Behaviour Research and Therapy 76 (2016) 76–80

Contents lists available at ScienceDirect

Behaviour Research and Therapy

journal homepage: www.elsevier.com/locate/brat

Shorter communication

Impact of education on clinicians' attitudes to exposure therapy for eating disorders

Glenn Waller*, Katrina D'Souza Walsh, Charlotte Wright

Clinical Psychology Unit, Department of Psychology, University of Sheffield, UK

ARTICLE INFO

Article history:
Received 12 July 2015
Received in revised form
2 November 2015
Accepted 24 November 2015
Available online 2 December 2015

Keywords:
Exposure therapy
Anxiety
Eating disorders
Training

ABSTRACT

It is well established that clinicians use exposure therapy far less often than the evidence would suggest is justified. This shortfall has been explained as being at least partly a result of clinicians' beliefs and attitudes about exposure and their trait anxiety. Recent studies have shown that attitudes to exposure therapy for anxiety disorders can be improved through a simple educational approach. This study aimed to determine whether a similar educational approach can improve therapists' attitudes to exposure therapy for the eating disorders, and whether clinician's pre-intervention characteristics influenced the impact of the training. Thirty-four eating disorder clinicians (30 female, four male; mean age = 39.0 years; 85.3% Caucasian) attended a 90-min didactic teaching session on the subject of the use of exposure in treatment of eating disorders. Their attitudes to exposure therapy were measured before and after the workshop, in a within-subject design. The outcome was a substantial improvement in attitudes, with a strong effect size (Cohen's $d = 1.68$) that was comparable to the outcome of a similar intervention among clinicians working with anxiety disorders. The improvement was not related to clinicians' anxiety levels, but was greater among those whose attitudes were more negative at the outset of the teaching. While this finding needs to be tested for long-term maintenance and its relationship to change in clinical practice, it adds to the evidence that a simple educational intervention is sufficient to result in substantial improvement in clinicians' attitudes to exposure therapy.

© 2015 Elsevier Ltd. All rights reserved.

Exposure with response prevention is a very powerful therapeutic technique, but it is used far less often than the evidence might suggest (Harned, Dimeff, Woodcock, & Contreras, 2013). It has potential uses in all disorders that have an anxiety-based component. This includes eating disorders, where anxiety is a key maintaining factor for behaviours such as restriction, bingeing, purging and body avoidance (e.g., Pallister & Waller, 2008). Furthermore, anxiety can lead the eating-disordered patient to want to avoid central elements of therapy, such as weighing (e.g., Waller & Mountford, 2015). These processes in eating pathology explain why evidence-based cognitive-behavioural therapy (CBT) for eating disorders has a strong exposure-based element (e.g., Fairburn, 2008; Waller et al., 2007).

However, despite its theoretical and empirical support, exposure-based therapy is used relatively infrequently with eating disorders (Turner, Tatham, Lant, Mountford, & Waller, 2014; Waller, Stringer, & Meyer, 2012). This low level of usage is similar to that in other diagnostic groups (e.g., Becker, Zayfert, & Anderson, 2004), and is explained at least in part by similar intra-clinician characteristics (Deacon, Lickel, Farrell, Kemp, & Hipol, 2013; Farrell, Deacon, Kemp, Dixon, & Sy, 2013). In the anxiety disorders, the reasons given for not using exposure are more related to clinicians' negative beliefs about exposure therapy (e.g., Deacon, Farrell, et al., 2013; Deacon, Lickel, et al., 2013) than to evidence of possible outcomes (Deacon & Farrell, 2013). In both anxiety and eating disorders, clinician anxiety is also associated with poorer use of exposure-based methods (Meyer, Farrell, Kemp, Blakey, & Deacon, 2014; Turner et al., 2014).

Different proposals have been advanced regarding how clinicians might be encouraged to improve their uptake of exposure therapy, including role plays, the use of case material, and attitude inoculation (e.g., Farrell, Deacon, Dixon, & Lickel, 2013). However, a more straightforward and efficient approach might be the use of psychoeducation to address negative attitudes to this therapeutic method. Deacon, Farrell, et al. (2013) have shown that a one-day didactic workshop has a very substantial positive effect on

* Corresponding author. Clinical Psychology Unit, Department of Psychology, University of Sheffield, Western Bank, Sheffield S10 2NT, UK.
E-mail address: g.waller@sheffield.ac.uk (G. Waller).

http://dx.doi.org/10.1016/j.brat.2015.11.014
0005-7967/© 2015 Elsevier Ltd. All rights reserved.

clinicians' attitudes to the use of exposure therapy (effect size; $d = 1.50$). Using a non-clinician sample, a much shorter piece of educational work showed a similar positive effect on beliefs about exposure, though with a smaller effect size (Arch, Twohig, Deacon, Landy, & Bluett, 2015). However, such an education-based approach has not been tested with clinicians who work with eating disorders, so it is not possible to assume that the findings of those studies will generalise to this field. Nor is it known whether individual clinicians are more or less likely to respond to such an intervention.

Therefore, this study aimed to demonstrate whether a relatively didactic teaching session can improve clinicians' attitudes to the use of exposure with response prevention, and whether clinicians differ in their attitudinal change according to their baseline characteristics. The primary hypothesis was that eating disorder clinicians would show an improvement in their attitudes and beliefs regarding exposure therapy following a brief teaching session. The second hypothesis was that the use of exposure and attitudes to it would be related to the clinicians' characteristics, with more negative attitudes among those clinicians: who had higher personal levels of anxiety; who used exposure less in their everyday practice; and whose training could be presumed to have involved more of an introduction to exposure therapy (psychologists and psychiatrists). The final hypothesis was that the degree of change in attitudes and beliefs would be related to the individual's characteristics, with a greater degree of change among those who were already familiar with and holding positive attitudes towards exposure therapy.

1. Method

1.1. Ethical clearance

This research received ethical clearance from the Research Ethics Committee of the Department of Psychology, University of Sheffield.

1.2. Participants

For the primary outcome variable (change in TBES scores), the effect size ($d = 1.50$) obtained by Deacon, Farrell, et al. (2013) was used to calculate the minimum sample size needed. For a one-tailed paired t-test with $P = .05$ and $alpha = 95\%$, only seven participants were needed. However, a larger number were targeted as the teaching was shorter in this study (1.5 h) than in the Deacon, Farrell et al. workshop (one day). The lower 'dose' of teaching might have a smaller effect than the larger dose, leading to the possibility that the power of this 1.5 h teaching session would be lower. Therefore, the number of participants should be well above the number indicated by Deacon, Farrell et al.'s effect size.

Thirty-four therapists participated (sufficient to yield a power of 95% even with a much smaller effect size of .6 (one-tailed $P = .05$). Each participant attended a didactic teaching workshop on using exposure with response prevention in CBT for eating disorders, at an international eating disorders conference. The workshop was one of several parallel sessions, so the attendees were likely to have a specific interest in CBT. Attendees were asked to take part in the research if they were happy to do so, and participation was anonymous. A total of 45 questionnaire packs were circulated, resulting in a participation rate of 75.6%. Of the 34 participants, 30 were female and four were male, while 29 (85.3%) were Caucasian. Their mean age was 39.0 years ($SD = 10.4$). They were from a range of professions, including clinical psychology ($N = 13$), dietetics ($N = 7$), psychiatry ($N = 4$), nursing ($N = 2$), social work ($N = 2$), family therapy ($N = 1$), occupational therapy ($N = 1$), counselling ($N = 1$), psychotherapy ($N = 1$), and art therapy ($N = 1$). One participant did not state their profession.

1.3. Measures and procedure

At the beginning of the session, each participant read the information sheet. To ensure that the participants were clear that the topic was exposure therapy rather than any other anxiety-provoking experience, the information sheet commenced with:

> 'Today's teaching session is about the use of exposure therapy in treating eating disorders. Clinicians have a range of attitudes to eating disorders and to the use of different treatment methods, making us more or less likely to use those methods. We would like to know what your attitudes are to using exposure therapy techniques in particular. We would also like to understand who is likely to have more or less positive attitudes to exposure therapy, and to determine whether or not teaching sessions (such as this one) have any impact on those attitudes in the short- and long-term'.

This point was reinforced in the introduction to the teaching, where the topic was defined as 'exposure with response prevention'. Participants then completed the consent form, and provided demographic information (gender, age, profession, whether they used exposure work, and what percentage of the time if they did). Following this, during the introduction to the workshop, they completed two self-report measures – the short form of the Intolerance of Uncertainty Scale (IUS-SF) and the Therapist Beliefs about Exposure Scale (TBES). The TBES was completed again during the final 5 min of the workshop, during questions.

1.3.1. Measures

The *Intolerance of Uncertainty Scale-Short Form* (IUS-SF; Carleton, Norton, & Asmundson, 2007) is an established and well-validated measure of the cognitions that underpin anxiety, with a clear factor structure, internal consistency and clinical validity. It consists of 12 items that make up two subscales – prospective anxiety (inability to tolerate uncertainty) and inhibitory anxiety (inability to act due to uncertainty). Higher scores indicate greater levels of anxiety. This measure has been shown to be a useful indicator of clinicians' anxiety (Turner et al., 2014).

The *Therapist Beliefs about Exposure Scale* (TBES; Deacon, Farrell, et al., 2013) is also a well-validated measure, which addresses clinicians' attitudes and beliefs regarding the use of exposure therapy. It consists of 21 items (e.g., 'Exposure therapy is difficult to tailor to the needs of individual clients'), which form a single scale. Higher total scores indicate more negative attitudes to the use of exposure therapy. The TBES has a very good test-retest reliability, as well as being responsive to teaching-based interventions (Deacon, Farrell, et al., 2013).

1.3.2. Teaching session

The teaching session[1] lasted for 90 min, and covered the following in terms of theory and evidence: the psychology and physiology of anxiety; mechanisms of anxiety development and maintenance (including safety behaviours); relationship of anxiety with eating; anxiety reduction mechanisms (exposure based); response prevention (in anxiety disorders and in eating disorders); evidence that clinicians often do not use exposure with eating disorders or other disorders; reasons why clinicians do not use exposure in different disorders; ways of using exposure with

[1] Copy of workshop slides available from the corresponding author.

Download English Version:

https://daneshyari.com/en/article/7262175

Download Persian Version:

https://daneshyari.com/article/7262175

Daneshyari.com