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

The Case of "Daniel": Flexibly Delivering an Inherently Challenging Treatment in the Face of a Complex Presentation

ALEXANDER M.B. TICE [a,b]

[a] Kennedy Krieger Institute, Johns Hopkins University School of Medicine, Baltimore, MD

[b] Correspondence regarding this article should be sent to Alexander M.B. Tice, 9810 Patuxent Woods Drive Suite J, Columbia, MD 21046.
Email: alexandertice@gmail.com

ABSTRACT

In this article, I respond to commentaries by Martin Franklin (2019) and by Liza Pincus and Andrea Quinn (2019) about my case study of "Daniel" (Tice, 2019), a 14-year-old young man presenting to therapy with Obsessive Compulsive Disorder (OCD) and Generalized Anxiety Disorder (GAD). I treated Daniel with a manual-based, 25-session treatment centered around the cognitive-behavioral approach of Exposure and Response Prevention (E/RP). A major theme running through my case study and the two commentaries is the need for flexibility in adapting the manual to be responsive to a variety of factors associated with Daniel's disorder, such as his personality, interests, life situation, attitude towards his symptoms, and his way of relating to the therapist. In the context of the commentaries, I review a variety of the specific ways in which I learned to be flexible. Some of these included (a) focusing on nonspecific factors in developing a strong therapeutic alliance and rapport; (b) paying particular attention to how I communicated relevant psychoeducational concepts to Daniel, particularly by the use of metaphors, in preparing him for the E/RP procedures and in encouraging his participation; and (c) focusing on the process of making decisions at important clinical choice points.

Key words: Cognitive-Behavior Therapy (CBT); Exposure and Response Prevention (E/RP); Obsessive-Compulsive Disorder (OCD); manualized treatment; therapeutic appliance; communication; metaphors; clinical decision-making; case study; clinical case study

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INTRODUCTION

When I approached working with Daniel on his manualized treatment during my 3rd year of graduate school, I wanted to learn as much as possible about the process of the Exposure and

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Response Prevention (E/RP) treatment for Obsessive-Compulsive Disorder (OCD). In fact, heading into the first assessment session, I had hoped to use Daniel's case to study and learn how to lead him to treatment success from the active ingredients of E/RP. From the start this mindset prompted me to have a reflective attitude throughout the treatment, which I believe benefitted both my own learning and clinical experience, as well as Daniel's outcome. As my supervisor in the case of Daniel, Dr. Martin Franklin, concisely noted in his commentary, "Every single case of (OCD) is different, and yet every single case is also exactly the same" (2019, p. 76); that is, while every OCD case is different, they all share much in common. Thus, while every patient presents with unique obsessions and compulsions, those symptoms also share a similar structure and function across patients. Franklin's succinct language points to one of the core concepts I took away from Daniel's case: how to flexibly deliver an inherently challenging treatment in the face of a complex presentation while at the same time utilizing the same theoretical and strategic principles.

It was therefore heartening to see the relevance and parallel of Daniel's treatment to "Linda," the case discussed in the commentary by Liza Pincus and Dr. Andrea Quinn (2019). It appears that these authors confronted many of the same obstacles, both general and specific challenges, that I found with Daniel, and that they too engaged in the reflective process that has so benefitted me as a former trainee, as well as my patients. Case studies in particular create an opportunity to improve clinical skills, both broadly, and in terms of navigating specific clinical decision points. As a trainee, a much of the learning comes vicariously through the cases of supervisors and other trainees alike. At The Child & Adolescent OCD, Tic, Trich & Anxiety Group (The COTTAGe), the clinic associated with Daniel's case, the weekly clinic meetings—often functioning akin to group supervision—enabled me to hear from my supervisor Franklin and other clinicians about the principles and techniques they used to navigate challenging cases and to achieve positive treatment outcomes. Written, systematic case studies provide a similarly important opportunity to better understand the specific and non-specific factors that can lead to success, in order to apply those principles and procedures to future cases.

Reading the commentaries from Franklin (2019) and from Pincus and Quinn (2019) on Daniel's case study provided yet another occasion for me to reflect upon that work, including the main lessons that I carry with me from the process and outcome of the case. In terms of the more general, non-specific factors, both Franklin and Pincus and Quinn highlight the importance of the therapeutic relationship, motivation, and effective communication to the eventual outcome of Daniel's case. Beyond those factors, it is also important to reflect on a few other critical decisions that can occur during treatment: how best to involve parents; whether to directly challenge anxious and/or obsessional cognitions or focus instead on distress tolerance; and how and when to adjust the frequency and context of treatment (i.e., the "dose").

CROSSCUTTING GENERAL CLINICAL SKILLS

Franklin highlighted the importance of a strong therapeutic relationship in the quest toward symptom remission, which was very consistent with my experience with Daniel. He wrote, "In OCD it is believed that a strong therapeutic alliance is not sufficient in and of itself to

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drive substantive symptom relief" (2019, p. 79) He also rightly argues that while rapport is not sufficient on its own, it is a necessary component to an inherently challenging treatment such as E/RP.

Stepping back to examine the context, exposure treatments like E/RP ask patients to do something they have not been doing in the past, and frankly do not want to do by the very nature of their symptoms. We know that negative reinforcement, avoidance, and escape are key variables that maintain the patient's distress and discomfort. Thus, when a therapist introduces a patient to a cognitive-behavioral model of OCD or other type of anxiety and describes the need to change the patient's long-standing patterns of behavior, the therapist should expect some degree of reluctance on the part of the patient. Some patients present to their first session very motivated, willing, and ready to do whatever they are pointed toward. However, with most OCD and other anxiety patients, the therapist needs to devote substantial session time to building rapport and a personal relationship with a patient. This trust supports patients in their process of making the jump into changing how they handle their negative feelings.

With Daniel, I intentionally spent time developing a therapeutic alliance and rapport, initially based on an existing belief that his progress would benefit from a good working relationship. Importantly, and in line with Franklin's point, session time used to build the relationship with Daniel early on in treatment came at the end of those sessions after completing other components of treatment, such as psychoeducation. In fact, later in treatment when Daniel's motivation waned, I would explicitly reward him with session time dedicated to talking about or engaging in his interests (e.g., video games) upon completion of in-session, in-vivo exposures. Thus, I understood at the time that falling back on the relationship we had developed would help move him along toward his treatment goals.

Upon reading the responses of Franklin and of Pincus and Quinn, I reflected on the development and overall quality of the clinician-patient relationship. I think it's important to acknowledge from my perspective that Daniel and I likely benefited from a bit of a head start in this area, in that I found it relatively easier to build rapport with him in comparison to some of my other patients. That experience seems to point toward the role of "fit" between the two people, possibly between personality characteristics or other individual differences, as in any interpersonal relationship, therapeutic or otherwise. From our first meeting, I perceived a goodness of fit between myself, Daniel, and his parents, that led to a strong relationship and open dialogue throughout the course of treatment.

In addition to the therapeutic alliance, Daniel's case study, as well as Franklin's and Pincus and Quinn's commentaries, prompted me to contemplate the critical role of effective communication in a treatment such as E/RP. In discussing some of the skills an expert in this area brings to the table, Franklin et al. wrote: "Experts were 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; 4) help patients recognize that the best way out is through." (2013, p. 746). Those skills reinforce the importance of being able to clearly communicate with patients throughout a course of E/RP.

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COMMUNICATION AND METAPHORS

Because E/RP is inherently a challenging treatment, it is critical that the clinician be able to communicate clearly the guiding theory, model, principles, and rationale of treatment. Both the child/adolescent and the parent(s) need to understand how OCD and anxiety function, the role of thoughts and behaviors, and how treatment will proceed. Equally important, the patient and parents must understand *why* we ask them to do various activities, especially exposures. Therefore, I spent considerable time with Daniel and his parents throughout the course of treatment introducing, discussing, and reinforcing their knowledge of the model and rationale for every aspect of treatment.

For children and adolescents, metaphors can often serve as helpful vehicles to communicate a range of complex ideas about symptoms and treatment. Going back to those expert skills, I found that one of my supervisor Franklin's clear strengths was an ability to communicate a variety of concepts through metaphors, especially those tailored to the activities and interests of a specific patient. If the patient was motivated by sports, Franklin would find ways of expressing messages through parallels in their sport. Conveying challenging concepts can be aided by analogies about music, art, videogames, or frankly most activities that children, adolescents, and families engage in.

As an example, I commonly use the flexible metaphor of a roller coaster in my practice to express a number of important ideas, including exposures. I often introduce the patient and/or parents to exposures through the following: "How do you feel riding a roller coaster the first time? What if you could ride a roller coast over and over, how would it feel on the second time? On the fifth, tenth, twentieth? How would you feel?" Most often, my patients respond that they don't like roller coasters and that they initially avoided them or found them very distressing, but that each ride would get less and less scary and eventually the patient might even get bored. I capitalize on that response to provide a parallel to the treatment, and with my knowledge of inhibitory learning theory (Craske et al., 2008). I say something roughly similar to: "So treatment is just like that, we need to 'ride this rollercoaster' or do exposures, over and over, so that 1) you can prove to yourself that your obsession or worry isn't true and isn't going to happen, and 2) so that you can prove to yourself that you can tolerate how you feel, even if it's anxiety. As discussed by Franklin and by Pincus and Quinn, and in greater depth below, I intentionally do not emphasize habituation per se. Rather I tailor my approach, e.g., asking the patient why I am asking him or her to do the exposures; and/or directly challenging the patient's obsessions (e.g., for Daniel, challenging the thought that "you will get sick if you touch this"); and/or distress tolerance (e.g., for Daniel, to propose that "you can feel very uncomfortable and still live your life normally").

Of course, metaphors can only be as helpful as how and when you use them to communicate messages. However, what I learned from Daniel's case is that repetition or rehearsal of important concepts can be as critical to learning as the explicit images we try to create in the patient's mind. Although I had introduced and described to Daniel the important concepts of E/RP during the initial phases of treatment, during the first plateau in treatment

progress, I reassessed his knowledge by gently quizzing him about those concepts. His struggles to clearly communicate the E/RP model and rationale in that moment showed me that I hadn't communicated as effectively as needed early on, and his ongoing difficulties verbally expressing core ideas throughout the middle and later sessions led me to integrate frequent questioning of his knowledge into our sessions. For example, if he indicated reluctance to complete a particular exposure (i.e., if her wished to avoid), I would ask him to tell me what he thought I would say about what he should decide. Overall, the effort to find new ways to convey ideas as well as the simple repetition or rehearsal of those ideas played an important role in Daniel's eventually successful journey.

UPS AND DOWNS IN PROGRESS

That journey included the typical ups and downs that almost every patient confronts, including plateaus or periods of lack of progress. The reflective process of completing the case study, as well as Franklin's supervision, focused our attention on these issues of patient knowledge deficits. In his supervision and in his commentary, Franklin highlighted the importance of the therapist's expert-level skills, including knowing how to "push the envelope" to make progress in treatment, rather than engaging in avoidance. (Franklin et al., 2013, p. 746). Exposure treatments can be difficult, and thus the ability to communicate difficult messages with both clarity *and* empathy is as critical to treatment success as being knowledgeable about the OCD model and about E/RP. From observing Franklin's clinical skills and his interpersonal style, I can say with certainty that he possesses the ability to get the most out of his patients, helping them continually push themselves outside of their comfort zone, while not invalidating the struggles they experience. Franklin (2019) summarized that ability perfectly: "Demonstrating to the patient that you like them and are on their side even when presenting information that could be perceived as critical" (p. 81).

All patients engaging in E/RP, including Daniel, need honest feedback about their progress in order to make as many gains as they are capable. Without it, they would not know what they would need to adjust or change, and eventually their treatment would suffer. Similarly, if one approaches feedback in a critical or harsh manner, the patient might lose trust in or stop listening to the therapist, which would similarly interfere with their progress. It is a delicate balance to maintain, but one that is possible. As a model of how I attempt to balance my communication in those conversations, with Daniel I recall having a conversation along the following lines:

> *Alex*: We can see from the monitoring form that the past couple weeks have been rough, and it seems you may have stalled out (or hit a plateau). I think it's important to go back through and review the model and rationale. So first, I'm proud of you for being able to do XYZ exposures, that tells me that you are really strong and able to do even more. Remember when we talked during the other session, that in order to keep making progress at beating the OCD, we need to keep pushing a bit further with each exposure, so that we can prove to ourselves that we don't have to listen to the OCD and so that we can achieve those goals we talked about [include specific goal here]. Well, I think we may have stalled out a bit, and we haven't been taking that

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next step each time. What do you think? Do you think you have been pushing yourself more each time?

Daniel: Well, I mean, yeah, I think so, the exposure we did with the trashcan last session was really hard, so uncomfortable and nasty.

Alex: I know you felt uncomfortable about it, but I really know you can do it even more, you have been doing a great job, and we just need to keep testing out whether your obsessions are accurate. Let's think, did you get sick last time?

Daniel: No.

Alex: Okay so what does that tell you? What do you think I would say we need to do? (falling back on previous sessions, to reinforce content that had already been introduced).

In these situations, I aim for positive reinforcement for past and future ability, as well as clear feedback about the need to continue to take steps forward. I tried to give Daniel confidence and to remind him of past successes, while also trying to reinforce and expand Daniel's understanding of what is happening and what decisions he needs to make next. In addition, as Franklin points out, humor can play a very important role to help "bridge difficult moments" such as these, as well as make the work more enjoyable overall. In the time since Daniel's treatment ended, I have come to recognize that being able to find and communicate challenging feedback with empathy and positivity was an important skill that I gained from Daniel's case. Furthermore, with the additional years of training under my belt since my time at COTTAGe, I agree wholeheartedly with Franklin's assertion that he would have gone in harder with Daniel at various points in treatment. With hindsight, I could have more directly communicated about the steps I felt Daniel needed to take (and could have graphed the data to be able to show him the trends), without compromising the relationship. As Franklin so eloquently put it: "The protocol itself is insufficient to ensure expert delivery of treatment, as the interpersonal context either adds or detracts from its effects" (Franklin, 2019, p. 81)

Finally, to link back to the discussion on rapport and the therapeutic relationship, effective communication of less than positive feedback is a complex dance. One not only needs strong rapport to be able to communicate feedback, but also needs to express messages that can be harder for the patients to hear, in a way that is supportive. One could argue that providing empathetic but constructive feedback would ultimately benefit the rapport (e.g., "You need to do the exposure you have been avoiding because without doing it you won't make the progress toward your ultimate goals"), although it requires a certain style to avoid undermining the relationship and outcome. I also continually attempt to communicate, both explicitly and implicitly, that I trust in the effectiveness of the model and the treatment, and that our negative feelings don't need to be avoided. I believe my trust and confidence helps patients to trust in the model, and to have faith that they are moving in the right direction, even if it does not feel that way in the moment.

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IMPORTANT CLINICAL DECISION POINTS

However, Pincus and Quinn (2019) accurately note a challenge I faced, that the treatment manuals often "tend to leave out important considerations, such as parental involvement for children and adolescents" (p. 85). From my experience with Daniel and as an overarching ethos, if at all possible, parents should be seen as a vital resource in the quest to symptom relief and true inhibitory learning. From my perspective, Daniel's parents' frequent presence in our sessions as well as their willingness to implement a reward system for exposure completion played a key role in his eventual positive outcome.

Of course, in navigating how best to involve parents, as with all clinical decisions, it will depend upon the patient, family, and the whole context of treatment. In a general sense, I usually advocate for greater parental involvement, assuming that involvement does not function as accommodation or escape/avoidance for the patient. For example, some parents adapt to contamination OCD symptoms by doing things like opening doors or pressing elevator buttons for their child, ostensibly to accommodate avoidance of the natural exposure and the inherent distress associated with it. Pincus and Quinn similarly reflected on the decision as to whether to hold sessions remotely by video to help parents with their schedules. I appreciated Pincus and Quinn's discussion of that issue, as an effective E/RP clinician needs to be cognizant of the ways that parents can reduce how they engage with their child's rituals and avoidance, and how the therapist may be engaging in those same patterns of avoidance.

Consistent with this, Pincus and Quinn were aware of the possibility of the patient viewing remote video sessions as being a replacement for more traditional in-person sessions. Given that Linda experienced the exposure sessions as particularly distressing, it would be counterproductive to accommodate further avoidance of her worries by reducing the frequency of her engagement with high anxiety-provoking situations. Pincus and Quinn's description of their client Linda's increased tolerance of those treatments once she had achieved some success was similar to Daniel's experience in many ways, despite the initial struggles. Furthermore, I completely agree with Pincus and Quinn's point that change in treatment structure or frequency should be a collaborative decision, and I would also suggest that for those conversations to be successful, we need to find the balanced communication discussed previously. We need the child's "buy-in" for treatment to be effective, as well as the parents, and as such, all of these decisions should be approached with care.

Another important decision point that I reflected upon focused on whether it would be more effective to emphasize directly challenging the content of a given patient's anxious or obsessional thoughts (i.e., cognitive restructuring) versus or promoting tolerance of his or her distressing thoughts and feelings. As Pincus and Quinn rightly point out, cognitive restructuring is often recommended for Generalized Anxiety Disorder (GAD), while many, including myself, would not often recommend it for the treatment of OCD (Comer et al., 2004). Pincus and Quinn point to their own clinical decision point with Linda about focusing on challenging worries directly compared to emphasizing that the patient can tolerate distress/discomfort. Given the territory, it was unsurprising to see the seemingly similar thoughts from Franklin (2019). His

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assertion that with the treatment of GAD worries are "almost by definition, moving targets" (p. 77) resonated with me with the central core message for learning being that patients with GAD can tolerate the uncertainty, discomfort, and distress they are feeling.

Linda's reported dysregulation, with her easily becoming emotionally elevated, and her rigid thinking would have understandably interfered with her ability to move forward in treatment based on an approach geared toward direct challenging of her worries (Pincus & Quinn, 2019). As Pincus and Quinn (2019) described, those factors increased Linda's resistance to alternative ways of thinking, which prompted the therapists to shift their emphasis to tolerance (p. 87). Based on the Pincus and Quinn's description of their work with Linda, I can only assume that they effectively communicated the key take-away messages from the exposure work, including that Linda should be more focused on tolerating negative feelings than looking for them to reduce. Although it seems that Linda did not benefit from the exposures becoming easier as much as other patients can, Pincus and Quinn clearly wanted Linda to learn that those negative feelings did not need to interfere with the life she wanted to live or the places she wanted to go to.

Interestingly, Franklin suggests that a patient learning that he or she can tolerate discomfort and uncertainty is a "by product" related to OCD treatment, specifically with consistent exposure practice. In fact, that appears readily consistent with Daniel's experience during our course of treatment. Although we did not focus on the tolerance message as much as directly challenging his concerns that he would get very sick if he touched "contaminated" things, Daniel acquired the knowledge that he could tolerate high levels of negative emotions, just by consistently exposing himself to germs.

CONCLUSION

Exposure and Response Prevention treatment by its very nature can be a challenging process, for the patient and sometimes for the clinician. The individual differences of the patient—in terms of motivation, readiness for change, style of thinking, familial support, and any number of other factors—certainly requires an effective clinician to maintain flexibility to get the most out of the interventions via the patient's investment in and commitment to them. Writing Daniel's case study, as well as reading reflections on his treatment by Franklin and by Pincus and Quinn, have provided me the opportunity to slow down and think deeply about the various ingredients of Daniel's treatment that impacted his clinical course and successful outcome, including specific clinical decisions by the therapist, specific treatment procedures, and the non-specific factors. Based on my personal experience I would recommend participation and immersion in systematic, psychotherapy case studies as an important learning experience, especially for both graduate students and early-career psychologists.

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