XR Therapeutics

Immersive Technology Therapist Training Manual

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Introduction

This manual covers a specific aspect of therapeutic intervention for people experiencing high anxiety, that is, how to arrange 'graded exposure' in a way which is manageable and predictable.

Carefully graded challenges within individually tailored situations can be created with immersive technology, and the participant is allowed to control when they are ready to move on to the next step.

For people with neurodiversity and others (please refer to additional manual for autistic/learning disabled participants) who may experience difficulties with the imaginal aspects of graded exposure, this immersive technology offers appropriate exposure for specific fears/phobias and avoidance behaviours (i.e. those which can be presented visually).

Thus, the manual does not cover broader aspects of psychological intervention for mental health conditions. The broader case formulation of a person's difficulties may have many elements. This specific intervention is designed to focus only on overcoming a specific fear or anxiety trigger or avoidance behaviour.

The immersive technology processes have been designed for an age range of 8 years upwards, with cognitive ability and capacity to partake in the treatment.

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RESEARCH PUBLICATIONS

Maskey, M, Lowry, J, Rodgers, J, McConachie, H & Parr, J (2014) Reducing specific phobia/fear in young people with autism spectrum disorders (ASD) through a virtual reality environment intervention. PLoS ONE9 (7): e100374. doi:10.1371/journal.pone.0100374

Maskey, Morag, Jacqui Rodgers, Victoria Grahame, Magdalena Glod, Emma Honey, Julia Kinnear, Marie Labus et al. "A Randomised Controlled Feasibility Trial of Immersive Virtual Reality Treatment with Cognitive Behaviour Therapy for Specific Phobias in Young People with Autism Spectrum Disorder." Journal of autism and developmental disorders (2019): 1-16.

Maskey, M., Rodgers, J., Ingham, B., Freeston, M., Evans, G., Labus, M., & Parr, J. R. (2019). Using virtual reality environments to augment cognitive behavioral therapy for fears and phobias in autistic adults. Autism in Adulthood, 1(2), 134-145.

1. Initial Training & Preparation

1.1. Direct training with the Lead Trainer

The expected background of the Therapist who will work directly with the person and the relatives/supporter is:

- Experience working with CBT or other talking therapy, at PWP or assistant psychologist level or above.
- The therapist will be supervised in delivery. Background reading will fill in much about the nature of anxiety in children and adults, and how various behaviours may reveal underlying anxiety (see suggested reading in 1.2).
- The supervising therapist will have expertise in Cognitive Behavior Therapy (CBT) for anxiety in children and young people and/or adults.

A face-to-face training and practice session of around 2-3 hours or completion of the online training should be carried out by any therapists before using the Boundless platform, alongside reading this Manual, and the Maskey papers cited above.

1.2 Introduction to CBT and anxiety – techniques to be used in psychoeducation with client Introducing the concept of the 'hot cross bun'.

This model is based on the idea that behaviour, physical response, thoughts, and emotions are all linked and all affect each other. Some participants will be able to engage in this more than others. Some will just need to know, e.g., that 'relaxation helps your body'.

- Create a generic situation to help explore how the person experiences and describes their emotions, using the hot cross bun. Beginning with some other emotion than anxiety (e.g. happy / cross / sad).

- Normalising anxiety – e.g. 'Everyone gets worried some of the time, it can be helpful, but if it is too bad it can stop us from doing things'.

- Individualising - Find out which words the participant uses to describe their anxiety (do they use 'worried' / 'scared'?).

- Using visual scales if helpful to give a shared understanding of what the person is like when they are a little / moderately / very anxious. (What am I like when I am number 3 on the anxiety scale? What would be happening to make me feel like that?). Modelling with different emotions using generic situations (e.g. for children "when I am going on holiday I am "3" excited, but the day I got a new puppy I was "5" excited). Adapt the situation described to the age of the participants and their emotional recognition.

- Exploring situations which make the person anxious (How do you know you would be less anxious in a medium situation than a high anxiety one?)

- Discussing the hot cross bun of anxiety. If you can change one or two elements, then anxiety may be reduced.

- Exploring what thoughts go through the person's mind when in an anxious situation. Developing rationalising thoughts/mantras. It is important not to describe these anxious thoughts as 'bad' thoughts as this can be taken literally, and they can infer that they have bad thinking.

- Introducing physical relaxation techniques and the importance of practicing them between sessions. (See suggested script, Appendix 1). If the client has a supporter they can be involved in practicing the relaxation skills.

Anxiety Scale

1.3 Individual Supplementary Reading / Preparation

Background reading – Principles of CBT:

"An Introduction to Cognitive Behaviour Therapy: Skills and Applications" by D Westbrook, H Kennerley & J Kirk, 2011, Sage Publications

"Think Good, Feel Good: A Cognitive Behaviour Therapy Workbook for Children" by P Stallard, 2002, Wiley.

On CBT / Anxiety in children:

"Helping children cope with anxiety" by J Eckersley, 2006, Sheldon Press.
"Anxiety in neurodevelopmental disorders: Phenomenology, assessment, and intervention" by V Grahame & J Rodgers, In Van Herwegen, J & Riby, DM (eds) Neurodevelopmental Disorders: Research Challenges and Solutions, 2014, Psychology Press, Abingdon, Oxford.

Considering adaptations of CBT for children with ASD:

"Exploring Feelings: cognitive behaviour therapy to manage anxiety" by T Attwood, 2004, Future Horizons.

Maskey, M, Lowry, J, Rodgers, J, McConachie, H & Parr, J (2014) Reducing specific phobia/fear in young people with autism spectrum disorders (ASD) through a virtual reality environment intervention. PLoS ONE 9(7): e100374.doi:10.1371/journal.pone.0100374. (This published paper on the development study explains the procedures well)

2. Preparation for Treatment

Review all relevant information already obtained prior to treatment, including:

- Level of anxiety/impact on functioning;
- Situations that make the person anxious;
- If possible, an idea of what situation/s the client is particularly anxious about should be explored at this stage, and therefore what their 'target situation' might be;
- Effect on individual/family life;
- What, if anything, the client does already to deal with their anxiety/coping strategies and any other therapy they have tried for anxiety;
- How the client describes anxiety in their own words (e.g. worried, scared);
- Some basic information about how anxiety is experienced (e.g. physical – heart-beating etc., worrying thoughts), if they can express this. Often clients find it difficult to recognise the physical sensations of anxiety. Some of the materials in the manual for neurodiverse clients may be useful here.

3.Treatment Process & Structure (Boundless)

3.1 Psychoeducation

Psycho Education Session

The following things should be explored with the client. If the client is a child, discuss with parent/carer/supporter observing if possible.

- **Basic CBT concepts.**
- **Explain that feelings, thoughts, behaviour and body are interactive and affect each other and draw out the "hot cross bun" as a visual support.**
- **Concrete examples of what happens in different situations e.g. thoughts, feelings behaviour and body reactions on Christmas Eve /birthday (if appropriate).**
- **Ask client about their hot cross bun in different situations (e.g. if they get a present, or win a game).**
- **Repeat this (thoughts, body reactions, feelings, behaviour) with a situation which makes them anxious.**
- **Referring back to the diagram, explain to the client that if we can change some of**
- **the elements, e.g. thoughts and body, we can help the anxious feeling reduce (because they are all interlinked).**
- **An introduction to anxiety, normalise it and an explanation of when anxiety can become a problem. E.g. "Everybody gets anxious sometimes and it can be helpful, it can keep us safe. But sometimes it gets too much, it stops us doing things, but we can learn how to control it".**

Introduce Scales of Levels of Emotions, if appropriate

Begin with a 6-point scale (or a scale you normally use, e.g. 0–10, with 10 being the worst). The therapist should model this with "excited", using different examples. They should then get the client to practice using intensity scales with "happy". This scale will be used to communicate within the immersive sessions.

Finally, the scales should be practiced using the client's own word(s) for anxiety.

Discuss with the client how to decide on the 'goal situation' that has been suggested for working on or explore with them which situation they find most difficult. Use the appropriate scale to find out their level of anxiety in this situation / what makes the level of anxiety lower or higher. This is a useful time to obtain information about the best stages for increasing difficulty in the immersive programmed scenes, details of what they find more/less anxiety-provoking in their situation, etc.

Work with the client to establish an observable and specific goal, for example, if the person is anxious about dogs; the goal may be that they will be in the same room as a dog for 5 minutes and manage their anxiety. If the person is not able to take a bus because of their anxiety, their goal may be that they will take a bus with their supporter to the town centre. This is like a 'contract' so the client knows exactly what they have agreed to try to do.

Introduce relaxation techniques

- Remind them that, due to the "hot cross bun", if we can relax the body, it will help the anxious feeling to be more manageable.
- Request all that are present to join in. Go through controlled breathing and progressive muscle relaxation (see Appendix 1).
- Ask the client how they feel after (if it is helpful).
- Ask the client and parent/carer to practice these techniques before the immersive sessions.

Discuss the use of positive statements or mantras (give examples, e.g. "I can do this"). You may be able to find out what they think (e.g. "It'll stop soon") and then explain what an alternative might be, using yourself as an example. Ask them to have a think about coming up with their own before the immersive sessions, if appropriate.

Give lots of positive praise as appropriate and remind them that they will be doing similar things (relaxation, scales etc.) in the immersive sessions.

Also, discuss that there won't be any 'nasty' surprises and that we don't want them to be 'highly (6/red) anxious' at any time.

Ask if they have any questions or anything that they would like explained again.

4. After the Psychoeducation Session

Write a summary note about the session as soon as possible after the psychoeducation session has taken place. Use the information obtained in the session to consider the person's graded scene and how the level of 'challenge' might be graded.

Example

The therapist had established that a child was particularly afraid of dogs when out and about and the dog was lively.

File note by therapist:
"Please do let me know if you think of anything I've missed! It occurred to me over the weekend that I didn't discuss with B whether or not barking/dog sounds affect his anxiety - apologies for this oversight."

Visit with B

B was verbally fluent and talkative, engaging well with the discussion about the hot cross bun of behavior, thoughts, body, and emotions. He was also able to confidently use the scales to grade his feeling strengths. He was able to identify thoughts and agreed to think about some coping statements with his mum before coming to the immersive sessions.

He engaged really well with the relaxation exercises and agreed to practice these before the next session. His specific anxiety is around dogs. He described that when he sees a dog he feels 'scared', his heart races and he wants it to go away (or get it away, e.g. "kill it"). He became distracted at times with humor around using pepper spray on the dog but was able to be guided away from this. He was able to use the scales to indicate that the main factors affecting his anxiety are:

- Size of the dog (Chihuahua would be OK, Labrador-sized dog would not);
- If the dog is on a lead;

Visit with B cont.

- How far away the dog is (e.g. on a lead at the end of the street would be tolerable, however, would be more anxious as it moved closer);
- How old (energetic) the dog is – if the dog is old and slow, this is more tolerable than one that is younger / jumpy, etc.

File note by Therapist:
If possible, it would be great to be able to manipulate all of the above features, i.e. be able to have a large/small dog, on or off the lead, which we could move closer to (or it move closer to us).

I appreciate the last point may be more difficult, but if it would be possible to be able to change the movement level of the dog, that would be a bonus.

We discussed these scenarios as if we were seeing a dog in the street. Do you think this would be possible? If not, I'm sure another setting such as a park/ square would be fine.

Example with an Adult:

The Therapist had established that the client was unable to drive their car, due to breaking down several months ago and sat for several hours in the cold, waiting for a breakdown service to arrive in the dark.

File note by Therapist:
"Does this all sound ok and do I need to do anything else prior to setting up the initial treatment scene of driving on a country road"? There doesn't seem to be any significant trauma for this event relayed by the client as I completed the PCL5 and they scored just under the threshold. However, noted they are triggered by certain reminders of the breakdown. They are more wanting treatment for anxiety around driving and breaking down, especially in the dark".

Initial setup session with T:

T was anxious when they attended the setup session as unsure if they would be working on their issue as soon as they met me. I made them aware today was about getting to know each other more and how more important areas may come up in our discussions today, since we had the assessment completed by them.

Initial setup session with T cont.

T was pleased about not looking at the driving issue today and was talkative and relayed more information about the issue they were seeking support for which included:

1. How they have been unable to drive their car since the breakdown.
2. How they get really anxious and worried if family ask them if they want to go out for the day (with someone else driving) and especially, if they will get home in the dark.
3. If their partner mentions an issue on the car that might need checking at the garage.
4. Seeing breakdown vehicles go past them when out.

T was able to establish goals for treatment and a graded hierarchy. Also used the ratings scales well when we practiced setup relaxation exercises via the relaxation scenes.
her setting such as a park/ square would be fine.

Contact with XRT clinical team:
"I haven't had a chance to look at the country driving scene yet so have some questions:

1. Does the scene have a day and night option due to the client finding the dark more anxiety provoking?
2. Can weather conditions be added – the client noted snow on the night of the breakdown?
3. Can we start gradually with the scene to get them used to it, or does it just start and you are in the middle of it all?
4. Do clients usually respond quickly – is this quicker than usual CBT?
5. What happens if a client says it isn't real (the scene) and not like their issue?

Sorry to ask all these questions, it's new to me all this technology stuff and guess I am a bit worried about getting it wrong or making the client feel worse. On that, can I keep in contact if I get stuck or have any questions please?"

5. Immersive Sessions

Before each new scene, learn and practise the controls. We would suggest arriving approximately 30 minutes before the first session to allow time for this, if the scene is new to you.

5.1. Before starting your session

- Talk through with the client and their supporters (if present) about what is going to happen.
- Remind clients that he/she/they can say stop/leave at any point; agree on how they will let you know they wish to do this.
- Ask for the current level on the 6-point scale for the agreed goal.
- Remind them about relaxation skills and take a few deep breaths together.
- Remind about positive coping statements and ask which ones the client is going to use (suggest, e.g., "I'm going to be OK, I can do this" if they do not have one prepared).
- Reintroduce the 'anxiety' scale for communication. Ask where the client is on their
- own 'anxiety' scale.

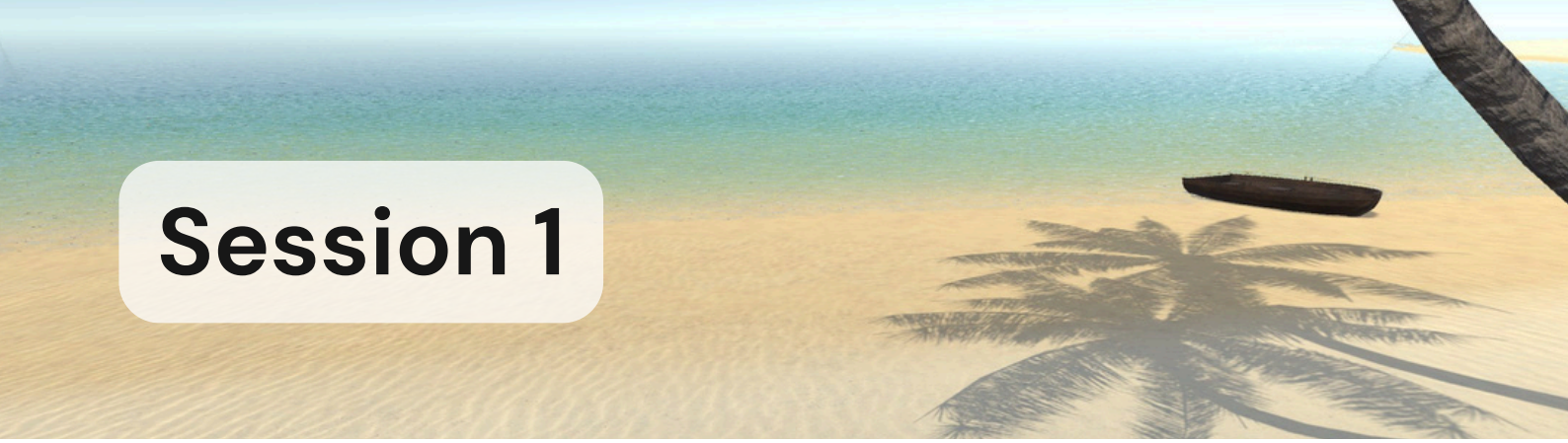
5.2. In the immersive sessions

General points:

In general, adjust your style to the client. If they tend to distract themselves by talking, remind them to look at the scene. If they get hung up on numbers, such as counting a breath in and then out, then just say 'slow' breaths.

If the client refuses to do physical relaxation exercises or finds them distracting, then try a 'stress' ball and encourage a focus on the relaxation after pressing (rather than tensing and continuously pressing it).

If the client says, "This is just immersive technology, it does not seem real", agree that it is not real but its value is in being able to practice. We have found that clients will go along with it, and practice. Remember that saying 'it's not real' may be one way of coping and that some anxiety is being felt.



Session 1

Begin by showing one of the relaxation scenes to help them become used to the immersive scenarios and understand that it is possible to move through the scene.

Introduce the relaxing scene/music, and go through the breathing and progressive muscle relaxation exercises. Give praise, "well done". Use the 'anxiety' scale so the client says how scared they feel viewing the treatment scene – if "high", do some more breathing and relaxation exercises. Ask the client what coping statement they will use.

Beginning at the lowest challenge level, navigate through the scene whilst;

- Frequently checking how high their anxiety level is;
- Reminding them about taking deep breaths and focusing on being relaxed;
- Frequently asking them about their thoughts / to repeat their positive coping statements;
- Constantly being aware of the person's body language / outward signs of anxiety (especially tense shoulders).

Repeat the scene until the client is consistently reporting a low level of anxiety, and using breathing techniques and coping statements effectively. With older children and adults, there may be an opportunity to explore their thoughts on the situation as it unfolds in the immersive sessions. This may give deeper insight into the thought processes and the specific triggers for the fear they are experiencing.

The client may say they are willing to go on to the next step but stay aware of their possible physical signs of anxiety. Gradually increase the difficulty of the scene, with the client's agreement, making sure that their anxiety level remains low, and repeating each stage until the client has 'mastered' their anxiety control at that level.

- Make sure not to rush/progress through challenge levels too quickly;
- Try and ensure the client is engaged with the scene at every stage e.g. not looking away to avoid engagement with feared situation.

The Therapist will get a sense of when a client requires a break, due to scene exposure demands and or, treatment content. Breaks will vary depending on each client's tolerance levels and complexity of their issue.

Session 1 cont.

A break can be a golden opportunity to check things such as changes to the Hot Cross Bun-fluid formulation, progress on the hierarchy and goals or, merely, dropping into a relaxation scene for a general discussion and regulating emotions. Most Therapists find session lengths of 20-30 minutes work well, especially if at step 2 PWP level. Step 3 (HIT) can also incorporate breaks in the usual 50-60 minutes and this to be client led.

At the end of the session, use lots of positive praise, discuss/remind the client of how far they have come in controlling their own anxiety (e.g. "You have done brilliantly! When we first started you were 5 scared of being on an empty bus, and by the end, you were able to be on a bus with 6 people and use your breathing and positive thoughts to keep yourself nice and calm – only at 2 scared! Well done!")

Note down where you had progressed to by the end of this session, so you know where to start when you have the next session.

Session 2

In the next session, start on a few stages before the final stage of the prior session, ensuring that the client's anxiety remains low, before moving on to more challenging levels. Depending on the client's scene or progress, it may be appropriate to reduce the level of support provided or frequency of reminders to use relaxation techniques, positive thoughts or praise are still encouraged.

If having a face-to-face session, it may occasionally be appropriate to allow the client to control their own scene using the tablet. Ensure that the client remains engaged with the scene and relaxation exercises at all times.

Be careful that the scenario is not navigated like a video game or used to avoid certain elements of the scene that are anxiety provoking, which will hinder progress.

Session 3 & 4

Repeat all steps from sessions 1 & 2, moving more quickly through the introduction /relaxation stages. Begin session 3 a few stages before the final stage of session 2, ensuring that the client's anxiety remains low, before moving on to more challenging levels.

Depending on the client's scene/suitability for the individual, it may be appropriate to reduce the level of support provided/ frequency of reminders to use relaxation techniques, use positive thoughts etc.

It may occasionally be appropriate to allow the client to control their own scene using the controls if it is an in person session – ensure that the client remains engaged with the scene and relaxation exercises if so. (Be careful that the scenario is not navigated like a video game).

5.3. At the end of the sessions

Consider and discuss with the client and family/supporter the steps to adopt, aiming for 'real' exposure. Real exposure can be in between sessions and setup via a behavioral experiment form (or your usual service form).

Agree and outline a plan that the client and their caregiver or supporter feels comfortable with. This is particularly important with adult clients in the sense that they need to agree a path to exposure that both the adult client and their supporter are comfortable with.

Write down the plan and proposed steps of increasing difficulty; this can be written into a visual format such as a ladder with steps going upwards (photocopy so each have a copy).

6. Measurement of Change

Standardized scales (such as the Spence Children's Anxiety Scale) may not include the exact item(s) of most concern to a client or their caregivers and may fail to reflect real change important to the individual family. We have developed a pre and post treatment questionnaire which measures real life change and can be used alongside standard measures you already use in your service. These questionnaires are on the Boundless platform and are quick to administer.

The questionnaire process followed was developed by the Research Units in Pediatric Psychopharmacology, (Arnold et al., 2003, Parent-defined target symptoms respond to risperidone in RUPP autism study: customer approach to clinical trials). The questionnaire asks questions such as 'how often?', 'how distressed?' and 'How does the fear interfere with daily activities? in a standard format to the parent/supporter and client, to enable a vignette to be written about the fear and its severity/impact before treatment.

Pairs of vignettes (for example, from baseline and at the last session of treatment) are later compared as definite improvement; minor improvement, no change, somewhat worse or definitely worse.

Additional Materials

Appendix 1: Scripts for Relaxation Training

- Muscle Relaxation
- Breathing

Appendix 2: Letter format for session visits

- My Immersive Therapy (for Children/Young People)
- In the Immersive setting

Appendix 3

- Advice to Therapists

Appendix 1

Scripts for Relaxation Training

We will start at the bottom of our bodies and work up learning how to relax each part of our body at a time. To learn what it feels like to have relaxed muscles, first of all we have to know what it feels like to have tense muscles. So I want you to screw up your toes as tight as you can, that's right really screw them up into little balls, feel how tight your toes and feet feel and hold them really really tight (hold for about 10 secs) and now let them go – see how relaxed and floppy they feel now.

Next I want you to pull your toes back up towards your knees as tight as you can. Feel it pulling down the bottom of your legs. Pull them back so they feel really tight and hold it, okay, and now relax your feet again. Do your legs feel a bit heavy? That's what it feels like to have relaxed legs and feet. Now we need to know about the top half of our legs. Press your knees together as tight as you can and push your bottom down hard on the chair or floor. Really feel those muscles in your legs pushing and hold them really tight (hold for 10 secs).

Ok and relax and give your legs a little shake. Now you have totally relaxed legs.

Next we will do our tummies. Take a deep breath in and pull your tummy in as tight as you can. Try to make it disappear. Pull it in really, really hard. That's right hold it tight (10 seconds) and then relax, feel how comfortable it feels when your body relaxes.
Next your arms, make arms like a muscle man and really show me those muscles. Pull them in really tight until your muscles start to bulge, good, now hold it there (for 10 seconds) and relax.

Shake your arms out and let them relax completely. Now clench your fists as tight as you can. Squeeze those fingers in really hard and feel how tight your arms and hands feel. Hold it (for 10 seconds) and now let your hands go floppy and relaxed.

Now I want you to try and touch your ears with your shoulders. Pull them up as tight as you can and see if you can feel the tightness in your neck and across the top of your back. Hold it tight like that (for 10 seconds) and now relax. Let your shoulders slump as the muscles let out all that tension and go floppy.

Muscle Relaxation cont.

Now we're onto our head. First of all wrinkle up your nose as tight as you can and hold it (for 10 seconds), now let it go and let your face go all droopy and soft. Now push your tongue against the roof of your mouth so that your mouth feels all tense and frozen, push it and hold it (for 10 seconds) and then relax and feel how nice it is.

Clamp your lips together, push them down and try to smile so that you can feel the tightness in your cheeks, hold it there (for 10 seconds) and then let all the tension escape.

Lastly just screw up your whole face as tight as you can so that you can feel the muscles pulling all round your head, really screw it up, that's right, and hold it there (for 10 seconds) and now let it all go and see how much calmer your head feels.

Appendix 1

Scripts for Relaxation Training:
Breathing

Sit comfortably and close your eyes.

Concentrate on taking a deep, slow breath in and as you do, feel the air flowing in through your nose.

Now, let the air out slowly as you concentrate on breathing out through your mouth. Take another deep breath in, again feeling the air coming in through your nose and then slowly let it out through your mouth.

In...Out...In...Out...

While you are concentrating on your breathing you are starting to feel more and more relaxed.

Now I want you to imagine there is a candle in front of you, and when you breath in... and out...in.... and out.... Your breathing makes the flame flicker.

Imagine the flame flickering as you slowly breathe in... and then again as you breathe out. Your breathing is now feeling very, very relaxed, and all your worries are draining away with every breath out.

In... and out... in... and out...in... and out.

Now imagine that you blow the candle out and when you are ready, open your eyes.

Appendix 2

Letter format for session visits

My Immersive Session Visits

(for Children/Young people, letter format to be adapted)

On Saturday 26th and Sunday 27th at 11.00 am, I will go and visit _____ in _____.

My mum or dad will come with me. When I am there, I will see (insert names), that I met before.

[INSERT PHOTOS OF ALL STAFF THE PERSON WILL MEET]

Staff Name

Staff Name

There will be some different rooms, the first one is where I can have a drink and a rest, where mum or dad will wait with _____.

Then I will go into a different room with _____, which is where I do the treatment.

Beside the _____ is an area with a sofa, where I can sit and talk or just relax quietly. When I am ready, me and _____will do some of the relaxing exercises that we practiced at home. We will also talk about some of the things we talked about at home, like my thoughts and how my body feels.

I can come out of the treatment room or ask for the scene to be stopped whenever I want. _____ will make sure she knows what I will say or do if I want this to happen. Sometimes, I will take breaks and come out of the room, to make sure I am feeling comfortable.

After I have practiced my scenes a few times, I will go back and see Mum.

Together, me and _____ will be able to control some of what happens in my scene, like how many pigeons there are. We will also keep talking about what is happening and how I am feeling.

If a client has a prior communication or cognitive assessment then the recommendations should be reviewed prior to the first appointment. Amongst other things, cognitive impairments can impact on comprehension, spoken language, vocabulary, memory, impulsivity, attention, processing and perceptual reasoning. Some people may have difficulties in all of these areas whereas others may have specific impairments in one area and strengths in other areas. Sometimes a person will be stronger at non-verbal tasks versus verbal tasks or it might be the other way round.

The issue of consent to receive the treatment needs to be explored in more detail with people who may not fully understand the potential risks and benefits. It is also important to determine a client's motivation to undergo the treatment as sometimes it may be somebody else who feels the treatment is important as opposed to the client Themselves.

If the issue of consent seems unclear then discuss the treatment process using a visual aid with the client (see resource pack), outline the potential benefits and side effects of the treatment and attempt to get the person to explain this back to you and indicate their decision clearly about wanting to continue. They should also be able to understand their right to withdraw or not undergo the treatment. If the client is unable to do this then you could only proceed with the treatment if deemed to be clearly in their best interests. A best interest decision should take into account the clients views, involve family members or carers and appropriate professionals. Consent should be revisited again prior to the exposure stage of treatment.

Research indicates that approximately 95% of people with learning disabilities find it difficult to access standard written information (All-Party Parliamentary Group for Education, 2011). Offer the easy-read resources provided and consider reading to or with the client to facilitate their understanding.

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