ONE

Why This Manual?

The most serious thinking about how to treat the children and families in our program happens mostly on Friday mornings. Within the confines of the University of Hawaii's Center for Cognitive Behavior Therapy, we provide mental health services to children between the ages of 6 and 18, mostly referred from Hawaii public schools and the Department of Health. A handful of those served are self-referred families from around the Pacific region who have sought specialty treatment for complex anxiety problems. The cases are almost always challenging—much harder than I remember seeing when I was receiving my own graduate training (a confession that my current trainees find quite satisfying), and there are nearly 15 therapists who require my regular supervision for their cases. Many of them are graduate students in training, and thus—quite appropriately—tend to request more guidance than the average practitioner. We meet for several hours each Friday morning to discuss cases and make decisions.

Friday is also the only day that we all see each other as a cohesive program—the graduate students, postdoctoral staff, and faculty supervisors. We typically all have lunch together after our morning meeting, giving us an important opportunity to socialize and share ideas, which is then followed by research and training meetings in the afternoon. This schedule means that we have only a small window of opportunity on Friday morning to make important decisions about our ongoing cases. These are some of the most important decisions we make all week, so we have to get them right. No one goes to lunch until we feel confident about the treatment plans.

Over nearly a 10-year period, the level of clinical complexity of this work has served to reform and even threaten many of my beliefs about effective therapy approaches. On the one hand, the children and families we were seeing had so many more challenges than I was first accustomed to that it seemed that many of the manualized approaches with which I had been trained would have limited success. I felt this not because I believed the techniques would not work, but because the family situations were often so complicated, the comorbidity so severe, or the need for treatment gains so rushed that the delivery of the appropriate techniques might never occur or would not occur quickly

enough to keep a family from giving up on us. For example, a child referred to us by a school social worker in October, and who has been out of school for more than a month, would not have time to cover all the requisite steps in a typical anxiety treatment manual before getting back into the classroom. It had to happen "yesterday." Similarly, an anxious child with challenging oppositional behaviors might not be inclined to participate and cooperate with cognitive-behavioral therapy (CBT), and perhaps would require some strategies for managing disruptive behavior. Other times, a case would go longer than 12–16 weeks, with clear evidence of the need to continue treatment, yet most manualized treatments for anxiety would have ended by then. Finally, children very often had more than one anxiety problem, which could mean that different manuals might be needed (e.g., one for obsessive–compulsive disorder, one for social anxiety). My training told me it was important to use treatments backed by scientific evidence, but how could treatment manuals be followed in such cases?

At the same time, I was often training new therapists to perform in these challenging circumstances without the luxury of time to go over every detail of every technique every Friday. Even if we didn't want to use a manual for the reasons described above, time constraints meant we would have to somehow. Without some structured way to teach the key strategies that work for childhood anxiety, there simply would not be enough time to train clinicians properly or to accept many of the referrals that seemed likely to benefit from our program. Training materials had to be written down and structured, so how could we *not* use a manual?

I eventually realized that solving this dilemma would require a new kind of manual.

THREE CRITICAL ISSUES

That manual would come to be organized around three main issues. First, to state the obvious, the best treatment plan in the world has little chance if the child and family are unwilling or unable to participate in the protocol. Thus *engagement* is always one of the first issues to address. A minimum level is necessary for the protocol to work, and given the fact that anxiety treatments can sometimes be uncomfortable for children and even parents, more engagement is probably better. That said, there is more to treating anxiety than a good therapeutic relationship, and indeed there is no evidence to suggest that engagement alone is sufficient for success. There are other things to think about as well.

With childhood anxiety, those other things involve specific procedures that are well documented but not always easy to implement. Properly exposing a child to a feared situation or appropriately constructing a list of feared situations takes special skills. In relatively straightforward circumstances, implementing the techniques can predominate clinical thinking, and without a doubt, it is important for us to get the techniques right. For that, it seemed, a manual would be ideal—all the techniques could be written down with their steps laid out neatly for therapists to follow. So the second issue is about the basic component strategies of CBT, or what I call the *fundamentals*.

There is, however, still one other critical issue that arises, particularly as cases present more complex circumstances with their family, schools, or community. This issue

concerns the pace, the timing, or selection of techniques themselves, not simply their proper execution. Should we start practicing feared situations with a child? How soon? Does this child need to practice some cognitive therapy skills first? Are social skills going to be important? How should we deal with a child's inability to perform therapy "homework"? This aspect of therapy is not about execution of techniques but rather about their selection, order, pace, intensity, and so forth—how they work together.

To take an example, consider an anxious 8-year-old girl who has trouble learning cognitive restructuring skills for some reason or another. On the one hand, the therapist might be wasting time going over cognitive material if it will ultimately be grasped only partially and hence offer little strategic value. So perhaps it makes sense to skip the cognitive exercises and move forward with other parts of the protocol. On the other hand, maybe taking the time to master a cognitive technique early in treatment would pay off richly later in treatment. Spend more time on cognitive skills? Skip cognitive skills? This kind of thinking came up all the time with our cases and required some time and effort to evaluate.

My experience with practicing clinicians, and indeed even my own training in university-based research clinics, suggested that these decisions were made in a way that did not always fit with a predetermined selection, order, or length of therapy sessions as dictated by many treatment manuals. Thus this third issue involves *case formulation*. By developing a working idea of why problems are the way they are, therapists have a guide for determining how to select, sequence, and pace known clinical strategies. In addition to addressing *engagement* and therapy *fundamentals*, this new manual would have to provide a framework for *case formulation*, too.

NO MORE SUPERVISION AS USUAL

In research the term "treatment as usual" refers to the actual care that is delivered under typical clinical circumstances. Although I have not seen the term "supervision as usual" used anywhere, it seems this concept applies equally well in that context. Given the lack of evidence on what content characterizes "supervision as usual," I can only write anecdotally about it. Supervision is the time when the deepest critical thinking about a case is meant to occur. In my opinion, "supervision as usual" seems to be characterized, at worst, by narrative descriptions of the therapy sessions themselves (e.g., "he said this, and then I said that") and, at best, by therapist-nominated problems that might warrant attention (e.g., "I don't know why she's not doing her homework again"), that is, if supervision happens at all. In many community practice settings, it simply does not happen, or it involves a checklist review of caseloads and current crises.

Wading through these issues and getting to the heart of the matter—the formulation—can take lots of time for any one case, and there may not always be sufficient time. But that is not the only problem. What has always made me uneasy is the well-known literature on confidence and clinical decision making: the idea that more discussion and details often add little to the accuracy of decisions, but merely increase therapist confidence (e.g., Oskamp, 1962). Perhaps our discussions were going nowhere clinically and simply ending when everyone's confidence level rose enough to inspire a collective urge

to move to the next case. Or to lunch. Even in our luxurious university setting, supervision as usual was definitely a problem.

Outside the university setting, the problem could only be worse: Such time to discuss and reflect on cases is generally unavailable or very limited. Thus, over the same 10-year period, these issues regarding clinical supervision were the subject of much discussion in our state mental health system as well. In my work with the state Departments of Health and Education, I learned just how much more time we have at our university center to conduct supervision. Not surprisingly, most practitioners in the field participated in clinical supervision approximately once a month. The time and resources for thinking about cases were meager, and given our beliefs about the importance of quality review and case formulation, something needed to be fixed.

As part of a university and state mental health partnership in practice development, several of us quietly plotted the death of "supervision as usual." A model eventually emerged to help restructure supervision (i.e., the process of making decisions about cases) so as to improve efficiency and effectiveness (e.g., Chorpita & Donkervoet, 2005; Daleiden & Chorpita, 2005). In essence, this model was an attempt to codify strategies addressing this third issue—case formulation—and to make it work for clinicians who did not have the luxury of time to regularly review every case in detail. In an attempt to address concerns about supervision, we made some important discoveries about how to innovate our own clinical decision making. Whether one participates in supervision or not, these ideas are highly relevant to the routine decisions and considerations of clinical work.

FUNDAMENTALS MEET CASE FORMULATION

So how do we incorporate these new ideas about flexible case formulation and clinical decision making into a treatment manual? Treatment manuals are supposed to be static and linear, right? Well, not necessarily. Over time, my colleagues and I came to see how *case formulation* could be combined with detailed instructions for clinical strategies drawn from well-tested evidence-based approaches (i.e., the *fundamentals*), and this combination would provide the basis for how best to proceed with a given client. This manual is therefore organized on those principles. On the one hand, clear and discrete descriptions of how to execute important clinical techniques are needed. These are provided in Part IV of this book, where each technique is described in its own self-contained unit or *module* so it can be easily performed by following the steps as outlined. The outlines of these techniques are relatively straightforward, for the most part, and may already be part of some therapists' repertoires. The challenge, however, is that the fundamentals are easy to do poorly and difficult to do well. Making them seem natural and fitting to each individual child's problem can take some practice and time. Once mastered, though, they are like reliable tools in one's toolkit.

Much of the rest of this book is really about case formulation—figuring out what to do when, for which reasons. This first chapter provides the overall framework for these decisions and points to how to use other parts of the book for different decisions under

various circumstances. As with the fundamentals, mastery of case formulation takes some practice, too.

THE FRAMEWORK FOR CASE FORMULATION

Back to Friday morning. If we accept the notion that not every child will receive the same exact course of strategies in the same order for the same period of time, then we also must acknowledge the likelihood that clinicians will be faced with a seemingly overwhelming number of choices at various decision points. Ideally, each of these decisions should be as informed as possible, yet there are so many sources of information that it can quickly become difficult to know what information to use at any given moment. More often than not, the key decisions are not quite in focus, or when they are, the information relevant to those decisions is either overlooked or unavailable.

The case formulation model that drives our decision process for this protocol is outlined in Figure 1.1. Note that decisions are represented by diamonds and proceed in a structured order. Each decision is also informed by one or more pieces of information, which can come from a variety of sources (represented by stacked documents with a curved lower edge). One key principle is that decisions are not made in the absence of the appropriate information; the information sources for the key decisions are shown in the first column. Finally, decisions can lead to actions, which are denoted by labeled rectangles, and each of these actions can be further supported by sources of information, which appear in the fourth column of the figure.

Beginning in the upper-left hand corner, the figure shows that the first decision a clinician faces is treatment selection. In the context of this manual, one must therefore decide whether the child's problem is primarily anxiety and therefore appropriate for the methods and techniques described. To make this decision, the clinician performs a comprehensive assessment and uses the results of the assessment to decide whether the primary problem area for the child is anxiety (with or without comorbidity—more on that later). Chapter 3 of this book provides information about how that assessment is performed and how that decision is made.

If treatment for anxiety is appropriate, the clinician must then address the question of whether treatment is actually possible. In other words, in order to benefit from the strategies and skills outlined in the manual, a child and family must be able to engage in treatment—that is, to meet regularly, and in most cases, be willing to rehearse skills outside of meetings with the therapist. Information about whether engagement exists often involves scheduling (e.g., days to get the first appointment scheduled). If therapy is already ongoing, this information can involve other sources of information, such as the frequency of missed sessions, amount of incomplete homework, or the frequency and promptness with which phone calls are returned. If the level of engagement threatens the ability to administer the protocol altogether, then engagement must be addressed. Although common, these circumstances do not typically characterize the majority of cases; thus the strategies for working on engagement appear later in the book (Chapters 6 and 11).

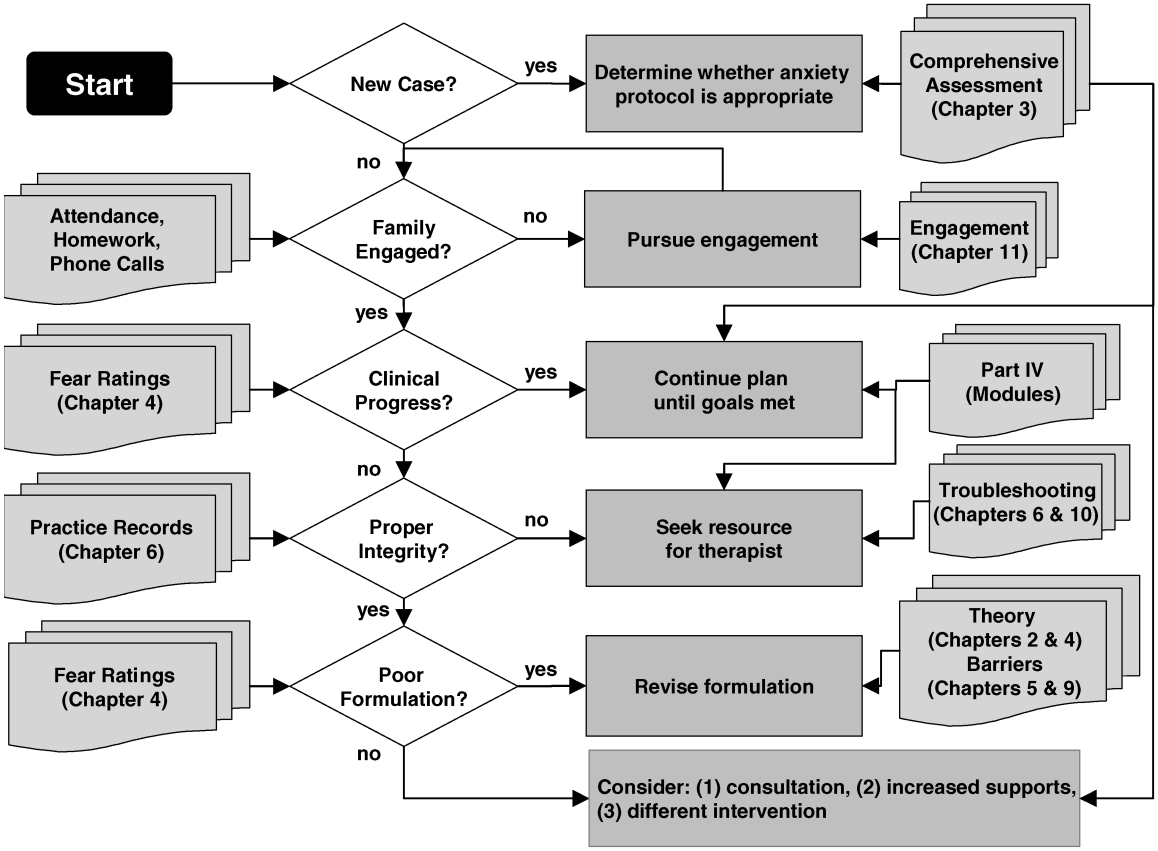

FIGURE 1.1. Case formulation: how to think with a manual. Adapted from Daleiden and Chorpita (2005). Copyright 2005 by W. B. Saunders. Adapted by permission.

Once engagement is observed or established, the decision making will then focus heavily on clinical progress. For a new case, this means getting a strategy in place that allows progress to be measured repeatedly over time. Repeated measurement of anxiety for this purpose is discussed in Chapter 4 and involves a list of feared situations for the child. This aspect of treatment allows one continually to reassess the success of the case formulation and adjust as necessary.

Once measurement is in place, ratings are obtained on a weekly basis, and these ratings inform a recurring review of clinical progress, as suggested by Figure 1.1. By this time, the therapist will be working from a treatment plan that suggests which techniques to use in what order (all treatment begins with a core plan that gets revised as needed). The details of the basic treatment plan and how it works are presented in Chapter 4. If the child is making progress, continuation of that treatment plan is recommended. Note that the action ("continue plan until goals met") is informed by the *fundamentals*, that is, the steps outlined in the treatment modules, as well as by information from the initial assessment, which spells out some of the goals for treatment.

If a child is not improving according to quantifiable ratings of progress, one must again consider the *fundamentals* (i.e., the proper execution of specific manualized techniques). In other words, clinicians should ask themselves whether they are performing the intervention properly. Because most of the treatment is organized around exposure, I have devoted three chapters to this single technique, covering the basics as well as how to troubleshoot its implementation. Troubleshooting involves the review of several records and information sources taken directly from treatment sessions (covered in Chapter 5). The same review of integrity is made not just for exposure but for all other clinical strategies as well, and Chapter 10 outlines methods to troubleshoot those. If there are problems with the implementation of specific techniques, Chapters 5 and 10 can to be used to identify possible solutions; more generally, additional therapist review of the modules could be needed.

Considering fundamentals should always precede jumping to case formulation decisions. In our supervision group, for example, before concluding that the basics are not working, a therapist must first demonstrate that these techniques were actually implemented properly. If not, then the tactic should be to fix the fundamentals rather than shifting to another direction. In my experience in training graduate students and community practitioners alike, there appears to be a strong bias toward jumping to a new plan. Who wants to believe he or she is not good at something? I certainly don't, and it is this rather normal reaction that often pushes a therapist prematurely onto a new plan when the old plan might have been fine—just poorly executed. Given the ubiquity of this error, the notion of "sticking to the plan" is given some serious attention in Chapter 4, which introduces the idea of the core treatment plan—in essence, every therapist's basic approach. That said, sometimes sticking to the plan simply does not work, and evidence mounts to justify a new approach. For example, comorbid oppositional behavior may interfere with even the best-designed exposure exercises. At this point, the appropriateness of the plan itself (here, to continue exposure) should be reconsidered. Given the complexity of revising a treatment plan, this decision should typically be informed by multiple sources of information. Important sources include clinical theory about childhood anxiety (Chapter 2), information about how treatment works under ideal circumstances (Chapter 4), information about how treatment works under less than ideal circumstances (Chapter 8), and strategies for selecting a new treatment plan consistent with a revised formulation (Chapter 9). In the context of a core theory about anxiety, the therapist is encouraged to hypothesize a new treatment plan and take appropriate action. The flowchart begins again in the upper left ("Start"), and the therapist continues to review engagement, clinical progress, and technical integrity, in turn. Although this method may sound complicated, in practice such reformulation often takes the form of "adding in" a reward program or a time-out program to address interference or obstacles with the ongoing treatment plan.

If the child is not improving despite what appears to be proper engagement, solid fundamentals, and an appropriate treatment plan, the therapist encounters the least desirable set of circumstances: being clinically "stuck" (see bottom rectangle in Figure 1.1). One should arrive at this stage only after reviewing all the prerequisite decisions and exhausting all other options. In this difficult set of circumstances, one may have to consider getting outside consultation, increasing the intensity of the intervention (e.g.,

considering a structured placement, adding other therapeutic supports), or whether another intervention altogether would be appropriate. Note that this action is informed by the initial assessment as well, which can be revisited to determine whether an entirely different approach would have been warranted (e.g., treating something other than anxiety). Fortunately, in our experience, this set of circumstances is rather rare. Most problems with clinical progress seem to be due to the earlier considerations outlined in Figure 1.1. Nevertheless, everyone can get "stuck" now and then, so this outcome is included in the figure for completeness.

HOW TO USE THIS MANUAL

Addis and Krasnow (2000) conducted a survey of practicing psychologists regarding their attitudes toward treatment manuals. One key finding is that practitioners for the most part do not use them. Here is the good news: The mere fact that you are reading a section called "How to Use This Manual" means you are exceptional. Keep up the good work (there is a lot more yet to read).

The bad news is that manuals may have some properties that make them unpopular or difficult to use. Two main themes presented by clinicians were that manuals do not emphasize (1) the importance of the therapeutic relationship or (2) individual case conceptualization. Let's briefly consider each of these in turn, because they speak directly to how to use this manual.

I have already said it, and I will say it again: The therapeutic relationship is important. One need not refer to the substantial and sometimes controversial literature on general versus specific factors in psychotherapy to be aware of this point. If an anxious child refuses to meet with you, you cannot get the job done. Thus a primary consideration in an ongoing case involves level of engagement (Figure 1.1). As mentioned earlier, this notion is covered generally in Chapter 11 and given special consideration regarding its most central procedures in Chapter 6.

That said, trying to teach someone how to manage the therapeutic relationship is a bit like trying to teach someone to be funny. This manual will give you plenty of things to consider regarding engagement, but chances are these are skills you already possess. Most of the therapists I have trained have shown remarkable ability to charm, delight, challenge, confront, and amuse the children they serve. It is an incredibly important skill and for many, perhaps, a gift. The book offers some illustrations, but if you are a practicing clinician, chances are your repertoire in this area is already an established part of your success. Go with what works for you and build off the suggestions and ideas in this book only when it seems appropriate.

Regarding the second theme, individual case conceptualization, this manual is a direct attempt to be different. The protocol is built around a case formulation framework, as outlined in Figure 1.1, and a flexible treatment planning algorithm covered in detail in Chapter 4. The case formulation and treatment planning processes are a major part of the protocol. Therapists should always know where they are with respect to the information in Figure 1.1 and should further know how the specific clinical strategies being used are tied to the formulation. It is best to read the main chapters of the book to

get a solid idea of how the case formulation and treatment planning process work. Once these are well understood, the vast majority of the "reading" of the protocol will involve selective use of the modules in Part IV. They do not need to be read front to back. They should be selected and implemented only as needed, in the order fitting the treatment plan that makes the most sense.

And finally, let us not forget what manuals may do best: detail the procedures for how to perform specific strategies. One of these strategies is so important, so central, so incredibly essential to learn, that three entire chapters and two treatment modules are devoted to it: exposure. Therapists in our program are taught to be masters of exposure. It is the most important tool in the anxiety treatment arsenal, and everything else a therapist does is designed to support it. So, read those parts and get good at exposure. If you are already good, then get better. It makes all the difference.

In summary, this protocol balances three areas: (1) engagement and the therapeutic relationship, (2) fundamentals (especially exposure), and (3) case formulation. All are important, and just like the figure shows, all are considered in that order. At least, that's how we do it every Friday.

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