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

When Psychological Comorbidities Demand Flexibility: Treatment Adaptations for Youth Anxiety Disorders

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ABSTRACT

The first author (LEP) is a third year clinical psychology doctoral student at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University, working under the supervision of the second author (AQ) at GSAPP's Anxiety Disorders Clinic, which the second author directs. As a fellow student clinician, the first author had a particular appreciation for Dr. Alexander Tice's treatment of "Daniel" (2019), a client with a complex clinical presentation who appears to have greatly benefited from his treatment with Tice, under the supervision of Dr. Martin Franklin. Much of Tice's experience applying theoretical principles to treating specific disorders, as well as finding a delicate balance between manual-based treatment and real-world clinical application of those manuals, reflects the experiences of the first author (LEP) as a cognitive-behavioral therapist working at a graduate student training clinic.

Key words: Obsessive-Compulsive Disorder (OCD); Generalized Anxiety Disorder; manualized CBT treatment; clinical supervision; clinical training; case study; clinical case study

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INTRODUCTION

Social psychologist Kurt Lewin famously wrote, "There is nothing so practical as a good theory" (Lewin, 1943), a maxim which appears to have informed both Dr. Alexander Tice's treatment of "Daniel" and the majority of the first author's (LEP's) graduate training. Tice's careful discussion of the theoretical models of both Obsessive-Compulsive Disorder (OCD) and Generalized Anxiety Disorder (GAD) seamlessly give way to his treatment selection. If not for a clear understanding of the development and maintaining factors of these disorders, Tice (as any clinician) would lack the justification for choosing any one treatment manual over another. Similarly, Tice's comprehensive assessment of Daniel provided invaluable clinical information that guided the course of treatment. Had he accepted that Daniel was suffering from OCD based

on parental reports, without following up with a full psychodiagnostic testing battery, he and his supervisor, Dr. Martin Franklin, may have missed the comorbid GAD, a crucial diagnosis that informed much of the way they implemented treatment.

As Tice writes, treatment manuals, which are developed directly from theoretical models, provide excellent guides for treatment planning, particularly for beginning clinicians, who often benefit from their clear and useful suggestions. However, as Tice so beautifully explains and which is at the core of his contribution to the field through the case of Daniel, the challenge that this particularly complex case presented was "to maintain flexibility while also ensuring fidelity to the core principles of [a given treatment]" (p. 2). Through the case study of Daniel, the reader comes to learn that "flexibility" does *not* mean that a psychological treatment should lack the basic structure, careful assessment, or theoretical application outlined in treatment manuals. In fact, Daniel's ultimate treatment success appears to have resulted from effective cognitive-behavioral treatment utilizing well-researched manuals while adapting to the real-world circumstances under which his treatment occurred. As a student clinician, the first author (LEP) has spent considerable time in training and supervision working to strike the type of appropriate balance reflected in Tice's case study among theory, research-based manuals, and real world circumstances.

The first author (LEP) has worked under the supervision of the second author (AQ) for approximately a year and a half. LEP has received invaluable training in applying the theoretical knowledge she has gained through her academic coursework about the etiology and maintenance of anxiety disorders to the treatment of these disorders in the real world, with real clients. Tice mentions several times throughout his case study the need for flexibility when working with clients with comorbid anxiety and related disorders, and LEP has found this to be perhaps the single most valuable lesson through her work in the Anxiety Disorders Clinic with AQ.

TREATMENT ADAPTATIONS FOR REAL WORLD TREATMENT LIMITATIONS

Tice's discussion about the ways in which manuals for anxiety disorders tend to leave out important considerations such as parental involvement for children and adolescents, as well as factors that might get in the way of successful treatment, such as transportation to the treatment center (p. 51), certainly reflects our experience implementing treatment manuals with fidelity. At the Rutgers Anxiety Disorders Clinic, we have found at times that scheduling conflicts can become a significant obstacle in treatment consistency, particularly when working with youth. LEP has worked with more than one adolescent whose fluctuating school and extracurricular schedule presents conflicts with treatment, and whose caregivers' busy schedules mean that we are unable to reschedule for another time slot if a conflict arises with our usual session time. This fact has created real barriers to faithfully implementing treatment manuals.

In terms of addressing scheduling difficulties, we see great merit in Tice and Franklin's decision to make use of virtual video sessions (p. 51), and LEP is considering implementing this practice in her own clinical work, particularly for a particular client—whom we'll "Linda"—

with a clinically severe clinical presentation. In considering video sessions as an option for clients like Linda in our clinic when scheduling conflicts make an in-person session impossible on a particular week, we would have to frame the proposal carefully to families, such that it would not be viewed by them as a replacement for in-person sessions.

Given the functional impairment caused by Linda's emotion dysregulation, one treatment session per week has often felt insufficient. The treatment dose appeared particularly low at the beginning of treatment, when Linda had not yet learned nor begun to practice self-regulation strategies. Similar to Tice's case of Daniel, we (LEP and AQ) have often felt that Linda would benefit from an increase in treatment dose; however, it would have been logistically difficult given her and her parents' schedules to see Linda in person more than once per week. Thinking about Tice and Franklin's decision to add the virtual sessions once treatment was already underway led us to an interesting clinical decisional dilemma: whether to wait to introduce a higher treatment dose as Tice and Franklin did, or whether to initiate it at the beginning of therapy. On one hand, we understand Tice and Franklin's rationale insofar that it took several sessions to gather sufficient data about Daniel and his response to treatment to conclude that he would benefit from a higher treatment dose. And further, that by the time Tice and Franklin increased the treatment dose, Daniel had already seen some gains and had developed a strong rapport with Tice, thus likely increasing Daniel's motivation to devote more time to treatment. Though our client Linda's motivation has waxed and waned throughout our treatment, she was especially resistant at the beginning. Exposure sessions were very stressful, and her mother struggled with Linda's willingness to come to the clinic. Treatment became more tolerable for her once she had achieved some initial successes and once she had built a therapeutic relationship with the first author, thus suggesting that we should wait before introducing an increase in treatment dose.

On the other hand, as previously mentioned, we can also see the benefit of frontloading treatment sessions from the beginning in order to increase learning right from the start, perhaps when symptoms are the worst. In this way of thinking, because Linda's symptoms were most functionally impairing at the beginning of treatment, perhaps increasing the treatment dose upfront would have contributed to quicker symptom relief. Additionally, it could be challenging to increase treatment frequency part way through treatment, particularly when working with rigid and rule-bound youth. Often parents or caregivers are the driving force behind seeking treatment for children and adolescents, so any significant change in treatment structure like the decision to change the frequency of treatment would have to be a collaborative decision. Ideally the youth should be involved in the discussion in order to maintain rapport and willingness to actively participate in treatment.

ADAPTING TREATMENT MANUALS IN THE FACE OF COMORBID DISORDERS

Another extremely useful contribution to the literature on treating anxiety disorders is Tice's discussion of how the guidance found within treatment manuals can be contraindicated for comorbid diagnoses when working with a clinically complex individual. That Daniel met criteria

for both OCD and GAD presented an important dilemma for Tice and Dr. Franklin, given that cognitive restructuring is often recommended for GAD treatment and contraindicated for OCD treatment. In this regard, we particularly appreciated Tice's sharp commentary on the distinct differences between the specific natures of feared outcomes in each diagnostic category (p. 17).

As therapist and supervisor, we (LEP and AQ) have had many discussions about working on cognitive restructuring versus promoting a more general tolerance of uncertainty for various clients. Often the subject of this type of conversation has been Linda, the aforementioned adolescent client in our clinic, who meets criteria for both Generalized Anxiety Disorder and Specific Phobia, and who presents with emotion dysregulation and rigid thinking that interferes broadly in her daily functioning. Due to Linda's clinically complex presentation, we have had to apply treatment manuals quite flexibly with this client.

For reasons we will explain, we selected *The Coping Cat Program* to begin Linda's treatment. The program includes a therapist treatment manual (Kendall & Hedtke, 2006a) and a client workbook (Kendall & Hedtke, 2006b). The first eight sessions of the manual focus on psychoeducation around the nature of generalized anxiety, teaching the client how to identify when she is feeling anxious in addition to some coping strategies for tolerating anxiety, including recognizing anxious thoughts, deep breathing and relaxation, and problem solving. The first half of the treatment manual seemed especially useful when we were selecting a treatment manual for Linda. Particularly as it was the first author's first time treating a youth anxiety case, we appreciated *The Coping Cat's* child-friendly language to explain the theory behind cognitive-behavioral treatment and the factors maintaining her anxiety. Similar to Tice's experience with his supervisor, the second author (AQ) as the supervisor supplemented the strategies listed in the therapy manual with some from her own clinical experience, including instructing LEP to teach Linda deep breathing using the relatable analogy of smelling a slice of pizza (inhaling) and then blowing on it to cool it down (exhaling).

The second half of *The Coping Cat* treatment manual focuses on building a fear hierarchy in order to expose the child to anxiety-provoking situations. It was within this latter half that we applied a more flexible approach to implementing the manual, for reasons similar to Tice and Franklin's decisions to veer from the exact recommendations provided in the Exposure and Response Prevention manuals they followed in Daniel's treatment. *The Coping Cat* includes cognitive restructuring—the process of challenging the client's distorted and often catastrophic beliefs—as part of reducing anxiety in the client's previously feared situations. As Tice mentions, cognitive restructuring is recommended in many treatment manuals for GAD. Although not necessarily contraindicated for Linda's comorbid Specific Phobia, as it may have been for Daniel's OCD, Linda's rigid thinking patterns led her to being resistant to alternative ways of viewing situations. Coupled with Linda's tendency to become easily elevated in response to feeling anxious, we decided to focus on teaching anxiety tolerance rather than attempting to disprove each individual cognitive distortion.

Tice describes the theory presented by Craske (2008) in her paper on the inhibitory learning model of exposure, which was the theoretical foundation on which we based the

exposure treatment for Linda's Specific Phobia and GAD. Tice summarizes the theory as follows: the individual's fears are not replaced by the new learning that occurs during exposure therapy, thereby suggesting that the original fear can return in the face of a slightly different stimulus (p. 13). Therefore, instead of aiming for fear reduction during exposures (found in the habituation model of exposure therapy), Craske advocates for focusing on tolerating fear across many different situations (Craske et al., 2008).

We conceptualized much of the Linda's dysregulation as a "fear of fear," because she appeared to become extremely emotionally elevated, very quickly, when anxiety arose. Therefore, while *The Coping Cat* provided a logical session sequence and many useful skills as well as psychoeducation tools, we adapted the exposure treatment, following Craske's model, to help Linda handle her anxiety across many different anxiety-provoking situations. We ultimately did not treat fear reduction as a treatment goal, but rather focused on fear tolerance. At times it was helpful for Linda to experience that an exposure did not feel as stressful as she had anticipated. However, Linda experienced intense anticipatory anxiety before starting exposures that did not diminish throughout treatment, even after she completed exposure tasks successfully. Therefore, the notion that exposures would get easier over time did not end up being crucial or helpful. Instead, we wanted her to learn that she could feel anxious and that anxiety did not have to get in the way of going to places in the community that she had previously avoided.

Similar to Tice's experience treating Daniel, the psychological comorbidities present in Linda's case led us to adapt a treatment manual to fit Linda's clinically complex presentation. It appears that both Tice and the first author (LEP) have benefited in our training by learning to develop treatment plans that include a combination of careful assessment and monitoring, the guidance of multiple theoretical models and multiple treatment manuals, and—particularly--an experienced supervisor's clinical expertise.

CONCLUSION

Tice's case study of his treatment with Daniel has contributed to the field of youth anxiety disorders by providing a thoughtful argument for and illustration of how to implement theoretically grounded and research-based treatment manuals in the real world. His case required flexibility to account for real-world issues, such as complex clinical presentations and everyday concerns that interfere with treatment. As a student clinician working at an anxiety disorders clinic, the first author (LEP) identified with much of Tice's experience and took away from his case study several ideas to implement in her future clinical work, such as virtual video sessions. She has learned that comorbidities in anxiety and related disorders present a unique set of challenges, particularly to student clinicians implementing treatment manuals, and that Tice's case study demonstrates how to effectively adapt the manuals to respond to the specific needs of each client.

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