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The role of therapist experiential avoidance in predicting therapist preference for exposure treatment for OCD

Stephanie Rabin Scherr, James D. Herbert *, Evan M. Forman

Drexel University, 3141 Chestnut Street, Stratton Hall, Philadelphia, PA 19104, USA

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ABSTRACT

Despite the overwhelming evidence that the behavioral components of cognitive-behavior therapies (CBTs) are critical for patient improvement, particularly in the case of anxiety disorders, there remains a wide gap between science and practice in their consistent use. In particular, exposure therapy for anxiety is under-used, even among self-proclaimed cognitive-behavior therapists. Some have speculated that this under-use is related to therapist discomfort with and avoidance of the temporary increase in distress that patients often experience during exposure therapy, and the secondary distress that this may cause in therapists themselves. Recent studies have begun to examine therapist characteristics that are associated with the use of evidence-based psychotherapies, but this research has focused on evidence-based practice as a whole rather than on specific interventions such as exposure, and have not addressed therapist psychological variables. We examined the role of therapists' experiential avoidance in the hypothetical use of exposure-based interventions to treat fictional patients for whom exposure therapy is clearly indicated. A total of 172 therapists watched simulated therapy intake sessions and were asked to designate the percentage of time they would allot toward various therapeutic modalities, including exposure. Results suggested that participants exhibiting higher experiential avoidance tended to allot less time to exposure therapy for the fictional patient. Additional therapist personality factors, such as intuitive personality style and attitudes toward evidence-based treatments, were associated with self-reported use of exposure therapy as well.

1. Introduction

There is strong and consistent evidence that cognitive behavior therapies (CBTs), broadly defined, are among the current gold standard treatments for various psychological disorders, including anxiety and mood disorders in particular (e.g., Abramowitz, Deacon, & Whiteside, 2012; Barlow, Gorman, Shear, & Woods, 2000; Butler, Chapman, Forman, & Beck, 2006; Foa et al., 2005b; Foa, Rothbaum, Riggs, & Murdock, 1991; Hoyer et al., 2009; Ollendick et al., 2009; Rapee, Gaston, & Abbott, 2009). CBTs for anxiety disorders are also more cost-effective than existing pharmacological treatments (Heuzenroeder et al., 2004). However, despite the overwhelming scientific evidence in support of the efficacy of CBTs and other evidence-based psychotherapies (EBPs), there remains a substantial gap between science and practice in the consistent use of EBPs (Gaudiano, Brown, & Miller, 2011b; Herbert, 2003; von Ranson, Wallace, & Stevenson, 2013).

In addition to general support for CBTs, there is evidence that the behavioral components of CBT (e.g., exposure, behavioral activation) are important—and perhaps the most important—active ingredients in multi-component CBT programs (e.g., Deacon & Abramowitz, 2004; Dimidjian et al., 2006; Feske & Chambless, 1995; Jacobson et al., 1996; Raes, Koster, Loeys, & De Raedt, 2011). In addition, there is currently little evidence that the addition of other treatment components, such as cognitive restructuring, results in consistently better outcomes than those produced by behavioral treatment alone (Longmore & Worrell, 2007).

One form of CBT that is particularly well established is exposure therapy for anxiety. Exposure-based treatments have demonstrated large effect sizes in treatment studies of panic disorder (Barlow et al., 2000), obsessive-compulsive disorder (OCD; Foa et al., 2005b), social anxiety disorder (Rapee et al., 2009), post-traumatic stress disorder (PTSD; Bradley, Greene, Russ, Dutra, & Westen, 2005; Foa et al., 2005a), and generalized anxiety disorder (Hoyer et al., 2009). In fact, exposure therapy for anxiety disorders arguably has stronger scientific support than any other form of psychotherapy for any mental disorder (Deacon & Farrell, 2013).

Despite these findings, published surveys of practicing clinicians report that EBPs, and especially exposure-based interventions, are

* Correspondence to: Drexel University, 3141 Chestnut Street, Stratton 119, Philadelphia, PA 19104, USA.
E-mail address: james.herbert@drexel.edu (J.D. Herbert).

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often dismissed in favor of modalities with less—and in some cases minimal—scientific support (Becker, Zayfert, & Anderson, 2004; Farrell, Deacon, Dixon, & Lickel, 2013a; Freiheit & Vye, 2004; Hipol & Deacon, 2013; Litz, Blake, Gerardi, & Keane, 1990; Rosen et al., 2004; Waller, Stringer, & Meyer, 2012). Moreover, even when exposure-based interventions are employed, their implementation is often far from optimal. On research surveys, community therapists report emphasizing patient self-directed exposure over therapist-assisted exposure, and typically combine exposure therapy with arousal reduction strategies such as progressive muscle relaxation and breathing retraining (Freiheit & Vye, 2004; Hipol & Deacon, 2013). These findings are concerning because exposure seems to be less effective when implemented only in a self-directed manner (Abramowitz, 1996), and pairing exposure with anxiety reduction strategies may actually interfere with treatment (Schmidt et al., 2000).

1.1. Therapist factors associated with use of EBPs

In an effort to better understand and address the gap between the scientific literature and front-line clinical practice, recent studies have begun to focus on therapist traits and personality factors that may be associated with EBP use. Sharp, Herbert, and Redding (2008) found that therapists who reported using the so-called "Power/Energy Therapies," which have little to no scientific support, scored lower on a measure of critical thinking skills than therapists who reported using cognitive-behavioral approaches. (Gaudiano, Brown, & Miller, 2011a; Gaudiano et al., 2011b) found that therapists' negative attitudes toward evidence-based treatments were associated with negative attitudes toward research in general, an intuitive thinking style, lower critical thinking abilities, and endorsement of erroneous beliefs about health. A study of social workers found that although 97% of the sample reported using some form of EBPs, 75% also reported using an unsupported treatment, such as Thought Field Therapy (Pignotti & Thyer, 2011).

There may be additional therapist-related factors at play. Even among CBT-oriented psychologists with strong interest and training in behavioral treatments and a commitment to EBP in principle, exposure therapy in particular is not completely accepted or widely used (Becker et al., 2004). Waller (2009) discusses this reluctance to use exposure, which he speculates is related to therapists' own anxiety, avoidance, and safety behaviors. He found that more anxious therapists, as measured by the Brief Symptom Inventory—Anxiety Scale, were less likely to use CBT techniques when treating patients with eating disorders (Waller et al., 2012). Castro and Marx (2007) express a similar concern that exposure therapy is not only strenuous for the patient, but may also evoke secondary distress in the therapist. This issue is reflected in the advice that therapists should increase their tolerance for patient distress before conducting exposure therapy for PTSD (Hembree, Rauch, & Foa, 2003).

In one of the few experimental studies concerning therapist use of exposure, Farrell, Deacon, Kemp, Dixon, and Sy (2013b) trained undergraduates to administer a brief exposure treatment and then randomized them to receive positive or negative beliefs about exposure therapy; the latter group subsequently delivered the treatment less effectively. In a separate study, Deacon et al. (2013) found that therapist attitudes toward exposure improved after completing a one-day didactic workshop about the approach. However, few studies have attempted to study systematically whether clinicians' own psychological characteristics influence their likelihood of using exposure with patients.

In recent years, experiential avoidance (EA; attempts to reduce distressing thoughts, feelings, or other negative subjective experiences even when doing so is ineffective and causes problems) has been studied as a process that is implicated in a wide variety of behavioral and psychological problems, including anxiety disorders (Hayes & Gifford, 1997). Although EA varies even within non-clinical populations (Hayes et al., 2004b), many studies have found that not only is EA associated with baseline psychopathology and moderates treatment outcome, but such avoidance is also a significant mediator of treatment outcome (Dalrymple & Herbert, 2007; Levin, Hildebrandt, Lillis, & Hayes, 2012). Strategies that target EA are integral to acceptance-based therapies, including Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2012).

Although the relationship between EA and various forms of psychopathology has been the focus of a growing body of research, no studies to date have measured therapists' own EA in an attempt to explore its potential impact on clinician use of exposure therapy. Some studies have successfully used therapist training programs based on ACT, which include a focus on reducing EA in an attempt to improve patient outcomes, thereby providing indirect support of a possible link between therapist EA and the use of emotionally-laden interventions such as exposure. In a non-randomized field study of therapists trained in ACT vs. solution-focused therapy, Strosahl, Hayes, Bergan and Romano (1998) found that the patients of ACT-trained therapists reported significantly better coping and were more likely to have completed treatment in the 5 months following initiation of treatment. ACT training has been shown to help clinicians confront and overcome uncomfortable experiences that arise during therapy, such as stigma and prejudice toward patients with substance abuse problems (Hayes et al., 2004a), and general stigma toward individuals with psychological disorders (Masuda et al., 2007). There is also evidence that ACT training leads to positive behavioral intentions, as Lillis and Hayes (2007) found that ACT was more successful than traditional multicultural training in increasing behavioral intentions to improve multicultural experience in a group of undergraduates. Despite this emerging evidence in favor of ACT training, there remains a shortage of research in training therapists to effectively administer EBPs.

As discussed above, exposure therapy typically elicits a temporary, although sometimes intense, increase in patients' negative affect in the service of fostering new learning. Patients often express hesitation about exposure because of this temporary distress, which may in turn lead to secondary distress in the therapist as an empathic response and/or if the therapist fears causing harm to the patient. Hembree et al. (2003) discuss the internal dialog that many therapists face as they conduct exposure, such as, "Do I stop the exposure because of how upset the patient is?" Therapists who exhibit a high degree of EA may be especially averse to the distress that arises when this internal dialog is paired with an increase in the patient's negative affect. These therapists may then inadvertently deprive their patients of effective exposure treatment in favor of less potent (but more palatable) talking therapies.

We hypothesized that therapists' own level of EA would result in a tendency to avoid using exposure, even when exposure treatment is clearly indicated. Clinicians were asked to make treatment decisions regarding hypothetical cases of individuals with OCD. OCD was chosen as the target disorder because Exposure and Response Prevention (ERP) has been shown to have specific efficacy for OCD (Abramowitz, Foa, & Franklin, 2003; DeRubeis & Crits-Christoph, 1998; Franklin, Abramowitz, Kozak, Levitt, & Foa, 2000; Lindsay, Crino, & Andrews, 1997), and administration of ERP tends to provoke a great deal of distress among patients, and indirectly in therapists themselves, thereby highlighting a context in which high levels of therapist experimental avoidance might come into play. We also sought to replicate previous findings (e.g., from Sharp et al. and Gaudiano et al.)