child throws tantrum	Parents come home
School:	Teacher give a test	Child asks to go to nurse	Child doesn't take test

Case Conceptualization in School

Understanding parental involvement with the school

- The parents are communicating with the school
- To the extent that they are highly emotionally reactive or low in emotional reactivity themselves, the school's response may be influenced by their communication

Case Conceptualization and Treatment Planning

Obtain information from school

- Clinical interview
- Evidence-based measures of anxiety and OCD
- Functional behavior analysis

Develop a working relationship with one point person in the school

- School Psychologist
- School Counselor
- Principal
- Teacher

Case Conceptualization in School

Highly Emotionally Reactive Child	School's Response
Thoughts: Perfectionist; Everything needs to be perfect; if something feels weird then something is wrong, and if something is wrong we need to fix it right away. If I feel weird, I'm going to die. I can't deal with physical symptoms. I need to feel right. I'm not going to change; Feelings: Anxiety, frustration Actions: Verbal and physical aggression, emotional threats, pestering, badgering, negotiation, reassurance seeking, refusal	Overly Accommodating Whatever you need You can go to the nurse's office at any time Under Accommodating Go back to class Your child is just truant This is "behavioral" Boiler Plate Accommodations Standard accommodations are used that don't match up with the conceptualization and treatment needs of the child

Treatment Planning and Consultation

Share case conceptualization with school

- Build professional credibility and expertise
- Increase treatment buy-in from school

Work with parents and school to develop a consistent plan for addressing treatment-resistant behaviors

- Communicate that the parents are not to blame and the child is not to blame
- We are all working together to combat the anxiety

Treatment Planning in the School

School's Response	Accommodations and ERP within the School
Overly Accommodating Whatever you need You can go to the nurse's office at any time Under Accommodating Go back to class Your child is just truant Boiler Plate Accommodations Standard accommodations are used that don't match up with the conceptualization and treatment needs of the child	HARD: ACCOMMODATE More powerful incentives offered for achieving these goals MEDIUM: TOLERATE Incentives earned for treatment goals Use the disorder as an incentive Eg., Child earns time with mom EASY: HAVE EXPECTATIONS Easy to achieve exposure goals Functional and respectful behavior goals

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Evidence-Based Treatment Strategies

Review treatment rationale for the school

1. It is important to implement treatment strategies that have been shown through research and clinical experience to actually treat anxiety and OCD (Abramowitz, Whiteside, & Deacon, 2005; Chapman, Gratz, Tull, & Keane, 2011; Mennin,2006; Watson & Rees, 2008; Wu, Lang, & Zhang, 2016)
   - Cognitive Behavioral Therapy
   - Exposure with Response Prevention
   - Dialectal Behavior Therapy
2. Temporary accommodations will be needed at school, which allow the child to work gradually on treatment goals

Treatment-resistant behavioral dysregulation requires immediate behavioral intervention

Evidence-Based Treatment Plan

Behavior Plan Hierarchy	Exposure Hierarchy
High Emotion Crisis: the goal is damage control Contain and wait out outbursts; minimize conflict and attention given to behavior Be ready to go to the hospital	**Hard** More powerful incentives offered for achieving these goals
Low to Moderate Emotion Reward a few easy to achieve expectations Ignore mild behavior meant to obtain reassurance or to wear parents down Ask the child to correct misbehavior	**Medium** Incentives earned for treatment goals Use the disorder as an incentive Eg., The child earns time with mom **Easy** Easy to achieve exposure goals Functional behavior goals respectful tone; use emotion words Daily structure and chores

Evidence-Based Treatment Plan

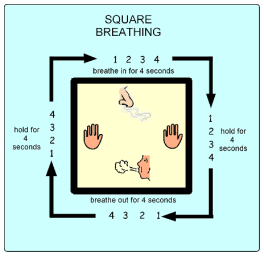
Behavior Plan at Home	Behavior Plan at School
1. Remove the tons of toys: That make it hard to discipline because they are a distraction and a constant unearned reward 2. Frequently reinforce behavior we want to see more of, including exposures: THIS IS TREATMENT 3. Give the child choices over appropriate things: These children have a high need for control 4. Don't wait to intervene with escalating behavior: Intervene ASAP and have a fail safe plan	1. Empty her desk: To remove distractions and unnecessary stimuli 2. Frequently reinforce behavior we want to see more of, including exposures: THIS IS TREATMENT; Give tickets for any behavior of this kind no matter how small 3. Give the child choices over appropriate things: These children have a high need for control 4. Don't wait to intervene with escalating behavior: Intervene ASAP

Evidence-Based Treatment Strategies

DISTRESS TOLERANCE strategies for coping with harder exposure triggers in school

Evidence-Based Treatment Strategies

Deep Breathing	Progressive Muscle Relaxation



Evidence-Based Treatment Strategies

Five Senses	Five Senses
•Vision –Look at a comforting scene, out the window, people watch **•Hearing** –Outside traffic, favorite music (soothing or upbeat), hum **•Smell** –Soap, Shampoo, Lotion, Candles, Baking	**•Taste** –Favorite food, soothing drink, mindful eating, peppermint/cinnamon candy **•Touch** –Touch something soothing or rough, apply lotion, run hands through hair, wear favorite fabric, hugs ****Distress Tolerance Kit****

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Temporary Accommodations

- **Temporary Accommodations**
  - Supports and services provided to help a student function at school
    - Based on individual case conceptualization
  - Follow the premise of gradual exposure
    - Can't be all or nothing
    - Needs to be flexible
  - Meeting the current needs of the student
  - Tracking progress and modifying accommodations

Temporary Accommodations

504 plan or Individualized Education Plan

- Examples of common temporary accommodations
  - Late arrival or modified school day
  - Cool down pass
  - School arrival buddy or check-in
  - Breaking down school assignments & reduce quantity
  - Extra time to complete tasks
  - Scheduling make-up work and tests
  - Class presentation alternatives

Conclusion

- School needs to be part of the treatment plan
  - Problematic behaviors are exhibited in school settings
  - Build collaborative relationship with school staff
- Implement evidence-based strategies focusing on environmental factors
  - CBT
  - ERP
  - DBT
- Incorporate individual and fluid accommodations

Presentation Summary

Describe evidence-based treatment across multiple settings to enhance pediatric OCD treatment compliance and response

1. Describe fundamental information regarding the nature and treatment of pediatric OCD and tailor evidence-based interventions to incorporate patient-specific internal factors.
2. Intervene with parents, family, school, and community to treat factors that function to maintain treatment-resistant pediatric OCD.
3. Design and deliver intensive, multisystemic evidence-based treatment within an outpatient setting to maximize outcomes among youth with treatment-resistant OCD.

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Thank You!

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