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Brief Report: Supporting Families in Intensive Treatment for Pediatric Anxiety and Obsessive-Compulsive Disorders

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Abstract
Pediatric anxiety rates have doubled during the COVID-19 pandemic (Racine et al., 2021), but access to care has not increased commensurately (Panchel et al., 2021). Intensive group- and family-based outpatient treatment that implements cognitive-behavioral therapy (CBT) with exposure and response prevention (ERP) for pediatric anxiety disorders and OCD is a treatment design that treats more children at one time and may facilitate treatment momentum with its intensive nature so that new patients can be treated sooner. This paper describes CBT-based interventions from an intensive treatment program for pediatric anxiety disorders and/or OCD that involves parents and that can be applied in relevant community-based settings with the hopes of increasing access to evidence-based care.

Keywords: CBT, intensive treatment, parenting, pediatric anxiety disorders, pediatric OCD

Impact Statement
Pediatric anxiety rates doubled during the COVID-19 pandemic (Racine et al., 2021), but access to care has not been able to meet the increase in demand (Panchal et al., 2021). Cognitive behavioral therapy (CBT) with exposure and response prevention (ERP) is a “well-established” treatment for pediatric anxiety disorders (Higa-McMillan et al., 2015) and a “probably efficacious” treatment for pediatric obsessive-compulsive disorder (OCD; Freeman et al., 2014); however, weekly outpatient treatment still only yields remission for about half of treatment participants (Bloch & Storch, 2015; Ginsburg et al., 2011). Even when a child has access to CBT and the opportunity to experience improvement, research has demonstrated that there are
additional factors that may contribute to poor treatment outcomes, such as parent psychopathology, which has been associated with poor treatment outcomes for children with anxiety and OCD (Garcia et al., 2010; Southam-Gerow et al., 2001).

Intensive group- and family-based outpatient treatment that implements CBT with ERP for pediatric anxiety disorders and OCD is a treatment design that treats more children at one time, and may facilitate treatment momentum with its intensive nature so that new patients can be treated sooner. This treatment set-up has resulted in significant reductions in both child- and parent-reported children’s anxiety symptoms and functional impairment (Sperling et al., 2020). Moreover, the treatment yielded significant decreases in parent-reported distress and demonstrated that greater reductions in parental distress by the end of treatment predicted more improvement for children (Sperling et al. 2021). Given that compared to before the pandemic, parents have endorsed increases in depression, anxiety, stress, and irritability (Westrupp et al., 2023) and that parental distress may impact children’s mental health as described above, it is imperative to recognize how we can ensure that treatment supports the family system. Despite the potential for intensive group- and family-based CBT to help families, programs of this kind are rare. CBT can, however, offer generalizable advice for treatments that involve family systems. The aim of this paper is to provide an overview of interventions that can be implemented for parents of children experiencing anxiety disorders and/or OCD, and whose children are enrolled in a treatment program that implements primarily CBT with ERP and involves parents. It is recognized that not just parents care for children. For the sake of brevity, “parents” will refer to all caregivers involved in raising children.

Providing Psychoeducation

Treating pediatric anxiety and OCD requires children to be willing to approach experiences that their worries or intrusive thoughts tell them not to do, in order to learn that their feared outcomes do not occur or at least that they can handle the challenges. The very
nature of the treatment is stressful; however, parents typically seek treatment for their children because they want their children to feel less distressed. Moreover, parents’ instincts pull them to protect their children (Silverman et al., 1995). If parents think that distress is harmful, they may inadvertently reinforce anxiety by facilitating avoidance or by providing reassurance to anxiety outside of child-focused treatment. Therefore, it is critical to involve parents in treatment so that they understand how the exposures work and how to support them outside of the office.

**Orienting to Inhibitory Learning and Rewards**

At the start of treatment, orienting parents and children to the inhibitory learning model for CBT with ERP, which explains how exposures work by either learning that they were not as challenging as expected or they at least were doable (Craske et al., 2014), allows everyone to understand the treatment approach. The family also can learn about a tangible reward system that will be used to reinforce brave efforts during treatment sessions as well as for completed action plan assignments. A description is provided of how the system is used to increase motivation and engagement in treatment and to create opportunities for parents to focus attention on bravery versus avoidance. Clinicians award the child with stars each day depending on what types of exposures were completed. Parents decide how many stars are worth each reward idea that is generated by the child (e.g., choosing dinner), to make the rewards motivating, and provide the rewards twice weekly to facilitate treatment engagement.

**Establishing Lines of Communication**

At the end of each treatment session, a clinician speaks with a parent and the child to review which exposures were covered during the session, what stars were earned, and what the action plan is for exposure rehearsal. This conversation not only provides an opportunity to keep parents informed of treatment progress, but it also models how to positively reinforce bravery. Moreover, keeping parents informed of treatment may reduce parents’ worries
about how treatment is progressing and facilitate parental support of exposures.

When clinicians are working with adolescents, who are tasked with separating and individuating, clinicians can speak with adolescents before the debriefing conversation with the parent to plan what specific information the adolescent would be willing to share and what topics the adolescent would prefer to keep general (e.g., describe the aim for the patient to complete one example of cognitive restructuring for an action plan, versus specify what kind of unhelpful thoughts would be the focus).

**Modeling and Practicing**

Holding recurring family meetings with parents and the child enrolled in treatment creates opportunities to discuss ways for parents to support their child at home. Below are examples of topics covered.

The focus of these meetings can be for clinicians to model what exposures look like, help parents practice tolerating their own distress when they see their children approaching difficult situations, and involve parents in exposures when indicated (e.g., a child practices hugging a parent that OCD has deemed contaminated). Parents practice praising willingness beforehand and bravery afterward and resisting urges to distract and reassure during exposures so children can learn that they can manage the experiences.

In addition, parents can role-play each stage of the reassurance-seeking hierarchy, one that gradually withdraws attention from reassurance-seeking behaviors. During this situation, children practice saying a commonly said phrase (e.g., “Do I look sick?”), and parents rehearse their role, depending on the level of the hierarchy at which the family is. The first level involves saying, “That sounds like your anxiety/OCD talking. Is that your anxiety/OCD talking?” The child answers, and then the parent responds to the question. In this way, the parent cues the child’s brain that it is anxiety or OCD talking and not the child during the first level. A family typically practices
one level of the hierarchy for a week before moving on to the next level, which is for a parent to respond to questions by nodding or shaking their heads depending on the question. For confessions, parents respond by using the “OK” gesture, and clinicians clarify that this gesture communicates the “OK” meaning and not others with negative connotations that have been expressed in some communities. The third level is for the parent to practice active ignoring. Parents also are informed about extinction bursts to prepare for how the reassurance seeking may worsen before improving.

**Supporting Parents Separately**

Offering separate groups for parents provides a space for parents to learn skills to support their children and to receive support themselves. A clinician first teaches behavioral parent training techniques based on the principal that while attention is being taken away from the unhelpful behaviors in treatment, it is important for parents to reallocate their attention to more helpful behaviors so that children see that they still receive support. The first set of skills, including child-directed play (or “one-on-one time” for older children), labeled praise, and tangible reward systems, focus on providing attention for more helpful behaviors (in general and not just brave efforts) and foster parents’ reestablishment of a positive connection with their children. Distress often can create conflict among family members, and these tools help parents create ways for their children still to receive attention but in more helpful ways. Next, parents learn how to implement effective commands and consequences, practice active ignoring, and implement time-outs when relevant. In addition to these skills, parents also learn how to validate children’s emotional experiences so that children feel heard, and parents practice striking the balance between validating and maintaining limits. Key components involve replacing the conjunction “but” with “and,” when parents validate and hold the other side to show that both can be true (e.g., “You’re frustrated with me because you cannot go to your friend’s house right now, and
you may go after you have completed your homework), and validate tentatively (e.g., “You seem worried” instead of “I know/understand you’re worried”) to manage the personal fable.

Parents also are taught how to reduce accommodation, a key reinforcer of anxiety and OCD. In line with this skill, parents learn ways to foster children’s independence and help them establish mastery in other domains while their children work on challenges in treatment. A part of this skill involves developing chore charts and corresponding allowance plans.

Parents learn how to praise effort, while the clinician supports children’s action plan completion at home. Parents often experience relief knowing that they do not have to micromanage the action plan, and this step also can reduce conflict at home.

A clinician teaches parents how to support siblings who have been impacted by the identified patient’s mental health challenges and how to support themselves. Self-care at first may seem like it is not relevant to parents. Therefore, it is important for them to learn how practicing self-care supports their children by modeling self-care, restoring one’s resources so that the parent can be more supportive of a child, and creating opportunities for mastery by having a child try something independently when a parent is not available. To facilitate self-care implementation, parents can identify a desired activity, a start time, and duration (e.g., read for 30 minutes each day at 9:30 P.M.). Following up on this action plan at a subsequent group increases accountability and reinforces self-care implementation.

**Conclusion**

Involving parents in treatment supports not only children but also the whole family system. Although distress has increased during the pandemic, the strategies above may be able to meet more of the needs in the community.
References


