Targeting clinician concerns about exposure therapy: A pilot study comparing standard vs. enhanced training

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ABSTRACT

Owing to concerns about the safety and tolerability of exposure therapy, many clinicians deliver the treatment in an overly cautious manner, which may limit its effectiveness. Although didactic training in exposure reduces clinician concerns about the treatment to a moderate extent, improved training strategies are needed to minimize these concerns and improve exposure delivery. The present study compared the effectiveness of a standard (i.e., didactic) exposure therapy training model to an "enhanced" training paradigm encompassing strategies derived from social-cognitive theory on attitude change. Clinicians ($N = 49$) were assigned to one of the two training approaches. Relative to standard training, clinicians who received enhanced training showed: (a) significantly greater reductions in concerns about exposure from pre- to post-training, and (b) superior self-reported delivery of the treatment. Reduction in concerns during training mediated the effects of training condition on clinicians' self-reported exposure delivery. These findings underscore the importance of addressing clinician concerns about exposure therapy in training contexts.

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A large body of evidence supports the effectiveness of exposure therapy in the treatment of anxiety and related disorders (e.g., Olatunji, Cisler, & Deacon, 2010). Given the considerable prevalence of these disorders and their associated functional impairment and economic burden on society, there is a high priority on effectively disseminating exposure to clinicians who treat anxiety (McHugh & Barlow, 2010). Unfortunately, many clinicians appear concerned about exposure being harmful and/or intolerable to clients, which acts as a critical barrier to its dissemination (Deacon & Farrell, 2013). A recent survey of more than 600 mental health professionals revealed that these concerns are common among practitioners from various mental health disciplines, including clinicians who routinely use exposure in their clinical practice (Deacon, Farrell, et al., 2013; Deacon, Kemp, et al., 2013; Deacon, Lickel, et al., 2013).

The clinical implications of clinician concerns about exposure are significant. Previous research has shown these concerns are related to clinicians' underutilization of exposure in clinical

practice (e.g., Becker, Zayfert, & Anderson, 2004). Furthermore, among exposure therapists, these concerns are associated with an overly cautious manner of delivering the treatment (e.g., premature termination of exposure; Deacon, Farrell et al., 2013; Harned, Dimeff, Woodcock, & Contreras, 2013) that differs significantly from the recommended prolonged and intense delivery of exposure (e.g., Abramowitz, Deacon, & Whiteside, 2011). A recent study showed that an analogue sample of exposure therapists with experimentally-induced concerns about the treatment exhibited more aspects of cautious delivery (e.g., choosing minimally distressing exposure tasks, more use of anxiety-reduction techniques) than therapists who were not exposed to these concerns (Farrell, Deacon, Kemp, Dixon, & Sy, 2013).

If clinicians who have significant concerns about exposure implement it with excessive caution, the overall effectiveness of the treatment is likely undermined. Applications of learning theory to exposure therapy suggest that effectiveness is maximized when clients develop strong inhibitory associations (i.e., associating feared stimuli with perceptions of safety and tolerability; Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014). Inhibitory associations are strengthened through several critical processes in exposure,

including violating clients' expectations for harm, eliminating use of safety behaviors, and facilitating learned tolerance of anxiety (Abramowitz & Arch, 2014). Clinicians who deliver exposure with excessive caution may unwittingly weaken clients' inhibitory associations, thereby attenuating treatment effectiveness. Indeed, recent research has demonstrated that less intensive delivery (e.g., frequent use of anxiety-reducing strategies) yields poorer outcomes compared to more intense delivery of exposure (Benito, Conelea, Garcia, & Freeman, 2012; Deacon, Kemp et al., 2013).

Training clinicians in a manner that minimizes their concerns about exposure will likely result in more competent delivery, ultimately yielding better outcomes for anxious clients (Zoellner et al., 2011). Thus, there is a critical need to identify effective strategies for minimizing clinician concerns about exposure. However, few studies have assessed such techniques. One study showed that didactic training in the theory and practice of exposure resulted in only moderately reduced concerns about the treatment, and this reduction was significantly smaller among clinicians already using exposure in their practice as compared to exposure-naïve clinicians (Deacon, Farrell et al., 2013). Similar results were found in a study of didactic exposure therapy training for eating disorder clinicians (Waller, D'Souza Walsh, & Wright, 2016). Two other studies suggest that augmenting didactic training with motivational enhancement strategies holds promise in improving clinician attitudes toward and delivery of exposure (Harned et al., 2013, 2014). However, participation in these studies was both time-intensive and predominantly web-based, and it may be that some clinicians prefer more short-term, traditional training formats that allow for greater interaction with trainers and other attendees. Thus, further research is needed to explore the effectiveness of alternative means of improving training in exposure therapy.

In previous work, several strategies for improving training in exposure derived from social-cognitive literature on attitude change have been proposed (for a comprehensive review, see Farrell, Deacon, Dixon, & Lickel, 2013). Based on previous work showing that some individuals' attitudes are more influenced by empirical evidence whereas others' are more influenced by emotion-based appeals, Farrell, Deacon, Dixon, et al. (2013); Farrell, Deacon, Kemp, et al. (2013) proposed that clinicians should be presented with a balance of: (a) summaries of empirical literature refuting common concerns about exposure, and (b) emotion-based appeals (e.g., case examples) attesting to the safety and tolerability of exposure. In addition to this balance of empirical and affective appeals aiming to accomplish attitude change on an *explicit* level, social-cognitive literature advocates strategies for attitudinal change on an *implicit* level; thus, Farrell, Deacon, Dixon, et al. (2013); Farrell, Deacon, Kemp, et al. (2013) also proposed use of simulated exposure exercises for clinicians to facilitate associative pairing between exposure therapy and notions of safety and tolerability. To preliminarily assess whether these proposed strategies reduce clinician concerns about exposure and improve its delivery above and beyond traditional didactic exposure training, the present study aimed to compare an "enhanced" form of exposure training to "standard," didactic training.

An expert presenter on exposure therapy (BJD) conducted six separate training workshops on the theory and practice of exposure. Whereas three of the workshops contained standard training methods (i.e., didactic instruction) known to moderately reduce clinician concerns about exposure (Deacon, Farrell et al., 2013), the other three workshops included the enhanced training strategies put forth by Farrell, Deacon, Dixon, et al. (2013); Farrell, Deacon, Kemp, et al. (2013). Clinicians' concerns about exposure therapy were assessed both prior to and immediately following the workshop. Additionally, a self-report measure of clinician delivery of exposure was completed at post-workshop. We hypothesized that, relative to clinicians receiving standard training, clinicians who received enhanced training would show greater reductions in concerns about exposure from pre- to post-workshop. We also hypothesized that clinicians receiving enhanced training would evidence superior self-reported exposure delivery. Finally, we hypothesized that reductions in clinician concerns about exposure from pre- to post-workshop would significantly mediate the relationship between training condition and self-reported delivery of exposure.

1. Method

1.1. Participants

Participants ($N = 49$) were mental health clinicians attending an 8-h workshop on the theory and practice of exposure therapy for anxiety. The sample age ranged from 31 to 73 years ($M = 51.5$, $SD = 10.5$). The majority of participants were women ($n = 32$, 65.3%) and Caucasian ($n = 46$, 93.9%). Nearly all reported earning either a Master's degree ($n = 37$, 75.5%) or Ph.D. ($n = 9$, 18.4%). On average, the sample had 18.7 years of experience ($SD = 9.6$) in clinical practice. Participants endorsed the following theoretical orientations: cognitive-behavioral ($n = 32$, 65.3%), family/systems ($n = 7$, 14.3%), humanistic/client-centered ($n = 5$, 10.2%), psychodynamic ($n = 3$, 6.1%), interpersonal ($n = 1$, 2.0%), and "other" ($n = 1$, 2.0%).

1.2. Measures

1.2.1. Therapist beliefs about exposure scale (TBES)

The TBES (Deacon, Farrell et al., 2013) is a 21-item questionnaire assessing clinician concerns about exposure therapy. Participants use a 0 (*disagree strongly*) to 4 (*agree strongly*) scale to indicate their agreement with statements illustrating potential concerns about exposure (e.g., "Exposure therapy often causes clients' anxiety symptoms to worsen"). Total scores on the TBES range from 0 to 84. Higher scores indicate greater concern about exposure. The TBES has demonstrated excellent internal consistency ($\alpha = 0.95$) and six-month test-retest reliability ($r = 0.89$). In the present study, the TBES was administered both before and after the workshop, and it showed good internal consistency (pre-workshop $\alpha = 0.85$, post-workshop $\alpha = 0.91$).

1.2.2. Exposure therapy case vignette (ETCV)

The ETCV (Deacon, Farrell et al., 2013) is a self-report version of a previously validated behavioral measure of exposure therapy delivery (see Farrell, Deacon, Dixon, et al., 2013; Farrell, Deacon, Kemp, et al., 2013). Participants are presented with a case vignette depicting a client fearful of contamination and are asked to make delivery-related decisions at four time points throughout a hypothetical exposure session. At each time point, participants receive information about the client, including a current rating of the client's subjective distress (0–100), observable anxiety symptoms (e.g., shaking, sweating), and a verbal report ("This is awful. I just know I'm going to get sick. I'm feeling lightheaded and I don't know if I should keep going.") Participants use a 0 (*very unlikely*) to 4 (*very likely*) scale to indicate their likelihood of engaging in a several potential actions.

The range of potential actions assesses both theoretically optimal (e.g., "Encourage the client to remain in contact with the object") and suboptimal (e.g., "Reassure the client that she will not get sick from the object") strategies for delivering exposure. Based on previous factor analytic work (Deacon, Farrell et al., 2013), responses across the four time points are aggregated to form three subscales characterizing distinct styles of exposure delivery. The 12-item Distress Reduction subscale includes actions designed to minimize distress (e.g., "Instruct the client to use arousal reduction strategies"). The 9-item Safety Behavior Acquiescence subscale