FOR PROVIDERS: FAST-A FAQS AND COMMON CHALLENGES

We have compiled a list of the most frequently asked questions and trouble-shooting topics from our trainings and consultations. Click on any of these topics to visit that section of the document.

There is a ton of information in here! You don’t have to know all of this to get started using FAST-A. You can go ahead and use the basic materials and come here for troubleshooting.

If you have additional questions feel free to reach out to our team at FAST@SeattleChildrens.org

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Do I have to go through every page of FAST-A with every family?

Nope! We’ve tried to create a flexible set of tools that you can use in different ways depending on your setting and the amount time you have with families, as well as the different levels of support each family might need. In fact, sometimes we only need one session of exposures (e.g., specific phobias).

Some families might benefit from the FAST-A Brief Version, while others might benefit from all (or parts) of the full FAST-A workbooks for children and teens. Sometimes you might just go over the FAST-A 2-pager for caregivers to give them the basic ideas and get them started. Even if you use the full workbooks, you might skip over some pages if you are short on time. The main thing is helping kids and their caregivers quickly begin the work of overcoming fears of normal situations by facing them.
Should caregivers participate in FAST-A meetings?

Ideally, caregivers can participate in every meeting and learn the skills to become their youth’s main support person. This can make treatment more efficient and improvements more durable. As you can see, we often ask that caregivers change their behaviors too! For younger children (younger than 7yo), caregivers are the primary people you would work with to address a child’s anxiety.

However, there are times when teens may choose to seek treatment without the knowledge or participation of caregivers, or when a teen will not participate openly with a caregiver present in meetings. This is especially true when anxiety pertains to something that feels very personal or embarrassing. Providers are welcome to adapt FAST-A to these different circumstances by reducing the session time that includes caregivers or only meeting with the teen to optimize youth engagement. Sometimes youth become more tolerant of caregiver participation over time, as they overcome some of their distress. It is not recommended to only meet with young children without involving caregivers.

When do I stop FAST-A?

The full FAST-A workbooks are designed to be deliverable in as few as 4 (50 minute) meetings, but providers can use FAST-A across more meetings if their setting allows for that, or their session lengths are shorter. You can discontinue regular meetings when you feel the family understands the skills, has begun to see improvement, and has a reasonable plan for continuing to work on anxiety issues independently.

You may also discontinue sessions as a patient transitions to a higher level of care (e.g., weekly therapy with a community-based outpatient therapist).

Some providers plan periodic check-ins or booster meetings to support continued progress over time. Other providers use FAST-A materials to help them deliver more intensive outpatient care of longer duration. Feel free to flex the tools to fit the needs of your setting and the families you work with.

Why doesn’t FAST-A teach relaxation skills?

Some treatment models for anxiety include a focus on training relaxation skills. FAST-A does not include this focus for several reasons: 1) Growing evidence suggests the inclusion of relaxation strategies may actually decrease treatment effectiveness, 2) Research has shown that exposure-only models are effective, and 3) FAST-A is streamlined for efficiency – by eliminating relaxation training youth can progress through treatment and see improvement even quicker.
From our perspective, there are several reasons relaxation skills may interfere with treatment for anxiety: 1) The focus on relaxation delays the key treatment ingredient (exposure), 2) Provider credibility goes down when we teach skills that do not solve the problem, 3) Patients become demoralized when they are told to relax but the skills don’t make them feel relaxed in their feared situations, and 4) Teaching relaxation can send the unhelpful message that anxiety is bad and that you need to reduce anxiety in order to face fears and function well. In contrast, learning that anxiety is not dangerous or intolerable, and that one can function well even in the presence of high anxiety, is helpful.

**Are there times we SHOULD teach emotion regulation skills?**

We recommend teaching emotion regulation skills only if needed to replace dangerous coping strategies such as non-suicidal self-injury or suicidal ideation. However, for most youth with an anxiety disorder, and without a history of unsafe coping or suicidal ideation, a course of treatment involving thoughtfully chosen brave practices that are conducted voluntarily should not require teaching of emotion regulation skills.

**Why don’t you teach kids to challenge their anxious thoughts?**

Historically, CBT for anxiety has often involved encouraging youth to notice and argue against their anxious thoughts, for example by examining the evidence that their anxious thoughts are not accurate. There are several reasons we do not encourage this practice in FAST-A:

1) Research supports the effectiveness of exposure-focused treatments without the cognitive thought-challenging component, so we opted for the simpler model to increase clarity, efficiency and learnability for both providers and families.
2) Our model uses experiential learning to challenge anxious thoughts (i.e., having new experiences that disprove the youth’s inaccurate anxious expectations). Emerging research suggests this may be more effective.
3) The mental exercise of challenging thoughts and examining evidence can become an unhelpful mental avoidance ritual, particularly for youth with OCD or GAD.
4) Research on exposure treatment has also found that it is helpful to enter exposure practice with one’s fearful negative predictions intact, because exposure learning is maximized when one’s mental expectations are very different from the exposure experience.

In conclusion, while a treatment focus on cognitive techniques to challenge anxious thinking may not be harmful for most youths, research supports our decision to prioritize exposure in FAST-A.
What about when the anxiety is linked to trauma?

Anxiety in the aftermath of a traumatic experience is normal. When heightened anxiety persists over time, even after the danger has passed, this may indicate a need for trauma-focused treatment. While exposure (facing distressing memories and feared-but-safe situations) is often at the heart of evidence-based treatments for trauma, there are other components of trauma treatment that may be important (such as making safety plans for ongoing risks, addressing painful trauma-related thoughts, or repairing important relationships). Rather than treating trauma-related anxiety with FAST-A, we recommend screening carefully for trauma and post-traumatic stress symptoms as part of your initial evaluation (using tools such as the CTS or CATS) and then referring for (or providing) trauma-specific interventions for youth who are affected.

What about when there is comorbid depression?

These gray boxes provide a quick reference:

**Start with FAST-A when:**
- Anxiety is a primary presenting concern
- Depressive symptoms appear to be caused by anxiety and anxiety-related impairment

*Useful strategies:*
- You may integrate brief psychoeducation about depression (such as with the FAST-D 2-pager) and briefly address relevant concerns such as poor sleep routine.
- Prioritize exposures that are behaviorally activating.
- Continue to regularly assess depressive symptoms (such as with the PHQ9) and shift the focus of treatment as needed if symptoms do not resolve.

**Start with FAST-D when:**
- The biggest presenting concerns have to do with mood
- Depressive symptoms appear to be caused by other stressors (not anxiety and associated impairment)

*Useful strategies:*
- You may integrate a brief focus on anxiety using the FAST-A Brief Version and/or the FAST-A Caregiver 2-pager.
- If anxiety interferes with follow through on intended behavior changes in FAST-D, you can shift to use FAST-A strategies and tools.

Here is the longer answer:
Comorbid anxiety and depression concerns are extremely common, especially in teens. Often anxiety problems precede the depression and contribute to the depression by interfering with functioning, blocking youth from the normally rewarding activities and social connection and positive identity development and progress toward goals that would otherwise promote good mood.

There is overlap between the key strategies of FAST-A and FAST-D in that both involve stopping avoidant coping and moving toward what is important to the youth even when that might be stressful or require some new skills or planning.

Given the difficulty of following through with activation strategies in the presence of untreated anxiety, and given the overall stronger treatment effects for anxiety interventions relative to depression interventions, we usually recommend starting with FAST-A. Particularly when anxiety problems seem to be driving the depression, FAST-A is a good starting point.

However, if the biggest presenting concerns have to do with mood, and if depression does NOT seem primarily driven by anxiety interference, but rather seems to have been triggered by a social stressor or other disruption, FAST-D may be a better starting point. FAST-A concepts can be taught in a brief way if needed.

When delivering FAST-A to a youth with comorbid anxiety and depression concerns, try to focus on exposures (“brave practices”) that are rewarding and activating and seem likely to improve the youth’s mood. Consider adding in brief education about depression and brief focus on relevant FAST-D targets (e.g., activation, sleep changes, or problem-solving), particularly if the youth’s ability to participate in FAST-A seems compromised by low mood.

If you do start with FAST-A, we recommend continuing to track depression symptoms over time using a measure like the PHQ-9. That way, if depression does not improve with FAST-A treatment, or if concerns related to suicidal ideation are identified, treatment can shift to focus on those concerns. Addition of a medication shown to help with anxiety and depression may also be considered.

**What about when there is comorbid disruptive behavior?**

Comorbid anxiety and disruptive behavior is common, in part because many youths have learned (consciously or unconsciously) that disruptive behavior works to get them out of situations they find frightening or stressful. Disruptive behavior may also be a manifestation of the “fight/flight/freeze” response that arises when an individual feels threatened.

First, assess whether disruptive behavior primarily occurs in the context of anxiety or feared situations. If yes, a course of FAST-A focused on reducing the anxiety may be
effective to address the disruptive behavior. Adding in caregiver skills from FAST-B or FAST-P, such as providing incentives for facing anxiety-provoking situations without engaging in disruptive behavior, or improving a caregiver-child relationship that has become strained by negative interactions, may also be helpful.

For other youth, disruptive behavior occurs outside the context of anxiety and will benefit from teaching caregiver skills shown to improve disruptive behavior (see FAST-B and FAST-P programs). Whether to begin with FAST-A or FAST-B/P in these situations may depend on what is causing the most impairment (anxiety or behavior) and whether the youth is motivated to participate in FAST-A treatment for anxiety.

Combined or concurrent FAST-A and FAST-B/P treatment is another option if provider and family time/resources allow.

What about when the youth cannot identify any specific fears for the situation?

FAST-A directs providers and families to identify the youth’s fear predictions (overestimating the likelihood or badness of feared outcomes, or underestimating one’s ability to cope) so that brave practices can be designed to experientially test out and disprove those predictions.

However, some youth struggle to articulate why they avoid certain situations. Various forms this can take, and strategies you can try, are described below.

- Some youth can be helped to identify their fears by asking simpler, specific, concrete questions, like, “If you do [insert specific brave practice], what do you think would happen? What else might happen?” instead of using words like “fears” or “thoughts” which can be abstract for some youth.

- Other youth struggle to articulate their fears because the fears feel too frightening to speak aloud (e.g., the imagined death of a caregiver) or produce shame (e.g., intrusive aggressive or sexual thoughts in OCD) or the youth fears that talking about it could make it happen (e.g., talking about fear of vomiting causes stomach distress and nausea so it feels risky to describe). Providers may have success by excusing caregivers from the room, offering some educated guesses about common reasons for not wanting to talk about it to see if those fit, and then being ready to normalize the youth’s concerns, showing that the youth will not be judged and the provider will not be shocked by whatever the youth might have to share.

- Other youth do not have specific fears so much as discomfort with the situation they avoid (such as finding it overstimulating or aversive on a sensory level) or when something must feel just right (such as repeating behaviors until something feels just right for youth with OCD). In some cases accommodation
(e.g., noise canceling headphones for a youth on the autism spectrum) may be reasonable to help the youth participate in an important activity or setting. In other cases (e.g., OCD repeating behaviors example from above), exposure/brave practice will be appropriate to test out a youth’s specific negative expectations about their body’s response to the situation, such as how strong that response would be, how it might change over repeated exposures, and how long the reaction would last and at what intensity if they persisted with the exposure. Incentives may also be added to encourage youths to practice tolerating situations they do not prefer but that are important for their development (e.g., remaining in the classroom).

- Other youth may need support with learning skills or developing plans to manage the things that make them uncomfortable in an avoided situation (e.g., getting along with peers during recess, signaling to a teacher when they need to use the bathroom). Youth with missing social skills may not have good insight into what is going awry in these uncomfortable situations, so providers may benefit from seeking input from adults in their environment to understand the possible sources of stress and skills or plans that may relieve that stress.

- In many cases, when a youth is not afraid but simply prefers to avoid the situation (such as a perfectionistic youth meticulously perfecting an art project to the extent it interferes with other educational goals), motivational conversations (e.g., exploring the costs of continuing to engage in perfectionism) can build a youth’s willingness to gradually get used to their avoided situations or stimuli (taking less time, work products being less perfect).

- Some youth, especially young children, may be avoidant of separation from caregivers, not due to specific fears, but because the presence of the caregiver helps them feel safer, protected and emotionally regulated more generally. It is natural for children to want to stay close to their caregivers as a product of evolution: Young humans are not well equipped to protect themselves from danger so moving closer to caregivers when feeling threatened is adaptive. Additional strategies for young children who resist separation can be to help them bond with adults in the new setting, become more familiar with the new setting and its routines, create positive and distracting activities upon separation, practice and incentivize good separation behavior, and discontinue parental responses that reinforce clinging and escalation (such as staying longer when the child acts up).

- Individuals with vasovagal syncope (fainting) may avoid certain stimuli or situations due to feelings of disgust, unease or discomfort, rather than any specific identifiable fear. Vasovagal syncope and associated strategies are discussed in the next section below.
What about youth who faint at the sign of blood, needles or injury?

Some youth experience a phenomenon called vasovagal syncope (fainting) in response to certain stimuli, such as the sight of blood, needles or injuries. Before fainting, individuals may experience feelings of disgust, nausea, dizziness, and general unease. Individuals may or may not experience fear that something bad will happen. While syncope is not dangerous in itself, falls from fainting can result in injury, so individuals with this tendency can be prepared with strategies such as lying down and elevating one’s legs, or sitting with one’s head between their knees so gravity will keep blood pressure from dropping in the brain. Applied Tension is another commonly used strategy for keeping blood pressure from dropping. Individuals should be discouraged from getting up suddenly to try to leave the situation as they may faint while standing. Brave practice with the stimuli that cause vasovagal syncope can reduce anxiety and the body’s reactions over time.

What about when the youth is not motivated to overcome their fears?

Kids and teens may not be eager to face their fears. Here are some strategies to try:

- **Make sure they understand the rationale** for facing fears and connect facing fears to the youth’s own goals (which may include simply feeling less anxious).
- **Have a motivational conversation**: Use a decisional balance approach to explore the pros and cons of treatment vs. letting things stay as they are. Elicit their ideas about ways life would be different if they could overcome their fears. Explore the downsides of continued avoidance.
- **Add incentives**. Encourage caregivers to reward the youth’s bravery. Small rewards can help, as well as promise of a larger reward when the youth meets a certain milestone (e.g., child with needle phobia becomes fully vaccinated).
- **Reduce accommodation**. Accommodation refers to things other people (often caregivers) do to help the patient avoid the age-appropriate, normal-risk situations that make them feel scared. Accommodations (like driving the long way to school to avoid scary bridges) help the patient feel more comfortable even though they have an untreated anxiety disorder. Common examples of accommodation are listed on the FAST-A 2-pager for caregivers. Reducing accommodation is exposure practice for youth; youth will be subjected to more uncomfortable situations or costs related to their anxiety and as a result they may become more motivated to participate in treatment. It is often best to reduce accommodations gradually and thoughtfully (vs. thrusting youths in to high anxiety situations without warning). Caregivers can prepare a statement such as “We’ve realized by doing [insert accommodation] we are not helping you and are actually making your anxiety worse over time. We love you too much to keep making this mistake and so we will start [describe immediate or gradual changes]. We know it will be hard but we also believe in you. Your FAST counselor can also help you prepare so you’ll be ready for these changes.”
What about when a youth gets freaked out and refuses an exposure?

Sometimes, despite agreeing to and intending to do an exposure, a youth will become anxious and suddenly refuse to do it, or will try to escape the situation mid-exposure. In that moment, full-scale retreat (doing no exposure, avoiding completely) will likely make future attempts more scary. Good strategies for this situation include:

- **Validating** that is hard/scary.
  “I get this feels super scary to you. You are doing a great job.”

- Identifying a modified or **slightly easier** brave practice they would be willing to do instead; find one step forward.
  “I can see this one is feeling too hard for you right now. Do you want to find something else we can do that feels a little easier, to start with?”

- **Reviewing the rationale** for why we are doing this.
  “Remember why we are doing this?”

- **Expressing confidence** in the youth and waiting supportively for a minute to see if they are able to proceed.
  “I believe in you. You can do this.”

- Ultimately, making sure the **youth feels they are in control** of what they do and do not try. If they feel cornered or forced into exposures they may not trust you and may be reluctant to return for future meetings.
  “You get to decide what you’re ready for. You’re in charge here.”

What about when anxiety isn’t decreasing during an exposure or across lots of exposures?

It is often helpful to ask patients to rate their level of anxiety during exposures on a scale from 0 (calm, no anxiety) to 10 (the most scared/anxious ever felt).

Very often during an exposure we will see fear ratings drop as the patient takes in the information that their fear expectations were not accurate. Ideally, patients will experience a drop in their anxiety level well before the end of the treatment session, so they do not leave in a state of high anxiety. Leaving session on a highly anxious note can sometimes make returning to a future session feel more daunting so it’s best to try to time exposures so there is enough time for new learning to occur and for anxiety to drop.

However, research has found that exposures can be effective even if the anxiety does not drop within a single exposure. The important thing about exposure is that the patient is fully engaged and participating, and is taking in new information that contradicts what they feared would happen.

To summarize: **Anxiety tends to drop during a single exposure but it doesn’t have to.**
That said, we DO expect to see anxiety decrease across repeated exposures to the same situation.

When anxiety remains high across many repeated exposures, the following troubleshooting strategies can be helpful:

- Check to see if the patient appears to be learning that their feared outcomes are less likely, less bad or more manageable.
  “From 0-100%, how likely does it feel that [feared outcome] will happen if you do [brave practice] again?”
- Check to see if the patient is engaging in avoidance behaviors during the exposure, such as distracting themselves, mentally reassuring themselves in some way, or using an unnecessary safety behavior that keeps them from learning the situation is safe. A replacement for mental self-reassurance is to “sit with uncertainty” and acknowledge that “maybe” their feared outcome could happen. The key is allowing the discomfort of that uncertainty to rise and fall without doing anything about it.
- Consider whether exposures are long enough (does the client briefly enter the situation and retreat while still in fear? should we experiment with longer exposures?) or frequent enough (might they benefit from repeated practice to really extinguish their fear expectations? are they doing enough at-home practice?) or well-designed enough (do the exposures actually provide an opportunity to disprove the patient’s core fears?) and did we prepare enough (did we identify falsifiable predictions, for example “my distress will last w minutes at x level” “I could not tolerate this more than y minutes without doing z” “if I do w and x for y minutes, then z would definitely happen”?) and did we debrief well (am I helping the patient take in the disconfirming evidence? are they over-focused on other things, such as judging themselves for being awkward or bad in some subjective way?)

In some cases, youths may simply need a higher level of care, such as adding a medication or enrolling in more intensive outpatient treatment, in order to benefit from these strategies.

What about when a youth seems to get more frightened after an exposure?

Occasionally an exposure experience will be “sensitizing” to the patient, meaning it results in increased anxiety. This most commonly occurs when the patient agrees to do something that they find very frightening, but then the patient does not remain in the exposure long enough to take in new safety learning, and the patient leaves the exposure situation in a state of high anxiety.

To prevent sensitizing exposures from derailing treatment, it is helpful to be sure you give patients enough time in early sessions to have a successful exposure experience. It can also help to choose early exposures for which the client’s fears are readily falsifiable, and during which patients are likely to experience relief. As sensitization can also occur
during between-session exposure practice, it helps to plan those practices well and be specific about when practices will be discontinued. And be sure to plan for homework! Sometimes a successful exposure in session, if followed by a week of avoidance, will come to feel scary and the patient may be reluctant to continue.

When sensitizing exposures do occur, it helps to acknowledge them and explain to the patient what happened so the patient does not begin to lose faith in exposure as something that will help them feel better.

**And what if the feared outcome actually happens?**

Sometimes exposures are sensitizing because the patient’s feared outcome actually occurs. For example, a family member could become ill or pass away after the patient discontinues a superstitious ritual designed to protect their loved ones; or a patient who fears vomiting actually vomits while doing an exposure about vomit (e.g., watching a vomit video).

Since we cannot predict the future, we want to be careful not to suggest exposures will “prove” their fears are impossible. We can prepare for the possibility of feared outcomes occurring by identifying all three types of fear expectations prior to the exposure: 1) The feared outcome is likely, 2) The feared outcome would be extremely bad, and 3) I could not manage it. By elaborating on the 2nd and 3rd expectations in detail, predicting all the ways it would be very bad and all the ways the patient would not cope well, we may still have an opportunity to find substantial counter-evidence in the experience of the feared outcome occurring.

In many anxiety disorders, the patients’ fears are **unlikely but not impossible**. Exposures are designed to be low risk (on par with the risks most people accept in their daily lives) but they are usually not without ANY risk. The reason we still do them, and tolerate the uncertainty that bad things could occur, is that for the individuals we treat, the avoidance behavior has been substantially interfering with their lives and goals and has been generating unnecessary anxious distress. And in many cases, the avoidance behavior the individual has been engaging in doesn’t actually guarantee that nothing bad will happen.

**Are there special strategies for generalized anxiety, where there isn’t one specific fear?**

Individuals with generalized anxiety experience frequent anxious distress related to a variety of fears, which can sometimes make treatment planning more confusing for the provider. In many cases there will still be one or two recurrent, specific situations or fears that are quite distressing and impairing, and these can be prioritized for brave practice.
A key principle to keep in mind is that **where there is excessive anxiety you can expect to find excessive avoidance**. Avoidance provides immediate relief but in the longer term it maintains anxiety by preventing individuals from learning they don’t need to be so anxious. Find the excessive avoidance and discontinue it. There will be a rise in anxiety immediately but as new learning sets in, the anxiety will decrease.

Excessive avoidance may take many forms, including classic **avoidance of situations** (e.g., staying away from dogs) or **social avoidance behavior** (e.g., avoiding anxious distress by seeking unnecessary reassurance or help from others, or staying close to a caregiver) or **mental activities designed to reduce anxiety** about things that are uncertain (e.g., reviewing past situations, planning for future situations, making lists, or strategizing to prevent possible bad outcomes) or other **unnecessary safety behavior** (e.g., working an additional 2 hours on a homework project that was already likely to earn an A).

Once we understand the avoidance behavior, we can do exposure (brave practice) to situations that usually provoke that avoidance behavior and instead tolerate the anxiety without engaging in those behaviors. This might include imagining bad outcomes in detail and sitting with uncertainty, accepting that “maybe that could happen” and not engaging in any avoidance behavior in that moment.

**But what about real problems and fears?**

In addition to excessive fears about unrealistic situations, individuals with generalized anxiety are also more likely to become fearful and preoccupied about a range of **realistic fears** (e.g., earthquakes, crime, social rejection). It may be helpful to encourage individuals to learn skills, make plans or change the environment to reduce the likelihood of bad outcomes. See the FAST-A decision tree (page 1 of the FAST-A Brief Version, or page 15 of the full workbook) for guidance on when to encourage preparation vs. doing straight up brave practice without such preparation.

For many individuals with generalized anxiety, there may be a fuzzy boundary here (e.g., being prepared for earthquakes is good, but carrying around a 15 lb. backpack with emergency supplies everywhere you go is excessive and will likely fuel a higher level of day-to-day anxiety about earthquake danger). FAST-A providers can help individuals explore the costs and benefits of putting lots of ongoing energy into preparing for low likelihood events (costs: effort and increased ongoing distress and awareness; benefits: sometimes marginal safety enhancement).

**Are there special considerations or tips for treating OCD?**

The central FAST-A strategy of **exposure** (or “brave practice”) is the gold standard intervention treating obsessive-compulsive disorder (OCD). Below are some considerations for making FAST-A most effective with OCD.
First, OCD is comprised of obsessions (recurrent and uncomfortable thoughts, feelings or images) and compulsions (things someone does over and over to get rid of or manage the obsessions). An example is fearing dangerous contamination from unlikely sources and then washing or cleaning excessively to reduce anxiety about this. The compulsions tend to work well in the moment for reducing distress, but in the long run the avoidance prevents individuals from learning their obsession is not dangerous and can be tolerated.

Other anxiety disorders involve the same process—experiencing fear/distress and managing that distress through avoidance.

**How is OCD different from other anxiety disorders?**

The difference between OCD and other anxiety disorders is often fuzzy, but a defining feature of OCD is that in many cases the avoidance behavior (the compulsion) has become fairly rigid and consistent, or “ritualized.” OCD compulsions can also be motivated by feelings other than anxiety or fear, such as needing to make things feel “just right” or symmetrical. OCD also has some common “flavors” or domains, including: washing/cleaning, checking, repeating, counting, arranging/symmetry, hoarding/saving, superstitious behaviors, rituals involving a family member, concerns one might harm self/others, concerns with contamination, sexual obsessions, and religious/moral obsessions.

A helpful inventory for identifying all the flavors of OCD a given individual is experiencing, and for raising the individual’s awareness about what concerns can be understood as OCD, is the [CY-BOCS](#).

**Are there special ways to do exposure for OCD?**

There is a special term for exposure when treating OCD: “Exposure with response prevention;” If you follow the steps outlined in FAST-A materials, you will be facilitating exposure (facing feared situations) and response prevention (not engaging in typical avoidance strategies).

In the FAST-A materials you will find examples of highly effective OCD exposures to help spark your creativity as you work with individuals with OCD. But remember, just like with all exposure practice, the exposures must be tailored to the individual, designed to evoke their obsessions and, by not engaging in avoidance, allowing them to encounter disconfirming evidence regarding 1) bad things happening, 2) how bad those things would be, and/or 3) how poorly the individual believes they would cope.
What does anxiety treatment look like with young children?

Research shows that exposure-based CBT works well for young children with anxiety too. The primary difference in treatment with very young children is that the caregivers take the lead. In collaboration with their clinician, caregivers work to identify accommodations they are making (ways they are helping their young child avoid anxiety-provoking but developmentally appropriate situations) and then find opportunities for exposure (encountering feared situations) to allow their child to practice developmentally-appropriate skills (e.g., separating during school drop-off) and get used to feared situations.