Journal of Anxiety Disorders 25 (2011) 155–163

Contents lists available at ScienceDirect

Journal of Anxiety Disorders

# Overcoming barriers to disseminating exposure therapies for anxiety disorders: A pilot randomized controlled trial of training methods

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ARTICLE INFO

*Article history:*
Received 30 March 2010
Received in revised form 25 August 2010
Accepted 25 August 2010

*Keywords:*
Dissemination
Online training
Exposure therapy
Motivational Interviewing

ABSTRACT

The present study evaluated methods for training mental health providers ($N = 46$) in exposure therapies (ETs) for anxiety disorders. A pilot randomized controlled trial compared: (1) an interactive, multimedia online training (ET OLT), (2) the ET OLT plus a brief Motivational Interviewing-based intervention (ET OLT + MI), and (3) a placebo control OLT. Assessments were completed at baseline, post-training, and one-week following training. Both ET OLT and ET OLT + MI received high satisfaction ratings and were comparably effective at increasing knowledge of ETs as well as clinicians' overt efforts to learn and use the treatment. ET OLT + MI was the most effective method for improving clinicians' attitudes toward ETs. Results indicate that OLT is effective for disseminating knowledge about ETs to clinicians, and suggest that supplementing OLT with a brief MI-based intervention may be a promising direction to address potential attitudinal barriers to adopting these highly efficacious treatments.



Anxiety disorders are the most common psychological disorder in the United States and are estimated to affect 28.8% of the population over a lifetime (Kessler, Chiu, Demler, & Walters, 2005). Anxiety disorders tend to start at a young age (Kessler et al., 2005), have a chronic course (Bruce et al., 2005; Keller et al., 1994), and result in significant disability (Buist-Bowman et al., 2006). Despite the widespread and often disabling nature of anxiety disorders, most individuals suffering from these disorders receive no or inadequate treatment (Wang, Berglund, & Kessler, 2000; Wang, Demler, & Kessler, 2002; Wang et al., 2005). Exposure therapies (ETs) include a family of highly effective psychosocial treatments that utilize exposure procedures to resolve anxiety disorders through repeated and prolonged contact of the client with the stimuli that are presumed to cause anxiety (Richard & Lauterbach, 2007). The basic premise of ETs is that individuals with anxiety disorders need to be exposed to anxiety-provoking stimuli in the absence of aversive consequences to learn that these stimuli are in fact not dangerous, they can tolerate anxiety, and anxiety will decrease over time through a process of habituation.

Efficacy of ETs has been well-documented in hundreds of clinical trials involving thousands of patients who suffer from anxiety disorders. Meta-analyses of this extensive research have found ETs to yield large effect sizes for pre- to post-treatment changes in panic disorder (Bakker, van Balkom, Spinhoven, Blauuw, & van Dyck, 1998; Gould, Otto, & Pollack, 1995), obsessive compulsive disorder (OCD; Abramowitz, 1996), social phobia (Fedoroff & Taylor, 2001; Feske & Chambless, 1995), post-traumatic stress disorder (PTSD; Bradley, Greene, Russ, Dutra, & Westen, 2005), and generalized anxiety disorder (GAD; Gould, Otto, Pollack, & Yap, 1997). Meta-analytic research has also shown that ETs are superior to waitlist and supportive control conditions and produce equivalent results as other, often more complex, psychosocial treatments (e.g., Bradley et al., 2005; Feske & Chambless, 1995). Moreover, ETs are tolerated as well as other psychosocial treatments, as evidenced by research indicating that rates of attrition do not differ across treatments (Feske & Chambless, 1995; Hembree et al., 2003). Studies comparing ETs to pharmacological treatments have generally found that both treatments have comparable short-term effects in the treatment of anxiety disorders, but ETs are superior in terms of longer-term outcome and tolerability (Gould, Buckminster, Pollack, Otto, & Yap, 1997; Gould et al., 1995).

Despite extensive research that overwhelmingly supports efficacy of ETs for anxiety disorders, as well as their relatively straightforward rationale and associated treatment strategies, very few mental health professionals use or are familiar with exposure procedures. Surveys of treatment providers have found that very few utilize ETs in their treatment of anxiety disorder clients (7–38%; Becker, Zayfert, & Anderson, 2004; Freiheit, Vye, Swan, & Cady, 2004; Rosen et al., 2004). Similarly, very few individuals with anxiety disorders report having received ETs (7–21%; Goisman, Warshaw, & Keller, 1999; Marcks, Weisberg, & Keller, 2009). Under-

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doi:10.1016/j.janxdis.2010.08.015

utilization of ETs in routine clinical practice appears to be primarily due to a lack of training opportunities. A U.S. survey of psychologists found that the most commonly endorsed reason for not using exposure to treat PTSD was limited training; 12–28% of psychologists reported having received training in ETs for PTSD or other anxiety disorders (Becker et al., 2004). Similarly, a European survey of trauma experts found that imaginal exposure was the least used treatment for PTSD, and participants reported that they had received less training in imaginal exposure than other psychosocial treatments (van Minnen, Hendriks, & Olff, 2010). However, even among clinicians who are trained in exposure procedures, many do not regularly use the treatment with their anxiety disorder patients. Additional perceived barriers to using ETs to treat PTSD include a preference for individualized treatment over manualized therapy, a concern that patients will decompensate or drop out of treatment, and a belief that ETs are contraindicated for many clients (Becker et al., 2004; van Minnen et al., 2010). These findings correspond to some of the common myths that exist about ETs among mental health professionals, including beliefs that the treatment is insensitive, overly rigid, ineffective, potentially iatrogenic, not generalizable to "real-world" clients and clinical settings, and perhaps even unethical (Feeny, Hembree, & Zoellner, 2003; Olatunji, Deacon, & Abramowitz, 2009; Richard & Gloster, 2007). Taken together, these findings suggest that another significant barrier to the dissemination of ETs is clinicians' beliefs that they will be unsafe, unacceptable, or not well tolerated by patients – beliefs that are not supported by either the research data or surveys of potential consumers (see Olatunji et al. (2009) for a review).

The primary aim of the present study was to evaluate methods for overcoming barriers to disseminating ETs for anxiety disorders, including lack of training and negative attitudes toward the treatment. To that end, we conducted a pilot randomized controlled trial (RCT) examining the comparative efficacy of two active training conditions and a placebo control condition. The first training condition utilized an online training (OLT) course that was designed to cover foundational knowledge about ETs as well as to address many of the common misconceptions about ETs. OLT was chosen as the training method because it possesses a number of advantages over traditional treatment manuals and instructor-led trainings (ILTs), such as a user-friendly design, the ability to elicit greater learner engagement via dynamic interactivities, the provision of realistic models of simulated therapist–client interactions, and improved accessibility (Weingardt, 2004). Moreover, OLT has been found to be an effective method of training mental health providers in evidence-based treatments in a number of RCTs (Dimeff, Beadnell, Woodcock, & Harned, in press; Dimeff et al., 2009; Sholomskas & Carroll, 2006; Sholomskas et al., 2005).

To further address potential attitudinal barriers to adopting ETs, a second training condition supplemented the ET OLT with a brief intervention that incorporated strategies from Motivational Interviewing (MI; Miller & Rollnick, 1991). MI is a brief yet powerful intervention for increasing motivation to change a variety of behavioral and health problems and is often used as a precursor to another active treatment to improve engagement and outcome in the subsequent intervention (Hettema, Steele, & Miller, 2005). In the present study, clinicians in this training condition (ET OLT + MI) participated in brief phone calls before and after completing the ET OLT that focused on discussing their beliefs about ETs and addressing any ambivalence they may have felt about learning and using ETs as a result of these beliefs. This approach is consistent with previous research indicating that supplementing a standard training workshop with a brief psychological intervention (Acceptance and Commitment training) improved clinicians' subsequent willingness to use the newly learned treatment (Varra, Hayes, Roget, & Fisher, 2008).

We hypothesized that the ET OLT and ET OLT + MI would result in comparable increases in knowledge as well as ratings of usability and acceptability. Further, we hypothesized that ET OLT + MI would outperform ET OLT in terms of improving clinicians' self-efficacy, motivation, attitudes toward exposure, and their use of exposure procedures in clinical practice. Finally, we hypothesized that both active training conditions would outperform the placebo control OLT on all outcomes except usability of the training course.

## 1. Method

### 1.1. Procedures

#### 1.1.1. Recruitment and screening

All procedures were approved by the University of Washington Institutional Review Board (IRB) and the Western IRB. Participant enrollment began in October 2008 and the final follow-up assessment occurred in December 2008. Participants were recruited via a Dialectical Behavior Therapy email listserv via an email that requested help evaluating an online training course in exposure therapies. Interested individuals completed a phone screen to determine eligibility. Inclusion criteria were: (1) at least 18 years of age, (2) currently employed as a treatment provider at a mental health agency or were students working to obtain a professional degree in a mental health-related field, (3) currently treating clients with anxiety disorders or were engaged in an educational curriculum that provided training in the treatment of anxiety disorders, (4) has access to a computer with a sound card and an Internet connection, and (5) minimal prior exposure to ETs. To ensure that participants had minimal prior exposure to ETs, individuals were excluded from participation if they had: (1) read any portion of published treatment manuals on an empirically supported ET or (2) attended a lecture, workshop, or intensive training on ET. Overall, 75 individuals contacted the study and were screened for participation. 24 did not meet inclusion criteria (17 had more than minimal prior exposure to ET, 2 were not currently treating clients, 1 had completed the control OLT in a previous study, 4 declined participation).

#### 1.1.2. Randomization

Following the screening, eligible participants ($n = 51$) were assigned to one of the three study conditions by the Participant Coordinator (PC) via a randomization minimization procedure (White & Freedman, 1978). Participants were matched on educational degree (1 = MD/Ph.D. or doctoral candidate; 2 = MA/MS/RN or current graduate student; 3 = BA/BS level; 4 = High School/AA) and clinical experience (1 = 7 plus years; 2 = 2–6 years; 3 = less than 2 years).

#### 1.1.3. Assessment procedures

Following randomization, participants were emailed a copy of the informed consent form and were scheduled for an experimental session. The experimental session involved sending participants an Internet link to a secured, encrypted assessment site to complete the baseline assessment. Once done, they were sent Internet links to their respective OLT course as well as to the post-training assessment. There was no time limit for completing the training, although participants were encouraged to set aside 2 h for its completion. Technical support was available should participants have had difficulties accessing the program. Upon completing the post-training assessment, participants were scheduled for the one-week follow-up assessment. At the scheduled follow-up assessment time, the PC sent participants an Internet link to the final assessment. Participants in the ET OLT + MI condition also had up to two brief (up to 20-min) MI-based phone calls: (1) after completing the baseline assessment and within 72 h of starting the OLT, and (2) within 24 h