The Cognitive Behaviour Therapist (2023), vol. 16, e25, page 1 of 12
doi:10.1017/S1754470X23000144

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ORIGINAL RESEARCH

Therapists' beliefs about excessive reassurance seeking and helping manage it: does experience play a role?

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(Received 29 March 2022; revised 20 June 2023; accepted 21 June 2023)

Abstract
Excessive reassurance seeking (ERS) is believed to play an important role in maintaining mental health problems, in particular anxiety disorders such as obsessive-compulsive disorder and health anxiety. Despite this, therapists commonly give into patients' requests for reassurance in clinical settings and are generally unsure how to handle the issue both in therapy itself and concerning advice to the patient's loved ones. In order to increase our understanding of therapists' perception of ERS and how interventions for ERS are managed, we examined therapists' perception and understanding of ERS, including its function, which emotional problems therapists associate it with, and what treatment interventions they consider important for managing ERS. Qualified therapists ($n = 197$) were benchmarked against international expert consensus ($n = 20$) drawn from leading clinical researchers. There was evidence that clinical experience right up to the expert level may result in less reassurance giving within treatment settings. Still, there were enough inconsistencies between the experts and other clinicians to suggest that ERS remains poorly understood and is not consistently dealt with clinically. Results are discussed in terms of how current treatment interventions may be limited for treating ERS, highlighting the need to consider new approaches for dealing with this complicated interpersonal behaviour.

Key learning aims

(1) To describe the role of excessive reassurance seeking in checking behaviour, including its negative personal and interpersonal consequences.
(2) To learn that therapists commonly report finding it difficult to manage reassurance seeking.
(3) To learn that therapists' beliefs about excessive reassurance seeking may play a key role in helping us understand how to tackle this complicated behaviour.
(4) To consider what therapeutic interventions may be appropriate and helpful for treating excessive reassurance seeking.

Keywords: Anxiety disorders; CBT; Checking; Reassurance seeking; Therapist behaviours

Introduction

Excessive reassurance seeking (ERS) has been conceptualised from a cognitive behavioural perspective as a high-potency safety-seeking behaviour complicated by its intrinsically interpersonal nature (Kobori and Salkovskis, 2013). Specifically, according to the cognitive behavioural

hypothesis, ERS represents a special type of checking behaviour akin to compulsive checking in obsessive-compulsive disorder (OCD) with the added potential of transferring responsibility to other people (Rachman, 2002; Salkovskis, 1985; Salkovskis, 1999). Consistent with such a view, a recent experimental study found that reassurance seeking transfers perceived responsibility and directly causes reassurance seeking behaviours (Leonhart and Radomsky, 2019). Studies have shown that ERS is particularly common in the context of OCD (Philpot *et al.,* 2022; Salkovskis and Kobori, 2015) and health anxiety/hypochondriasis (Rachman, 2012), but is also evidenced in depression (Joiner *et al*., 2001) and various anxiety disorders (Rector *et al*., 2011). Although ERS can be considered a transdiagnostic phenomenon (Rector *et al*., 2011), there is emerging evidence that disorder-specific cognitive and behavioural processes motivate and generate reassurance seeking (Halldorsson and Salkovskis, 2017a; Parrish and Radomsky, 2010). For example, there is evidence to suggest that individuals with OCD seek reassurance and experience the effects and consequences of receiving it differently when compared with individuals with other anxiety problems (Halldorsson and Salkovskis, 2017a). This difference has clinical implications as it suggests that a 'one size fits all' treatment approach may not work, requiring clinicians to adapt how they respond to ERS and what they advise carers and patients when managing this complex behaviour across different disorders. Concerns have been raised regarding therapists' ability to respond appropriately to requests for reassurance within clinical settings (and even what an appropriate response would be). For example, Gillihan *et al.* (2012) identified therapist's inappropriate provision of reassurance as one of the common pitfalls in exposure and response prevention (ERP) for OCD and that 'inexperienced therapists may unwittingly spend whole sessions providing reassurance to their OCD patients – for example, by telling them how unlikely their feared consequences are to occur – which is counterproductive to recovery as it serves the same function as rituals' (p. 254).

It is unclear why therapists find it challenging to manage ERS within the context of anxiety problems given the risk that, by giving reassurance, they might be helping to further establish the vicious cycle of reassurance seeking (Warwick and Salkovskis, 1985). Therapists are unlikely to scrub their patients' hands with disinfectant if asked. Both parties should be fully aware of the counterproductive nature of ERS. Thus, therapists' beliefs are particularly important to make sense of such difficulties and inconsistencies in approach. These beliefs may involve therapists' concerns about ruptures in the therapeutic relationship, fears that the client may be unable to tolerate their distress and experience symptom exacerbation, drop out of therapy and more. There are likely to be similarities with therapist beliefs linked to the under-utilisation of exposure-based interventions in cognitive behavioural therapy (Cook *et al*., 2004; Deacon *et al*., 2013; Hipol and Deacon, 2013). It is also possible that therapists may find it difficult to tolerate their own discomfort were it to be triggered by the refusal of reassurance. Perhaps therapists believe they lack options in substituting reassurance with something different and less counterproductive (Halldorsson and Salkovskis, 2017b).

Because of the seeming similarities between compulsive checking and ERS, ERP remains the most commonly suggested approach for treating ERS, particularly within the context of OCD and health anxiety (Abramowitz and Braddock, 2008; Furer *et al*., 2001; Rachman, 2002; Taylor *et al*., 2005). The mechanism of change is considered to be habituation (Foa and Kozak, 1986) or inhibitory learning, whereby learning of new non-threat (i.e. inhibitory) associations interferes with the individual's ability to retrieve previously established fear-associated responses (Craske *et al*., 2014). Using either theoretical framework, the ultimate goal is *stopping* the patient from seeking reassurance and their carers providing it (Gillihan *et al*., 2012). This intervention may be problematic for four main reasons. Firstly, it fails to consider the interpersonal components involved in ERS, which distinguishes it from other types of safety-seeking behaviours. For example, people who engage in compulsive checking typically do not involve others in their checking rituals (Rachman, 2002). In contrast, ERS is 'between people' in that a person seeks reassurance, gets reassurance and then either accepts it or decides that further reassurance is

https://doi.org/10.1017/S1754470X23000144 Published online by Cambridge University Press

needed. Second, it is primarily focused on *stopping* the giving of reassurance as opposed to trying to weaken the negative belief that drives the person seeking reassurance and thereby it being sought. Third, it may implicitly blame those who are involved in providing reassurance (e.g. family members) as it suggests that it is their fault that the anxiety problem persists. This is particularly important to consider in long-standing and severe anxiety problems where people's relationships are sometimes consumed by reassurance (Halldorsson et al., 2016). Furthermore, offering reassurance may allow some degree of help with coping with normal everyday activity, such as making it possible for both the caregiver and the sufferer to leave the house with a minimum of checking time and later rumination. Finally, it potentially hinders clinicians from considering whether any other behaviours are more adaptive (non-pathological), which patients and their caregivers can substitute for reassurance.

What should therapists be doing? We argue that we not only need to look at what therapists can do for patients who are not seeking treatment but also what therapists should be doing for patients who are in treatment. For patients who are not seeking treatment, there is evidence to suggest that it is inappropriate for mental health professionals to be recommending prescriptively to carers that reassurance should be withheld. That is, although carers understand that reassurance is, at best, a short-term solution, it helps them to 'move on', lowers their own distress and decreases the risk of triggering aggressive behaviours and increased levels of anxiety in the person seeking reassurance (Halldorsson *et al*., 2016; Kobori *et al*., 2017). The issue of therapeutic intervention in severe and persistent reassurance seeking was illustrated using a single-case experimental design with an older adult suffering from severe and chronic OCD. The main conclusions from that study were that a cognitive behavioural therapy which focuses on helping people who engage in ERS to shift from seeking reassurance to seeking support might be beneficial (Halldorsson and Salkovskis, 2017b). Further support for this intervention comes from recent work by Neal and Radomsky (2019, 2020), which has shown that support provision is both effective (Neal and Radomsky, 2019) and acceptable for patients and their caregivers (Neal and Radomsky, 2020).

In order to increase our understanding of how interventions for ERS may need to be improved, the present study evaluates the perspectives taken by those responsible for helping patients overcome ERS, in that it examines therapists' perception and understanding of such behaviour. The aim of the study was not to address a specific hypothesis, but rather to explore which emotional problems therapists associate ERS with, how they understand its function and, importantly, what cognitive behavioural interventions they consider important and not important when treating ERS. We also examined whether the more experienced therapists had a different understanding. Finally, qualified clinicians working in routine clinical practice with varying degrees of experience were benchmarked against international expert consensus drawn from leading clinical researchers.

Method

Participants

In total, 197 participants took part in this study which was split into three groups: (i) qualified therapists with up to five years of clinical experience ($n = 89$); (ii) qualified therapists with more than five years of clinical experience ($n = 88$); and (iii) 20 participants were defined as 'international expert therapists' who were specifically approached and invited to participate in the study. All participants were provided with a copy of the study information sheet and were requested to sign a consent form before filling in the questionnaire. The majority (80%) of qualified therapists were recruited from various CBT workshops for anxiety problems (e.g. OCD, health anxiety) in the UK over an 18-month period. Workshop attendees were given information about the study prior to the start of the workshop and those who volunteered to take

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part completed the questionnaire (in paper format) prior to the workshop. It took approximately 15–20 minutes to complete the questionnaire. The study was also advertised within national health services (NHS) in the UK and the remaining 20% of qualified therapists were recruited via the NHS. The international expert group were specifically approached via email and invited to participate in the study by completing the questionnaire online. One of the authors has a strong international presence in the field and contacted people prominent in the field requesting participation. Recruitment also included identifiable research consortia and groups, such as the Obsessive Compulsive Cognitions Working Group (1997, 2003), an international working group consisting of expert researchers and clinicians in the field of OCD. The expert group had extensive clinical experience in specialist settings in addition to training therapists and publishing extensively in the field of clinical psychology, in particular cognitive behavioural theory and practice. In total, we contacted 22 experts and 20 completed the questionnaire (response rate of 91%). The experts were based in the UK, USA, Canada, Australia and the Netherlands.

Procedure

All the participants were provided with a copy of the information sheet that described the purpose of the study and were asked to consent to taking part.

Measures

Therapist Beliefs about Reassurance Seeking in Emotional Disorders Scale

The Therapist Beliefs about Reassurance Seeking in Emotional Disorders Scale (TBRS – see Supplementary material) is a self-report measure specifically designed for this study to examine therapist beliefs and experiences of reassurance seeking within the context of various emotional disorders. In addition, it explores therapists' reactions to requests for reassurance, how they understand the function of reassurance, and what treatment techniques they consider essential when treating ERS. The questionnaire items were generated based on descriptions of the mechanisms and treatment techniques commonly associated with reassurance seeking in emotional problems. Items were also created through consultation and piloting with senior clinical researchers. The TBRS is organised into three sections. The first section asks respondents to identify what therapeutic model they use in their practice (e.g. CBT, Counselling, Eclectic, Integrated, Psychiatric, Psychodynamic, Systemic approaches), what disorders they associate reassurance seeking with, and their clinical experience. Clinical experience was measured in years working as a therapist post-qualification and by asking participants to estimate how many patients they had treated (with a given diagnosis) over the last 12 months. That is, therapists were presented with a list of 14 different mental health problems and asked to state how many patients (by circling the following categories: 0; 1–5; 6–10; 11–15; 16–20; 20+) with that particular problem they had treated over the last 12 months. This was done because the type and amount of treated disorders may impact therapist exposure to ERS and, consequently, their beliefs about the behaviour. In the second part of the measure, respondents are asked to rate how much they agree (0 = 'do not agree at all' to 100 = 'agree completely') with each of 47 statements regarding ERS (e.g. 'Requests for reassurance are attempts to reduce anxiety'; 'Repeated reassurance seeking is always problematic'; 'Providing reassurance increases the urge for further reassurance'). The final part of the questionnaire lists 16 treatment techniques considered relevant to CBT for anxiety problems for individuals who engage in ERS. Respondents are asked to rate each treatment intervention with regard to whether they find it 'undesirable' (coded as –1); 'not necessary' (coded as 0); 'preferable' (coded as 1) or 'essential' (coded as 2) when treating ERS.

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Table 1. Participants' demographic information, clinical experience and therapeutic model

		≤5 years of clinical experience ($n = 89$)	>5 years of clinical experience ($n = 88$)	International expert therapists ($n = 20$)
Gender	% (*n*) female	69.7 (62)	72.7 (64)	35 (7)
Age	*M* (*SD*)	35.50 (8.58)	47.32 (8.66)	55.95 (10.80)
Clinical experience in years	*M* (*SD*)	2.88 (1.34)	15.10 (7.92)	25.65 (12.38)
Therapeutic model	CBT	95.5%	86.2%	100%
	Non-CBT	4.5%	13.8%	0%
Current profession	CBT therapist/clinical psychologist	80.9%	76.1%	100%
	Counselling psychologist	7.9%	6.8%	
	Nurse	4.5%	8.0%	
	Mental health practitioner	2.2%	1.1%	
	Medic	2.2%	4.5%	
	Social worker	—	1.1%	
	Other	2.2%	2.3%	
Training background	Clinical psychology	44.3%	42.7%	
	Mental health nurse	20.5%	24.7%	
	Mental health worker	0%	6.7%	
	Counselling psychology	10.2%	7.9%	
	Medicine	2.3%	2.2%	
	Occupational health	3.4%	3.4%	
	Psychiatry	2.3%	0%	
	Social worker	8.0%	5.6%	
	Psychotherapist	4.5%	2.2%	
	Not reported	4.5%	4.5%	

Non-CBT includes Counselling, Eclectic, Integrated, Psychiatric, Psychodynamic and Systemic approaches.

Results

Table 1 shows the participants' demographics, clinical experience (number of years practising), therapeutic model, current profession and training background.

For statistical analysis of 'therapeutic model', the non-CBT models were collapsed into one group due to small numbers. A 3×2 chi-squared test indicated a significant association between the type of therapeutic model and group, $\chi^2(2) = 7{,}054$, $p = .029$. Further partitioned chi-squared tests using Fisher's exact test showed that qualified therapists with over 5 years of experience reported significantly greater use of non-CBT treatments than the less experienced therapists ($p = .038$). We also explored participants' caseloads over 12 months and experience in treating different mental health problems (to ensure participants had similar 'exposure' to cases where ERS is a common problem). Chi-squared tests revealed that there was a significant association between group (up to five years of clinical experience versus over five years of clinical experience) and one disorder, i.e. OCD, $\chi^2(5) = 12.966$, $p = .03$. However, when adjusting for multiple comparisons by applying Holm-Bonferroni correction (with 14 comparisons and alpha = 0.05), significance was lost. No other significant group differences were found.

What emotional problems do therapists associate ERS with?

Figure 1 shows the percentage of participants in each group who reported ERS a common feature in any of the given emotional problems. There was a significant association between participant's experience and whether or not they considered ERS to be a common feature of panic disorder, $\chi^2(2) = 13.272$, $p = .001$, with the expert group finding it significantly less likely than therapists with up to five years of clinical experience. No other significant group differences were found

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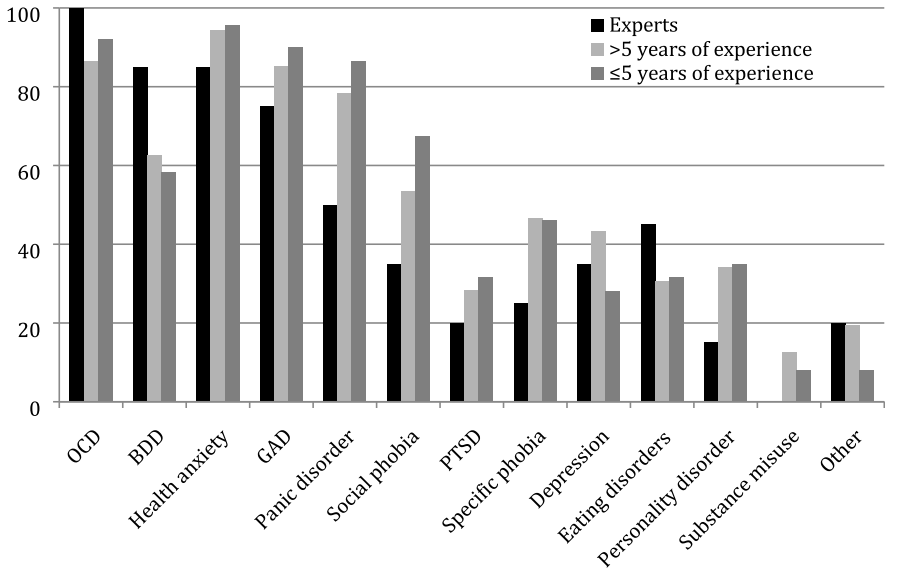

Figure 1. Percentage of therapists who link ERS with specific disorders. OCD, obsessive-compulsive disorder; BDD, body dysmorphic disorder; GAD, generalised anxiety disorder; PTSD: post-traumatic stress disorder.

($p>.05$). Overall, ERS was most commonly associated with OCD and health anxiety and least likely to be associated with substance misuse.

How do therapists understand the function of ERS?

To examine how therapists understand the function of ERS, we first combined all participants into one group for descriptive analysis of the TBRS scale. Then, all 47 questionnaire items were entered into a factor analysis using Varimax rotation to determine the constructs or domains within the questionnaire. Descriptive data were calculated for each factor item and alpha coefficients. Factor loadings and properties of the scale are presented in the Supplementary material. The model that best fit the data was based on five factors. They were: (i) Advisability of giving reassurance (e.g. 'Carefully planned reassurance can be helpful in the treatment of anxiety disorders'); (ii) Linking reassurance and anxiety (e.g. 'Providing reassurance may enhance anxiety'); (iii) Personal difficulties in dealing with reassurance (e.g. 'I feel guilty if I withhold reassurance'); (iv) Struggling with not giving reassurance (e.g. 'I find it very hard to resist giving my patients reassurance'); and (v) Positive beliefs about reassurance (e.g. 'By offering reassurance to my clients shows that I care'). Each questionnaire item could be scored from 0 ('don't agree at all') to 100 ('agree completely'). Factor loadings below 0.4 were suppressed (this included one item), i.e. loadings above 0.4 were considered to represent substantive values. Items with multiple loadings on the five factors (these included three items) were allocated to the factor where they had the highest loading and conceptually made the most sense (Pett *et al.*, 2003). Alphas for the five factors were then calculated, ranging from .68 to .75, suggesting acceptable internal consistency (Field, 2013). Average inter-item correlations for the five factors were consistent with recommendations for assessment of narrower constructs, ranging from .283 to .412 (Clark and Watson, 1995).

To examine whether the amount of clinical experience affected therapist beliefs about ERS, a mixed model ANOVA was conducted with the three group conditions as a between-subjects factor and the five factors identified earlier as a within-subjects factor. For each factor the scores were calculated as mean ratings (that is, the total score for each factor divided by the number of items which constitute it). Mauchly's test indicated that the assumption of sphericity had been

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Table 2. Mean ratings on the five subscales for each of the three groups

Subscale	<5 years of experience ($n = 89$)	>5 years of experience ($n = 88$)	Experts ($n = 20$)	*F*-test
Advisability of giving reassurance: mean (*SD*)	36.01 (10.17)	36.8 (10.7)	36.6 (12.3)	$F_{2,\ 194} = 0.111$, $p = 0.90$, $\eta^2 = 0.001$
Linking reassurance and anxiety: mean (*SD*)	65.6 (14.0)[a]	68.9 (14.1)	74.6 (18.9) [a]	$F_{2,\ 194} = 3.441$, $p = 0.03$, $\eta^2 = 0.034$
Personal difficulties in dealing with reassurance: mean (*SD*)	40.5 (14.8)[a]	34.9 (12.7)[a]	36.9 (15.2)	$F_{2,\ 194} = 3.613$, $p = 0.03$, $\eta^2 = 0.036$
Struggling with not giving reassurance: mean (*SD*)	18.4 (14.2)[a,b]	17.5 (16.8)[a,c]	8.6 (9.4)[a]	$F_{2,\ 194} = 3.597$, $p = 0.03$, $\eta^2 = 0.036$
Positive beliefs about reassurance: mean (*SD*)	29.0 (8.4)	30.1 (10.0)	29.3 (12.3)	$F_{2,\ 194} = 0.290$, $p = 0.75$, $\eta^2 = 0.003$

Note: Differences between groups are indicated by superscript letters (a–c), where in each row of the sub scale scores, means showing the same superscript letters differ from one another, alpha level $p<0.05$.

violated $\chi^2(9) = 85.60$, $p<.0001$. Therefore, degrees of freedom were corrected using Huynh-Feldt estimates of sphericity. This analysis revealed a significant main effect of subscales, $F_{3.32,\ 644.37} = 339.23$, $p<0.0001$, but the between-groups factor was not significant $F_{2,\ 194} = 0.1$, $p = .91$. These main effects were modified by a significant interaction (group by subscale), $F_{6.64,\ 644.37} = 3.84$, $p<.001$.

As a significant interaction was found, simple main effect one-way ANOVAs were conducted which revealed that the groups differed significantly (with small effect sizes) with regard to their ratings on three subscales (see Table 2): 'Linking reassurance and anxiety', 'Personal difficulties in dealing with reassurance' and 'Struggling with not giving reassurance'. No significant differences were found between the three groups scoring on the remaining two subscales: 'Advisability of giving reassurance' and 'Positive beliefs about reassurance'. Post-hoc tests showed that the experts scored significantly lower than both groups (who did not differ) on the 'Struggling with not giving reassurance' subscale and significantly higher than the therapists with up to five years of clinical experience on the 'Linking reassurance and anxiety' subscale. Finally, therapists with over five years of clinical experience scored significantly lower on the 'Personal difficulties in dealing with reassurance' subscale than their colleagues with less than five years of clinical experience.

What treatment interventions do experts consider part of and not part of CBT when treating ERS within the context of emotional disorders?

The number of experts endorsing each CBT intervention is displayed in Table 3. The items are grouped according to whether they were determined as an important part of CBT for ERS (from the highest mean to the lowest) or not an important part of CBT (from the lowest mean to the highest). Based on guidelines from Stobie (2009), the following criteria were used to categorise a technique as part of CBT: no more than 10% of the expert sample rated the item as not part of CBT, and more than 50% of the sample rated it as either preferable or essential. A technique was considered not part of CBT if less than 10% of the sample rated as essential, and more than 75% rated it as either not part of CBT or not necessary. As shown in Table 3, based on this categorisation, the techniques that the experts regarded should be part of CBT for ERS included, for example, 'Offering a rationale for the detrimental role of ERS', whereas 'Offering your patient repeated reassurance when requested' was not considered part of CBT. The expert group did not agree on one item: whether 'Strongly instructing your patient to stop seeking any reassurance' should or should not be part of CBT. Comparisons between the three groups revealed that the

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Table 3. Experts' ($n = 20$) view on what should be and should not be part of CBT for ERS

Treatment Intervention	Item mean (*SD*)	Undesirable *n* (%)	Not necessary *n* (%)	Preferable *n* (%)	Essential *n* (%)
Should be part of CBT					
Offering a rationale for the detrimental role of excessive reassurance seeking	1.90 (.31)	0 (0%)	0 (0%)	2 (10%)	18 (90%)
Explaining the role of reassurance seeking in maintaining anxiety	1.85 (.37)	0 (0%)	0 (0%)	3 (15%)	17 (85%)
Helping your patient to develop an alternative response to seeking reassurance, e.g. support	1.80 (.41)	0 (0%)	0 (0%)	4 (20%)	16 (80%)
Exploring your patient's beliefs about reassurance seeking	1.80 (.41)	0 (0%)	0 (0%)	4 (20%)	16 (80%)
Working with your client to test out the effects of seeking reassurance repeatedly on their anxiety and urges to seek further reassurance	1.55 (.51)	0 (0%)	0 (0%)	9 (45%)	11 (55%)
Rehearsing with relatives/carers ways of responding without giving reassurance	1.50 (.61)	0 (0%)	1 (5%)	8 (40%)	11 (55%)
Weighing up the benefits and costs of seeking reassurance	1.50 (.61)	0 (0%)	1 (5%)	8 (40%)	11 (55%)
Exploring how and from whom your patient seeks reassurance	1.45 (.60)	0 (0%)	1 (5%)	9 (45%)	10 (50%)
Drawing a diagram explaining the problem with reassurance seeking, which includes links between thoughts, feelings and behaviours	1.45 (.60)	0 (0%)	2 (10%)	7 (35%)	11 (55%)
Inviting relatives/carers to a session in which reassurance is discussed	1.30 (.57)	0 (0%)	1 (5%)	12 (60%)	10 (50%)
Exploring the interpersonal effects of repeated reassurance seeking	1.20 (.62)	0 (0%)	2 (10%)	12 (60%)	6 (30%)
Advising relatives/carers to stop offering any reassurance	1.15 (.93)	2 (10%)	1 (5%)	9 (45%)	8 (40%)
Should not be part of CBT					
Offering your patient repeated reassurance when requested	−.90 (.30)	18 (90%)	2 (10%)	0 (0%)	0 (0%)
Being deliberately unresponsive to all requests for reassurance from your patient	−.65 (.67)	15 (75%)	3 (15%)	2 (10%)	0 (0%)
Allowing your patient to contact you outside therapy sessions if they need reassurance	−.60 (.68)	14 (70%)	4 (20%)	2 (10%)	0 (0%)
Undetermined					
Strongly instructing your patient to stop seeking any reassurance	−.50 (1.05)	4 (20%)	6 (30%)	6 (30%)	4 (20%)

categorisation of items was identical across all groups, suggesting they agreed on what was considered part of CBT and not part of CBT for ERS.

Discussion

This study examined therapists' beliefs about excessive reassurance seeking and helping manage it. Specifically, we assessed therapists' clinical experience and difficulty in treating ERS, the degree to which they associate ERS with different emotional problems, how they understand its function and what CBT interventions they consider important and not important when treating this complex interpersonal behaviour. Therapists were clearly aware of the problems and difficulties associated with ERS. However, experts had a clearer view of how to manage it clinically. This awareness was also present to a lesser degree in less experienced therapists. Therapists saw ERS as occurring across diagnoses and agreed on which treatment interventions were and were not appropriate.

With regard to clinical experience and beliefs about ERS, there is little previous research to draw on. In the present study, despite therapists ranging from novice to highly experienced

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experts, the extent of therapist experience did not overall have a significant impact on their beliefs about ERS. However, some minor differences were identified – there was an indication that clinicians with greater clinical experience find it easier to manage ERS in treatment and link ERS to anxiety problems. Also, experts seem to find it easier to resist requests for reassurance when compared with their less experienced colleagues. Considering that therapist experience is often seen as a proxy for therapist quality, based on the notion that more experience equals a better therapist (Norton *et al*., 2014), this finding may be seen as somewhat positive. That is, novice therapists mostly agree with experts on the function of ERS. However, an agreement between the groups does not guarantee an accurate understanding of the function of ERS – they could all be equally wrong, highlighting the need for evidence to base such recommendations.

Consistent with previous research which has associated ERS with a range of anxiety problems (Abramowitz and Moore, 2007; Heerey and Kring, 2007; Kobori and Salkovskis, 2013; Onur *et al*., 2007; Parrish and Radomsky, 2010; Woody and Rachman, 1994), therapists reported that ERS is a transdiagnostic phenomenon. However, in contrast to the depression literature (Starr and Davila, 2008), therapists typically did not associate ERS with depression. Interestingly, a proportion of therapists in each group associated ERS with non-anxiety/mood problems such as personality disorders. However, these results should be interpreted with caution because they are simply a measure of participants' experiences and suggest that there is room for expanding research on ERS beyond anxiety disorders and depression.

What CBT interventions do therapists consider important and not important when treating ERS? In particular, are ERP principles still guiding therapists? The answer to this question is complicated. Firstly, it seems that there is no relationship between therapist experience and what treatment interventions are considered part of CBT or not part of CBT for ERS. Secondly, it seems clear that therapists at all levels are guided by the current literature and encourage carers to stop giving reassurance and rehearse with the carer ways of responding without giving reassurance. Notably, some therapists felt it was appropriate to strongly instruct their patients to stop seeking any reassurance – all in concordance with ERP principles. However, this finding must be weighed against other interventions the therapists reported as part of CBT. In particular, the therapists reported that patients should be helped to develop an alternative response to seeking reassurance, for example, support seeking. In addition, they did not feel it was part of CBT for therapists to be deliberately unresponsive to patients' requests for reassurance. These findings highlight therapist beliefs about ERS as an important area of intervention in therapist training and clinical supervision, as they may directly impact on therapist's assessment of the appropriateness of applying particular treatment interventions for ERS.

There are some limitations, of course. Therapists were mainly recruited from those who opted to attend training workshops which may limit the generalisability of the findings as they may not represent the general population of therapists. It should also be noted that the expert group consisted mainly of therapists with expertise in anxiety and related disorders with less varied clinical training background compared with the other groups which may have had an impact on findings. Second, although the sample size in the current study was considered sufficient for exploratory factor analysis, sample sizing (item ratio) in factor analysis remains debated in the literature (Field, 2013; Floyd and Widaman, 1995). Thus, further studies with larger samples recruited more broadly are necessary.

Based on findings from this study, there is evidence to suggest that ritual prevention based on ERP principles remains a critical component of CBT for anxiety-related problems. However, we remain critical of its use in the treatment for ERS and encourage a different approach to treating this complex interpersonal behaviour, which emphasises helping the person seek a different response – a response that is not intended to avoid disaster. This response may involve helping the client shift from seeking reassurance to seeking support, defined as *interpersonal behaviour, verbal or non-verbal, that is intended to get (or give someone) encouragement, confidence or assistance to cope with feelings of distress* (Halldorsson and Salkovskis, 2017a; Halldorsson and Salkovskis, 2023).

https://doi.org/10.1017/S1754470X23000144 Published online by Cambridge University Press

Thus, when a person seeks support, the person intends to deal with the perception of threat and the associated distress alone, with no further fears about the consequences of the perceived threat or anxiety. Consequently, this response is not catastrophy based and thus does not interfere with belief disconfirmation as in the case of safety-seeking behaviours like reassurance seeking (Salkovskis, 1996). Having identified support-seeking as a potentially helpful alternative, a logical next step is to offer an experimental analysis of this intervention. A recent single-case experimental design examining the effects of treating ERS using this approach has proven successful (Halldorsson and Salkovskis, 2017b), calling for further studies examining this treatment intervention.

Key practice points

(1) Clinical manifestations of reassurance seeking and giving are most evident in OCD and health anxiety, but are present across multiple disorders, varying in meaning and function.
(2) Therapists, patients and their loved ones alike understand that excessive reassurance seeking is counterproductive and harmful, but struggle to understand why and typically see it as a serious and complicated problem.
(3) Existing interventions mainly focus on helping the patient stop seeking reassurance. However, this is unlikely to help. Helping patients shift from seeking reassurance to seeking support may be a beneficial clinical intervention.

Further reading

Leonhart, M. W., & Radomsky, A. S. (2019). Responsibility causes reassurance seeking, too: an experimental investigation. *Journal of Obsessive-Compulsive and Related Disorders*, *20*, 66–74.
Rachman, S. (2002). A cognitive theory of compulsive checking. *Behaviour Research and Therapy*, *40*, 625–639.

Supplementary material. The supplementary material for this article can be found at https://doi.org/10.1017/S1754470X23000144

Data availability statement. The data that support the findings of this study are available from the corresponding author, upon reasonable request.

Acknowledgements. None.

Author contributions. **Brynjar Halldorsson:** Conceptualization (equal), Formal analysis (lead), Investigation (lead), Methodology (lead), Project administration (lead), Writing – original draft (lead); **Paul Salkovskis:** Conceptualization (equal), Writing – review & editing (equal).

Financial support. This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Competing interests. The authors declare none.

Ethical standards. This study received ethical approval from the University of Bath Ethics Committee. The authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS.

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Cite this article: Halldorsson B and Salkovskis PM. Therapists' beliefs about excessive reassurance seeking and helping manage it: does experience play a role? *The Cognitive Behaviour Therapist*. https://doi.org/10.1017/S1754470X23000144