Exposure Treatment

Exposure treatment ("exposure") is a cognitive behavioral therapeutic approach to treating pathological anxiety. Although exposure may be delivered in a variety of formats, exposure generally involves the systematic and guided confrontation of an anxious individual to feared objects and/or situations. Exposure is thought to reduce anxiety through the modification of underlying maladaptive beliefs about feared stimuli, and by extinguishing conditioned fear responses. Exposure has been shown to be a highly effective treatment for a number of anxiety-related problems compared to medication and other psychological treatments.

The main providers of exposure treatment for anxiety are psychotherapists with a master's or doctorate-level training in psychology. Such exposure therapists include counselors, clinical psychologists, licensed clinical social workers, and psychiatrists. Although exposure has been used to effectively treat a number of psychological problems, recipients of exposure treatments are generally children or adults diagnosed with an anxiety disorder such as specific phobias, obsessive-compulsive disorder (OCD), panic disorder, agoraphobia, posttraumatic stress disorder, or social anxiety disorder (social phobia).

Modern exposure treatments for anxiety disorders derived from earlier approaches such as systematic desensitization, which involved having a client imagine encountering feared stimuli while simultaneously engaging in relaxation techniques. Later research showed that concurrent relaxation was not a necessary treatment component, leading several psychologists (including Isaac Marks, Edna Foa, and David Barlow) to develop a more efficient technique. Modern exposure is usually delivered in weekly, hour-long therapy sessions and is time-limited in nature (e.g., 12–16 weeks). For some anxiety-related problems such as specific phobias, exposure therapy may require fewer sessions. Exposure treatments may be delivered in individual or group format, with or without the assistance of a therapist, or over electronic mediums (such as through video webcams).

The initial stage of exposure treatment is dedicated to functional analysis of a client's presenting problems—a detailed investigation of the client's main concerns, what triggers the client's fears, and what the client does to avoid or reduce the resulting anxiety (i.e., safety behaviors). After collecting this necessary information, the therapist then explains the case conceptualization to the client, provides accurate information regarding the nature of anxiety and the factors that maintain it, and describes a recommended course of exposure-based treatment for the client's approval.

The next step of exposure treatment involves the therapist and client collaboratively devising a fear hierarchy—a rank-ordered list of a client's feared objects and/or situations to be encountered over the course of therapy. The fear hierarchy serves as a sort of road map and task checklist for the therapist and client during

treatment. The type and number of items on the fear hierarchy depend on the client's presenting problem(s) and the treatment provider's method. Typically, fear hierarchies are approximately 10 items long per client problem. Exposure tasks can include intentional induction of feared body sensations (interoceptive exposure), repeatedly recalling a traumatic memory or unwanted thought in detail (imaginal exposure), or coming into actual contact with feared objects and/or situations (*in vivo* exposure).

Once a fear hierarchy is constructed, the client begins to systematically encounter the identified stimuli. Clients often complete initial exposure tasks in the presence of the therapist ("therapist-guided exposure"), but they are usually expected to conduct exposures independently outside of therapy sessions as well ("client-directed exposure"). Although clients may choose to start with the least anxiety-provoking task on the fear hierarchy, there is no obligation to do so if a client prefers to start with a more challenging task.

Before beginning an exposure task, the therapist and client briefly discuss the goal of the particular exposure. The therapist also acknowledges that the client is likely to become anxious during the task, but that the anxiety indicates that the task is being conducted correctly. The therapist further emphasizes that the anxiety the client will experience during the exposure is only temporary. It is also valuable to identify what a client is afraid might happen during an exposure task; this way, the client's fearful beliefs can serve as hypotheses to be tested during the exposure "experiment." Therapists also encourage clients to refrain from resisting the anxiety, distracting themselves from the anxiety, or engaging in safety behaviors during exposures in order to maximize the chances of improvement.

During an exposure, the therapist and client usually track predetermined indices of an exposure task's "success." One popular subjective index is the Subjective Units of Distress Scale, which involves clients reporting their level of anxiety, ranging from 0 (no anxiety) to 100 (maximum possible anxiety). Other indices include tracking whether or not the client's feared outcome has happened (e.g., whether or not sitting in an enclosed space has resulted in anticipated suffocation) and the client's perceived ability to tolerate the discomfort evoked by the exposure task. Exposure tasks may be relatively short or long in duration, depending on (1) the nature of the task and (2) how long it takes for the client's fearful beliefs to be disconfirmed and/or the client to experience a significant reduction in anxiety ("habituation"). Following an exposure, the therapist reviews the task with the client, underscoring the client's anxiety toleration during the task and highlighting whether or not the client's feared outcome actually happened. Clients are encouraged to repeat the exposures outside of therapy in varied contexts (such as in different locations) to maximize chances for long-term improvement. Exposure treatments last as long as necessary for the client to experience symptom reduction and improved quality of life. It is also advisable for therapists and clients to continue exposure treatment

until the most difficult exposure item on the fear hierarchy has been successfully completed multiple times in multiple contexts.

Throughout the course of treatment, exposure therapists might also provide some form of cognitive therapy—therapy that involves discussing and challenging a client's core beliefs that may be maintaining the psychological problem. Common thought styles that are challenged during exposure treatment include a client (1) overestimating the likelihood and severity of possible negative outcomes associated with feared stimuli (e.g., whether or not a socially anxious client is highly likely to say something embarrassing during a conversation with strangers and, if so, if the embarrassment will truly be unbearable) and (2) being unable to tolerate uncertainty (e.g., needing a 100% guarantee that a feared event will not occur).

Exposure treatments for phobias and other anxiety disorders have been studied in many randomized controlled trials (RCTs). Results from RCTs suggest that exposure-based therapies are the most effective treatment available for anxiety problems. Exposure therapies have demonstrated superiority to no treatment, placebo treatments, and non-exposure-based treatments. Exposure therapy is not generally improved by the addition of medications, and exposure therapy is more effective than medication for some anxiety problems (e.g., OCD and specific phobias). Accordingly, exposure is considered the best first-line treatment for anxiety disorders. Despite the strong research evidence highlighting the effectiveness of exposure treatment for anxiety problems, many therapists are hesitant to provide it. This reluctance often stems from therapist reservations regarding the dangerousness or ethicality of encouraging a client to encounter his or her feared objects and/or situations. For example, some therapists report fears that providing exposure will lead a client to quit therapy, become retraumatized, experience unbearable anxiety, or have a medical emergency in response to experiencing intense distress. Yet research shows that these concerns are unfounded, as these feared outcomes of providing exposure treatment are remarkably infrequent. Therefore, it is beneficial to remind wary therapists as well as anxious clients that a client's long-term improvement will likely outweigh any short-term anxiety associated with conducting exposures.

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See also: Barlow, David H. (1942–); Cognitive Restructuring; Exposure, Imaginal; Exposure, *In Vivo*; Exposure, Interoceptive; Foa, Edna B. (1937–); Habituation; Marks, Isaac M. (1937–); Safety Behavior; Subjective Units of Distress Scale; Systematic Desensitization

Further Reading

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CLIMBING UP THE LADDER

In exposure treatment, individuals gradually confront their fear in a series of steps of increasing difficulty—very much like climbing the steps of a ladder. The bottom steps are least fear-provoking and the top steps evoke the greatest fear levels. This is termed an *exposure hierarchy* and usually consists of about 10–12 steps.

To start, the clinician works with the individual to create a list of feared situations related to the phobia. The list may be generated by asking the individual a series of questions regarding the impact of the phobia on his or her life. For example, "What situations do you avoid because of this phobia?" and "What would you like to be doing but feel you are not able to because you have this fear?" For a person with a spider phobia, this may include such situations as walking in the backyard, going in the basement, entering the garage, and sleeping with the window open. The clinician will also add situations that the individual might not report because including these types of situations in the exposure hierarchy will ensure the greatest fear reduction—for example, the clinician might recommend looking at a spider web, looking at a spider, touching a spider with a pencil, touching a spider with a finger, and holding a spider. The clinician will then ask the individual to rate the amount of fear expected when encountering each situation using a subjective units of distress scale (SUDS). Once all of the situations are rated, they are organized in a hierarchy or ladder from low to high fear.

The clinician uses the hierarchy to guide exposure treatment. Treatment begins with the individual choosing a step on the ladder to start exposure practice with. For some people this may be the bottom step but others may choose to start higher. The step should create some level of anxiety, otherwise a higher step should be chosen. For example, an item with a fear level of 5 will not facilitate fear reduction because it is not associated with any significant fear level. Ideally, the hierarchy ranges from a SUDS of 30 (e.g., walking in the garage) all the way up to 100 (e.g., holding a spider). The individual practices a step repeatedly until he or she achieves significant fear reduction on that step. For example, practicing touching a spider with a pencil may be associated with a SUDS rating of 60 to start, but with prolonged exposure the

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