



## Shorter communication

## Facets of clinicians' anxiety and the delivery of cognitive behavioral therapy



Liat Levita, Paulina Gonzalez Salas Duhne, Carla Girling, Glenn Waller\*

Department of Psychology, University of Sheffield, UK

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## ABSTRACT

Psychological therapists commonly fail to adhere to treatment protocols in everyday clinical practice. In part, this pattern of drift is attributable to anxious therapists being less likely to undertake some elements of evidence-based therapies – particularly the exposure-based elements. This study considers what facets of anxiety (cognitive, behavioral, physiological) are related to junior clinicians' reported use of cognitive-behavioral therapy techniques. Thirty-two clinicians (mean age = 28.9 years; mean length of CBT experience = 1.5 years; 23 female, nine male) who offered CBT were assessed for their cognitive, behavioral and physiological characteristics (Intolerance of Uncertainty scale; risk taking; skin conductance response and heart rate variability). While the three different facets of anxiety were relatively poorly associated with each other, as is usual in this literature, each facet was linked differently to the reported delivery of CBT techniques ( $P < .05$ ). Overall, higher anxiety levels were associated with a poorer use of exposure methods or with a greater use of other behavioral or cognitive methods. Of the three facets of anxiety, only physiological reactivity showed an association with the clinicians' temporal characteristics, with more experienced therapists being more likely to have greater skin conductance responses to positive and negative outcomes. These findings suggest that clinicians who are more anxious are less likely to deliver the full evidence-based form of CBT and to focus instead on less challenging elements of the therapy. Potential ways of overcoming this limitation are discussed.

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Cognitive-behavioral therapy is a relatively efficacious intervention for a range of psychological disorders when delivered in well-controlled research trials. However, while these findings can be generalised to everyday practice (Persons, Bostram, & Bertagnolli, 1999; Persons, Roberts, Zalecki, & Brechwald, 2006; van Ingen, Freiheit, Stacey & Vye, 2009), there is evidence that such strong outcomes commonly are not achieved in such settings. CBT is often found to be less effective when delivered in routine clinical settings (e.g., Gibbons, Stirman, DeRubeis, Newman, & Beck, 2013). While this difference might be attributable in part to patient and contextual variables (e.g., more complex patients; less detailed case supervision), there is also evidence that therapist effects play a role. In particular, therapists drift away from delivering evidence-based therapies (Waller, 2009). This pattern of drift is associated with clinician characteristics, such as beliefs about the value and utility of specific methods (e.g., Deacon et al., 2013). Notably,

therapists' own anxiety levels have been associated with poorer implementation of some elements of evidence-based therapies (e.g., Harned, Dimeff, Woodcock, & Contreras, 2013; van Minnen, Hendriks & Olf, 2013; Waller, Stringer, & Meyer, 2012). A common finding is that therapists use exposure-based methods relatively rarely, despite their extensive empirical support (Harned et al., 2013). It has been suggested (Waller, 2009) that this failure to use some well-evidenced therapeutic tools is the result of the clinician engaging in safety behaviors, because the avoidance of such methods (with their likelihood of temporarily raising patients' anxiety) makes the clinician feel more positive in the short term.

To date, our understanding of the impact of clinicians' anxiety on therapy delivery has been limited by a focus on the more cognitive domains of that emotion. However, anxiety is a multifaceted construct, with behavioral and physiological elements playing a role. Assessment of anxiety clinically has generally followed Lang's (1968) tripartite model, where the examination of three domains of anxiety is needed – cognitive, behavioral and physiological. Thus, applying the 'hot cross bun' construct (Padesky & Mooney, 1990) to understanding clinician anxiety, it is apparent

\* 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](mailto:g.waller@sheffield.ac.uk) (G. Waller).

that it will be important to understand how that anxiety is maintained by its cognitive, behavioral and physiological underpinnings. While the cognitive facet can be largely represented by constructs such as intolerance of uncertainty (e.g., Carleton, Norton, & Asmundson, 2007), behavioral aspects are more centred on a lack of propensity for risk-taking (Maner et al., 2007). Physiological aspects of anxiety are more complex to measure (Cacioppo, Berntson, Larsen, Poehlmann, & Ito, 2000). However, a key element appears to be heightened physiological arousal in situations of unpredictability (e.g., Grupe & Nitschke, 2011), as measured by skin conductance responses (SCR) and cardiovascular measures such as heart-rate variability (HRV). Each of these three facets of anxiety - cognitive, behavioral and physiological - can be suggested to be associated with the clinician's performance, driving whether or not they deliver CBT appropriately.

Understanding the nature of the anxiety facets that are relevant to the delivery of CBT elements is important for two primary reasons – the identification of clinicians who will need additional support to deliver specific elements of the therapy, and the planning of interventions to support those clinicians (e.g., Deacon et al., 2013; Farrell, Deacon, Dixon, & Lickel, 2013). Such identification is likely to be particularly important early in the clinician's career, as learning at this time can be critical to long-term practice.

Therefore, the aim of this research is to determine the association between different facets of junior therapists' anxiety and their reported implementation of specific CBT techniques. It is hypothesised that greater clinician anxiety will be associated with a lower use of exposure-based CBT methods, though no prediction is made regarding the relative importance of those elements of anxiety. A secondary aim was to determine whether the different facets of anxiety are associated with temporal factors – specifically age and experience – at this early stage in the therapists' practice.

## 1. Method

### 1.1. Ethics

This study was approved by the Research Ethics Committee of the Department of Psychology, University of Sheffield. All participants provided informed consent.

### 1.2. Participants

The participants were 32 relatively junior therapists, who reported using CBT as part of their clinical training and practice. Of the 32, 23 were female and nine were male. They were drawn from UK clinical psychology or Improving Access to Psychological Therapies courses. They had a mean age of 28.9 years ( $SD = 5.54$ ; range = 23–47). For those clinicians who provided the necessary information, they had been practicing as clinicians for a mean of 2.50 years ( $SD = 1.65$ ), and had a mean period of experience as CBT therapists of 1.53 years ( $SD = 1.57$ ; range = .4–5.7). None were accredited CBT practitioners (in keeping with their relatively junior status), and only three had undertaken CBT courses prior to their current training.

All participants were volunteers, recruited following presentations about the research to the relevant groups. The only exclusion criterion was that the participants could not have any cardiovascular abnormalities, given the impact that this could have on the physiological dependent variables.

### 1.3. Measures and procedure

Participants completed the following, in order: consent form; demographic details; measure of one cognitive component of

anxiety (intolerance of uncertainty); experimental element addressing the behavioral (risk-taking) and the physiological facets of anxiety (SCR; heart rate variability); and a measure of CBT technique usage. They were then debriefed and paid £5 for taking part.

**Intolerance of Uncertainty Scale (IUS; Carleton et al., 2007).** The 12-item version of the IUS is a self-report measure that addresses the two elements of this cognitive construct – prospective anxiety (inability to tolerate unpredictability) and inhibitory anxiety (inability to initiate action due to uncertainty about the outcome). The scale has satisfactory psychometric properties and clinical utility (Carleton et al., 2012; Carleton et al., 2007), and has been used in previous research into clinician's use of skills (e.g., Turner, Tatham, Lant, Mountford, & Waller, 2014). Higher scores indicate greater levels of this cognitive facet of anxiety. The clinicians' mean scores in this study were: Prospective anxiety = 17.0 ( $SD = 4.69$ ); and Inhibitory anxiety = 8.69 ( $SD = 2.56$ ).

**Balloon Analogue Risk Task (BART; Lejuez et al., 2002).** The BART is a computerized measure of risk taking behavior, with well-established convergent validity (DeMartini et al., 2014). It models real-world risk behavior through the conceptual frame of balancing the potential for reward versus loss in a situation of unpredictability, and hence can act as a correlate of the behavioral component of anxiety. In this case, the BART was used to reflect the tendency for clinicians to differ in how they see the use of different methods as more or less risky (balancing potential benefits with potential harm to the patient). In this version of the BART (run using EPrime 2), participants were asked to pump up a virtual balloon in order to win points. Each pump caused the balloon to incrementally inflate and ten points to be added to the counter. Each balloon had a different breakpoint, whereby the balloon over-inflated and exploded. Consequently, each pump led to greater potential reward but also greater risk. Participants could stop the trial at any point and collect their points. However, if the balloon burst, participants lost all the points for that trial. Participants were not informed of the balloon breakpoints, and there were 30 trials in total. Thus, in this task, participants can take the risk of pumping up the balloon for more points (and potentially over-inflating the balloon so that it bursts and they lose all the points earned), or can reduce their risk (and potential gain) by ceasing the inflation of the balloon early. Thus, the task measures the individual's risk-taking, with more pumps (adjusted for 'unpopped balloons') indicating greater risk-taking and lower behavioral anxiety. The mean adjusted number of pumps in this study was 50.75 ( $SD = 11.6$ ).

**Physiological reactivity.** Two such measures were taken. These were recorded during the performance of BART, so that physiological reactivity was measured during active processing rather than during a passive state.

The first measure was *skin conductance response* (SCR), used to examine changes in sympathetic nervous system activity. An SCR recording system (MP46, Biopac, Goleta, CA) together with Acq-Knowledge 4.3 (Biopac) software was used to monitor the SCR as it varied with eccrine sweat gland activity. SCR was sampled at 200 Hz using disposable electrodermal gel electrodes (Biopac model EL507) attached to the distal phalanx of the pointer and middle fingers of the non-dominant hand. The SCR is an established correlate of the strength of emotional and cognitive states (Figner & Murphy, 2011), but does not distinguish specific emotions (Cacioppo, Berntson, Larsen, Poehlmann & Ito, 2000). For analysis, a smoothing baseline removal and a low-pass filter (1 Hz) were used, and the SCR threshold level was set to .02 umho. A higher SCR amplitude indicates greater physiological reactivity. Measurements were taken over the period 1–3 s following outcome – the point during BART when either the balloon popped and points were lost (negative outcome), or when points were collected (positive

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