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Use of evidence-based assessment for childhood anxiety disorders in community practice

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ABSTRACT

High-quality assessment is essential to the delivery of effective treatment for childhood anxiety disorders. However, relatively little is known about how frequently child clinicians utilize evidence-based assessment (EBA) techniques in practice, and even less is known about the factors that influence EBA use in such settings. Thus, the current study presents data from a survey of 339 clinicians from a variety of professional backgrounds concerning their use of EBA for childhood anxiety disorders and explores issues preventing EBA implementation. Results indicated infrequent EBA use with clinicians citing practical barriers (i.e., time, access, knowledge, cost) and negative beliefs about EBA techniques (i.e., unhelpful) as issues preventing implementation. Implications for future EBA dissemination and implementation efforts are discussed.

1. Introduction

Anxiety disorders are among the most prevalent psychiatric diagnoses in youth (Demertzis & Craske, 2006), and if left untreated often lead to significant impairment (Beidel et al., 2006; Biggs, Sampilo, & McFadden, 2011; Mychailyszyn et al., 2010Mychailyszyn, Méndez, & Kendall, 2010) and additional psychopathology (Kendall, Settipani, & Cummings, 2012; Woodward & Fergusson, 2001). Fortunately, our understanding of anxiety has improved dramatically over the past 25 years and evidence based treatments (EBTs) have demonstrated efficacy in treating this disorder (Kendall et al., 2012). In general, EBT protocols are applied to specific diagnostic categories; meaning effective treatment is predicated on an accurate diagnosis (Jensen-Doss & Weisz, 2008; Pogge et al., 2001). Thus, psychometrically sound, evidence-based assessment (EBA) is essential to the delivery of effective treatment (Mash & Hunsley, 2005).

Experts agree that structured diagnostic interviews represent the gold standard in EBA (Ehlert, 2007; Joiner, Walker, Pettit, Perez, & Cukrowicz, 2005; Schneider & Döpfner, 2004; Silverman & Ollendick, 2005). Compared to unstructured interviewing methods, structured interviews yield more objective data, increase the specificity of gathered information, and enable comprehensive evaluation of a range of diagnoses (Di Nardo, 1983; Edelbrock & Costello, 1990; Endicott, 1978). Moreover, patients have a positive attitude toward structured interviewing (Jonasson, Jonasson, Ekselius, & von Knorring, 1997; Marshall et al., 2001; Newman et al., 1999Newman, Walker, & Getfland, 1999; Pinninti, Madison, Musser, & Rissmiller, 2003; Suppiger et al., 2009) and believe that this approach promotes the therapeutic relationship and enables therapists to better understand their patients' problems (Bruchmuller, Margraf, Suppiger, & Schneider, 2011). Numerous interviews have been developed for reliable and valid diagnosis of anxiety disorders in youth, e.g., Anxiety Disorders Interview Schedule for Parents and Children (Silverman & Albano, 1996).

In addition to structured interviews, rating scales are an important component in EBA as they provide a cost-effective and efficient solution for identifying symptoms and tracking clinical change (Silverman & Ollendick, 2005; Whiteside, Gryczkowski, Biggs, Fagen, & Owusu, 2012). A number of valid and reliable rating scales have been developed for assessing childhood anxiety disorders (Silverman & Ollendick, 2005). Such scales demonstrate utility for child clinicians as they can be used to obtain data from multiple informants (e.g., children, parents, teachers) and capture information that might not have been reported by the child during clinical interview due to social desirability, embarrassment, or unwillingness to cooperate (Chorpita, Albano, & Barlow, 1996; Velting et al., 2004Velting, Setzer, & Albano, 2004). Thus, rating scales can serve

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as an important supplement to structured interviews when providing an evidence-based approach to assessment.

Due to the importance of EBA in the delivery of effective psychotherapy, the degree to which structured interviews and rating scales are implemented in clinical practice is an important indication of the overall quality of services being offered (Hunsley & Mash, 2007). As such, studies exploring test usage among practicing clinicians have a long history within our field (e.g., Louttit & Browne, 1947) and have, unfortunately, provided considerable evidence that EBA is generally not implemented in clinical practice (e.g., Bruchmuller et al., 2011). However, relatively little research has explored child clinicians' use of EBA (Archer, Maruish, Imhof, & Piotrowski, 1991; Cashel, 2002; Kamphaus, Petoskey, & Rowe, 2000; Tuma & Pratt, 1982), and even less is known about how clinicians assess childhood *anxiety* (Jensen-Doss & Hawley, 2010).

Lack of knowledge about EBA use among child anxiety clinicians may be an example of the limitations of the traditional approach to dissemination and implementation (DI). Historically, DI efforts have involved unidirectional transmission of information about evidence-based practice (EBP; including assessment and treatment practices) from advocates (e.g., researchers, EBP developers) to behavioral health stakeholders (e.g., clinicians, policy makers; Beutler, Williams, Wakefield, & Entwistle, 1995). However, this approach does not yield information about the important contextual factors that influence EBP use in clinical settings (Becker, Nakamura, Young, & Chorpita, 2009). As such, early decisions regarding EBP DI were based on an incomplete understanding of clinical environments and generally failed to achieve widespread and sustainable adoption in such settings.

In response, collaborative approaches emphasizing a reciprocal exchange of information between EBP stakeholders and advocates about behavioral health innovations and clinical practice have become more common (Nadeem, Olin, Hill, Hoagwood, & Horwitz, 2014). Such efforts have identified a number of practical and philosophical barriers to EBP implementation, and research suggests that attending to these issues improves the effectiveness of implementation efforts (Chorpita & Regan, 2009; Rogers, 2001; Stirman, Crits-Christoph, & DeRubeis, 2004). However, relatively little research has investigated barriers to implementation within the context of EBA (Bickman et al., 2000; Bruchmuller et al., 2011; Epstein, Langberg, Lichtenstein, Kolb, & Simon, 2013; Garland, Kruse, & Aarons, 2003; Jensen-Doss & Hawley, 2010).

To expand the understanding of EBA use in community settings, the current study surveys child therapists from a variety of disciplines about their use of EBA for anxiety, as well as their reasons for not implementing such practices. Given the findings of previous research in the adult literature and to a lesser extent, the child literature, we predicted that EBA use would be low overall. Considering prior research examining clinician characteristics and trends of general EBP use (Aarons, Hurlburt, & Horwitz, 2010; Beidas & Kendall, 2010; Jensen-Doss & Hawley, 2010; Rogers, 2001), we also hypothesized that PhD-level psychologists, recently graduated clinicians, and anxiety specialists would be more likely to use EBA. Finally, we collected brief qualitative data concerning clinicians' reasons for not implementing EBA.

2. Method

2.1. Participants

The sample consisted of 339 clinicians who reported providing outpatient treatment for childhood anxiety disorders. This same sample was also used to examine treatment practices in a study reported elsewhere (Whiteside, Deacon, Benito, & Stewart, in press). Two hundred and sixty-five of the respondents provided their profession, which included social workers (SW; $n = 113$, 42.6%), doctoral level psychologists (PhD; $n = 49$, 18.5%; and PsyD; $n = 31$, 11.7%), masters degree licensed counselors ($n = 44$, 16.6%), and marriage and family therapists (MFT; $n = 28$, 10.6%). Just under half of the sample (44.6%) endorsed specializing in childhood anxiety disorders, which did not differ between professions. The respondents reported practicing for an average for 15.42 years ($n = 264$, sd = 10.2, range 1–43 years), with approximately 95% practicing for at least three years. Years of experience differed by profession with respondents holding a PsyD ($m = 10.81$) or degree in MFT ($m = 12.11$), being newer to the field than social workers ($m = 15.04$), PhD psychologists ($m = 17.80$), and masters level therapists ($m = 19.09$), F (4, 259) = 4.69, $p < .01$. The majority of the respondents endorsed multiple orientations ($m = 2.02$, s.d. = 1.1) with cognitive behavioral endorsed most frequently (81.4%), followed by family systems (54.8%), patient-centered (38.8%), eclectic (36.9%), and psychodynamic (27.0%).

2.2. Procedures

Clinicians were identified and recruited through a series of two electronic surveys. The first survey was used to identify therapists who work with anxious children. The survey was emailed directly to all psychologists and social workers who had supplied an email address to the state of Minnesota licensing boards and to all mental health professionals practicing within a regional health system ($n = 7{,}273$). A link to the survey was also included in email newsletters sent to the members of the statewide professional organizations for psychologists, social workers, and marriage and family therapists (e.g., Minnesota Psychological Association). An initial invitation and two reminders were sent through each channel. The survey inquired about the populations of patients to which the clinician provided treatment. Because the link was included in newsletters, it is not known how many clinicians viewed the invitation. A total of 2869 clinicians responded to the survey.

Among the respondents to the initial survey, 1002 clinicians reported treating youth with anxiety disorders. Anxiety disorders were defined based upon the categorization of DSM-IV (the classification system in place during the study): generalized anxiety disorder (GAD), social phobia, specific phobia, panic disorder with or without agoraphobia, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD); and two anxiety disorders diagnosed in childhood (separation anxiety disorder and selective mutism). These are also the disorders covered by commonly used structured diagnostic interviews and rating scales (i.e., Silverman & Albano, 1996 and Birmaher et al., 1997 respectively). These clinicians were emailed a follow-up survey about their assessment (current study) and treatment practices (Whiteside et al., in press). A total of 339 respondents completed the questions regarding EBA and were included in the current study. An additional 66 began the survey, but did not complete enough items to be included in the current study. A response rate of 34% (339 of 1002) is comparable to previous surveys (i.e., 27–30%; Addis & Krasnow, 2000; Becker et al., 2009).

2.3. Measures

2.3.1. Demographic information

Respondents were asked to indicate their profession, theoretical orientation, number of years in practice, and the frequency with which they treated patients with each of the anxiety disorders. Respondents could endorse the following theoretical orientations: (1) CBT, including solely cognitive or behavioral approaches; (2) psychodynamic, encompassing psychoanalytical, (3) family systems, (4) patient centered, including humanistic, supportive, Rogerian, and experiential approaches, and (5) Eclectic. Frequency