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Highlights...

Our page 1 stories look at how DBT can help patients change, and exposure therapy delivered via telehealth.

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Monthly reports on the problems of children and adolescents growing up

DBT

Building commitment to change: Lessons from DBT

By Andrea L. Gold, Ph.D.

"In my experience, one of the chief reasons for many therapy failures and early terminations is inadequate commitment by either the patient, the therapist, or both." — Marsha Linehan, Ph.D. (Linehan, 1993, p. 285)

Every day in my work as a therapist, supervisor, and clinical team member, I seek out opportunities to assess and strengthen commitment in myself and others. Much of what I do to build commitment I learned from dialectical behavior therapy (DBT). DBT describes commitment as an intention to take specific actions (or inaction) as a clear plan toward one's goal. Here I share lessons on commitment work in psychotherapy, which I have drawn from my training in DBT, my clinical experiences treating individuals and families with severe anxiety and emotion dysregulation, and my experiences both receiving and providing supervision and consultation on interdisciplinary treatment teams. First, I frame and flesh out commitment in the broader context of DBT. Then, I describe specific commitment strategies taught and practiced in DBT.

DBT, including its adaptation for adolescents (DBT-A), never assumes commitment and instead treats it as a behavior to be explicitly elicited, learned, and reinforced (Linehan, 1993; Miller, Rathus, & Linehan, 2007). Similar to all other treatment strategies in DBT, commitment strategies draw from other types of psychology and psychotherapy research (e.g., social psychology, motivational interviewing, CBT). Commitment is relevant for any psychotherapeutic process targeting change, and therefore useful in the context of other treatment approaches beyond DBT. In other words, I encourage you to keep reading even if you do not practice DBT.

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OCD

Delivering exposure therapy via telehealth: Benefits and challenges

By Elena Schiavone, Jennifer Freeman, Ph.D., and Erin O'Connor, Ph.D.

Since the onset of the COVID-19 pandemic, the need for anxiety and obsessive compulsive disorder (OCD) treatment for youth has persisted, if not increased. This pandemic has introduced new triggers, intensified existing worries, and infused broader uncertainty. New triggers include illness concerns (i.e., worries about contracting or spreading COVID-19), social isolation, disruption of routine, and increased family conflict. In contrast, however, the pandemic has increased access to care for some via the expansion of telehealth services. This article details the benefits and challenges the authors have experienced delivering exposure therapy, a treatment that involves gradually confronting feared stimuli, via telehealth.

Prior to the pandemic, telehealth mental health services were gaining popularity (Frueh et al., 2000; Monnier et al., 2003; Richardson et al., 2009). Telehealth services have advantages over in-person care, particularly increased accessibility by addressing common treatment barriers (e.g., removing need for transportation, travel time, and childcare) and expansion

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OCD

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of regional coverage. Research indicates that telehealth psychotherapy outcomes are comparable to that of in-person treatment for youth and adults across several modalities and disorders, including evidence-based practices (EBPs) for anxiety, OCD, and related disorders (Aboujaoude, 2017; Acierno, Knapp, & Tuerk, 2017; Comer et al., 2017). However, research and clinical guidelines for exposure therapy delivered via telehealth are limited.

Benefits

- Completing treatment where anxiety and OCD "live." Anxiety and OCD often "live" in the home, meaning many triggers are specific to one's home environment. Telehealth overcomes a significant in-office treatment challenge: the inability to complete exposures with items in one's home. Translating completion of exposures from the office to the home can often be a challenge for families because at-home exposures can look different and feel tougher. Completing exposures via telehealth facilitates this transition and helps youth complete naturalistic exposures in real-life settings (e.g., kitchen or bedroom).
- Easy completion of visual exposures. Telehealth easily supports exposures featuring visual aids or video. For example, to treat a specific phobia of needles (a common and interfering fear for youth), exposures often include looking at images of needles and watching videos of immunizations or blood draws. Telehealth easily supports these exposures with screen-sharing features. The therapist can display pictures or videos, easily manipulate the size of an image, and quickly pause and replay videos; such abilities help therapists modify an exposure to the appropriate difficulty.
- Insight into the home environment. Video conferencing with families at home allows therapists to gain valuable insight into a youth's environment. For example, a therapist is able to observe that a youth with separation anxiety lives in an apartment with little privacy, making it difficult to practice being alone. Observations like these can be critical to a therapist's decision-making for what exposures to assign for homework and how to best support youth in completing exposures.
- Inclusion of additional household members. Telehealth allows for the inclusion of family members not typically involved in treatment, such as siblings or other caregivers to join sessions. Siblings can join with the patient in their "fight" against anxiety/OCD by completing exposures and modeling how to face one's fears. A caregiver or relative can participate and learn how to reduce reassurance and help the youth face day-to-day naturalistic exposures.
- Caregiver participation across households and locations. In a family where all caregivers live under one roof, one caregiver can attend sessions and easily relay information to the other caregiver(s). However, many families have diverse structures and there are often caregivers across several households that would benefit from attending sessions. In office-based treatment, multiple caregiver attendance often requires various family members coordinating schedules and childcare. With telehealth, caregivers can join sessions remotely — from home, work, or a car. This type of family involvement is crucial, as exposure therapy with youth relies upon caregiver support to participate in exposures that arise across homes.
- Minimization of barriers to treatment. Telehealth services overcome several treatment barriers by allowing families to complete treatment from where they are most comfortable. It also removes the need for travel time, a mode of transportation, and childcare. This is particularly powerful in advancing mental health equity given that treatment barriers often negatively impact families with lower incomes disproportionately (Bringewott & Gershoff, 2010). Families experiencing treatment barriers often have higher rates of missed sessions in office-based treatment. Our center — and others (Wood et al., 2020) — have experienced an increase in attendance with telehealth.
- Higher dose of treatment. The increased session attendance in telehealth increases the dose of treatment. As higher doses of psychotherapy are associated with better treatment outcomes (Klein et al., 2003; VanDeMark et al., 2010), increased treatment dose associated with telehealth is noteworthy. Exposure therapy, in particular, relies upon regular sessions for youth to learn exposure skills (e.g., intentionally facing one's worries, sitting with distress, resisting avoidance behaviors).
- Increased willingness to commit to weekly treatment. We have observed that families seem more willing to commit to weekly treatment via telehealth rather than in-office treatment, which facilitates future treatment engagement. This may be connected to other telehealth benefits, particularly reduced treatment barriers.

Challenges

- Impeded rapport building. Rapport building is particularly crucial for exposure therapy given that exposure relies upon trusting one's provider enough to intentionally choose to tolerate distress. Video conferencing often feels less intimate, which can inhibit connectedness and rapport, and tools for developing rapport with youth (i.e., games) are more challenging via telehealth. Building rapport via video conferencing is particularly difficult with some youth (e.g., those who are young, depressed, and/or on the autism spectrum).
- Limited camera view. Telehealth provides therapists with a limited view of youth and their families. How limiting this is depends on camera angles, furniture arrangement, etc. Limited views can impede exposure delivery and broader communication. Families' non-verbal communication can be particularly helpful for exposure therapy (e.g., assessing a youth's distress and family engagement). Assessing a youth's distress level is particularly important as it allows the therapist to determine if an exposure is appropriately challenging, especially with youth whose self-report is unreliable.
- In-home distractions. Completing sessions in the home has several benefits, but it can also include distractions. For example, a caregiver

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may feel pulled to help siblings with homework completion or settle sibling disputes. Likewise, youth may become distracted by wanting to play with electronics or siblings. These realities of the home environment can break a youth's focus, which is integral to completing effective exposures.

- Lack of privacy. In some home environments, access to privacy may be limited. In these cases, youth and family may feel less comfortable sharing sensitive information and completing exposures. When in view of others, youth may not complete exposures they consider embarrassing, such as eating in the bathroom to target contamination worries.
- Technological issues. While sometimes video conferencing works seamlessly, one can experience significant technological difficulties. Therapists and youth may experience poor video quality due to poor WIFI signal strength, internet disconnection, and poor audio due to microphone difficulties. Technological difficulties can range from mildly annoying to significantly disruptive.
- COVID-19-specific limitations. Due to stay-at-home orders and social distancing guidelines, in-community exposure homework possibilities are restricted. This is particularly treatment interfering for youth whose fears "live" outside of home, such as youth with social worries or specific phobias. Due to COVID-19 regulations, youth with needle phobias cannot visit doctors' offices without medical necessity. Due to social distancing, youth with social worries may not be able to complete exposures involving interactions with peers. Lastly, exposures targeting contamination or illness fears are complicated to navigate during the pandemic as careful sanitation is encouraged for public health.

Discussion

As detailed in this article, there are numerous benefits and challenges to completing exposure therapy via telehealth. Many of the listed benefits are interconnected. For example, telehealth's lower burden on families (e.g., no transportation needed) can increase a family's willingness to commit to weekly sessions, lead to higher attendance and higher dose of treatment, and reduce overall strain on families. Of note, the benefits telehealth offers are contingent upon which delivery model you are comparing it to. For example, the first and third benefits listed above are particularly salient for telehealth treatment over in-office treatment; however, benefits are minimized when compared to in-person home-based treatment. Overall, the authors believe that the benefits (e.g., decreased burden on families, completing treatment where anxiety and OCD "live," increased attendance) outweigh the challenges (e.g., impeded rapport building, distractions in the home, technological difficulties). While there may be particular benefits to in-person treatment for some cases, the benefits of telehealth are significant and can help advance inequities in access to treatment. While difficulty navigating technology may have previously been a barrier, the pandemic has led to increased video conferencing literacy and comfort with this technology as a medium for healthcare and meaningful communication. The authors wrote this article as a result of being propelled into telehealth by the pandemic. While the authors have learned much about exposure delivery via telehealth, there remains much to learn. Given that healthcare looks to be permanently changed by the pandemic, more investigation should be conducted to help navigate this new landscape.

Note: The authors are a part of the Pediatric Anxiety Research Center at Bradley Hospital and have been providing exposure therapy via video-based telehealth to youth with anxiety and OCD since March 2020.

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