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Theory-based training strategies for modifying practitioner concerns about exposure therapy

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ABSTRACT

Despite the well-established efficacy of exposure therapy in the treatment of pathological anxiety, many therapists believe this treatment carries an unacceptably high risk for harm, is intolerable for patients, and poses a number of ethical quandaries. These beliefs have been shown to account for two related problems: (a) underutilization of exposure therapy, and (b) overly cautious and suboptimal delivery the treatment, which likely attenuates treatment outcomes. At present, there is little guidance for those who train exposure therapists to address these concerns. This article reviews therapist negative beliefs about exposure therapy and discusses their modification based on findings from social and cognitive psychology pertinent to belief change, including dual-processing in reasoning, the need for cognition and affect, and attitude inoculation. A number of strategies are offered for augmenting training in exposure therapy in order to promote positive beliefs about the treatment. These strategies involve: (a) therapists engaging in simulated exposure therapy exercises and presenting arguments in defense of exposure's safety, tolerability, and ethicality, and (b) training therapists using emotion-based appeals (e.g., case examples) to supplement research findings. Directions for future research on practitioner concerns about exposure therapy are discussed.

1. Introduction

Exposure therapy is a central component of many cognitive-behavioral (CBT) approaches for anxiety disorders and entails guiding patients in repeatedly confronting feared stimuli. A wealth of randomized controlled trials demonstrate the effectiveness of exposure-based treatments for anxiety disorders such as panic disorder (e.g., Gloster et al., 2011) and obsessive–compulsive disorder (e.g., Foa et al., 2005), and meta-analyses support exposure-based therapy as an effective transdiagnostic approach for pathological anxiety (e.g., Norton & Price, 2007). The National Institute for Clinical Excellence (2011) and the American Psychiatric Association (2009) have published practice guidelines advocating exposure-based therapies as first-line treatment approaches for anxiety disorders.

Despite its well-documented effectiveness in the treatment of pathological anxiety, exposure therapy is uniquely difficult to disseminate to practitioners owing to pervasive concerns about its use. Richard and Gloster (2007) noted that exposure suffers from a "public relations problem" among therapists, many of whom are concerned with the perceived intolerability and questionable ethicality of the treatment. More recently, Deacon, Farrell, et al. (2013-this issue) validated the Therapist Beliefs about Exposure Scale using a sample of over 600 practicing therapists. Mean scores on the scale indicated that the average clinician harbors a moderate degree of negative beliefs about exposure therapy. Surprisingly, negative beliefs about exposure are evident even among self-reported exposure therapists (Deacon, Farrell, et al., 2013-this issue; Deacon, Lickel, Farrell, Kemp, & Hipol, 2013; Richard & Gloster, 2007). Clearly, in spite of its effectiveness, exposure therapy is viewed by many mental health professionals as a treatment that carries a number of unacceptable risks.

2. Negative beliefs about exposure therapy

Many therapists hold negative beliefs about evidence-based treatments in general, including concerns related to their perceived rigidity, insensitivity to patients' unique needs, damaging effects on the therapeutic relationship, and inapplicability to actual clinical practice (Addis & Krasnow, 2000; Addis, Wade, & Hatgis, 1999). Although these broad-based beliefs about evidence-based treatments are likely applicable to exposure therapy, this treatment is associated with a variety of unique therapist concerns. Based on a comprehensive literature review of therapist reservations about the treatment, Deacon, Farrell, et al. (2013-this issue) identified an array of negative beliefs specific to exposure therapy. Although a

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factor analysis indicated that these beliefs load onto a single factor, three thematically distinct domains of therapist concerns were evident. Specifically, exposure therapy is widely perceived as harmful, intolerable, and unethical.

2.1. Exposure therapy is harmful

Many clinicians worry that exposure therapy will directly produce harmful physical and/or psychological consequences, either for the patient or the therapist. In the context of imaginal exposure for patients who have experienced trauma, therapists often fear that discussion of trauma-related memories will "retraumatize" the patient (Cook, Schnurr, & Foa, 2004) or cause the therapist to experience "vicarious traumatization" (Zoellner et al., 2011). Therapists who provide interoceptive exposure to patients with panic disorder report concerns that this treatment may cause patients to lose consciousness and/or "decompensate" (Deacon, Lickel, et al., 2013). Ironically, such concerns represent the very maladaptive beliefs about the dangerousness of anxiety-related body sensations that interoceptive exposure is intended to modify (Craske & Barlow, 2008). Finally, therapists worry that exposure therapy may lead to a worsening of patients' symptoms, attrition, and treatment refusal (Becker, Zayfert, & Anderson, 2004; Deacon, Lickel, et al., 2013; Feeny, Hembree, & Zoellner, 2003). These perceived dangers likely cause many practitioners to view exposure therapy as posing an unacceptable risk of harm.

2.2. Exposure therapy is intolerable

In addition to its perceived harmfulness, exposure therapy is often believed by therapists to be intolerable to patients who undergo it (Rosqvist, 2005). Many clinicians believe that patients are likely to refuse participation in exposure-based treatment and will drop out at higher rates than other psychotherapies (van Minnen, Hendriks, & Olff, 2010). Such concerns are especially pronounced in the context of intensive exposure approaches, such as prolonged hyperventilation for patients with panic disorder (Deacon, Lickel, et al., 2013). A related therapist belief is that exposure therapy must be delivered in a cautious, low-intensity manner in order ensure its tolerability. In support of this notion, therapists concerned with the potential dangers of interoceptive exposure (e.g., decompensation) are especially likely to use adjunctive diaphragmatic breathing techniques with their panic disorder patients (Deacon, Lickel, et al., 2013). Many practitioners believe that arousal reduction strategies (e.g., relaxation, controlled breathing) are necessary for patients to tolerate exposure therapy. Indeed, this belief was the single most commonly endorsed reservation about exposure therapy in a large sample of practicing clinicians (Deacon, Farrell, et al., 2013-this issue).

2.3. Exposure therapy is unethical

Exposure therapy is perceived by some practitioners as inherently unethical. To illustrate, a clinician quoted in a *New York Times* article on exposure therapy titled "The Cruelest Cure" characterized this approach as "torture, plain and simple" (Slater, 2003). This belief likely reflects the view that the deliberate evocation of distress inherent in exposure-based treatment is at odds with the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (2002), which directs therapists to "do no harm." Similarly, therapists have expressed concern that exposure is associated with increased risk for legal troubles, such as being the target of a malpractice lawsuit or accused of ethical violations (Kovacs, 1996). Even practitioners who do not view exposure therapy as inherently unethical may worry that this treatment poses serious ethical risks such as endangering patients' confidentiality or facilitating boundary violations by conducting exposure sessions outside the office (Olatunji, Deacon, & Abramowitz, 2009).

3. Clinical implications of negative beliefs about exposure therapy

Negative beliefs about exposure therapy have a two-fold detrimental impact on the dissemination of this treatment. First, several studies have demonstrated these beliefs to be influential in therapists' decisions to forego use of exposure (e.g., Becker et al., 2004; van Minnen et al., 2010). Negative beliefs about exposure are also problematic because they elicit an overly cautious delivery style among exposure-using therapists that differs markedly from the widely advocated prolonged and intense delivery of exposure (e.g., Abramowitz, Deacon, & Whiteside, 2011). Two studies using correlational designs have shown exposure-related concerns to be associated with a suboptimal delivery style, including allowance of safety behaviors, reassuring patients of safety, and premature termination of exposure tasks (Deacon, Farrell, et al., 2013-this issue; Harned, Dimeff, Woodcock, & Contreras, 2013-this issue). An experimental investigation demonstrated that therapists with negative beliefs about exposure exhibited more cautious delivery of the treatment (i.e., selection of less anxiety-evoking exposure tasks, greater use of arousal-reduction techniques) compared to therapists with more positive beliefs (Farrell, Deacon, Kemp, Dixon, & Sy, 2013-this issue). Taken together, these findings imply that therapists who hold negative beliefs about exposure therapy are likely to either eschew its use or deliver it with excessive caution.

The detrimental effects of negative beliefs about exposure on its delivery have important implications for treatment outcome. Inhibitory learning theory (Craske et al., 2008) suggests that exposure therapy is effective to the extent that patients experience a violation of negative expectancies for harm and learn that fear is tolerable. The unnecessarily cautious delivery of exposure therapy may result in less improvement by preventing patients from acquiring sufficient inhibitory learning. Accordingly, research suggests that cautious delivery of exposure can produce suboptimal outcomes. For example, a recent study examining variations in the delivery of interoceptive exposure showed that a cautious delivery style was associated with attenuated outcomes and high rates of fear sensitization compared to intensive delivery of the treatment (Deacon, Kemp, et al., 2013). In this study, aspects of a more cautious approach to exposure included use of anxiety-reduction strategies (i.e., diaphragmatic breathing) between exposure trials, limited number of exposure trials, and lengthy rest periods between trials. A striking example of the effects of exposure delivery style and outcomes is a clinical trial by the Pediatric OCD Treatment Study Team (2004) in which exposure therapy was provided at two study sites. The effect size for exposure was more than four times greater at one site than the other despite numerous measures taken to standardize treatment delivery across study sites. According to one of the primary authors of this study (M.E. Franklin), this difference was likely driven by therapists at one site implementing exposure in a markedly more cautious manner (e.g., creating less intense exposure tasks) than the other site (see Deacon & Farrell, 2013). In summary, clinicians who deliver exposure therapy in a cautious manner owing to negative beliefs about this treatment may not achieve optimal patient outcomes.

4. Augmenting training by promoting positive beliefs about exposure therapy

Addressing therapist concerns about exposure therapy is of paramount importance in improving the dissemination of this