Basal Exposure Therapy (BET)

Basic principles and guidelines

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"In BET I've learned that I may experience my emotions as being dangerous, but that they never really are. By exposing myself to my fears I realized that thoughts and feelings cannot destroy or harm me, and all of a sudden I had a life that was possible to live."

BET patient

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BASAL EXPOSURE THERAPY

A 3RD GENERATION COGNITIVE BEHAVIORAL APPROACH TO MENTAL DISORDERS

Basic principles and guidelines

The BET modality's values

The overall objective of BET is to promote more functional cultural attitudes to health and the human condition. The World Health Organization (WHO) defines health as the complete absence of pain and discomfort. In contrast to this definition a healthy person in the perspective of BET is the one who is capable and willing to relate to and accept his or her emotions and inner experiences.

BET is rooted in compassion, equality and respect for all individuals as responsible human beings who create their lives through deliberately chosen actions. Practicing BET requires flexibility and determined cooperation in combination with perseverance and determination to promote lasting changes in individuals and systems.

When therapists and staff act in accordance with these values, they contribute to the realization of the overall objective of BET.

WHAT IS THE PROBLEM – AND WHAT IS THE SOLUTION?

CENTRAL ASSUMPTIONS OF THE BET MODEL

THE PROBLEM
The patient avoids unpleasant and fearful inner experiences

THE PATIENT'S CONDITION IS UNDERSTOOD AS A PHOBIA

- The patient suffers from an impending existential threat
- *Existential catastrophe anxiety* is experienced as an intrusive feeling and fear of falling to pieces, falling apart, or getting stuck in eternal pain or emptiness
- The expectations of a devastating catastrophe have led to a fear of affective arousal wherein the patient uses any or all means (e.g. self-harm, dissociation, stops eating, inactivity, making oneself numb) to decrease affective arousal or to keep emotional experiences at bay

THE SOLUTION
The patient chooses to expose him or herself to what is habitually avoided

PHOBIAS ARE TREATED BY EXPOSURE TO WHAT IS FEARED

- Basal Exposure Therapy is a focused preparation and coordinated implementation of *exposure* to affective arousal and the experience of *existential catastrophe anxiety*
- The patient is prepared for basal exposure through systematic elimination of behavioral disturbances and the establishment of a working alliance
- In principle*, exposure* is carried out in the same way that fear of "external objects" is treated, e.g., phobias for elevators, snakes, or spiders
- Through repeated experiences with basal *exposure*, the patient experiences that the expected catastrophe does not happen
- The experiences achieved through exposure motivate and enable the patient to replace avoidance with self-exposure and acceptance whereby promoting self efficacy and long-term functional self-regulation

COMPLEMENTARY EXTERNAL REGULATION (CER)

The objective in BET is to develop the patient's ability for self-regulation of affect and behavior. CER aims at facilitating and consolidating functional choices and actions and minimizes the necessity of force.

UNDER-REGULATION

The patient is met with an under-regulating therapeutic stance

- The patient is seen and treated as an equal who is responsible for his or her choices and actions
- Appeal, demands and threats are met with affirmative / validating communication (see page 8). Validation of the underlying emotions reduce the incidence of such behaviors (and promotes extinction)
- Coping is met with solution-focused interventions that enhance functional choices of action and empower the patient

INSTRUMENTAL EXTERNAL REGULATION

When there is an acute threat to life and health, the health professionals take action

- On clear indications of danger to life and health, staff enter the situation and solve the problem according to medical procedures
- Focus is only on physical injury or potential injury. The patient is given a choice to cooperate
- The cause of injury or what the patient wants to do next is given no attention; verbal interaction is restricted to medical procedures
- When the situation is medically handled and resolved, staff pull out and reinstate under-regulation (as before the incident)

OVER-REGULATION

The patient is under-stimulated to create new motivation for change

- After repeated complementary *regressive* responses when under-regulated, a coordinated decision is made by the team, and the patient is subjected to over-regulation
- The patient is regulated to a greater extent than indicated by a conventional assessment of the need to protect life and health
- Everything is slowed down and there will be delays in order to create a sense of stagnation, boredom and restlessness
- In a friendly and empathetic atmosphere the team awaits the patient's complementary *progressive* response
- When the patient takes the initiative and clearly describes the coping strategies he / she will use, the situation is turned back to under-regulation

VALIDATING COMMUNICATION

The patient's life is characterized by chaos, pain and fear. In BET, *validation* is applied as a primary intervention to provide a relational space for all of the emotions that the patient is unable to deal with in his/ her *existential loneliness*.

THE PURPOSE OF VALIDATION

To validate the patient's feelings and experiences

- *Validation* communicates: "I SEE YOU". The patient is included into an accepting relationship
- What the patient feels is, as a subjective experience, true and real, no matter what or who it implies
- *Validation* is aimed at feelings and experiences and is therefore independent of, and no validation of, the issues at hand

THERAPEUTIC EFFECT

Emotions and behavior are regulated in the relational context and affect consciousness increases

- *Validation* creates a "relational space" for the patient's feelings and is viewed as a "first aid intervention" for more flexible (self-) regulation of affects and behavior
- The patient achieves awareness and insight into his/her own emotions, and cognitive functioning improves
- *Validation* challenges the patient's rigid ways of reaction and offers a space for new and more flexible ways to relate to self and others
- What used to be diffuse, chaotic physical discomfort now appears as distinct feelings that can be described and communicated

THE THERAPIST TAKES RESPONSIBILITY FOR HIS/HER OWN PERSPECTIVE

To validate is to "speak for oneself"

- The therapist's validation is based on his/her subjective observations and interpretations of what the patient feels and experiences
- When using validating communication the therapist takes full responsibility in acknowledging that his/her own observations and understanding can be completely different from what the patient actually experiences
- Example: "I may be wrong, but to me it seems that you are sad"
- The therapist finalizes the sentence just there. To add a question or a soothing statement can move the focus away from the affective content and the patient may then experience that his or her pain is not seen and fully recognized

Levels of mental functioning: Regression and Progression

PROGRESSION

Uncoordinated regulation

Mental organization	**Therapeutic/mileu therapy challenge** (The course of treatment proceeds "bottom-up")
STABILE REFINEMENT/GRADATION NEUROTIC FUNCTIONING	Invite and challenge towards seeing nuances/shades of gray. Including when the patient is in a state of strong affective arousal
	Refer to the process, consider what the patient now does differently that makes it possible to view oneself and others in a more nuanced way
	Praise the patient for the way interpersonal challenges are met
UNSTABLE REFINEMENT LOW FUNCTIONING NEUROTIC	When the patient is not in a state of strong affective arousal: challenge the patient to see nuances with open-ended questions
	When the patient is in a state of strong affective arousal: accept regression and polarizing/splitting
	Appear nuanced in the relationship (with both good and bad features/sides)
BEGINNING REFINEMENT HIGH FUNCTIONING BORDERLINE	Identify a more nuanced perspective, *validate* integration *of* "good – bad" within the same person or matter
	Praise the patient for relating to reality as complex and nuanced
	When the patient is not in a state of strong affective arousal: invite to seeing 'shades of gray' by presentation of alternative ways to view people and situations
	When the patient is in a state of strong affective arousal: *validate* the contradictions between "good" –"bad"
LOW FUNCTIONING BORDERLINE **POLARIZATION** BORDERLINE PSYCHOTIC	*Validate polarization of* "good-bad", accept and allow *splitting*
	Let *splitting* "good" vs. "bad" play out in daily life Offer "objects" (assume roles) that can represent "the good" or "the bad"
	Take care of staff by clarifying the function of roles and special challenges, especially those tied to *devaluation and idealization*
	Validate the patient's fear of chaos (i.e., fragmentation/psychosis)
FRAGMENTATION DISORGANIZATION PSYCHOSIS	To advance, or "invite" *polarization/splitting* by *validating* the patient's experience of "good/bad", positive-negative, secure-insecure
	Endure being the one who limits autonomy, navigate ethical challenges; maintain empathy, provide care
	Practice general *external regulation*, reduce/limit external stimulation, appear as clear and predictable

Coordinated CER

REGRESSION

MULTIDISCIPLINARY COORDINATION

There may be incidences that are experienced as dramatic, and within the treatment team there may be conflicting perspectives on how to counteract *regression* and promote *progressive* complementary responses. The treatment team continuously coordinates the process according to treatment principles and goals as to hold a steady course, also when being "on a rocky road".

SHARED FOCUS, DIFFERENT FUNCTIONS

BET is a comprehensive, thoroughly coordinated treatment

- Who is supposed to do what, when, where and how? Through frequent evaluation and process coordination a shared focus and a collective therapeutic stance is established, maintained and strengthened
- Tasks related to *exposure* therapy are distributed; systematic mobilization and integration of the team members' various skills and resources create positive synergy effects and facilitate effective treatment

MANAGEMENT OF SPLITTING

Roles and management of staff

- The patient creates his/her own reality based on earlier relationship experiences. When working with splitting, the therapist and staff accept the roles they are "given" by the patient. We attempt to foster the patient's development (see page 9) rather than correcting his or her perceptions
- Acceptance of *splitting* prevents *regression* to psychotic functioning. *Splitting* is a natural phase in the course of development where the patient, through new relational experiences, gradually includes him/herself in a "common nuanced reality"
- The roles and functions of each individual co-worker are specifically reflected upon. Staff members who are *devalued* or *idealized* by the patient over time are taken explicit care of. It is easier to stay focused and be in these roles when one sees the benefits this has for the patient

COORDINATION OF COMPLEMENTARY EXTERNAL REGULATION

Respect autonomy, be "calm and collected", safeguard life and health

- An under-regulating therapeutic stance implies that staff exhibit psychological flexibility and an extensive accept of pain; we do not respond to appeals, demands and threats, and are able to stand witnessing that the patient struggles to self-regulate
- Over-regulation as a result of *regressive* complementary responses is administered only when a coordinated team decides for that to happen
- When there are indications of imminent danger to life and health, staff intervenes there and then. How the situation was handled is recapitulated afterwards without involving the patient
- Counter-transference – staff members' emotional reactions to what is happening are identified. Our own reactions help us understand the patient's use of *attachment strategies* and may provide warnings of "derailment" in the process
- All contributions are valued. When decisions are made, however, everyone involved unite loyally to implement interventions/measures
- Legal liability is held by the patient's psychologist/psychiatrist

"So … when all other treatment efforts had failed I was admitted to the BET-program, persistently holding onto the belief that health professionals are and should be responsible for me and my life. But then, all responsibility was assigned to me, the patient. Confused and perplexed I thought … what the hell do I do now?"

BET patient

THE THERAPEUTIC PROCESS IN BASAL EXPOSURE THERAPY

Understanding and approach

BET phase 1: CER AS SECURE BASE

Long-lasting negative interactions with the health care system has maintained and reinforced the patient's avoidant ways of coping and aggravated his/her problems. The patient is existentially alone in the world and experiences intrusive fear and pain. Our task is to 'see' the patient, reinforce functional behavior and initiate reversal of the marginalization processes in which the patient is trapped.

THE PATIENT IS SEEN, AND IS ASSIGNED RESPONSIBILITY

Under-regulation elucidates for the patient what has to be dealt with

- The patient is met with an under-regulating therapeutic stance and approach
- The experience of *existential loneliness* and *catastrophe anxiety* is *validated* and functional coping is reinforced and empowered
- In between therapeutic sessions and meetings the patient is in a situation where he or she has to mobilize unused resources, try out new strategies and directly and verbally express his/ her wants and needs

THE WISH FOR AND WILLINGNESS TO CHANGE IS FOCUSED...

There will be made no efforts to remove the patient's fear and pain

- The patient's attempts to change his/her condition/situation by fleeing (*avoidance* of fear and pain) is identified and *validated*
- The idea and hope that someone will eventually remove the patient's fear and pain is "punctured"; it is emphasized that that attempt for a solution has been chased for years without any result …
- Hopelessness, helplessness and other feelings signifying that fear and pain cannot be simply removed, are *validated*
- We start to establish a working alliance based on two principles: 1) that nobody can simply remove fear and pain, and 2) that the patient actually wants his or her life to be different

… AND THE PATIENT IS SEEN AND ASSIGNED RESPONSIBILITY

Over-regulation safeguards life and health and motivates for treatment

- Health professionals are present and take over when the patient is unable or unwilling to refrain from dysfunctional and destructive coping strategies
- We are friendly and caring, slow down the pace of everything we do and await the patient's initiative to return to under-regulation and new efforts to use functional coping strategies

BET phase 2: WORKING ALLIANCE

The patient is individually responsible for his/her own life. It is the patient's own choices that determine whether the current condition and situation will continue in the same way, or whether something could be different.

THE PATIENT IS MADE RESPONSIBLE

The patient has a choice

- The patient is taught and explained BET phases 2, 3 and 4
- The patient can choose to continue to *avoid*, and thereby maintain the symptoms and functional impairment, or enter into an "agreement" to collaborate with the therapist and milieu staff to break habitual patterns of *avoidance*
- The extent to which the patient has entered into an "agreement" about working together towards the goal of *exposure* is not necessarily directly expressed, but is manifested through the patient's adherence to the process
- A working alliance is fostered via open-ended questioning, reflection and *validation*, always pragmatically anchored in the perspective that symptoms of mental disorder are caused by *avoidance* (see page 6)

DISTURBING/ DISRUPTIVE ELEMENTS ARE INCLUDED

The "therapeutic room" has space for everything

- The patient's attitudes and reactions are met with an investigative and empathetic attitude. Nothing is viewed as a "disruption" that one should attempt to remove. In particular, ambivalence and resistance should be accepted
- Reflection and supervision helps therapists and staff to identify and examine their own reactions and counter-transferences, and to re-establish and consolidate a focused and empathetic approach to the patient and the therapeutic tasks

A WORKING ALLIANCE IS ESTABLISHED – AND RE-ESTABLISHED

We strengthen the patient's preconditions to benefit from treatment

- The first and most important objective in BET is to offer the patient experiences related to being in a working alliance as to increase his or her ability to benefit from treatment
- To establish a working alliance with poor functioning patients demands engagement, patience and a painstaking systematic effort
- The patient's feelings of responsibility may unravel when relationships are experienced as being complicated and challenging
- It is the therapist's and ward staff's task to continually maintain and strengthen the working alliance and to re-establish this alliance in case the patient disengages from collaboration in the therapeutic process

BET phase 3: FOCUS ON AVOIDANCE

Mental disorders are created and maintained by conscious and unconscious (automatic) *avoidance* behavior. Insight into the function of a behavior provides the opportunity to break old, problem maintaining, maladaptive behavior patterns.

THE PATIENT IS MADE RESPONSIBLE

The patient causes his/her own condition and situation

- Symptoms and functional impairment are consequences of the patient's actions
- The patient can choose to examine his/her *patterns of avoidance* in cooperation with the therapist and ward staff, or accept (the fact) that treatment will continue to consist of *external regulation* to manage symptoms and secure the patient's health and safety

THE AVOIDANCE BEHAVIOR IS FOCUSED AND IDENTIFIED

The focus is on <u>what</u> the patient does, not on reasons for behaviors

- Concrete actions and patterns of typical *avoidance* behavior are identified and viewed in relation to symptoms and functional impairment
- *Avoidance* behaviors that the patient is aware of and realizes, are seen as being consciously chosen – even though, for the patient, they are experienced as necessary actions
- Unconscious, automatic patterns of *avoidance* are understood as affect- and impulse-driven dysfunctional coping strategies, for which the patient has not yet the freedom to choose

THE WORKING ALLIANCE IS SECURED

The patient is not yet ready to let go of the old patterns of behavior

- A continual, intense focus on the patient's *avoidance* behavior may be experienced as invasive and critical. At this point, the patient should not do anything else other than be aware. The task is to examine the *avoidance* behavior and its patterns together with the therapist
- The therapist presents indications and interpretations as observations and not as the "Truth" about the patient. The therapist's skills lie in the ability to meet and manage difficulties and obstacles, not that he/she knows the patient better than the patient him/herself
- The working alliance is maintained with a pervasive attitude of acceptance, acknowledgement, and empathetic validation of the patient's need for *avoidance* as protection against existential catastrophe anxiety

BET phase 4: EXPOSURE

Instability decreases and symptoms are moderated as the patient gradually allows him/herself to be overwhelmed by the *existential catastrophe*, and experiences that his/her fear is unfounded.

THE PATIENT IS ASSIGNED THE RESPONSIBILITY

The patient's choices determine whether change and progress occur

- An overview of *avoidance behaviour* and *patterns of avoidance* gives the patient a real choice of action
- Each time the patient chooses to *avoid* in a situation well-suited for *exposure*, the change the patient desires is delayed

EXPOSURE IS GRADED

Systematic desensitisation prepares the foundation for "flooding"

- *Exposure* occurs when the patient chooses not to *avoid* in situations well-suited for *exposure*, and in situations which occur in daily life
- To foster the ability to regulate affect and the experience of control, the patient in collaboration with the therapist experiments with heightening and lowering affective arousal. This is a gradual approach to the patient's *existential catastrophe anxiety that* follows the principles for *systematic desensitisation*
- In daily life, a suitable balance alternating between *exposure* and *functional diversion* is prescribed for the patient
- When the time is right, the patient is encouraged to "let it all go" (*"flooding"*). Exposure is always based on the patient's deliberate choice, never on the use of force
- During *flooding* the therapist does nothing to reduce the patient's affect (fear and pain), but is present and *validates* what the patient is going through and experiencing

EXPERIENCES ARE INTEGRATED

Habituation renders the old patterns of avoidance redundant

- It is paradoxical that *exposure* to what is feared actually reduces fear. This is emphasized and clarified
- The patient and therapist identify and reflect over the different consequences of *exposure* and *avoidance*
- The decreased intensity of affective arousal following successive trials of *exposure* is identified and linked to the patient's reduced expectations of a catastrophe. Biological explanatory mechanisms (*habituation* to aversive stimuli) are presented
- The patient's concrete experiences of *habituation* due to *exposure* are highlighted in preparing for new rounds of "non-*avoidance*"

BET phase 5: SOLUTION FOCUSED CONSOLIDATION

The patient has single-handedly caused change by *exposing* him/ herself to *existential catastrophe anxiety*. Real autonomy is now about practicing self-exposure independent of a *secure base*.

SWITCHING TO A SOLUTION FOCUSED APPROACH

The patient's behaviour was the problem; the patient's behaviour is the solution

- Concrete actions and typical *self-exposure* patterns are identified and associated with changes in symptoms and improved psychosocial functioning
- *Self-exposure* that the patient is attentive to and aware of, is viewed as consciously chosen, functional solutions
- Unconscious, automatic patterns of *self-exposure* indicate that the patient's self regulating skills are improving and that the former dependency on the health care system is reduced

THE PATIENT IS EMPOWERED

The patient is given total credit for change and success

- An absence of symptoms and increased ability to function are consequences of the patient's choices and actions
- The patient's actions represent recently acquired functional patterns of behaviour that prevent future lapses in functioning

AUTONOMY IS CONSOLIDATED

The patient's behaviour in terms of self-exposure is recognized and admired

- The therapist points out, interprets, and expresses admiration for the patient's behaviour and choice of actions. Instead of the earlier focus on behaviour which created and maintained the problem, the focus is now placed upon behaviour which solves the problem
- The patient's *self-exposure* is highlighted as the cause of the increased ability to *self-regulate* in a functional way. Thereby the experience of creating predictability in one's own life through one's choices of actions is emphasized
- The patient becomes the owner of the solution; self efficacy is enhanced
- The working alliance tapers off as the patient's autonomy is strengthened and consolidated, i.e., discharge is planned and carried out

KEY TERMS AND THEIR USE IN BET

AFFECT CONSCIOUSNESS	The ability to experience and consciously recognize distinct feelings
ATTACHMENT STRATEGIES	Relational behavior that aims at protecting the individual against perceived danger
AVOIDANCE	All conscious and ”automatic” behavior, including all verbal and non-verbal ”actions” that increase the distance to – or reduce – inner discomfort, pain and painful feelings
BORDERLINE FUNCTIONING	Reality is experienced as black-and-white. See ”splitting/ polarization” below
DEVALUATION	To reduce worth. For example, to speak down to or belittle a person
EXISTENTIAL CATASTROPHE ANXIETY	Fear of falling apart, into pieces, or getting stuck in eternal pain or emptiness
EXISTENTIAL LONELINESS	A condition that evolves when the experience of being alone in the world creates insecurity
EXPOSURE	To choose to not avoid feelings and experiences that are associated with discomfort and fear
EXTERNAL REGULATION	To make arrangements and implement measures to regulate affects and behavior, including pharmaceutical interventions
FLOODING	To let oneself be overwhelmed, not holding back (like diving right into the water)
FUNCTIONAL DIVERSION	Deliberately chosen actions that move one’s attention away from whatever is painful (”time-outs”)
HABITUATION	Adaptation. Increased tolerance for the experience of discomfort, pain, and fear
IDEALIZATION	To give a high value – to select something or someone who is held in high regard or “to put on a pedestal”
PROGRESSION	Demonstrates behavior towards a higher level of mental functioning. Increased ability to self-regulate, reduced need for external regulation
REGRESSION	Lapses to an “earlier” level of psychological development. Decreasing ability to self-regulate, increasing need for external regulation
SECURE BASE	The ideal parent/child relationship. The child is given the opportunity to explore the world, yet safeguarded when confronted with insurmountable challenges. It learns to relate to and handle insecurity and develops self-efficacy
SELF-EXPOSURE	Exposure independent of the secure base
SELF-REGULATION	Ability to regulate one’s own feelings and behaviors in functional ways
SPLITTING / POLARIZATION	Dividing the world into ”good” vs. ”bad”. Reactions, thoughts, and actions are designed to protect the good (prevent catastrophe) by maintaining the division between “good” and “bad”
SYSTEMATIC DESENSITAZION	A gradual exposure to the feared object/what is feared (like step by step wading into water)
VALIDATION	To validate thoughts and emotional states, to acknowledge what the patient experiences as being real and true

Something happens to you when you through BET realize that you actually can be and feel free and that you don't have to spend all your time fighting. You observe thoughts come and go and that is that ... they are just thoughts. By accommodating and accepting emotional experiences and let any feeling stay with me means that I can live a normal life without producing symptoms. And I'm not continuously tired of combating something that I really never knew what was all about."

BET patient