Mental Health Evidence-Based Therapeutic Intervention

Exposure Therapy: A Literature Review and Efficacy Analysis

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Introduction

Exposure therapy is a therapeutic intervention that has evidence-based demonstrations of being effective in treating a range of mental health problems. It is a form of cognitive behavioral therapy (CBT) and has several variations. Exposure therapy was first successfully used to treat anxiety disorders and phobias to help people confront their fears but has also been helpful more recently in the treatment of posttraumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), and eating disorders (ED).

The American Psychological Association (APA, n.d.) classifies several variations of exposure therapy, with the two main ones being *in vivo exposure* (IVET) where a patient faces a feared object, activity, or situation in real life and *virtual reality exposure* (VRET), which uses technology to recreate the traumatic memory or problematic situation. The purpose of this paper is to explain exposure therapy and the theories and components of this therapeutic intervention, to provide evidence of the efficacy of exposure therapy by reviewing evidence-based studies from academic literature, and to reflect on this type of intervention in my future practice.

Theories

The prevailing theory behind exposure therapy has been the emotional processing theory (Weisman & Rodebaugh, 2018). This theory proposes that fear is activated through networks that include information about the feared stimulus, any escape or avoidance reactions to it, and the meaning of the threat or fear. When this fight or flight fear still persists even when there are not any clear signs of danger, then the fear can become problematic and interfere with functioning. Chronic avoidance of a situation can leave these associations in place because people do not remain in a situation long enough

for new learning, or emotional processing to occur. The emotional processing theory proposes that repeatedly exposing a person to their fear can alter the relationships between the fear trigger(s) and these cognitive networks through *habitation*, or staying in contact with the feared stimulus long enough until there is a reduction in anxiety.

A more recent theory behind exposure therapy is the inhibitory learning theory, which is grounded in the principles of extinction and memory (Weisman & Rodebaugh, 2018). It emphasizes tolerating the fear rather than replacing it and that old fear-based learning is not erased by extinction but is tolerated by new learning that can inhibit the expression of the fear (Chesham, Malouff, & Schutte, 2018).

Basic Components

The goal of exposure therapy is to confront the feared stimuli with repeated presentations and engage with it until the fear is resolved. I recently read two different interpretations of the word **F-E-A-R**. The first is to **F**orget **E**verything **A**nd **R**un. The other strategy is to **F**ace **E**verything **A**nd **R**ise and has the same philosophy as exposure therapy. Exposure therapy does not work in every situation. But substantial research supports and documents the efficacy of exposure-based therapy in most interventions (Blakey et al., 2019).

An intervention using exposure therapy begins with psychoeducation and involves a therapist helping a client create a fear hierarchy that ranks the feared objects, activities, or situations in order of difficulty. The hierarchy begins with mild exposures and progresses to more challenging ones (See Appendix B). Using in vivo exposure therapy, the client will engage with the real feared stimulus while receiving emotional support from the therapist. The exposure is normally gradual, starting with mild or

moderate stimuli. Sometimes the process of "flooding" is used, when the exposure starts with the most difficult tasks first, but this is rare. Safety behaviors, which are actions used by the client to prevent, escape from, and reduce the severity of the perceived threat from the exposure, are usually removed during the therapy (Blakey et al., 2019). The core feature of exposure therapy is confronting the feared stimuli or situation repeatedly and with a prolonged confrontation (habitation) in order to allow for the reduction in anxiety. A strong therapeutic alliance between the clinician and the client has been found to help facilitate change (Capaldi, Asnaani, Zandberg, Carpenter, & Foa, 2016).

In some instances the feared object, activity, or situation is not easily accessible for the clinician, such as in cases of fear of flying, or it may be difficult to manipulate and control the environment, such as a public speaking audience. Virtual reality exposure therapy (VRET) began to be used in the 1990s and offers advantages over the traditional way. This type of exposure therapy is conducted by a trained therapist in a private, safe, and controlled environment (Chesham, Malouff, & Schutte, 2018). VRET provides a simulated visual and auditory experience that is immersive by creating a computer-generated environment (Lindner et al., 2017). After meeting with the client and determining their course of treatment, the therapist covers the client's eyes with a head mounted display with optical lenses and a separate display for each eye to create stereoscopic depth (Linder et al., 2017). Virtual technology is programmable, and the environments can be custom-made to fit a client's specific anxiety, phobia, or situation. The images on the displays are updated by a computing unit that is triggered by the client's head movements, which are captured and relayed by sensors. The therapist can control verbal interactions during VRET and can manipulate certain scenarios'

characteristics, such as the dialogue style being friendly or unfriendly, the genders and even gestures of the virtual humans, and the dialogue topic's degree of personal relevance (Kampmann, Emmelkamp, & Morina, 2019). VRET may be useful for clients who are reluctant to participate in IVET, but it is limited by the high cost of the virtual reality software (Grochowska, Jarema, & Wichniak, 2019).

A study was conducted with PTSD clients to compare IVET treatment to a VRET intervention (McLay et al., 2017). The results of this research showed that PTSD symptoms improved with both interventions, with no statistically significant differences between the two groups. A meta-analysis by Chesham et al., (2018) also found no difference in efficacy between the two variations of exposure therapy.

Literature Review

Anxiety Disorders

Anxiety disorders are some of the most common mental disorders, having an estimated lifetime prevalence of about 29%, and exposure therapy has been found to be a very effective therapeutic intervention for them (Lindner et al., 2017). Exposure therapy is often associated with fears and phobias. Once recent study with clients who had acrophobia, or a fear of heights, used exposure therapy and found evidence that it helped clients overcome this fear (Donker, Van Esveld, Fischer, & Van Straten, 2018). Other research with exposure therapy was conducted on people with spider phobias. Using an increased number of and longer duration of sessions led to large improvements to behavioral symptoms (Blakely et al., 2019). An exposure therapy study with those who fear driving- which is a specific phobia characterized by an intense, persistent fear of driving when one anticipates or is exposed to driving stimuli- resulted in a decrease in the

frequency of distorted thoughts and anxiety scores (da Costa, de Carvalho, Ribeiro, & Nardi, 2018). Using a fear hierarchy, this study of exposure therapy began with an initial session of getting a drivers license and gradually increased the fear stimulus to a final session of a crowded street with a traffic jam, a tunnel, and road construction.

One of the most widely reported areas of exposure therapy research is with clients who have a social anxiety disorder. Public speaking anxiety is a common condition that can be effectively treated with exposure therapy (Anderson, Edwards, & Goodnight, 2017; Lindner et al., 2019). One study in particular used VRET with eight exposure exercises of different public speaking tasks of increasing severity (Lindner et al., 2019). Each three-hour session began with the therapist giving instructions and extracting catastrophic beliefs from the participant that could be tested during the exposure. The participant would do the VRET speaking task and then evaluate it afterwards with the therapist while listening to an audio recording of their speech, using mental imagery to help them imagine themselves in the third person. The goal was to disprove the catastrophic beliefs that the client had previously. This was then followed by IVET exposure. Their findings concluded that both VRET and IVET were efficacious for public speaking anxiety (Lindner et al., 2019). An additional meta-analysis of the efficacy of exposure therapy for general social anxiety also found that it was effective and essentially showed no difference between IVET and VRET exposure (Chesham et al., 2018).

Post-traumatic Stress Disorder

After initially being used for anxiety disorders, exposure therapy has been widely used in treating PTSD in more recent years. Exposure to the traumatic memory is the

common denominator for nearly all interventions for PTSD (Peri, Gofman, Tal, & Mashiach, 2015). Multiple studies have found exposure therapy to be an effective treatment for PTSD (Motraghi, Seim, Meyer, & Morissette, 2014; Capaldi et al., 2016; McLay et al., 2017; Nirdam & Vermetten, 2018; Thorp et al., 2019).

One interesting study used the behavioral response of approaching (rather than avoidance) as an added component of exposure therapy for PTSD by having patients walk on a treadmill before and during their treatments (Nijdam & Vermetten, 2018). The idea is that walking is a forward movement, and it relies on cognitive-motor interactions that help facilitate problem solving. The group of combat veteran patients in this study who walked on the treadmill towards self-chosen pictures of their deployment before their exposure therapy showed significantly greater improvement in their PTSD symptoms than those who received only the exposure therapy (Nijdam & Vermetten, 2018).

An empirical study by Thorp et al. (2019) used clinical psychologists and social workers trained in exposure therapy to lead twelve 90-minute sessions that engaged in PTSD fear but in safe situations along with homework assignments that also involved exposure. The older male combat veterans experienced significant improvements in their PTSD symptoms after the intervention (Thorp et al., 2019).

Eating Disorders

Exposure therapy has also been used to treat people with serious eating disorders. A 2017 meta-analysis of 19 studies on the use of VRET as an intervention in the treatment of bulimia nervosa and binge eating disorder showed a decrease in eating disorder behaviors (de Carvalho, de Santana Dias, Duchesne, Nardi, & Appolinario,

2017). A 2019 study with adults in an inpatient eating disorder setting structured their intervention around psychoeducation on the treatment approach, having the patients develop an exposure hierarchy containing fear-evoking stimuli related to eating, completing exposure exercises, and then progressing gradually through the hierarchy to higher fear-evoking exposure activities such as food with higher calories (Farrell et al., 2019). The results of this study found that the patients showed significant reductions in their eating-related fears and from their pre-treatment avoidance behaviors (Farrell et al., 2019).

Obsessive-Compulsive Disorder

The debilitating psychiatric condition of OCD was once thought to be untreatable, but the symptoms can be reduced through exposure therapy (Hezel & Simpson, 2019). Hezel and Simpson (2019) state that exposure therapy provides information to clients with OCD that is contradictory to their existing fear structure when the outcomes that they so dread end up not occurring. As a result, they form new and more realistic memory structures that do not include a fear response. When clients with OCD refrain from engaging in compulsions during exposure therapy, they are learning to break the ritualistic behavior found in OCD. However most will remain symptomatic and some will not benefit from the treatment (Hezel & Simpson, 2019).

Barriers

Wolitzky-Taylor et al. (2018) report in their study that, in spite of the effectiveness of exposure therapy, there are barriers to both delivering and receiving this intervention. They conducted a series of interviews with patients, focus groups, providers, administrators, and policy makers to find out why more people do not take

advantage of exposure therapy, particularly those suffering from anxiety disorders. Factors that affected patients included a lack of awareness about exposure therapy. In spite of their assumption that patients would not want to experience a deliberate exposure to their feared stimuli, their research found instead that patients preferred exposure therapy over medication (Wolitzky-Taylor et al., 2018). Clinicians reported a lack of training in professional education on how to conduct exposure therapy and erroneous beliefs that it is harmful to patients or only suitable to a narrow range of patients (Wolizky-Taylor et al., 2018). A graduated exposure to feared stimuli is used in most cases over flooding, or the full immersion form of exposure therapy.

With virtual reality technology increasing, some tools are now available to people to use VRET as a form of self-help without the use of a therapist (Temming, 2018). Or there may be a virtual therapist who periodically checks on the client to see how they are feeling and to offer encouragement. This type of exposure therapy can be a barrier to a client, as it is not possible for the person to have a conversation with a therapist that can go in any direction (Temming, 2018). Temming (2018) stated that "there was a lot of hype about smartphone mental health apps, and very few of them saw any kind of extensive real-world use".

Future Use

I am currently interning at a local hospice and am interested in becoming a hospice social worker following graduation. The field of university student mental health is also an area of interest that I have. With exposure therapy used with clients with anxiety disorders and phobias, as well as PTSD, I feel that it could be a beneficial therapeutic intervention in many areas of social work. Hospice patients sometimes have

death phobias, and I have heard before of doing exposure therapy with hospice clients: taking them to a cemetery or helping them write their obituary.

In April of this year I attended a Demystifying Death conference, and the keynote speaker was a VA nurse who spoke about "soul injuries" that sometimes surface when someone is on their deathbed. A soul injury was defined as an overlooked, un-assessed, and penetrating wound that separates someone from their own sense of self and causes them to feel defective, inadequate and unworthy. As a culture we are afraid of emotional pain, and the speaker talked about the need to stop being afraid but to validate it instead. To me this is a type of exposure therapy that can be used in a hospice setting. The speaker said that she has had dying veterans with PTSD expose their inner most thoughts and fears related to their soul injuries, and they would often say afterwards, "Why didn't I learn how to do this years ago?". This type of intervention has value for hospice social workers.

The research that I found on virtual reality exposure therapy (VRET) was especially fascinating to me and is an intervention that appears to be growing due to advances in technology and potential lowering of costs. I think that this is a type of therapeutic intervention that will be used more in the future regardless of the social work setting. With college campuses having an increased number of students suffering from anxiety, I can see how using VRET would be effective in treating them, provided they have the software. I could use this in a college mental health social work position.

Conclusion

Exposure therapy is a sometimes under-utilized intervention treatment that has a lot of efficacy demonstrating its success. With the recent interest in VRET in an

increasingly anxious world, it is a newer method of conducting exposure therapy to help those with anxiety disorders, PTSD, eating disorders, and OCD. Practitioners need to be trained in how to conduct exposure therapy in order to offer different therapeutic interventions to their clients.

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Appendix A: Guidelines for Conducting Exposure

1. **Exposure practices should be planned, structured, and predictable**. Decide in advance what you will do in the situation and how long you will stay. Plan in advance when you will complete your practice and put it in your schedule. Have a back-up plan in case the original does not work out.

2. **Exposure practices should be repeated frequently and spaced close together**. The more closely paced the practices, the more fear reduction that you are likely to experience. It is a good idea to practice being in the same situation repeatedly until it becomes easier.

3. **Exposure pace can be gradual**. Do not assume that you must do the most difficult thing you can imagine right away, but be sure to choose practices that are challenging. The more difficult the items that you practice, the quicker you will learn to be more comfortable. Try to choose practices that are challenging but not so difficult that you will not complete them.

4. **Expect to feel uncomfortable**. It is perfectly normal to feel awful during initial exposure practices. Also, these practices may leave you feeling tired and anxious afterwards. With repeated practices, these feelings will decrease. Success should not be judged by how you felt in the situation. Rather, success should be judged by whether you were able to stay in the situation despite feeling awful or not.

5. **Try not to fight your fear.** Fighting the anxiety will have the effect of increasing your anxious feelings. Instead, just let it happen. The worst thing that is likely to happen is that you will feel temporarily uncomfortable.

6. **Do not use subtle avoidance strategies during exposure**. Complete the practices without the use of distraction, medications, alcohol, leaving early, avoiding eye contact, and other such strategies.

7. **Use exposure practices to test negative predictions about the consequences of facing your fear.** Before beginning an exposure, ask yourself what you are afraid might happen during the practice. The conduct the exposure practice to test the accuracy of your fearful prediction. Afterwards, think about the evidence you gained from your experience and how it compares to your original fearful prediction.

8. **Rate your fear on a scale from 0 to 100**. During exposure practices it can be helpful to pay attention to how you are feeling and to notice the variables that make your anxiety go up and down during the practice.

9. **Exposure practices should last long enough for a significant reduction in anxiety**. Continue each exposure practice until your anxiety goes down, no matter how much time it takes. A good rule of thumb is to continue an exposure practice until

your anxiety rating on the 0-100 scale decreases by at least half (e.g., below 40 if it peaked at 80).

10. **Practices should take place in different settings to generalize learning**.
    Conducting exposure practices in multiple settings will help bring about a more broad decrease in your anxiety. It is often helpful to conduct exposures with your therapist, at home, and in other settings. It can also be helpful to conduct some exposures by yourself because sometimes the presence of other people can make us feel artificially safe.

Appendix B: EXPOSURE HIERARCHY FORM

Create a list of anxiety-producing situations, beginning with the most distressing, and ending with the least distressing. Rank how distressing each item is on a scale of 1- 10.

Anxiety, Obsession, or Compulsion Trigger	Distress Level (1-10)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Appendix C: Exposure Therapy for Anxiety Self-Assessment of Needed Skills

An exposure therapist will demonstrate the ability to skillfully…

…be socratic and collaborative.

Effective: Client and therapist collaborate together to dictate content and tempo based on agreed-upon plan

Less Effective: Non-directive where the client dictates content and tempo

Less Effective: Directive where the therapist forces agenda without client input

… explain behavioral model of anxiety, and formulate and share behavioral conceptualization of the presenting problems.

Effective: Therapist broadly describes the behavioral model of anxiety, emphasizing and highlighting aspects that are particularly germaine to the client's individualized experience of the antecedents, behaviors, and consequences

Less Effective: Therapist broadly explains the behavioral model of anxiety, but does not emphasize how it applies to the client's own experiences

Less Effective: Therapist reviews the clients specific experience of anxiety, but without couching it in the larger perspective of a behavioral model of anxiety.

… develop a hierarchy of fears, including dimensions that make fears more or less intense.

Effective: Identifying a range of different fear triggers (e.g., "giving a presentation in class," "talking to strangers," "standing at a crowded bus stop") including dimensions that might make triggers more or less anxiety provoking (e.g., speaking to men vs. women, small or large audience, friends vs. acquaintances vs. strangers, etc.)

Less Effective: Identifying fear tiggers based on "typical" clients with that diagnosis

Less Effective: Identifying overly broad (e.g., "doing things in public"), narrow (e.g., "being called into work on Christmas Day"), or personally-irrevelant (e.g., "meeting with world leaders") targets for the hierarchy.

…identify safety behaviors and collaboratively negotiate to minimize or eliminate safety behaviors during exposures.

Effective: The therapist and client jointly explore strategies the client uses to minimize anxiety or perceived threat, and negotiate an agreement to minimize of, ideally, refrain from engaging in these strategies while conducting exposures.
Less Effective: The therapist adopts an authoritarian stance of resonse prevention without client input or consideration of client concerns.

Less Effective: Therapist does not attend to, or is permissive about, the use of safety behaviors during exposure.

…plan and conduct exposure exercise in session.

Effective: Therapist and client select an appropriately challenging in-session exposure that is relevant to client's treatment goals and follows logically in the sequence of exposures. Therapist works out the details of the exposure with the client, collaboratively sets a behavioral goal that is achievable, observable, and measurable, and initiates an appropriately difficult in-session exposure.

Less Effective: The therapist dictates the exposure without client input, consideration or client concerns, or consideration of relevance to the client's environment.

Less Effective: The therapist places little structure around the exposure, and allows the exposure to unfold in a haphazard manner.

…plan and assign exposure exercises for self-directed practice between sessions.

Effective: Therapist negotiates an appropriately challenging homework assignment for exposure that fits with client's treatment goals and logically follows from previous in-session and homework exposures.

Less Effective: The therapist does not assign between-session exposure practice.

Less Effective: The therapist assigns between0session exposures that are unrelated to the in-session exposure, or is likely to be too easy or difficult for the client.