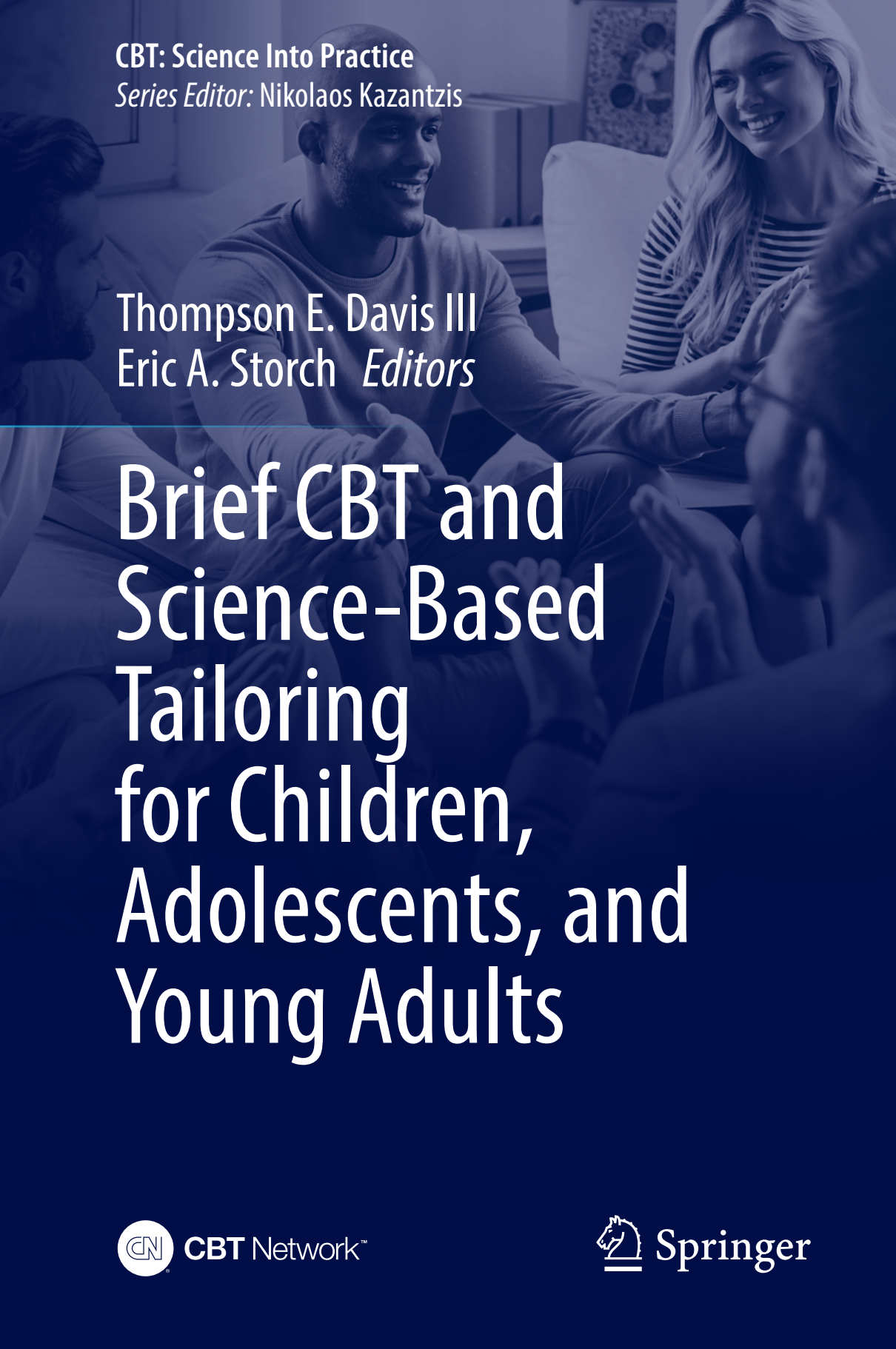

CBT: Science Into Practice
Series Editor: Nikolaos Kazantzis

Thompson E. Davis III
Eric A. Storch *Editors*

Brief CBT and Science-Based Tailoring for Children, Adolescents, and Young Adults

CBT Network™

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CBT: Science Into Practice

Series Editor

Nikolaos Kazantzis, Cognitive Behavior Therapy Research Unit
Melbourne, VIC, Australia

This series addresses topics that reflect current thinking in the field of cognitive behavior therapy, the most widely accepted form of therapy across mental health disciplines. Despite the consensus that CBT is an effective treatment modality, much of the existing clinical literature focuses on single facets, such as specific disorders or populations. Mostly it does not take into account the latest evidence for transdiagnostic change mechanisms and processes. This series provides guidance on how the latest evidence can be translated into practice. Volumes focus on enhancing flexibility in both the selection and delivery of techniques tailored to individual clients. Each provides clinical insights enhanced by case studies and vignettes to ensure relevance for the practicing professional.

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Editors

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Editors
Thompson E. Davis III
Department of Psychology
The University of Alabama
Tuscaloosa, AL, USA

Department of Psychology
Louisiana State University
Baton Rouge, LA, USA

Eric A. Storch
Department of Psychiatry
and Behavioral Sciences
Baylor College of Medicine
Menninger, Houston, TX, USA

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In a moment where youth mental health problems are on the rise, this is the book we need! Expertly curated, it brings together leading clinical researchers to provide innovative strategies for distilling our current evidence-based treatments into state-of-the-art brief interventions. These treatments—shown to be potent, efficient, and cost effective—offer hope for reaching the many children, adolescents, and young adults with mental health needs. It is sure to be an indispensable clinical resource.

Tara S. Peris, Ph.D.
Professor and Vice Chair for Research
Interim Director, Division of Child and Adolescent Psychiatry
Program Director, ABC Children's Partial Hospitalization Program
Co-Director, UCLA Child OCD, Anxiety, & Tic Disorders Program
Department of Psychiatry & Biobehavioral Sciences
Semel Institute for Neuroscience & Human Behavior

When something works, it may seem evident that more of that thing will produce results more quickly and more effectively. Yet clinicians like myself are hesitant to move too fast or come on too strong in exposure-based treatments out of a sincere commitment to doing no harm. ERP already endures an entirely false stigma of being inherently traumatizing. This collection provides well-researched guidelines on brief and intensive exposure-based treatments for a variety of anxiety-based conditions in a variety of settings, as well as exploring the ethics around implementation. I found it immensely encouraging.

Jon Hershfield, LCMFT, director of Center for OCD and Anxiety at Sheppard Pratt

From the costs and benefits, to the state of current science, to detailed breakdowns of the brief interventions, this book should become part of every child clinician's library. Furthermore, clinicians can use the information contained herein to help advocate for change in the healthcare systems they are embedded in, pushing for more effective, briefer treatments to become offered as part of standard care.

Caleb W. Lack, Ph.D./University of Central Oklahoma

In a time when there is an unmet demand for services that work, the use of brief, intensive, and/or concentrated treatments needs to be considered. This book guides therapists on how to provide effective and efficient treatments to meet these demands and to ensure access to more patients. Our youth are facing unprecedented rates of anxiety and depression, and we need tools that can help them return to their expected developmental tasks as soon as possible.

Karen G. Martinez-Gonzalez, MD, MSc
Chair, Department of Psychiatry
University of Puerto Rico

"*Everything you need to know…and more.*"
This is an extraordinarily well organized, well presented and thorough update on brief and intensive treatments for anxiety disorders in youth. Topics not typically discussed, such as ethics of exposure therapy, cost effectiveness of brief therapies, underlying neuroscience, summer camps, parent training, integrating medication treatment, pediatric health conditions, suicide and use of digital technology, are included in admirable detail and are of great interest. The most comprehensive examination of brief intensive therapies published to date.

Daniel A. Geller, MD
Professor of Psychiatry
Harvard Medical School
The Michele and David Mittelman Family Chair in Psychiatry

Like Superman squeezing coal into diamonds, Davis and Storch have compiled the definitive guide to brief, concentrated psychotherapy. Like the treatments they describe, each chapter of this book gets right to the point.
As clinicians struggle to meet surging mental health needs and patients struggle to access evidence-based care, the streamlined and economical approaches described here have never been timelier.

Eli R. Lebowitz, Yale Child Study Center, Author of Breaking Free of Child Anxiety and OCD.

Thompson Davis and Eric Storch score big in this edited volume on Brief, Intensive, and Concentrated (BIC) treatments for a host of child and adolescent problems and disorders. Although these treatments were initially pioneered with the internalizing disorders, here they are extended to externalizing disorders, health problems, and other problematic areas in childhood and adolescence. The chapters in this volume, written by national and international scholars, not only cover the field, they stretch the field, and they guide us into the next generation of evidence-based brief treatment practices. It is time that we rethink, and perhaps even retire, the long-held tradition of extended weekly sessions for many of these problems. This volume belongs in the hands of clinicians and researchers alike—it is a book whose time has come, and it is most welcome!

Thomas H. Ollendick, University Distinguished Professor Emeritus, Virginia Tech

This is the go-to book on brief and intensive treatments. The reader is not only guided through the current evidence base, but they are also provided with condition-specific guidance on implementation, along with fantastic case examples to bring it to life. This makes it an informative, practical and much needed resource for therapists.

Dr Amita Jassi, Consultant Clinical Psychologist, Maudsley Hospital, UK.
This volume is a must-read for both researchers and clinicians in youth mental health. International expert authors showcase the frontier of evidence-based Brief, Intensive and Concentrated (BIC) individual and group interventions. After discussing the ethics and economics of BICs, each chapter summarizes research about mental health conditions and existing treatment programs. The authors masterfully explain theoretical rationale behind treatments, emphasizing clinical mechanisms of change and essential practice elements. Vivid case examples provide detailed and descriptive implementation of these cutting-edge treatments.

Daniel L. Hoffman, PhD, ABPP
Director, Cognitive Behavioral Therapy Practice at Northwell, New Hyde Park, NY
Assistant Professor, Department of Psychiatry, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell, Hempstead, NY

Building upon exceptional prior work, this book innovatively designs brief therapy approaches for childhood disorders. It emphasizes ethical considerations, advocating for patient-led therapy that aligns with their goals. With a focus on higher attrition rates, it encourages learning through practical application. Culturally sensitive and emphasizing informed consent, it explores cost savings and post-intervention resource use. Going beyond cost-effectiveness, it considers equality, individual preferences, and factors like equity. An essential read for advancing pediatric mental health care.

Mariel Paz y Miño M, PhD Clinical Psychologist Universidad San Francisco de Quito, Ecuador.

A critical next step in the advancement of evidence-based therapies, this edited volume provides a state-of-the-science summary of brief, intensive, and concentrated (BIC) treatments for childhood psychiatric conditions, while also spotlighting the key concerns and considerations needing to be addressed when developing, disseminating, and promoting BICs. In so doing, it provides a much-needed bridge between what we know as field, as well as where we need to go.

Simon A. Rego, PsyD, ABPP, A-CBT
Chief of Psychology, Montefiore Medical Center
Professor of Psychiatry and Behavioral Sciences, Albert Einstein College of Medicine

Efforts to increase access to mental health care by delivering the most potent elements of our best treatments have accelerated exponentially. In this timely, capacious volume, Storch and Davis bring together the best of these innovations, offering a snapshot of the current state of the science, and demonstrations for clinicians and interested in how to engage in brief, accessible practices. This is a vital compendium for those wishing to deliver the most efficient, high-quality care clinical science can offer.

Matthew D. Lerner, Ph.D., Associate Professor, Life Course Outcomes (LCO) Research Program Leader, AJ Drexel Autism Institute, Drexel University

Access to evidence-based mental health care for children is fraught with challenges for families; and the oftentimes lengthy and costly treatment can be an added burden. This much-needed book provides solutions to accessible, efficient, and effective mental health treatment for children, which will reduce waiting times and improve service provision of clinicians. World's leading experts from across the globe share their innovative approaches and clinical insights in this comprehensive and exciting volume. A must-read for all clinicians working with children!

Professor Lara Farrell
Griffith University Centre for Mental Health
Australia

Thompson Davis
This book is dedicated to Thompson IV and Maggie for their sweet (and occasionally mischievous) giggles and smiles. Also, to Allison for her encouragement and support.
Eric Storch
This book is dedicated to my parents for teaching me that the mark of person is through helping others. And, to my Ellie, Noah, Maya, and Jill for making my heart smile always. Finally, to Ben for a once-in-a-lifetime friendship that I am forever grateful for.

Foreword

Conflicts of Interest

Kazantzis disclosed his royalties from the Guilford Press (Therapeutic Relationship in Cognitive Behavior Therapy; *Cognitive and Behavior Theories in Clinical Practice*), Routledge (*Using Homework Assignments in Cognitive Behavior Therapy*), and Springer Nature publishers (CBT: Science into Practice Book Series; *Handbook of Homework Assignments in Psychotherapy: Research, Practice, and Prevention*). He also disclosed editor stipend from the Association for Behavioral and Cognitive Therapies for his role as Editor-in-Chief for *Cognitive and Behavioral Practice* (Elsevier).

I am delighted that the book *Brief CBT and Science-Based Tailoring for Children, Adolescents, and Young Adults* is being published in the CBT: Science into Practice book series. In the ever-evolving landscape of mental health treatments, the journey from the inception of behavioral, cognitive, and cognitive-behavioral therapies (CBTs) to their current refined forms has been both enlightening and challenging. The realization that therapy can be effective for many disorders has spurred a relentless pursuit to decipher the intricate workings of these treatments—what, for whom, and how they work. The undeniable efficacy of youth-focused behavioral and cognitive-behavioral treatments has been a cornerstone, but not without its own set of challenges. A significant percentage of individuals participating in randomized clinical trials still do not respond adequately to traditional interventions, prompting a crucial question: Can we distill these treatments into more concentrated, potent forms?

The answer to this question has given rise to an exciting field of study—Brief, Intensive, and Concentrated (BIC) treatments. This edited volume, contributed by Dr. Thompson (Tom) Davis III and Dr. Eric Storch, two of the foremost scholars in our field, is dedicated to delving into the world of BICs, showcases insights from an international community of experts and practitioners. The objective is twofold: to provide a comprehensive understanding of these condensed treatments and to demonstrate their adaptability in addressing a diverse range of mental health concerns.

The exploration of BICs, however, prompts a delicate balance between innovation and respecting the foundations laid by conventional treatments. The tension between the comfort of established methods and the potential benefits of condensed interventions challenges us to reevaluate therapeutic norms. This volume acts as a guide through this tension, urging readers to consider several crucial perspectives.

Firstly, BICs should not be seen as replacements but as alternatives or enhancements to existing evidence-based treatments. They offer flexibility, stop-gaps, and potentially stronger formulations tailored to individual patient needs. Secondly, the focus on refining and amplifying outcomes ensures that BICs contribute to the ongoing evolution of therapeutic interventions. Thirdly, BICs may serve as stepping stones for patients, meeting them at their current level of readiness for change and enhancing their motivation for more extended interventions. For some individuals, working through a specific phobia with a skilled CBT therapist may represent more than sufficient content for a therapy session agenda, others perhaps those with prior experience of psychological therapy or having engaged in self-help and having acquired beneficial skills, may wish to work on multiple problems simultaneously (e.g., a phobia, panic during public speaking, and marital communication issues). The point here is that flexibility and adapting therapy to briefer forms may be the individual's preference.

Ethical considerations are paramount in this exploration. The volume emphasizes the importance of ethical practices in introducing BICs, ensuring that they are not used as shortcuts but as responsibly tested alternatives. Following the Editors' introduction (Chap. 1), the next chapter underscores the need to avoid unintentionally transforming potentially helpful treatments into harmful ones (Chap. 2). Then, as would be expected, the cost-effectiveness of brief therapies is discussed (Chap. 3) and the current state of the science of brief and intensive treatments are reviewed in a clinician-friendly synthesis (Chap. 4).

BICs extend beyond traditional anxiety treatments, reaching into areas where immediate and intensive intervention is crucial. This volume aims to challenge preconceptions and expand the notion of BICs to cover a spectrum of disorders and scenarios requiring prompt stabilization. Given the pioneering BICs, One-Session Treatment (OST), developed over four decades ago by Swedish psychologist Dr. Lars-Göran Öst, the book proceeds with expert contributions on specific phobia (Chap. 5), selective mutism (Chap. 6), and obsessive-compulsive disorder (Chap. 7).

The authors contributing to this volume offer diverse perspectives on BICs—their strengths, perils, and their place in the evolving landscape of mental health treatments. In doing so, we strive to contribute to the continuous advancement of our field, with a particular focus on serving children, adolescents, and young adults. A chapter is devoted to the use of summer camps as opportunities to provide brief interventions (Chap. 8), before centering on separation anxiety disorder (Chap. 9), social anxiety disorder (Chap. 10), brief parent training (Chap. 11), and specific considerations in the use of brief CBT for pediatric conditions (Chap. 12) as well as digital single-session interventions for youth (Chap. 13). A chapter is also devoted to single-session scalable interventions integrating pharmacotherapy (Chap. 14).

Importantly, a chapter is dedicated to suicide and crisis intervention (Chap. 15), technology in brief interventions (Chap. 16), and multi-cultural considerations (Chap. 17). The editors then present a compelling conclusion, where they note the limitations of the current evidence base, emphasize the importance of tailoring interventions for the individual, and outline of future directions for enhancing efficacy by both joining with parents and caregivers and emphasizing those treatment processes that have a clear evidence base (Chap. 18). I applaud all the contributors to this volume for their excellent work.

The editors bring a wealth of professional experiences to this volume. Dr. Thompson (Tom) Davis III is the Department Chair and Professor of Psychology (Child Clinical Concentration) at the University of Alabama, and an Adjunct Professor of Psychology at Louisiana State University. He has published widely in the areas of specific phobia and anxiety in children, and also has interests in the intersection of anxiety and autism. Dr. Eric Storch is Professor and McIngvale Presidential Endowed Chair at the Baylor College of Medicine. Dr. Storch specializes in CBT of adult and childhood OCD, as well as other anxiety and OC-related disorders. Dr. Storch has been the principal investigator on multiple federally funded grants, and has also published widely on the topics of his research. With such backgrounds to draw on, Dr. Davis and Dr. Storch are eminently qualified to offer this book; they have produced a book with a rich synthesis of evidence to guide practice.

The practice of CBT is ideally flexible in content, duration, and intensity. Each technique should be tailored to the individual based on both the features of the individual's presentation, but also based on their preferences and existing skills. The purpose of Dr. Davis and Dr. Storch's book is to provide a comprehensive understanding of BIC treatments and to demonstrate their adaptability in addressing a diverse range of mental health concerns. Dr. Davis and Dr. Storch have performed exceptionally well in this regard.

Nikolaos Kazantzis
director@cbtru.com
https://www.cbtru.com
Cognitive Behavior Therapy Research Unit
Melbourne, VIC, Australia

Beck Institute for Cognitive Behavior Therapy
Philadelphia, PA, USA

Contents

Chapter 1
Fresh Squeezed, into Concentrate: Brief, Intensive, and Concentrated Treatments

Thompson E. Davis III and Eric A. Storch

Fifty years of research into behavioral, cognitive, and cognitive-behavioral therapies (CBT) and their progeny and hybrids has led to the conclusion that therapy "works" for a wide number of disorders (Weisz et al., 2017). Ensuing efforts have expanded to try to uncover the "what" in those treatments works and for "whom" and "how" they work. Generally, youth-focused behavioral and cognitive-behavioral treatments have been found to be the most effective treatments (but not the only effective ones); moreover, these treatments work for a wide variety of diagnoses (Weisz et al., 2017). However, a closer inspection of findings encourages treatment researchers to not rest on their accomplishments. Even with the best techniques therapists have to offer, the field routinely sees 25–50% of individuals participating in randomized clinical trials who either do not respond or who have an inadequate

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Thompson Davis reports having received research funding from NSF, NHS, and OAR. He receives book royalties from Springer and occasional fees for trainings/workshops for One-Session Treatment.

Eric Storch reports receiving research funding to his institution from the Ream Foundation, International OCD Foundation, and NIH. He was a consultant for Brainsway and Biohaven Pharmaceuticals. He owns stock less than $5000 in NView. He receives book royalties from Elsevier, Wiley, Oxford, American Psychological Association, Guildford, Springer, and Jessica Kingsley.

T. E. Davis III (✉)
Department of Psychology, The University of Alabama, Tuscaloosa, AL, USA

Department of Psychology, Louisiana State University, Baton Rouge, LA, USA
e-mail: tom.davis@ua.edu

E. A. Storch
Department of Psychiatry & Behavioral Sciences, Baylor College of Medicine, Menninger, Houston, TX, USA

T. E. Davis III, E. A. Storch (eds.), *Brief CBT and Science-Based Tailoring for Children, Adolescents, and Young Adults*, CBT: Science Into Practice,
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treatment response (McKay & Storch, 2009), and it is apparent that not all treatments work equally well for all youth diagnoses (Weisz et al., 2017). To better understand why treatment works for some and why it does not for others (or at least not as well), the goal of treatment research has often been to distill what is often 16 to 20, 50-min sessions of established treatment protocols down into the most efficacious components/techniques of the intervention. Subsequently, those pieces are reassembled into new treatment packages of 16–20 streamlined sessions or, ideally, fewer. As a result, a distinct area of treatment inquiry has been the squeezing of treatments down into their most concentrated and often cost-effective forms: what have been coined brief, intensive, and/or concentrated (BIC) treatments (Öst & Ollendick, 2017).

The following edited volume is dedicated to better summarizing and understanding these BICs, particularly with input from an international community of experts and practitioners. As well, a goal is to demonstrate the flexibility and variety of mental health concerns BICs have been crafted to address. Perhaps one of the oldest and best-known BICs, One-Session Treatment (OST; Davis III et al., 2012, 2019), was originally developed by Swedish psychologist Dr. Lars-Göran Öst over 40 years ago to quickly treat specific phobias in adults (Davis III et al., 2012; Öst, 1987, 1989; Öst et al., 2001). This 3-h, massed CBT blended potent and efficacious behavioral and cognitive components into a single session that led to impressive clinical outcomes far greater than only half or so of patients showing clinical improvement—initially closer to 80–90% of individuals showing clinically meaningful improvement, though this impressive rate has decreased with greater complexity of cases and movement away from the treatment developer (Zlomke & Davis III, 2008). Surprisingly, youth found the treatment proceeded per their expectations and did not feel manipulated or harmed by the intensive format (Svensson et al., 2002). Since then, BICs and particularly those for anxiety, have flourished and now been found to work better than wait-list conditions and as well as or better than traditional multi-session treatment (e.g., Öst & Ollendick, 2017). The cost-effectiveness of BICs compared to multi-session CBT in "real-world" effectiveness trials has also begun to be demonstrated (e.g., Wang et al., 2022 in Wright et al., 2018, 2022, 2023). Moreover, BICs utility even in those with comorbid disorders has started to be evaluated too (e.g., BICs to treat disorders in those comorbid with autism; Davis III & Brennan, 2024; Davis et al., 2007; Iniesta-Sepulveda et al., 2018).

Interestingly, 20 years ago, two important questions were asked in an otherwise small commentary in *Clinical Psychology: Science and Practice*: Where to go from here, and is it ethical to provide a long-standing treatment when there are potentially more evidence-based alternatives (Ollendick & Davis, 2004)? In two decades of attempting to decide where we are going and is what we are providing ethical, there is a need to avoid hubris and respect what has gone before and what has worked; however, that deference should not also prevent innovation, refinement, and improvement. As such, there is understandably a tension that exists between the comfort and ease of what has been when contemplating what may be. With this in mind, there are many thoughts, plans, and considerations when laying out a volume of this type and an understanding that innovation often comes from standing on the

shoulders and work of those who went before us. One obvious concern is if this volume is a call to do away with the many decades of work that have come before in favor of less (and possibly cheaper because of less) treatment. In answer to this important point, we suggest as one reads through this volume to keep in mind the following considerations:

1. Efforts to study and refine therapy may not be (and are often not) geared toward replacing existing tried-and-true evidence-based treatments. BICs may be developed to offer alternatives, stop-gaps, or theoretically stronger formulations that better match the patient's toleration for intervention—or even a certain subgroup of patients. Moreover, further refinement may actually lead to a better understanding of when traditional multi-session therapies are the best path for a given individual patient.
2. Efforts to study therapy and develop BICs may be geared toward refining and amplifying outcomes—if not finding all together new treatments.
3. One of the many important things taught to new therapists is that patients do not always have the same goals as the therapists. BICs may offer a step on the way of patients arising to the growth therapists see possible with longer-term intervention. As evidence for this, attrition has been found to be less of an issue with BICs than traditional multi-session treatment (Öst & Ollendick, 2017). Anecdotally, we have commonly seen a brief intervention not only address the targeted issue and possibly a related comorbid condition (Davis et al., 2013), but also it has served to quickly establish patient faith and "buy-in" to therapeutic intervention. Taking a page from motivational interviewing, BICs may be a way to meet the patient at their level and readiness for change and quickly enhance their motivation for more (e.g., Miller & Rollnick, 2023).
4. BICs are so much more than intensive specific phobia, OCD, or anxiety exposure therapies. In fact, we hope this volume stretches the notion of BICs beyond these disorders to areas where more intensive and immediate intervention may be needed before more traditional multi-session interventions can occur (e.g., more potent, brief crisis interventions that move beyond safety planning and serve to stabilize patients in less restrictive environments for longer-term intervention to continue the work).
5. Coming full circle—one-size does not fit all and ethically should not be made to. Ethical considerations work both ways in that it is potentially unethical to use a multi-session treatment when it is not the current evidence-based treatment standard, but it is also unethical to use an inadequately tested BIC when the evidence supports longer-term multi-session intervention. This consideration is also important when weighing patient benefit across cultures and the globe.

As a result, an important part of this volume and this work is to build upon the many decades of research and treatment that have gone before, not necessarily replace it.

At some point too, it will be important to continue the work of determining what does not work. Almost 20 years ago Lilienfeld (2007) also offered Potentially Harmful Treatments (PHTs) for consideration and emphasized that identifying harmful psychological therapies should even take precedence over cataloging and

promoting the most evidence-based ones. As the field considers endeavors to further improve and condense existing therapies, it is important to remain mindful that earlier evidence-based criteria largely relegated treatments to lower experimental statuses for a lack of evidence with no malice (i.e., a treatment may not have been studied enough or at all; Task Force, 1995). No negative connotation was generally implied other than more work was needed to substantiate the effects of a treatment or that a separate research team might be needed to replicate prior findings—a very different notion than this may be a treatment that actually harms its recipients. In the push to develop and test BICs, it will be important to make sure new potentially *helpful* treatments do not unintentionally become potentially *harmful* treatments by assuming an adequate dose of treatment when more is actually needed, by allowing for managed care to further restrict treatment access and options when that decision is counter to professional judgement, in providing an intensity that is out of step with a particular client or disorder, or in myriad other ways.

So, in these veins this volume offers a balanced, international group of authors to speak on the current state of BICs—their strengths and their perils. Long-standing BICs like OST for specific phobia are discussed, but so are less certain topics like how one should apply a BIC-focus to complement psychopharmacology (or even if one can or if it would in fact cause harm). Inevitably, monetary concerns surrounding BICs compared to other more traditional treatments will be a factor and so a chapter on cost-effectiveness has been included that extends beyond a simple less-is-cheaper-and-therefore-better explanation to include relative expense, quality of life, and other factors. The goal of this volume was less to focus on establishing a list of evidence-based "super-treatments" and more to summarize the ongoing work to continuously edge our field forward and ethically evaluate our progress—hence a chapter devoted to ethical considerations. In the end, the goal is to summarize how we might best take what we know about disorders and treatment and carefully, ethically work towards the underserved 25–50%.

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Chapter 2
The Ethics and Experience of Brief Therapy: The Case of Exposure Therapy

Sarah C. Jessup and Bunmi O. Olatunji

1 Exposure Therapy: A Critical Component of CBT

Anxiety disorders are among the most common mental health disorders for children, adolescents, and young adults (Essau & Gabbidon, 2013), and are developed and maintained partially through learned fear associations and subsequent avoidance of feared stimuli (Mowrer, 1951). Exposure therapy is designed to target such fear and avoidance and is considered the most empirically supported treatment for anxiety-related disorders (Silverman et al., 2008; Wolitzky-Taylor et al., 2008; Foa & McLean, 2016). Through exposure therapy, anxious individuals repeatedly confront feared stimuli without engaging in safety rituals to allow for disconfirmatory experiences. Unlike other treatment modalities, exposure therapy initially evokes distress rather than soothing it (Olatunji et al., 2009). Although fear often declines throughout exposure therapy, modern inhibitory retrieval theory suggests that this habituation is not necessary for treatment to be successful (e.g., Craske et al., 2008). The inhibitory retrieval model (Craske et al., 2008, 2014, 2022) posits that exposure works as individuals learn to *tolerate* their distress rather than eliminate it. Due to its unique characteristics and intensive nature, exposure therapy lends itself as a helpful lens through which clinicians consider a variety of ethical challenges.

Exposure therapy falls under the broader umbrella of cognitive-behavioral approaches to treatment. In fact, exposure to feared stimuli is widely regarded as the central component to successful cognitive-behavioral therapy (CBT) for anxiety disorders (e.g., Chorpita et al., 2002; Silverman et al., 2008). Standard CBT tends to be short-term and agenda-driven, consisting of approximately 11–18 sessions delivered weekly. With the rise of brief interventions, CBT has maintained its primary

S. C. Jessup · B. O. Olatunji (✉)
Vanderbilt University, Nashville, TN, USA
e-mail: olubunmi.o.olatunji@vanderbilt.edu

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therapeutic components including exposure, but has become more condensed and intensive, often consisting of 10 sessions or less (Öst & Ollendick, 2017; Ollendick, 2014). In fact, exposure-based CBT protocols for anxiety have been shown to deliver a full, effective course of treatment in one-week and in the case of specific phobia, as short as one day (Öst, 1989). Similarly, an intensive CBT for panic disorder which involved 9 hours of therapist contact over two consecutive days was developed for the purpose of delivering evidence-based treatment to a largely rural patient population that must travel long distances to find a treatment provider (Deacon & Abramowitz, 2006). This shift toward more brief and intensive treatment holds promise in increasing access, efficiency, and cost-effectiveness of treatment and has yielded encouraging results (Öst & Ollendick, 2017). When compared to standard CBT, meta-analytic results indicate brief, exposure-based CBT yields comparable effects in terms of treatment gains and maintenance, as well as lower rates of attrition (Öst & Ollendick, 2017).

As brief CBT interventions for youth, adolescents and young adults continue to yield promising effects and become more widely utilized, it is critical that clinicians carefully consider the ethics of providing intensive treatment. This chapter will use exposure therapy as an example to discuss ethical considerations likely to arise with brief, intensive CBT interventions. We will review the distinctive features of CBT that contribute to its efficacy, how such features apply to exposure therapy, and the ethical considerations associated with each feature. In total, there are six distinctive features that have been found to distinguish CBT from other treatment modalities, including psychodynamic-interpersonal therapy (Blagys & Hilsenroth, 2002). While the following sections focus primarily on ethical considerations for exposure therapy, many of which were originally suggested by Gola et al. (2016) and Olatunji et al. (2009), they are positioned to be largely applicable to CBT and brief interventions more broadly.

2 Distinctive Features of CBT and Related Ethical Considerations

2.1 Use of Homework and Outside-of-Session Activities

One distinctive feature of CBT is the use of homework and outside-of-session activities. Homework provides clients with the opportunity to practice and apply the skills learned during the treatment session and is believed to be a critical feature in maintaining treatment gains (Beck et al., 1979). Homework and outside-of-session activities help patients generalize what is learned in session to the real world (e.g., Hollon & Beck, 1994), which is thought to reduce fear renewal after successful treatment (e.g., Craske et al., 2022). Indeed, meta-analytic reviews have shown that the degree of homework compliance and the skills acquired through homework are significantly related to superior treatment outcomes (Kazantzis et al., 2016;

Mausbach et al., 2010). Similarly, exposure therapy often involves leaving the clinic space to conduct exposures in real world settings, which allows safety learning to be applied to a wider range of situations (Craske et al., 2014). As interventions become more condensed and intense, it will be important to maintain fidelity to this element of CBT so as not to compromise the generalizability of learning. At the same time, conducting brief and intensive exposure interventions outside of sessions also give rise to ethical challenges that warrant special consideration.

As patients conduct exposures outside of the treatment setting, whether it be for homework or an out-of-office exposure, there is an inherent risk to privacy and confidentiality. Although ethical considerations for informed consent (APA Ethics Code, sections 3.10, 10.01) will be discussed in more detail later in the chapter, it is critical that the patient agrees to and fully understands the benefits and risks before conducting exposures outside of the office. As part of the consent process, the client and caregiver should be informed that reasonable precautions will be taken to preserve confidentiality, but that there is no guarantee privacy and confidentiality can be completely protected (APA Section 4.02: Discussing the Limits of Confidentiality). For instance, homework exposures often involve activities that are more likely to be perceived as "out of the ordinary" by siblings, grandparents, or other family members (e.g., repeatedly touching contaminated surfaces in public). Similarly, patients who undergo a brief and intensive intervention often find that loved ones or work colleagues ask questions about absences that risk privacy. To maintain confidentiality and minimize intrusions on privacy (APA Ethics Code, Section 4), proactive conversations with caregivers and patients should involve how much the patient wants or plans to disclose to others.

Although out-of-office exposures can be especially beneficial in school, community, or social settings where avoidance behaviors are present and/or that closely align with the patient's values (e.g., places of worship), they are also accompanied by risks to confidentiality. When conducting exposures outside of session, there is a greater probability that the patient or therapist will be recognized, particularly in smaller communities. Conducting out-of-office exposures with a patient who is a young child may draw attention if the child is recognized with an adult who is not their parent or is recognized by other children who may ask more questions than adults would (Gola et al., 2016). For adolescent and young adult clients, there is an increased probability of running into a peer. According to Section 5.02 of the Ethics Code (APA, 2017), psychologists must "take responsible precautions to respect the confidentiality rights of those with whom they work." The therapist should discuss plans in advance with the client and family to maximize the likelihood that confidentiality is maintained and take steps to minimize intrusions on privacy (APA Ethics Code, Section 4.04). The first author recently completed exposures at a place of worship for an adolescent client with obsessive-compulsive disorder (OCD) who had been avoiding attending services. When discussing the exposure in advance, the adolescent expressed concerns that they may encounter a peer from the youth group while completing the exposure. Steps were taken to protect confidentiality, including the creation of a cover story (therapist would be introduced as a family friend), the therapist dressed in accordance with religious norms and de-identified

themselves as a mental health professional (e.g., removing staff badge; Olatunji et al., 2009), and exposures were conducted during non-peak hours. Consistent with recommendations from Olatunji et al. (2009), the therapist also resisted actions that would divulge the nature of the therapist-client relationship to the public (e.g., refrained from visibly recording anxiety or distress responses on a clipboard). The decision to conduct out-of-office exposures was a collaborative effort between the therapist, adolescent, and consenting caregiver in which the benefits (resuming a valued activity) and risks (potential run in with a peer) were carefully weighed. The therapist and client also collaborated on when the out-of-office exposure should be completed. In this instance, it was determined that conducting exposures during non-peak hours was ideal, given that it minimized likelihood of encountering a peer *and* most directly tested fears of attending worship at the "wrong" time. It is worth noting however that there are instances in which scheduling sessions when less people are around may help to maintain confidentiality, but also minimize the anxiety elicited (e.g., in cases of social anxiety). This is an important balance to consider and can be collaboratively discussed with the client.

There are also important considerations that ethically relate to APA Principle E (Respect for People's Rights and Dignity), including maintaining appropriate boundaries, when conducting brief CBT interventions such as exposures. Professional boundary concerns are among the most frequently reported ethical dilemmas for both psychologists and graduate students (Pope & Pope & Vetter, 1992; Fly et al., 1997; Gola et al., 2016). In the case of out-of-office exposures, temporary boundary crossings, or deviations from traditional, strict forms of therapy (Zur, 2001), may occur when riding in the car with a client afraid of crossing bridges or making a home visit for a client with hoarding disorder or agoraphobia. It is often difficult to maintain the boundaries of the traditional therapist-client relationship once out of the office space, as the conversation naturally becomes more casual and the setting more informal (Gola et al., 2016; Altis et al., 2015). However, such temporary boundary crossings are often clinically appropriate, necessary steps, and can positively impact the therapeutic relationship (Olatunji et al., 2009; Pope & Keith-Spiegel, 2008). For instance, the first author worked with an adolescent client who developed contamination OCD during the COVID-19 pandemic. The contamination concerns were specific to the home environment given that the client perceived her parents' cleaning practices as insufficient to protect against germs. As a result, the client avoided common areas in the home including the kitchen, living room, and laundry room, which prevented her from eating meals with her family, joining family movie night, and doing her own laundry. Although some fears could be effectively tested in the office, it became clear that the majority of impairment was in the home environment. Further, the client began attributing her exposure success to the office space (e.g., "nothing bad happened because the clinic is safe, but my house is still dangerous…"). In collaboration with the client and her parents, it was determined that a temporary boundary crossing (i.e., home visits) would be a necessary treatment component. The therapist collaborated with parents to conduct home exposures at clinically appropriate times (e.g., after school, while parents prepared dinner) and assigned complementary homework exposures that would encourage the client to approach

feared spaces (e.g., fill safe/clean water bottle in kitchen sink). Through this temporary boundary crossing, the adolescent was able to regain her independence, resume valued family activities, and began contributing to previously feared household chores (e.g., putting away dishes, taking out kitchen trash).

It is important to note that boundary crossings concretely differ from boundary *violations* (e.g., exploitative dual relationships; Olatunji et al., 2009). When engaging in a temporary boundary crossing during an out-of-session exposure, Olatunji et al. (2009) recommend a cost-benefit analysis in considering the best and worst possible outcomes that could result from the boundary crossing (also see Altis et al., 2015). It may also be useful to consider whether the boundary crossing is done for the client's benefit, with informed judgment, and previously agreed upon with the patient (Gutheil & Brodsky, 2008). When working with children, adolescents, young adults and their families, the therapist should also consider the role of the clinician's age and gender and the client/family's cultural identities when determining whether boundary crossings are appropriate, necessary, and productive (Gola et al., 2016; Pope & Keith-Spiegel, 2008).

2.2 Direction of Session Activity

The second distinctive feature of CBT is the direction of session activity. In contrast to many other theoretical orientations, CBT adheres to an agenda-driven approach, such that the focus of the discussion is generally decided beforehand, and patients are actively directed toward specific topics and tasks (e.g., Beck et al., 1979; Craighead et al., 1994). Therapists providing intensive CBT have a responsibility to maintain fidelity towards this active, agenda-driven treatment approach as interventions become briefer and more condensed (APA Ethics Code, Principle B: Fidelity and Responsibility). A collaborative working relationship where psychologists "establish relationships of trust with those with whom they work" (APA Ethics Code, Principle B) is critical for treatment success. Given that exposure therapy in CBT requires patients to engage in distressing activities (e.g., confrontation with threatening stimuli), a strong alliance between patient and therapist may be useful (Buchholz & Abramowitz, 2020). Indeed, collective empiricism which involves collaboration between the therapist and client to establish common goals, has been shown to be one of the primary change agents in CBT (Dattilio & Hanna, 2012).

A common myth of exposure-based CBT is that exposures are done "to" the client rather than "with" the client (Feeney et al., 2003). Instead, exposures are a collaborative process designed to respect the person's autonomy while also challenging them to confront their feared beliefs and attain their goals. To maintain treatment fidelity and act in the best interest of the client (Principle B, APA, 2017), the therapist and client should work together on agenda-items, including the development of the exposure hierarchy. Consistent with the directive features of CBT, effective exposure treatment involves initiating discussion with the client to create an exposure hierarchy list that is unique to the individual and most directly confronts their

fears. Such collaboration should persist throughout the exposure process, including jointly deciding when an exposure should end and when to proceed up the hierarchy. During brief exposure-based interventions, it will be especially important for the therapist to actively balance challenging the patient to complete difficult exposures despite high levels of anxiety, with adapting exposures as needed so clients can experience success throughout treatment. To maintain treatment fidelity, therapists should be directive, but allow the patients to control the pace of the exposure. For difficult exposures, therapists should also continue to allow sufficient time for habituation or post-exposure processing even with the brief, condensed nature of the intervention. Post-exposure processing can be crucial for consolidating learning and identifying expectancy violations, shifts in beliefs, or mistaken cognitions that change as a result of exposure (Abramowitz et al., 2019).

It is worth noting that by collaboratively engaging in exposures, therapists are also adhering to Principle A of the Ethics Code (Beneficence and Nonmaleficence) and Section 3.04 (Avoiding Harm; APA, 2017). Consistent with Principle A, psychologists should take steps that will maximally benefit the patient and "take care to do no harm." Contrary to beliefs that exposure therapy can be harmful, there is no evidence that exposure is any more dangerous than other psychological interventions (for a review, see Olatunji et al., 2009). With patients taking an active role in their treatment, they are empowered to set the pace of the exposures. Further, the collaborative process will allow the therapist to better understand which environmental factors (i.e., occasion setters) increase or decrease the likelihood of the feared outcome and thus, optimize the benefit of exposure from a learning perspective (Craske et al., 2022). For example, one author treated a young adult with contamination-based OCD who feared brief contact with common household cleaners would irreparably damage their health. After initiating discussion about occasion setters during exposure (i.e., ways to maximize benefit), the young adult noted that distraction (e.g., holding a conversation with a family member) during exposure increased perceptions of recklessness around household chemicals and thus, increased the perceived likelihood that the feared outcome would come true. The collaborative nature of treatment sessions allowed the therapist to better understand the functional role of distraction, which is traditionally eliminated to optimize learning (Craske et al., 2022), and design an exposure that maximized benefit to the client (Principle A, APA, 2017). For work with younger children, the therapist should exercise clinical judgment regarding the child's insight into the exposure process. This could be a place where collaboration with consenting caregivers or other family members may also be useful.

2.3 Teaching of Skills Used by Patients to Cope with Symptoms

Through the lens of CBT, therapists adhere to a psychoeducational approach and teach their patients skills to help them cope more effectively in difficult situations (Beck et al., 1979; Beck & Freeman, 1990). In contrast to psychodynamic-interpersonal

therapy through which patients are thought to more effectively cope as they achieve greater understanding of their difficulties (Luborsky, 1984; Strupp & Binder, 1984), cognitive-behavioral approaches emphasize "learning through doing" (Blagys & Hilsenroth, 2002) and brief, exposure-based interventions are no exception.

Exposure therapy is designed to initially evoke distress rather than soothing it (Olatunji et al., 2009), and therapists are encouraged to use such experiences to teach patients how to cope with negative emotions. Contrary to common clinician concerns that exposure is intolerable or could exacerbate symptoms, there is an abundance of research demonstrating that exposure is safe and well-tolerated (Olatunji et al., 2009). For instance, one study found there was only a 0.01% risk of a serious negative event occurring during exposure for youth clients (Schneider et al., 2020). In fact, despite therapist hesitations, exposure therapy is generally held in high regard by patients (Olatunji et al., 2009) and compared to alternative treatments, is perceived as more acceptable and effective long-term by both anxious individuals (Deacon & Abramowitz, 2005) and parents of anxious children (Brown et al., 2007). Further, despite clinician concerns, attrition rates for exposure therapy are comparable to, or lower than, attrition rates for other treatment modalities, including cognitive therapy, pharmacotherapy, relaxation, waitlist, and pill placebo interventions (Johnco et al., 2020; Ong et al., 2016). Prior to initiating exposure therapy, therapists should consider how their own biases and competencies may interfere with their ability to teach their patients skills during exposure. Indeed, the APA Ethics Code stipulates that psychologists must "exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence and the limitations of their expertise" do not prevent access and benefit to care (Principle D; APA, 2017). Each exposure exercise represents an opportunity to teach patients how to cope with distress or anxiety as it arises.

Although exposure is a safe and tolerable treatment, it is possible that patients could experience potentially adverse psychological reactions during exposure. For instance, a patient who fails to habituate to high distress may become discouraged or express doubts in the effectiveness of treatment (Olatunji et al., 2009). Consistent with the inhibitory retrieval theory (Craske et al., 2014), it is helpful for therapists to frame exposures as tests of negative expectancies (e.g., "did the feared outcome occur, was it as bad as expected?") rather than emphasize that fear will decline or go away over time. While the former teaches patients that they can tolerate negative experiences as they arise, the latter may inadvertently send the message that anxiety is a negative experience that should be eliminated (Abramowitz & Arch, 2014; Arch & Craske, 2011). This framing may be especially important in brief or condensed interventions where there is less opportunity for fear reduction.

Additionally, it is not possible to fully control the exposure environment. Thus, unexpected, "negative" events may occur during or after an exposure. A patient who touches a door handle without washing may become ill, a socially phobic individual may be negatively evaluated during a speech, or a driving phobic individual may get in a car accident. Therapists can take steps to minimize risk (Section 3.04, APA, 2017) by anticipating that exposures may not always go as planned, taking reasonable steps to prevent foreseeable harm, and framing exposures "as a test of

probabilities, predictions, and costs" (Olatunji et al., 2009). Upon completion of the exposure, the therapist may probe the client to consider even if a feared outcome *did* occur, was it as catastrophic as the client anticipated? Were they able to remain in the situation and/or tolerate their distress despite the discomfort? Such experiences represent valuable learning opportunities, often referred to as "desirable difficulties" (Bjork, 1994) that are believed to strengthen exposure and facilitate long-term change (Craske et al., 2008; Abramowitz et al., 2019).

2.4 Emphasis on Patients' Current and Future Experiences

Whereas psychodynamic-interpersonal therapy focuses on the patient's past and unresolved conflicts, CBT highlights the impact that the patient's dysfunctional beliefs have on current and future functioning (Blagys & Hilsenroth, 2002). Therapists should emphasize that skills learned during CBT are intended to promote more adaptive functioning (i.e., less avoidance, distress) in the future (Goldfried & Davison, 1994). With the pressure of fewer sessions to make significant treatment gains, therapists may be more effective focusing on the patient's current difficulties and how these may impact future experiences (Blagys & Hilsenroth, 2002).

When designing exposures (or conducting brief interventions more broadly), therapists should consider that an individual's current and future experiences may be influenced by their identity. According to Principle E (Respect for People's Rights and Dignity), psychologists should be "aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working" with each patient (APA, 2017). For instance, a therapist may need to modify and adapt exposures for social phobia with transgender youth to ensure the treatment is both efficacious and culturally sensitive (Busa et al., 2018). Compared to social exposures for cisgender youth, it may be important not only to consider interpretations of ambiguous social experiences, but also the potential for experiences of discrimination and victimization that contribute to perceived rejection (Wells et al., 2020). Further, factors such as increased rejection sensitivity (Wells et al., 2020) and access to gender affirming care (Butler et al., 2019) may play important roles in transgender individuals' experiences with social anxiety. More broadly, as interventions become increasingly intensive, it will be critical that clinicians continue to challenge patients in a way that benefits their treatment and respects their values (Principles A and E, APA, 2017).

It may also be useful to consider a patient's motivation for treatment, current level of avoidance, and values when designing exposures. Such considerations highlight the importance of therapists providing services that fall within the boundaries of their competence (Section 2.01; APA, 2017). Given that avoidance is a fundamental component of anxiety disorders, it is unsurprising that some patients will be hesitant or unwilling to complete exposures even with a strong understanding of

treatment rationale. Consistent with modern inhibitory retrieval theory (Craske et al., 2014), it may be useful to frame exposures as a series of "mini experiments" designed to test negative predictions (Olatunji et al., 2009). Exposures can be broken into smaller steps to instill confidence and encourage approach behavior. In an effort to "do no harm" (Section 3.04; Principle A), therapists should always also keep in mind that the patient has the ultimate say in which exposures are completed and when. Therapists should not force patients to do something they do not want or consent (Sections 3.10, 10.01) to do, but can remind the patient of their goals and values. For instance, the therapist could encourage the client to consider how the brief intervention now, albeit scary and difficult, aligns with their values and goals for the future. Consistent with this approach, motivational interviewing has been shown to be a beneficial adjunct to exposure-based CBT and enhances treatment adherence and outcomes by decreasing patients' ambivalence or reluctance to engage in exposures and building patients' self-efficacy and intrinsic motivation to engage in treatment (Guzick et al., 2021; Simpson et al., 2008; Merlo et al., 2010).

2.5 Providing Patients with Information About Their Treatment, Disorder, or Symptoms

CBT is also distinct in its emphasis on providing patients with information about their treatment, disorder, or symptoms (Blagys & Hilsenroth, 2002). Therapists adhering to a cognitive-behavioral framework explicitly discuss the rationale for treatment and specific techniques to be used (e.g., Beck et al., 1979). In addition, patients are provided with detailed information about their symptoms through handouts, worksheets, or books. Together, this psychoeducation is believed to help orient patients to the rationale and technique being used, increase patients' ability to cope, as well as instill hope that symptom distress can be alleviated (Fennell & Teasdale, 1987). This emphasis has important implications for patients' autonomy, active involvement in treatment, and consent to the treatment process.

Ethically, this distinctive feature of CBT closely aligns with the importance of informed consent. Psychologists are expected to inform patients "as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, involvement of third parties, and limits of confidentiality" (Section 10.01; APA, 2017). Much of what has been discussed thus far in the chapter speaks to the important information that should be conveyed to patients during informed consent, including that exposure is a treatment designed to evoke distress, is meant to be a collaborative process, and when completed outside of the office may have implications for confidentiality. During the informed consent process, therapists should also outline what to expect in a brief, exposure-based intervention (e.g., risks, benefits), so the patient can autonomously decide whether to proceed.

Special considerations must also be taken into account when delivering CBT to children, adolescents, and young adults. Given that psychologists should obtain