Considering CBT With Anxious Youth? Think Exposures

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Following a historical précis regarding exposure and a brief description of a representative cognitive-behavioral therapy (CBT) program for anxiety disorders in youth, we discuss several factors related to conducting exposure tasks in youth. Topics include assessing anxious situations, creating a hierarchy, and using imaginal, as well as in vivo and in- and out-of-session exposure tasks. We also describe and discuss the posture of the therapist with regard to the development and maintenance of rapport, the process of consulting with the child, the use of shaping and rewarding effort, the restraining from reinforcing avoidance, modeling for parents, and how to deal with the occasional less-than-successful exposure task. Developmental level of the child and contextual factors are examined as they might influence the design and implementation of exposure tasks. Last, we consider professional practice issues of liability, applications in private practice, and the challenges that face new therapists undertaking exposures. Examples and illustrations from actual clinical cases are included throughout.

One of the major advances in the field of youth anxiety has been in the development of effective treatments for these disorders. Specifically, results of approximately 15 randomized investigations show that cognitive-behavioral therapy (CBT) for anxious youth has been found to be effective (i.e., an approximate 65% of youth across studies and treatment conditions no longer meeting diagnostic criteria for their principal pretreatment anxiety diagnosis at posttreatment) across settings, cultures, and age ranges (e.g., Barrett, Dadds, & Rapee, 1996; Ginsburg & Drake, 2002; Hayward et al., 2000; Kendall, 1994; Kendall et al., 1997; Masia, Klein, Storch, & Corda, 2001). Although variations among CBT programs exist with regard to the types of skills introduced (e.g., social skills, relaxation training, communication skills), a common thread throughout all of the successful CBT programs can be said to be child engagement in hierarchy-based exposure tasks (i.e., using a graduated approach, child experiences anxious distress in real or imagined anxiety-provoking situations). Most researchers and theoreticians would agree that successful engagement in exposure tasks is necessary for positive treatment outcome when treating child anxiety. Indeed, Kazdin and Weisz (1998) asserted that a key element of all CBT for child anxiety is exposure to the feared stimuli.

Despite the accepted importance of exposure tasks when treating anxious youth, very little is known about the nature and content of exposure tasks and currently there are no guidelines for conducting effective exposure tasks with youth. For example, what are the components of exposure tasks? What areas should be addressed in advance of conducting an exposure task? How does a therapist plan an exposure task with a child? What factors should be considered when conducting an exposure task? What are the professional issues and ethical considerations? The purpose of this article is to offer our experience in providing researchers and clinicians with guidelines and suggestions for creating and implementing effective exposure tasks when treating anxious youth.

First, a brief historical and theoretical discussion of conducting exposure tasks with anxious youth is presented. Second, a sample CBT program is described to provide a framework for conducting exposure tasks with youth. Third, we describe the common components and core features of conducting exposure tasks, such as creating a hierarchy of feared situations, planning the type (imaginal versus in vivo) and location (in-session versus out-of-session) of exposure tasks, measuring the child's subjective distress during exposure tasks, and establishing a reward system for the child's effort. Fourth, we discuss therapist and child characteristics and behaviors that may contribute to exposure task outcomes. We conclude with a discussion of professional and ethical considerations when conducting exposure tasks with youth. In short, we provide a discussion of issues pertinent to anyone who is considering using CBT with anxious youth, and we do so with the intent of encouraging therapists to think about and to use exposure tasks.

History and Theory

Disagreement and controversy exist regarding the explanation for the positive effect of exposure treatment.

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Counterconditioning, extinction, habituation, cognitive change, and coping skills development are all examples of the potential mechanisms mediating the relationship between exposure treatment and meaningful decreases in anxiety responses. In this section, we briefly describe each of these potential change mechanisms.

In 1924, Jones reported in a case study that the most successful procedure for reducing fear is the simultaneous presentation of a pleasant stimulus (e.g., food) with the targeted anxiety-producing stimulus (in this case, a white rabbit). Jones's work was perhaps the earliest example supporting the use of what later came to be termed counterconditioning (Wolpe & Lazarus,1966), or the elimination of a classically conditioned response following repeated pairing of the conditioned stimulus (e.g., white rabbit) with an opponent or antagonistic unconditioned stimulus (e.g., food). Building upon the work of Jones (1924) and classical conditioning theorists (e.g., Pavlov, 1927), Wolpe (1958) developed an exposure treatment that he called systematic desensitization, which he based on principles of counterconditioning. According to this theory, fears can be counterconditioned by confronting the feared stimulus (i.e., through exposure) while simultaneously engaging in a process called reciprocal inhibition, or suppression of the anxiety response by engaging in a biologically incompatible behavior (e.g., relaxation). In addition, systematic desensitization involves the creation of an anxiety stimulus hierarchy in which the individual and therapist generate a list of anxiety-provoking situations and sort the situations by level of fear elicited in each situation. Systematic desensitization begins by confronting feared situations low on the stimulus hierarchy while engaging in reciprocal inhibition and then moving up to the next situation on the hierarchy when the previous situation elicits minimal or no fear.

Although Wolpe's theory has provided the framework for exposure treatments used today, treatment studies with adults have found that reciprocal inhibition may not be a necessary part of exposure tasks; individuals experience decreased anxiety in extinction trials even when relaxation or other anxiety inhibitory responses are not engaged (e.g., Gillan & Rachman, 1974). In addition, individuals have successfully decreased their anxiety responses to hierarchies when presented with the most anxiety-provoking items prior to lesser anxiety-provoking situations, suggesting that neither reciprocal inhibition nor gradual exposure are essential to decreasing anxiety (Marks, 1987; Wilson, 1973). It is worth noting, however, that although gradual exposure may not be necessary for the reduction in anxiety to occur, this approach often makes treatment more palatable and may decrease treatment attrition.

Other behavioral explanations for the effectiveness of exposure tasks include extinction and habituation. Extinction occurs when the unconditioned response (e.g., fear reaction) no longer follows the conditioned stimulus (e.g., giving a speech) over repeated trials. During exposure tasks, operant extinction plays a role as the individual ceases to be negatively reinforced (by a decrease in anxiety) through avoidance of the anxiety-producing stimulus but, instead, experiences a decrease in anxiety while in the presence of the feared stimulus. Habituation occurs when an individual stays in the presence of the feared stimulus until the stimulus no longer evokes a distressing level of arousal (the length of time in the presence of the feared stimulus varies by individual).

In our work with children and adolescents, we have found that a successful exposure trial with one stimulus/situation is often accompanied by a reduction in anxiety to other stimuli/situations. Although one could argue that this represents an extinction generalization effect, investigators and practitioners have speculated that cognitive changes may underlie effective exposure treatment. In general, cognitive mediational models of anxiety reduction suggest that the effects of exposure tasks rely on changes in maladaptive fear schema (Beck, Emery, & Greenberg, 1985) and reductions in negative self-talk (Treadwell & Kendall, 1996). A general cognitive shift can follow exposure treatment and lead clients to reinterpret and change how they see the relationship between the anxiety-provoking stimulus/situation and their reaction to it, the adequacy of their own resources, and/or the saliency of the threat. Indeed, following successful exposure treatment, clients report changes in their expectancy that unwanted anxiety would follow a conditioned stimulus (e.g., flying in a plane; Thompson, 1994; Wilson, 1995).

Coping skills development may also be important to successful exposure treatment. Children rate their ability to cope with feared situations as much higher following exposure tasks (e.g., Kendall et al., 1997), an increase in coping that is associated with decreases in distressing anxiety. This finding is consistent with Bandura's (1977) formulation of self-efficacy. The knowledge that coping skills are available to manage anxiety may increase self-efficacy and decrease threat, thus decreasing anxiety.

In sum, each of the theoretical explanations for the effectiveness of exposure tasks (counterconditioning, extinction, habituation, cognitive change, and coping skills development) has gained at least some empirical support; however, there is currently no consistent evidence documenting the superiority of one of these potential mechanisms of change. Although, our clinical experience suggests that some or all of these factors likely interact to produce clinically meaningful change during exposure tasks. Further, the mechanism of change may vary across individuals. Thus, aspects of each of these theories

will be incorporated into our discussion of and recommendations for conducting effective exposure tasks. With this in mind, we will suspend the theoretical discussion and focus instead on the practical aspects of conducting clinically beneficial exposure tasks. To aid our discussion, we will provide a framework in which exposure tasks are conducted by describing a sample CBT program for anxious youth.

A Sample CBT Program for Anxiety in Youth

Regardless of which theoretical model (e.g., habituation, extinction, coping) a therapist embraces, exposure tasks allow youth (child or adolescent) to face their fears/anxieties while developing adaptive behavior in response to the feared stimulus/situation. There are several adaptations of CBT for use with anxious youth (e.g., see Albano, Marten, Holt, Heimberg, & Barlow, 1995; Barrett et al., 1996; Beidel, Turner, & Morris, 2000; Kendall, 2000; Manassis et al., 2002; March & Mulle, 1998; Piacentini, Bergman, Jacobs, McCracken, & Kretchen, 2002). Our CBT programs (e.g., Howard, Chu, Krain, Marrs-Garcia, & Kendall, 1999; Kendall, 2000; Kendall, Choudhury, Hudson, & Webb, 2002a; Kendall, Kane, Howard, & Siqueland, 1989) follow a gradual exposure model in which the child, following educational preparation, is progressively exposed to a hierarchy of anxiety-provoking situations.

The program, referred to as the "Coping Cat Program" (where youth move from being scaredy cats to coping cats), is divided into two segments, each approximately eight, 1-hour sessions. The first segment focuses on skills training and the second segment focuses on skills practice. During the first phase of treatment, the child learns several basic skills that are integrated into a plan for dealing with anxiety (e.g., Kendall, Aschenbrand, & Hudson, 2003). Following rapport-building activities, the child first learns about physiological/bodily reactions to anxiety (both the client's and the therapist's) in general and, more specifically, about his or her own particular physiological responses to anxiety-provoking situations. The child is shown how physical reactions can be cues to let us know when we are anxious and to signify that we need to help our body relax. The second step involves helping the child recognize and attend to his or her self-talk. This involves the child identifying what his or her expectations and fears are about a specific situation. The third step involves problem-solving about what actions and attitudes can be taken. This may involve changing one's self-talk (using coping thoughts) or taking specific actions that help us cope more effectively in the situation. The final step involves evaluating the effort that was made and rewarding oneself accordingly. These four concepts comprise the FEAR plan:

F—Feeling frightened? (awareness of physical symptoms of anxiety)
E—Expecting bad things to happen? (recognition of anxious self-talk)
A—Attitudes and Actions that will help (behavior and coping talk to use when anxious)
R—Results and Rewards (self-evaluation and administration of reward for effort)

Once a child demonstrates understanding (based on therapist clinical judgment) of the concepts within the FEAR plan, the child is ready to apply and practice the FEAR plan in anxiety-provoking situations—an important component of CBT that is accomplished through exposure tasks. In general, exposure tasks involve having the child experience anxious distress in real or imagined anxiety-provoking situations, become accustomed to the provocative situation, and practice using various coping strategies. Prior to an exposure task, the therapist and youth discuss and develop an application of the FEAR plan (see Table 1 for a sample of a FEAR plan to be used in an exposure task).

But this is just the start. There are several other factors involved in conducting exposures with anxious youth. Teaching the FEAR plan in the first phase of the treatment prepares the child for the exposure phase, but the challenging work for the therapist has just begun. The therapist, in collaboration with the child, plays an active role in planning and conducting effective exposure tasks. The therapist's role is akin to that of a supportive yet challenging coach whose goal is to both assist the child with genuine engagement in feared situations and to have the child

Table 1
A Sample FEAR Plan Developed for Application in an Exposure Task

Exposure Task:
Child to ask a security guard for directions to his therapist's office.

Feeling Frightened?
Yes! I am scared. My heart is pounding. My SUDS is a 5.

Expecting bad things to happen?
I am afraid he won't know where my therapist's office is.
What if I mess up?
What if he ignores me?
Maybe he will laugh at me.

Attitudes and Actions that can help
I can take deep breaths and use my relaxation.
I can think to myself, *I can do it. I just have to try.*
So what if I mess up in front of him, everyone makes mistakes.
He probably won't laugh at me.
That's okay if he does not know where my therapist's office is. I can call her because I have her phone number.

Results and Rewards
I will ask and I will feel proud of myself for being able to talk to strangers. I will know that I can do it.

do it on his or her own. In the next section of this article we describe how the therapist assesses the child's anxiety with regard to exposure tasks, develops a fear hierarchy, creates in- and out-of-session imaginal and in vivo exposures, and teaches self-reward to children for effort.

Features of the Exposure Task

Assessing Anxious Situations and Creating a Hierarchy

Conducting effective exposure tasks involves an accurate assessment of what prompts the child's distress. When working with youth, it is important that the therapist not make assumptions about the child's fears. Instead, the therapist assesses the situation, the exact nature of what is feared, and what the youth expects will happen when faced with his or her feared situation. Parent report, youth report, and observational assessments help pinpoint the nature of the child's anxieties.

Throughout treatment, the therapist gathers additional data to help develop and arrange the hierarchy. The hierarchy is a collaborative effort between the therapist and the child, and is best constructed when the therapist is knowledgeable about the child's fears and anxieties before actually writing down the entries of the hierarchy. Some children are not able to generate specific situations that make them nervous, but the therapist can facilitate the hierarchy by offering suggested entries.

The first step in developing a fear hierarchy involves the therapist and child generating anxiety-provoking situations. These entries are eventually sorted into easy, medium, and challenging categories. A friendly dialogue helps the therapist obtain specific situations from the child regarding his or her anxieties. For example, if a child suggests "talking to new people," the therapist can help the child be more specific, perhaps dividing the entry into two: "talking to new kids my age who I have never met" and "talking to kids my age who I have met before." The situations are written down on a worksheet, in the *Coping Cat Workbook* (Kendall, 1990; Kendall, Choudhury, Hudson, & Webb, 2002b), for use later in treatment. Figure 1 provides an example of a fear plan for a child diagnosed with social phobia.

Assessing Subjective Units of Distress

After the child and therapist identify challenging situations, the child rates how anxiety-provoking the feared situations are on a Likert-type scale called The Subjective Units of Distress/Discomfort Scale (SUDS; Wolpe, 1969). SUDS were originally used with ratings on a 0 to 100 scale (0 = *no distress* and 100 = *highest level of situational distress*). Recently, SUDS have been measured on smaller scales, such as 0 to 10 (Wolpe, 1991) or 0 to 8 as implemented in the Coping Cat programs (Kendall, 2000; Kendall et al., 2002a). When working with children, the smaller range

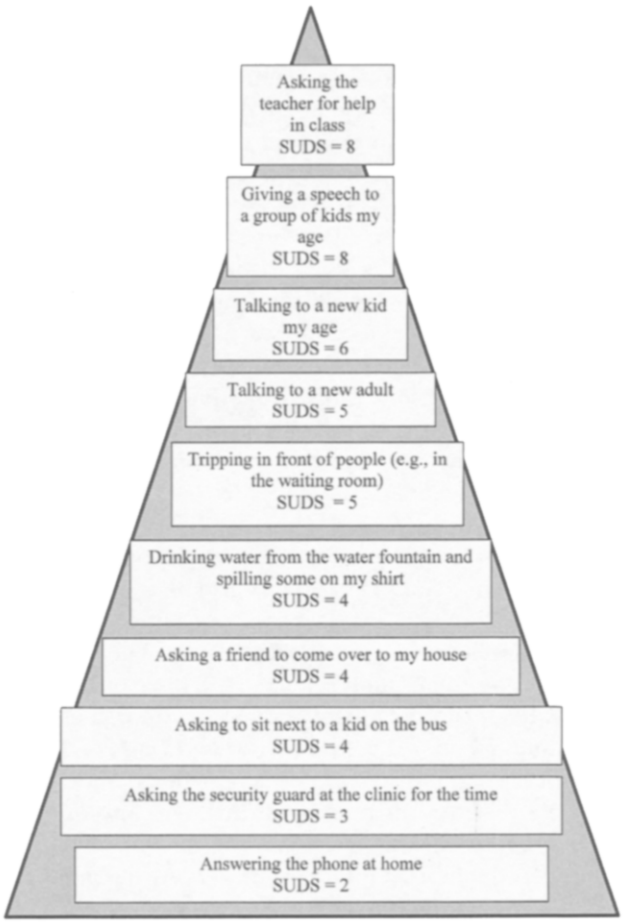

Figure 1. A sample fear hierarchy to be used for exposure tasks with a socially phobic child.

helps to simplify and ease the child's decision-making process. It is also helpful to use a visual aid when explaining the SUDS rating system. For example, we use a "feelings thermometer" or "feelings barometer" that ranges from 0 to 8 (or 0 to 10) and has simple descriptors next to each number, such as "this is a cinch" (for 0) or "this is the scariest!" (for 8). Cartoon faces ranging from a smiling face (for 0) to an extremely frightened face (for 8) also facilitate a child's understanding of SUDS ratings. Children can also personalize their SUDS rating system by making their own descriptors/anchors for the different levels.

Once the rating system is in place, the child provides a SUDS rating for how nervous the child would feel in each of the identified anxiety-provoking situations. The therapist uses this information, with the child's guidance, to place each situation in a hierarchy. A wide range of feared situations with varying levels of SUDS is preferred. When designing the first exposure task, the therapist starts with a minimally challenging situation. Importantly, the therapist checks in with the child regarding his or her

fear rating before setting up the first exposure task-situations and their relative ranking in the fear hierarchy may change throughout treatment.

SUDS ratings are also used during exposure tasks. When engaging in an exposure task, the therapist asks the child for a SUDS rating, both immediately before and after the exposure task. This information can serve a variety of functions. First, SUDS ratings can be used as a method of providing feedback to the child about the level of anxiety in the context of the feared object/situation. SUDS ratings are viewed and treated as "data" regarding what happens to the youth's anxiety when in a specific situation. For example, if the SUDS rating following the exposure task is lower than the initial SUDS rating prior to participating in the exposure task, the therapist may point out to the child that his or her anxiety decreased after being in the feared situation. Soliciting multiple SUDS ratings from the child during an exposure task can provide more "data." Distress can also be assessed at the midpoint of the exposure task or at fixed intervals during the exposure task (e.g., every 30 seconds). The child and therapist can then graph the data and discuss the SUDS ratings (e.g., Did the anxiety ratings go down at all? Did the ratings go up first before they went down? Do the ratings for each exposure task follow a pattern?). Although multiple SUDS ratings taken during an exposure task provide more information regarding the child's distress in a given situation, it is important to note that more frequent assessments of SUDS ratings may be intrusive and/or not feasible while engaging in certain exposure tasks. For instance, when a child is asked to engage in a brief or discreet action, such as raising his or her hand in class at school, collecting SUDS ratings at 30-second intervals may not be feasible considering the limited time frame and location.

To maximize beneficial gains, most exposure tasks call for clients to remain in contact with the feared stimulus or in the provocative situation until anxiety is reduced by at least 50% (some advocate durations that lead to even greater reductions in anxiety before terminating the exposure task). Because decreasing ratings of distress can be a good indicator that the child is feeling more comfortable in a feared situation, SUDS ratings are useful for guiding the length of an exposure task. Considering this, monitoring SUDS ratings is especially helpful during exposure tasks that do not have a clear end—for instance, when a socially phobic adolescent engages in a conversation with another teen or when a separation-anxious child separates from Mom or Dad for an indefinite length of time. SUDS levels are used differently when exposure tasks have a clear end—for example, asking a stranger a question, "messing up" intentionally on a timed test, or walking to school alone. If a therapist uses SUDS ratings to define the end of these exposure tasks, the therapist can repeat the exposure task until the SUDS ratings decrease. Keep in mind that, whether determined through decreasing SUDS ratings or through repetition, the main goal for the therapist during an exposure task is to assist the child in confronting what is feared until the child feels an acceptable level of comfort in the feared situation.

Although we have found children to be fairly reliable reporters of their own anxiety levels when creating the fear hierarchy and during the exposure tasks, sometimes children report SUDS ratings that seem inconsistent with their appearance and/or behavior (i.e., higher or lower than the therapist would anticipate). In the section pertaining to developmental factors, we will discuss in more detail a potential explanation for this inconsistency (e.g., child difficulty with emotional identification); however, it should be noted here that objective SUDS ratings made by the therapist for the child can be useful in reconciling seemingly inconsistent child reporting (regardless of the reason). Therapist ratings are based on several factors, including the child's appearance (e.g., facial expression, posture), behavior (e.g., avoidance, reluctance, shaking, trembling voice), and verbal expressions (e.g., expressing a desire to leave). The therapist's perception of the child's anxiety may be different from the child's self-reported discomfort. For example, a child may report SUDS ratings that decrease during an exposure task, whereas the therapist observes and rates that the child's SUDS ratings are remaining the same during the exposure task. If through observation and clinical judgment the therapist believes that the child's ratings are not accurate, the therapist can use his or her own SUDS ratings to guide the length or number of the exposure tasks and as data to present to the child.

Imaginal and In Vivo Exposure Tasks

After the hierarchy is constructed and SUDS ratings are explained to and understood by the child, two types of exposure tasks can be implemented: imaginal and in vivo. Imaginal exposure tasks are often used when first starting exposures with the child, but can be used throughout treatment. By having the child role-play the feared situation by him- or herself or with the therapist, imaginal exposure tasks allow the child to practice coping before the in vivo exposure task. When working with younger children, props, puppets, and toys can be used for "play acting" the feared situation.

Imaginal exposure tasks are useful with children who have more abstract worries. For example, children with generalized anxiety disorder (GAD) may worry about death or illness of a family member, local violence or international war, or family financial problems. These situations can be adapted to imaginal exposure tasks where the therapist has the child describe and role-play the situation in detail—discussions of the feared (anticipated)

catastrophes. The exposure task will be most successful when the child explains or role-plays how the situation will progress and end. Other imaginal exposure tasks include having the child write out a story about the feared catastrophe and then read it out loud to the therapist repeatedly until the anxiety decreases. For example, a therapist working with a 7-year-old girl with GAD who worried about her parents dying, created an exposure task about "what would happen." The child and therapist acted out what would happen if her parents died, including the child's affective experience, who would take care of her, where she would live, what would happen to her parents after they died, and what would happen to her brother and sister. Although it was reassuring for the child to know that her parents were in good health, it was beneficial for the child to have discussed her irrational fear and address several of her related fears.

In vivo exposure tasks involve the child facing the feared situation "live and in person." The child enters the feared situation while actively dealing with (coping with) anxious arousal. Prior to conducting an in vivo exposure task, the therapist has the child practice through role-play and imaginal exposure. Exposure tasks are tailored for the child's fears and can be changed to make them more or less challenging/difficult. For example, when beginning exposures with a socially phobic child, an initial exposure task may involve giving a speech to another therapist who is warm, smiles at the child, and praises the child for performance. As the child progresses in treatment, a more challenging exposure task may be used: giving a speech when the therapist in the audience whispers to someone, closes his or her eyes, looks bored, or even asks a difficult question. It is important for the child's therapist to address the child's expectations, prepare the child for a variety of negative events, and help the child problem-solve how to cope with these situations. Through this experience the child learns to challenge expectations, cope with anxiety-provoking situations, and feel a sense of mastery.

In- and Out-of-Session Exposure Tasks

The exposure tasks mentioned thus far are typically conducted within the therapy session, but exposure tasks take place both in and out of session (see Table 1 for examples of in-session and out-of-session exposure tasks). There are times when the optimal exposure task cannot be conducted in the therapy office. When an exposure task is to occur outside the session (and/or out of the office), the therapist prepares the child through imaginal exposures. The therapist may also need to work with other adults in the child's life to facilitate successful out-of-session exposure tasks. For example, a therapist in our clinic was working with an 8-year-old boy who was excessively anxious about separating from his mother. Because the child's separation anxiety involved his mother, it was important to have her be a part of both the in- and out-of-session exposure tasks. Indeed, some parent training and practice had to be implemented. The therapist instructed the mother about how to use a fear hierarchy, obtain SUDS ratings before and after the exposure task, and not to reinforce avoidance. Both in- and out-of-session exposure tasks were used. Notice that the situations are graded in difficulty.

In session:

1. The parent stood outside the waiting room.
2. The parent went to a different floor in the building.
3. The parent took a walk in the neighborhood during the session.
4. The parent drove in the neighborhood while carrying out errands.

Out of session:

1. The child played in her room while the mother did laundry in the basement.
2. The child stayed in the house while the mother gardened outside.
3. The mother walked around the block while the child remained in the home.
4. The mother left the child with a babysitter for increasing amounts of time.

Rewards for Effort

Following an exposure task it is important that the therapist and child evaluate the outcome and that the therapist reward the youth for his or her effort. Time needs to be set aside so that the therapist and youth can discuss features of the exposure task, including how the child was feeling, what the child was thinking, and how the child chose to cope. The therapist and child talk about what made the exposure task easy or difficult, what obstacles the child encountered, and whether or not the child would respond the same way in the future. The therapist praises the child for his or her effort and communicates clearly that the reward was for the effort, even if the exposure task was viewed to be only partially successful.

Confronting anxiety-provoking situations is difficult work for the youth and should be recognized as such. Positive reinforcement increases the likelihood that the child will engage in the next exposure task and provides a sense of accomplishment and confidence that anxious youth often lack. Rewards are typically discussed prior to engaging in the exposure task. The therapist and child, and possibly the child's parents, develop a list of potential rewards that are consistent with the child's likes. External rewards can be provided by a parent or the therapist and can include gift certificates, toys, candy, games, or social activities such as going out for an ice cream or spending

time at the end of the session playing a game with the therapist. Rewards need not be large or extravagant, even with adolescents, as most youth respond to even modest rewards that are tailored to their likes.

Another type of reward is self-reward. Anxious youth often set the bar too high and engage in self-reward far too infrequently. Parents and therapists will not be with the youth during every exposure opportunity, so children are encouraged to reward themselves after facing a challenge (e.g., participating in an exposure task). Self-reward can be as simple as having a child give him- or herself a "pat on the back." The therapist and youth make a list of enjoyable activities that can be done as a way of rewarding him or herself, such as quiet reading time or playing with the family pet. Importantly, regardless of the particular type, rewards should be given after the child has attempted an exposure task both in session and at home, even if only partial success is achieved. Feedback and rewards are best when presented immediately following an exposure task, when possible.

This section emphasized that exposure tasks in CBT for anxious youth can be executed in diverse ways (e.g., imaginal or in vivo) and locations (e.g., home, school, therapy room). Cognitive work before and after the exposure task promotes the generalization of coping in future challenging situations. Using SUDS ratings provides invaluable data regarding anxiety level during exposure tasks. The next section will outline how the therapist executes these goals while maintaining therapeutic rapport with youth and parents.

Posture of the Therapist

At first blush, exposure tasks may appear counterintuitive. Effective interventions should mitigate, not exacerbate, anxiety. If one takes this perspective, exposure tasks could certainly be viewed as unnecessarily cruel and antitherapeutic. In our experience, parents and children may mistakenly hold this view initially. Research suggests that some therapists may be reluctant to start exposures. Barlow (1994) reported that the number of behavior therapists using exposure tasks was fewer than would be expected. It is possible that exposure tasks are viewed as running counter to the therapeutic "safe haven" that many therapists wish to create for their clients (Friedberg & McClure, 2002). Alternatively, it may be exceedingly uncomfortable for some therapists to "create distress." Therapists may have difficulty tolerating their own anxiety during a child's exposure task or, alternatively, may perceive themselves as ill-equipped to manage the child's (or parents') anxiety during the exposure tasks. Parents and children alike often need to be oriented to the rationale and empirical foundations underlying the use of exposure tasks.

It is important for therapists to weigh the short-term discomfort created during an exposure task with the long-term gains provided by such procedures. Exposure tasks provide unique opportunities for the therapist to view the child's anxiety in real time and to evaluate the level of anxiety associated with different situations and events. More importantly, however, exposure tasks provide otherwise unavailable opportunities for youth to practice the skills learned in therapy and to work toward mastery and nonavoidance. It is advised that therapists monitor and address any failures to complete of out-of-session exposure tasks and to correct any lingering or newly surfacing misconceptions.

Developing and Keeping Rapport

The relationship between the child and the therapist is one of collaboration. That is, the therapist and child together negotiate and plan for current and future exposure tasks, and the exposure tasks are viewed as "experiments." Thus, the therapist does not "tell" the child what is likely. Instead, the therapist and child together arrange for the collection of "data." The involvement of the child in the selection of difficulty level, order or sequence, and degree of therapist involvement allows the child to view an exposure task as one of his or her own making. Involvement in planning promotes an increased likelihood of successful completion of the exposure task.

Given that the therapist will be asking the child to do challenging tasks, it is critical to remain focused on the child-therapist relationship throughout the exposure sequence. In the midst of an anxious moment, it may be easy for a child to lose sight of the long-term benefits of exposure tasks. The upkeep of the previously established (preexposure) rapport may be a challenge with some children, but it is our experience that well-planned and -implemented exposure tasks facilitate, rather than hinder, the therapeutic relationship with the child. To this end, therapists should take great care to collaborate with the child in the preparations before the exposure task as well as jointly assessing coping attempts during and after. Emphasis is placed on attempts to cope (effort) and not solely on specific outcomes.

Consulting With the Child: But Not in the "Negotiation Trap"

Consultation and negotiation are critical components in planning and executing exposure tasks. Initially, the child and therapist confer in the arrangement of an exposure task, during which time problems may arise. In the "negotiation trap," the child may select exposure tasks that are not likely to elicit anxiety (i.e., too easy), argue that a proposed exposure task is too easy (with the hopes of avoiding it altogether), or may attempt to direct the focus of the exposure task to an area in which he or she feels more competent. For example, a separation-anxious child balks at the thought of a separation expo-

sure task and suggests a social/peer exposure task instead. The provision of choices for current and future exposure tasks is an effective method to stay out of "the trap." Therapists may select several possible exposure tasks that he or she deemed appropriate in difficulty level, sequence, and content and then allow the child to select a specific exposure task. On occasion, verbal contracts can be used in the planning of an exposure task (e.g., "Let's make a deal: If you ——, then . . ."). The therapist permits more difficult exposure tasks in an area in which the child feels competent. In our experience, reminders about the rewards of coping (e.g., feelings of pride, privileges) can also side-step the "trap." Exposure tasks toward the end of treatment tend to be less susceptible to the trap as children become collaborative architects of their own exposure tasks. Exposure tasks later in treatment require less therapist direction as the child prepares for coping in the absence of the therapist after treatment.

Shaping Processes

There are occasions when shaping is useful to achieve the "gold standard" (ideal) exposure experience. Gold-standard exposure tasks are prolonged, repeated, and potentially prevent the use of distraction and/or safety behavior. However, the completion of an ideal exposure task may not be possible without compromise on one of these standards. For example, a child with separation anxiety disorder (SAD) who also had a phobia of the dark would not remain alone in the dark without counting down the time to completion of the exposure task. Although counting is a form of distraction, it was permitted in an effort to increase compliance with exposure tasks and enable the child to feel a beginning sense of self-control and mastery. The counting was phased out in subsequent exposure tasks.

Careful: Do Not Reinforce Avoidance

Unfortunately, the gold-standard exposure task may also be compromised by indications of subtle avoidance. Avoidance might be evident when a child makes light conversation during the exposure task to avoid fully experiencing the anxious arousal or to avoid completing the exposure task. Failure to complete an exposure task may be the result of (a) real events, (b) pseudo-events (excuses), or (c) outright refusal to engage in exposure tasks. The latter however, has been rare in our work with anxious children.

Real events are those life occurrences that are unexpected, yet truly result in a child's inability to complete an exposure task (e.g., child illness). Pseudo-events are those proposed by parents and children as real intervening variables but are, in fact, thinly veiled avoidance. For instance, a child reports noncompletion of an out-of-session exposure task. Upon therapist questioning, it comes to light that the exposure task might have been "doable" if the child had made a slight modification to the plan. But the child didn't make the adjustment and, instead, said it couldn't be done. Specifically, the child was assigned an exposure task that involved asking her teacher a question during class. The child reported that the exposure task was not completed because the child's teacher was ill and a substitute teacher taught the class. The child could have changed the exposure plan (ask a different teacher a question in class) and completed it successfully. On occasion, it may be the parents who join with the child to avoid an anxiety-provoking situation. In both circumstances, it is important for the therapist to monitor for such pseudo-events and to address them as soon as they are detected.

Modeling for Parents

Parents of anxious children can display a variety of reactions to their child's anxiety, including being overly empathic and protective and overly critical and intolerant. Parenting an anxious youth can be difficult, and the preferred approaches to quell excessive anxiety are not necessarily intuitive. Accordingly, it is the role of the therapist to model for parents the recommended ways to manage and minimize youth anxiety. Therapists can model exposure task selection and implementation, enthusiasm for the treatment, acceptance of the child, pride in the child's efforts and accomplishments, and unwavering support of the child's attempts at coping. Additionally, the therapist models acceptance of and tolerance for the child's anxious distress. Well-meaning parents can have difficulty in tolerating their child's anxious distress and, unwittingly, behave in ways to reduce/minimize their child's negative affect (a short-term solution). The therapist models the alternative and beneficial approach.

Dealing With Less-Than-Successful Exposure Tasks

Despite excellent planning, and though rare, some exposure tasks are not fully successful. Less successful exposure tasks may result from a therapist's underestimations of child anxiety and coping skill, parental interference, chance occurrences, and other unfortunate events. For example, a therapist might plan an exposure task involving separation between a child and parent. If the exposure task is beyond the child's coping (e.g., too long a duration), the child may seek out the parent before the end of the intended period of separation. Such a less-than-successful exposure task is never truly a failure as it is always the source of valuable information. In this case, it became clear that the duration of the exposure task underestimated the severity of the child's separation anxiety. In one sense, exposure tasks are practice opportunities, and therapists can emphasize that,

as with all practice, there will be setbacks. Practice is intended to lead to improvement, so repetition is the key. Additional exposure tasks are oftentimes warranted and recommended.

Dealing With Resistance

The stage is set for an exposure task: the therapist has done preparatory work and the child arrives for the session. In this instance, a SAD child had recently succeeded in coming to the sessions without his mother. The scheduled exposure task is to ride to a local candy store and purchase some candy. Upon arrival at the session, the therapist reminds the child of the scheduled exposure task, but the child resists. The child cries and says he won't do it. How to proceed?

It is not recommended that the exposure task be done when the child is in such distress, but it is also not recommended that the task be avoided. Rather, the therapist buys time, recognizing that the tears will dissipate and that, after a few minutes, the task will be seen differently. During the wait, the therapist can help provide the child with a sense of control. Do you want to ride in the front or the back of the car? Do you want to listen to the radio or play a CD? Do you want to pick the CD? Do you want to drive? This last question resulted in a stoppage of tears and a smile and laugh. "I can't drive" was the comment. With similar questions and pauses, the child was soon dry-eyed and the therapist made the decision to restate the plan, and the choices that were made (i.e., sit in back, listen to a CD, etc.) and proceed. Resistance to the exposure task was not met with rigidity, but with an adjustment, a delay, and eventual cooperative undertaking. The child cooperated and the exposure task went well.

Youth Characteristics

We have already highlighted the role the therapist plays when conducting exposure tasks with anxious youth. The therapist and child collaborate on the design and implementation of exposure tasks and the therapist encourages coping and discourages avoidance. During exposure tasks, the therapist is aware of the child's level of distress and is concerned with how he or she models behavior for parents—both while maintaining a therapeutic alliance with the family. We now discuss how characteristics unique to each child (e.g., developmental level, contextual factors) are incorporated into design and implementation of exposure tasks.

Developmental Level

Anxiety treatment experts have written in general terms about the importance of attending to a child's developmental level when designing and implementing treatment programs (e.g., Barrett, 2000; Hudson, Kendall, Coles, Robin, & Webb, 2002; Kendall, Lerner, & Craighead, 1984; March & Mulle, 1998; Silverman & Ollendick, 1999). For instance, Kendall et al. (1984) described the unfortunate state of the "developmental uniformity myth" where children are all seen as the same, and further argued that "children" are not a homogeneous group that will all benefit from the same exact application of treatment strategies. Rather, "children" are highly varied developmentally and a child's developmental level requires consideration when intervening. This section discusses the developmental and contextual factors when conducting exposure tasks.

Age is often an easy, albeit inexact, proxy for developmental differences. Indeed, social, physiological, cognitive, and emotional developmental differences are inexactly captured by chronological age. Nevertheless, age is a potentially useful proxy for more sophisticated measurements. The need to attend to developmental level when conducting exposure tasks begins when the clinician is providing the child or adolescent with a rationale for the exposure tasks. Younger children will likely benefit more from a simplistic explanation whereas adolescents may appreciate a more detailed, and even slightly technical discussion about exposure tasks (e.g., using terms such as "hierarchy," "habituation," etc.). Appreciating the child's developmental level will aid with rapport building and facilitate the attainment of germane developmental tasks. For example, in the case of an adolescent, a detailed discussion regarding exposure tasks might make the teen feel "older" and more mature, thus increasing the teen's ownership of his or her distress. Increasing ownership (and autonomy) may in turn facilitate treatment compliance.

Exposure tasks provide an opportunity to challenge maladaptive cognitive schemas in anxiety-disordered children (Kendall, Choudhury, Chung, & Robin, 2002). Successful challenging of such schemas via exposure tasks depends, at least in part, on the youth's level of cognitive development and ability to articulate the nature of their unrealistic fear or worry. Consider a school-avoidant teen, who may avoid school for any number of reasons (e.g., separation, social phobia, performance concerns). For the younger or cognitively delayed child, articulation of the nature of the child's fear may be difficult. In this case, it is helpful to the clinician to secure parents' or other family members' help in identifying the specific nature of the youth's fear. When working with cognitively immature or delayed individuals, more information about the nature of the youth's anxiety may be learned from careful behavioral observation than from discussion. Related, it may be advantageous to have parents use a behavioral chart to record, at home, specifics about the youth's anxious behavior.

Consideration of social development is also key when conducting exposure tasks, particularly when working with

socially anxious children and adolescents. Some anxious children may have knowledge of age-appropriate social skills (e.g., importance of smiling, making eye contact, etc.) but need coaching and encouragement. Others, however, may have "knowledge deficits" requiring explicit teaching in social skills prior to an exposure task. Failure to assess level of social development and address deficits prior to implementing an exposure task may inadvertently set the stage for a less-than-successful experience.

Two areas of emotional development are relevant to this discussion of exposure tasks: emotion identification and emotion regulation. Considering emotion identification, children who are more skilled at identifying emotional experiences are more likely to provide the clinician with reliable SUDS ratings than are children who are less skilled in this area. For children who have difficulty in differentiating between mild, moderate, and intense emotional experiences, providing SUDS ratings can be challenging. In this case, an emphasis on emotion identification is undertaken prior to the implementation of exposure tasks. Similarly, some children are better at regulating their emotional experiences than are others. Indeed, anxious children have been shown to have difficulties managing emotional, evocative situations (Suveg & Zeman, 2004). Children who have greater difficulty managing the physiological components of anxiety might need more assistance in relaxation prior to exposure tasks.

Attending to the child's developmental level will also help guide the clinician in determining the extent to which families should be included in treatment. Research is beginning to suggest that younger children may benefit more from including families than older children (e.g., Barrett et al., 1996; Cobham, Dadds, & Spence, 1999). This makes sense when one considers that some fears that involve the family (e.g., SAD) are more common in younger children (Kashani & Orvaschel, 1990; Velez, Johnson, & Cohen, 1989). In these cases, exposure tasks necessarily involve the family. Further, younger children are more likely to need assistance from family members to complete out-of-session exposure tasks. On the other hand, adolescents may value more autonomy (less family participation). Although it is certainly reasonable that an adolescent be given more autonomy in treatment, it is also important to monitor whether he or she actually carries out the exposure tasks. If not, the clinician will need to negotiate with the adolescent and perhaps secure the assistance of a family member or friend when implementing the out-of-session exposure tasks.

Contextual Factors

This section highlights examples of ways that contextual factors can be considered when conducting exposure tasks with children and adolescents. Through the use of examples, we suggest that attending to such factors facilitates treatment progress and success. For a more in-depth and theoretical discussion of the importance of considering developmental level and contextual factors (e.g., ethnicity, culture, gender, and religion) in the treatment of childhood disorders, the reader is referred to Piacentini and Bergman (2001) and to Silverman and Ollendick (1999).

Contextual factors encompass ethnic, cultural, gender, and religious issues. The clinician need not automatically assume that each of these areas is of central concern to the child and/or his or her family. Rather, it is the clinician's responsibility to consider which of these areas, if any, need to be weighed as a factor in treatment. Consider the case of a 12-year-old boy who presented with religious obsessions (i.e., fear of doing something bad and that God would be mad at him) and compulsions (i.e., reciting prayers in his head and blessing himself throughout the day at school). During the initial interview with the child and his family, the clinician learned that he attended a private religious school and that his family held strong religious beliefs. When explaining the treatment of the child's obsessions and compulsions (i.e., use of exposure and response prevention), the family was very concerned and felt conflicted given their strong religious beliefs. The child also expressed serious concerns, not only because the treatment itself was anxiety provoking but because of the perceived moral implications of treatment and a concern about being punished. A sensitive discussion with the child and his family regarding their beliefs and the treatment allayed their concerns and matters proceeded well and favorably.

Professional Practice Issues

For the practitioner, we acknowledge that there are questions about the application of exposure tasks, especially out-of-office exposure tasks. What about liability when out of the office? How can a private practitioner, or someone in practice in isolated settings, arrange for exposure tasks? What about billing? Last, there are challenges that face a therapist who is inexperienced with the planning and conduct of exposure tasks. We discuss each of these issues. It is worth noting that once the decision to use exposure tasks has been made and once all the cautions are considered, the actual conduct of an exposure task is quite doable.

Questions about liability can be raised when the child is outside the therapist's office on an exposure task. What if, for example, when the exposure task has the child at a shopping mall on his or her own, the child gets lost or is kidnapped? What happens when, as an intended step in a hierarchy, the youth is taken for a ride in a car? What if there is a crash? Although we recognize that there are some legitimate concerns, we also point out that these

Table 2
Examples of Different Types of Exposure Tasks

Brief Description of the Exposure Task	Target Problem/ Disorder	In Session	Out of Session	Props Needed	Other People Needed
Giving a speech: 1) have people whispering during the speech 2) have people ask questions (planned or unplanned) during the speech 3) vary the size and/or age of the audience	SoP	X			X
Tripping in front of people 1) sitting in the waiting room of the clinic 2) in other parts of the building 3) outside of the clinic	SoP	X			X
The therapist and child walk around either inside or outside the building looking messy or unkempt, and making funny faces.	SoP	X			X
Playing a board game, where the therapist changes the rules during the game.	GAD (perfectionism, rigidity)	X	X	Game	
Conduct a survey to gather information about a belief (e.g., a mean teacher: asking others "Have you ever had a mean teacher?)	GAD, SoP	X	X	Questionnaire	
Have the child do something incorrectly (a minor infraction) and be reprimanded.	GAD	X			
Ask the parent to be late when picking up the child from the therapy session: 1) anticipated 2) unanticipated 3) vary the duration	SAD, GAD	X	X		
Go to a store and purchase something from a clerk, without any help from the therapist.	GAD, SoP, SAD		X	Small amount of money	
Blowing up balloons until they burst.	GAD; specific phobia	X		Balloons	
Reading poetry in front of the therapist (or a small audience) in the voice of someone famous (e.g., Sylvester Stallone). With or without an audience.	GAD; SoP	X	X	Poetry	X
Pay for a purchase with slightly less than the correct amount of money. 1) friendly clerk 2) less friendly clerk	GAD	X	X	Money	X
Internet exposure. Have youth surf news sources and report their feelings. The youth and therapist discuss any worries that develop. Talk about the likely conclusions of each news story and the several possible perceptions of the same news.	GAD	X		Computer with internet	
Walk around the outside of the house at night in the dark.	Specific phobia, GAD		X		
Saying something silly/stupid on purpose while talking to a clinic confederate or to the client's friend.	SoP, GAD	X	X		X
Taking a fake test (out of date IQ measure) and provide "red marks," a "see me" note, or other questionable feedback.	GAD, SoP	X		Fake test	
Having a parent be increasingly away from the session 1) away by distance 2) away for longer durations	SAD	X			
The child handwrites a composition with the nonpreferred hand and then lets someone else read it without explanation.	GAD, SoP	X			X
The therapist and child practice buying things in front of other people (e.g., at a local store, at a vending machine), asking questions or looking lost.	SoP, GAD	X			X
Arrange for the child not to sleep in the parents' bed. 1) having alternate activities for the child 2) having mom/dad take child back to bed and wait for him/her to fall back asleep	SAD		X	Alternate activities (e.g., books to read)	X
Jumping in a swimming pool (without toe-testing the temperature)	GAD, SoP		X	Pool access	
Calling an expert to get information (e.g., child fears health of a parent) about health issues.	GAD; SAD	X		Phone access	X
Joining (starting) a club at school (or in the community).	SoP; GAD		X	List of extra-curricular school activities	
Going to the mall, shopping alone, and meeting at a time and in a place that is not "nailed down" in advance.	GAD; SoP; SAD		X	Mall access (shopping area access)	
Riding public transportation (appropriate for the age of the child)	GAD, SAD, SoP		X	Schedules, money	
Calling a classmate on the phone to get info about a class assignment	SoP, GAD	X		Phone access	
Entering and sitting with someone at the school cafeteria	SoP, GAD		X	Permission to be at the school	

Note. SoP = Social Phobia; GAD = Generalized Anxiety Disorder; SAD = Separation Anxiety Disorder.

several "what ifs" sound remarkably akin to the musings of an overprotective parent. Few children are kidnapped from shopping malls, and serious automobile accidents are not at all common. The risks are actually quite low. And, even if something were to happen, insurance coverage (as is the case for all unlikely events) is available and provided. There is another liability issue to be considered: that associated with *not* using exposure tasks. Based on the available evidence, providing exposure tasks as part of therapy is the preferred treatment for anxiety disorders and to not do so would be practicing less than "best practices." With an increasingly informed consumer/public, there are liabilities that are linked to use of non-empirically supported treatments, and to a failure to maintain continuing education about and practice of "best practices."

Though easier than planning a wedding, making the arrangements for some exposure tasks might seem foreboding. Arranging for a trip to the local high school's history class not only necessitates planning a specified day, but also may require prior contacts and discussions with school personnel. Also, estimation of the total time needed to complete the exposure task is important so that billing concerns and hourly rates can be addressed with the family in advance. Out-of-office exposure tasks may last greater than 1 hour in duration and entail consideration of travel time and other expenses (e.g., bus fare). We encourage the therapist to be flexible and fair and communicate with the family candidly regarding additional fees, if any. Sometimes, the best exposure tasks take the greatest amount of preparation.

However, effective exposure tasks can be much simpler than the example just mentioned (trip to school). For starters, refer to the entries in Table 2, where a variety of diverse types of exposure tasks are provided. If the preferred task is to have the child talk in front of an audience of peers, perhaps an adequate exposure would be to have the child present in front of several adults and one or two peers. The demands of orchestrating this exposure task would likely be much less than needed for an audience of youth. If this adjusted plan is still seen as too demanding, then a walk into a local store where there are other people can be orchestrated and the child can interact with clerks (buy something, ask questions) and other patrons. This exposure task can be undertaken without complicated preparations or arrangements. Not unlike the child (or parent) who tries to not do the exposure task due to a pseudo-event (excuse), it is typically the case that creative modifications (by the therapist) will result in an exposure task that is available and achievable, as well as therapeutic for the child.

Undertaking any new therapeutic procedures comes with the challenges that are linked to being inexperienced. With exposure tasks and anxious youth, the inexperienced therapist has to be especially careful not to be overprotective of the child. In some ways, anxiety disordered youth are quite adept at getting parents and other adults to adjust so that the anxious youth can avoid situations thought to cause distress. The therapist needs to be alert to being protective. In contrast, the therapist is confident for the child and exudes confidence in the task, the procedure, and the child's ability to complete the exposure task. It's not a "Maybe," it's a "You can do it."

Closing Comment

We close by sharing the observation of an interesting "side effect" of exposure tasks. Not only do exposure tasks empower the child, but they have also been known to affect the therapist. A therapist trainee who verbally identified herself as "a CBT therapist" was nevertheless otherwise quite modest in her endorsement of exposure tasks (an experienced CBT therapist could tell that she was inexperienced). Following her use of exposure tasks, her attitudes and beliefs were changed. She came to supervision with an enthusiastic statement about "Wow this stuff really works. The kid came alive. He was so proud he could do it." Are you considering working with anxious youth? Don't just think about exposures, try them out!

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