

Exposing Clinicians to Exposure: A Randomized Controlled Dissemination Trial of Exposure Therapy for Anxiety Disorders

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Abstract

Objective: The present study evaluated three technology-based methods of training mental health providers in exposure therapy (ET) for anxiety disorders. Training methods were designed to address common barriers to the dissemination of ET, including limited access to training, negative clinician attitudes toward ET, and lack of support during and following training.

Method: Clinicians naïve to ET ($N = 181$, $M_{age} = 37.4$, 71.3% female, 72.1% Caucasian) were randomly assigned to (a) an interactive, multimedia online training (OLT), (b) OLT plus a brief, computerized motivational enhancement intervention (OLT + ME), or (c) OLT + ME plus a Web-based learning community (OLT + ME + LC). Assessments were completed at baseline, posttraining, and 6 and 12 weeks

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following training. Outcomes include satisfaction, knowledge, self-efficacy, attitudes, self-reported clinical use, and observer-rated clinical proficiency.

Results: All three training methods led to large and comparable improvements in self-efficacy and clinical use of ET, indicating that OLT alone was sufficient for improving these outcomes. The addition of the ME intervention did not significantly improve outcomes in comparison to OLT alone. Supplementing the OLT with both the ME intervention and the LC significantly improved attitudes and clinical proficiency in comparison to OLT alone. The OLT + ME + LC condition was superior to both other conditions in increasing knowledge of ET.

Conclusions: Multicomponent trainings that address multiple potential barriers to dissemination appear to be most effective in improving clinician outcomes. Technology-based training methods offer a satisfactory, effective, and scalable way to train mental health providers in evidence-based treatments such as ET.

Keywords: dissemination; online training; exposure therapy; anxiety disorders

EXPOSURE THERAPY (ET) IS among the most efficacious psychological treatments currently available, with extensive research documenting large treatment effects for each of the anxiety disorders (Norton & Price, 2007). ET involves systematically confronting feared but nondangerous stimuli so that erroneous

beliefs about danger are disconfirmed and fear is reduced. Given that anxiety disorders are the most common class of psychological disorders, affecting 29% of the U.S. population over a lifetime (Kessler, Chiu, Demler, & Walters, 2005), the widespread use of ET in clinical practice could have a profound impact on public health. However, few mental health providers report using ET in their clinical practice (7–38%; Becker, Zayfert, & Anderson, 2004; Freiheit, Vye, Swan, & Cady, 2004; Rosen et al., 2004) and few individuals with anxiety disorders report receiving ET (7–21%; Goisman, Warshaw, & Keller, 1999; Marcks, Weisberg, & Keller, 2009). Thus, ET remains largely inaccessible to those who could benefit from it.

Barriers to the Dissemination and Implementation of ET

As with other evidence-based treatments (EBTs), a primary barrier to the widespread dissemination of ET is a shortage of trained clinicians. A survey of U.S. psychologists found that 27–28% had received training in imaginal or in vivo exposure for PTSD, whereas only 12% had received training in exposure for other anxiety disorders (Becker et al., 2004). Moreover, the rate of adoption among clinicians trained in ET is quite low. For example, among psychologists trained in imaginal exposure for PTSD, 46% never use the treatment and 25% use the treatment with less than half of their PTSD patients (Becker et al., 2004). Similarly, among practicing psychotherapists who had nearly all received training in cognitive-behavioral therapy for anxiety disorders, one-third or less reported using therapist-assisted in vivo exposure or interoceptive exposure to treat obsessive-compulsive disorder, social phobia, panic disorder, and/or PTSD (Hipol & Deacon, 2013). This suggests that providing clinicians with training in ET is a necessary but insufficient step toward increasing the use of ET in routine clinical practice.

A second barrier to the adoption of ET is negative beliefs about exposure. ET has been described as having a “public relations problem” (Richard & Gloster, 2007) and common clinical lore suggests that ET is insensitive, contraindicated for many clients, potentially damaging, and perhaps even unethical (Olatunji, Deacon, & Abramowitz, 2009). Concerns about ET typically stem from the fact that these treatments require clinicians to deliberately elicit anxiety by having clients confront the stimuli that make them anxious so that new learning can occur. Despite the fact that common clinician concerns (e.g., that ET will lead to symptom exacerbation or dropout) are not supported by empirical data (Deacon, Lickel, Farrell, Kemp, & Hipol, 2013; Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002;

Hembree et al., 2003; Olatunji et al., 2009), many clinicians remain hesitant or unwilling to use ET. Importantly, clinicians who have received training in ET endorse concerns about ET at rates comparable to those who have not received training (Becker et al., 2004), suggesting that existing training methods may not adequately address these attitudinal barriers.

A third barrier to the dissemination of ET, as well as other EBTs, is the limited availability of ongoing support for clinicians after they have received training. Ongoing support typically involves supervision or consultation with an expert to encourage adoption, provide feedback, and increase proficiency. For example, a workshop followed by weekly individual consultation with an expert has been used to disseminate prolonged exposure therapy for PTSD in the Veterans Health Administration, with results indicating that expert consultation enhanced clinicians’ confidence in their ability to deliver the treatment beyond the effects found for the workshop alone (Karlin et al., 2010). This is consistent with the emerging consensus that training is unlikely to substantially change clinician behavior or impact client outcomes without the addition of ongoing support (Beidas & Kendall, 2010; Herschell, Kolko, Baumann, & Davis, 2010). However, few therapists (37.5%) report having access to experts in cognitive-behavioral treatment for anxiety disorders in their community (Hipol & Deacon, 2013) and, when available, these services are both costly and time intensive.

USING TECHNOLOGY-BASED TRAINING METHODS TO ENHANCE THE DISSEMINATION OF ET

Technology-based training methods are gaining in popularity and may help to address each of these barriers to the dissemination of ET. Online training (OLT) has been proposed as a cost-effective method of making training in EBTs widely accessible and has several potential advantages over traditional training methods (e.g., improved learner engagement, greater opportunities for active practice, and enhanced learner control; Weingardt, 2004). Research has found that OLT generally outperforms treatment manuals and is comparable to or better than workshops in improving clinician knowledge of EBTs (Dimeff, Beadnell, Woodcock, & Harned, 2011; Dimeff et al., 2009; Sholomskas & Carroll, 2006; Sholomskas et al., 2005; Weingardt, Villafranca, & Levin, 2006). In addition, computer-based training and OLT have been found to be effective and efficient methods of increasing knowledge of ET specifically. Two studies found that review of a brief (60- to 90-minute) computerized self-help program for phobia/panic led to similar improvements in nursing and medical

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