THE UNIVERSITY OF MELBOURNE

Exposure to exposure:

How to overcome common concerns about exposure therapy for anxiety and deliver it in a confident, safe, and maximally effective manner

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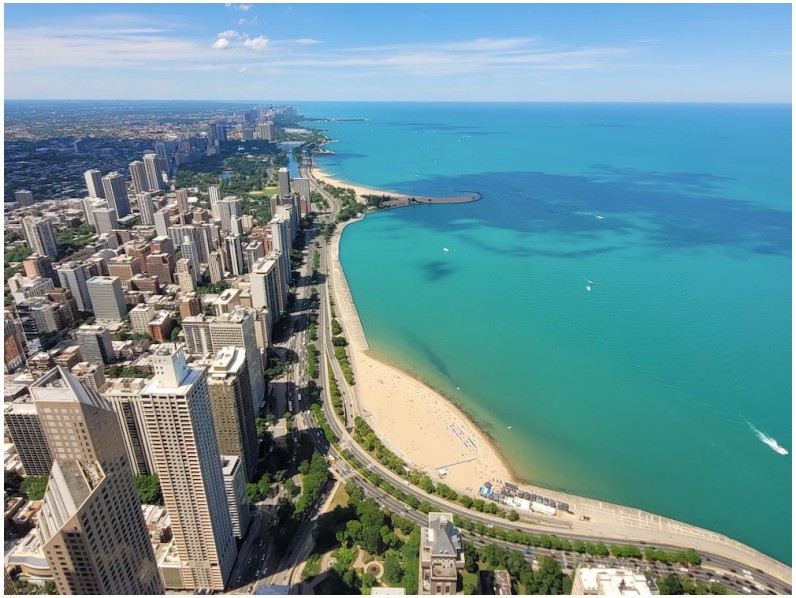
Welcome!

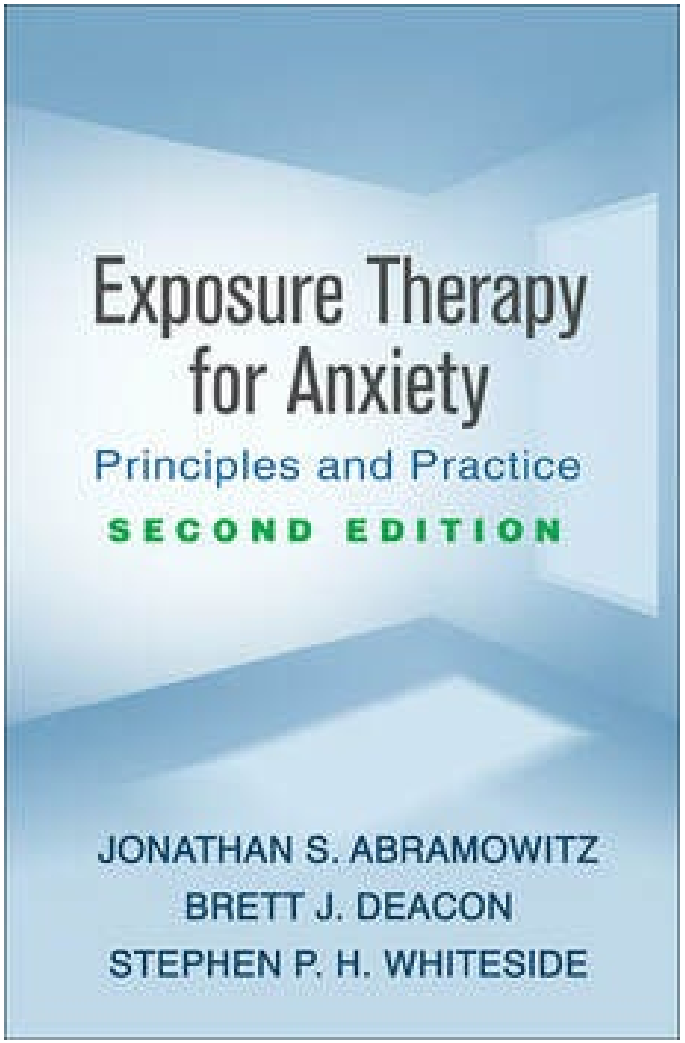
- About me



Melbourne, Australia

My Background

- Education
- Research, clinical work, and training



A Note on Today

- This is an area where there are clear differences in theory and practice among world leaders
- I don’t claim to have all the answers
- My goal: tell you about what I do, why I do it that way, wrap that discussion in relevant science and philosophy, and learn from you about the same

- What makes a successful workshop? One thing

Plan for Today's Workshop

- Schedule:
- Morning session: 10:30 – 13:00 (15-minute break at 11:45)
- Lunch: 13:00 – 14:00
- Afternoon session: 14:00 – 17:00 (15-minute break at 15:30)
- 5 hours total workshop time

Plan for Today's Workshop

- "How to overcome common concerns about exposure therapy for anxiety and deliver it in a confident, safe, and maximally effective manner"
- Clinical emphasis
- Some case examples, video and audio clips, and interactive moments/role plays
- I want to hear from you
- Let's have some fun!

Thought Experiment

- What would it look like to create from scratch a 5-week exposure treatment program for clients with social anxiety and/or panic disorder that would maximize client outcomes as well as provide the best “exposure to exposure” for trainee therapists to combat their negative beliefs?

Butter Knife Exposure Demonstration

- I need a volunteer!

Butter Knife Exposure Demonstration #1

- "Alright. It looks like we're about ready to begin the exposure task. As we agreed upon, you will do an exposure with this butter knife. Sorry, I know this is a bit stressful, but as we've discussed, it's quite likely to be helpful.
- The core fear you mentioned is that you might lose control and stab yourself with it. It's good to remember that you've held a knife just like this countless times in your life – thousands - and have never stabbed yourself with one. I know it feels scary, but if we examine the evidence, the probability of you actually losing control and stabbing yourself with this knife is very, very low. Basically then, this task then will give you an opportunity to learn that this feared outcome does not happen, which will provide corrective learning for your core fear.
- We will have you hold the knife for one full minute. This will be an experiment to see if your feared outcome comes true.
- To get ready for the exposure and to ensure your anxiety is under control, let's take three slow, controlled breaths together.
- In a moment, you may take the knife from my hand and hold it. I know this task will evoke some anxiety and I want you to know that I will be here to support you and assist if anything goes wrong.
- Are you ready? Ok, let's begin. Please take the knife and hold it. I'll keep track of the time. (begin task)
- (After 30 seconds): You're halfway done. How are you holding up? Do you need a break, or can you keep going?
- (After 60 seconds): Alright, you may stop now. Well done! You've held the knife for a full minute and look – just as we knew along - you didn't stab yourself. Can you see now that your core fear was wrong?"

Butter Knife Exposure Demonstration #2

- “Alright. It looks like we’re about ready to begin the exposure task. As we agreed upon, you will do an exposure with this butter knife.
- The core fear you mentioned is that you might lose control and stab yourself with it. This exposure will allow you to see for yourself what happens when you hold this knife and do not use any safety behaviours to protect yourself. Will the worst-case scenario finally happen? Will you die a gruesome death right here and now? There is only one way to find out.
- We’ll begin by having you hold the knife as close to your neck as you are willing. As we proceed, I’ll ask you to keep bringing the knife closer and closer. I won’t say or do anything to reassure you. Quite the opposite, I will encourage you to make the task more difficult as you go along. The further you push it, the more you stand to learn from this exposure. So, let’s do this with that “bring it on” attitude we discussed!
- Now, let’s jump right in. Take the knife in your hand. Bring it as close to your neck as you can.
- You’re doing great! Bring the knife even closer. Good. Think about those serrated edges. They can slice through butter easily. I bet they could do the same with skin. Don’t you think?
- Great job! I love to see how you’re leaning in to your anxiety, bringing it on. That’s the spirit!
- Well, so far, you haven’t stabbed yourself yet. Maybe you’ve just gotten lucky? Maybe you haven’t held it long enough? Or close enough? Let’s keep going and find out….

Butter Knife Exposure Demonstration

- Compare and contrast those 2 exposures
- Thoughts?

Exposure Therapy for Anxiety

- Recommended first-line treatment for anxiety disorders in clinical guidelines (e.g., RANZCP, APS, NICE, APA)
- Most evidence-based CBT approach to anxiety
- Often combined with but not reliably augmented by other CBT techniques or medication
- Emphasizes optimizing inhibitory learning

Inhibitory Learning

- Anxious people have learned associations between certain stimuli and predicted threats
- These associations produce prediction errors
- Exposure emphasizes providing the client with information that disconfirms threat predictions in all relevant contexts
- Previous threat associations are retained in memory but inhibited by new learning
- A recent personal example

What Makes Exposure Intensive?

- Exposure is all about learning (about numerous things)
- Inhibitory learning is maximized when exposure is delivered in an intensive manner that provides the most disconfirmatory information about prediction erros (i.e., threat beliefs)
- Exposure is most effective when delivered in an anxiety-increasing (intensive) manner

Slide from Our Exposure Group: It's All About the Learning!

- What can be learned from such exposures?
  - Anxiety/embarrassment is safe, tolerable, and doesn't last long
  - You can behave the way you want even while highly distressed
  - Feared outcomes are unlikely to happen (i.e., people generally are nice and don't care; panic is harmless) – and even if they do, it's not so bad
  - As a result of learning these things, <u>your confidence and performance improve</u>

What Makes Exposure Intensive?

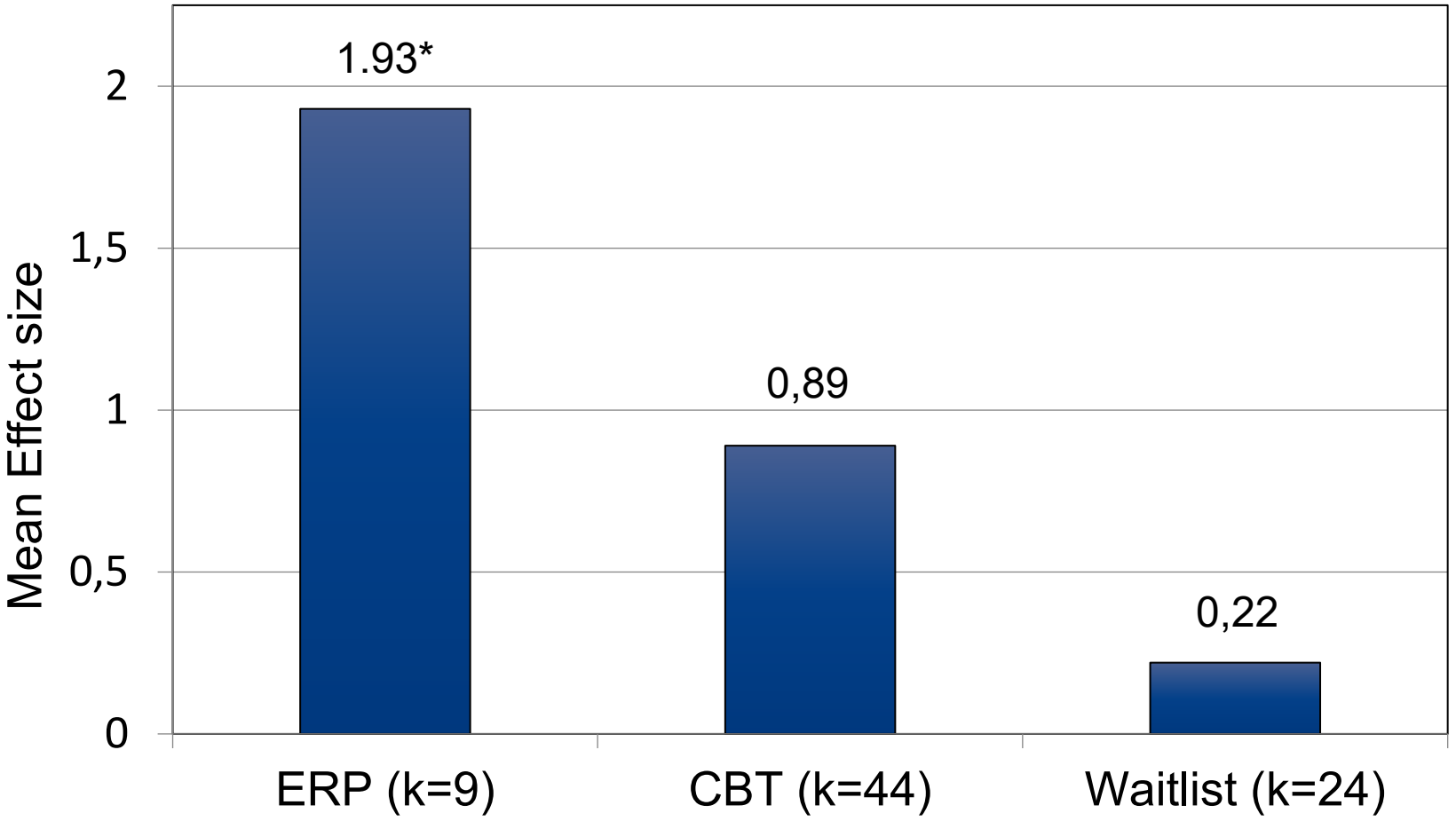
- Higher anxiety during and across exposure sessions
- Early and vigorous elimination of safety behaviors
- No use of anxiety management “skills”
- Encouragement of anti-phobic behaviors and “bring it on!” attitude
- More frequent and longer sessions
- Higher proportion of sessions involving exposure
- Emphasis on intensively targeting threat beliefs

Intensive Exposure is Most Effective

- Research support: some examples
- Two types of exposure therapies for child anxiety disorders
  - Intensive exposure (ERP) for OCD
  - Coping-based exposure for other child anxiety disorders (e.g., Coping Cat)

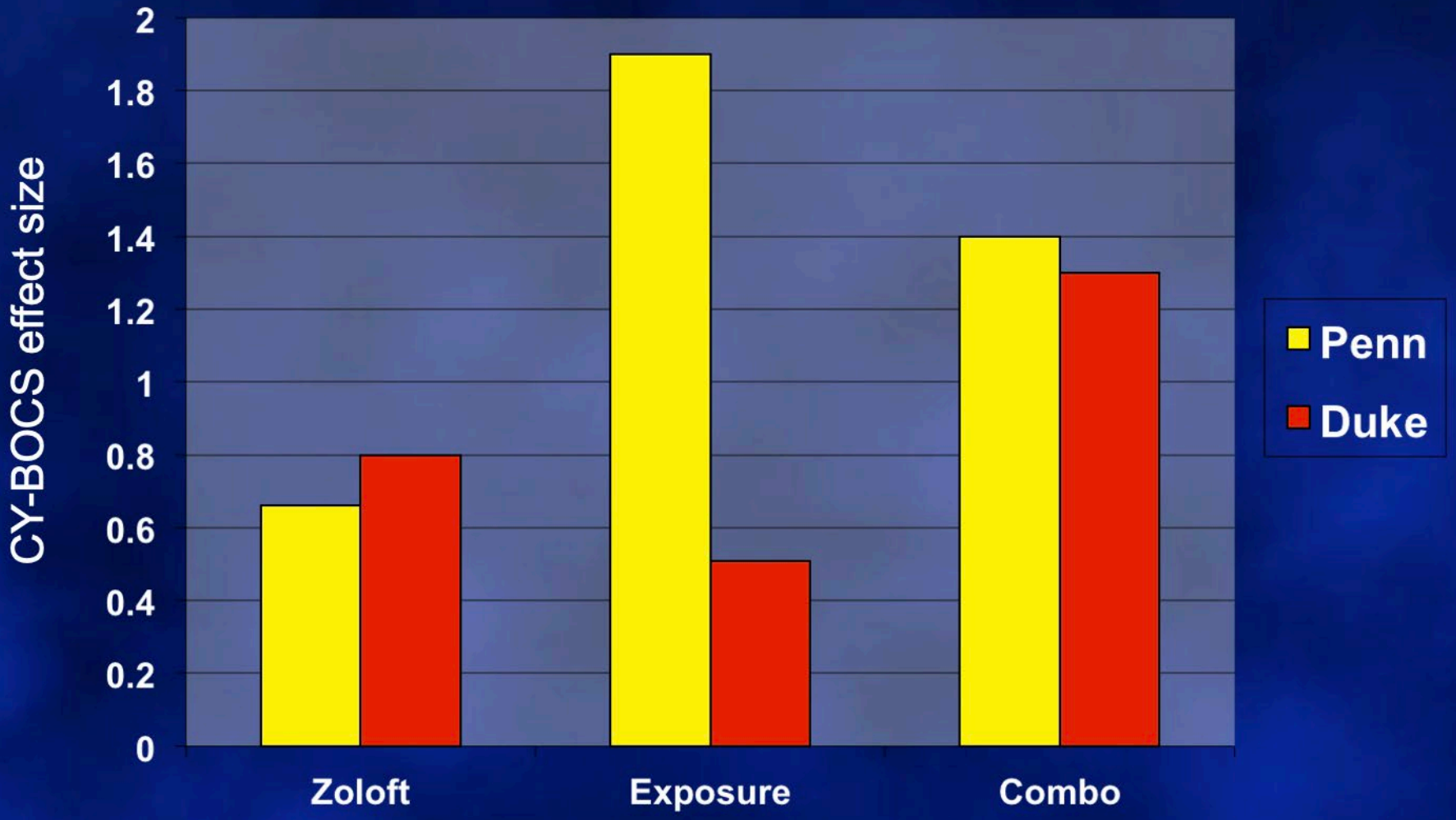
Ale, McCarthy, Rothschild, & Whiteside (2015). Components of cognitive behavioral therapy related to outcome in childhood anxiety disorders. *Clinical Child and Family Psychology Review, 18,* 240-251.

Intensive Exposure is Most Effective



Ale, McCarthy, Rothschild, & Whiteside (2015). Components of cognitive behavioral therapy related to outcome in childhood anxiety disorders. *Clinical Child and Family Psychology Review, 18,* 240-251.

Site x Treatment Interaction in the POTS Study



Pediatric OCD Treatment Study Team (2004). *JAMA*

Explaining Therapist Variability

- What explains the site x treatment interaction?
  - Likely driven by "super-therapists" at Penn who set a more ambitious agenda with regard to exposure tasks and pushed their clients harder to pursue it (Marty Franklin, personal communication, 2010)
- Why would some therapists, but not others, deliver exposure therapy in this manner?

Intensive Exposure is Most Effective

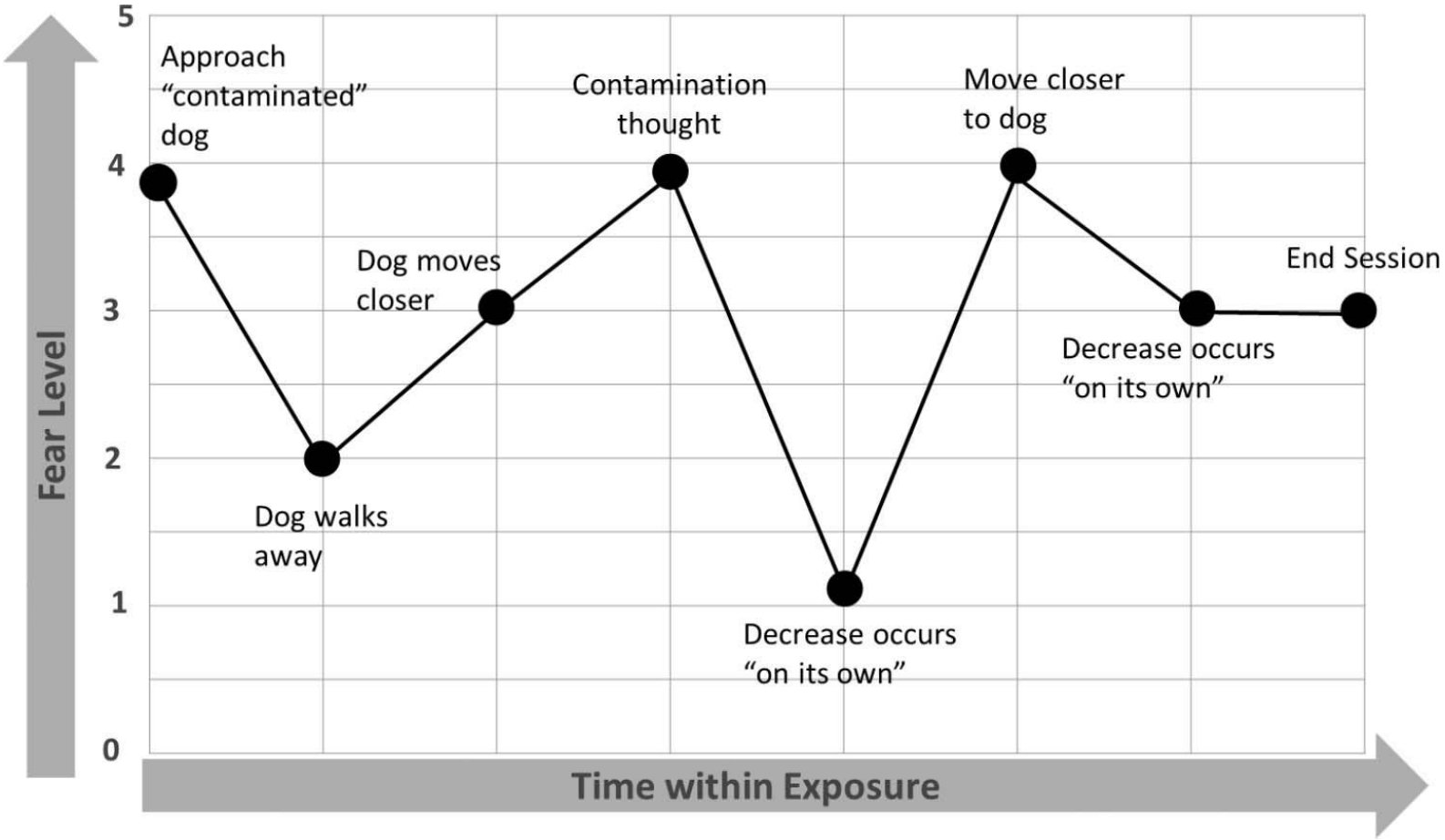
- What is habituation?

- Does habituation within exposure sessions predict clinical outcomes?

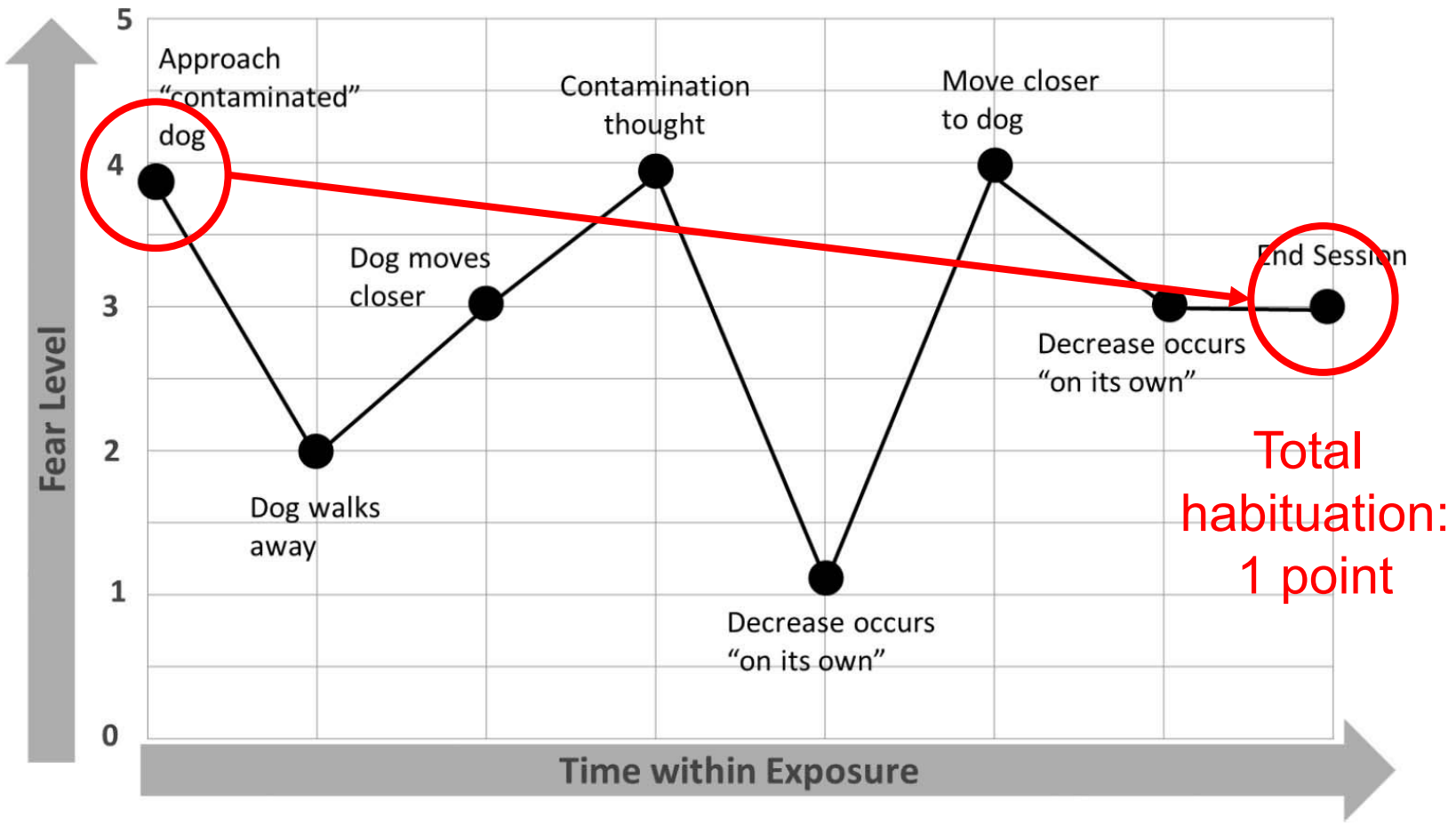
Benito et al. (2018). Measuring fear change within exposures: Functionally-defined habituation predicts outcome in three randomised controls trials for pediatric OCD. *Journal of Consulting and Clinical Psychology, 86,* 615-630.

Intensive Exposure is Most Effective

MEASURING FEAR CHANGE WITHIN EXPOSURES

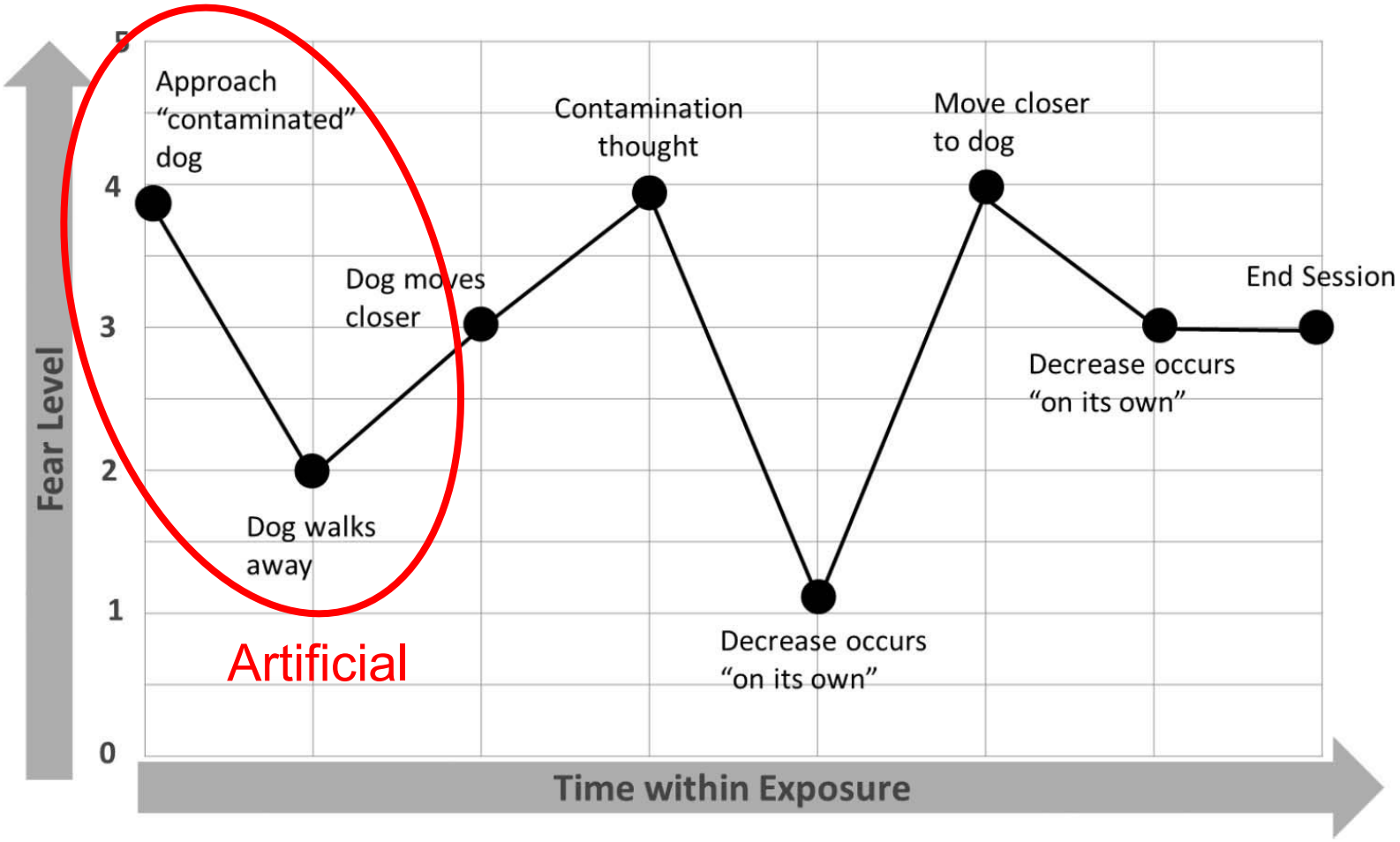


Traditional Way of Measuring Habituation



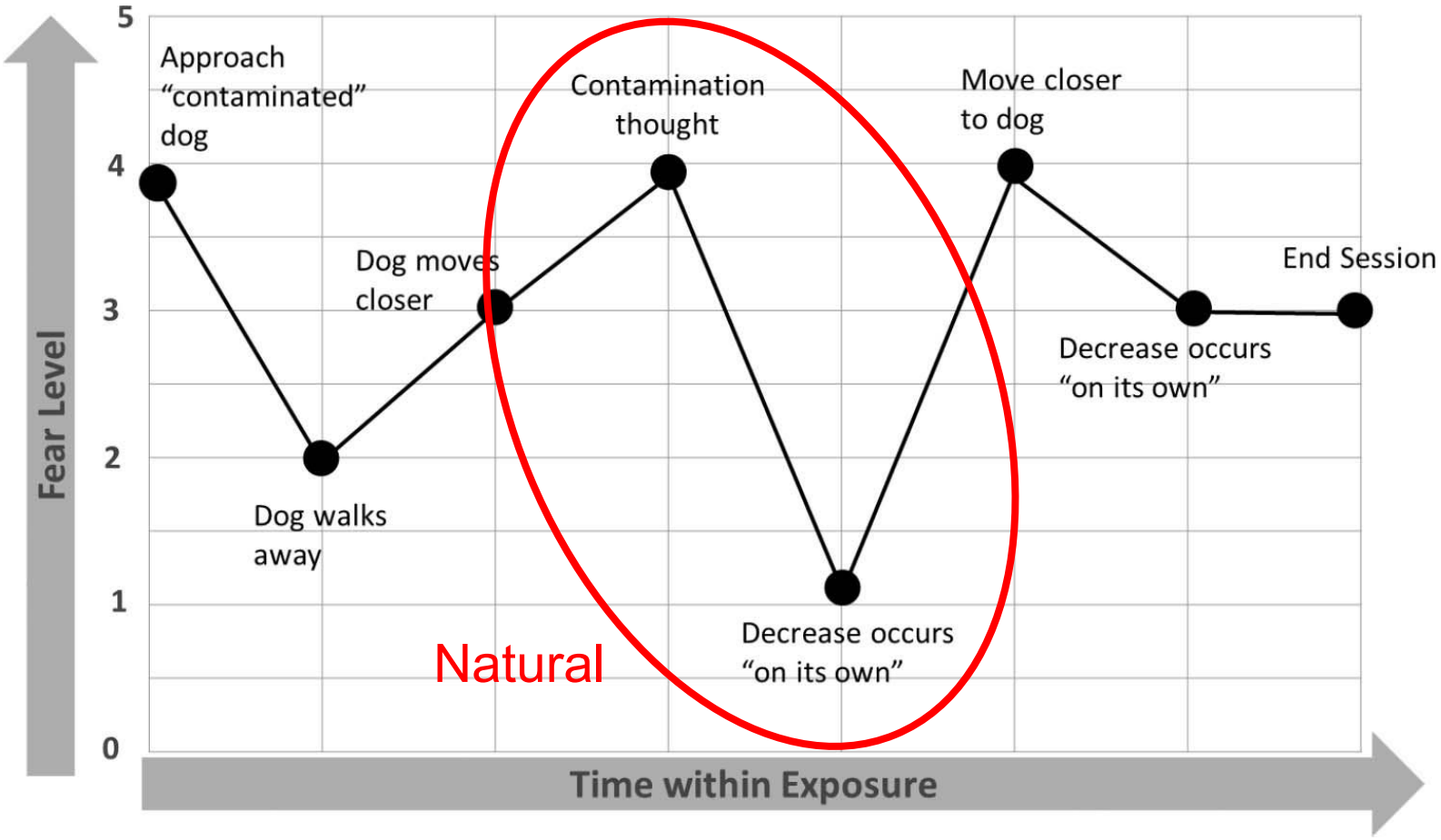
Artificial vs. Natural Anxiety Decrease

MEASURING FEAR CHANGE WITHIN EXPOSURES



Artificial vs. Natural Anxiety Decrease

MEASURING FEAR CHANGE WITHIN EXPOSURES



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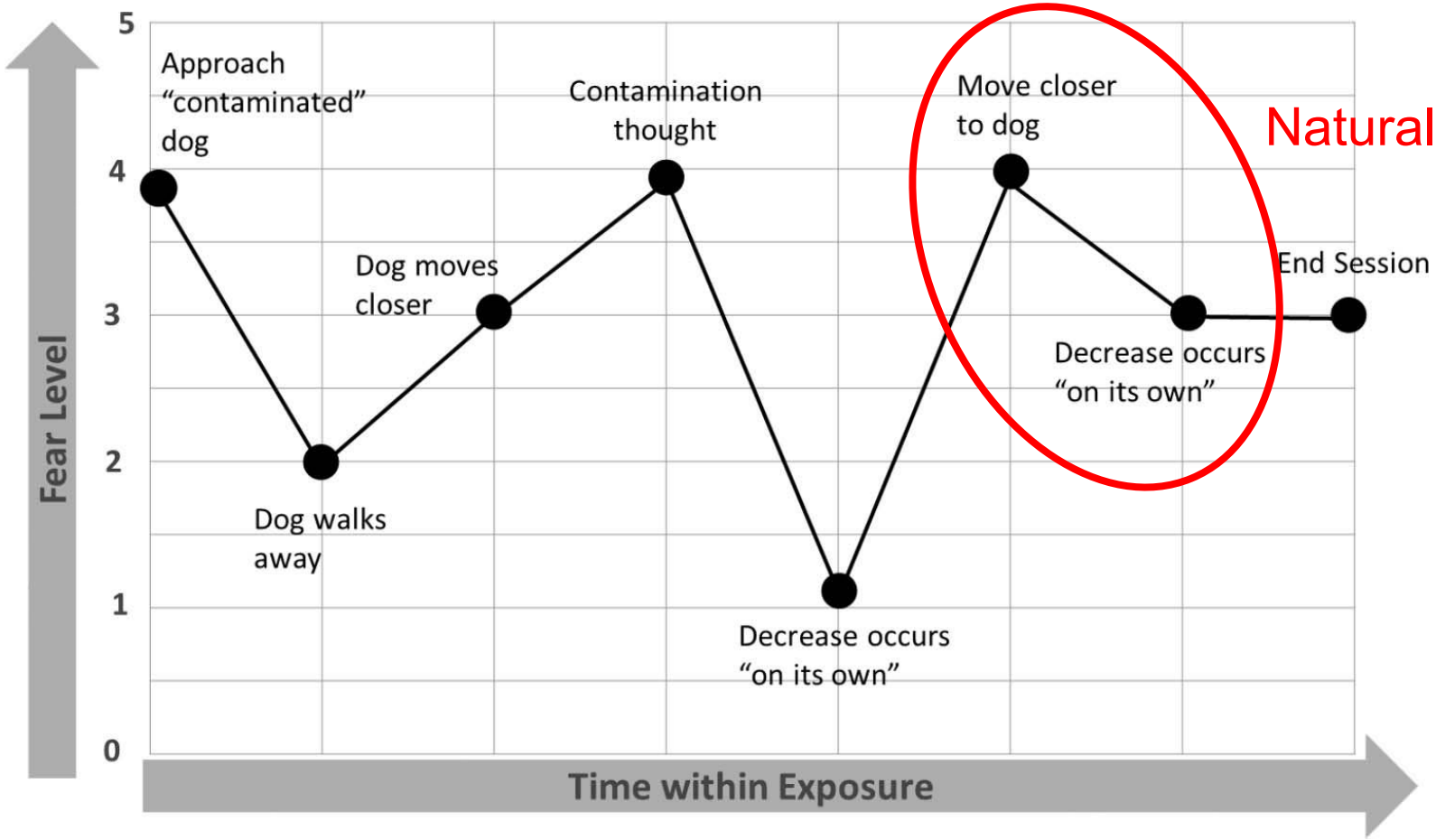
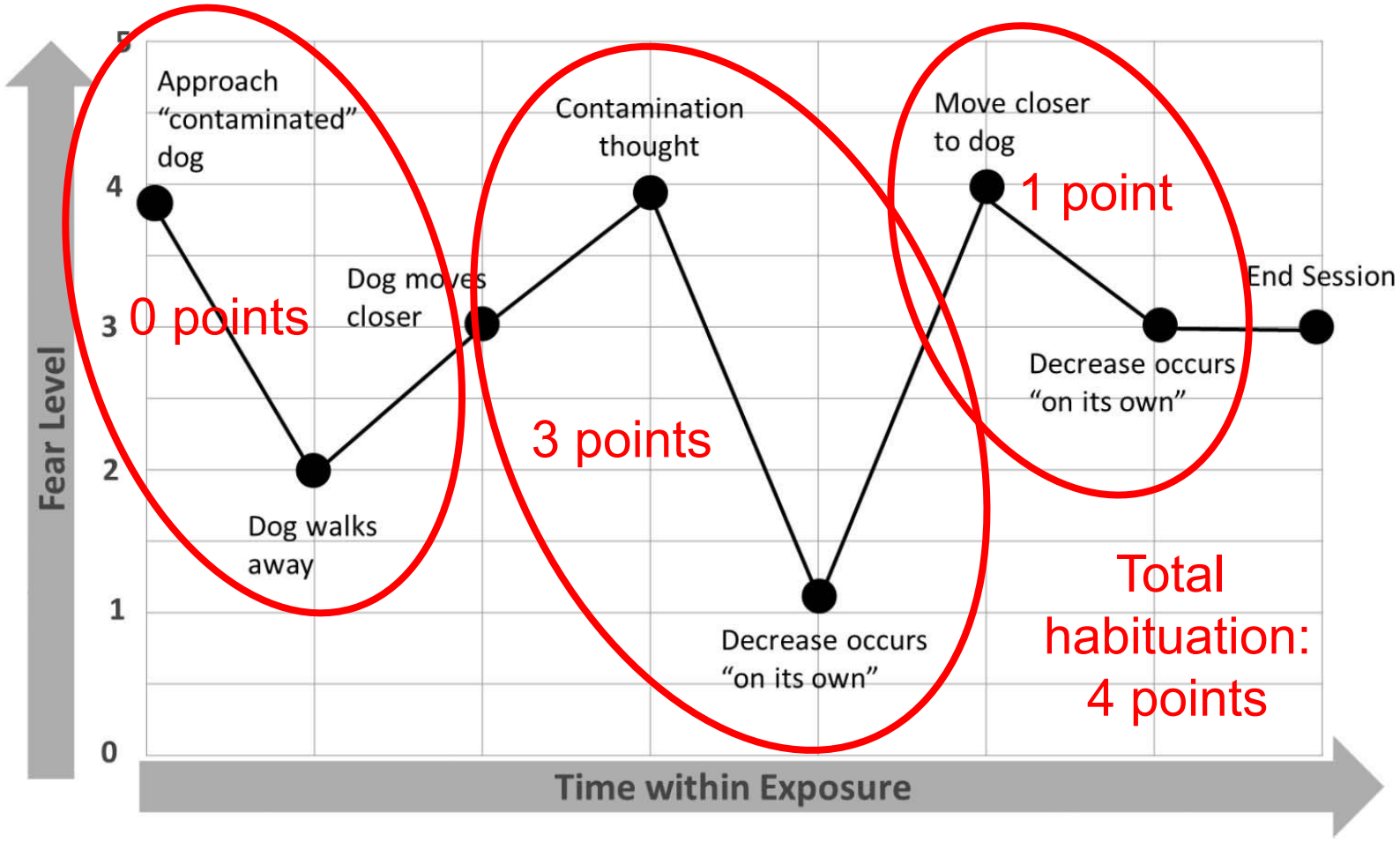


Only Natural Habituation Predicts Improvement



Intensive Exposure is Most Effective

- ***"Results:*** Greater cumulative habituation across treatment was associated with larger reductions in symptom severity, greater global improvement, and increased odds of treatment response. Fear activation, fear variability, and nonhabituation fear decreases did not predict any outcomes."

Benito et al. (2018). Measuring fear change within exposures: Functionally-defined habituation predicts outcome in three randomised controls trials for pediatric OCD. *Journal of Consulting and Clinical Psychology, 86,* 615-630.

Therapist Behaviour and Client Outcomes in Pediatric OCD

- "More therapist behaviors that encourage approach—and less use of accommodation, unrelated talk, and externalizing language—predicted greater subsequent habituation during individual exposure tasks (exposure-level), and also predicted improved patient clinical outcomes via higher "total dose" of habituation across treatment (patient-level indirect effect)."

Benito et al. (2021). Therapist behavior during exposure tasks predicts habituation and clinical outcome in three randomized controlled trials for pediatric OCD. *Behavior Therapy*, 52, 523-538

Of Interest

- These variations in exposure outcomes based on variations in exposure delivery in the pediatric OCD trials occurred despite therapists being extensively trained and experienced and following a standardized protocol
- Where do the differences come from?

Intensive Exposure is Most Effective

- How to get the most points?
- Keep increasing anxiety during and across exposures
- Allow anxiety to go down on its own…
- …then, increase the difficulty of the task when the client is ready
- Avoid engaging in behaviors that decrease anxiety

Benito et al. (2018). Measuring fear change within exposures: Functionally-defined habituation predicts outcome in three randomised controls trials for pediatric OCD. *Journal of Consulting and Clinical Psychology, 86,* 615-630.

Golden Rule for Therapist Behavior During Exposure

ANXIETY UP = GOOD

ANXIETY DOWN = BAD

Back to the Butter Knife

- ANXIETY DOWN
  - Providing reassurance prior to the task by examining evidence (cognitive restructuring) and noting I'm a safe person
  - Apologizing for the task
  - Encouraging anxiety management skills prior to task
  - Setting the duration in advance
  - Offering to alter, pause, or terminate the task if desired due to distress

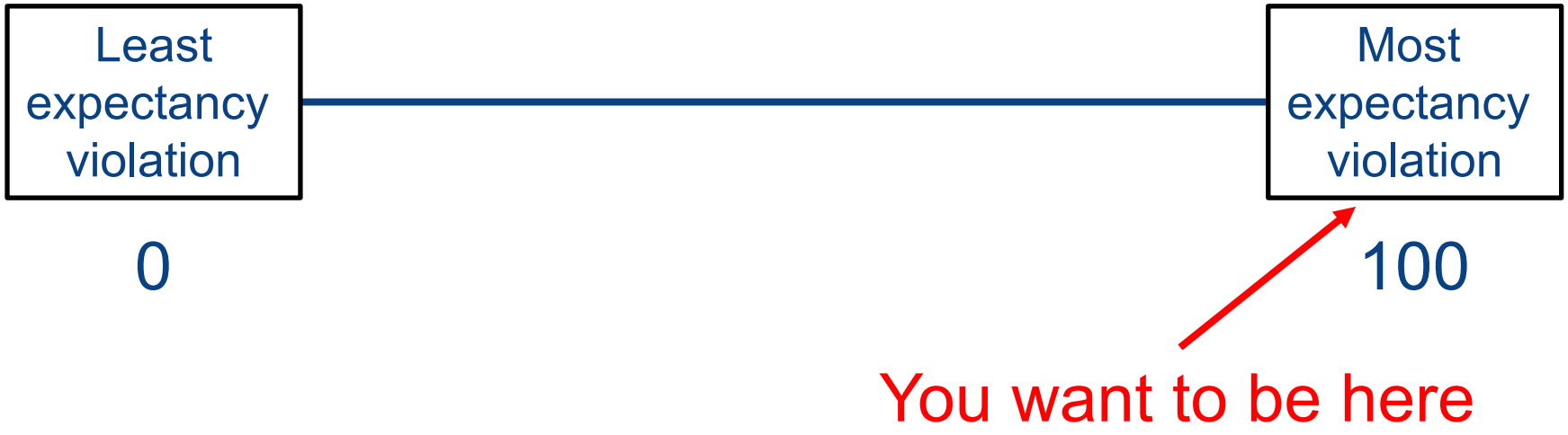
Back to the Butter Knife

- ANXIETY UP
- Encouraging “bring it on” attitude
- Heightening risk/uncertainty prior to and during task
- Setting behavioral expectations of the client in advance
- Telling, not asking, the client how to behave
- Encouraging pushing the task further to maximize learning

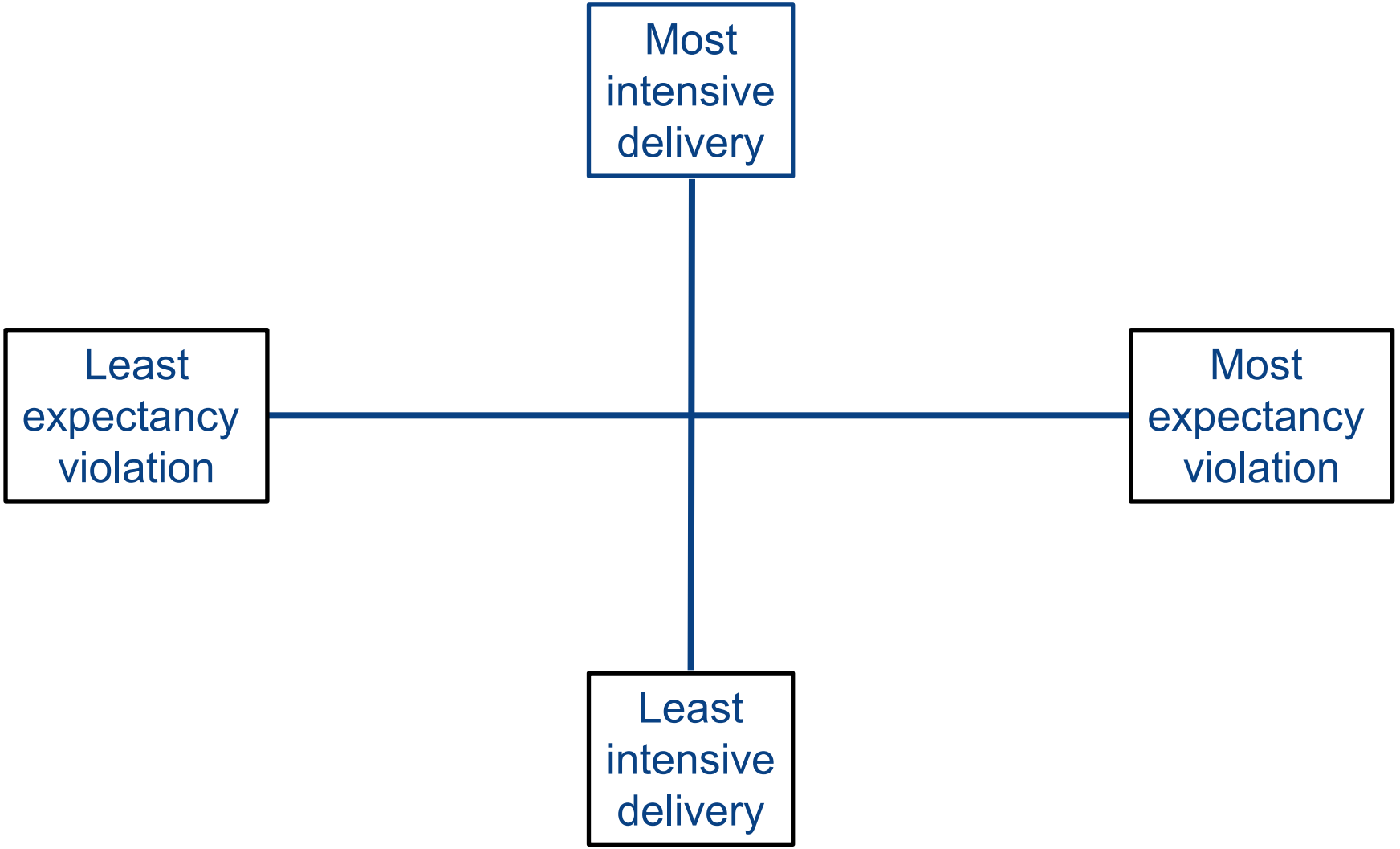
SURPRISE!

For any given exposure, ask yourself
"How many points of expectancy violation can I get?"

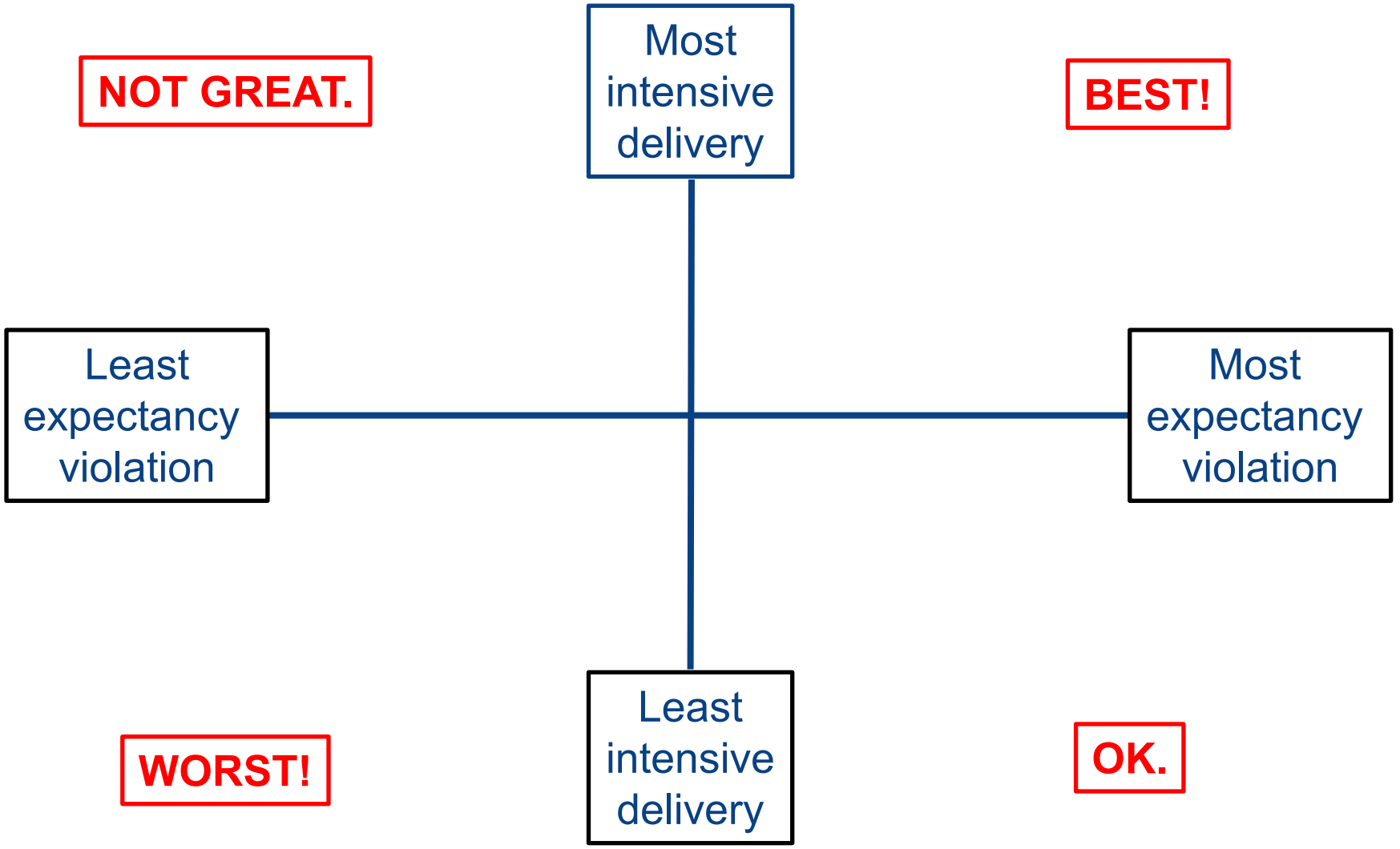
The more, the better. How to accomplish this?



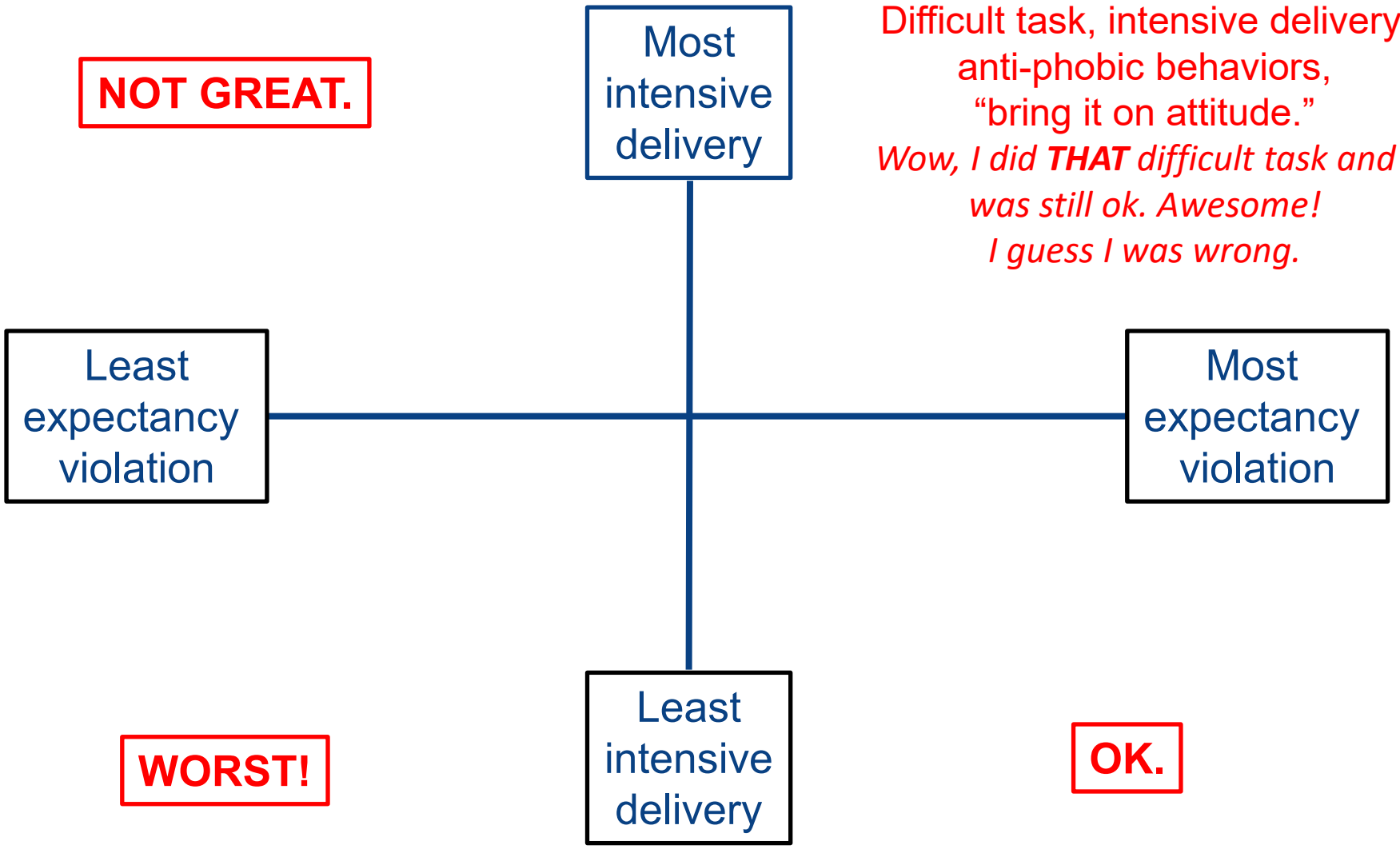
Relationship between Intensive Delivery and Expectancy Violation: The 2x2 Exposure Table



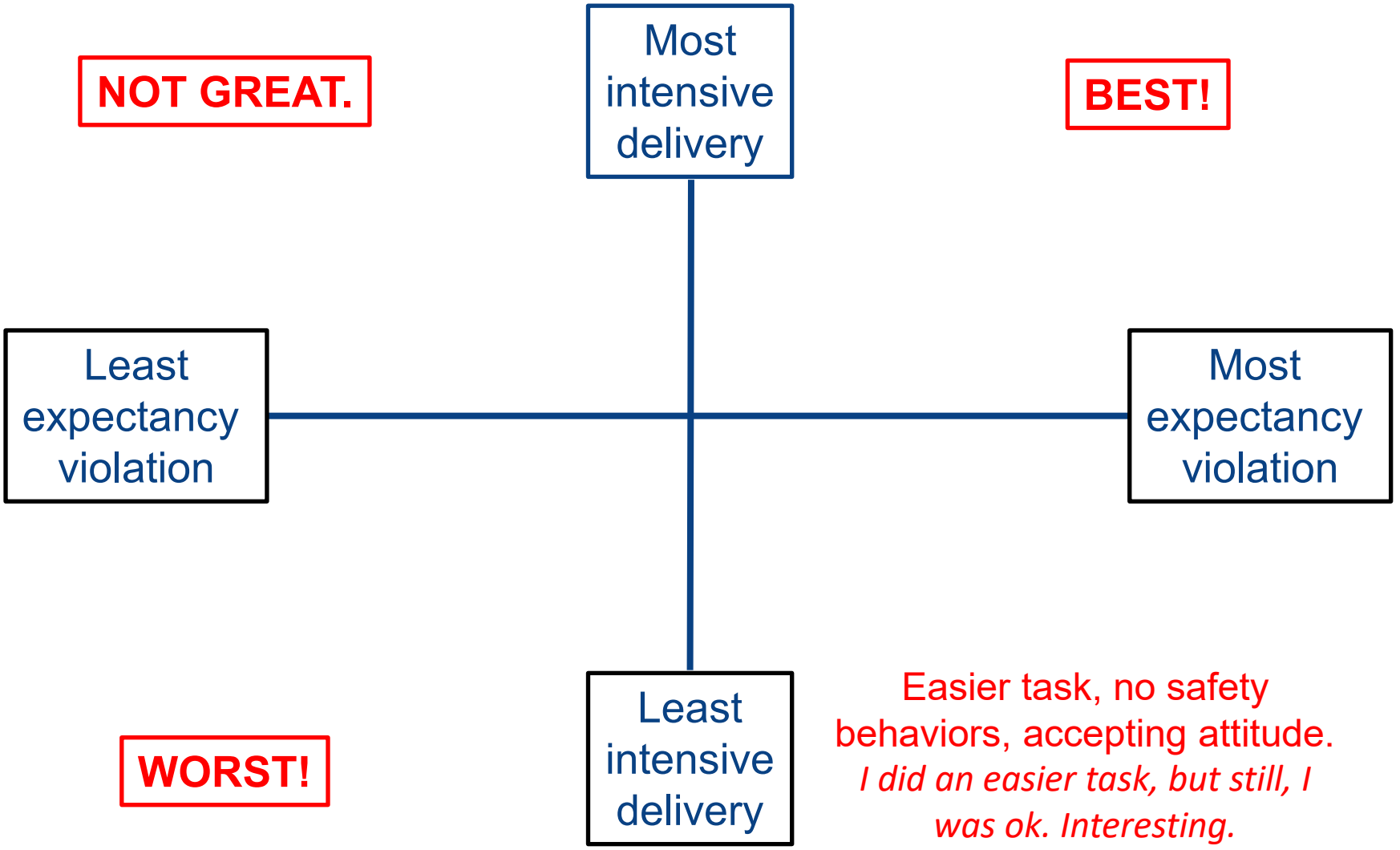
The 2x2 Exposure Table



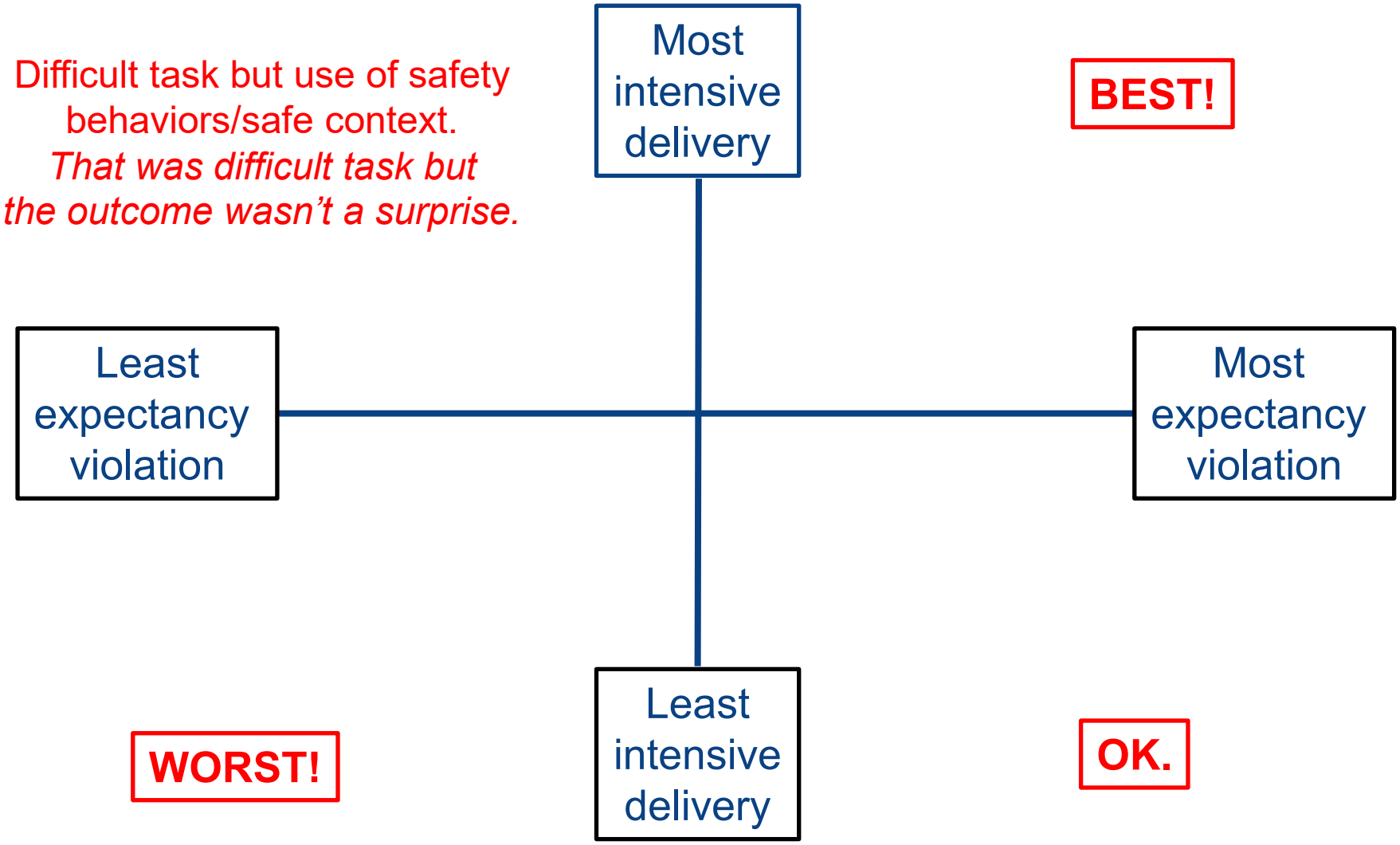
The 2x2 Exposure Table



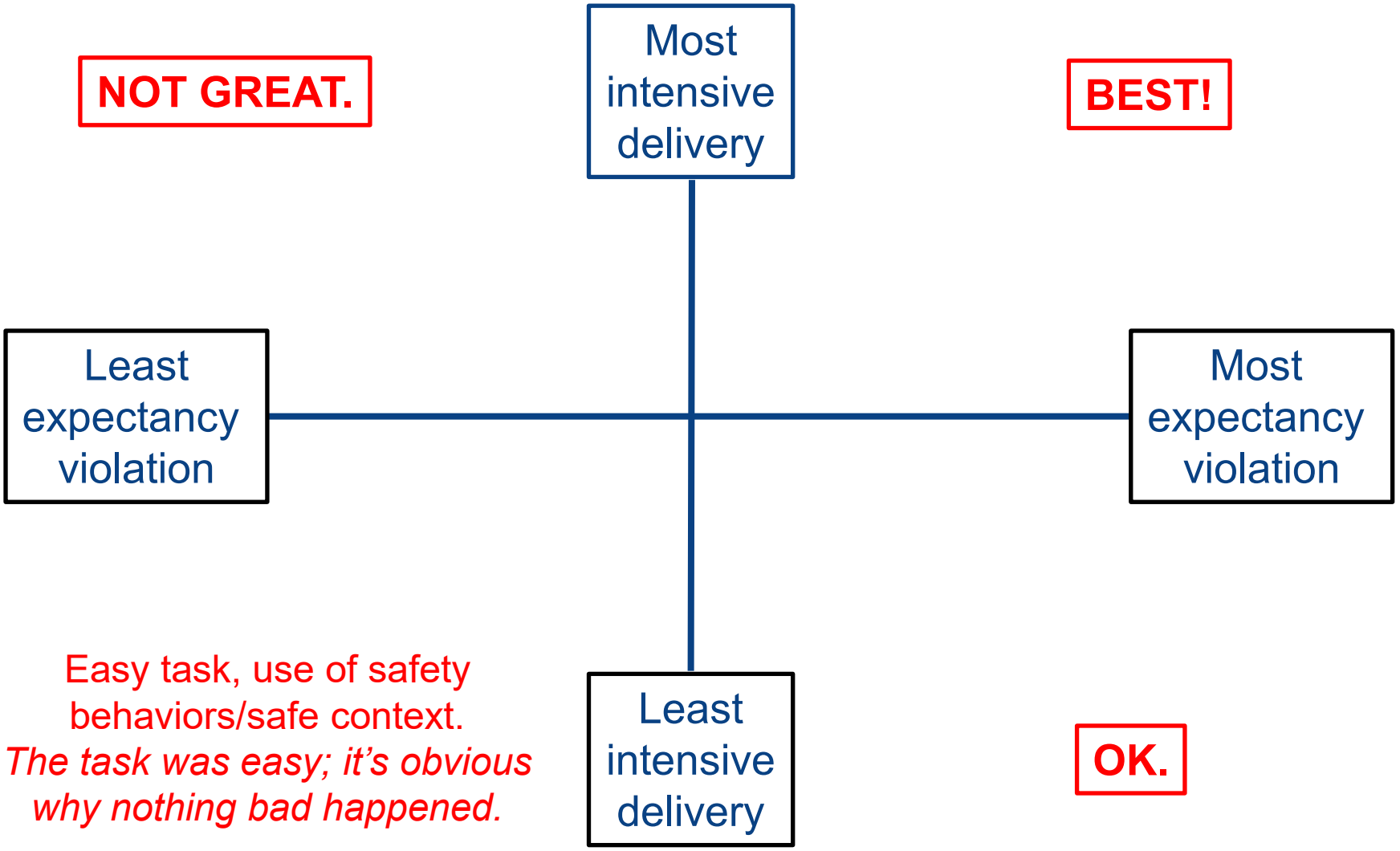
The 2x2 Exposure Table



The 2x2 Exposure Table



The 2x2 Exposure Table



Candy Time!

- 15 minutes
- Get into pairs
- Each take a wrapped candy
- Take turns being the client and therapist, 5 minutes each – assess client anxiety as you go
- Your goal as therapist: get the most points!
- Afterwards, we'll discuss

Candy Time!

- Reflections?
- How did it feel to be the therapist?
- Did any discomfort show up? About what?

The Good News

- Exposure works!
- It's an ideal therapy: powerful, efficient, parsimonious, straightforward – and also acceptable to clients
- Exposure for anxiety is one of the great success stories in the history of mental health treatment
- It's not just a therapy…

Exposure is Part of Life

How did you learn to ride a bicycle?

How did you learn to drive a car?

Exposure is Part of Life

- How did you learn to:
  - Ask someone out on a date?
  - Give a speech in class?
  - Handle a difficult boss?
  - Deal with being stuck in traffic?
  - Handle uncertainty with a medical issue, yours or a family member's?

Exposure is Part of Life

- How were you able to do these things despite the high anxiety they evoked?
- Did you require the use of anxiety-reducing coping skills (e.g., cognitive restructuring, mindfulness, diaphragmatic breathing) in order to tolerate the distress these tasks evoke and perform them competently?

Lunch Atop a Skyscraper

Lunch Atop a Skyscraper: The Photographer

Exposure is Part of Life

- How do you imagine these construction workers were able to get to this point?

- What story does it tell about human nature?

Exposure is Part of Life

- Life IS exposure ~~therapy~~!
- People are inherently resilient and act like it if they believe it, and through learning from approach behavior and not avoidance
- Exposure therapy is therefore best seen as an approach to life, not a treatment for an anxiety disorder per se

From Our Exposure Groups: Safety Behaviour Elimination

- If you're not using safety behaviours, what are you doing instead?
  - Learning to test feared outcomes
  - Learning to tolerate distress
  - Learning to function with distress
  - *Living your life the way you want instead of the way your anxiety wants*

- Key point: <u>EXPOSURE IS A LIFESTYLE!</u>

From Our Exposure Groups: You Have a Choice!

- Wait until you have eliminated your anxiety to start fully living your life

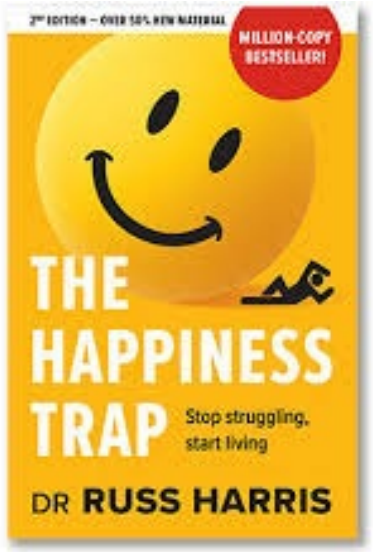
vs.

- Start fully living your life right now regardless of, and even with, your anxiety

- Note: The paradoxical effects of controlling vs. accepting anxiety!

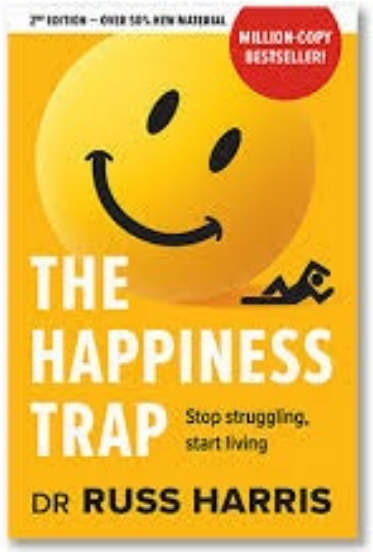
Merging Exposure with Philosophy

- Happiness does not entail feeling good/not feeling bad
- Rather, it involves living a rich, full, and meaningful life in accordance with one's values while being willing to accept the internal experiences that show up along the way



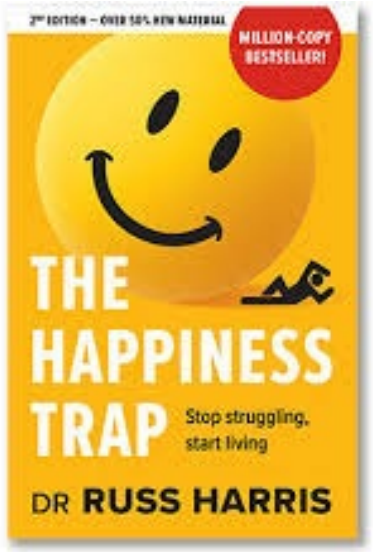
Merging Exposure with Philosophy

- Take-home message:
- Exposure is a powerful tool for empowering clients to live more valued lives by directing their efforts toward important behavioral goals as opposed to managing internal experiences



Merging Exposure with Philosophy

- Note: this directly contradicts the *DSM*-based biomedical paradigm which views anxiety- related internal experiences as symptoms of mental illness that require “skills and pills” to manage
- Optimal exposure is incompatible with this approach and cannot be coherently integrated with it



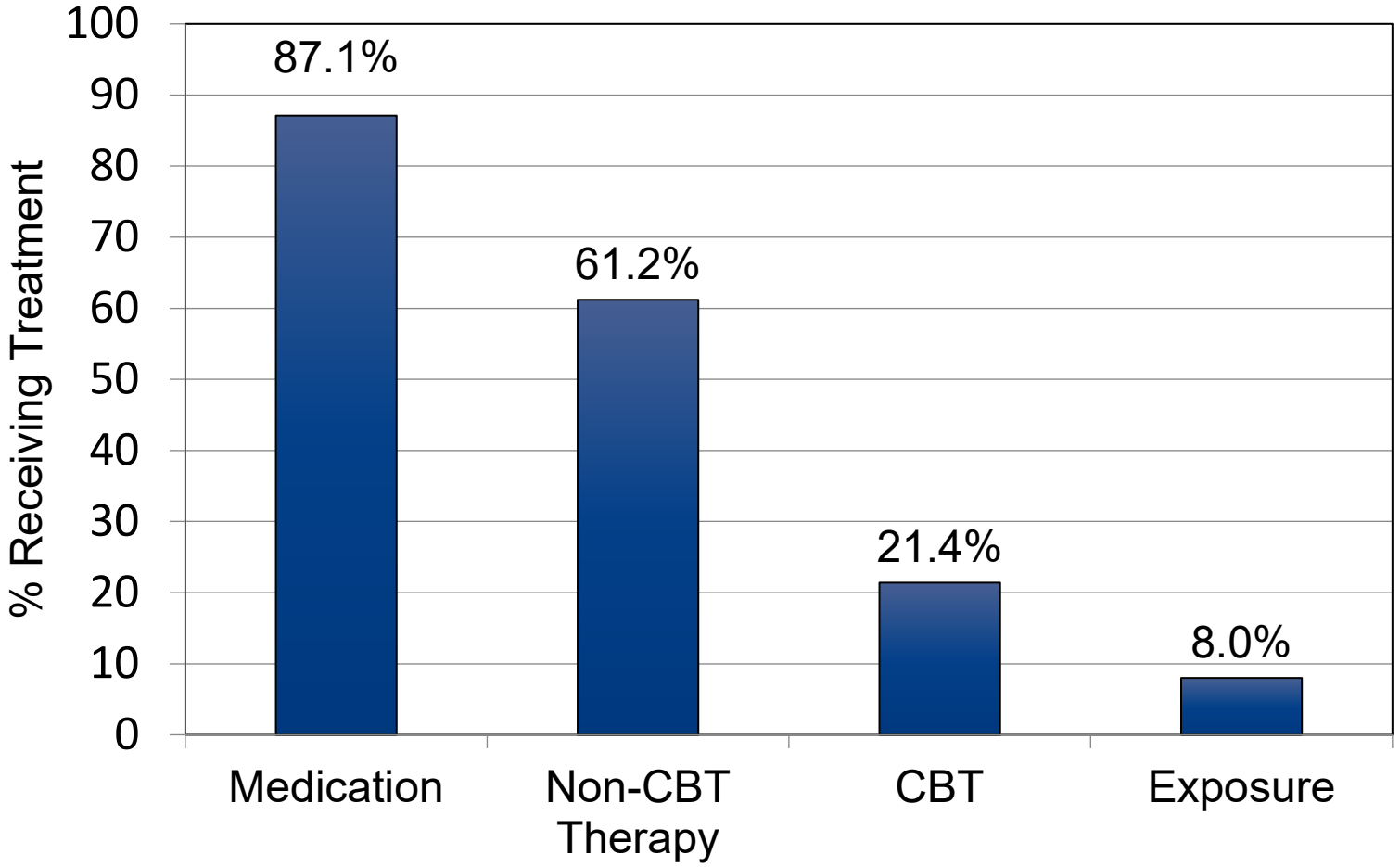
The Good News

- Exposure works!
- It's an ideal therapy: powerful, efficient, parsimonious, straightforward – and also acceptable to clients
- Exposure for anxiety is one of the great success stories in the history of mental health treatment
    - However…

The Bad News

- Two dissemination failures:
  - 1. Clinicians rarely deliver exposure therapy
  - 2. When they do, it is often delivered in an unnecessarily cautious manner
- Treatment-seeking anxious clients rarely receive the most effective therapy available

Dissemination Failure in the US



Wolitzky-Taylor et al. (2015). Has evidence-based psychosocial treatment for anxiety disorders permeated usual care in community mental health settings? *Behaviour Research & Therapy, 72,* 9-17.

Dutch Exposure Therapy Use

- Survey among 207 youth mental health care professionals in the Netherlands and Belgium

Table 2
The use of exposure and other techniques (in percentage of cases).

	Mean use (in % of cases)	*SD*
Overall exposure use	54.1	27.0
Therapist-guided exposure	54.1	34.6
Self-guided exposure	56.9	36.0
Parent-guided exposure	50.9	33.0
Cognitive strategies	70.4	33.1
Relaxation strategies	60.8	33.5

De Jong et al. (2020). Therapists' characteristics associated with the (non-)use of exposure in the treatment of anxiety disorders in youth: A survey among Dutch-speaking mental health practitioners. *Journal of Anxiety Disorders, 73,* 1-8.

Dutch Exposure Therapy Use

- "Zooming in on exposure use, both therapist-guided, self- guided, and parent-guided exposure were used only in about half of the cases (respectively in 54, 51 and 57 % of the cases). When comparing the use of the different strategies, exposure was used significantly less often than cognitive strategies, $t(164) = 6.91$, $p < 0.001$, ES: Cohen's $d = .54$, and relaxation strategies, $t(164) = 2.47$, $p = 0.007$, ES: Cohen's $d = .22$ respectively."

De Jong et al. (2020). Therapists' characteristics associated with the (non-)use of exposure in the treatment of anxiety disorders in youth: A survey among Dutch-speaking mental health practitioners. *Journal of Anxiety Disorders, 73,* 1-8.

What's the Problem with Exposure? Four Anecdotes

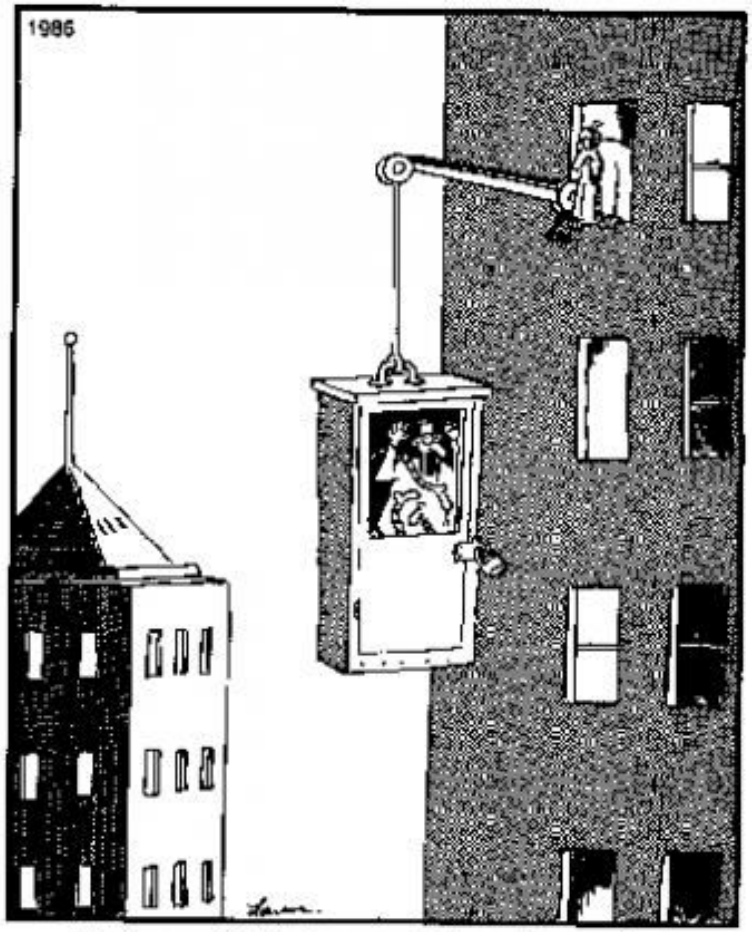
- Minneapolis Veterans Affairs Medical Center PTSD Clinic (2002)
- University of Wyoming Student Counseling Center (2004-2014)
- University of Melbourne Psychology Clinic (2 months ago)
- University of Melbourne Psychology Clinic (3 weeks ago)

Anecdotes

- Those are mine. What are some of yours?

- What's the problem with exposure? Why does it seem to have a bad reputation despite being so effective?

“The Cruelest Cure”
(Slater, 2003, New York Times, p. 3)



Professor Gallagher and his controversial technique of simultanously confronting the fear of heights, snakes and the dark.

To be Fair

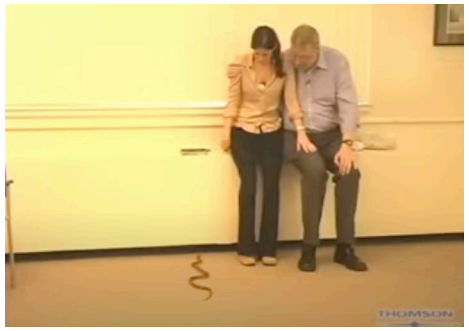
- Exposure is hard!

Case Example: Exposure for a Snake Phobia










Yay, Exposure Works!








What's Missing?




???




This is MUCH Harder than it Looks!




Belief system




Exposure's Unique Therapist Requirements

- Belief that asking clients to experience high anxiety is safe, tolerable, and ethical
- Belief that clients have the capacity to withstand their own anxiety and do not need to be rescued from it
- Belief that one's own anxiety is safe and tolerable
- Translating these beliefs into a confident, anxiety-increasing (intensive) delivery style
- These are challenging requirements!

Exposure's Unique Therapist Requirements

- Would you be willing to ask an anxious client to:
  - Spill a large handful of coins in a crowded food shopping center?
  - Hyperventilate for 30 minutes?
  - Eat fries off the table/floor at McDonald's?
  - Describe killing their own child in vivid detail?
  - Lay on the floor, hands behind their back, and allow a spider to crawl freely over them?

Exposure's Unique Therapist Requirements

- Would you be willing to do these things yourself?
- Could you model doing them for your client while showing no visible fear?
- Exposure can be very challenging!
- Optimal exposure requires therapists to have a particular *set of beliefs* that translate into a particular *style of delivery*

Exposure's Unique Therapist Requirements

- Many of us are kind, gentle, compassionate people who wish our clients to experience reduced distress
- This is a good thing – if aimed in the right direction
- The danger: short-term protection from distress (our own and the client's) prevents long-term improvement
- When this happens, we allow our own issues to prevent the client from having the best outcome

Exposure's Unique Therapist Requirements

- What to do then with a case like this?
- Case study: Mick, 38-year-old Australian man with harm-related intrusive thoughts about his children

Exposure's Unique Therapist Requirements

- What concerns might we have regarding safety, tolerability, and ethicality of using exposure with Mick?

- What would exposure look like in order to be optimally helpful?

Exposure's Unique Therapist Requirements

- The effects of one week of daily hour-long imaginal exposure practices

Exposure's Unique Therapist Requirements

- Course of therapy with Mick
- What would have happened if I had foregone exposure to protect him from his and my distress?
- I directed my compassion toward his longer-term improvement and believed he was able to tolerate shorter-term comfort to get there
- Let me offer an analogy

An Analogy

- Exposure therapy is like going to the gym to work out in order to become more fit
- Therapist is like a personal trainer who develops an individualized workout plan and shepherds the client through it with support, motivation, and accountability
- Both parties understand that accepting discomfort and pushing through it is not just an inherent requirement for increasing fitness, but is beneficial to the client
- A coddling approach precludes increased fitness

Kane Hamilton – Prime40 Personal Training

Slides from Our Exposure Group: The Gym Analogy

- Doing exposure therapy for anxiety is like working out in the gym to improve your fitness
- Your therapist is like a personal trainer
- What makes a good personal trainer?
  - Knowledge
  - Belief in your resilience
  - Willingness to push you as needed
  - Encouragement along the way
  - Accountability

Slides from Our Exposure Group: The Gym Analogy

- A personal trainer who coddles you, doubts your capacity to tolerate exertion, and emphasises the need for you to stay comfortable while working out is lousy at their job!

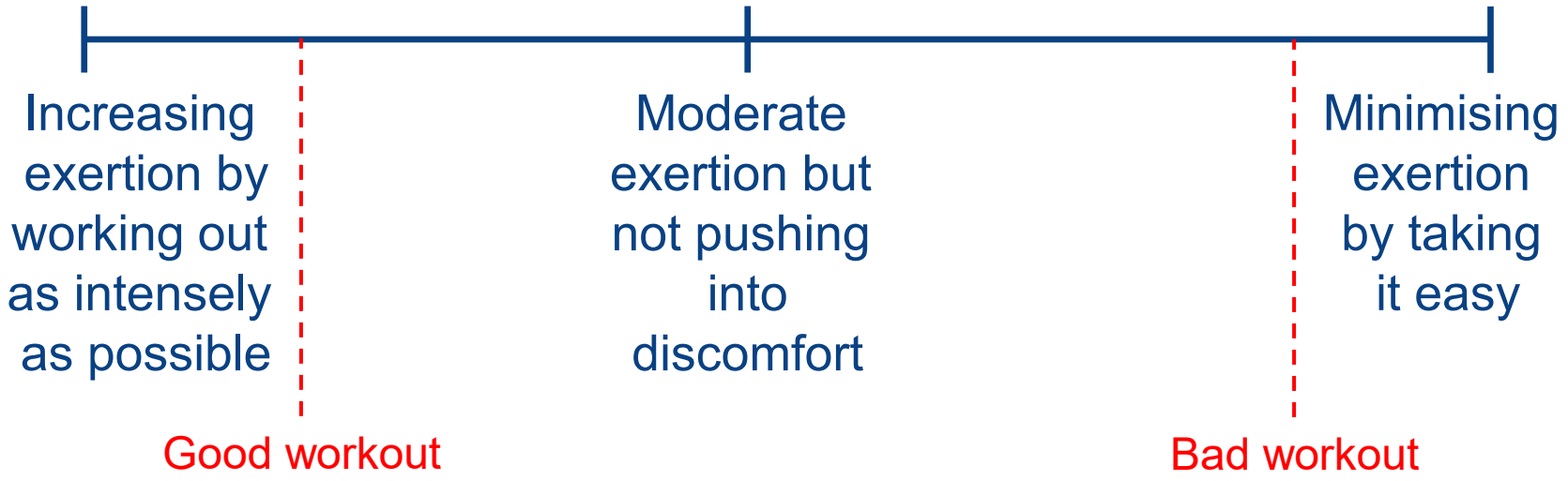
- Why?

Slides from Our Exposure Group: The Gym Analogy

- What is required of you in order to reach your goals to the fullest possible extent?
  - Knowing how to work out
  - Regularly working out
  - Bringing the right attitude to the gym

Slides from Our Exposure Group: Mindset in the Gym

- Who else has experienced what happens when you bring the wrong attitude to the gym?
- Attitude determines the quality of a workout!



Slides from Our Exposure Group: The Gym Analogy

- A gym membership by itself does nothing
- Meeting with a personal trainer only works if you incorporate that work into your longer-term lifestyle
- Reaching your long-term fitness goals requires a lifestyle that supports them
- This lifestyle is anchored in a philosophy on what it means to live life well with respect to fitness and health

Slides from Our Exposure Group: The Gym Analogy

- With regard to your anxiety, what does this lifestyle look like going forward?
- What does the philosophy look like? What is the approach to living life?

- Discuss this with your therapist today!

The Gym Analogy

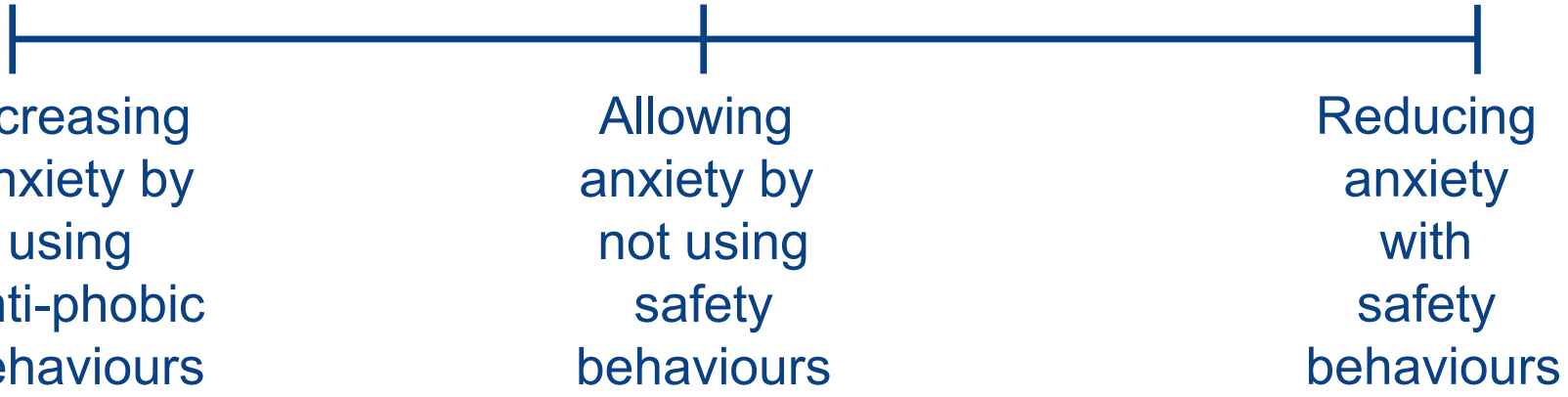
- Thoughts? Reactions?

Slides from Our Exposure Group: Back to Exposure

- Exposure provides corrective learning for maladaptive beliefs about danger and intolerability of distress and uncertainty
- Exposure tasks should be done without using safety behaviours
- They work best when you have an anti-phobic attitude and lean into anxiety

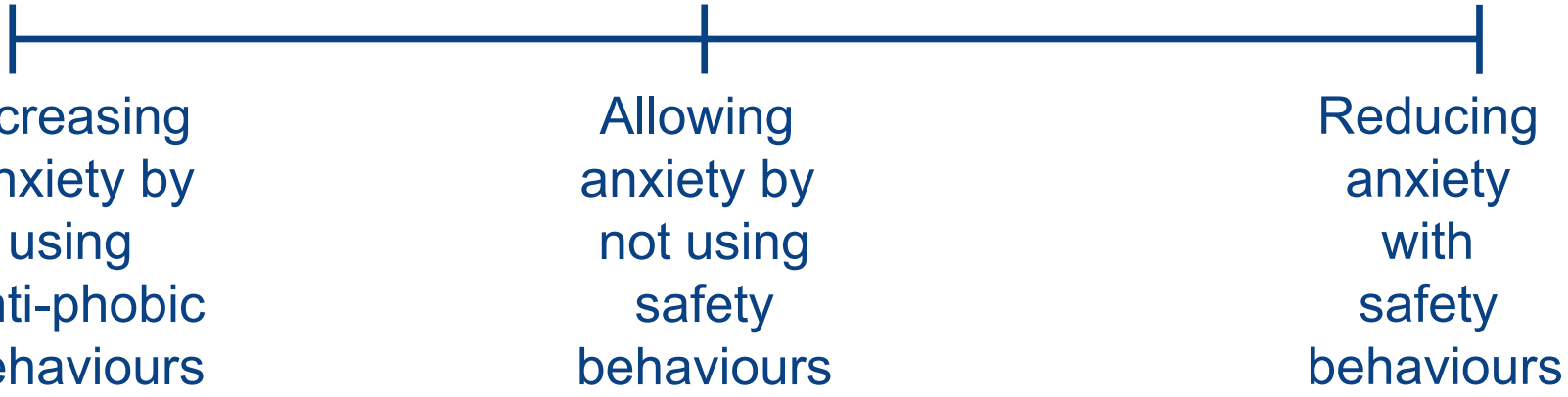
Slides from Our Exposure Group: The Exposure Mindset: Bring it On!

- What does this look like?
- What does this NOT look like?



Slides from Our Exposure Group: Let's Try an Example

- Exposure task: having a conversation with a stranger
- What would this look like using each of the three points on the continuum below?



Show: https://www.youtube.com/watch?v=3zsM3jBwWIM&t=18s (first 40 seconds)

Slides from Our Exposure Group: Another Example

- Exposure task: trying to be rejected
- Day 1: https://www.youtube.com/watch?v=zmIeo2bZVoQ
- Day 57: https://www.youtube.com/watch?v=3YVW3lqfevc

Questionnaires

- Please take a few minutes and complete 2 brief questionnaires

Introducing “Exposaphobia”

- “The extreme fear (and associated avoidance) of using exposure therapy procedures occurring in trained mental health professionals” (Schare & Wyatt, 2013, p. 251)
- Symptoms: fear, avoidance, and/or dislike of exposure
- Note: avoidance can be overt or subtle

Diagnosing Exposaphobia: The Therapist Beliefs about Exposure Scale

- Administered web-based survey to 637 American therapists who work with anxious clients
- Constructed 21-item TBES

- *"Arousal reduction strategies, such as relaxation or controlled breathing, are often necessary for clients to tolerate the distress exposure therapy evokes."*
- *"Most clients have difficulty tolerating the distress exposure therapy evokes"*
- *"Clients are at risk of decompensating (i.e., losing mental and/or behavioral control) during highly anxiety-provoking exposure therapy sessions."*

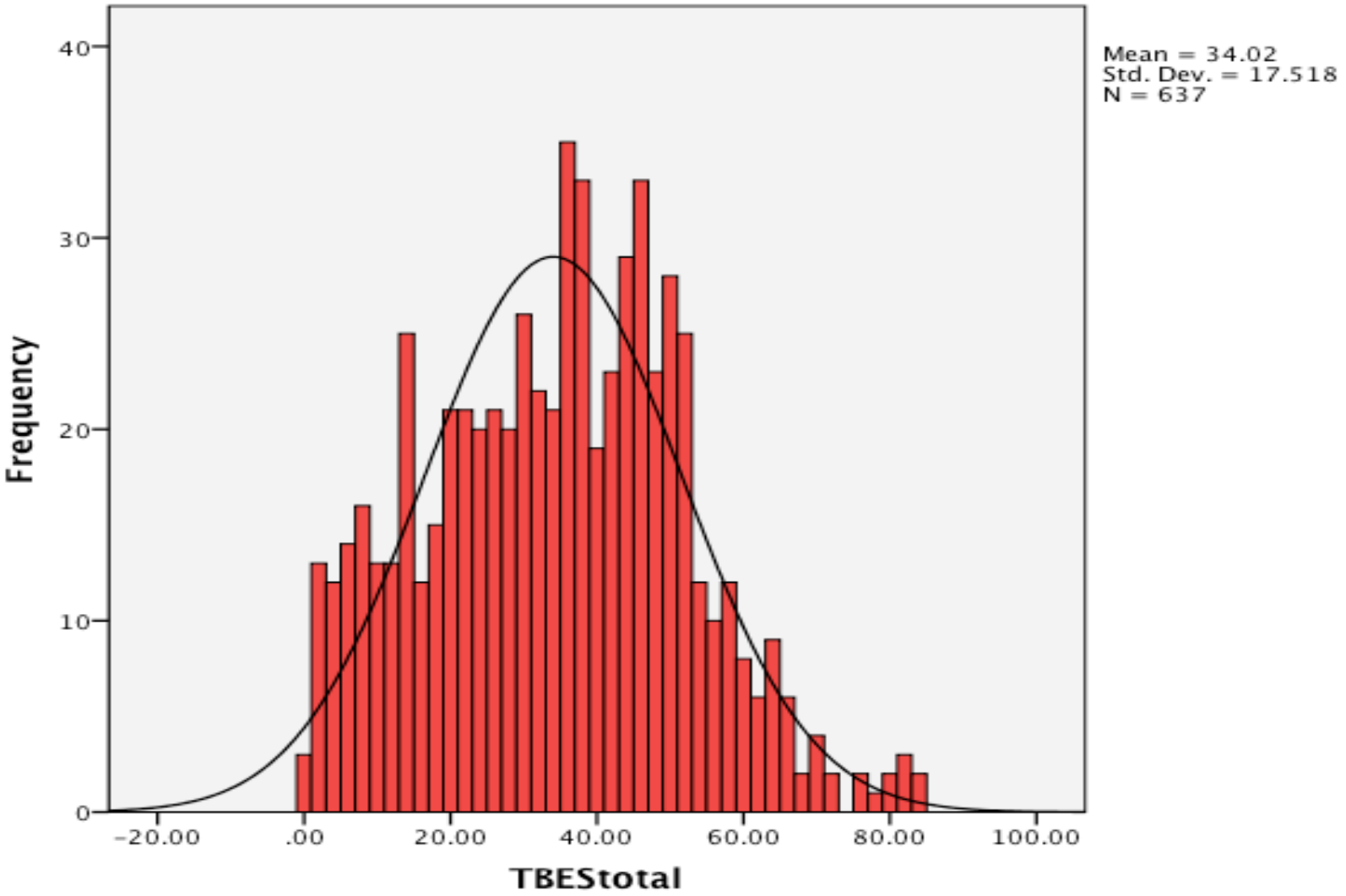
Deacon, Farrell, Kemp, Dixon, Sy, Zhang, & McGrath, P. (2013). Assessing therapist reservations about exposure therapy for anxiety: The Therapist Beliefs about Exposure Scale. *Journal of Anxiety Disorders, 27,* 772-780.

Therapist Beliefs about Exposure Scale

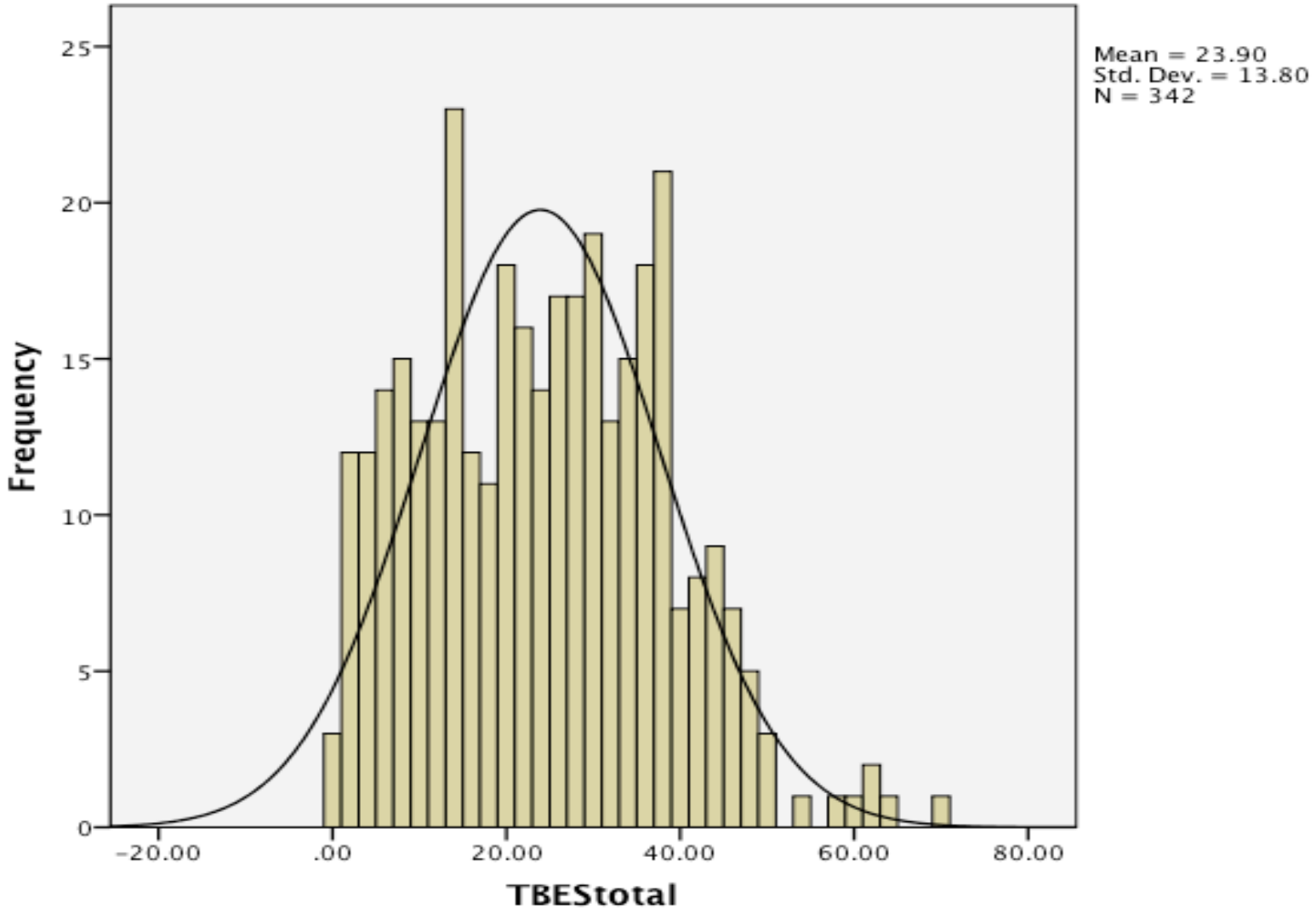
Psychometric properties

- α = .95
- Single factor explained 51.7% of item variance
- All items had salient |.40| loading on this factor
- 6-month test-retest *r* = .89

Distribution of TBES Scores



Distribution of TBES Scores among Exposure Therapists (*n* = 342)



Who Has Exposaphobia? Correlates of Higher TBES Scores

- Older age: *r* = .34
- Less training (masters vs. Ph.D.): *d* = .96
- Higher anxiety sensitivity (belief that anxiety symptoms are harmful): *r* =.17
- Psychodynamic, humanistic, and family systems theoretical orientations vs. C/B (*d*s > 1.0)

Deacon, Farrell, Kemp, Dixon, Sy, Zhang, & McGrath, P. (2013). Assessing therapist reservations about exposure therapy for anxiety: The Therapist Beliefs about Exposure Scale. *Journal of Anxiety Disorders, 27,* 772-780.

Exposaphobia Around the World

- TBES has been translated into German, Dutch, Chinese
- Currently being translated into Spanish, French, and Swedish
- Very consistent findings

Deacon, Farrell, Kemp, Dixon, Sy, Zhang, & McGrath, P. (2013). Assessing therapist reservations about exposure therapy for anxiety: The Therapist Beliefs about Exposure Scale. *Journal of Anxiety Disorders, 27,* 772-780.

Dutch TBES

- TBES mean score = 27.4 (SD = 11.6)

Table 3
Correlations (Pearson/Spearman) for therapists' characteristics and the use of exposure.

Characteristic	Type of exposure		
	Therapist-guided	Self-guided	Parent-guided
Age^{S} (years)	−.22*	−.34*	−.25*
Experience^{S} (years)	−.05	.03	−.06
Caseload^{P} (% workweek)	.01	.20	.11
Beliefs^{P} (TBES)	−.37*	−.51*	−.41*
Depression^{P} (DASS)	−.02	−.04	−.08
Anxiety^{P} (DASS)	−.05	−.15	−.10
Stress^{P} (DASS)	.06	−.11	−.05

* = Significant at $\alpha = 0.01$ (one-sided), S = Spearman's Rho, P = Pearson's *r*.

De Jong et al. (2020). Therapists' characteristics associated with the (non-)use of exposure in the treatment of anxiety disorders in youth: A survey among Dutch-speaking mental health practitioners. *Journal of Anxiety Disorders, 73,* 1-8.

Exposaphobia Around the World

- Systematic review on studies using the TBES
- “Negative beliefs about exposure therapy were associated with reduced use in all 14 studies that used the TBES…The majority of studies found a medium to large effect size…(p. 364; Langthorne, Beard, & Waller, 2023)

Diagnosing Exposaphobia, Part II: The Spun Glass Scale

- The "*spun glass theory of the mind*" (Meehl, 1973)

Brown, E., & Deacon, J. (2024). Assessing barriers to psychologists implementing exposure therapy on anxious clients: The spun glass scale. *Manuscript in preparation*.

Diagnosing Exposaphobia: The Spun Glass Scale

- Administered survey to 63 American therapists who work with anxious youth (SGS α = .87)
- Also administered TBES and a perceived barriers scale which assesses perceived barriers to exposure therapy, including child refusal, parent refusal, client crisis, lack of time, previous unsuccessful attempts, a need to focus on other client concerns, difficulty choosing a tolerable task, and client symptoms not being appropriate for exposure

Brown, E., & Deacon, J. (2024). Assessing barriers to psychologists implementing exposure therapy on anxious clients: The spun glass scale. *Manuscript in preparation*.

Diagnosing Exposaphobia: The Spun Glass Scale

- Mean SGS score = 14.05 (*SD* = 6.13)
- Correlation with TBES = .56 (*p* <.001)
- Correlation with perceived barriers scale = .29 *(p < .01)*
- Scores decreased following a day-long workshop (*N* = 26; *d* = 1.45)

Brown, E., & Deacon, J. (2024). Assessing barriers to psychologists implementing exposure therapy on anxious clients: The spun glass scale. *Manuscript in preparation*.

If Exposure Therapists Are Anxious…

- Do they use safety behaviours?
  - Examples: teaching clients arousal-reduction techniques, coaching their use as coping strategies during exposure tasks, reassuring clients of their safety, terminating exposures when client anxiety becomes high
- Correlation between total therapist safety behaviour and TBES = **.71**

Meyer, J. M., Kelly, P. J., & Deacon, B. J. (2020). Therapist beliefs about exposure therapy implementation. *the Cognitive Behaviour Therapist*, 13, 1-14.

If Exposure Therapists Are Anxious…

- Total therapist safety behaviour use was predicted (sr^2 = .34; p < .001) by concerns they are necessary to protect the client (safe and tolerable), preserve the alliance, and ensure task adherence
- When therapists use anxiety-reducing strategies to manage anxiety during exposure, *whose anxiety is being managed*?

Meyer, J. M., Kelly, P. J., & Deacon, B. J. (2020). Therapist beliefs about exposure therapy implementation. *the Cognitive Behaviour Therapist*, 13, 1-14.

How Might Therapist Safety Behaviours Maintain Exposophobia?

- Misattribution of safety (near misses)
- Unable to learn what happens if not used
- Prevent development of distress tolerance
- Prevent learning to function with distress
- Send the message that feared outcomes are legitimate concerns

Kane Hamilton – Prime40 Personal Training

Exposophobia in the Gym

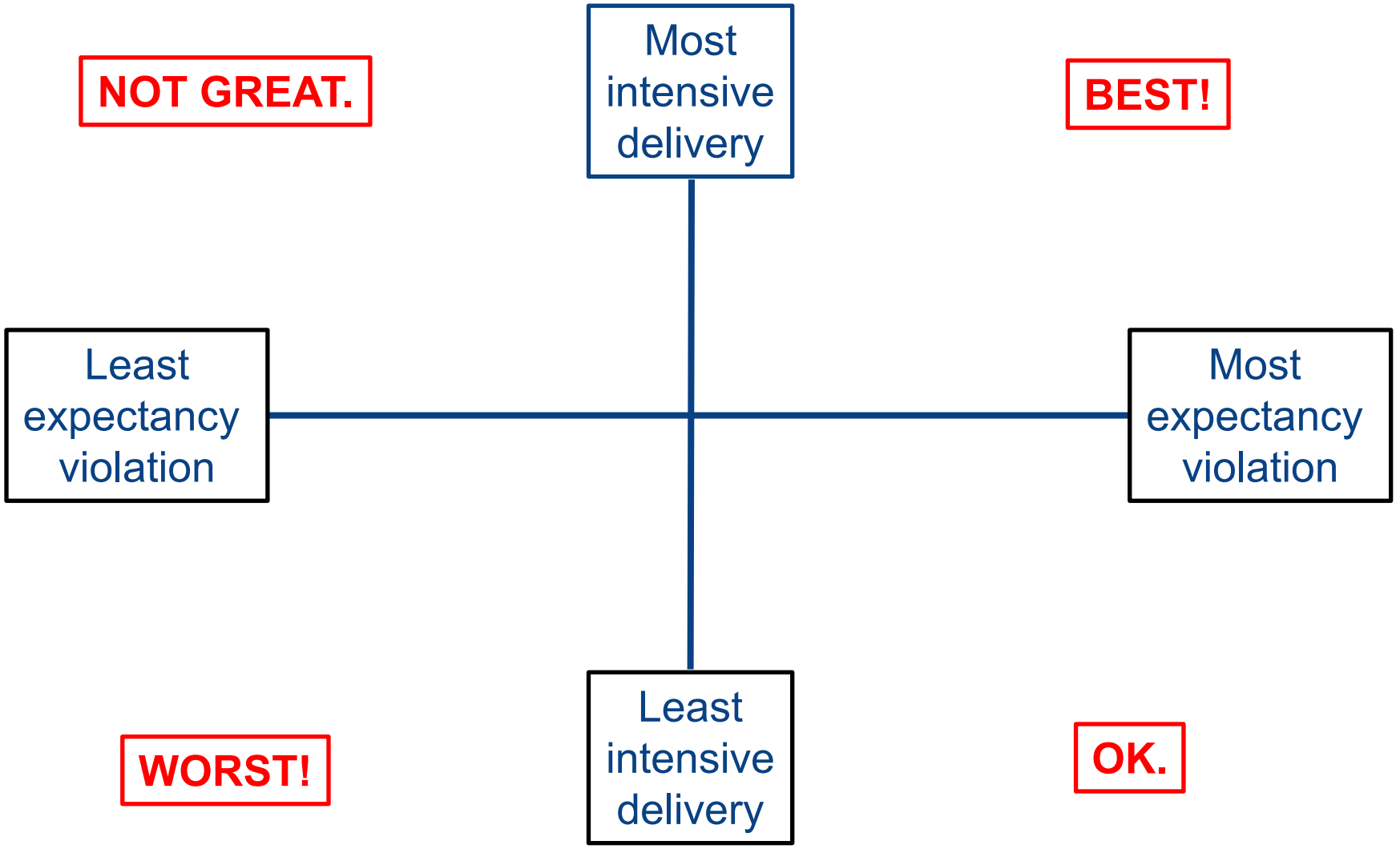
- "Let's get ready to begin today's workout. We're going to have you walk slowly on the treadmill for three minute-long trials, each followed by a rest period for you to practice your controlled breathing skills. Remember to counteract negative thoughts with positive thoughts. Feel free to discontinue the task at any time if you become too uncomfortable."

"Please like me, don't get me into trouble, and don't leave!"

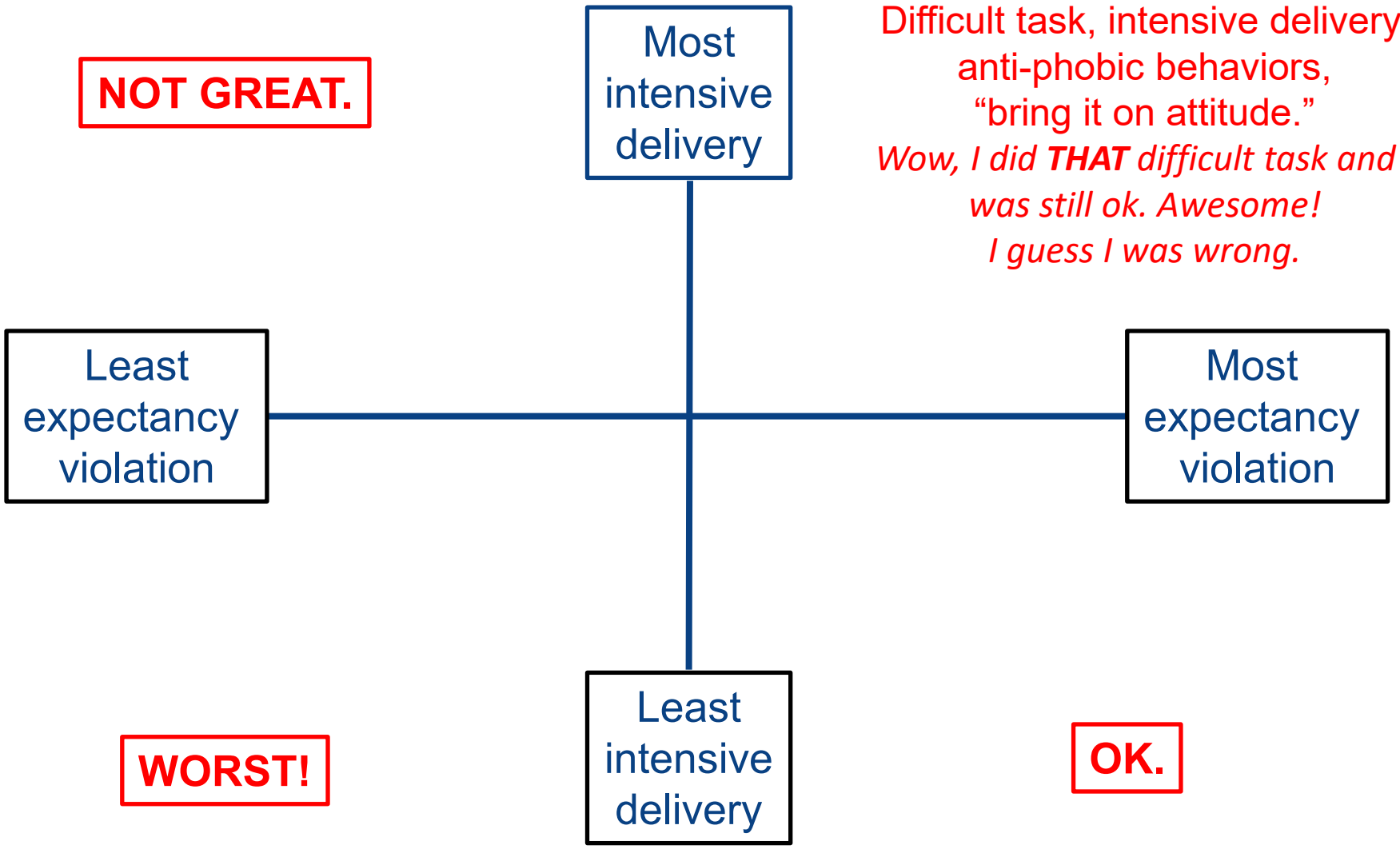
Exposophobia in the Clinic

- If that sounds ridiculous in the gym, is it any less ridiculous in the therapy room?

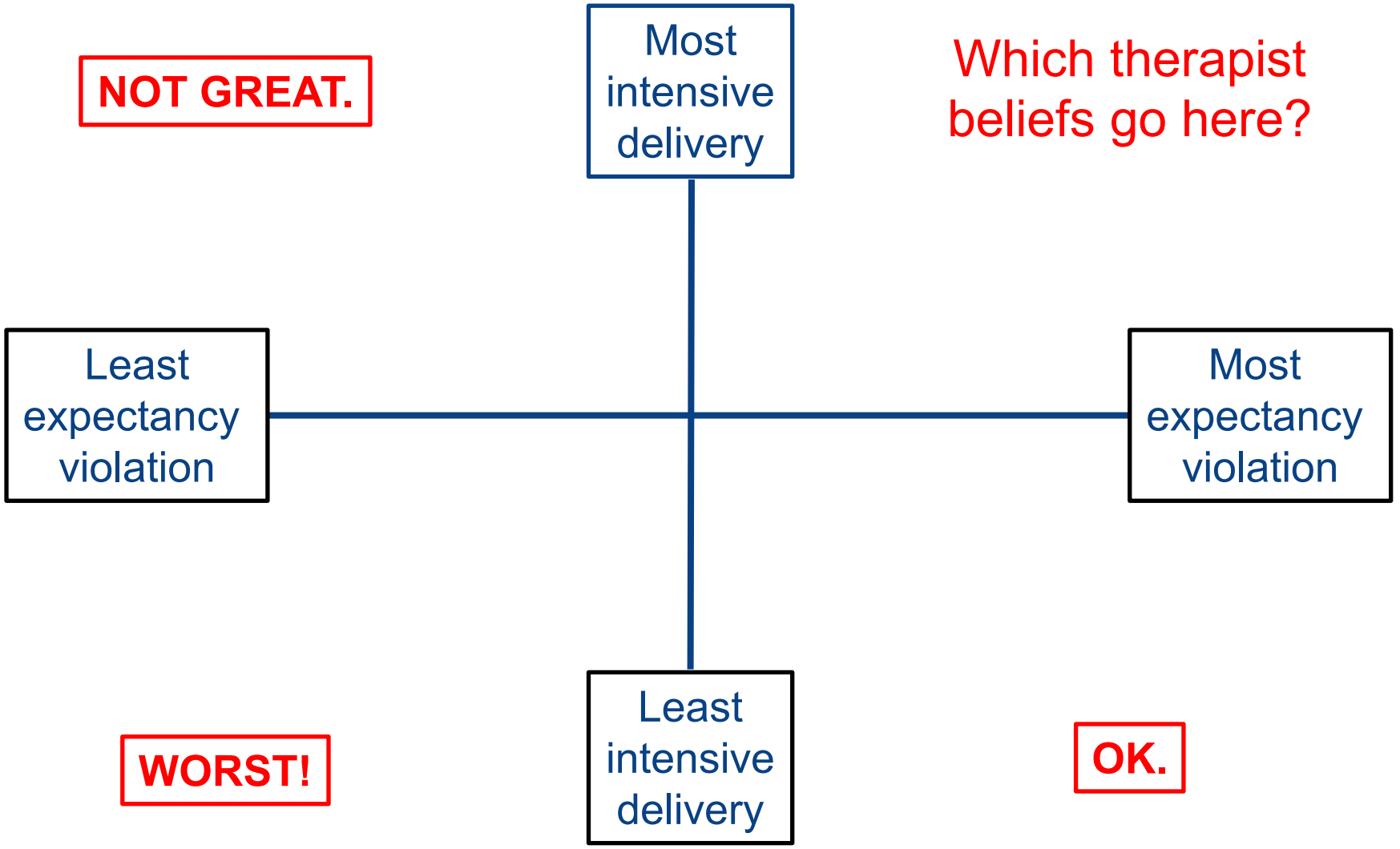
The 2x2 Exposure Table



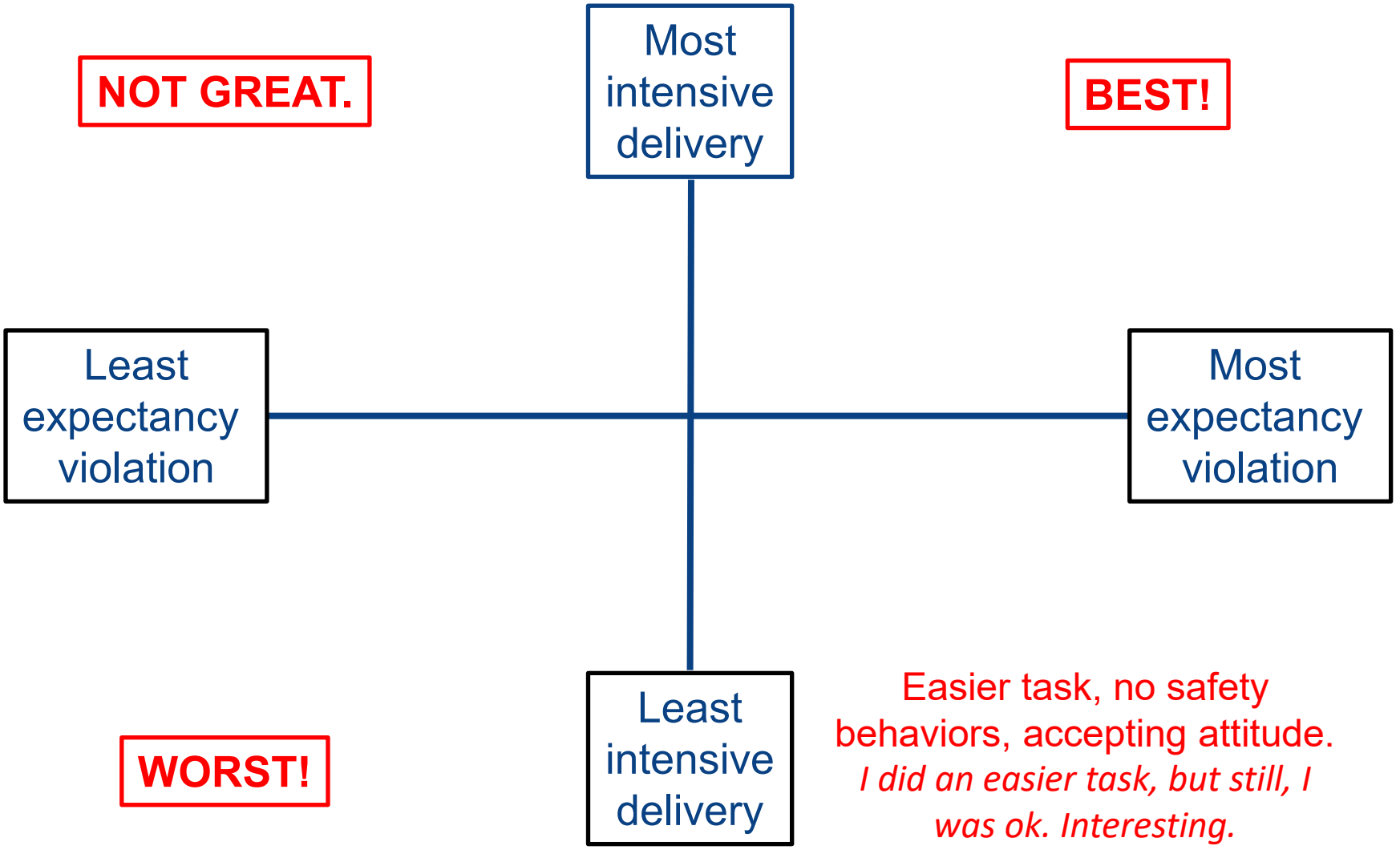
The 2x2 Exposure Table



The 2x2 Exposure Table



The 2x2 Exposure Table



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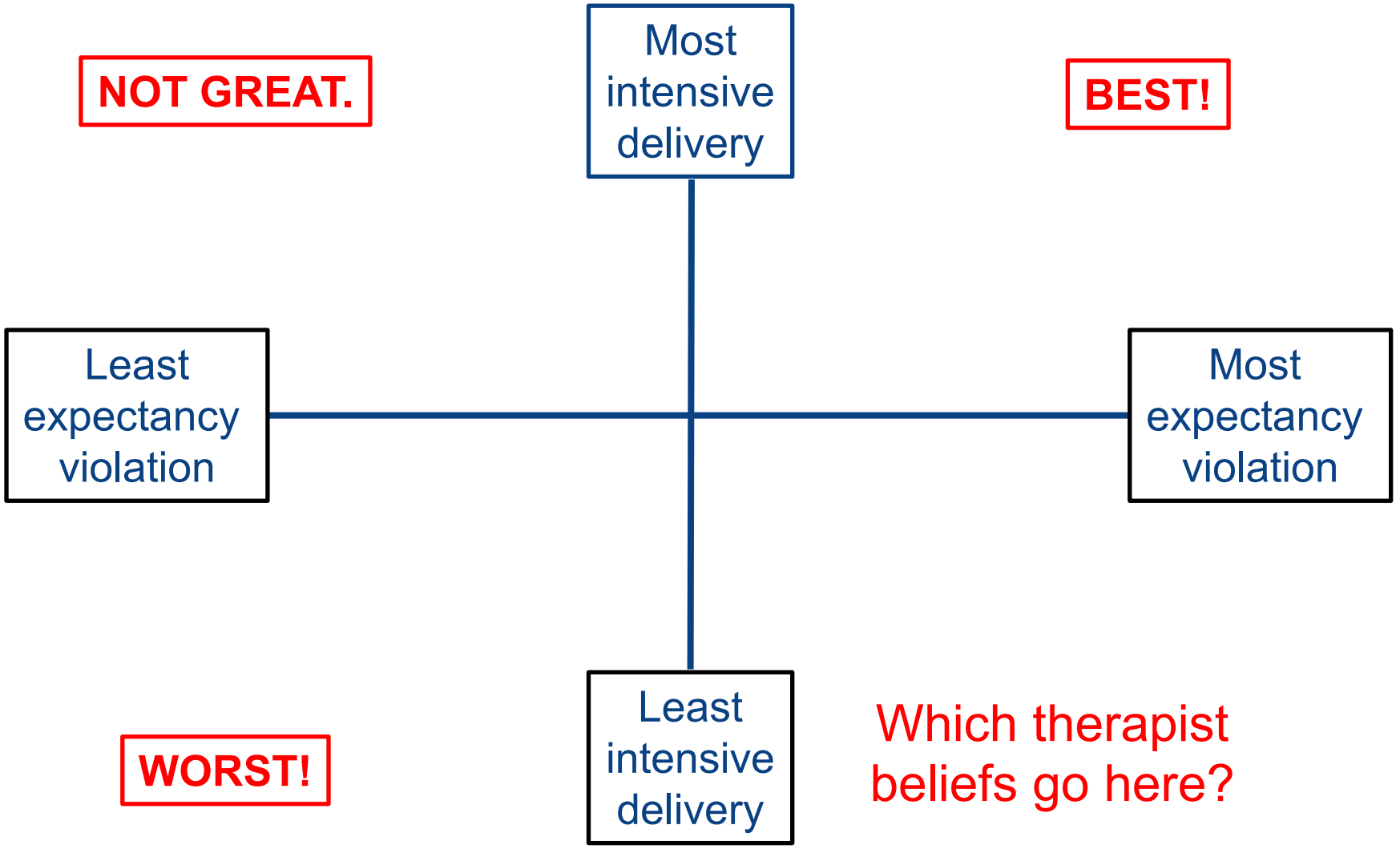

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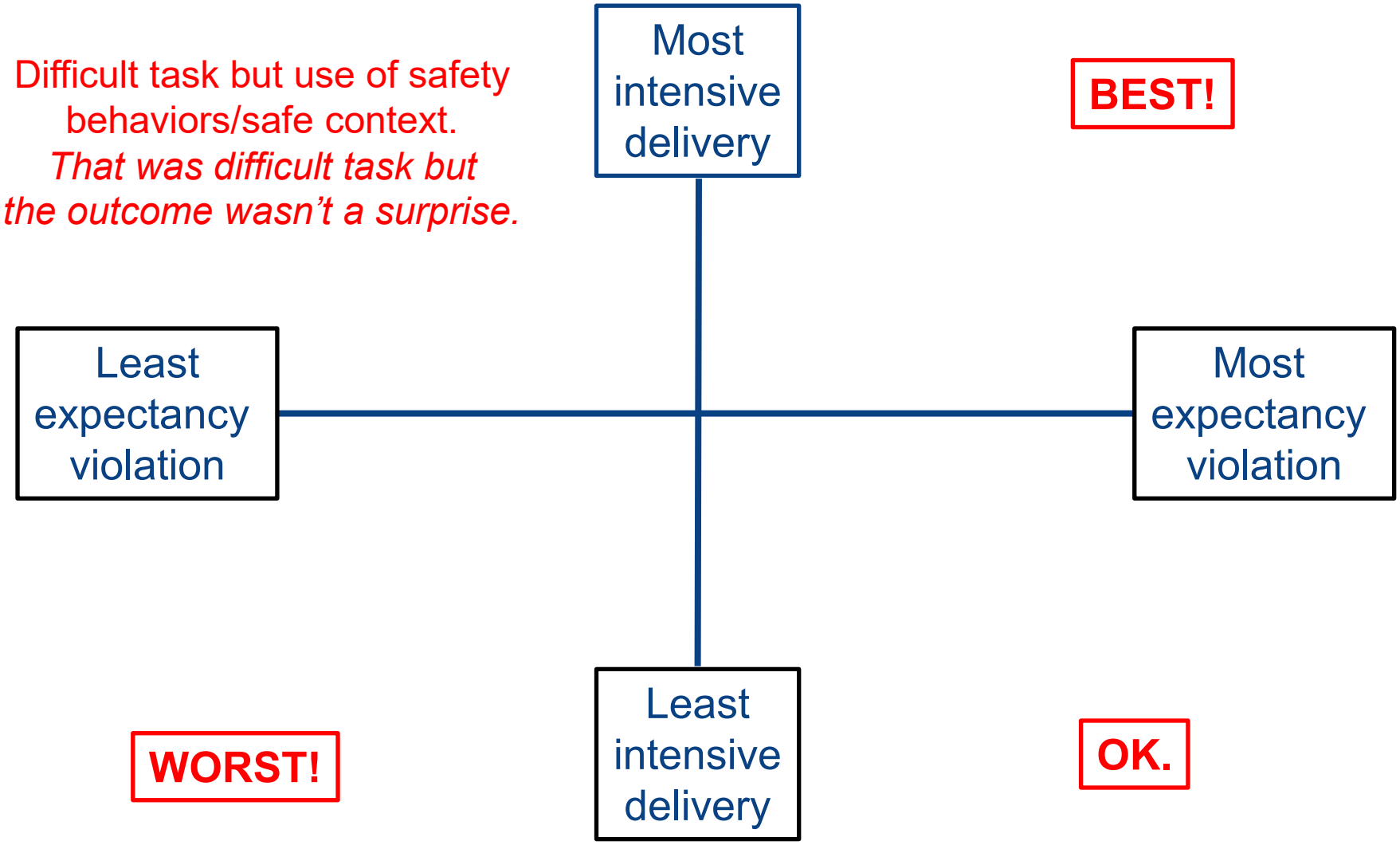
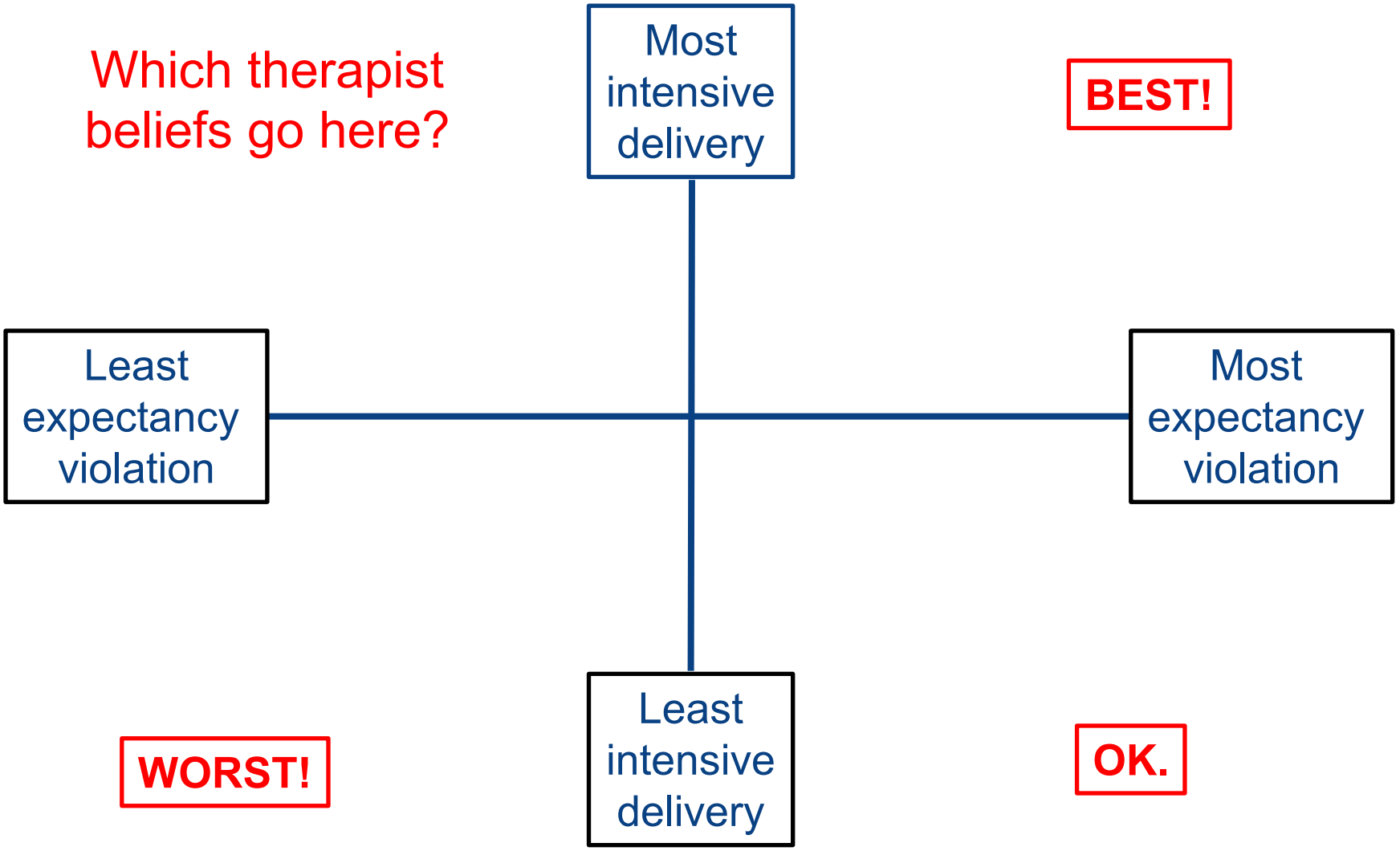


The 2x2 Exposure Table

Which therapist beliefs go here?



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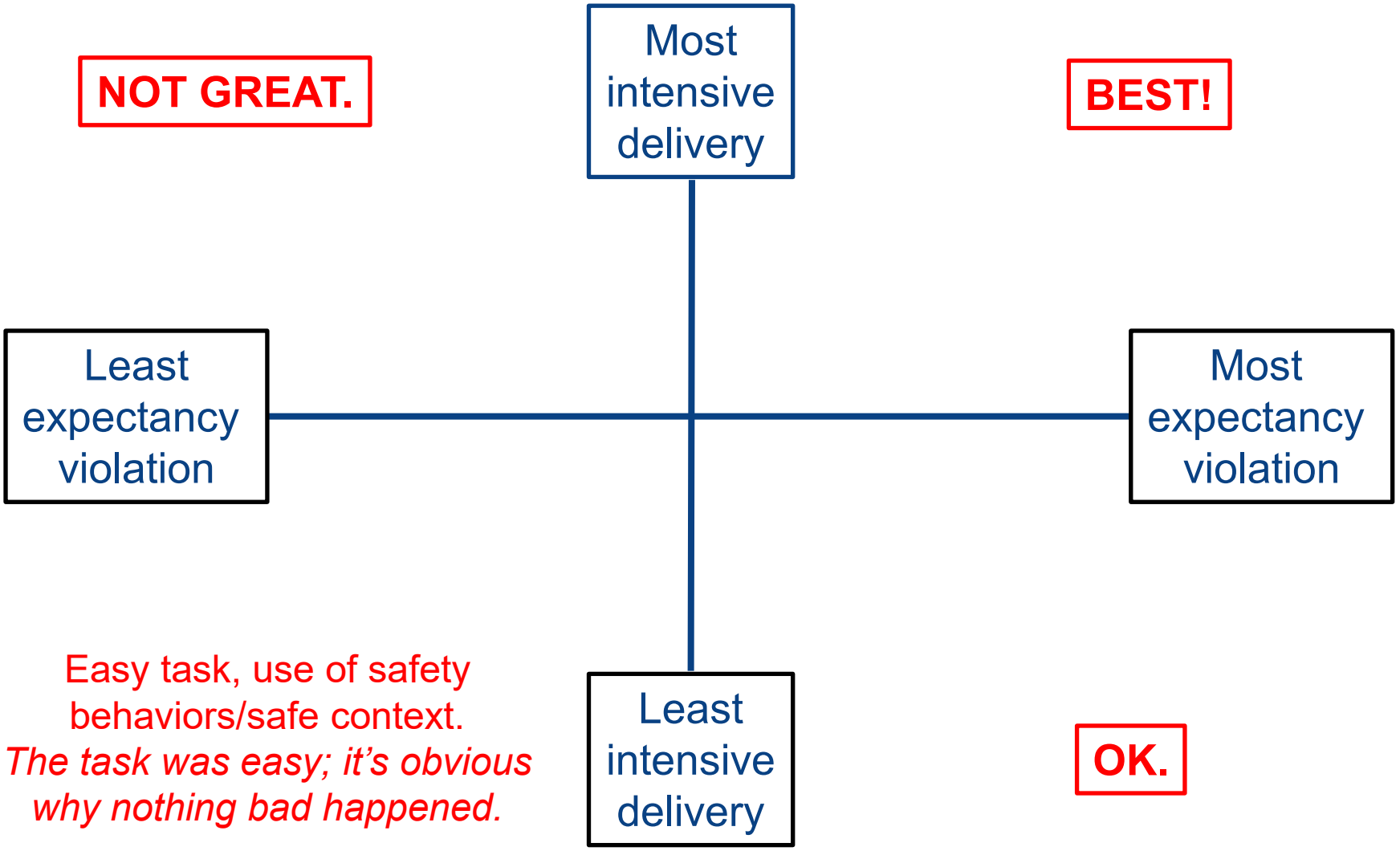

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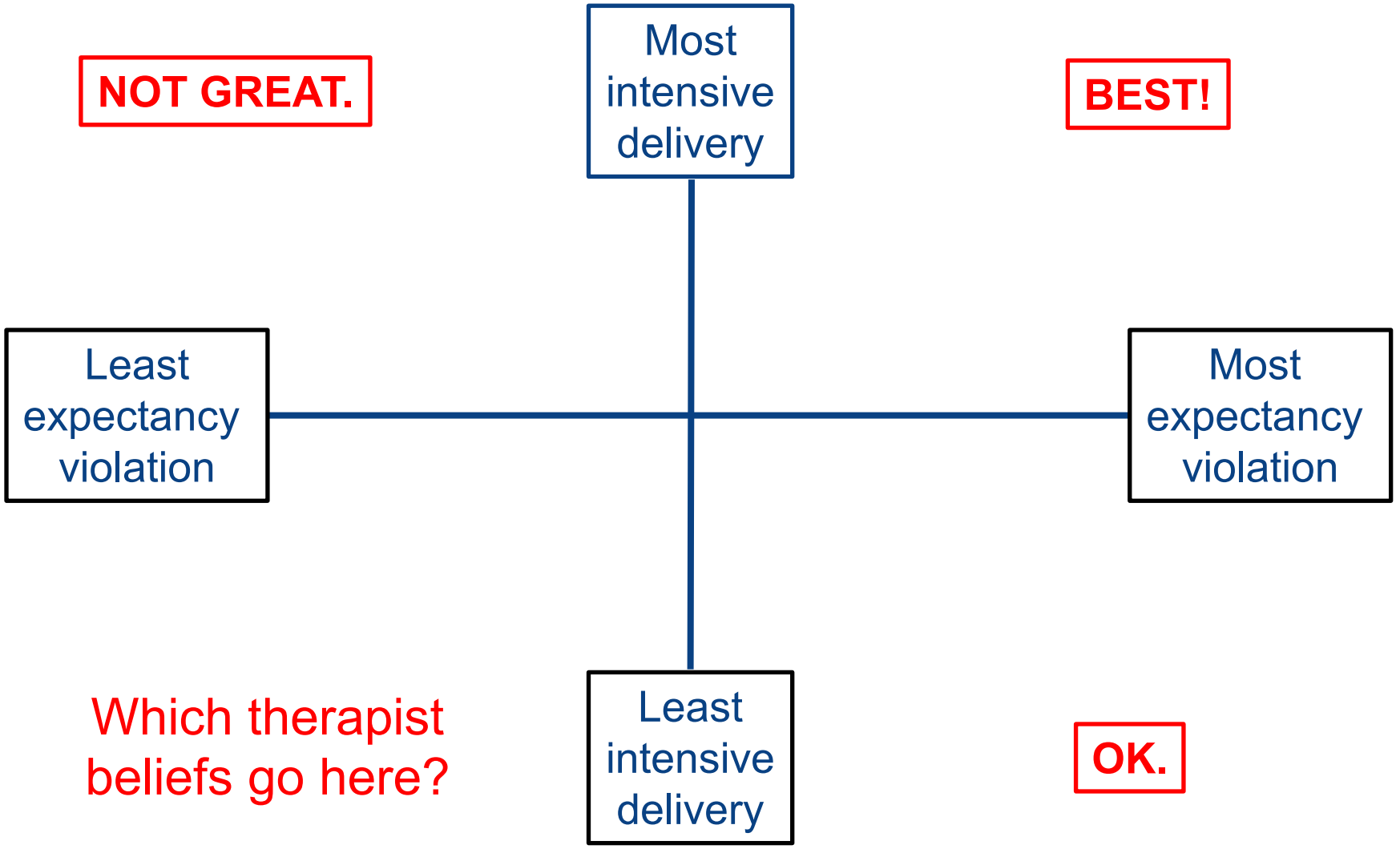


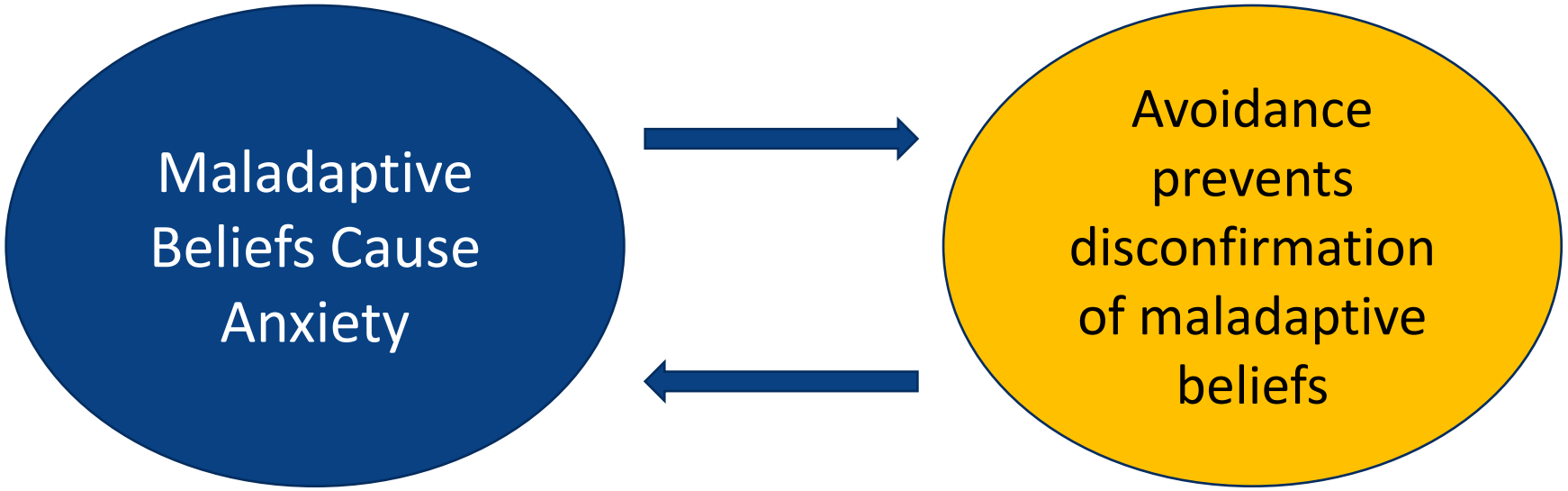
If Therapist Safety Behaviours Maintain Exposophobia…

- How can exposophobia be “treated?”
- “Exposure to exposure” without using safety behaviours!
- Creates new learning for you and helps your clients in the process.

Benefits of Exposure to Exposure

- Academic knowledge only goes so far
- Comfort and confidence with exposure is principally learned through experience
  - We have 2 mental systems, and exposure to exposure is needed to engage your emotional system/gut/mind
- Just as our anxious clients do, we can *behave our way into a new belief system*

The Basic Anxiety Model Applies to Us as Well!



KEY TREATMENT TARGETS _ CATASTROPHIC BELIEFS AND AVOIDANCE

EXPOSURE THERAPY

Benefits of Exposure to Exposure

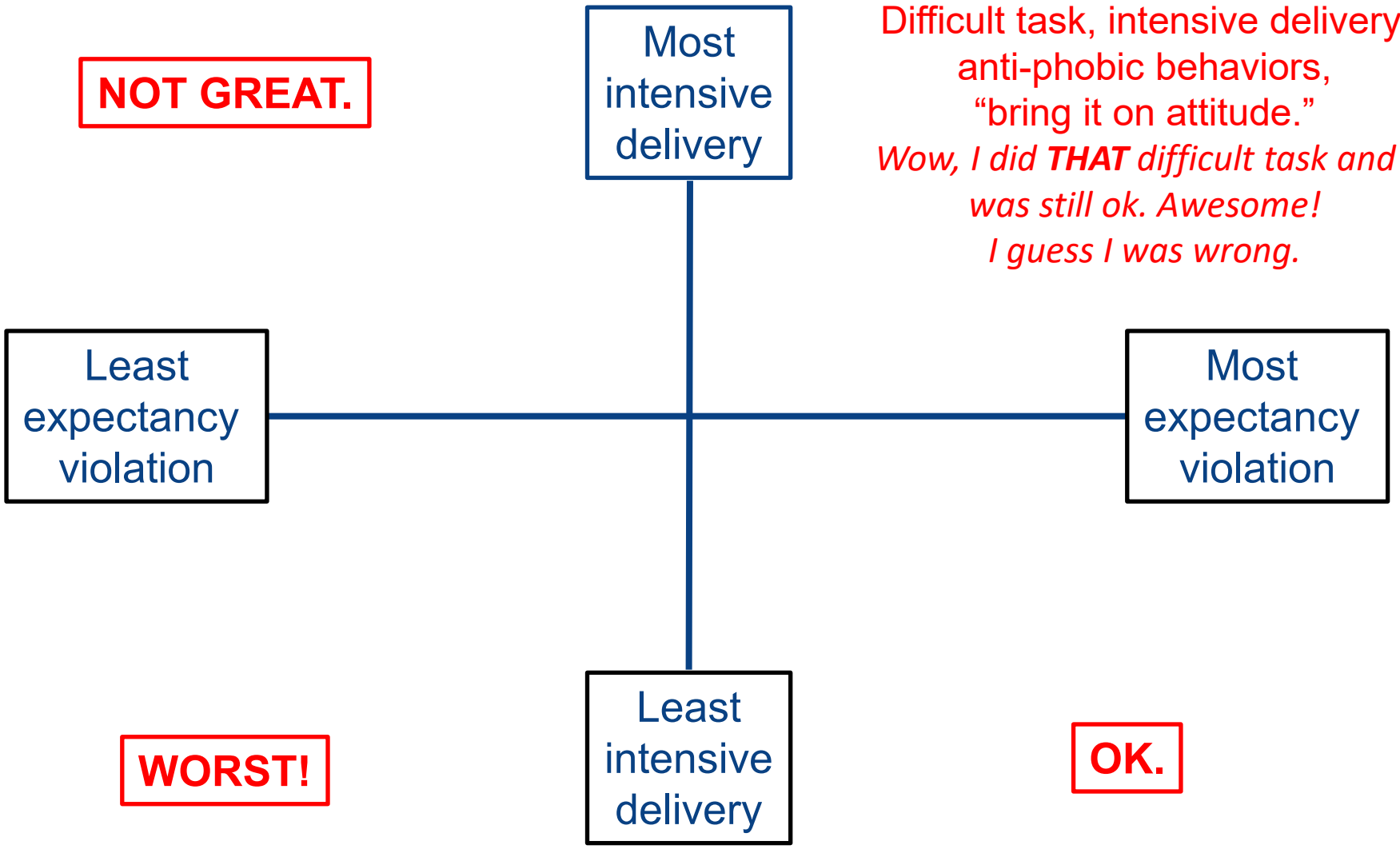
- Every exposure session with a client is one for you as well
- Reflect on your beliefs about exposure, anxiety, and anxious clients and the extent to which they may affect how you deliver exposure
- Create your own exposure plan and follow through
- If you know how to do exposure with clients, you know how to do it for yourself!

Benefits of Exposure to Exposure

- Note on our exposure therapy groups
- How I structured the group exposure tasks and paired this with therapist training
- The results

- An analogy: CrossFit

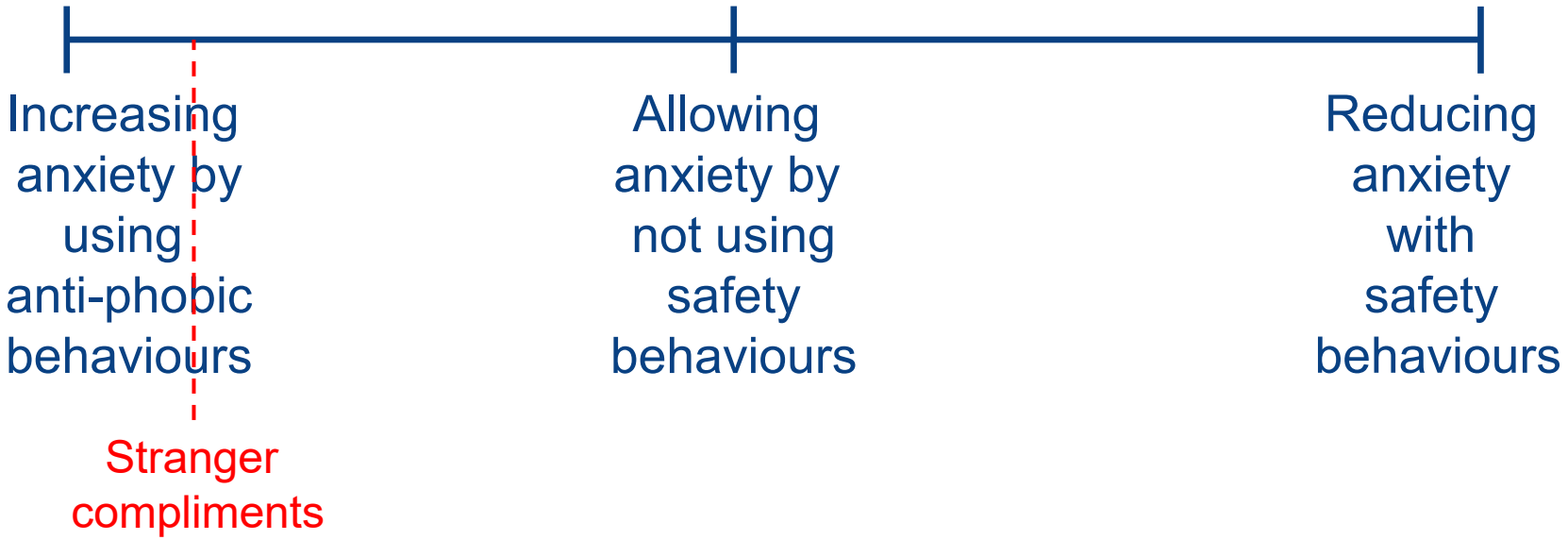
The 2x2 Exposure Table



Slide from Our Exposure Group: Bringing it on in Exposure

- Asking strangers for compliments

  https://www.youtube.com/watch?v=xBPdftU4syg



And Finally…Good News!

- Clients are less concerned about exposure than their therapists!

Client vs. Therapist Perceptions of Exposure Therapy: A Direct Comparison

- Participants:
- Therapist sample (*N* =192)
- Client sample (*N* = 104)
  - Undergoing intensive residential ERP for at Rogers Memorial Hospital in the US
  - All with primary diagnosis of an anxiety disorder (mostly OCD) and high levels of severity
  - Mean # days in exposure therapy =14.7 (*SD* = 8.4)

Riemann, B. Deacon, B. J., Farrell, N. R., & Kinnear, K. (2014, November). Myth #4: Patients participating in exposure perceive treatment as unethical, intolerable, and harmful. In Farrell, N. R., & Kemp, J. J. (Chairs), *Myth-busting exposure therapy for anxiety.* Symposium presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, Nashville, TN.

Demographics

GROUP	AGE	GENDER	ETHNICITY
THERAPISTS	48.8 (12.0)	62.0% FEMALE	87.5% CAUCASIAN
CLIENTS	28.5 (11.4)	52.8% MALE	83.1% CAUCASIAN

Measuring Client Perceptions of Exposure

- Administered the Client Beliefs about Exposure Scale (CBES)
  - 15-item measure, items scored 0 – 4 (disagree strongly, disagree, unsure, agree, agree strongly)
  - Range of 0 – 60 (higher score = more concerns)

Measuring Client Perceptions of Exposure

1. “I have difficulty tolerating the distress exposure therapy evokes”.
2. “Exposure therapy interferes with my ability to form a good working relationship with my therapist”.
3. “Exposure therapy is not helpful because it does not address the root cause of my anxiety disorder”.
4. “I feel uncomfortable conducting exposure therapy sessions outside the office with my therapist, even if deemed necessary to confront a feared situation”.
5. “Exposure therapy is too constraining; it prevents me from being able to choose what to talk about during therapy sessions.

Measuring Client Perceptions of Exposure

6. “I will drop out of therapy because it is difficult for me to tolerate the distress exposure therapy evokes”.
7. “It is unethical for exposure therapists to temporarily evoke distress in their clients in order to promote improved long-term mental health”.
8. “I fear that I will lose mental and /or behavioral control during highly anxiety-provoking exposure therapy sessions”.
9. “Conducting exposure therapy sessions outside the office endangers my confidentiality”.
10. “Exposure therapy has caused my anxiety problems to worsen”.

Measuring Client Perceptions of Exposure

11. “It is not necessary for me to directly confront feared situations in order to overcome my anxiety problems”.
12. “Exposure therapy places me at a greater risk of harm than other psychotherapies in which clients do not directly face their fears”.
13. “Exposure therapy is inhumane”.
14. “I will refuse to participate in exposure therapy”.
15. “I fear that I may experience physical harm caused by my own anxiety (e.g., loss of consciousness) during highly anxiety-provoking exposure therapy sessions”.

Measuring Therapist Perceptions of Client Perceptions

- Same measure
- Instructions: “Answer each item according to HOW YOU THINK THE AVERAGE INDIVIDUAL WITH AN ANXIETY DISORDER WOULD RESPOND. In other words, do not provide the answer that applies to you, but rather click on the answer that you think would be provided by the average individual with an anxiety disorder.”

Results

GROUP	RELIABILITY	MEAN (SD)	RANGE
THERAPISTS	α = .92	28.3 (9.6)* *p* < .001	1 - 59
CLIENTS	α = .88	12.1 (8.5)	0 - 30

Results and Discussion

- Therapist scores were not significantly correlated with age or gender
- Client scores were not significantly correlated with age, gender, or days in therapy (p = .72)

- Take home message: relax. Clients find exposure to be much more acceptable, safe, tolerable, and ethical than most of us expect.

If Therapist Safety Behaviours Maintain Exposophobia…

- How can exposophobia be “treated?”
- “Exposure to exposure” without using safety behaviours!
- Creates new learning for you and helps your clients in the process.

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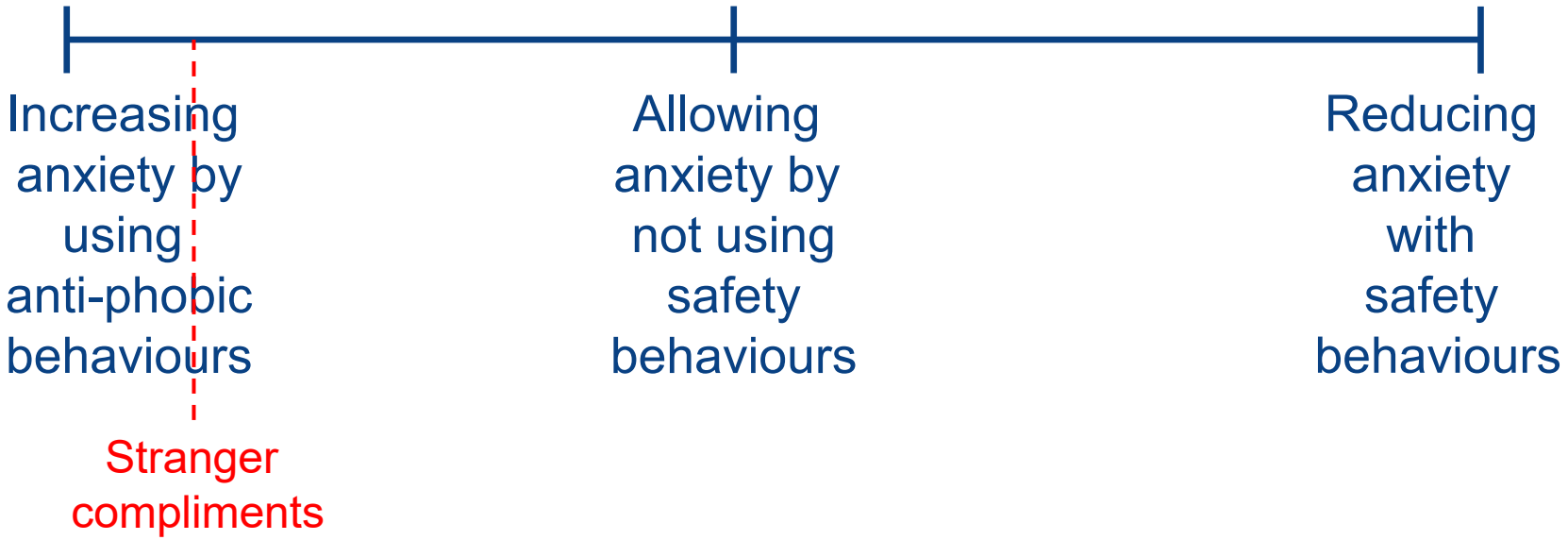

Benefits of Exposure to Exposure

- In the spirit of exposure to exposure, let's give it a go!
- Pair up with a new person
- The task
- Needs to be timed: bring your phone

- What's at stake

Final Exercise

- Reflections

Thank You!

- I welcome your questions!

- Email: brett.deacon@unimelb.edu.au