Commentary on Adapting an Exposure and Response Prevention Manual To Treat Youth Obsessive-Compulsive Disorder and Comorbid Anxiety Disorder: The Case of "Daniel"

Forests and Trees: Commentary on the Case of "Daniel"

MARTIN E. FRANKLIN [a,b,c]

[a] University of Pennsylvania School of Medicine, Philadelphia, PA
[b] Rogers Behavioral Health – Philadelphia, PA
[c] Correspondence regarding this article should be sent to: Marin E. Franklin, COTTAGe, University of Pennsylvania School of Medicine, 3535 Market Street, 6th floor, Philadelphia, PA 19104
Email: marty@pennmedicine.upenn.edu

ABSTRACT

The Case of "Daniel" (Tice, 2019) provides an in-depth look at the implementation of an empirically supported psychotherapy, Exposure and Response Prevention (E/RP), in the treatment of a boy with a severe and complex symptom presentation. The discussion begins with explication of guiding theory pertaining both to the disorders that were targeted, Obsessive-Compulsive Disorder (OCD) and generalized anxiety disorder (GAD), as well as their cognitive-behavioral treatment. The assessment and hierarchy-development aspects of the case are presented, and treatment targets identified. Implementation of E/RP followed a specific treatment manual, but the discussion of case material goes beyond the manual in addressing the interpersonal context of therapy, challenges met and overcome along the way, and the importance of using positive reinforcement for effort in keeping a child moving successfully towards more and more challenging tasks. The role of the therapist's own interpersonal style is also addressed in how this factor may facilitate and complicate treatment delivery, and therapists are encouraged to examine how this may affect what they do and do not do even in the context of protocol-driven treatment.

Key words: Obsessive-Compulsive Disorder (OCD); Exposure plus response prevention (E/RP), children and adolescents; cognitive-behavioral therapy; case study; clinical case study

---

INTRODUCTION

The first task required when attempting to comment coherently on a case study like that of Dr. Alexander Tice's client "Daniel" is to lay out the pathway one wishes to traverse. In this instance, my hope is to bring the reader first through the case from the standpoint of guiding theory, both the theory of generalized anxiety disorder and that of obsessive-compulsive disorder, and of their treatment via cognitive-behavioral methods.

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu/
Volume 15, Module 1, Article 2, pp. 75-83, 03-22-19 [copyright by author]

From there, we delve into how these theoretical concepts interact with the clinical details of the case, and how specific cognitive and behavioral techniques are chosen and employed based on guiding theory. Indeed, Tice has assisted us in conducting such an analysis by carefully laying out separate sections explicating theory, case formulation, and treatment course, which are visited in sufficient detail to promote understanding of how these pieces fit together in informing and driving the interventions provided.

However, there are broader ideas at work here too, and revisiting those more non-specific issues may help round out the contribution of the Case of Daniel in terms of presenting a generalizable conclusion that is applicable both to this case but also beyond it, to other cases one may encounter in clinical practice. After nearly three decades of subspecialty practice in the area of OCD, it is my habit to confound my students initially by telling them that every single case of OCD is different, and yet every single case is also exactly the same. My hope is to unpack that *koan* as I discuss this case study in particular.

THE FOREST OF THEORY

Theory begins with the definitions of the concepts we wish to explain, and Tice has, appropriately enough, done exactly that within Section 3 of his case study. Obsessions and compulsions are defined in accordance with the DSM-5 (APA, 2013), a consensus document informed both by expert opinion as well as scientific inquiry. The functional link between obsessions and compulsions is also emphasized, i.e., obsessions give rise to anxiety or discomfort, and compulsions are intentional behaviors or mental acts designed to reduce the obsessional distress or the likelihood of a feared outcome. DSM-5 is intentionally agnostic with respect to causality or, specifically in the case of OCD, providing a reason why obsessions occur in the first place. Indeed, even classic cognitive-behavioral theories like Mowrer's Two Stage Theory (1960) is similarly indifferent to this phenomenological origin. Dissatisfaction with this stage of affairs led to the explication of more detailed cognitive and cognitive-behavioral accounts of OCD, several of which are described in this section.

Tice then describes the most influential of these integrated cognitive-behavioral models, the one put forth by Foa and Kozak (1985, 1986) under the broad umbrella term of "Emotional Processing Theory." In Emotional Processing Theory, repeated exposure to feared stimuli (e.g., thoughts, situations) works to reduce fear and associated functional impairment *because* it provides opportunities to receive corrective information inconsistent with what is contained about these associations in the "fear network." What is crucial here is that in OCD in particular, compulsions (like handwashing) and other forms of passive avoidance (e.g., not touching contaminated surfaces) must be reduced and ultimately eliminated in order for such corrective information to be generated. For example, if a child believes that a parent will die if the child experiences such a thought unless the child engages in extensive repeating compulsions, then experiencing the thought without refraining from the compulsions in theory will produce little relief or improvement because disconfirmation is prevented by the compulsions themselves.

Thus, Emotional Processing theory demands that compulsions must be eliminated in order to foster this crucial cognitive change. This fundamental theoretical tenet, which is

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu/
Volume 15, Module 1, Article 2, pp. 75-83, 03-22-19 [copyright by author]

strongly emphasized in the supervision of OCD cases being treated with ERP, then translates to a difficult clinical reality, which is that the therapist must somehow convince a child to take this risk and refrain from behaviors that he/she believes will keep the parent safe. In Tice's case of Daniel, the primary obsessional fear has to do with getting sick via contamination, and the compulsions that prevent disconfirmation involve washing. Tice brings us through this translational process in the case details but, as I explicate in further detail below, leaves out some of the non-specific methods used to help this particular child make such a leap of faith. Theory notwithstanding, the therapist's demeanor matters a great deal in bringing theory to life in the clinic. How this is done must be emphasized more fully in writing about E/RP procedures, lest therapists continue to give short shrift to this delicate interpersonal process that is made even more complicated by the involvement of family members who must also learn to promote learning at the expense of reassurance. Not an easy task, I assure you.

Tice also grapples with GAD definitions and guiding theory in this section, as well as the theoretical overlap between OCD and GAD. This theoretical overlap, as well as non-overlap, has clinical implications as described in the treatment section, but perhaps deserves greater explication here. These conditions resemble one another in some ways, yet are still considered to be distinct entities; moreover, comorbidity of GAD in OCD is a common occurrence (e.g., Masi et al., 2004), which further complicated the clinical picture and selection of techniques for Daniel. Comer and colleagues (2004) attempted to impose greater clarity on efforts to distinguish the two entities theoretically and, by extension, clinically, and they emphasized the following: 1) identification of an identifiable trigger, which is more likely in GAD than in OCD; 2) greater preponderance of imagery (OCD) as opposed to verbal content (GAD); 3) content that is more realistic and logical (GAD); and 4) greater reliance on active forms of avoidance to "neutralize" content (OCD).

The case of Daniel allows us an opportunity to see how such distinctions are made clinically and, by extension, which cognitive and behavioral techniques are emphasized depending on which category the worry/obsession is considered. GAD worries are, almost by definition, moving targets, and thus process-oriented procedures focused on improving tolerance of discomfort and of uncertainty may prove as valuable as exposure itself. In some contrast, the exposure-based procedures coupled with response prevention are considered the most active ingredient in the treatment of OCD, where the therapist teaches the patient to confront fear-evoking stimuli by leaning into them rather than away. While improvements in tolerance of uncertainty and of discomfort are byproducts of this approach, the primary targets are the thoughts and situations themselves that provoke the unwanted thoughts and feelings. This subtle distinction in treating GAD versus OCD is clearly evident in the approach Tice took in Daniel's case, and by all means of assessment it appears to have been highly successful.

HOW THEORY WAS APPLIED IN THE CASE OF DANIEL

Right up front in the assessment section, it is clear that Daniel spends a great deal of his time worrying/obsessing, and Tice is challenged right away in distinguishing which content is obsessional and which is better viewed as worry. The clear association between contamination-related obsessions and washing compulsions allows for a relatively straightforward decision

about that content. Alternatively, worries about world events, academic performance, and family health and finances could just as easily fall under the GAD umbrella, if not for the strong association with active forms of avoidance, i.e., compulsions, to neutralize the content and thereby reduce/eliminate associated anxiety.

From the standpoint of the selection of treatment techniques, designation of the content to either OCD or GAD concerns then led, as logic would have it, to the use of different techniques to address each in turn. For example, response prevention is a critical tool in combating OCD, whereas it is not as important in GAD, where active forms of avoidance are less likely to be used to escape discomfort or reduce the likelihood of associated harm. Accordingly, Tice employed response prevention techniques liberally in addressing the contamination fears. He did this by looking to reduce and ultimately eliminate all forms of active avoidance (e.g., washing) to prevent disconfirmation of feared outcomes (e.g., becoming sick) and of the need to do so in order to experience reduced distress both in the moment and long-term. Further, as is so often the case in OCD, parental accommodation had to be addressed essentially as another form of compulsion, and parent training around this issue was emphasized so as to reduce and ultimately eliminate this method of dealing with Daniel's OCD fears. Tice built the OCD hierarchy in the early treatment sessions, which was a reflection of our view that OCD was causing the most functional impairment and thus needed to be addressed first, even if done so hierarchically.

NON-SPECIFIC TREATMENT FACTORS

I was pleased indeed to see Tice specifically address the therapeutic relationship across treatment in his case description, as this is often given insufficient attention in the literature and even in treatment manuals that are putative guides to the implementation of treatment by less experienced therapists in the context of clinical trials. In the OCD treatment outcome literature there is little controversy about the importance of specific techniques in treatment: E/RP has been found more efficacious than a number of interventions that equate for therapist contact time (Freeman et al., 2014; Piacentini et al., 2011; Simpson et al., 2011), which clearly suggests the value of these specific procedures.

In a paper written specifically to help therapists develop expert-level competence in E/RP for pediatric OCD (Franklin et al., 2013), a number of non-specific factors are discussed. These are thought to be important in developing a proper therapeutic context to promote within and between session adherence to the manualized procedures and to foster the kind of interpersonal connection thought to support change. Specifically, expert therapists are thought to be able to: 1) make reliable predictions about OCD and the effects of treatment adherence as well as non-adherence; 2) keep the complex simple; 3) foster empathy and reduce the sense of being alone; and 4) help patients recognize that, in the words of poet Robert Frost, "the best way out is always through." These therapeutic accomplishments, and thinking through what should be accomplished in treatment, was driven by a desire to better understand the site effects found in the Pediatric OCD Treatment Study I ("POTS I"; Pediatric OCD Treatment Study Team, 2004).

Specifically, CBT alone at one site was substantially more efficacious than it was at another, while at the same time combined treatment with sertraline plus weekly CBT did not

differ at all between the sites. Efforts were made to create a common culture so as to foster a "POTS" way of coming at OCD, and it is interesting to note that no site effects were found in the subsequent POTS II (Franklin et al., 2011) and POTS Jr. (Freeman et al., 2014) studies conducted at the same clinical sites that participated in POTS I. Increased emphasis was placed in studying therapist training on setting an ambitious agenda in hierarchy creation, and in moving quickly up that hierarchy. Indeed, this same emphasis was also placed in training when I was invited to be the primary trainer in the NORDLOTS trial (Thomsen et al., 2013; Torp et al., 2015); notably, 40% of the CBT-treated sample achieved responder status at mid-treatment, with 73% achieving it at post-treatment.

It is from the above framework that clinical supervision in this case was driven, with emphasis upon (a) understanding of guiding theory, (b) the ability to explain the theory to the patient and his family, (c) mastery of the details of the CBT procedures to be implemented, and (d) attention to the non-specific factors thought to serve as the bedrock of the therapeutic intervention being provided. In OCD it is believed that a strong therapeutic alliance is not sufficient in and of itself to drive substantive symptom relief, as indicated in multiple randomized controlled trials that either did or did not include Exposure and Response Prevention (for a review see Franklin et al., 2013, 2015). At the same time, it is also believed that alliance strength is necessary in the successful implementation of *any* treatment. This is especially true of one that specifically requires that patients confront the situations that provoke their distress while reducing and ultimately eliminating the very coping behaviors they have been relying on to keep from being overwhelmed or to prevent dreaded outcomes. This is a tall order, and promoting a sense of support and confidence in the therapist in both patient and family can only help to make that easier to achieve.

THE INTERPERSONAL CONTEXT: WHAT TICE TOLD US

Tice begins the section on "The Therapeutic Relationship Across Treatment" by emphasizing the importance of "building a strong, open, honest, and trusting relationship with Daniel from the first session" (p. 50). Certainly this seems obvious, but Tice shares some of the ways that he attempted to do so, particularly including talking initially and in detail about Daniel's interests in sports and video games. Emphasizing the overlap in those interests is a great way to begin putting together the foundation upon which the entire treatment will later rest. Tice took his time in doing so, devoting session time to ensure that Daniel felt listened to, understood, and supported. It has been my experience as a supervisor that sometimes a less experienced therapist trying to implement manualized treatments does not pay sufficient attention to this developmental step, worried perhaps that the manual does not specifically explicate how this should go, or how long it should go, and thus such interaction might be viewed as "off task." It was clear though that Tice recognized the importance of this back and forth. He carefully allowed the relationship to breathe and develop before pushing Daniel to discuss difficult content and then confront anxiety-evoking thoughts and situations while simultaneously reducing and ultimately eliminating compulsions and other forms of avoidance. Tice states explicitly that E/RP is a challenging therapy that will necessitate the client pushing him- or herself outside the comfort zone, and the therapeutic relationship will be the vehicle by which this difficult territory is traversed.

Tice also recognized that, with a patient of Daniel's age, positive reinforcement in the form of rewards for efforts would be important. However, Tice also recognized that it would have been difficult to know what Daniel might actually have found rewarding if those early conversations had not allowed Tice to unearth this information. Such a search must be tailored to the specific patient, and thus manuals can only guide the process generally (e.g., "Provide time to engage in rewarding activities after successful completion of exposure tasks in session."). It is up to the therapist and supervisor to find the patient's interests and to know when to rely on them to move the treatment forward.

Another important element of alliance was humor, both as a reward for hard work well done, but also to help bridge difficult moments in treatment in which Daniel's mood needed improvement to help him engage more effectively in the therapy. As Tice's supervisor listening to the videotapes of his sessions, I could see that Tice was especially skilled at doing this, and successfully walked the fine line between using humor to move the treatment but without allowing it to interfere with engagement by serving as a distraction from the work at hand. This relational aspect of treatment was essential to the long-term outcome, and it is heartening to see it discussed in the case presentation on equal footing with theory and CBT procedures. Indeed, if that leg of the stool is rickety, then proper theoretical conceptualization and skilled implementation of CBT procedures would likely be insufficient to move the treatment towards a positive and durable outcome.

THE INTERPERSONAL CONTEXT: WHAT TICE DIDN'T TELL US

Academically oriented, clinical case study writing is a highly specific form of communication, wherein emphasis is placed on guiding theory, thoughtful and empirically justifiable selection of clinical targets, and detailed explication of how clinical procedures were used in the case under consideration. Appropriately enough, Tice provided each of these elements in detail, which allows us as readers to see the connection between each of these elements; he also spent time discussing the interpersonal and family context of the case and how these factors came into play in treatment. What does not—but really should because of its clinical impact—come out in high relief in formal writing of this kind are some of the even more specific aspects of the therapist's own interpersonal style that helped move the case along. Thus, because senior writers often feel less constrained by conventional writing rules, I take it upon myself to delve into greater detail about a key element of this treatment discussed at Tice's dissertation defense by his committee. The crucial point here is that Tice is an unfailingly positive person who brings palpable energy and enthusiasm to every context he finds himself in, and thus the rapport-building process comes very naturally to him. This was the strength upon which his entire treatment with Daniel was built, and in this case it allowed a young patient with severe and complex symptoms to feel comfortable enough to engage fully in a treatment that was designed intentionally to make him uncomfortable as much as possible.

At the same time, one may wonder whether unfailing positivity can potentially get in the way of providing direct feedback when the patient is not engaging sufficiently in the treatment, is not completing assignments between sessions competently, or does not understand in sufficient depth the key definitions and concepts that comprise E/RP. Tice duly noted that there were

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu/
Volume 15, Module 1, Article 2, pp. 75-83, 03-22-19 [copyright by author]

times in treatment when Daniel's partial compliance raised issues about his motivation, which in turn led to an exploration of whether Daniel understood the core concepts such that he could make changes to assignments on the fly, create his own assignments, or tap readily into the overarching purpose of a given exposure. We wound up doing some remedial work on his understanding when it became clear that he was struggling to implement the treatment flexibly, which then raised questions about how this could be the situation so late in the game, since Tice had had a good deal of priori clinical experience.

Many years back, as a practicum student myself, I received some profound guidance from a clinical supervisor, who noted that my behavior in session did not match my behavior or demeanor outside session. I thanked him for his generous compliment, which led him to smash his palm against his forehead, only somewhat jokingly. "That wasn't a compliment, Marty: you need to learn to be yourself in the consulting room just as you are outside of it." My own interpersonal style tends to be a bit more humor-driven if not acerbic, and I learned over time how to use that fundamental approach to drive treatment forward, but I also had to come to recognize when it was not serving the treatment as well as was needed.

Did Tice's positive, sunny outlook and his friendly demeanor lead him to hold back a bit at times when Daniel's resistance to compulsions dipped below the standards we felt important to achieve, i.e., 75% or higher compulsion resistance? In reading the case again, I saw several points where I would likely have gone in hard, using one of Daniel's sports metaphors to ask Daniel if he were playing basketball and shooting 40% from the free throw line whether or not the opponent would choose to intentionally foul him in the fourth quarter? Might calling Daniel to task have led to a faster reduction in symptoms, saving time and money for the family? Quite possibly, but I also recognize that doing so potentially would have risked the rapport, and the ultimate positive outcome.

As a therapist and a softball coach for many years, I have found that this balance between support versus pushing the client/player is critical to keep squarely in mind, as perhaps the potential negative effects of carefully placed unfailing directness can be mitigated by all the up-front work done on rapport building, and demonstrating to the patient that you like them and are on their side even when presenting information that could be perceived as critical. At the same time, if the proof is to be found in the pudding, then the outcome measures in Daniel's case indicate that the pudding was just fine as is, and should not have been tampered with by adding vinegar. I raise this here only as an opportunity to encourage self-evaluation by therapists, even those who are delivering protocol-based treatments. As is clear to those of us who have spent our professional lives developing, testing, and disseminating manualized treatments, the protocol itself is insufficient to ensure expert delivery of treatment, as the interpersonal context either adds or detracts from its effects even if the extant literature does not bring this point out as clearly as it explicitly should.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. Washington, DC: American Psychiatric Publishing.

Comer, J. S., Kendall, P.C., Franklin, M. E., Hudson, J. L., & Pimentel, S.S. (2004). Obsessing/worrying about the overlap between obsessive-compulsive disorder and generalized anxiety disorder in youth. *Clinical Psychology Review, 24,* 663-683.

Foa, E. B., & Kozak, M. J. (1985). Treatment of anxiety disorders: Implications for psychopathology. In A. H. Tuma, & J. D. Maser (Eds.), *Anxiety and the anxiety disorders* (pp. 421-452). Hillsdale, NJ: Lawrence Erlbaum Associates.

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*, *99*(1), 20-35.

Franklin, M. E., Dingfelder, H. E., Coogan, C. G., Garcia, A. M., Sapyta, J. J., & Freeman, J. (2013). Cognitive behavioral therapy for pediatric obsessive compulsive disorder: Development of expert-level competence and implications for dissemination. *Journal of Anxiety Disorders 27,* 745-753.

Franklin, M., Kratz, H., Freeman, J., Ivarsson, T., Heyman, I., Sookman, D., McKay, D., Storch, E., & March, J. (2015). Cognitive-behavioral therapy for pediatric obsessive-compulsive disorder: empirical review and clinical recommendations. *Psychiatry Research*, *227,* 78-92.

Franklin, M. E., Sapyta, J., Freeman, J. B., Khanna, M., Compton, S., Almirall, D., ... & Foa, E. B. (2011). Cognitive behavior therapy augmentation of pharmacotherapy in pediatric obsessive-compulsive disorder: The Pediatric OCD Treatment Study II (POTS II) randomized controlled trial. *Journal of the American Medical Association*, *306*(11), 1224-1232.

Freeman, J., Sapyta, J., Garcia, A., Compton, S., Khanna, M., Flessner, C., Fitzgerald, D., Mauro, C., Dingfelder R., Benito, K., Harrison, J. Curry, J., Foa, E., Moore, P., & Franklin, M. (2014). Family-based treatment of early childhood obsessive-compulsive disorder: The Pediatric Obsessive Compulsive Disorder Treatment Study for Young Children (POTS Jr.)—A randomized clinical trial. *Journal of the American Medical Association Psychiatry, 170,* 689-698. *doi: 10.1001/jamapsychiatry.2014.170*

Masi, G., Millepiedi, S., Mucci, M., Poli, P., Bertini, N., & Milantoni, L. (2004). Generalized anxiety disorder in referred children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43*(6), 752-760.

Mowrer, O. (1960). *Learning theory and behavior*. New York: Wiley.

Pediatric OCD Treatment Team. (2004). Cognitive-behavior therapy, sertraline, and their combination for children and adolescents with obsessive-compulsive disorder: The Pediatric OCD Treatment Study (POTS) randomized controlled trial. *Journal of the American Medical Association*, *292*(16), 1969-1976. *doi: 10.1001/jama.292.16.1969*

Piacentini, J., Bergman, R. L., Chang, S., Langley, A., Peris, T., Wood, J. J., & McCracken, J. (2011). Controlled comparison of family cognitive behavioral therapy and psychoeducation/relaxation training for child obsessive-compulsive disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 50*(11), 1149-1161.

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu/
Volume 15, Module 1, Article 2, pp. 75-83, 03-22-19 [copyright by author]

Simpson, H. B., Foa, E. B., Liebowitz, M. R., Ledley, D. R., Huppert, J. D., Cahill, S., . . . Petkova, E. (2008). A randomized, controlled trial of cognitive-behavioral therapy for augmenting pharmacotherapy in obsessive-compulsive disorder. *The American Journal of Psychiatry, 165*(5), 621-630.

Thomsen, P. H., Torp, N. C., Dahl, K., Christensen, K., Englyst, I., Melin, K. H., . . . Ivarsson, T. (2013). The Nordic Long-Term OCD Treatment Study (NordLOTS): Rationale, design, and methods. *Child and Adolescent Psychiatry and Mental Health, 7:*41, 1-13. doi:http://dx.doi.org/10.1186/1753-2000-7-41

Tice, A.M.B. (2019). Adapting an exposure and response prevention manual to treat youth obsessive-compulsive disorder and comorbid anxiety disorder: The case of "Daniel." *Pragmatic Case Studies in Psychotherapy, 15*(1), Article 1, 1-74. Available: http://pcsp.libraries.rutgers.edu.

Torp, N. C., Dahl, K., Skarphedinsson, G., Thomsen, P. H., Valderhaug, R., Weidle, B., Melin, K., Hybel, K., Becker Nissen, J., Lenhard, F., Wentzel-Larsen, T., Franklin, M. E., & Ivarsson, T. (2105). Effectiveness of cognitive behavior treatment for pediatric obsessive-compulsive disorder: Acute outcomes from the Nordic Long-Term OCD Treatment Study (NORDLOTS). *Behaviour Research and Therapy 64,* 15-23.