



## Assessing therapist reservations about exposure therapy for anxiety disorders: The Therapist Beliefs about Exposure Scale



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### ABSTRACT

Exposure therapy is underutilized in the treatment of pathological anxiety and is often delivered in a suboptimal manner. Negative beliefs about exposure appear common among therapists and may pose a barrier to its dissemination. To permit reliable and valid assessment of such beliefs, we constructed the 21-item Therapist Beliefs about Exposure Scale (TBES) and examined its reliability and validity in three samples of practicing clinicians. The TBES demonstrated a clear single-factor structure, excellent internal consistency ( $\alpha s = .90-.96$ ), and exceptionally high six-month test-retest reliability ( $r = .89$ ). Negative beliefs about exposure therapy were associated with therapist demographic characteristics, negative reactions to a series of exposure therapy case vignettes, and the cautious delivery of exposure therapy in the treatment of a hypothetical client with obsessive-compulsive disorder. Lastly, TBES scores decreased markedly following a didactic workshop on exposure therapy. The present findings support the reliability and validity of the TBES.

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### 1. Introduction

A substantial body of research demonstrates the effectiveness of exposure-based cognitive behavioral therapy (CBT) for the anxiety disorders (Deacon & Abramowitz, 2004; Olatunji, Cisler, & Deacon, 2010). Exposure therapy (also known as exposure and response prevention) is the central procedure in numerous empirically supported treatment protocols for post-traumatic stress disorder (PTSD; e.g., Schnurr et al., 2007), obsessive compulsive disorder (OCD; e.g., Foa et al., 2005), social phobia (e.g., Davidson et al., 2004), panic disorder and agoraphobia (e.g., Gloster et al., 2011), and specific phobias (e.g., Ollendick et al., 2009). Exposure to feared stimuli is an empirically supported principle of change for pathological anxiety (Abramowitz, Deacon, & Whiteside, 2010; Lohr, Lilienfeld, & Rosen, 2012), and the need to train clinicians in the competent delivery of exposure has been identified an important healthcare priority (McHugh & Barlow, 2010).

Unfortunately, exposure therapy is underutilized by practitioners and difficult for clients to access. Most therapists, even those with specialized training in exposure therapy, rarely provide this treatment to their anxious clients (Becker, Zayfert, & Anderson,

2004; van Minnen, Hendriks, & Olf, 2010). When clinicians use exposure therapy its implementation often differs markedly from the typically prolonged and intense manner recommended in treatment manuals (Deacon, Lickel, Farrell, Kemp, & Hipol, 2013; Freiheit, Vye, Swan, & Cady, 2004; Hipol & Deacon, 2013). Most clients with anxiety disorders do not receive efficacious treatment of any kind, and few receive competently delivered exposure therapy (Böhm, Förstner, Külz, & Voderholzer, 2008; Young, Klap, Shoai, & Wells, 2008).

Negative beliefs about exposure therapy appear common among practitioners and likely pose an important barrier to the dissemination of this treatment (Feeny, Hembree, & Zoellner, 2003; Gunter & Whittal, 2010; Olatunji, Deacon, & Abramowitz, 2009; Zoellner et al., 2011). Therapists may fear that exposure will harm clients by producing cognitive decompensation (Becker et al., 2004), symptom exacerbation (Cook, Schnurr, & Foa, 2004), and physical harm (Rosqvist, 2005). To illustrate, Deacon et al. (2013) found that exposure therapists reported concerns that prolonged and intense interoceptive exposure would cause panic clients to decompensate, lose consciousness, experience a worsening of symptoms, and drop out of therapy. Therapists may also worry that exposure will harm themselves via vicarious traumatization (Zoellner et al., 2011) or malpractice litigation (Kovacs, 1996). Additionally, therapists may believe that the deliberate evocation of anxiety in exposure therapy is inherently unethical (Olatunji et al., 2009), unacceptably aversive to clients (Zoellner et al., 2011), and increases dropout rates (van Minnen et al., 2010). Finally,

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therapists may believe that exposure is insensitive to the unique needs of the client and requires concomitant treatment strategies (e.g., controlled breathing) to be safe, tolerable, and effective (Feeny et al., 2003).

Despite a wealth of anecdotal reports that therapist reservations about exposure therapy impede its dissemination and optimal delivery, little empirical research has examined these issues. Several studies have demonstrated that therapist concerns about exposure are linked to its underutilization (e.g., Becker et al., 2004; van Minnen et al., 2010). Two studies have examined the association between negative beliefs about exposure therapy and the manner in which it is delivered. Deacon et al. (2013) reported that therapists with greater concerns about the dangers of intense and prolonged interoceptive exposure for panic disorder were more likely to use controlled breathing strategies with their clients. Using an experimental design with an analog therapist sample, Farrell, Deacon, Kemp, Dixon, and Sy (in press), found that therapists with negative beliefs about exposure delivered this treatment in a more cautious manner to a confederate client with OCD. These preliminary research findings are consistent with the notion that therapist reservations about exposure may compromise its effective delivery. To illustrate, theorists have suggested that beliefs about the intolerability and dangerousness of exposure therapy may prompt clinicians to select less anxiety-evoking exposure tasks, permit clients to use safety behaviors, encourage the use of arousal-reduction strategies, and fail to expose clients to their most feared situations (e.g., Deacon & Farrell, 2013; Rothbaum & Schwartz, 2002).

Little empirical research exists to substantiate widespread speculation that negative beliefs about exposure are pervasive among clinicians and impede its competent delivery. A principal reason for this state of affairs is the absence of a reliable and valid measure of therapist reservations about exposure therapy. Historically, reports of therapist concerns about exposure therapy have been theoretical (e.g., Olatunji et al., 2009) or relied on study-specific items with unknown psychometric properties (e.g., Becker et al., 2004). The availability of a reliable and valid measure would inform future research by permitting the empirical examination of the frequency and consequences of negative practitioner beliefs about exposure therapy. Accordingly, the present series of studies were conducted to characterize the psychometric properties and construct validity of a novel measure: the Therapist Beliefs about Exposure Scale (TBES). With items based on therapist reservations about exposure identified from a comprehensive review of the existing literature (e.g., Becker et al., 2004; Deacon & Farrell, 2013; Feeny et al., 2003; Gunter & Whittal, 2010; Olatunji et al., 2009; van Minnen et al., 2010; Zoellner et al., 2011), the TBES was developed to provide an efficient, reliable, and valid assessment of a wide range of therapist reservations about exposure therapy. Three studies were conducted to examine the following characteristics of the TBES: (a) psychometric properties (e.g., factor structure, internal consistency, test–retest reliability), (b) association with therapist demographic characteristics, reactions to clinical depictions of exposure, and exposure therapy delivery style, and (c) modifiability following didactic training in exposure therapy.

## 2. Study 1: psychometric properties and preliminary construct validity of the Therapist Beliefs about Exposure Scale

### 2.1. Methods

#### 2.1.1. Participants

In an attempt to obtain a diverse and nationally representative sample of practitioners who provide psychotherapy to clients

with anxiety disorders, email invitations were sent to members of therapist directories and were posted on electronic mailing lists representing numerous mental health professions and clinical specialties in the United States. Participants were recruited from the following online therapist directories: Academy of Cognitive Therapy, American Association of Pastoral Counselors, Anxiety Disorders Association of America, Association of Behavioral and Cognitive Therapies, Association for Comprehensive Energy Psychology, EMDR International Association, Family and Marriage Counseling, and the International Obsessive Compulsive Disorder Foundation. Email solicitations were also posted on electronic mailing lists for the Counselor Education and Supervision Network, and APA Divisions 29 (Psychotherapy), 53 (Society of Clinical Child and Adolescent Psychology), 54 (Society of Pediatric Psychology), and 56 (Trauma Psychology). The survey was initiated by 923 therapists, 637 of whom completed all TBES items and comprised the final sample. Given the indeterminate number of individuals who received invitations to participate in this study, it was not possible to calculate a precise response rate.

The mean age of the sample was 35.3 years ( $SD = 12.2$ ) and the majority of participants were women ( $n = 433$ ; 68.0%) and Caucasian ( $n = 603$ ; 94.7%). Most therapists reported earning a master's degree ( $n = 291$ ; 45.7%), Ph.D. ( $n = 244$ ; 38.3%), or Psy.D. ( $n = 39$ ; 6.1%). Membership in mental health professions was as follows: clinical psychology = 39.2% ( $n = 250$ ), social work = 21.5% ( $n = 137$ ), counseling psychology = 12.2% ( $n = 78$ ), counseling = 11.6% ( $n = 74$ ), marriage and family therapy = 11.1% ( $n = 71$ ), and pastoral counseling = 4.7% ( $n = 30$ ); 84 participants (13.2%) reported affiliations with other mental health professions (some participants selected multiple professions). The majority of therapists worked in private practice ( $n = 476$ ; 74.7%) or hospital settings ( $n = 102$ ; 16.0%). Respondents reported that approximately half of their caseload ( $M = 52.4\%$ ,  $SD = 25.5\%$ ) involved treating clients with anxiety disorders, and 61.1% ( $n = 389$ ) advertised themselves to clients as specialists in the treatment of one or more anxiety disorders. Participants indicated that the following theoretical orientations guided their work (some participants selected multiple orientations): cognitive ( $n = 507$ ; 79.6%), behavioral ( $n = 414$ ; 65.0%), family/systems ( $n = 217$ ; 34.1%), psychodynamic ( $n = 206$ ; 32.3%), experiential/humanistic ( $n = 156$ ; 24.5%), and "other" ( $n = 273$ ; 42.9%).

#### 2.1.2. Measures

*Therapist Beliefs about Exposure Scale (TBES)*. Based on a comprehensive review of literature on therapist reservations about exposure therapy, the authors developed an initial pool of 23 items assessing a variety of negative Therapist Beliefs about Exposure therapy, including perceptions that it is intolerable, aversive, unethical, unacceptable, harmful, traumatizing, and inhumane. Respondents indicated their agreement with each item on a 5-point scale ranging from 0 ("disagree strongly") to 4 ("agree strongly").

*Anxiety Sensitivity Index-3 (ASI-3)*. The 18-item ASI-3 (Taylor et al., 2007) measures the fear of anxiety-related body sensations based on beliefs about their harmful consequences and has three six-item subscales assessing physical concerns (e.g., "It scares me when my heart beats rapidly"), social concerns (e.g., "It scares me when I blush in front of other people"), and cognitive concerns (e.g., "When my thoughts seem to speed up, I worry that I might be going crazy"). ASI-3 total and subscale scores have been shown to possess good internal consistency, as well as excellent convergent, discriminant and criterion-related validity (Taylor et al., 2007). Internal consistency ( $\alpha$ ) for each ASI-3 scale was adequate in the present study (total score = .90; physical concerns = .83; social concerns = .77; cognitive concerns = .87).

*Case vignettes*. Four case vignettes depicting the use of exposure therapy with anxious clients were constructed for the present

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