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Helping people thrive in spite of anxiety

Interview by Danielle Irving-Johnson

Stephanie Woodrow is a licensed clinical professional counselor and national certified counselor with a private practice in the Washington, D.C., area that specializes in the treatment of adults with anxiety disorders, obsessive-compulsive disorder and related disorders. She has presented at the annual conferences of the Anxiety and Depression Association of America (ADAA) and the International OCD Foundation.

Danielle Irving-Johnson: In 2019, you were named an emerging leader by ADAA. What does that honor mean to you and to the counseling profession?

Stephanie Woodrow: This recognition reinforces the importance of training and education over a specific degree. The other recipients of this award have been psychologists, whom I respect personally and professionally. For me to receive this award demonstrates that the contribution of a master's-level clinician can be equally valuable. I appreciate the ongoing efforts of ADAA to support providers who practice evidence-based treatment, regardless of their degree.

DIJ: What are your areas of specialization? What sparked your interest in those areas?

SW: I specialize in treating anxiety disorders, obsessive-compulsive disorder and related disorders, including hoarding disorder, body dysmorphic disorder and body-focused repetitive behaviors. Many people with these specialties have firsthand experience themselves or [experiences through] a close relative. However, I don't fit into either category. I wish I could point to a meaningful personal experience to explain why I picked this specialization, but I can't.

My uncle, Ken Woodrow, is a psychiatrist at Stanford University who also owns a private practice. He wisely once told me that part of how he selected his specialization was knowing he wanted to work with patients whose disorders had evidence-based treatment and a decent success rate — something I hadn't considered at that point.

DIJ: What is the importance of having a specialty in the counseling profession?

SW: No one can be great at everything, or even good at everything. Specializing allows clinicians to focus on one area and become an expert in diagnosing, treating and advocating.

Developing an expertise is even more important for counselors, who, unlike psychologists, rarely have the opportunity to specialize in graduate school or to work with experts as mentors. Once clinicians earn their degree, their education from then on becomes about trainings and continuing education, and frequently these programs are offered to all providers regardless of licensing. Counselors shouldn't need to prove our worth, but because most people don't understand the difference among advanced degrees, the training that comes with specialization is even more important.

DIJ: What are the disorders outlined in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* that are associated with anxiety? Are there any commonalities regarding the symptoms or criteria?

SW: In the *DSM-5*, there are 14 disorders falling into the categories of anxiety disorders, obsessive-compulsive disorder and related disorders: tic disorders (including Tourette's syndrome), separation anxiety disorder, selective mutism, specific phobia,

social anxiety disorder, panic disorder, agoraphobia, generalized anxiety disorder, obsessive-compulsive disorder, body dysmorphic disorder, hoarding disorder, trichotillomania (hair-pulling disorder), excoriation (skin-picking disorder), and illness anxiety disorder.

With most of these, there are two common threads. Except for aspects of hoarding disorder and the body-focused repetitive behaviors (trichotillomania and excoriation), there is no pleasure in any aspect of the disorders. Behaviors are aimed at reducing distress, anxiety, discomfort, disgust or fear. Engaging in them offers minimal short-term relief, but there isn't enjoyment in performing these rituals or compulsions. This is often misunderstood by people without these disorders.

The other commonality, which I emphasize to my patients, is that the formula for treatment of most of these disorders is the same. This is very important because it's common for people to have multiple and co-occurring anxiety disorders. I explain to my patients that I don't teach $1 + 1 = 2$, because if I taught them how to respond to only that specific set of numbers or circumstances, that's the only problem they could solve. However, if I teach addition — the method — then it doesn't matter what problems present themselves because patients know the formula to address all of them.

DIJ: What are some of your best practices or modalities to assist with treatment of anxiety?

SW: With most anxiety disorders, as well as obsessive-compulsive disorder, the golden standard evidence-based treatment is cognitive behavioral therapy (CBT) and, more specifically, exposure and response prevention

(ERP). ERP includes exposing patients to stimuli that trigger unwanted thoughts or images without engaging in any rituals or distress-reducing behaviors. This allows patients to experience their anxiety naturally decline without the rituals and to learn that their worst fears are unlikely to occur — and even if they did, that it wouldn't be as catastrophic as feared. Depending on the patient, I also incorporate aspects of acceptance and commitment therapy (ACT), dialectical behavioral therapy and mindfulness.

DIJ: What is one of the biggest myths or misconceptions about anxiety?

SW: Many patients come into my office and say their goal for treatment is to get rid of their anxiety, because anxiety feels awful and interferes with their lives. The truth is that eliminating anxiety would put us at a deficit. What people are actually asking is, “How can I thrive without anxiety interrupting my life?”

Using one of the core principles of CBT, we can change how anxiety affects us by changing how we think about it. Rather than thinking, “I can't do X because of my anxiety,” this can be reframed to, “I'm anxious about X, which means I really care.” Whether this is a meeting, trip or event, thinking about the activity as important rather than causing distress can change how we behaviorally respond to the anxiety, thereby impacting our emotions about the situation.

From an ACT perspective, we want people to live their lives in spite of anxiety and to be open-minded and curious. If anxiety is about the future and we make the change from worry about possible outcomes to curiosity about what might occur, our willingness to engage increases, and we're more likely to allow the experience to be whatever it's going to be.

DIJ: How have your education and experiences helped prepare you for the opening of your new practice?



Stephanie Woodrow

SW: In addition to guidance from my uncle, I had the good fortune of working for Steven Israel, an experienced psychiatrist, in his solo private practice. Although my uncle helped me with the bigger picture of my career, I learned everything about the daily ins and outs of private practice from Dr. Israel. I watched him interact with patients, navigate insurance, manage crises and respond to challenging situations. Working for him and seeing his passion for helping patients inspired me to return to school and earn my counseling degree.

When I decided to open my practice, my uncle and Dr. Israel were instrumental in aiding me and guiding me throughout the process. However, the strength to take the risk to go out on my own and the drive to succeed came from the unwavering love and support of my father, Dave Woodrow. Some of the professors from my counseling program at Johns Hopkins University, especially Marsha Riggio, have been my greatest champions, including pointing out my shortcomings to assist me in my personal and professional development.

I also found wonderful mentors through ADAA, namely Ruth Lippin, Kimberly Morrow and Elizabeth Dupont-Spencer, whom I affectionately refer to as my “Three Wise Women.” These women are master's-level clinicians who run solo private practices and offer ongoing wisdom from their experience, all of which inspires me. I feel extremely lucky to have so many talented people in my corner.

DIJ: What advice would you give to a professional counselor aspiring to build a private practice?

SW: Being in a solo private practice can be isolating, but a group practice can also require a lot of compromise. I always recommend talking to several people about their experiences — good and bad — before making any decisions. It's important to understand steps other practitioners have taken,

how it turned out, what unexpected challenges arose, and what the costs would be to achieve something similar.

As an anxiety and OCD [obsessive-compulsive disorder] specialist, I'm fortunate to have a few networking and consultation platforms and, as a result, I never feel isolated. I'm part of a private Facebook group for OCD therapists, with anywhere from 10 to 30 posts daily where we ask and provide suggestions, guidance and support. I have two monthly online peer-consultation groups through ADAA — one on OCD and related disorders and another on social anxiety. In addition, I attend the annual conferences of ADAA and the International OCD Foundation, and I participate in webinars.

Staying connected with the professional community is helpful clinically, but also as a business owner [because] providers aren't naturally businesspeople, and most of us didn't take courses about this in school.

DIJ: In your practice, you choose to use the term “patient” rather than “client.” What is your reasoning behind that preference?

SW: There are no formal guidelines about which term to use, so for the most part, it's left to the individual provider. I prefer *patient* for several reasons.

First, patients are people seeking health care. Whether it's from a medical doctor, a physician's assistant, a radiologist or another provider, the term used is based on the idea that treatment-seekers are patients, regardless of the provided health care services.

Second, using *patients* recognizes that mental health is part of health care. There continues to be a social stigma about mental health care. When patients tell me they need to cancel their appointment because they're too busy or can't take time off work, I ask if they would make the time if it were a broken leg or a nagging cough. Unfailingly, they say yes. I believe that when I describe the people I work with as patients, I am advocating for equal recognition and treatment of physical and mental health conditions.