

## **The Anxiety Disorders Clinic for Children and Adolescents (TADCCA) at Aarhus University in Denmark**

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### **ABSTRACT**

This article serves as an introduction to the two case studies in this issue of *PCSP*. The first is the single case of "Erik," a 12-year-old boy with cognitive difficulties and multiple anxiety disorders who was seen with his family in a cognitive behavioral therapy group program designed for children with anxiety problems. The second case study is one of the total group of six families in which Erik was participating; as such it includes a summary of Erik's case in the context of the other five who participated. The group was conducted by a combination of a senior doctoral clinical psychologist and eight students. They were part of a training clinic, called The Anxiety Disorder Clinic for Children and Adolescents (TADCCA), in the Educational and Research Clinic of the Department of Psychology at Aarhus University in Aarhus, Denmark. This article describes the background and context of the TADCCA in which the two case studies took place.

*Key words:* childhood anxiety disorders; adult anxiety disorders; Cognitive Behavioral Therapy (CBT); training in CBT; Cool Kids Program; group CBT; case studies; clinical case studies

### **HISTORY PRECEDING THE TADCCA CLINIC**

Starting in 2005 and continuing until 2011, Dr. Esben Hougaard, a clinical psychology faculty member in the Department of Psychology of the University of Aarhus, established an Anxiety Specialty Clinic at the University. As explained by Dr. Hougaard (2008a, 2008b) in a past issue of the *PCSP* journal, the Anxiety Specialty Clinic offered cognitive-behavioral therapy (CBT) free of charge for clients with anxiety disorders, mostly panic disorder and social phobia, provided by supervised student therapists. The 16 students in the program were in their eighth semester or later of a 5-year clinical psychology masters program and the clients they saw in the Anxiety Specialty Clinic were, ordinarily, their first clients in psychotherapy. Clients were recruited from a newspaper advertisement and from the Clinic's website. They were invited to send in a brief description of their problems, which is used for diagnostic screening.

The training program had a span of two semesters and included a theoretical course on CBT of anxiety and depression. The theoretical course consisted of 12 three-hour classes plus 2

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two-day workshops in the first semester, and 4 six-hour “conferences” with student presentations of their theoretical papers and case-reports in the second semester.

A special format of clinical training and therapy was used. After an assessment interview the clients in the group program were offered 2-4 individual sessions with their student therapist. They then met for an intensive group program each day from 9 am to 2 pm over 5 days in one week. Each group generally included 8 clients and 8 students. Doctoral clinical psychologists led the first two hours of the day with the whole group present and then designed exercises, mostly to be carried out in small groups with 4 clients and 4 students, with the students as therapists the rest of the day. The purpose of this format was to present students with therapeutic models and to provide them with the opportunity of gradually learning to be in charge of the group therapy. A systematic case study of one of the treatment groups in the Anxiety Specialty Clinic, including detailed descriptions of both therapy process and outcome, has been presented by Dr. Hougaard (2008a, 2008b) in an earlier issue of *PCSP*. Also, an individual, systematic case study drawn from one of Dr. Hougaard's groups, with a special focus on investigating change mechanisms, has been completed for the *PCSP* journal (Jensen, Hougaard, & Fishman, in press).

## **HISTORY OF THE TADCCA CLINIC**

In 2008 I was at a 6 month research stay at the Centre for Emotional Health at Macquarie University, Sydney, to study the evidence-based, cognitive-behavioral "Cool Kids" program for treating anxiety disorders in children developed by Ronald Rapee and his colleagues (Rapee, Wignall, Hudson, & Schniering, 2000). At that time, no evidence-based treatments for children with anxiety disorder were available in Denmark, and access to treatment for children with anxiety disorders within the public health system in Denmark was scarce and random. The purpose of my research stay was to be trained in the Cool Kids treatment program for children with anxiety disorders, and in the Anxiety Disorders Interview Schedule for children and parents (ADIS-C/P) (Albano & Silverman, 1996), a semistructured diagnostic interview for children with anxiety disorders. Returning to Denmark in August 2008, I adapted and translated the manual and workbooks for the Cool Kids program into Danish, and established a design for an uncontrolled pilot test of the feasibility and efficacy of the Cool Kids program in Denmark.

With Dr. Hougaard's encouragement, I agreed to establish TADCCA, a training clinic for anxiety disorders in children and adolescents that would parallel Dr. Hougaard's adult anxiety training clinic. We decided to conduct a shared teaching program for 16 students of which 8 were attached to the child anxiety treatment program, and 8 were attached to the adult anxiety treatment program.

TADCCA is now well established, and it employs a staff consisting of two full-time masters-level clinical psychologists, two full-time PhD psychologists, and a full-time post-doctoral fellow. TADCCA is presently conducting several large randomized controlled trials of the efficacy of CBT for children with anxiety disorders (Thastum, 2011).

In early 2009, however, when the clinic started up, and at the time of the two systematic case studies in this PCSP issue, the clinic consisted only of myself and the eight students. When the students started the theoretical part of the program, which was the same as that described above as part of Dr. Hougaard's training program although with inclusion of child anxiety relevant literature, we had not yet started the recruitment of children to the treatment program, and the students assisted in the final adaptation and translation of the Cool Kids workbooks and therapist manual, and in the translation of the questionnaires which we planned used in the evaluation of the treatment program. In February 2009 I put an advertisement in a local paper and informed local school psychologists about our new, free-of-charge clinic and the first group with children aged 7-10 began in the spring. The children in the case studies in this issue of *PCSP* are drawn from this first group. The case study of Erik (Lundkvist-Houndoumadi & Thastum, 2013a) in its initial draft was written by Irene Lundkvist-Houndoumadi, one of the students working in this first group. This initial draft was an example of the systematic case study that all the students who participated in the program had to write to pass the program. The study of the responders and nonresponders in Erik's group (Lundkvist-Houndoumadi & Thastum, 2013b) was later written as Ms. Lundkvist-Houndoumadi's master thesis.

## **PRESENT STATUS OF THE TADCCA CLINIC**

Ms. Lundkvist-Houndoumadi's case study of Erik and the group Erik participated in was a pilot-test for the adaptation of the Cool Kids program from an Australian to a Danish setting. The success of the pilot-test (Thastum, Matthiesen, & Jørgensen, 2011) led to the development of funding for a program of research to systematically investigate the efficacy of the Cool Kids program (Hudson et al., 2009) in the Danish setting. Following our experience in using case studies in our pilot program, we have designed case studies into our research, using a mixed method approach as recommended by Dattilio and associates (Dattilio, Edwards, & Fishman, 2010). As with the pilot cases, students in training are a core element in the clinical work associated with the different components of the research program. In other words, the research and training conducted by the TADCCA are thoroughly integrated.

Specifically, the present research consists of the following components:

- 1) A randomized controlled trial (RCT), including 110 participants (aged 7-15 years) with an anxiety diagnosis as the primary diagnosis. Participants are randomly allocated into either a 3-month wait-list control condition or a treatment condition. The treatment consists of ten 2-hour group sessions with 6 children and their parents. Results are measured by independent diagnostic interviews with the children and their parents at post-treatment and at 3-month follow-up using the Anxiety Disorder Interview Schedule (ADIS-C/P; Albano & Silverman, 1996), as well as by self-report child and parent scales pre- and post-treatment, and at 3-month and 12-month follow-up.
- 2) An evaluation of the outcome of an individualized treatment plan for children who have not responded adequately to the RCT, by use of systematic case study methodology. Three months after the end of the manual-based group treatment, children who show a limited or a lack of response (measured by the Clinical Global Impression-Improvement of Anxiety scale

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[Shaffer et al., 1983]) are offered additional individualized treatment at the clinic, if they do not receive treatment elsewhere and the primary problem is still in the internalizing/negative affect area.

Approximately 20 % of the children in the RCT have so far not responded adequately when measured three months after the end of treatment. At a clinical conference a new case formulation is created for the child and an individualized treatment plan is made in consultation with the parents. The effectiveness of the treatment is assessed on the basis of both qualitative and quantitative data (see below). Systematic case studies will be written up for all the non-responders included in this project.

- 3) One or more good-outcome and poor-outcome cases will be selected from the cases participating in the RCT and will be written up as systematic case studies.
- 4) Note that there will be a rich database of qualitative and quantitative data available for all the case studies included in items 2 and 3. The qualitative data include notes on the course of therapy; video recordings of therapy sessions; case studies written by psychology students; and semi-structured interviews. The quantitative data include standardized self-report measures completed by the children and their parents (at pre-treatment, post-treatment, 3-month follow-up, and 12-month follow-up); and diagnostic interviews (the ADIS-CP) and the Children's Global Assessment Scale completed by the therapists (at pre-treatment and post-treatment).

## **THE CLINICAL TRAINING PROGRAM**

### ***Admission and Final Papers for Passing***

The clinical training program spans over two semesters (one year), and 12 students are accepted in each year. There are thus 12 students in the program at any one time. The students are at minimum in their 8<sup>th</sup> semester of an undergraduate curriculum. Before entering the program they have had theoretical courses in child and adult psychopathology, psychotherapy for various disorders, and a training course in basic counseling skills. The students apply for participating in the program, and are selected based on their previous grades and motivation for the program. Previous experience with psychotherapy is not a selection criterion. This program is the only program at the department that offers students hands-on experience with psychotherapy, and the program is thus very popular. To pass the program the students have to write both a theoretical paper on anxiety disorders in children and a systematic case study on one of their clients organized according to the guidelines in this *PCSP* journal.

### ***Therapy Research Participation***

The students in the clinical training program are contributing to the mixed method research outlined above. Specifically, each semester about 3 treatment groups with 6 children and their parents each are running over a period of 3 months in the RCT study, and the non-responder treatment is running continuously over the year. The group treatment starts in February and 3-4 students are attached to each group. The main therapist of the group treatment

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is one of the clinical psychologists in the Clinic, but the students are each connected to 1-2 children and their parents in the group. The students are responsible for having the clients complete the session rating scales as mentioned earlier, and they help the children and the parents with the session-by-session tasks. Also the students discuss difficulties with last week's homework with their families in the start of the session, and they help the families with planning the homework during the following week at the end of the session. When appropriate, the students are allowed to arrange a home visit with their families during the group treatment. Although the clinical psychologist is responsible for the treatment, the students are thus functioning as co-therapists for their families. In addition, the students document the unfolding therapy process, the child's and parents' commitment to treatment and motivation, the impact of the child and family's life situation while in therapy, and the therapeutic alliance.

When the students have participated in one group treatment program, they have the opportunity of being co-therapists together with a clinical psychologist in the individualized non-responder treatment, and in some instances, when there are children who for some reason do not fit into the research program, these experienced students are allowed to conduct an individual, manualized treatment program with the child together with another student in the program. During the one-year clinical training program, most students participate in 2-3 group session programs, and 1-2 individualized treatments.

The students are supervised in groups of six for 3 hours a week during the whole program. The supervision is conducted by a clinical psychologist in the clinic, typically the same psychologist who has been responsible for the group treatments in which the students have participated. In the first hour of the supervision all children whom the students are in contact with are reviewed. Discussion focuses on how the child and the parents are working in the therapy, and how the collaboration is with the family. Problems are discussed in the group, and advice is provided on how the students can work with the family. If the students want it or if it is considered important by the supervisor, obstacles to the therapeutic progress, including the students' personal problems, can be focused on.

In the second two hours, individual students present and the other students function as a reflecting team. Often in this process a case formulation is prepared for the child in supervision using Carr's (2006) model, in which distinctions can be made among different types of risk factors, including: *predisposing* factors, *precipitating* factors, *maintaining* factors, and *protective* factors. In addition, the following sorts of questions are used to stimulate reflection: "What is the core of the problem?" "How are the parents influencing the child's anxiety?" and, "How do you adapt the manual to the child's problem?" The supervisor interviews the supervised student, and then invites the reflecting team to discuss one or two specific episodes during the session.

### ***Didactic Activities***

In the didactic component of the training program, the students read texts on etiology, biology, classification, epidemiology, environmental influences, diagnosis, case-formulation, and treatment of anxiety disorders in children. The students meet with the teachers three hours

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weekly, and the teaching format is a combination of presentations by the students and the teachers, discussion, and exercises.

Early in the first semester we arrange two 2-day courses in assessment, case formulation, and CBT techniques. In the assessment course the students learn about anxiety diagnosis according to the ICD-10 and DSM-IV classification systems, and they watch videotaped examples of diagnostic interviews based on the ADIS-C/P format. Ratings of severity and symptoms are discussed, and the students conduct diagnostic interviews with another student role-playing a child with an anxiety disorder. Also the students are introduced to the self-rating scales used in the Clinic, and they learn how to conduct a case formulation. In the course on CBT-techniques, the students are introduced to the structure and content of the Cool Kids manual and to the main treatment techniques used in the program. They watch videos of treatment sessions, and role-play some of the therapeutic elements (e.g., cognitive restructuring, exposure hierarchies, assertiveness training and problem solving) acting as therapists, children, and parents. Also they are introduced to the daily work in the Clinic and to the duties they are expected to carry out during the program.

All students are given a handbook for the Clinic, in which there are chapters on systematic case study methodology, statistical procedures for inferring clinical and statistical significance at the single case level, being a new therapist, a description of the content and psychometric properties of the measures used in the Clinic, and a detailed review of all the practical procedures in the Clinic and the research protocol.

In the second semester more focus is on feedback and discussion concerning the student's ongoing work on the systematic case study and on the theoretical paper.

All in all, we believe the training program we have developed is able to maintain a proper balance and complementarity between didactic education and experiential clinical training.

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