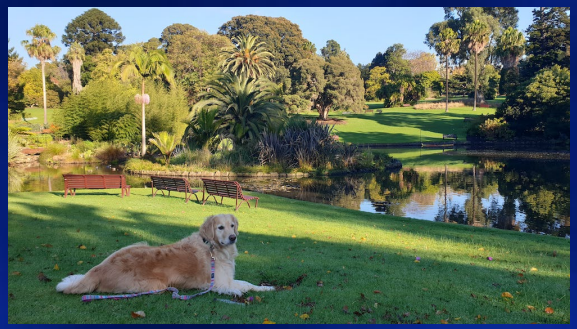
The Diagnosis and Treatment of Exposaphobia

(Or, Why Clinicians Dislike Exposure Therapy and What to Do About It)

Brett Deacon, Ph.D.

Associate Professor and Convener, Master of Psychology (Clinical) Program, University of Melbourne

Thank You!



Exposure Therapy for Anxiety

- Based on cognitive-behavioral theory
- Direct exposure to feared stimuli
- Safety behaviors faded and eliminated
- Typically graded approach based on hierarchy
- Practiced in a variety of contexts
- May be combined with CBT procedures/drugs

Abramowitz, Deacon, & Whiteside (2019). *Exposure therapy for anxiety: Principles and practice (2nd ed.).* New York: Guilford Press.

Common Applications of Exposure

- Social anxiety: prescribing social interactions
- Panic disorder: inducing body sensations
- Agoraphobia: riding a bus, driving over a bridge
- PTSD: reliving traumatic experiences
- Phobias: holding a spider, having blood drawn
- OCD: touching contaminants, confronting UITs

Efficacy of Exposure Therapy

- Recommended first-line treatment for anxiety disorders in clinical guidelines (e.g., NICE, APA)
- Most evidence-based CBT approach to anxiety
- Exposure is most effective when delivered in an anxiety-increasing (intensive) manner that optimizes inhibitory learning

The Good News

- Exposure works!
- It's an ideal therapy: powerful, efficient, parsimonious, straightforward, easy to deliver
- Exposure for anxiety is one of the great success stories in the history of mental health treatment

Exposure Therapy in Action: What We Show Our Students in Class








See How Well It Works!








But Wait a Minute…




???




This is MUCH Harder than it Looks!




Exposure-compatible belief system

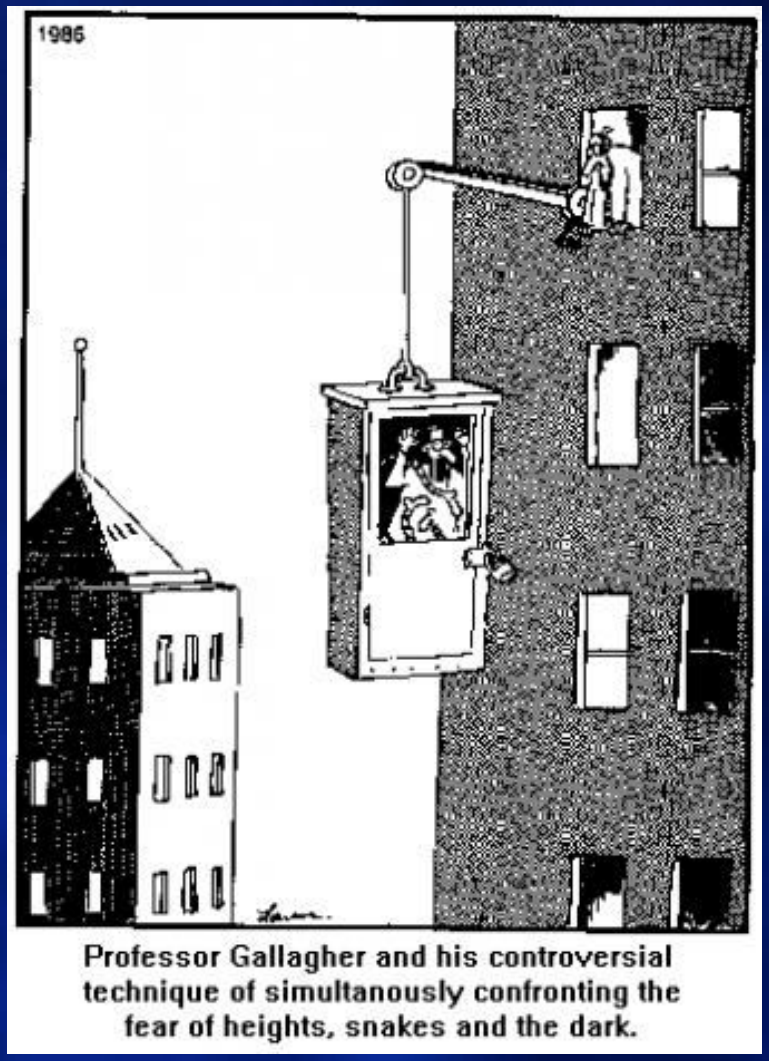



Unique Therapist Requirements

- Belief that asking clients to experience high anxiety is safe, tolerable, and ethical
- Belief that clients have the capacity to withstand their own high anxiety
- 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!

“The Cruelest Cure”

(Slater, 2003, New York Times, p. 3)

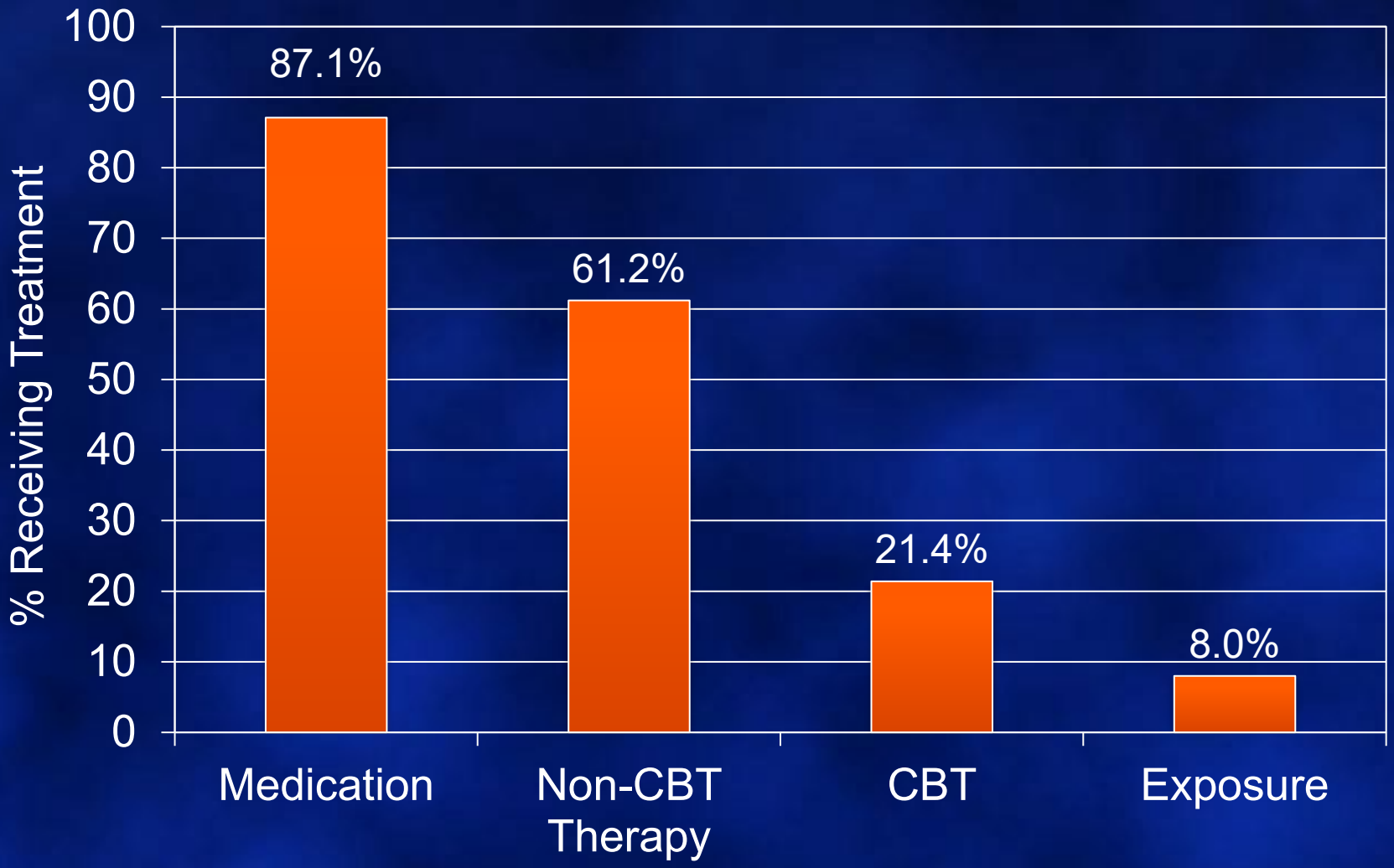


Professor Gallagher and his controversial technique of simultanously confronting the fear of heights, snakes and the dark.

The Bad News: Dissemination Failure

- Two dissemination failures:
  - 1. Clinicians rarely deliver exposure therapy
  - 2. When they do, it is often delivered suboptimally
- Treatment-seeking anxious clients rarely receive exposure therapy

Dissemination Failure in the US



N = 201 in Los Angeles County Adult Outpatient Psychiatry Clinic. Wolitzky-Taylor et al. (under review). *Has evidence-based psychosocial treatment for anxiety disorders permeated usual care in community mental health settings?*

Dissemination Failure in the Netherlands

- 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.

Dissemination Failure in the Netherlands

- "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.

Sources of Dissemination Failure?

- A parsimonious explanation: *many clinicians do not like exposure therapy*
- According to a 2023 systematic review and meta-analysis, the following are evidence-based causes of low use of exposure:
  - Lack of training
  - Non-CBT theoretical orientation
  - Negative beliefs about exposure

Langthorne, D., Beard, J., & Waller, G. ()2023). Therapist factors associated with intent to use exposure therapy: A systematic review and analysis. *Cognitive Behaviour Therapy, 52,* 347-379.

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

Understanding Exposaphobia

- Our research on therapist negative beliefs about exposure
  - Nature
  - Correlates
  - Causes
  - Modification

Diagnosing Exposaphobia:
The Therapist Beliefs about Exposure Scale

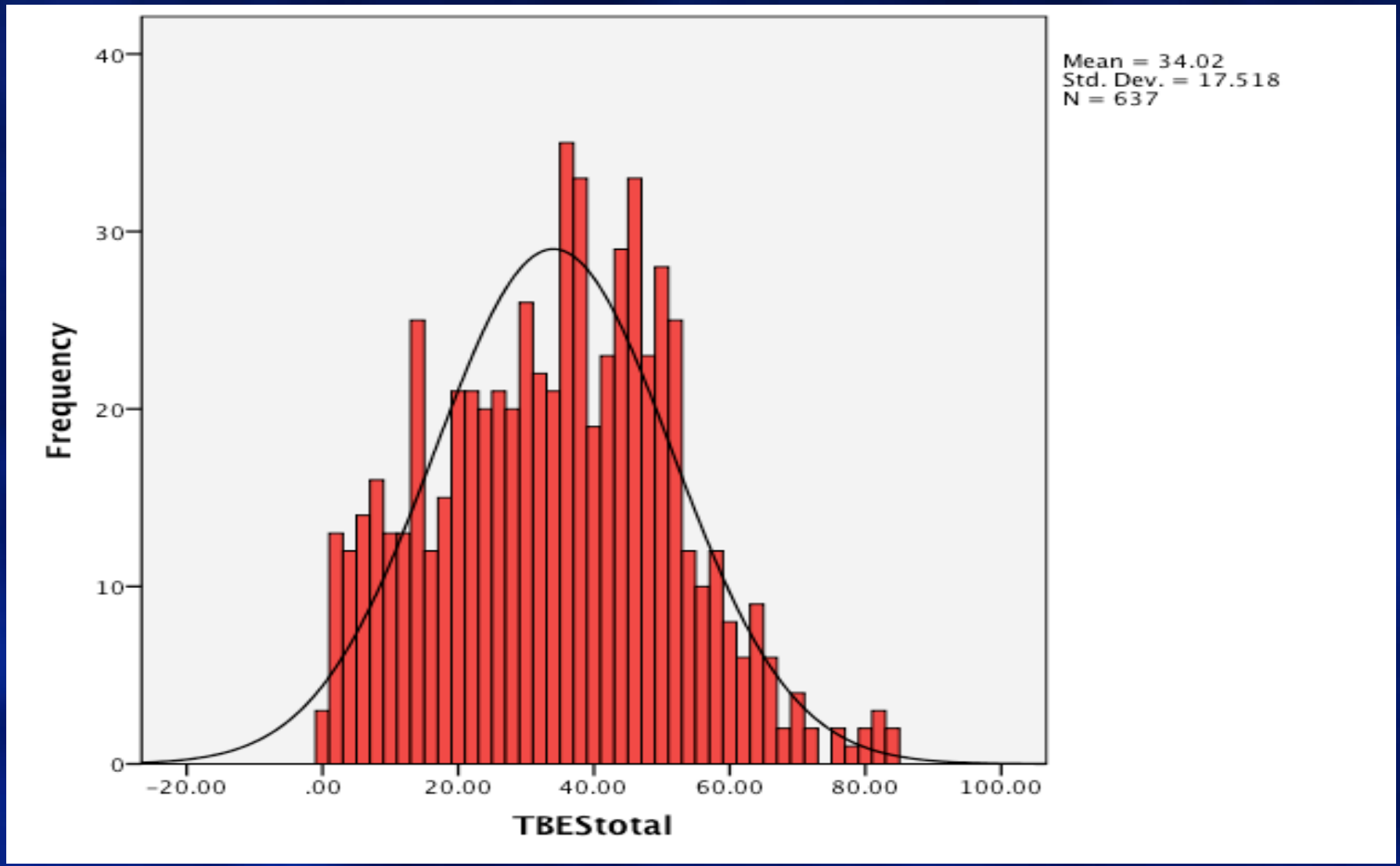
- Administered web-based survey to 637 American therapists who work with anxious clients
- Constructed 21-item TBES
  - *"Arousal reduction strategies, such as relaxation or controlled breathing, are often necessary for clients to tolerate the distress exposure therapy evokes."*
  - *"Most clients have 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.

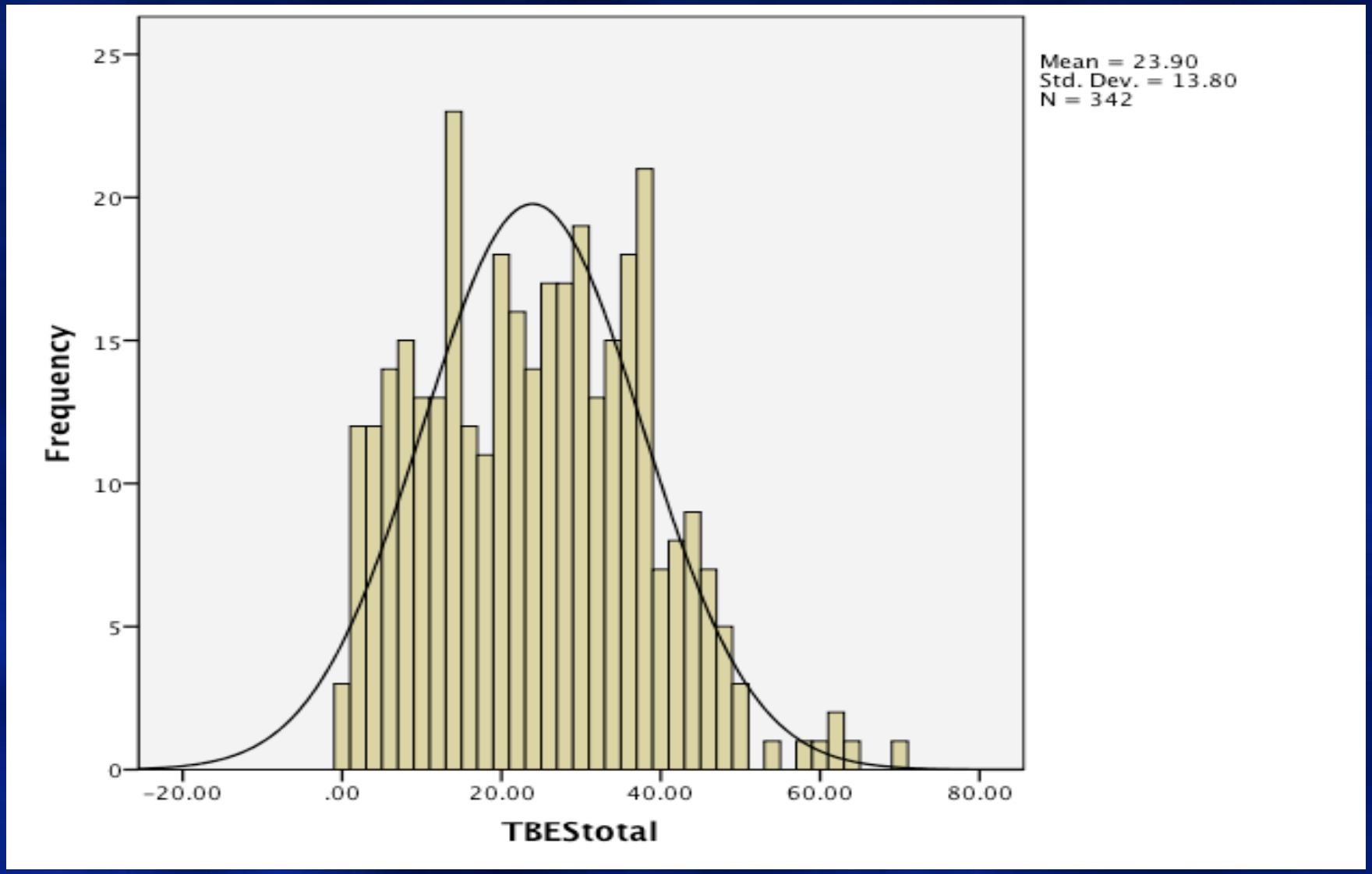
Therapist Beliefs about Exposure Scale

- 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



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.

Correlates of Higher TBES Scores

- Meehl (1973): Spun glass theory of the mind
- Belief that clients are fragile and will "break" if subjected to even minor distress
- Our 10-item Spun Glass Theory of the Anxious Mind Scale
  - *"People with anxiety disorders are emotionally fragile."*
  - *"People with anxiety disorders must be protected from becoming too anxious."*
  - *"Emotional distress is traumatic for people with anxiety disorders."*
- Correlation with TBES: r = .56

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

Do Negative Beliefs about Exposure Cause Suboptimal Delivery?

- How to test predicted causal relationship between negative beliefs about exposure and its unnecessarily cautious delivery?
- Our laboratory experiment
  - Hour-long video-based training, 2 conditions
  - Exposure session with an anxious “client”
  - Videos coded for therapist behavior

Farrell, Deacon, Kemp, Dixon, & Sy (2013). Do negative beliefs about exposure therapy cause its cautious delivery? An experimental investigation. *Journal of Anxiety Disorders, 27,* 763-771.

Do Negative Beliefs about Exposure Cause Suboptimal Delivery?

Farrell, Deacon, Kemp, Dixon, & Sy (2013). Do negative beliefs about exposure therapy cause its cautious delivery? An experimental investigation. *Journal of Anxiety Disorders, 27,* 763-771.

Do Negative Beliefs about Exposure Cause Suboptimal Delivery?

- Therapists in high TBES condition, vs. the low TBES condition (*ps* < .05):
  - Reported higher anxiety
  - Selected an easier exposure item
  - Spent more time using controlled breathing
  - Spent more time reassuring the client of safety
  - Spent more time distracting the client
  - Pushed the client less to approach the item
  - Were less interested in using exposure in the future

Farrell, Deacon, Kemp, Dixon, & Sy (2013). Do negative beliefs about exposure therapy cause its cautious delivery? An experimental investigation. *Journal of Anxiety Disorders, 27,* 763-771.

Exposaphobia Around the World

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

Dutch Exposaphobia

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.

Do Negative Beliefs about Exposure Cause Suboptimal Delivery?

- 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, D., Beard, J., & Waller, G. ()2023). Therapist factors associated with intent to use exposure therapy: A systematic review and analysis. *Cognitive Behaviour Therapy, 52,* 347-379.

If Exposure Therapists are Anxious…

- Do they use safety behaviours?
- Measured by the Exposure Therapy Delivery Scale Coping subscale
  - 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

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

Negative Beliefs and Safety Behaviors

- Sample: 98 Australian psychologists
- Administered TBES, ETDS Coping Exposure scale, and a measure about beliefs about these safety behaviors

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

Negative Beliefs and Safety Behaviors

- Correlation between total therapist safety behavior use (ETDS Coping Exposure scale) and TBES = .71
- Total therapist safety behaviour use was predicted (sr^2 = .34; p < .001) by beliefs they are necessary to protect the client (safe and tolerable), preserve the alliance, and ensure task adherence

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

Negative Beliefs and Safety Behaviors

- When therapists use anxiety-reducing strategies to manage anxiety during exposure, *whose anxiety is being managed*?

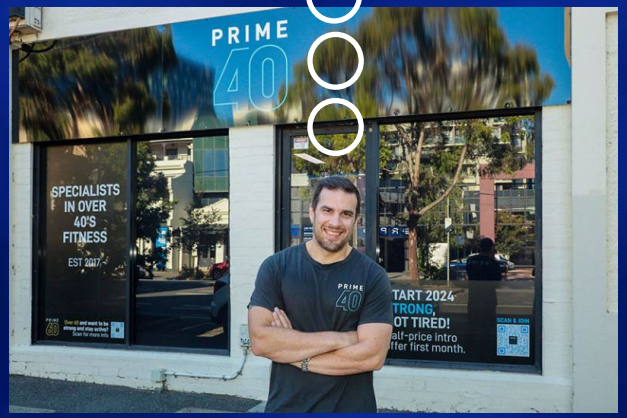
Meyer, J. M., Kelly, Peter J., & Deacon, B. J. (2020). Therapist beliefs about exposure therapy implementation. *The Cognitive Behaviour Therapist*, 13, 1-14.

If Personal Trainers Were Exposure Therapists…

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 60-second 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 workout at any time if you become too uncomfortable."

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



Key Questions

- To what extent do therapist negative beliefs about exposure reflect the lived experience of clients who participate in it?
- Existing research and limitations
- How can this be optimally studied?

Therapist vs. Client 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)

Pearse, S., Riemann, B., & Deacon, B. J. (2024). Negative beliefs about exposure therapy: A direct comparison between therapists and anxious clients undergoing intensive residential ERP. *Manuscript in preparation*.

Measuring Client Perceptions of Exposure

- Administered the Client Beliefs about Exposure Scale (PBES)
  - Modeled from the TBES
  - 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

- Sample items:
- “I have difficulty tolerating the distress exposure therapy evokes”.
- “Exposure therapy interferes with my ability to form a good working relationship with my therapist”.
- “It is unethical for exposure therapists to temporarily evoke distress in their clients in order to promote improved long-term mental health”.
- “I fear that I will lose mental and/or behavioral control during highly anxiety-provoking exposure therapy sessions”.

Measuring Therapist Perceptions of Exposure

- Same measure (CBES)
- 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 **Cohen's *d* = 4.04**
CLIENTS	α = .88	12.1 (8.5)	0 - 30

Take-Home Message

- Therapists generally believe that clients are moderately concerned about exposure therapy, which may cause failure to deliver exposure and/or overly cautious delivery
- Clients find exposure to be much more acceptable, safe, tolerable, and ethical than therapists expect
- Clinicians should be heartened by these findings!

Treating Exposaphobia

- Our client vs. therapist study is useful psychoeducation for correcting negative beliefs about exposure
- Complements large body of research showing:
  - High treatment acceptability
  - Similar attrition rates to other therapies*
  - Few adverse effects

Treating Exposaphobia: Reducing Therapist Concerns about Exposure

- *N* = 162 workshop attendees
- Presenters and workshop content
- Mean pre-workshop TBES = 33.1 (*SD* = 11.1)
- Mean post-workshop TBES = 17.3 (*SD* = 9.8)
  - $t(162) = 20.02$, $p < .001$, $d = 1.50$
- Non-exposure-using therapists demonstrated greater TBES change ($d = .72$)

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.

Optimizing Therapist Training

- Enhancing workshop training to reduce TBES
- Theory-based strategies for augmenting traditional training:
  - "Exposure for the exposer"
  - Defending position that exposure is safe, tolerable, and ethical (attitude inoculation)
  - Balancing empirical and emotional appeals
  - Mythbusting strategies outlined in the *Debunkers Handbook*

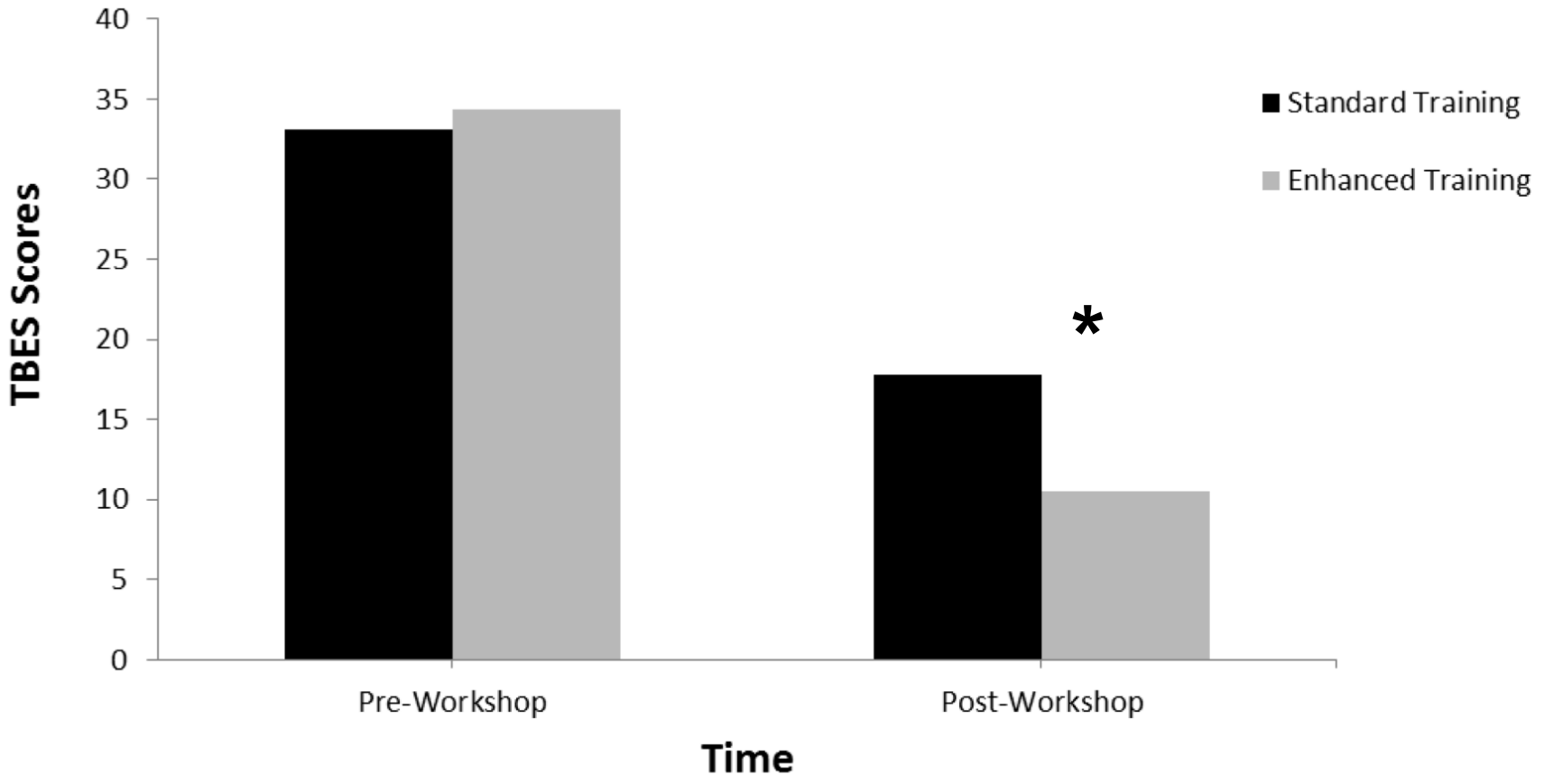
Farrell, Deacon, Dixon, & Lickel (2013). Theory-based training strategies for modifying practitioner concerns about exposure therapy for anxiety. *Journal of Anxiety Disorders, 27,* 781-787

Optimizing Therapist Training: Results from a Pilot Study

- 49 workshop attendees
- Assigned to 2 exposure therapy workshops
  - Standard training
  - Enhanced training
    - Negative beliefs highlighted, normalized, and countered with accurate "mythbusting" information, case examples, and video testimonials from former clients
    - 5-minute hyperventilation exposure

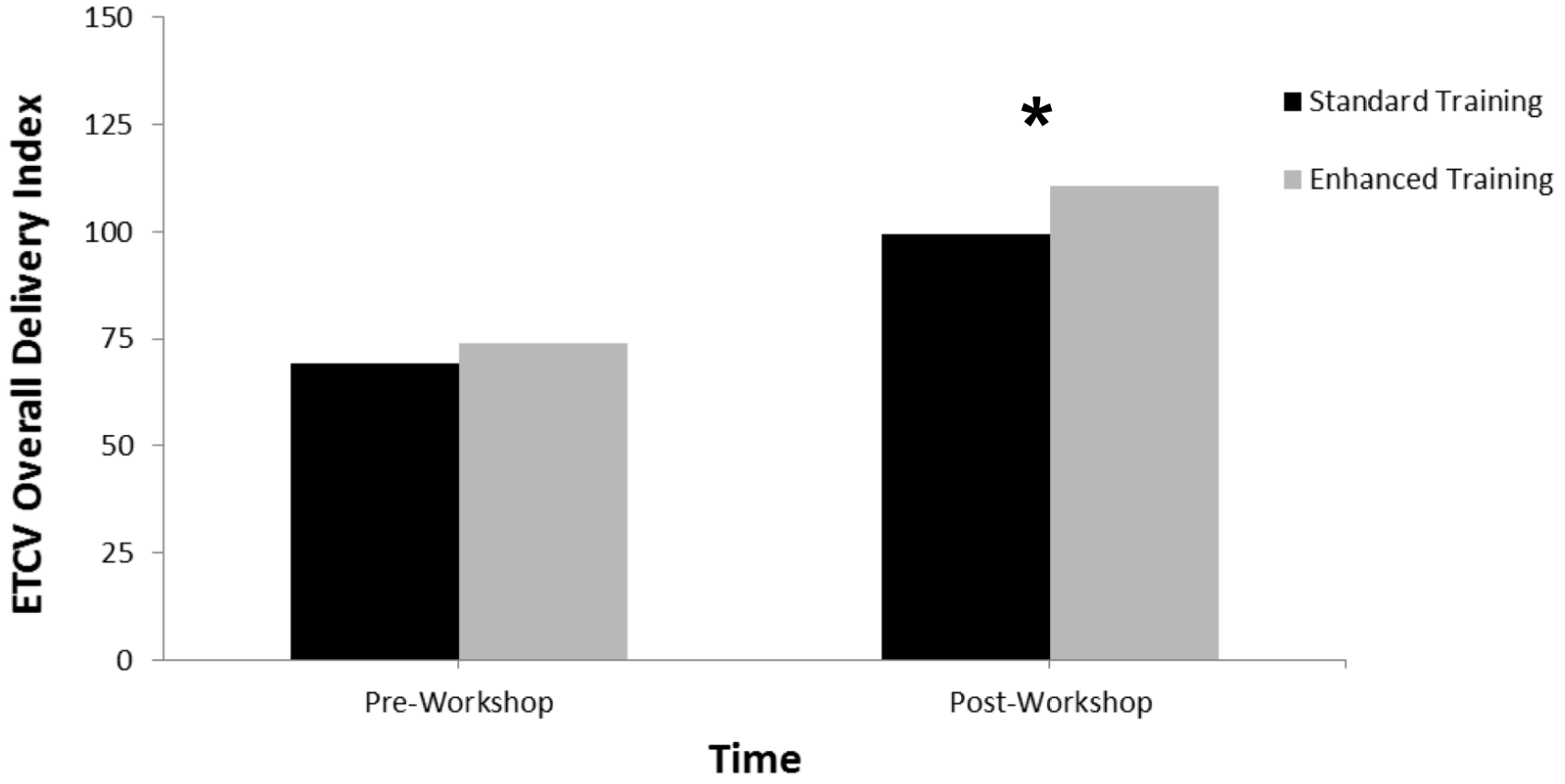
Farrell, N. R., Kemp, J. J., Blakey, S. M., Meyer, J. M., & Deacon, B. J. (2016). Targeting clinician concerns about exposure therapy: A pilot study comparing standard vs. enhanced training. *Behaviour Research and Therapy, 85,* 53-59

TBES Change Pre-Post Workshop



* d = .76, p = .01

Exposure Therapy Delivery Vignette Change Pre-Post Workshop



* *d* = .68, *p* = .02

Traditional Training is Not Enough

- Despite the value of accurate information and workshop-style training, a meta-analysis of more than 15 studies found that following participation in targeted exposure therapy training:
  - Knowledge increased significantly
  - *Actual use of exposure techniques with anxious clients did not*

Trivasse, H., Webb, T. L., & Waller, G. (2020). A meta-analysis of the effects of training clinicians in exposure therapy on knowledge, attitudes, intentions, and behavior. *Clinical Psychology Review, 80,* 101887.

“Exposure to Exposure”

- Conceptualizing trainees/clinicians as equivalent to anxious clients with maladaptive beliefs and associated avoidance behaviors
- Conceptualizing exposure training as “exposure to exposure”
- Structuring the process similar to exposure therapy with anxious clients

Kemp, J., Benito, K., Herren, J., Brown, Z., Frank. H. E., & Freeman, J. (2023). Exposure to exposure: A protocol for leveraging exposure principles during training to address therapist-level barriers to exposure implementation. *Frontiers in Psychiatry, 14,* 1096259.

Exposure to Exposure Example Training Curriculum

- 1. Complete self-report measures (TBES)
- 2. Didactic training (classroom, workshop)
- 3. Create hierarchy of self-relevant exposure tasks
- 4. Complete at least 3 trials of self-exposure, then practice with partner taking turns in client/therapist roles

Kemp, J., Norris, L. A., Fenley, A., Kidd, A., Mamaril, E., Herren, J., Freeman, J., & Benito, K. (in press). Evaluating the relationship between therapist negative beliefs about exposure and delivery behavior. *Cognitive and Behavioral Practice.*

Exposure to Exposure Example Training Curriculum

- 5. Deliver exposure with anxious clients while testing specific anxious beliefs (e.g., using anxiety-increasing behaviors will prove intolerable for the client)
- 6. Plan an upcoming exposure session and approach it as a formal behavioral experiment with reflections before, during, and after

Kemp, J., Norris, L. A., Fenley, A., Kidd, A., Mamaril, E., Herren, J., Freeman, J., & Benito, K. (in press). Evaluating the relationship between therapist negative beliefs about exposure and delivery behavior. *Cognitive and Behavioral Practice.*

The Exposure Guide

- Used to support quality monitoring
- 4-page guide, takes 2-5 minutes to complete after each exposure session
- Prompts therapists to reflect on exposure preparation in session, therapist behaviors during exposure, postprocessing the outcome, and the exposure overall
- Anchored in theory that anxiety up = good, anxiety down = bad

Benito et al. (2021). Improving delivery behaviors during exposure for pediatric OCD: A multiple baseline training trial with community therapists. *Behavior Therapy, 52,* 806-820.

The Exposure Guide

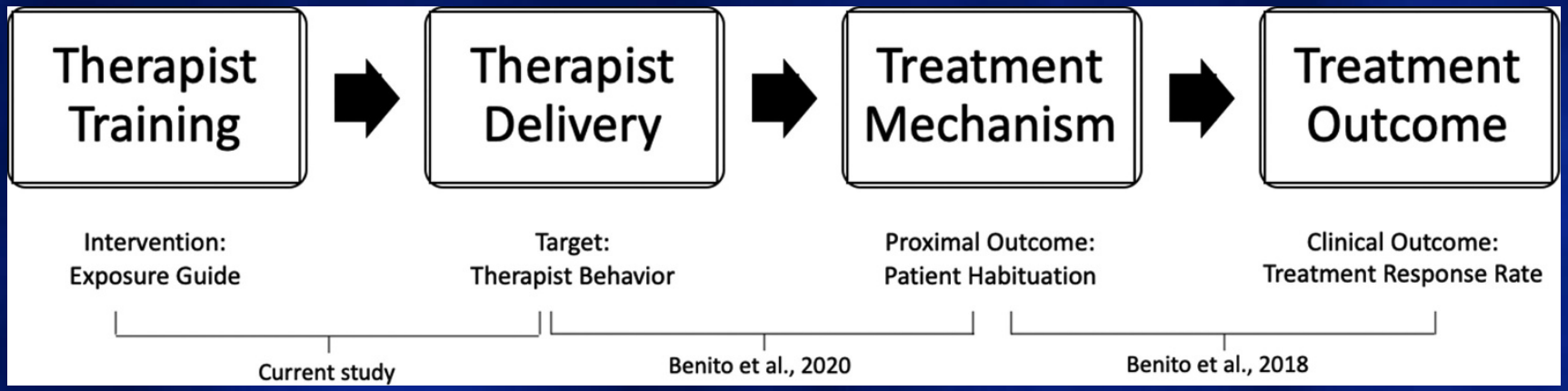
Table 2. Therapist behaviors included in the exposure guide (EG) and exposure process coding system (EPCS).

Behavior	Definition
Fear increasing[a]	
Encourage approach	Facilitates contact with the exposure, including redirection to the task (e.g., "Keep looking at the video"), discouraging avoidance/rituals (e.g., "Try to resist asking for reassurance"), requests to describe fear content (e.g., "What are the worries saying?"), discussion of the stimulus (e.g., "The trash can is out").
Intensify	Changes the exposure task to make it more difficult (e.g., contaminant on both hands instead of one) or makes a statement likely to increase fear by providing new relevant information (e.g., "This carpet hasn't been washed in forever") or opinion (e.g., "Wow, that is *a lot* of vomit").
Reduce parent accommodation	Discourages family accommodation during the exposure; either independent of or in response to-actual occurrence of accommodation (e.g., "Your mom is going to resist answering questions").
Fear decreasing[a]	
Accommodation	Changes the exposure task to make it less difficult (e.g., instructs decrease contact with the stimulus) or makes a statement likely to decrease fear by providing new relevant information (e.g., "I eat this all the time and nothing bad happened to me") or opinion (e.g., "I think you'll be ok").
Unrelated talk	Engages in talk not related to the current exposure and could serve to decrease focus on the exposure task. Content may be general (e.g., "What are you guys up to this weekend?") or include CBT components with limited relevance for patient experience in current task (e.g., planning homework).
Encourage relaxation	Encourages relaxation techniques, such as deep breaths, muscle relaxation, or pleasant imagery (e.g., "Remember how to control your breathing?").
Fear neutral[b]	
Teaching	Therapist provides information about a CBT principle or symptom that relates to the current exposure
Externalizing	Therapist refers to OCD or anxiety as being separate (e.g., "You're the boss of Mr. Worry").
Changing anxious thoughts	Therapist leads the child to use a cognitive or coping strategy to manage fear during the exposure (e.g., evaluating the likelihood of a feared consequence, using coping statements).

Benito et al. (2021). Improving delivery behaviors during exposure for pediatric OCD: A multiple baseline training trial with community therapists. *Behavior Therapy, 52,* 806-820.

Exposure to Exposure Using the Exposure Guide

- Promising data from several small N studies



Benito et al. (2021). Improving delivery behaviors during exposure for pediatric OCD: A multiple baseline training trial with community therapists. *Behavior Therapy, 52,* 806-820.

In Closing

- Exposaphobia is a principal cause of our failure to routinely provide anxious clients with the most effective therapy for their issues
- Concerns about exposure are common among even exposure therapists, powerfully influence their delivery, and almost certainly worsen client outcomes

In Closing

- Traditional didactic training has produced a majority of therapists with negative attitudes toward exposure who deliver it suboptimally or eschew it in favor of less evidence-based alternatives
- “Exposure to exposure” that mirrors the process of effective exposure therapy for anxious clients is a promising method for effectively treating exposaphobia

In Closing

- This is an exciting area of emerging research with significant implications for therapist training and client outcomes
- Please join me!

Thank You!

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