



Therapist perceptions and delivery of interoceptive exposure for panic disorder



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ABSTRACT

Interoceptive exposure (IE) is widely regarded as an essential procedure in the cognitive-behavioral treatment of panic disorder (PD). However, treatment manuals differ substantially in their prescribed delivery of IE, and little research exists to inform the optimal manner of its implementation. The present study examined therapists' perceptions and delivery of IE for PD. Results revealed substantial variability in how clinicians provide IE. In contrast to the prolonged and intense manner in which exposure techniques are traditionally applied, many therapists reported delivering a low dose of IE accompanied by controlled breathing strategies. Concerns about the potential adverse effects of IE were common despite the fact that participants reported the actual occurrence of negative outcomes of IE in their own practice to be extremely infrequent. It is possible that some therapists deliver IE in a cautious manner in an attempt to minimize the perceived risks associated with this treatment.

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1. Introduction

Methodologically rigorous clinical trials have demonstrated the efficacy of numerous cognitive behavioral therapy (CBT) approaches to the treatment of panic disorder (PD) with or without agoraphobia (e.g., Barlow, Gorman, Shear, & Woods, 2000; Clark et al., 1994; Gloster et al., 2011). These treatments target the fear of panic itself by providing corrective information intended to disconfirm maladaptive beliefs regarding the dangerousness of panic-related internal and external cues. In particular, direct exposure to feared arousal-related body sensations, also known as interoceptive exposure (IE), is considered an essential component of effective CBT for PD (Craske & Barlow, 2007). By engaging in sensation-induction tasks such as hyperventilation or spinning in a chair, clients with PD learn that panic-related bodily sensations such as heart palpitations and dizziness are harmless and tolerable (Antony, Lidley, Less, & Swinson, 2006; Schmidt & Trakowski, 2004). Indeed, reduction in the fear of fear appears to mediate improvement in CBT (Smits, Powers, Cho, & Telch, 2004).

Whereas most evidence-based CBT approaches for anxiety disorders such as obsessive-compulsive disorder, post-traumatic stress disorder, and specific phobias primarily emphasize exposure-based techniques (e.g., Foa et al., 1999, 2005; Ollendick et al., 2009), CBT treatments for PD often utilize a variety of

therapeutic procedures. For example, Barlow and Craske's (2007) empirically supported panic control treatment includes cognitive reappraisal techniques and diaphragmatic breathing skills in addition to in vivo exposure and IE, and symptom-induction exercises are not introduced until the final stages of treatment. Clients following this approach complete a pre-specified number of IE trials (e.g., 3 min-long trials of hyperventilation), each of which is followed by the use of cognitive and controlled breathing strategies and a rest period of sufficient length to allow anxiety symptoms to subside. This method of delivering of IE differs markedly from the typical implementation of exposure therapy for other anxiety disorders in which trials are conducted in a prolonged manner without concurrent arousal-reduction strategies and continue until the client's anxiety has habituated (e.g., Abramowitz, Deacon, & Whiteside, 2010). In contrast to panic control treatment, other effective CBT treatment packages for PD minimize or omit cognitive and controlled breathing techniques and emphasize the prolonged and intense delivery of IE (e.g., Arntz, 2002; Otto et al., 2009; Telch et al., 1993).

Although a large body of research supports the overall efficacy of CBT treatment packages for PD that include IE (McHugh, Smits, & Otto, 2009), little empirical guidance exists to clarify the optimal delivery of IE. Few dismantling studies have examined CBT for PD; one exception was reported by Schmidt et al. (2000) who found that removal of controlled breathing did not detract from overall treatment outcomes. Investigations of variations in the delivery of IE itself have yielded inconsistent findings, with one study demonstrating an advantage of concurrent cognitive reappraisal (Carter,

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Marin, & Murrell, 1999) and two others failing to do so (Deacon et al., 2012; Smits et al., 2008). Deacon et al. (2012) also found that the efficacy of IE was not enhanced by the addition of controlled breathing strategies. In summary, there is scientific consensus that IE is an important ingredient in effective CBT for PD (American Psychiatric Association, 2009) but existing research provides little empirical guidance to inform the manner in which IE is best delivered. As a result, there may be substantial variation among therapists in the application of this procedure, and this variation is likely influenced by factors other than research evidence.

Exposure therapy is associated with a host of negative beliefs among therapists including the perception that it is unethical, harmful, intolerable, and poses a risk management problem (Deacon et al., in press; Olatunji, Deacon, & Abramowitz, 2009). Deacon and Farrell (in press) hypothesized that negative beliefs about exposure therapy affect the manner in which therapists deliver this treatment to anxious clients. Concerns about safety and tolerability might prompt well-meaning clinicians to provide exposure in a less-than-intense manner (e.g., with concurrent use of arousal-reduction strategies) in order to minimize its perceived risks (Farrell, Deacon, Kemp, Dixon, & Sy, in press). Prolonged and intense IE may be seen by some therapists as unacceptably aversive and unsafe owing to the perceived dangers of high anxiety itself (e.g., decompensation, loss of consciousness). Relative to the use of in vivo and imaginal exposure techniques for other anxiety disorders, the implementation of IE for PD may be particularly susceptible to therapist reservations about exposure. IE is the least used exposure-based technique (Freiheit, Vye, Swan, & Cady, 2004; Hipol & Deacon, in press) and was rated as the least ethical, acceptable, and helpful form of exposure in a survey of university students and psychotherapy outpatients (Richard & Gloster, 2007).

Despite its established efficacy, exposure-based CBT for PD does not work for all clients and many individuals experience a fluctuating course of residual panic symptoms following treatment (Brown & Barlow, 1995). It is possible that variations in the implementation of this treatment are associated with differential client outcomes. In particular, the delivery of IE in a cautious manner by therapists concerned with its potential adverse effects may produce less beneficial outcomes than the confident delivery of IE in a prolonged and intense manner. As a first step in investigating this possibility it is necessary to understand how therapists deliver IE and the factors associated with their style of delivery. Accordingly, the present study examined perceptions and style of delivery of IE among therapists who use this procedure in the treatment of clients with PD. Given the inconsistency with which CBT treatment packages implement IE and the lack of clear scientific guidance for its optimal delivery, it was hypothesized that therapists would vary considerably in their style of delivering IE as well as the extent to which they endorse various risks associated with this treatment.

2. Method

2.1. Participants and procedure

Therapists with practice listings on the Anxiety Disorders Association of America's "Find a Therapist" online directory (<http://www.adaa.org/netforum/findatherapist>) were sent an email invitation to participate in a web-based survey on the use of IE. A total of 727 emails were sent to association members. Of these, 62 were returned due to delivery failure. A total of 117 therapists initiated the survey; 98 individuals reported using IE in the treatment of clients with PD and remained eligible to complete the survey. After removing 32 cases due to incomplete data, the final sample consisted of 66 therapists who completed all survey items. The final sample comprised 9.9% of all valid email contacts. This

figure likely underestimates the true response rate as therapists who do not use IE for PD, of which there are many, may have elected not to initiate the survey.

The mean age of the sample was 47.3 years ($SD=10.1$) and 34 participants (51.5%) were men. Ethnicity was not assessed. Therapists reported a mean of 16.1 ($SD=9.5$) years of experience as a licensed mental health service provider. The majority of respondents ($n=52$) were doctoral-level psychologists; additional participants reported earning a terminal master's degree ($n=9$), MD ($n=2$), or other degree ($n=3$). Respondents reported having used IE to treat an average of approximately 99.2 PD clients ($SD=150.7$; median = 50; range = 3–1000).

2.2. Measure

The Interoceptive Exposure Survey was constructed for the present study to assess therapists' perceptions and delivery of IE. Respondents began by providing demographic information. The next section contained several questions concerning the manner in which therapists deliver IE. One question assessed the use of rest periods between IE trials. Respondents were asked,

"We are interested in the typical amount of time you allow clients to rest between consecutive trials of an IE exercise. At one extreme, therapists do not allow clients to take any break between trials and continue the exercise in a prolonged, uninterrupted manner; at the other extreme, therapists allow their clients to rest between each trial until their anxiety has decreased entirely. When conducting IE with panic disorder clients, how would you characterize the manner in which you use rest periods between trials?"

Responses were provided on a 100-point scale ranging from 0 ("Extended breaks between trials until anxiety decreases entirely") to 100 ("No rest period, consecutive uninterrupted trials"). Therapists were also asked to specify the average number of seconds they allowed clients to rest between IE trials.

An additional question assessed the manner in which therapists choose the number of IE trials to be used. Respondents were asked,

"We are interested in how you typically structure a session of IE with your clients. On one extreme, therapists ask their clients to complete a prespecified number of trials per session (e.g., 3 one-minute trials); at the other extreme, therapists ask their clients to continue participating in an unlimited number of consecutive trials until their anxiety has habituated. When conducting IE with panic disorder clients, how would you characterize the manner in which you typically structure IE sessions?"

Responses were provided on a 100-point scale ranging from 0 ("Small, pre-specified number of trials") to 100 ("Unlimited number of trials until habituation"). A follow-up question asked therapists to specify the average number of minutes per IE session PD clients spent engaged in IE exercises (not including between-trial rest periods, controlled breathing, etc.).

The next section assessed respondents' concurrent use of cognitive reappraisal techniques and controlled breathing strategies with IE. For each strategy, participants were asked to indicate whether or not they used it, the extent to which they believed it enhances the efficacy of IE on a 0 ("Not at all") to 100 ("Extremely") scale, and to select from a list reasons for using it (if applicable), including (a) "it facilitates habituation," (b) "it facilitates cognitive change (i.e., corrects catastrophic threat appraisals)," (c) "it increases self-efficacy in tolerating the distress associated with anxiety-related body sensations," and (d) "it makes IE more acceptable and less aversive to clients."

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