



Do negative beliefs about exposure therapy cause its suboptimal delivery? An experimental investigation



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ABSTRACT

Despite its effectiveness, exposure therapy is underutilized and frequently implemented in suboptimal fashion. Research has shown negative beliefs about exposure are related to its underutilization, and these beliefs are held by exposure therapists and may play a causal role in its suboptimal delivery. This study examined the effect of negative beliefs about exposure on treatment delivery. Participants ($n = 53$) received training in basic exposure implementation and were given additional information intended to elicit either positive or negative beliefs about the treatment's safety, tolerability, and ethicality prior to conducting an exposure session with a confederate client. Results indicated that participants with experimentally induced negative beliefs about exposure delivered the treatment more cautiously (e.g. creation of a less ambitious exposure hierarchy, selection of a less anxiety-provoking exposure task, attempts to minimize client anxiety during exposure) compared to participants with positive beliefs who pursued more ambitious delivery of exposure (e.g. encouraging clients' use of oppositional actions). The present findings suggest that therapist reservations about exposure cause suboptimal delivery and may adversely affect client outcomes.

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1. Introduction

Various forms of exposure therapy (ET) have consistently generated empirical support in the treatment of anxiety disorders (Deacon & Abramowitz, 2004; Olatunji, Cisler, & Deacon, 2010), including posttraumatic-stress disorder (e.g. Foa, Rothbaum, Riggs, & Murdock, 1991; Taylor et al., 2003), obsessive-compulsive disorder (e.g. Abramowitz, Franklin, Schwartz, & Furr, 2003; Franklin, Abramowitz, Kozak, Levitt, & Foa, 2000), panic disorder (e.g. Barlow, Gorman, Shear, & Woods, 2000; Gould, Otto, & Pollack, 1995) and social and specific phobias (Öst, 1996; Rapee, Gaston, & Abbott, 2009). Findings supporting the efficacy of ETs in clinical trials extrapolate to “real world” practice (Stewart & Chambless, 2009). Clinical practice guidelines published by the American Psychiatric Association (2011) and the National Institute for Clinical Excellence (2011) recommend ET approaches as first-line anxiety treatments. Clearly, ETs are a well-established treatment for anxiety disorders, and the need to disseminate them is a high priority (Gunter & Whittal, 2010).

However, despite the well-documented effectiveness of ET, its implementation is hindered by two dissemination problems: (a) it is an underutilized approach, and (b) when used, it is frequently

delivered in an unnecessarily cautious manner (e.g., refraining from use of highly anxiety-provoking exposure tasks, prematurely terminating exposure tasks, frequent use of anxiety reduction strategies; Deacon & Farrell, 2013). Becker, Zayfert, and Anderson (2004) found that a large majority (83%) of doctoral-level psychologists treating PTSD reported not using ET. Similarly, van Minnen, Hendriks, and Olff (2010) reported that most trauma experts did not utilize ET in treatment of PTSD, and found that both client factors (e.g. comorbidity) and therapist factors (e.g. fear of client dropout) predicted decisions to not use exposure. This is despite published findings that ET for PTSD is more effective and as safe and tolerable as other non-exposure methods (Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002; Hembree et al., 2003). The underutilization of ET is not specific to PTSD. A study on the implementation of exposure in Germany found that although almost all therapists in the study requested coverage for ET from obsessive-compulsive clients' health insurers, over 80% of the clients reported that no exposure component was used in their treatment (Böhm, Förstner, Kulz, & Voderholzer, 2008). In addition, Becker et al. (2004) noted that less than 15% of clinicians who received specialized training in ET to treat PTSD reported using the therapy when treating other anxiety disorders.

When ET is used, research shows that therapists frequently deliver it in a manner that appears to be cautious. Freiheit, Vye, Swan, and Cady (2004) surveyed a large group of CBT-oriented psychologists and found that many reported delivering ET in combination with other techniques, including relaxation training,

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meditation, and breathing retraining. Research has demonstrated that arousal-reduction strategies are not evidence-based adjuncts for ET (Deacon et al., 2012) and may even interfere with long-term improvement (Schmidt et al., 2000). In addition, many therapists favor client-guided ET over therapist-assisted exposure. For example, client self-directed ET was used approximately three times more often than therapist-assisted exposure among a sample of practitioners in Wyoming (Hipol & Deacon, 2013). These results are troubling, as ET is more effective when implemented in a therapist-assisted manner (Abramowitz, 1996; Gloster et al., 2011).

What might account for these two dissemination-related problems concerning ET? This question has been more thoroughly addressed in regards to the problem of underutilization. Specifically, research has revealed that many therapists hold a wide array of negative beliefs about ET (Deacon et al., 2013a) that contribute to its underutilization (e.g. van Minnen et al., 2010). Several authors have described therapists avoiding use of exposure due to concerns that it will lead to symptom exacerbation (Olatunji, Deacon, & Abramowitz, 2009), client decompensation (Rosqvist, 2005), direct client harm (Richard & Gloster, 2007), and eventual treatment dropout (van Minnen et al., 2010). Other literature has speculated that therapists believe ET to be aversive and intolerable to clients (Feeny, Hembree, & Zoellner, 2003; Rothbaum & Schwartz, 2002), only applicable to research settings and ineffective in “real world” practice (Becker et al., 2004), associated with a greater risk of malpractice lawsuits (Kovacs, 1996), and intolerable for therapists due to the provocation of negative affect in the client (Litz, 2002). For a more thorough critical review of negative beliefs about ET, see Deacon and Farrell (2013), Feeny et al. (2003), and Olatunji et al. (2009).

Negative beliefs about ET are present even among clinicians who utilize the treatment. Richard and Gloster (2007) surveyed therapists from the Anxiety Disorders Association of America who endorsed numerous reservations about using ET, including that it is too aversive and potentially damaging to the client. It is conceivable that therapists' negative beliefs about ET are responsible for why the treatment is frequently delivered in cautious fashion. Three studies have provided correlational evidence for this hypothetical causal relationship. Deacon and colleagues (2013) showed that scores on a measure of negative beliefs about ET were normally distributed among a sample of ET therapists, and negative beliefs about ET were associated with more cautious ET delivery in the context of a hypothetical case vignette. Therapists in this study who had more negative beliefs about ET were more likely to emphasize distress reduction in the delivery of ET as well as acquiesce to client requests to engage in safety behaviors. Furthermore, Harned, Dimeff, Woodcock, and Contreras (in press, this issue) recently demonstrated that negative attitudes toward exposure were predictive of a number of aspects of cautious ET delivery, including ineffective handling of client avoidance, reassuring clients of safety, and premature termination of exposure tasks. Finally, a recent therapist survey on interoceptive exposure (IE) revealed associations between therapist concerns about harmful effects of IE and cautious IE delivery (Deacon, Lickel, Farrell, Kemp, & Hipol, 2013). Specifically, therapists who reported greater concern about potential IE-induced harm (e.g., decompensation, symptom exacerbation) were more likely to emphasize controlled breathing in their delivery of IE to clients with panic disorder.

Although previous research has established a link between therapists' reservations about ET and a cautious delivery style, this research is correlational in nature and has not evidenced a causal relationship between these variables. Experimental research is necessary to demonstrate the hypothesized causal relationship between negative beliefs about ET and its cautious delivery because it appears that therapist delivery of exposure therapy plays a critical role in treatment outcome. Specifically, the effectiveness of

exposure has shown to be attenuated by a less intense delivery, such as using a limited number of brief exposure tasks, encouraging clients to use arousal reduction strategies (e.g. controlled breathing), and allowing clients to engage in safety behaviors (Deacon et al., submitted for publication, 2012; Powers, Smits, & Telch, 2004).

The objective of the present study was to determine the effect of therapists' beliefs about ET on the delivery of the treatment. To examine this effect, two experimental conditions were utilized in which participants received training in the delivery of ET to treat fear of contamination. Within the “Negative Beliefs” (NB) condition, participants' beliefs about ET were manipulated to have a high degree of concern about ET use. A second “Positive Beliefs” (PB) condition received information designed to reduce concerns about consequences of ET use. All participants completed an ET session with a confederate trained to act as a contamination phobic client. Participants created a hierarchy of exposure tasks before choosing a task from the hierarchy and guiding the client in its completion. We hypothesized that the ET delivery style of NB participants would be characterized by more cautious decision-making, including a less ambitious hierarchy of exposure tasks, choosing a less difficult exposure task to conduct, and terminating the task earlier as compared to PB participants. Additionally, we predicted that NB participants would exhibit more frequent allowance of client safety behaviors, greater attempts to alleviate distress (e.g. providing reassurance, encouraging use of controlled breathing), and less use of “fear-oppositional actions¹” (Wolitzky & Telch, 2009). Lastly, we hypothesized that NB participants would report greater levels of anxiety before and during the ET session as well as more negative attitudes toward future use of ET.

2. Methods

2.1. Participants

Participants included students recruited from undergraduate psychology classes at the University of Wyoming who reported that they were considering pursuing a career as a mental health professional. Participants were recruited via an email advertisement offering brief training in the delivery of ET for anxiety disorders. Exclusion criteria for the study included having previously taken a class from the second author, as this would have likely compromised the effectiveness of the study manipulation. The sample consisted of 53 participants (*M* age = 19.9 years, 56.6% female, 86.8% Caucasian), with 26 randomly assigned to the NB condition and 27 randomly assigned to the PB condition. A computer-based randomization procedure was used to assign participants to conditions. Previous research has indicated that inexperienced students can be taught to administer exposure competently in a relatively brief period of time (Solem, Hansen, Vogel, & Kennair, 2009).

2.2. Materials

Contamination Obsessions and Washing Compulsions (COWC) Subscale of the Padua Inventory–Washington State University Revision (PI-WSUR). The COWC Subscale of the PI-WSUR (Burns, Koertge, Formea, & Sternberger, 1996) is a 10-item measure that assesses a range of different concerns related to fear of becoming contaminated (e.g. “I feel my hands are dirty when I touch money”). In previous research, it has demonstrated acceptable internal

¹ Fear-oppositional actions, or simply oppositional actions, are effective ET augmentation strategies and are defined as client behaviors that oppose safety behavior tendencies.

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