

## A Retrospective Examination of the Similarity Between Clinical Practice and Manualized Treatment for Childhood Anxiety Disorders

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*The objective of this study was to facilitate the bidirectional communication between researchers and clinicians about the treatment of childhood anxiety disorders, including obsessive-compulsive disorder. Forty-four children were assessed before and after cognitive behavioral treatment with the parent versions of the Spence Child Anxiety Scale and Child Sheehan Disability Scale. In this retrospective study, treatment sessions were coded for the presence of exposures, relaxation, anxiety management, and behavior management. Results showed improved functioning within the clinical sample and suggested that treatment could be shorter, with exposure exercises implemented earlier in the course of treatment than described in manuals. Moreover, improvements in functioning were positively related to the use of exposures, and negatively related to the use of other anxiety management strategies. These results are discussed in the context of efforts to increase the availability of evidence-based treatments and are interpreted as supporting the development of more flexible treatment manuals.*

**E**PIDEMIOLOGICAL data suggest that anxiety disorders are the most common disorders in childhood (Merikangas & Avenevoli, 2002) and place children at increased risk for other forms of dysfunction (Merikangas & Avenevoli, 2002). Fortunately, efficacious treatments, including cognitive behavioral therapy (CBT), have been identified for a variety of childhood anxiety disorders, including obsessive-compulsive disorder (Abramowitz, Whiteside, & Deacon, 2005; Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; In-Albon & Schneider, 2007; POTS, 2004; Walkup et al., 2008). Despite the proliferation of treatment manuals to disseminate the use of CBT, evidence-based behavior therapy is not widely available in community outpatient settings (Goisman, Rogers, Steketee, Warshaw, et al., 1993; Goisman, Warshaw, & Keller, 1999; Storch et al., 2007; Valderhaug, Gotestam, & Larsson, 2004). As a result of the limited availability of behavioral interventions, the effectiveness of treatment in clinical settings has been found to be significantly lower than the efficacy of treatment in research labs (Weisz, Donenberg, Han, & Weiss, 1995; Weisz & Jensen, 2001).

One reason for the lack of availability of evidence-based behavioral therapy is that practitioners in the community infrequently use these approaches. For instance, almost 70% of clinicians report rarely or never using treatment manuals, often citing concerns regarding the perceived length and lack of flexibility of these protocols (Addis, 2002; Addis & Krasnow, 2000). The treatment of anxiety disorders provides a clear illustration of this disconnect between researchers and practitioners. Although there are multiple manuals describing the implementation of evidence-based procedures for childhood anxiety disorders, including obsessive-compulsive disorder (OCD; e.g., Kendall, 2000; March & Mulle, 1998), these procedures are rarely used in community settings (Storch et al., 2007; Valderhaug et al., 2004).

The responsibility for increasing the use of empirically based interventions may not rest solely with the practitioner. Despite the fact that many researchers emphasize the importance of exposures (Barlow, 1988; Beidel, Turner, & Morris, 2000; Davis & Ollendick, 2005; Kazdin & Weisz, 1998; Kendall et al., 2005; Marks, 1969; Silverman & Kurtines, 1996), many manualized treatments for childhood anxiety do not clearly deliver this message. Instead, most manuals begin with anxiety management skills (e.g., cognitive restructuring, relaxation training) before beginning exposures. For example, the most recognizable treatment for childhood anxiety disorders, *The Coping Cat* (Kendall, 2000), begins with eight sessions to develop an anxiety management plan,

followed by eight sessions of graduated exposures. Manuals for the treatment of OCD follow a similar format, although exposure exercises are typically initiated as early as the fourth session (e.g., March & Mulle, 1989). Although other treatments place a clear emphasis on exposures (Beidel et al., 2000; Chorpita, 2007), the manuals that have been held up as the standard barriers for the field in randomized controlled trials, and thus likely receive the most press, have followed a format of cognitive work followed by exposure (e.g., Walkup et al., 2008).

When faced with a multifaceted treatment program without guidelines regarding which components are the most effective, it is perhaps understandable that clinicians view manualized treatments as long and inflexible. As a result, practitioners may decide to select a limited number of CBT techniques and end up focusing on non-exposure-based strategies that are less distressing (for patient and therapist) and easier to administer in the office. In fact, even practitioners who endorse using CBT also report rarely using exposures and instead focus more on cognitive techniques and relaxation (Freiheit, Vye, Swan, & Cady, 2004; Goisman et al., 1993; Valderhaug et al., 2004). This is unfortunate given that a recent review of meta-analyses of treatments for *adult* anxiety concluded that there is strong support for behavioral treatment (e.g., exposures) but that, at least for some disorders, there does not appear to be increased benefit from adding cognitive techniques (Deacon & Abramowitz, 2004).

To overcome these obstacles, multiple researchers have encouraged the conduction of treatment outcome research by front-line practitioners and clinics with an increased focus on external validity (Addis, 2002; Green, 2008; Hatgis et al., 2001; Weisz et al., 1995). Consistent with this approach, the current study examines the content of clinic-based treatment for childhood anxiety disorders in an effort to influence clinicians and researchers to develop and implement flexible empirically based treatments. Specifically, the content of clinic-based treatment was compared to prominent protocols for the treatment of childhood anxiety disorders and OCD. In addition, the relation between therapeutic techniques and treatment outcome, measured by symptom reduction and improvement in functioning, was also examined. It was hypothesized that clinic-based treatment would be shorter in duration and include exposure exercises earlier in the course of treatment than published protocols while achieving significant symptom improvement. In addition, it was predicted that the degree to which exposures were used in treatment would be positively related to the amount of symptom improvement. Finally, exploratory analyses were conducted to investigate factors that might influence the use of treatment techniques.

## Methods

### Participants

Data regarding 43 child patients (21 male, 48.8%) ranging in age from 6 to 18 ( $M=11.59$ ,  $SD=3.2$ ) seen in an outpatient clinic between January 2005 and March 2008 were extracted from an IRB-approved clinical database. Patients were selected on the basis of having questionnaires regarding anxiety symptoms completed before and after treatment. A wide age range was preserved to reflect the variability in patients likely to be treated for anxiety. The majority of children were Caucasian (34, 79.1%; 14.0% unidentified). Parents were predominantly married (37, 86.0%) and had a 4-year degree (33, 80.5%). Diagnoses were made by a doctoral-level clinical psychologist or child psychiatrist after an evaluation as part of regular clinical practice. Diagnoses for all patients were determined consistent with the criteria outlined in the *DSM-IV* (American Psychiatric Association, 1994).

The majority of the patients had a primary anxiety disorder (40, 93.0%) and many had multiple diagnoses (28, 65.1%). The most common primary diagnoses were OCD (20, 46.5%) and generalized anxiety disorders (6, 14.0%). Although the majority of patients had at least one non-OCD anxiety disorder (31, 72.1%), children with a primary OCD diagnosis were examined separately for some analyses to remain consistent with common research practices (e.g., In-Albon & Schneider, 2007). Although OCD is an anxiety disorder, for the sake of parsimony these groups will be referred to as the Anxiety and OCD groups throughout this report.

### Setting

The patients were seen in a child anxiety disorders clinic that is part of a Department of Psychiatry and Psychology within a midwestern medical center. The anxiety clinic is known within the region for behavioral therapy for anxiety disorders, particularly OCD, and receives referrals from psychiatrists, other physicians, therapists, and families. The majority of the patients are covered by third party payers, including the medical system's health plan and outside insurers. The institution is a teaching hospital that includes a psychiatry residency and psychology postdoctoral fellowship. Clinical notes are maintained in an electronic medical record.

### Treatment

Treatment was provided by one of four therapists: a licensed doctoral-level clinical psychologist specializing in the treatment of childhood anxiety disorders, a postdoctoral clinical psychology fellow, or one of two master's-level therapists. The care of all the patients was coordinated and supervised by the licensed doctoral psychologist. All therapists had detailed knowledge of and

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