THE UNIFIED PROTOCOL FOR THE TRANSDIAGNOSTIC TREATMENT OF EMOTIONAL DISORDERS IN CHILDREN (UP-C): A CASE STUDY

EL PROTOCOLO UNIFICADO PARA EL TRATAMIENTO TRANSDIAGNÓSTICO DE LOS TRASTORNOS EMOCIONALES EN NIÑOS (UP-C): ESTUDIO DE CASO

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Abstract

This case study aims to describe the application of the Unified Protocol for Transdiagnostic Treatment in Children (UP-C) to an 8-year-old female child (B.) with comorbid anxiety disorders (e.g., separation anxiety; specific phobia (dogs); agoraphobia; social anxiety). The UP-C is a transdiagnostic cognitive-behavioral approach for children and parents that aims to reduce the frequency and severity of aversive emotional experiences through the development of more adaptive emotion regulation strategies. After 15 group treatment sessions, B. demonstrated significant reductions in anxiety symptomatology as well as functional improvements. This case illustrates the clinical utility of the UP-C for children with a range of emotional disorder symptoms.

Keywords: unified protocol; transdiagnostic treatment; children; emotional disorders; case study.

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Resumen

Este estudio de caso pretende ilustrar la aplicación del Protocolo Unificado para el Tratamiento Transdiagnóstico en Niños (UP-C) en una niña de 8 años (B.) con trastornos de ansiedade comórbidos (e.g., ansiedad por separación; fobia específica (perros); agorafobia y ansiedad social). El UP-C es un enfoque cognitivo-conductual transdiagnóstico, para niños y padres, destinado a reducir la frecuencia y la gravedad de las experiencias emocionales aversivas mediante el desarrollo de estrategias de regulación de las emociones más adaptativas. Después de 15 sesiones de tratamiento en grupo, B. mostró reducciones significativas en la sintomatología de ansiedad, así como mejoras en su funcionamiento. Este caso ilustra la utilidad clínica del UP-C para niños con una serie de síntomas de trastornos emocionales.

Palabras clave: Protocolo unificado; transdiagnóstico tratamiento; niños; trastornos emocionales; estudio de caso.

Introducción

The experience of emotional disorders (EDs), such as anxiety and depressive disorders, during childhood is prevalent (Kessler et al., 2005) and is associated with high comorbidity (Brown et al., 2001). EDs can have a significant impact on a child's life and family context (Bittner et al., 2007). When left untreated, these disorders often lead to disturbed emotional states in adulthood (Achenbach et al., 1995; Copeland et al., 2014; Pine et al., 1998).

In recent decades, several clinically efficacious interventions have been developed for the treatment of EDs in children, with cognitive-behavioral therapies (CBT) (Kennedy et al., 2018) presenting higher levels of empirical support. However, most CBT therapeutic protocols are disorder-specific and are not suitable for the simultaneous treatment of comorbid disorders (Lundkvist-Houndoumadi & Thastum, 2017), which may be one of the reasons why the total remission of anxiety symptoms is rare (Kennedy et al., 2018).

To overcome these limitations, a transdiagnostic treatment, the Unified Protocol (UP) or Transdiagnostic Treatment of Emotional Disorders (Barlow et al., 2008), has been designed to address EDs. This treatment is an emotion-focused and evidence-based approach based on principles of CBT, which includes the identification and modification of maladaptive thoughts through exposure and extinction of defensive avoidance mechanisms (Barlow, 2008; Barlow & Craske, 1989). By allowing the use of a single therapeutic protocol for several clinical conditions (Craske et al., 2007), this new approach provides a more cost-effective use of resources than other therapeutic interventions that require intensive training in several manualized interventions (Addis et al., 1999). Furthermore, the UP (Barlow et al., 2008), by placing the therapeutic focus on core processes common across EDs, such as neuroticism, avoidance, rumination, and anxiety sensitivity, provides clinically meaningful results in both principal and comorbid diagnoses (Ellard et al., 2010). The Unified Protocol intervention has been adapted to address EDs in children (The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders in Children [UP-C]; Ehrenreich-May, Kennedy, Sherman, Bilek, & Barlow, 2018) and in adolescents (The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders in Adolescents [UP-A]; Ehrenreich-May, Kennedy, Sherman, Bilek, Buzzella et al., 2018).

The UP-C is an extension of the UP that has been adapted for children between 6 and 12 years old; this single-intervention approach comprises cognitive-behavioral strategies such as opposite action, problem solving, cognitive reappraisal and exposure, as well as mindfulness techniques (Kennedy et al., 2018). Moreover, the UP-C also addresses central emotional parenting behaviors, such as criticism, inconsistency, overprotection, and modeling of strong emotions, which are common in parents of children with anxiety and depressive disorders. The UP-C comprises 15 weekly group sessions of 90 minutes for children and their parents, conducted separately by two therapists. The skills worked on during the intervention sessions with the children are based on the analogy of an "emotion detective", which makes the UP-C more appealing and interactive for children (Ehrenreich-May, Kennedy, Sherman, Bilek, & Barlow, 2018).

Research on the UP has provided support for the efficacy of this intervention in children with EDs (Ehrenreich-May et al., 2017; Kennedy et al., 2019). An RCT conducted by Kennedy, Bilek & Ehrenreich-May (2019) compared the UP-C with an anxiety-focused CBT program and revealed that while both therapeutic approaches were effective in treating anxiety symptoms, the UP-C led to more significant improvements in treatment response at follow-up, depression, emotion regulation and cognitive reappraisal. Recently, a feasibility study that explored the feasibility, acceptability, and preliminary efficacy of the UP-C in a Portuguese sample of children with EDs demonstrated low dropout rates, high attendance rates, and high levels of child and parent satisfaction with the intervention. In addition, significant reductions in children's levels of anxiety and depression and of interference and severity of this symptomatology were observed at posttreatment and at the 3-month follow-up (Caiado et al., 2022).

This case study describes the application of the UP-C to an 8-year-old patient, with comorbid anxiety symptoms presenting a detailed overview of the UP-C and the main results obtained.

Case Conceptualization

B. (pseudonym) is an 8-year-old Portuguese female who lives with her mother, her twin sister, and her father. At the beginning of the UP-C, B. and her mother reported that her main difficulties were fear of being alone or separated from her mother, fear of dogs, fear of closed spaces and of new situations/activities and anxiety in performance situations (e.g., tests, going to the board, doing presentations).

A few months before B. presented for treatment, her father had been hospitalized due to COVID-19 complications. During that time, she complained of head and stomach aches when going to school, as well as urine losses. After this experience, B. became anxious about being apart from her family, as she feared that something bad would happen to them. She would refuse to go to after school activities, spend the night away from home (something that had not previously caused her stress), or let her mother go anywhere without her (including the bathroom), and she would become very anxious if her mother or any other person would be late to pick her up from school, fearing something bad had happened to them or that they had abandoned her. She justified these behaviors with thoughts such as "I want to stay and take care of you", assuming a caretaker role regarding her loved ones.

In addition to these difficulties, B. also presented with an intense fear of dogs. Despite owning a dog herself, she would become very scared whenever she saw other dogs, to the point of screaming and exhibiting avoidant behaviors (e.g., crossing the road to the opposite side of where the dog was, asking to leave places when she would spot a dog, steering far from dogs and climbing on her mother's lap when a dog was close) when she saw dogs other than her own. The fear was more intense regarding bigger dogs, especially dogs bigger than her own.

B. also presented some agoraphobic symptoms, such as being afraid of enclosed spaces, including bathrooms, airplanes, boats, or cable cars, due to fear of being closed-in and not being able to get out. Due to this fear, she would often avoid some transports (e.g., she refused to go on vacation abroad for fear of going on an airplane), as well as adopt some safety behaviors in places such as public bathrooms (e.g., going only with her mother, not closing the doors all the way).

Evaluation situations, such as tests or presentations, were also stressful stimuli to B. She would complain of head and stomach aches 1 to 3 days prior to the situations, would have difficulty sleeping the night before any of these situations, and verbalized thoughts such as "I can't do it, I'm going to fail". It was also hard for her to participate in class, including activities such as answering questions out loud or completing exercises on the board, both of which she avoided for fear of doing something wrong and being made fun of by her classmates. Her fear was amplified that fact that her twin sister presented no fear of participating in classes, which not only made B. feel bad in comparison but also made her fear for her sister whenever she got a wrong answer.

B. also presented some difficulties regarding openness to new experiences. She avoided all new things, especially things she would perceive as risky to her well-being. She

would refuse to try things like rollercoasters, radical sports such as slide or rappel, or getting close to mascots like Mickey Mouse at Disneyland, fearing something bad would happen to her (i.e., she would get hurt).

Assessment

Prior to treatment, B.'s emotional symptomatology was assessed via the Mini Neuropsychiatric International Interview for Children and Adolescents (MINI-KID; Rijo et al., 2016; Sheehan et al., 2010) after receiving informed consent from the parents. Once the diagnostic interview was made, the therapist rated the overall severity of B's difficulties with a score of 5 (markedly ill) on the Clinical Global Impairment–Severity scale (CGI-S; Guy, 1976). The CGI-S assesses the overall severity of children's difficulties in comparison to past patients with the same diagnoses on a scale from 1 (normal, not at all ill) to 7 (among the most extreme ill of patients) from the therapist's perspective. This scale, as well as the Clinical Global Impairment-Improvement (CGI-I), is rated on a scale from 1 (very much improved) to 7 (very much worse), were administered after the end of treatment to assess the therapist's perspective of the child's improvement or worsening compared to the child's initial state at the beginning of the intervention.

Additionally, B. and her mother completed a battery of self-reported measures at baseline, posttreatment and at the 3-month follow-up, as follows:

The Revised Child Anxiety and Depression Scale (RCADS; Chorpita et al., 2000; Pereira & Pedro, 2019) was used to assess children's anxiety and depression symptoms. The RCADS has 47 items, answered on a 4-point Likert scale (0 = never to 3 = always) and comprises two subscales: (1) depression (10 items) and (2) anxiety (37 items distributed across five dimensions: separation anxiety disorder, generalized anxiety disorder, panic disorder, social phobia, and obsessive-compulsive disorder). Higher total scores on the anxiety and depression subscales indicate more severe symptoms.

The Child Anxiety Life Interference Scale for children (CALIS-C; Lyneham et al., 2013; Marques et al., 2015) and for parents (CALIS-P; Lyneham et al., 2013; Marques et al., 2015) are two parallel measures that assess the life interference and impairment of the core symptomatology experienced by the child from the child's (CALIS-C) and parent's (CALIS-P) views. The CALIS-P comprises two subscales: (1) the Child Interference Subscale and (2) the Family Interference Subscale. The Portuguese version has 9 items (CALIS-C) and 16 items (CALIS-P) scored on a 5-point Likert scale (0 = not at all to 4 = a great deal). Higher scores indicate greater interference of the child's symptoms in the life of the child and the family.

Course of Treatment and Progress Assessment

Course of Treatment

B. and her mother completed the full UP-C, with a total of 15 weekly group sessions and a duration of 90 minutes. Throughout the treatment, B. and her mother used the UP-C Children and Parents workbooks (Ehrenreich-May, Kennedy, Sherman, Bilek, & Barlow, 2018), which are structured through the analogy of an "emotion detective" and organized into five core sections around the acronym CLUES: (1) "Consider How I Feel", (2) "Look at My Thoughts", (3) "Use Detective Thinking", (4) "Experience My Fears and Feelings" and (5) "Stay Healthy and Happy".

Below is a brief description of the children's and parents' contents covered in the five core CLUES sections of the UP-C:

(1) ***Consider How I Feel (Sessions 1–4)***: regarding children's contents, the first section of the UP-C is dedicated to introducing the model and structure of the UP-C, identifying the top problems, developing the relationship between group members and the therapist, providing psychoeducation about emotions (e.g., function of emotions; parts of an emotional experience; emotional normalization; avoidance cycle) and training behavioral activation, body scanning and interoceptive exposure. The contents of the parents' section focus on providing psychoeducation

about children's emotions and about emotional parenting behaviors and analyzing positive reinforcement and empathy as the opposite behaviors for criticism.

During the first session, B. identified four top problems: (1) fear of separation from the mother; (2) fear of dogs; (3) fear of performance situations (e.g., tests, going to the board, oral presentations) and (4) fear of closed spaces and new situations/activities. These top problems were rated on a scale from 0 (not at all a problem) to 8 (extreme problem) by B. and her mother.

In Table 1, we present the Top Problems severity in the first session, considering B. and her mother reports.

In this section, B. learned how to distinguish the three parts of her own personal experience of anxiety (e.g., thoughts: "something bad will happen to my mother"; body clues: "racing heart and sweating hands"; and emotional behaviors: "always stay close to my mother"). B. also worked with her therapist to analyze the short- and long-term consequences of specific emotional behaviors associated with the experience of anxiety, the cycle of avoidance, and the importance of engaging in opposite actions for her emotional experiences. During this section, B. learned about the relationship between her physical sensations and emotions, how to identify the physical sensations she experienced when she was anxious (e.g., racing heart) and how to use interoceptive exposure and body scanning techniques to notice these sensations without making anything to make them disappear.

(2) ***Look at My Thoughts (Session 5):*** in this section of the UP-C, children learn the concept of flexible thinking through thought identification and identification of "thinking traps" (i.e., the main cognitive distortions, including jumping to conclusions, thinking the worst, ignoring the positive, and mind reading). Parents learn about inconsistent reinforcement and punishment and the opposite parenting behaviors of consistent discipline and reinforcement. In this section, B. was able to identify the thinking traps more related to her own emotional experience (i.e., thinking the worst: "if my mother walks away from me, it means she will disappear/have an accident").

(3) ***Use Detective Thinking (Sessions 6-7):*** The contents of the children's section focus on exploring cognitive flexibility and problem-solving strategies and applying them to their own emotional experiences. The contents of the parents' section focuses on analyzing the parental behavior of promoting healthy independence as the opposite behavior of overprotection. In this section, B. learned the skill of detective thinking and how to apply this skill to her own thinking traps, practicing this skill using her personal examples (e.g., fear of being separated from her mother; fear of dogs; fear of closed spaces; fear of performance exposure situations). B. also learned the problem-solving steps and applied them to her personal examples (e.g., arguments with friends/family).

(4) ***Experience My Fears and Feelings (Sessions 8-14):*** This section of the UP-C focuses on mindfulness and exposure techniques. Children learn about present moment awareness and nonjudgmental awareness and plan and execute individualized situational emotion exposures gradually, in sessions and at home. Parents learn about the concept of situational emotion exposure and discuss their role when children practice exposures at home. Additionally, in these sessions, parents discuss the last parenting behavior of healthy emotional modeling as the opposite

Table 1

Top Problems severity in the first session

Top Problems		Children reports on the severity of top problems	Parents' reports on the severity of the top problems
Top Problem 1	Fear of separation from the mother	8	8
Top Problem 2	Fear of dogs	6	6
Top Problem 3	Fear of performance situations	6	7
Top Problem 4	Fear of closed spaces and new situations/activities	6	8

behavior of parental modeling of intense emotions and avoidance behaviors.

For B., the emotional awareness strategies learned in this section were particularly useful for social interaction situations and in moments of worry. B. learned to use these techniques whenever she engaged in negative judgments about herself, especially in performance or social situations, during which she tended to ruminate and negatively analyze her performance. Additionally, the present-moment awareness exercises were useful for worrisome situations in which B. usually had difficulty remaining engaged in the present moment, particularly before going to bed. The use of these emotional awareness strategies was also useful during individual exposure exercises. In session 11, B. began building a hierarchy ("emotion ladder") in which she rated each exposure proposed by the therapist on a scale from 0 (no strong emotion) to 8 (very, very strong emotion). After building this hierarchy, B. performed the proposed exposures during sessions 11 to 14, starting with the tasks that caused less anxiety/fear toward her ultimate goals. For example, the first step in her hierarchy pertaining to their fear of separation from the mother consisted of staying in the session without her mother and without knowing where her mother was (lower intensity exposure), and the last step in this hierarchy consisted of her mother traveling abroad without B. (higher intensity exposure). During sessions 11 to 14, before beginning each of the exposure tasks, B. worked individually with her therapist, and during exposure exercises, she applied the skills learned in the previous UP-C sections, particularly the detective thinking skill. Throughout the exposure sessions, B. performed several tasks associated with her main areas of difficulty (Top Problems). Specifically, during sessions 11 to 14, to work on the fear of being separated from her mother, fear of dogs, closed spaces and new situations/activities, some interventional exposures were completed, such as staying away from her mother or doing chores without her mother, staying around dogs, staying in closed places, and trying new activities (e.g., slide). To work on the fear of performance situations, some social exposure exercises, in performance contexts, were conducted, such as making presentations to the group of children and parents or asking questions to unknown people.

(5) ***Stay Healthy and Happy (Session 15):*** In the last session, children review the skills they have learned, create a plan and celebrate the progress and gains. Parents review the skills and opposite parenting behaviors learned, create a plan for furthering progress, learn how to distinguish lapses from relapses and celebrate children's progress. Additionally, during the parenting session, in addition to addressing the specific parenting content (i.e., emotional parenting behaviors), all the strategies and skills learned by the children are discussed and analyzed. In this last session, B. had the opportunity to review all her achievements through a video that summarized her main therapeutic gains throughout the program using some photos and videos of the different exposure tasks she had done. At the end of this session, all the children in B. 's intervention group participated in a small group party to celebrate the end of the program.

Assessment of Progress

As described in the "Assessment" section, B.'s progress evaluation during treatment with the UP-C was assessed via the scores on the RCADS and CALIS-C/CALIS-P. B. and her mother completed these measures at pre- and posttreatment to assess treatment-based changes in B.'s anxiety and depressive symptomatology. Table 2 shows the results of B. progress in anxiety (RCADS and CALIS-C/CALIS-P) and depression (RCADS) symptomatology after the 15 treatment sessions.

Concerning the RCADS, at the beginning of the intervention, B. presented elevated symptoms of anxiety (Social Anxiety T-score = 24; Separation Anxiety T-score = 18; Generalized Anxiety T-score = 18) and depression (Depression T-score = 14). At posttreatment, B. symptoms of anxiety (Social Anxiety T-score = 12; Separation Anxiety T-score = 7; Generalized Anxiety T-score = 8) and depression (Depression T-score = 9) were no longer clinically significant, with both anxiety and depression scores below the confidence interval established for the Portuguese population (Pedro & Pereira, 2019).

Regarding the CALIS-C/CALIS-P, the initial score presented by B. and her mother at the beginning of intervention was very high (CALIS-C T-score = 23/CALIS-P

Table 2.

Pre- to Posttreatment Changes.

	Portuguese Population normative data		Pretreatment	Posttreatment	3-Month Follow-up
	M	*S.D.*			
RCADS Total	50.48	*19.81*	91	50	31
RCADS Total Depression	7.19	*4.90*	14	9	7
RCADS Social Anxiety	12.16	*4.97*	24	12	8
RCADS Separation Anxiety	5.49	*3.19*	18	7	4
RCADS Generalized Anxiety	9.50	*4.25*	18	8	5
CALIS-C	7	*5.37*	23	8	2
CALIS-P TOTAL	12.83	*10.57*	22	22	19
CGI-S			5 (*Markedly ill*)	2 (*Borderline mentally ill*)	
CGI-I				1 (Very m*uch improved*)	

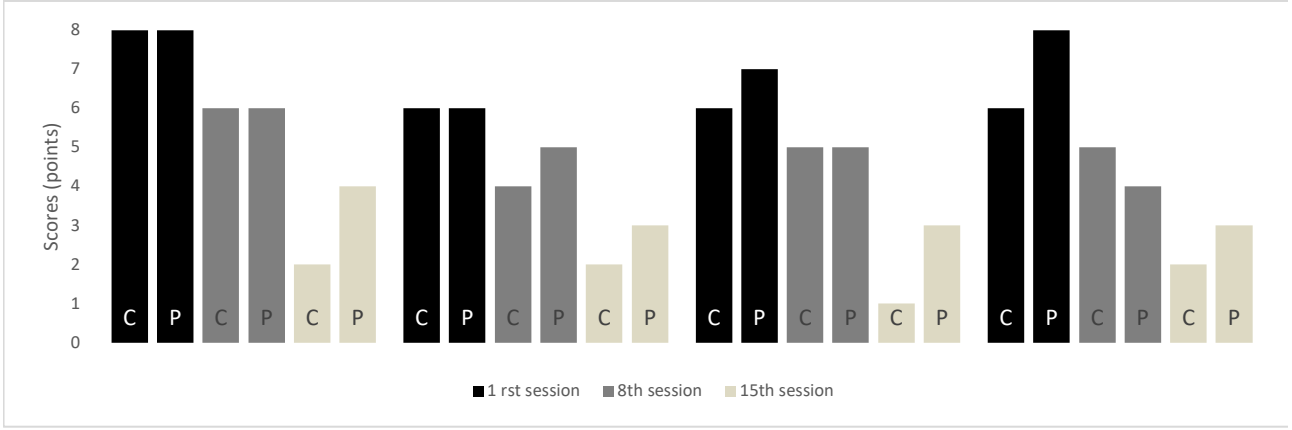
Note. Means (*M*) and standard deviations (*SD*) for RCADS (Pedro & Pereira, 2019) and CALIS-C/CALIS-P (Marques et al., 2015) measures in the Portuguese population.

T-score = 22). Throughout treatment, this score decreased from child view until reaching a score of 8 (CALIS-C) and after treatment, maintaining a score of 22, from mother perspective.

Therapist classified the overall improvement (CGI-I; Guy, 1976) as 1 (very much improved) and the severity of symptoms in the posttreatment as 2 (borderline mentally ill), indicating that B.'s global clinical impairment was improved after UP-C. Moreover, in the final session, B. and her mother rated the severity of her Top Problem 1 at 2 (B.) and 4 (mother), Top Problem 2 at 2 (B.) and 3 (mother), Top Problem 3 at 1 (B.) and 3 (mother) and Top Problem 4 at 2 (B.) and 3 (mother), suggesting a decrease in the severity and impact of these difficulties on B.'s life. In Figure 1, we present the Top Problems severity progress

Figure 1.

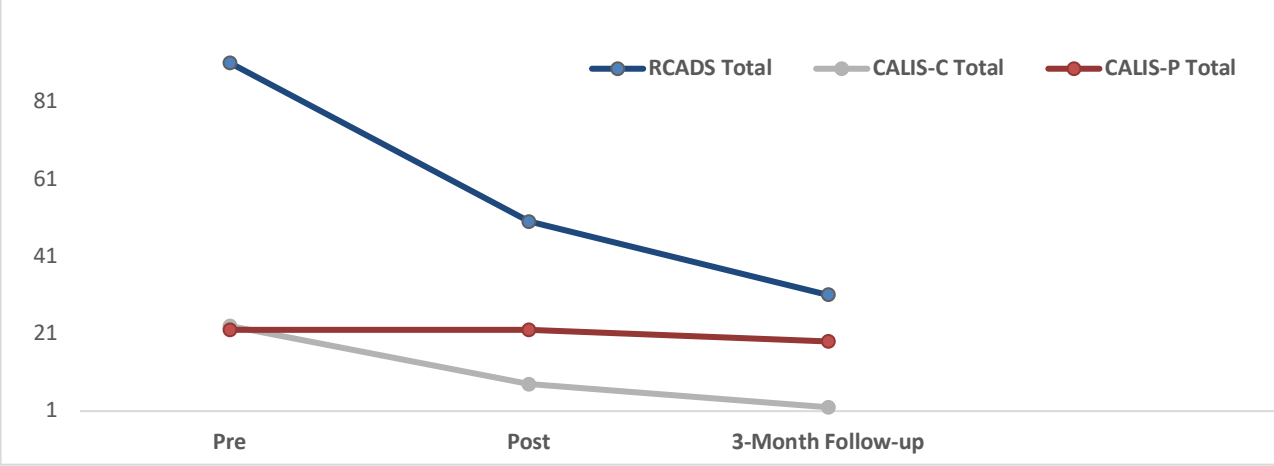
Children and parents' reports on the severity of the four top problems throughout the UP-C.



Note. C: children's report; P: Parents' report.

Figure 2.

Results of RCADS and CALIS-C/CALIS-P at the 3-month follow-up.



throughout the UP-C, considering B. and her mother reports.

In addition to changes in the primary symptomatology presented by B., it was also possible to identify significant changes in B.'s social functioning. During the intervention, there were some improvements in her social functioning, manifested by a greater involvement in activities and ability to interact with others.

Follow-up

Following the completion of the UP-C, B. and her mother were contacted 3 months after treatment to assess whether the improvements achieved posttreatment were maintained over time. In Figure 2, we present the results of the 3-month follow-up for the anxiety (RCADS and CALIS-C/CALIS-P) and depression (RCADS) variables. These two measures showed a decrease in the 3-month follow-up scores compared to the posttest scores. As shown in Table 1, these scores were lower than the pretest scores for the RCADS (Social Anxiety T-score = 8; Separation Anxiety T-score = 4; Generalized Anxiety T-score = 5; Depression T-score = 7) and for the CALIS-C/CALIS-P (CALIS-C T-score = 2/CALIS-P T-score = 19).

Discussion and Conclusions

This case study illustrates the clinical usefulness of the UP-C, suggesting that this intervention could be effective not only in reducing anxious and depressive symptomatology but also in improving overall functioning. In addition to the improvement in their emotional symptomatology reported by the quantitative results, it is possible to identify some functional changes. After the implementation of this program, B. was able to stay in the car and in her house without her mother, be around dogs, try new activities, and make presentations at school more safely and confidently.

As mentioned before, this intervention is useful for children with anxiety and/or depressive disorders but is particularly helpful for children for whom these symptoms co-occur (citation), as is the case of B. Using a traditional single-disorder protocol, the intervention would have been longer as the different concerns presented by B. would have been treated separately.

The results of this study showed a decrease in the severity of the four top problems identified by B. and her mother at the beginning of the intervention as well as a reduction of the anxious and depressive symptoms, ac-

cording to the therapists' reports (CGI-S), from pre- to posttreatment and a major improvement in overall clinical impairment (CGI-I). Additionally, a decrease in anxiety and depression levels along with a reduction in the interference of this symptomatology in the child's and family life, as reported by B. These improvements were maintained after 3 months of follow-up. Although depression was not the main diagnosis of B., it was interesting to observe significant improvements in this variable as well. Although there were significant decreases in the primary symptomatology presented by B., the interference of the severity of this symptomatology, from the mother's perspective, did not change significantly throughout the treatment. This fact may be related to B.'s mother's higher expectations regarding the improvements presented, or to a lower appreciation of the gains achieved.

Preliminary evidence from feasibility studies of the UP-C in the Portuguese population suggests that this program is feasible and acceptable for the treatment of a varied range of EDs (Caiado et al., 2022). Up to this point, we have used the UP-C to treat a diverse range of anxiety and mood diagnoses, including specific phobia, separation anxiety disorder, generalized anxiety disorder, social phobia/performance anxiety, selective mutism, anxiety disorder not otherwise specified, panic disorder, anxiety-related disorder, obsessive-compulsive disorder, illness anxiety disorder and depression (citation). We are currently conducting a randomized controlled trial to examine the efficacy of the UP-C in a range of anxiety and mood disorders. The case of B. illustrates that UP-C may be an effective therapeutic approach for cooccurring disorders by focusing on the underlying common mechanisms of EDs. Despite the proven clinical utility of the of the application of UP-C to this case study, the therapists identify some barriers to its implementation, including difficulty addressing all the content due to time constraints (especially in the modules 2 and 5) and difficulty in complying with the stipulated duration of the sessions (especially parental sessions and children´s exposure sessions).

Recommendations to Clinicians and Students

To implement the UP-C, training is recommended for therapists in which they learn and practice the application of several core strategies of the UP-C. A thorough reading of the UP-C therapist's manual and workbook is also advised.

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