



Exposure therapy for youth with anxiety: Utilization rates and predictors of implementation in a sample of practicing clinicians from across the United States

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ABSTRACT

Exposure therapy is a highly effective, evidence-based treatment technique for children and adolescents with anxiety disorders. Regardless, therapists in the community are reported to use exposure relatively rarely compared with other approaches. The goal of the present study was to identify how practicing clinicians treat youth with anxiety disorders across the United States and what factors contribute to their use of exposure therapy. Recruited from public directories, 257 private practice therapists who treat anxious youth were surveyed. Non-exposure cognitive-behavioral techniques like cognitive restructuring and relaxation techniques were used significantly more frequently than exposure. Providers with more training in exposure therapy and fewer negative beliefs about this approach reported using exposure significantly more in the treatment of youth with social anxiety, obsessive-compulsive, and panic disorders. Self-identification as an anxiety disorder specialist significantly predicted exposure use for youth with posttraumatic stress disorder. Most therapists in private practice have minimal training in exposure therapy, perceive a lack of training options, and believe there would be a benefit to acquiring more training. The implications of these findings are discussed, including how to optimally design training opportunities in exposure therapy.

1. Introduction

Anxiety disorders are among the most common mental health disorders in children and adolescents, with over 31% of youth in the United States estimated to meet criteria for an anxiety disorder by the age of 18 (Merikangas et al., 2010). When left untreated, anxiety disorders often run a chronic course (Keller et al., 1992; Perkonig et al., 2014) and are associated with the development of other mental health problems, such as substance abuse (Woodward & Fergusson, 2001). Fortunately, a substantial amount of evidence supports cognitive-behavioral therapy (CBT) as an efficacious intervention for youth with anxiety disorders (e.g., Chorpita et al., 2011; Higa-McMillan, Kotte, Jackson, & Daleiden, 2016; Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012; Jordan, Reid, Mariaskin, Augusto, & Sulkowski, 2012).

Exposure therapy has been shown to be the key ingredient in CBT for anxiety (Ale, McCarthy, Rothschild, & Whiteside, 2015; Olatunji, Cisler, & Deacon, 2010; Peris et al., 2015, 2017; Voort, Svecova, Jacobson, & Whiteside, 2010; Whiteside et al., 2015), though community providers report using exposure relatively infrequently to treat adults with anxiety disorders (Becker, Zayfert, & Anderson, 2004; Cook, Biyanova, Elhai, Schnurr, & Coyne, 2010; van Minnen, Hendriks, & Olff, 2010; Whiteside, Deacon, Benito, & Stewart, 2016; Wolitzky-Taylor, Zimmermann, Arch, De Guzman, & Lagomasino, 2015), particularly when compared with other CBT techniques like relaxation or cognitive restructuring (Hipol & Deacon, 2013; Whiteside et al., 2016). Some recent literature has begun to explore how practicing clinicians treat anxious children and adolescents as well. A survey of clinicians in a Hawaiian community mental health system showed that therapists used

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exposure therapy with fewer than 25% of trauma-exposed youth (Borntrager, Chorpita, Higa-McMillan, Daleiden, & Starace, 2013) and with fewer than 15% of youth with anxiety disorders (Higa-McMillan et al., 2016). This pattern was also recently observed in a sample of practicing clinicians in Minnesota who treat youth with various anxiety disorders (Whiteside et al., 2016). The present study sought to extend the emerging literature on barriers to exposure therapy use by surveying therapists around the entire United States about their treatment practices for youth with anxiety disorders. This survey focused on therapists in private practice, who make up a large portion of the psychology workforce and may be especially expected to use evidence-based techniques like exposure as they are often perceived as experts, but have not been adequately studied by previous surveys of exposure use (American Psychological Association, 2009; Whitaker, Weismiller, & Clark, 2006).

Towards the goal of building a practice-to-research bridge where feedback from practicing clinicians can be used to inform future dissemination and implementation (DI) efforts, it is important to identify factors that explain why some clinicians underutilize exposure techniques. This aim is particularly pertinent considering that exposure therapy use tends to wane more over time than other CBT techniques (Chu et al., 2015; Edmunds et al., 2014; Southam-Gerow et al., 2010). Several theoretical models of DI (e.g., Beidas & Kendall, 2010; Southam-Gerow, Rodríguez, Chorpita, & Daleiden, 2012) underscore the importance of client/family, provider, intervention, and organizational/systems factors that may influence the implementation of evidenced-based practices to treat youth with anxiety. Clinician-specific factors may be a particularly important barrier to the DI of exposure-based practices, as therapists often hold negative beliefs towards exposure therapy (e.g., that patients will decompensate or drop out of treatment if they participate in exposure therapy; Deacon et al., 2013; Olatunji, Deacon, & Abramowitz, 2009) and report concern for their own emotional reactions to exposure (Harned, Dimeff, Woodcock, & Contreras, 2013; Zoellner et al., 2011). Therefore, in order to guide future DI efforts, this study sought to investigate several potential provider-specific barriers, specifically those related to provider demographics, training history, emotional sensitivities, and beliefs about exposure therapy.

With regard to demographics, two studies suggested that females may be less likely to implement trauma-related exposure (Devilley & Huther, 2008; van Minnen et al., 2010), although it is unknown if gender impacts the utilization of non-trauma-related exposure. An aim of the current study is to determine whether female therapists use exposure less with children with various anxiety and related disorders.

A much larger amount of research, however, has investigated how training history and education impact exposure utilization. These studies suggest practicing clinicians with higher self-reported education or specialization in treating anxiety may be more likely to use exposure (Harned et al., 2013; Higa-McMillan, Francis, Rith-Najarian, & Chorpita, 2015; Higa-McMillan, Nakamura, Morris, Jackson, & Slavin, 2015; Hipol & Deacon, 2013; Jacobson, Newman, & Goldfried, 2016; Whiteside et al., 2016). However, it remains unclear how critical *specific* training in exposure therapy is for sustained implementation, compared to obtaining a higher level of education or developing a self-reported specialization. Consistent with three studies focused on post-traumatic stress disorder (PTSD; Becker et al., 2004; Russell & Silver, 2007; van Minnen et al., 2010), one study conducted with Dutch therapists found that higher levels of self-reported specialized training in exposure therapy was associated with higher exposure therapy utilization (Sars & van Minnen, 2015). Though training appears critical to exposure implementation, there is a lack of data on how receptive practicing clinicians who treat youth with anxiety disorders are to receiving more exposure-specific training or how they would prefer to receive this additional training.

Clinicians' emotional sensitivities may also contribute to the poor DI of exposure therapy, as clinicians with higher anxiety sensitivity appear

to be more hesitant about the implementation of exposure (Harned et al., 2013). For example, a clinician who is less tolerant of experiencing physical manifestations of anxiety may be less likely to model and use interoceptive exposure with adolescents with panic disorder. Similarly, novice therapists may fear that they would not be able to handle watching their patient endure situations that cause them to re-experience a traumatic event (Zoellner et al., 2011). Disgust sensitivity could also leave practitioners more hesitant to conduct disgust-provoking exposure such as those that target obsessions related to harm, sexuality, or contamination. Taken together, practitioners' emotional sensitivities have received little attention in the literature, yet may be significant barriers to using exposure.

In addition to therapists' emotional sensitivities, their beliefs about exposure therapy are another important factor that may determine their implementation of this treatment. Clinicians are often dubious of evidence-based practices more broadly, and as a result, they are less likely to implement these approaches (e.g., Borntrager, Chorpita, Higa-McMillan, & Weisz, 2015; Brookman-Frazee, Haine, Baker-Ericzén, Zoffness, & Garland, 2010; Lilienfeld, Ritschel, Lynn, Cautin, & Litzman, 2013). Much less research has studied attitudes towards specific techniques such as exposure. A few studies have described several common negative beliefs that have been associated with less exposure utilization by practicing clinicians (Whiteside et al., 2016) and suboptimal exposure delivery (Deacon et al., 2013; Harned et al., 2013). Emerging research suggests that younger children are less likely to receive evidence-based treatments (Borntrager et al., 2013; Brookman-Frazee et al., 2010; Higa-McMillan et al., 2016). While this could be due to a variety of factors, it is plausible that clinicians may have negative beliefs about the use of exposure therapy with youth that deter them from using these techniques (Meyer, Farrell, Kemp, Blakey, & Deacon, 2014; Ringle et al., 2015; Southam-Gerow et al., 2012; Whiteside et al., 2016). For example, clinicians may believe that youth are more likely to drop out from exposure-based treatment or that exposure exercises will hinder alliance with children or parents, though there is a lack of data to support either of these fears (Imel, Laska, Jakupcak, & Simpson, 2013; Kendall et al., 2009; Ormhaug & Jensen, 2018; Öst, Havnen, Hansen, & Kvale, 2015; Reid, Bolshakova et al., 2017).

In summary, practicing therapists in the United States often treat youth with clinical anxiety, yet there is limited research about how often exposure therapy is utilized by these clinicians. This study addresses current gaps in the literature by focusing on the treatment of youth with anxiety rather than adults, recruiting private practitioners rather than general community-based clinicians, and assessing multiple clinician-specific factors that may inhibit exposure therapy implementation. Less is known about how often exposure is used for youth with anxiety, though children may be particularly less likely to see a therapist who uses exposure (Higa-McMillan et al., 2016). To date, only two studies have surveyed child and adolescent therapists, each in specific states in the United States. We sought to survey a nationally representative sample of therapists to enhance the generalizability of findings to date. We also specifically assessed private practitioners, a rarely studied group who make up a large portion of practicing therapists (American Psychological Association, 2009; Whitaker et al., 2006), as most studies have focused on community clinicians more broadly, despite private practitioners often being advertised as experts. This study also used psychometrically validated measures of clinician-specific factors that may inhibit exposure implementation, including provider disgust sensitivity, anxiety sensitivity, training in exposure therapy, and provider beliefs about exposure. The few studies that have compared the frequency of exposure with other techniques have not included several third-wave approaches that are growing in popularity (e.g., values-based action, cognitive defusion), and thus we also included these practices to accurately compare exposure therapy utilization with other common techniques.

The first aim of the current study was to survey therapists to

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