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Highlights…

Our page 1 stories this month look at how to help guide parents of children with behavior problems, and the use of exposure with response prevention for OCD.

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Free Parent Handout…

Spanking doesn't work and is counterproductive

Parenting

'What gets attention gets repeated': Learning about parenting from our pediatricians

Rebecca Newland, Ph.D.; Maya Ayoub; and Stephanie Shepard Umaschi, Ph.D.

Utilization of primary care providers is nearly universal for children, with 27 well-child visits recommended by the American Academy of Pediatrics between birth and 18 years of age. Given the important role pediatricians hold and the frequency of visits, pediatricians are among the most trusted professionals with whom children and families interact. Accordingly, pediatricians are commonly called upon to address childhood behavioral health concerns and are seen by parents as a credible source of parenting advice and support. Despite awareness that parent training is the most effective strategy for addressing behavioral concerns in young children and for preventing the onset of externalizing and internalizing disorders, pediatricians identify multiple barriers to providing parent training to the families they serve.

Pediatricians are faced with a limited capacity to deliver parenting guidance due to the length of visits and competing priorities during their brief time with patients. At the same time, they identify inadequate referral options for families, long waiting lists for services, and low rates of follow-through for families referred for mental health treatment or parenting intervention

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OCD

Clinical considerations for implementing exposure and response prevention for pediatric OCD

Jenny Herren, Ph.D., and Elizabeth Brannan, M.D.

Obsessive-compulsive disorder (OCD) is a neurobehavioral disorder that impacts individuals across the lifespan. Cognitive behavioral therapy using exposure with response prevention (E/RP) has been identified as the first-line and "gold standard" treatment for OCD and has been well-studied in children and adolescents (Freeman et al., 2014). Exposure-based treatment involves an individual purposefully facing anxiety-provoking stimuli while refraining from engaging in rituals or avoidance. Research studies with youth (ages 8–17) and younger patients (under 8) have identified individual and family-based E/RP to be an efficacious, well-tolerated, and acceptable treatment for OCD (Freeman et al., 2014). Delivering exposure in a developmentally sensitive manner for youth is important to facilitate optimal treatment response. This article focuses on a few key considerations when using E/RP with a pediatric population. To exemplify the principles, we will give examples of E/RP with a 10-year-old female ("Julia") presenting with a primary fear of contamination through toxic chemicals. Rituals involve checking, cleaning, reassurance seeking, counting, and avoidance measures.

- **Don't forget the "RP" in E/RP.** Response prevention is a key ingredient in E/RP and essential for symptom improvement. Theoretical underpinnings of OCD suggest that symptoms are maintained through

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enting principles, which pediatricians can then offer to parents to explain strategies and guide their later choices. For example, the phrases "what gets attention gets repeated" and "what you feed grows; what you starve dies" help parents understand and apply the concept of differential attention to increase desired behavior through praise and encouragement while decreasing undesired (but not unsafe) behavior by withholding attention. This can be further reinforced and modeled by delivering frequent, specific, genuine praise to parents during visits to "feed" their use of positive parenting strategies as well as to model for parents how effective praise can increase desired behaviors among their children. Finally, the parent-friendly handouts provided by Incredible Years can be distributed for parents to review and to guide brief practice during long wait times at the pediatrician's office.

To further illustrate, there are a number of simple strategies that can be discussed, modeled, and coached in pediatrics visits to build parents' use of strategies that increase child compliance. This includes giving warnings prior to transitions (e.g., "The timer is set for 5 more minutes of play, and then it will be time to clean up"), giving "start" commands rather than "stop" commands (e.g., "Please put your toys on the shelf" rather than "Don't leave this mess"), providing the child with choices (e.g., "Do you want to start by putting the blocks in the bucket or collecting all your airplanes?"), using when/then commands (e.g., "When you clean up your toys, then you can watch your show"), and following up with praise for compliance (e.g., "You were a big help. You cleaned it all up!"). At the same time, pediatricians can provide brief psychoeducation to help parents understand that limit testing is to be expected among young children, which can gently challenge parents' negative attributions about their child's behavior. Normalizing a young child's noncompliance also has the potential to reduce parent frustration and anger that often leads to harsh, punitive responses. Pediatricians can take these approaches learned in the workshop into their interactions with all parents, whether they are presenting with child behavior problems or simply typical parenting challenges.

Conclusions

In an 11–20-minute appointment, there may not be sufficient time to fully address behavioral health concerns. Yet, with proper training and support, pediatricians can be equipped to provide brief parenting guidance and support that may either mitigate the need for more intensive interventions or motivate parents to seek higher levels of parenting support as indicated. Delivering Incredible Years workshops for medical professionals is one promising approach used in Rhode Island to support pediatricians in learning these skills.

References

Bauer NS, Sullivan PD, Hus AM, et al. Promoting mental health competency in residency training. *Patient Educ Couns* 2011; 85:260–264.

Webster-Stratton C. The Incredible Years: Parents, teachers, and children training series. In *Innovative mental health interventions for children: Programs that work* (SI Pfeiffer & LA Reddy, eds.). New York, NY: Haworth Press; 2001

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OCD

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a negative reinforcement cycle via rituals or avoidance. When creating a hierarchy, it is important to identify what rituals should be resisted during and following an exposure. By including specific details around rituals or avoidance behavior, it will help therapists to more accurately gauge the difficulty level of a particular exposure. In Julia's case, a therapist would want to discuss ritual prevention prior to starting the exposure and considerations for after the exposure is completed in the office. If Julia immediately goes to the car and uses the hand sanitizer in her backpack to ensure toxins are removed from her hands, it will undo her office exposure work. Additionally, it is important to assess for rituals that are subtle or mental. Julia counts her heartbeats to ensure her body is not shutting down. Therefore, exposures involve Julia refraining from counting and sitting with the fear that her body is being poisoned.

- **Apply the "Goldilocks Principle."** When working with a pediatric population, it is ideal for exposures to be "just right" — that is, not too easy and not too hard. Completing a challenging yet manageable exposure helps build self-efficacy and facilitates learning. Therapists should be mindful of the pace of exposures when working with youth. For initial exposures, choose easier exposure items that promote mild distress to set the stage for a successful exposure, increase the child's confidence, and gauge his or her ability to provide accurate feedback regarding their anxiety level. Increasing the difficulty of the exposure is often easier than starting with something too hard. If an exposure is too hard, a child may not be able to resist rituals and will reinforce the anxiety-maintaining cycle. Signs that an exposure is too hard include the child refusing to do it, ritualizing, rushing through the task, tantruming, shutting down, "white knuckling" with an intent to ritualize or escape later, or stopping. For Julia, her proximity to a "toxic" cleaning product, whether the cap is on or off, and eating in the presence of a cleaning project are both variables used to create a challenging yet manageable exposure.
- **Involve caregivers in treatment.** OCD affects the entire family, not just the child. Accommodation within the family is a common occurrence in pediatric OCD and adversely impacts treatment outcome. Family accommodation refers to ways in which other family members assist or mod-

ify their own behaviors in response to a child's symptoms. Common examples in childhood OCD include providing reassurance, allowing avoidance, participating in rituals, and changing family routines based on OCD symptoms. From a theoretical perspective, family accommodation serves as a reinforcement of the child's symptoms. It provides relief in the short term but maintains symptoms over time. For Julia, she frequently seeks reassurance from her parents that she is not sick or contaminated. An important part of treatment is having her parents respond to Julia in a different way, such as labeling her questions as OCD and then not answering them. Reducing reassurance should be completed in a collaborative and planned manner with the child. Additionally, caregivers can be a helpful source of information around ritualistic behaviors at home.

Helping the parents

A difficult part of OCD treatment for parents is seeing their child in distress. It is often the case that families are making extensive accommodations to rescue their child from discomfort, and the E/RP model may feel counterintuitive to them. Without involving the caregivers and directly addressing parental distress, it can impede exposure success. To address parental discomfort, take steps to ensure caregivers understand the rationale for E/RP and agree with treatment. Validate and normalize parental distress, including processing parental emotions and explaining that feeling bad in the short run leads to getting better in the long run. It is important to consider how much distress parents can tolerate when selecting exposures in treatment. A critical part of Julia's treatment is checking in with parents around their own distress and their feelings around reducing reassurance.

- **Make E/RP fun.** Doing exposures is challenging for a number of reasons, and children may not be motivated to engage in tasks that are distressing to them. Making the exposure task as fun and engaging as possible is one way to enhance motivation for E/RP and make it more acceptable to children. Being silly, humorous, or animated can make exposures more tolerable and fun and allows for the child to have a different experience with a feared task than they were expecting. Pretending to be OCD yourself or having a stuffed object represent OCD can help to externalize it as well as make the task more engaging. Play is another avenue to help make an exposure more tolerable. For Julia, she likes playing a game, "contaminated UNO," in which she rubs the cards on various cleaning supplies and plays with them without engaging in handwashing or reassurance seeking. At home, Julia also enjoys baking with her dad and this fun activity is used to help engage Julia in home exposures. For instance, she bakes cookies while the kitchen cabinet door to the cleaning supplies is open, which evokes her fear that her cookies may be contaminated by toxic fumes. Her exposure task is to then eat cookies with her family. In addition to making the exposure task itself more fun, children and adolescents may also benefit from external rewards for completing exposures. Remember that E/RP is hard work and youth may need incentives to increase engagement.
- **Augment treatment with medication, as appropriate.** For children with moderate to severe OCD, the combination of E/RP and a selective serotonin reuptake inhibitor (SSRI) has been shown to be more effective than E/RP or an SSRI alone (American Academy of Child and Adolescent Psychiatry, 2012; Freeman et al., 2014). Initiating medication is often a complex decision for families, and it is helpful to educate families about the role of medication to treat OCD in combination with behavioral therapy. While E/RP is the first-line and more durable treatment intervention, SSRIs can be a useful and sometimes necessary augmenting "tool" to help enable children to most effectively engage in and benefit from E/RP. Common situations when a medication evaluation may be indicated include: difficulty engaging in E/RP due to severity of symptoms, persistent and impairing symptoms despite using E/RP, barriers to treatment that are not responding to behavioral interventions, and comorbid symptoms that are interfering with E/RP. For example, untreated attention-deficit/hyperactivity disorder (ADHD) is often comorbid with OCD and can lead to problems with the impulse control required for ritual prevention and with the focus necessary to attend to the exposure at hand to allow the habituation process to occur. These are essential for E/RP success, and treatment of ADHD may be a necessary prerequisite to effective E/RP. Another important consideration is that OCD often requires and responds to higher-end SSRI dosing as compared to depressive disorders. This includes what is considered "supra-therapeutic" dosing, such as using fluoxetine (Prozac) up to 80 mg or sertraline (Zoloft) up to 250–300 mg if the child is responding at lower doses but has residual impairing symptoms and is not demonstrating adverse effects that would limit titration.

In conclusion, E/RP is an effective and acceptable treatment for pediatric OCD. When working with a child and adolescent population, it is important to consider developmental modifications in the implementation of the treatment. If E/RP is being hindered by comorbid disorders and/or a degree of anxious distress that makes engagement in purposeful distress-inducing exposures too difficult, medication interventions may be indicated.

References

American Academy of Child and Adolescent Psychiatry. Practice parameter for the assessment and treatment of children and adolescents with obsessive-compulsive disorder. *J Am Acad Child Adolesc Psychiatry* 2012 Jan; 51:98–113. doi: 10.1016/j.jaac.2011.09.019.

Freeman J, Garcia A, Frank H, et al. Evidence base update for psychosocial treatments for pediatric obsessive-compulsive disorder. *J Clin Child Adolesc Psychol* 2014; 43:7–26. doi: 10.1080/15374416.2013.804386. Epub 2013 Jun 9.

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