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EXTENDING THE POSITIVE EFFECTS OF EXPOSURE THERAPY

Exposure therapy is a type of cognitive behavioural therapy supported by a large body of evidence as being an effective and powerful method to overcome anxiety. It improves quality of life by enabling a person to confront a fear and therefore cease avoiding something they feel a sense of dread about.

An example here would be of a person who is terrified of dying in a plane crash. By avoiding all air travel, they successfully avoid the dreaded event but significantly decrease their quality of life. As this is done with the intention of controlling fear it's a defence mechanism people struggle to let go of as it's often experienced as effective.

Successful use of exposure therapy requires a great deal of commitment and investment from a client and sometimes needs lengthier sessions. If they're fully committed to brave something that scares them it's possible to change unwanted learned responses into desired outcomes.

Such therapy has been hugely effective for conditions such as obsessive-compulsive disorder, post-traumatic stress disorder, specific phobias and most presentations of anxiety provoking intrusive thoughts.

The success of exposure therapy is greatly enhanced if a

threefold approach is used. Only one or two of these it often doesn't bring about equally satisfactory results.

The threefold approach:
1. Introducing relaxation techniques
2. Addressing cognitive distortions
3. Behavioural exposure

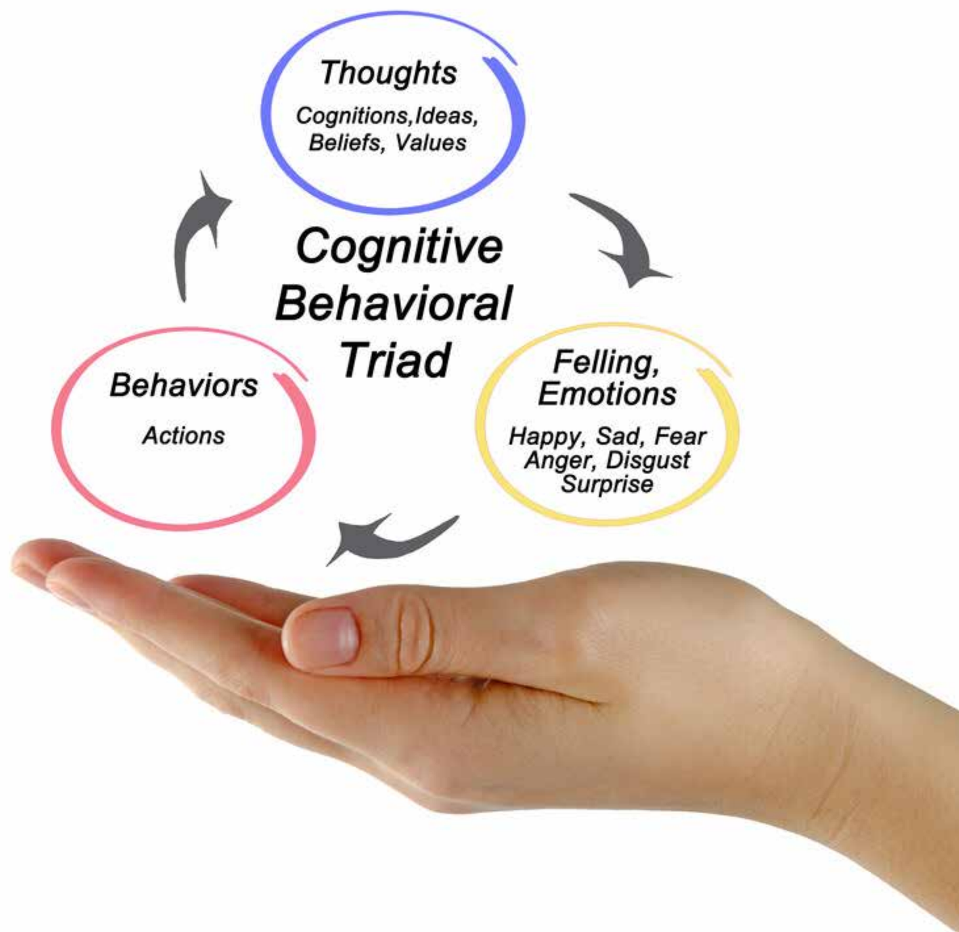
Sometimes, if considered beneficial some pharmacological intervention is also prescribed.

1.RELAXATION TECHNIQUES
When confronted with something a person fears it elicits a state of physical arousal with a real feeling of being in danger. A person's physical response may actually escalate due to the additional fear created by the physical distress.

Through these relaxation techniques, a person can enhance their ability to bring their physical arousal levels down. These levels will automatically decrease with continued exposure, but relaxation techniques can assist in achieving this result faster and is a helpful skill which can be transferred to effective mastery of other situations as well.

Should a person phobic of dogs be locked in a room with one their initial reaction would be an immediate flooding in terms of physical response. If this person is left in the room with the dog for hours and nothing distressing happens during this time they'll no longer have any discernible physiological response left as the initial acute elevation can't be maintained indefinitely.

The success of this approach will also come about due to the cognitive shift from "I'm in danger" to "Nothing's happening, I'm not in danger". This method of exposure is called flooding. This should be used with great caution as it can discourage clients from being willing to engage in the therapeutic process as it's often perceived as a lot more terrifying than gradual exposure. With flooding care should be taken not to abort prematurely. Should all physical arousal not be completely resolved the exercise may serve to confirm how frightening and traumatic the feared anxiety is.



2. COGNITIVE DISTORTIONS
Distorted beliefs that create anxiety and dread need to be addressed in conjunction with relaxation and exposure techniques. The belief that something is dangerous and intolerable to face leads to active avoidance. Initially a better awareness of distorted thinking is created through psychoeducation which assists in understanding how thoughts and anxiety create distressing physical response which can lead to escalation of fear.

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An accurate understanding of distorted thoughts is pivotal as exposure exercises are innovatively tailor-made, based on the specific fears deduced from them. Fears can be around something tangible such as being terrified of clowns or spiders; scared of heights, crowded rooms or public speaking. Sometimes fear the can be related to thought patterns. Examples here would be fearing judgement by others or rejection when approaching the opposite sex. In these cases, exposure is not geared towards convincing a client that there are no risks with these situations but rather to create greater comfort and acceptance when rejection and judgement happen. Fear of judgement and rejection can be very limiting as people may avoid healthy behaviours such as social situations and romantic partnerships.

Once understanding is attained through psychoeducation, alternate and more accurate cognitions are introduced as part of the pre-exposure preparation. During exposure itself relaxation exercises should be paired with affirming internal dialogue. Affirmation could include reminding the person the threat is imagined and not real, that no real harm will come to them and that the physical reaction experienced is temporary and will subside. It can also include ents around capability and motivation to succeed.

As mentioned earlier,

understanding the fearful thought is important. Gary, a successful businessman in his fifties believed throughout his life that he had a heights phobia. It emerged his fears were not about heights but an unwanted intrusive thought that he may lunge from a high place and die. This enabled formulating a more effective exposure plan based on a fear of jumping rather than a fear of heights.

3. BEHAVIOURAL EXPOSURE

Exposure is either done through a gradual and systematic desensitisation or through flooding. Flooding needs to be used with caution by experienced practitioners.

Systematic desensitisation can be planned in conjunction with a client by creating a hierarchy of exposure together. By effectively moving up in the hierarchy of difficulty confidence is gained through mastery on every level. Clients are less likely to abandon

the process as their gains are evident and their little successes confirm their ability to successfully attempt the next step in their hierarchy. Exposure can be vividly imaginal, in vivo (real) or even in a virtual reality format. In fact, all three methods can be used in a hierarchy of exposure which may start by imagining an occurrence, then experiencing it virtually and eventually getting exposed to the actual experience. An example of a hierarchy could be:

3/10 Imagining a dog
4/10 Looking at images of a dog in a book
5/10 Watching a documentary about dogs
6/10 Being in close proximity to a dog that is locked up and, on a lease,
7/10 Entering the premises of the dog but it is still leased
8/10 Letting go of the lease but someone is holding the dog
9/10 Letting go of the dog and allowing it to venture around you.
Steps don't have to be this small if the client is able to effectively tolerate bigger steps.

It's recommended to have small tolerable exposure exercises between sessions. This could include watching YouTube videos of feared events or attempting smaller and less frightening steps to further desensitise. Desensitising exposure to thought related content that's actively being suppressed could include having to write a thought out repeatedly or creating and writing stories about a dreaded event. In the case of obsessive compulsive disorder both thought, and behaviour may require desensitisation through exposure. This would require gradual desensitising techniques such as exposure to the obsession paired with some behavioural response prevention.

Many people believe they want to overcome their fears and may seek therapy in order to assist them with the process, but if they're not willing to be exposed to what they fear results are likely to be unsatisfactory. Exposure requires commitment and to some extent an admirable level of courage. MHM

References available upon request

Africa in a 3 month period. Perhaps the intervening years will have brought change to this national picture.

STRESSED OUT AND SEDATED

Why are so many people using sedatives? The answer may lie in reported levels of distress. Just how stressed out are members of the SADAG community? Respondents were asked to reflect on various feelings that they would have experienced over the past 30 days. Nearly half reported feeling 'depressed' and that 'everything was too much effort'. Over a third felt 'hopeless', 'worthless', 'tired' and 'nervous'. A quarter owned to feeling unhappy and 'could not be cheered up'. These are all examples of people in distress, as is reflected in these high levels of agreement with multiple items taken from the Kessler's 10-item Psychological Distress Scale.

Of all the substances used in the past 90 days, sedatives were the most compellingly correlated with each of Kessler's distress items used in this survey (p<0001 across all items). These all took the form of positive correlations, implying the greater the degree of perceived distress, the higher the frequency of sedative use. Feeling tired? Take a sedative. Feeling depressed? Some sedation could do. Restless? Nervous? Consider sedation. Is everything too much effort? Try sedation.

For the purposes of this study, Sedatives included: Sleeping tablets, Serapax, Rohypnol and Valium as core examples. This is in line with the WHO ASSIST (Alcohol, Smoking, and Substance Use Involvement Screening Test) screening tool that was used to assess broad substance use in the online SADAG community. However, Sedatives are not the only substances that can sedate a community.

SEDATIVES AND OPIOIDS – A BAD ROMANCE?

Weak to moderate positive correlations were found between frequency of sedative use in the past three months, and a number of other substances including: cocaine, amphetamines and opioids. Of these, the strongest positive correlation was between sedatives and opioids, indicating that when individuals increased the consumption of one of them, there was a concomitant increase in the use of the other. What's also interesting is the frequency of reported opiate use is also positively correlated with all of Kessler's 10-item Psychological Distress Scale ($p<0.05$ across all items). Same distress, similar solution? Sedatives and opiates could equally and effectively numb emotional pain.

Both legal and illegal opioids figured in this study, and it may be worthwhile to conduct further research into whether legal opiates, such as Codeine, are the specific substances correlated with sedative usage. Whether staying asleep or choosing to kill the pain, the surveyed members of the SADAG virtual realm may be coping in unhelpful ways. If the use of legal substances, such as sleeping tablets and codeine-bearing pain tablets in tandem, is not recognised as a potentially problematic practice, this type of substance use could become a bad romance.

SEEKING HELP OR STAYING ASLEEP?

Only 15% of this sample have already contacted the SADAG-DSD funded Substance Abuse helpline to date. As such, these survey findings provide a window into the world of SADAG community members who fall outside of this helpline client base. We can now learn more about community members and stakeholders who have not self-identified as people impacted by substance use and possible over-use.

A total of 66% of respondents stated they would be willing to call this helpline for personal use, should the need arise. Just under 80% stated they would consider calling the helpline for family members or friends in need of support. A series of non-parametric T-tests yielded some interesting additional insights. People who reported personal use of Whoonga (street drug) in the past three months, were the only group of substance users statistically associated with calling in to the helpline. Deeper analysis revealed that people who called the substance abuse helpline were most likely to be frequent Whoonga users.

There was a statistically significant relationship identified between the frequency of inhalant and hallucinogen use and the desire to make a future call to the helpline to gain help for friends and relatives. 'Further investigation indicated the people who reportedly wouldn't call the helpline also reported a greater frequency of inhalant or hallucinogen use than others in a sample.

Could these findings, taken together, point to the interaction of two important norms at work in the world of substance use? Is the first a mental boundary between legal and illegal substances? Is this a belief bound by the 'war on drugs' approach that many academics and commentators argue has shaped the 2013-2017 South African National Drug Master Plan? Do these legality boundary norms intersect with the second norm, centered on safety? This safety norm could be created through the social construction of drug use, where some substances are defined as so-called 'street drugs' and prescription medications are defined as safe substances? Only additional research into these perceptions will tell us more. MHM

References available upon request