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Our page 1 stories look at barriers and solutions to using exposure therapy with youth with OCD and ADHD, and at ways to address cultural diversity in child and adolescent mental health services.



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- AAP recommends COVID vaccines
- How one treatment program uses VBC

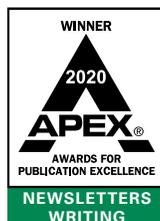
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Free Parent Handout...

- Time to remember: Vaccines don't cause autism



Monthly reports on the problems of children and adolescents growing up

CABL

OCD

Exposure therapy for youth with comorbid ADHD: Challenges and solutions

By Grace Cain, Jennifer Herren, Ph.D., and Jennifer Freeman, Ph.D.

Exposure-based Cognitive Behavioral Therapy (CBT) is the gold standard of treatment for both anxiety disorders and Obsessive-Compulsive Disorder (OCD) (Freeman et al., 2014). During exposure therapy, patients gradually confront and closely attend to feared stimuli while resisting safety behaviors or compulsions.

Up to 80% of pediatric patients with OCD have comorbid disorders (Storch et al., 2008), often including attention-deficit/hyperactivity disorder (ADHD), and approximately 25% to 50% of children with ADHD suffer from at least one anxiety disorder (Sciberras et al., 2014). As a result, clinicians treating anxiety and OCD are likely to work with patients with co-occurring ADHD and it is important to consider the impact of comorbid presentations when delivering exposure-based CBT. This article details the challenges the

authors have observed during exposure therapy with youth with comorbid ADHD, and the tools the authors have used to support patients during exposures. The challenges and tools discussed in this article are not only relevant to youth with comorbid ADHD; they may be beneficial to all patients, particularly younger patients and patients with Autism Spectrum Disorder.

Challenges with ADHD

Engaging in exposure therapy can be particularly difficult for youth with ADHD because exposures require patients to attend closely to distressing stimuli, and to resist the urge to engage in compulsions or avoidance behaviors (Storch et al., 2008). These two main expectations for patient behavior during exposure rely on attention and impulse regulation, areas of executive

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Diversity

A humble approach to address disparities in healthcare

By Aditi V. Hajirnis

Humility is not thinking less of yourself, it's thinking of yourself less.

—C. S. Lewis

The United States has seen remarkable growth in cultural diversity over the past few decades, with its population becoming increasingly multiracial and multicultural. The population of minority groups has increased at a much faster rate even among children and youth. At the same time, minority youth face increasing disparities in their mental health and in access to mental health services. These disparities

have been further aggravated by the lack of culturally competent services that can address their specific mental health needs within the context of their culture, family, and community.

The Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care (Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, 2003) found that clinical uncertainty, stereotyping, healthcare prejudice or bias may

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OCD

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function that are impaired in patients with ADHD.

- **Impulsivity.** Impulsivity may lead patients starting an exposure before they have fully considered its difficulty level. This can result in patients attempting exposures that are too difficult, ultimately resulting in the patient ritualizing or being flooded (so overwhelmed that they emotionally shut down). Patients with limited impulse control may also inadvertently make exposures more difficult. For instance, a child might plunge their entire hand in a dirty trash can when the plan was to place only one finger inside. Similarly, patients with ADHD and OCD may be less able to control their urge to ritualize immediately after viewing feared stimuli.
- **Inattention.** When treating youth with comorbid anxiety disorders and ADHD, it is important to consider how inattention might impact their exposure experience. Changes in a patient's reported distress level may be due to inattention instead of a natural decrease in anxiety. For example, during an imaginal exposure in which a patient is asked to picture a feared event, it may be particularly difficult to gauge the degree to which a patient is fully engaged in an exposure or whether they have been distracted by another stimuli, such as a sound, loose thread on their shirt, or a wandering thought.

While inattention and impulsivity may present unique challenges for exposure therapy, there are specific tools that clinicians can use to address ADHD symptoms during exposure therapy.

Tools

Caregiver involvement and behavioral management tools can be integrated into treatment to support patients with comorbid ADHD during exposure therapy. The tools mentioned below are skills that clinicians, caregivers, and teachers can utilize. They can be modeled by the clinician during sessions and presented to caregivers as tools to utilize outside of sessions.

- **Parent involvement.** While caregiver involvement is often an important

aspect of therapeutic treatment for youth, caregiver participation and behavioral management training are particularly useful tools for patients with comorbid ADHD. In addition to behavioral training and psychoeducation, caregivers can observe therapist-led exposures and practice leading exposures themselves. Caregiver understanding of and involvement in exposures is especially helpful in mitigating difficulties that patients with ADHD might face in carrying out exposures, such as difficulty initiating homework exposures on their own.

- **Labeled praise.** In addition to parent involvement, providing labeled praise to patients with ADHD

For example, during a bug exposure, a clinician might ask a patient questions about the bug's appearance, such as "what color is the bug?", "how large is it?", "how many legs does it have?" to encourage the patient to attend closely to the bug. . . . clinicians can scale their use of these statements in response to patient's reported distress level and appeared anxiety to ensure that exposures are a manageable difficulty level.

for their effort and attention during exposures is a powerful tool. Labeled praise, providing a compliment with specific language about what a patient has done well, clearly signals specific behaviors you would like to see a patient engage in more. The labeled aspect of praise (i.e., "Great job keeping your hand near that bug") also re-engages a child's focus and acts as a reminder about the exposure task. Specific praise is not only reinforcing in terms of patients' positive behaviors and motivation to engage in exposures but may be used to increase the difficulty of an exposure. For example, statements like, "Great job looking at the *big nasty fly*"

or "Good work resisting *washing your hands* after touching that *dirty pencil*" signal to the child what they are doing well and increase the salience of the feared stimuli.

- **Attention statements and questions.** Clinicians can use statements that aim to refocus a patient's attention. Keep a running narrative by describing what the patient is doing, asking the child to describe what is happening, or asking attention questions to refocus a patient's attention. For example, during a bug exposure, a clinician might ask a patient questions about the bug's appearance, such as "what color is the bug?", "how large is it?", "how many legs does it have?" to encourage the patient to attend closely to the bug. As with labeled praise, specific questions and running narratives about an exposure can make an exposure more difficult. Therefore, clinicians can scale their use of these statements in response to patient's reported distress level and appeared anxiety to ensure that exposures are a manageable difficulty level.
- **Active ignoring.** Clinicians can also utilize active ignoring of behaviors they wish to see decrease, paired with labeled praise for behaviors they want to see increase, to better manage session time and noncompliance. For example, if a patient retreats to the other side of the room to play with a toy, a clinician can clearly label their expectation, such as "Please come back and sit down in your chair" and then turn away from the patient and only reengage the patient in conversation when they display positive behaviors (i.e., "Thank you for coming closer. Please sit in your chair" or "Thank you for rejoining me. Great listening!"). If a patient becomes emotionally dysregulated or engages in unsafe activities, active ignoring should cease until the patient is better regulated. While active ignoring can be utilized to shape patients' behaviors, and can be used in response to reassurance seeking, it should not be broadly applied to anxious distress or ritualizing.
- **Reward systems.** Reward systems can act as an incentive to stay on

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track with exposure goals, create a tangible representation of a patient's hard work, and become a point of pride for patients. This is a particularly affirming experience for patients with ADHD who often experience rejection and negative attention at school and in social situations (Mrug et al., 2012). A reward system that allows for both immediate in-session rewards (e.g., break or game) and future rewards (e.g., point system that can be used to earn special time with family, preferred foods, or small toys) is particularly helpful in motivating patients. While reward systems are not necessary, they can act as a helpful interim incentive for completing exposures and counteract the short-term incentive of avoiding feared stimuli, until the benefits of symptom alleviation become apparent. Sticker charts that provide a visual representation of rewards are particularly helpful for younger children and visual learners (older patients may choose to keep a running tally or use a jar of marbles).

- **Increasing engagement.** Some patients may present with opposition to exposures. Clinicians should avoid using punishments to encourage exposure practice, and patients should agree to exposures. When patients are opposed to trying exposures, it is important that clinicians try to understand why. Exposures that are too difficult may cause significant distress and discourage patients from attempting exposures in the

future. If a patient reports that an exposure is too difficult, choose a less difficult exposure. If a patient is feeling unmotivated or tired, validate their experience while reiterating the importance of attempting exposures during difficult moments (i.e., "I know you aren't feeling up to an exposure today and I think it's important that we still try one."). If a patient presents as oppositional and does not report any of these emotional barriers (although they may still be present), provide encouragement, remind the patient of a reward they can receive for attempting an exposure and set a limit (i.e., "I think you can give it a try. I know you are brave. If we do one exposure, we can play a game. If we don't, we will do exposure planning for the rest of session"). In this instance, it is especially important to provide labeled praise when a patient is willing to engage in session to any degree or attempt an exposure. In some cases, a clinician may decide to forgo completing an exposure to discuss an emergent crisis of the week or to protect their rapport with a patient.

Children with ADHD may experience additional challenges during exposure therapy due to dysfunction in attention and impulse control. However, to support youth with ADHD in completing exposures, clinicians can utilize attention questions and statements to increase focus on exposure tasks, behavioral management tools — such as labeled praise, active

ignoring, and reward systems — and caregiver involvement.

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Jennifer Freeman, Ph.D., is the Director of Research and Training at the Pediatric Anxiety Research Center (PARC), Associate Director of Research at Bradley Hospital, and Professor (Research) of Psychiatry and Human Behavior at the Warren Alpert Medical School of Brown University. Dr. Freeman provides clinical services to youth with anxiety, OCD, and related disorders. Dr. Freeman's current research is focused on health services-related questions about barriers to accessing CBT for youth with anxiety disorders.

Jennifer Herren, Ph.D., is a staff psychologist at the Pediatric Anxiety Research Center (PARC) and an Assistant Professor (Clinician Educator) in the Department of Psychiatry and Human Behavior at Brown University.

Grace Cain, B.A., is a clinical research assistant at the Pediatric Anxiety Research Center (PARC). She started working at PARC in June 2020 after receiving her B.A. in Psychology with a minor in Child and Family Studies from Bryn Mawr College.

Diversity

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contribute to racial and ethnic disparities in healthcare. The report contended that cultural competency training for clinicians can help close healthcare disparities for racial and ethnic minorities.

From cultural competence...

Simply put, cultural competence is the ability to interact effectively with people of different cultures. It has been described as a necessary condition for working effectively with diverse patients. It is a skill that can be taught or acquired. It comprises four components: 1) awareness of one's own cultural

worldview; 2) attitude towards cultural differences; 3) knowledge of different cultural practices and worldviews; and 4) cross cul-

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tural skills. It operates under the assumption that enhanced knowledge about another

culture will result in greater competency in practice. However, the behavior and beliefs of people might not always reflect those of their cultures. And the knowledge of culture alone is not sufficient to predict the behaviors and attitudes of patients. Cultural competence has been criticized for its focus on factual knowledge and its potential to stereotype cultural groups (Fisher-Borne, Cain & Martin, 2015). This led to a shift from cultural competence frameworks to that of cultural humility and sensitivity.

...to cultural humility

In 1998, Tervalon and Murray-Garcia introduced cultural humility as a more suitable approach to multiculturalism. Cultural humility is a dynamic process of