

Running Head: THERAPIST BARRIERS TO EXPOSURE

Therapist Barriers to the Dissemination of Exposure Therapy

Brett J. Deacon, Ph.D.*

Nicholas R. Farrell, M.A.

University of Wyoming, Department of Psychology, Dept. 3415, 1000 E. University Ave., Laramie, WY 82071, USA

*Corresponding author, Tel: 1-307-766-3317; fax 1-307-766-2926; e-mail:

bdeacon@uwyo.edu

Therapist Barriers to the Dissemination of Exposure Therapy

With hundreds of clinical trials and dozens of meta-analytic reviews attesting to its effectiveness (Deacon & Abramowitz, 2004; Olatunji, Cisler, & Deacon, 2010), exposure-based cognitive-behavioral therapy (CBT) is the most empirically supported psychological treatment for the anxiety disorders. Clinical practice guidelines published by the American Psychiatric Association (2011) and the National Institute for Clinical Excellence (2011) recommend exposure-based CBT approaches as first-line anxiety treatments. Relative to pharmacotherapy, exposure-based therapy typically produces similar short-term benefit and superior long-term maintenance of treatment gains (e.g., Barlow, Gorman, Shear, & Woods, 2000). Exposure therapy is also more cost-effective (Heuzenroeder et al., 2004) and more acceptable and preferable to clients and their caregivers (Brown, Deacon, Abramowitz, & Whiteside, 2007; Deacon & Abramowitz, 2005). Taken together, these observations support a strong case for exposure-based CBT as the treatment of choice for anxiety disorders. Indeed, this treatment may have more scientific support than any other psychotherapy of any kind, for any mental disorder.

Despite its demonstrated effectiveness, exposure therapy is rarely used by practicing clinicians. To illustrate, in a sample of over 800 licensed doctoral-level psychologists, Becker, Zayfert, and Anderson (2004) found that fewer than 20% of respondents reported using exposure therapy to treat clients with posttraumatic stress disorder (PTSD). Indeed, exposure was not widely utilized even among trauma experts with specialized training in this approach. These findings were replicated in a more recent survey of more than 250 trauma experts by van Minnen, Hendriks, and Olf (2010). Imaginal exposure was the least used treatment for PTSD, and respondents preferred both

Eye Movement Reprocessing and Desensitization and supportive counseling to exposure therapy despite the weaker scientific evidence for the efficacy of these approaches.

The underutilization of exposure therapy is not specific to PTSD. A German study found that although almost all therapists requested coverage for exposure therapy from obsessive-compulsive disorder (OCD) clients' health insurers, over 80% of their clients reported that no exposure component was used in their treatment (Böhm, Förstner, Kulz, & Voderholzer, 2008). In addition, Becker et al. (2004) reported that fewer than 15% of clinicians with expertise in PTSD reported using exposure therapy when treating other anxiety disorders due to a lack of training. Poor dissemination of CBT to mental health practitioners has resulted in a lack of client access to this treatment (Gunter & Whittal, 2009). The majority of adults with an anxiety disorder do not receive efficacious treatment (e.g., Stein et al., 2004; Young et al., 2008; Young et al., 2001), and when clients are able to access psychotherapy, it is rarely evidence-based (Goisman, Warshaw, & Keller, 1999; Taylor et al., 1989).

Dissemination failure alone cannot fully account for the underutilization of exposure therapy. A startling finding revealed by Becker et al. (2004) is that the majority of therapists who had received training in exposure therapy did not use this treatment. Why would therapists trained in this approach, and presumably aware of its well-established scientific efficacy, shun exposure for less substantiated therapies? We propose that *negative beliefs about exposure therapy (e.g., that it is unethical, intolerable, and unsafe) impede the utilization of this treatment, even among therapists trained to administer it.*

Findings from therapist surveys reveal that even when exposure therapy is utilized, it is often implemented in a suboptimal manner. Freiheit, Vye, Swan, and Cady (2004) found that psychologists, nearly all of whom reported using “CBT” with their anxious clients, utilized techniques such as relaxation and breathing retraining more frequently than exposure in the treatment of anxious clients. Comparable findings were reported by Hipol and Deacon (2010) in a survey of Wyoming mental health practitioners. Therapist-assisted exposure was used by less than 30% of clinicians in the treatment of clients with OCD, social phobia, panic disorder, and PTSD. Of interest, the majority of therapists who did utilize exposure with their clients also reported using breathing retraining, progressive muscle relaxation, meditation, and non-directive supportive therapy. Similar to the psychologists surveyed by Freiheit et al. (2004), Wyoming therapists utilized client self-directed exposure more than twice as often as therapist-assisted exposure (Hipol & Deacon, 2010).

Surveys of practicing clinicians (Freiheit et al., 2004; Hipol & Deacon, 2010) indicate that the implementation of exposure therapy in the community, when it occurs, is very different from its typical manner of delivery in treatment manuals studied in clinical trials (e.g., Kozak & Foa, 1997). The primary differences can be summarized as follows: (a) community therapists emphasize client self-directed exposure rather than therapist-assisted exposure, and (b) community therapists typically combine exposure therapy with arousal-reduction strategies such as progressive muscle relaxation and breathing retraining, whereas treatment manuals typically omit such procedures and focus on the delivery of repeated, prolonged exposure tasks. The modal delivery of exposure by community therapists is concerning, as exposure appears less effective when

implemented in a self-directed manner (e.g., Abramowitz, 1996), and arousal-reduction strategies are not evidence-based adjuncts and may even interfere with long-term improvement (e.g., Schmidt et al., 2000). Why do practitioners tend to implement exposure therapy in this manner? We hypothesize that *clinicians who use exposure therapy minimize the intensity of its delivery due to concerns about the adverse consequences of subjecting clients to high anxiety during exposure tasks*. This notion begs the question: how might minimizing the intensity of exposure therapy affect client outcomes?

Research has yet to directly address how therapist beliefs about exposure might influence the manner and effectiveness of its delivery. However, indirect evidence may be found in the Pediatric OCD Treatment Study (POTS Team, 2004), a large-scale, placebo-controlled clinical trial comparing exposure therapy, sertraline, and their combination in the treatment of children and adolescents with OCD. The study's primary finding was that combined treatment was superior to exposure therapy and sertraline alone, which did not differ from each other. However, this outcome was qualified by an extraordinarily large difference in the efficacy of exposure at two different study sites. Despite using procedures designed to standardize adherence with the exposure therapy treatment manual (e.g., direct supervision, case conferences, training meetings, review of videotaped sessions), exposure was more than four times as effective in reducing OCD symptoms at the University of Pennsylvania than at Duke University. At the Pennsylvania site, exposure alone was as effective as combination treatment; at Duke, augmentation with sertraline more than doubled the efficacy of exposure therapy. How can such findings be explained? Franklin et al. (2004) reported significant variation

between therapists in client outcomes, and suggested that site differences were driven by “super-therapists” who may have set a more ambitious agenda with regard to exposure tasks and pushed their clients harder to pursue it (M.E. Franklin, personal communication, September 10, 2010). One (admittedly speculative) possibility raised by the POTS study is that *therapists who attain the best client outcomes deliver exposure therapy in a particularly intensive manner owing to their confidence in the safety, tolerability, and efficacy of this treatment.*

In summary, despite its status as the most effective psychological treatment for the anxiety disorders, exposure-based CBT is rarely utilized, even by clinicians trained in its delivery. Moreover, the minority of therapists who provide exposure therapy often do so in a less-than-ideal manner. A number of empirical findings suggest that therapists hold negative beliefs about exposure that may hinder its utilization and affect the manner in which it is delivered to anxious clients. These therapist-level barriers are reviewed below.

Barriers to the Dissemination of Evidence-Based Psychological Treatments

Undoubtedly, exposure therapy is affected by the same set of therapist barriers that obstruct the utilization of evidence-based psychotherapies more generally. These include a lack of training opportunities in CBT and an emphasis on training mental health professionals in practices not supported by scientific evidence. To illustrate, the majority of social work and professional clinical psychology (Psy.D.) graduate programs do not require a didactic and clinical supervision in *any* evidence-based treatment. Even when such training is provided (e.g., in psychiatry residency programs), it is often cursory and insufficient to instill adequate competency. At present, most required psychotherapy

training in psychiatry, social work, and clinical psychology is not evidence-based (Weissman et al., 2006).

In the absence of scientifically-grounded training, many mental health professionals are deeply ambivalent about the relevance of research to their clinical practice. In contrast to medicine in which there is near-unanimous agreement that practice should be guided by treatment guidelines derived from research evidence (Wolfe, Sharp, & Wang, 2004), mental health professionals often reject evidence-based treatments on the grounds that findings from clinical trials are invalid and irrelevant to real-world practice (e.g., Silberschatz, in Persons & Silberschatz, 1998). Indeed, the typical mental health practitioner is more likely to prize his or her intuition and experience over scientific evidence (Garb & Boyle, 2003). The notion that all psychotherapies are equivalent (aka, the “Dodo Bird” verdict), which remains popular despite clear evidence to the contrary (Hunsley & DiGiulio, 2002), provides little motivation for practitioners to seek additional training in evidence-based practices. The current tension between skeptical mental health practitioners and exasperated clinical scientists (Tavris, 2003) is reminiscent of the conflict that raged among physicians a century ago about whether the practice of medicine was an art or a science (Baker, McFall, & Shoham, 2009).

In 2006, the American Psychological Association published the organization’s position statement on evidence-based practice in psychology. This report was the product of the Task Force on Evidence-Based Practice, a group composed of both ardent supporters and vehement opponents of the movement to identify and disseminate empirically supported treatments like exposure therapy. The Task Force defined

evidence-based practice as, “the integration of the best available research with clinical expertise in the context of client characteristics, culture, and preferences” (p. 273). This definition officially sanctions the notion that research evidence and clinical judgment are equally valid methods for selecting appropriate interventions. The report provides little guidance for resolving conflicts between the clinician’s intuition and findings from empirical research, and therapists thus appear free to consider their own practice “evidence-based” without regard to whether the treatments they use have passed muster in clinical trials. Indeed, a recent survey of clinical psychologists found that respondents, on average, characterized 73.1% of their services as evidence-based according to the APA’s definition (Berke, Rozell, Hogan, Norcross, & Karpiak, in press). The modal response, provided by approximately one-third of psychologists, was 100%. Thus, a striking incongruity exists between the low utilization of empirically supported treatments like exposure therapy and the high rate at which clinicians believe their practice is “evidence-based.”

Negative therapist beliefs about the use of manualized treatments constitute another barrier to the dissemination of empirically supported treatments. Addis, Wade, and Hatgis (1999) identified several such beliefs about manuals, including: (a) the therapeutic relationship will be compromised, (b) treatment proceeds according to a one-size-fits all approach and cannot be adequately individualized to specific clients, and (c) therapist input and creativity will be stifled, thereby leading to job dissatisfaction. Although the accuracy of these perceptions is highly debatable (Addis et al., 1999; Barlow, Levitt, & Bufka, 1999), they are commonly held by practicing clinicians and

serve to dampen enthusiasm for the use of empirically supported treatments, including exposure therapy, that are often delivered using treatment manuals.

Dissemination efforts are also hampered by a host of economic and practical concerns. Learning a new psychotherapy is expensive, time-consuming, and requires a great deal of effort. Gray, Elhai, and Schmidt (2007) found that among a sample of trauma experts, the most endorsed barriers to use of empirically supported treatments included insufficient time to learn the treatment and attend training seminars, as well as the prohibitive expense associated with such training. Because experts in exposure-based CBT tend to be clustered in urban areas associated with major medical centers, many practitioners in rural settings lack convenient access to training opportunities.

Taken together, a large number of practical and ideological barriers contribute to the failure to adequately disseminate empirically supported treatments to mental health professionals. Principal among these include a lack of training in evidence-based interventions and the perception that science is only tangentially relevant to the practice of psychotherapy. In addition to these more general reservations about evidence-based treatments, exposure therapy is subject to a potent set of intervention-specific negative beliefs which we discuss below.

Therapist Barriers to the Dissemination of Exposure Therapy

Exposure therapy has a public relations problem with many in the field of psychotherapy (Olatunji, Deacon, & Abramowitz, 2009; Richard & Gloster, 2007). Prejudice against exposure often stems from the fact that this intervention evokes distress (albeit temporary), rather than soothes it, as one might intuitively expect a treatment for anxiety to do. More specific negative beliefs about exposure include: (a) it is unethical,

(b) it poses an unacceptably high risk of harm to clients, and (c) it is stressful and potentially harmful to the therapist. In this section, we present a critical analysis of these concerns. Using case examples from our own clinical practice, we illustrate the manner in which endorsement of these beliefs might affect the manner in which clinicians implement exposure therapy.

Exposure therapy is unethical. The first principle in the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (2002) admonishes psychologists to "take care to do no harm" and "safeguard the welfare and rights" of their clients. Because exposure therapy entails deliberate provocation of anxiety and distress, some therapists believe its very nature violates accepted ethical standards. One therapist, quoted in a *New York Times* article (Slater, 2003), described exposure as "torture, plain and simple." Our experience suggests that this sentiment is commonplace among therapists across the mental health professions, particularly those with psychodynamic and humanistic theoretical orientations, and is a primary reason why some practitioners do not provide exposure therapy – and would not do so, even if they were trained in this approach.

Some practicing exposure therapists likely harbor concerns about the ethicalness of this treatment. They may not consider exposure to be *inherently* unethical, but may tie its acceptability to the manner in which it is delivered. Exposure tasks that evoke very high levels of client anxiety, or that place the client in "extreme" situations beyond those encountered by most people on a daily basis (e.g., immersing one's hands in garbage), may be considered both unnecessary and ethically indefensible by well-meaning clinicians. Therapists who adopt this perspective may deliver exposure in an overly

cautious and sympathetic manner in an attempt to safeguard their clients' rights and dignity. Consider the following case:

Mr. A is a 27-year-old Marine Corps veteran who served in operation Iraqi Freedom and currently suffers from combat-related PTSD. During his tour of duty he witnessed the deaths of numerous Iraqi civilians and members of his unit from gunfire and improvised explosive devices. He is bothered by intrusive recollections of these events and experiences distressing images of people around him being maimed and killed by explosions when he is in crowded public places.

A therapist overly concerned with upholding the ethical principles of beneficence and non-maleficence (APA, 2002) might forego prolonged imaginal exposure with Mr. A, reasoning that asking him to revisit his painful memories would be inhumane. Alternatively, the therapist might implement imaginal exposure but allow the client to withhold the specific details of his traumatic experiences to minimize his distress. Rothbaum and Schwartz (2002) noted that overly sympathetic or cautious exposure therapists run the risk of unintentionally reinforcing their clients' fears. In the case of Mr. A, such an approach might also deprive him of the opportunity to emotionally process his traumatic memories, thereby preventing habituation to the full range of fear cues associated with his PTSD. The client might also fail to learn that particularly anxiety-provoking stimuli are not accompanied by catastrophic outcomes, and that he possesses the ability to tolerate the distress they evoke.

Practitioners who believe exposure therapy to be unethical, either intrinsically or according to its manner of delivery, might benefit from considering the work of a physical therapist or physician. Often, their treatments involve exposing clients to

temporary, manageable amounts of pain and distress for the sake of long-term recovery. Indeed, the experience of temporary discomfort is sometimes necessary to ensure the desired longer-term outcome. The process of exposure therapy requires that clients “invest anxiety now for a calmer future” (Abramowitz, Deacon, & Whiteside, 2010). Well-meaning therapists who minimize the anxiety invested by their clients for ethical and humanistic reasons are paradoxically depriving their clients of the optimally effective treatment they deserve.

Clinicians often assume that clients perceive exposure therapy as aversive and unethical, and will instead prefer to undergo treatment that does not entail the distress associated with directly facing one's fears. Fortunately, exposure therapy appears to be held in generally high esteem by anxious clients and their caregivers. Compared to pharmacotherapy, exposure-based CBT is rated as more credible, acceptable, and likely to be effective in the long-term (Brown et al., 2007; Deacon & Abramowitz, 2005; Norton, Allen, & Hilton, 1983). Moreover, exposure therapy is rated as at least as acceptable, ethical, and effective as cognitive therapy and relationship-oriented psychotherapy by undergraduate students and agoraphobic clients (Norton et al., 1983). The finding that therapist reservations about exposure therapy are not shared by clients who receive this treatment provides an important counter-point to the notion that exposure therapy is inherently inhumane and unethical.

Exposure therapy is harmful to the client. Exposure is believed by some practitioners to place clients at an unacceptably high risk of harm in various ways. Most commonly, therapists worry that clients will be harmed by their own anxiety during exposure tasks. This concern reflects a number of myths about the nature of anxiety itself.

One such misconception is that the experience of prolonged, intense anxiety-related somatic symptoms may lead to a medical emergency, such as loss of consciousness or heart attack. A similar belief is that anxiety is literally intolerable in high doses. Some therapists believe their clients to be sufficiently fragile that the experience of high anxiety will cause them to decompensate, perhaps in the form of a psychotic episode or loss of control over their own behavior. A related belief is that trauma sufferers may be “revictimized” by the recollection of a painful memory. Other concerns associated with high anxiety during exposure tasks include the possibility of symptom exacerbation and/or treatment refusal and attrition. Common to these beliefs is the assumption that clients with anxiety disorders lack the resilience necessary to safely experience their own anxiety symptoms.

Exposure therapy is also sometimes assumed to pose a threat to clients in the form of dangerous stimuli used during exposure tasks. Examples include animals (e.g., dogs), potential contaminants (e.g., toilet seats), and external situations (e.g., driving). Some therapists believe that “extreme” exposure tasks, the likes of which appear at the top of many client fear hierarchies, are especially likely to be harmful.

How might such beliefs affect the delivery of exposure therapy? Consider the following three cases:

Mr. P, age 45, experiences daily, unexpected panic attacks. During his attacks, he has prominent symptoms of dizziness, shortness of breath, and heart palpitations which he fears will lead to a loss of consciousness. He avoids physical exercise and participation in any activities that evoke these sensations.

Mrs. G, age 28, gave birth to her first child two months ago. Since that time she has experienced intrusive, unwanted obsessions about stabbing her daughter with knives and drowning her in the bathtub. She has turned parenting duties over to her husband and avoids being alone in the house with her daughter.

Mrs. R is a 26-year-old married woman who is interested in having children. However, she is unwilling to become pregnant due to a severe phobia of vomiting. She believes that vomiting might cause her to choke and die, and avoids stimuli that might cause her to become nauseous and/or ill.

Mr. P's exposure therapy would be expected to emphasize interoceptive tasks such as hyperventilation and breathing through a straw. A therapist who believes that the anxiety-related body sensations evoked by these exercises are potentially dangerous might employ concurrent arousal-reduction strategies such as relaxation and breathing retraining. Similarly, the therapist might encourage the client to perform the exercises using a small number of brief trials, each separated by a long rest period to allow his symptoms to subside. In this manner, the client would be spared from experiencing anxiety symptoms that the therapist fears could escalate to potentially dangerous levels. Unfortunately, the client would not be able to learn that the experience of prolonged and intense anxiety-related physical sensations, such as those experienced during his panic attacks, do not lead to catastrophic outcomes.

Mrs. G is extremely distressed by her obsessions and is ashamed of their content. A therapist concerned about the harmful effects of high anxiety is likely to be especially cautious in the use of exposure with this client. Concerned that Mrs. G would be unable

to tolerate the distress associated with imaginal exposure to obsessions involving the violent death of her beloved daughter at her own hands, the therapist may forego this technique altogether. Alternatively, the therapist might allow the client to conduct imaginal exposure in a self-directed manner in order to avoid the heightened anxiety associated with sharing the details of her obsessional fears with the therapist. Concerned that the client might decompensate due to intolerably high anxiety during situational exposures (e.g., giving her daughter a bath) and act on her harming obsessions, the therapist might refrain from implementing in vivo exposure, or require the husband to be present as a safety measure. Exposure therapy conducted in this manner runs the risk of reinforcing the client's catastrophic beliefs about being crazy for having such obsessions and posing a threat to her daughter's safety.

Mrs. R's emetophobia is driven primarily by the belief that she may choke and die during the act of vomiting. Despite the obvious therapeutic value of having the client vomit during exposure, the cautious therapist might elect to forego such an "extreme" task in order to avoid subjecting the client to intolerably high anxiety and the possibility, however remote, that vomiting may actually prove harmful. An exposure therapist concerned about the client's safety may proceed with tasks such as viewing video clips of individuals vomiting and asking the client to engage in activities with the potential to induce mild stomach discomfort (e.g., moderate exercise immediately following consumption of a large meal). Although such exposure tasks may be useful, they would not provide sufficient corrective information regarding the client's principal feared outcome. Accordingly, the client would fail to learn that the act of vomiting itself is

acceptably safe and tolerable (albeit unpleasant), and might continue to postpone her plans for starting a family.

Exposure therapists can take heart in the realization that, by definition, individuals with anxiety disorders are *already* experiencing significant anxiety symptoms in their daily lives. As such, the experience of high anxiety during exposure tasks is not novel, and in most cases is likely to be no more intolerable or dangerous than the anxiety symptoms clients are used to dealing with from time to time. It is also useful for therapists to remember that despite its distressing and sometimes dramatic nature, anxiety is an adaptive response that is designed to protect us from harm. It is rather absurd to suppose that evolution equipped humans with an alarm system for dealing with threats to our survival that is, itself, dangerous.

A very large body of research attests to the tolerability, safety, and efficacy of exposure therapy. This treatment is not reliably associated with increased risk of client attrition relative to other psychotherapies, and symptom exacerbation is rare, temporary if it occurs at all, and unrelated to prognosis (Olatunji et al., 2009). These observations aside, it is undeniable that the unique requirements of exposure therapy sometimes place clients at greater emotional and/or physical risks than many traditional forms of verbal psychotherapy. For example, exposure can involve the remote but real potential for harm when clients handle snakes or touch “contaminated” objects such as garbage cans. Although when conducted properly these exercises involve acceptably low levels of risk, exposure therapists must carefully consider the client’s safety when designing and implementing exposure practices. Strategies for minimizing risk such as negotiating

informed consent, determining acceptable levels of safety during exposure tasks, and dealing with negative outcomes are reviewed by Olatunji et al. (2009).

Exposure therapy is harmful to the therapist. This treatment is often viewed as posing a number of risks to the therapist. Concerns about one's ability to tolerate the client's negative affect represent a significant therapist barrier to the dissemination of exposure therapy (Litz, 2002). This concern may be especially likely to arise in the context of imaginal exposure for PTSD, during which the therapist listens to detailed accounts of often horrifying trauma narratives. Some therapists believe that such experiences can be "vicariously traumatizing" and produce persistent, negative psychological effects. Other practitioners may question their ability to tolerate their own negative affect during particularly intense exposure sessions.

Clinicians who believe exposure to be inhumane, intolerably aversive, or potentially dangerous may also worry about the legal risks associated with the use of this treatment. Boundary crossings associated with exposure sessions conducted outside the office might be viewed as paving the way for an inappropriate dual relationship. Therapists may believe that especially anxiety-provoking exposure tasks increase the risk of malpractice lawsuits from clients who may decompensate and/or experience harm in other ways from the treatment.

The following case examples help to illustrate the manner in which negative therapist beliefs about exposure may affect its delivery:

Mr. L, age 50, was repeatedly sexually abused in his early teens by a 16-year-old boy. He is ashamed of his failure to fight off the perpetrator and frequently bursts

into tears when discussing his sexual abuse history. He attempts to suppress memories of the abuse and avoids external cues associated with the trauma.

Ms. W, age 23, experiences frequent, unexpected panic attacks during which she fears that she will suffocate and die. She requires the presence of a trusted friend or family member when leaving home and avoids traveling more than a few miles from a local hospital next to her home where she frequents the emergency room.

The use of imaginal exposure would doubtless evoke substantial distress for Mr. L., and a therapist concerned about his or her own ability to tolerate the client's anxiety might elect not to use this procedure. Alternatively, the therapist might attempt to minimize the client's anxiety by implementing imaginal exposure in a client self-directed manner, or by allowing the client to refrain from elaborating on the most distressing elements of the trauma narratives during therapy sessions. Therapists who attempt to protect themselves from emotional distress during exposure run the risk of depriving clients from fully overcoming their pathological anxiety. In the case of Mr. L., failure to conduct prolonged imaginal exposure might prevent him from emotionally processing the full range of memories associated with his history of sexual abuse. The client's failure to habituate to particularly distressing traumatic memories would likely maintain his avoidance and belief that he is unable to tolerate the distress associated with recalling memories of his trauma history.

In vivo exposure for Ms. W. might involve traveling increasingly further outside her "safe zone" around the hospital. An obvious exposure task would be for her to drive outside of town to a rural area where immediate help would be unavailable in the event of

a panic attack. A therapist who is overly concerned with the ethical “slippery slope” of conducting an out-of-the-office exposure with a client of the opposite sex might assign this task as homework, rather than risking the appearance of impropriety by accompanying the client. Given that the client is currently unable to perform this task on her own, the failure to conduct this exposure in a therapist-assisted manner increases the risk that the exposure would result in a negative outcome, such as the client prematurely terminating the task due to high anxiety. Such an outcome might decrease the client’s self-efficacy and foster the perception that she will not be able to fully benefit from exposure therapy.

Practitioners who lack the ability to tolerate their own distress during exposure therapy sessions are ill-equipped to provide this treatment in a competent fashion. We agree with Gunter and Whittal's (2009) contention that, “Trust in the intervention, comfort in administering it, and confidence in one’s ability to address client reactions to exposure treatment are all vital prerequisites to the use of exposure in clinical practice” (p. 196). Exposure therapists must strike a balance between empathy for their client's distress and maintaining a professional distance that allows for therapeutic, professional responses (Foa & Rothbaum, 1998). This balance is difficult to maintain in some instances, as when trauma victims recount particularly terrible experiences during imaginal exposure. However, even the most compassionate therapist must remember that it is his or her job to assist the client in recovery from clinical anxiety, and losing emotional control or withholding exposure therapy is incompatible with this goal. Indeed, clients draw strength from the therapist's outward expressions of confidence in their ability to tolerate the distress associated with particularly difficult exposures. An

important aspect of one's development as an exposure therapist involves learning to cope with and accept the emotional distress clients exhibit during particularly challenging therapeutic tasks. From time to time, unburdening oneself by talking to colleagues, or seeking distraction in the form of other professional or personal activities, is useful to cope with the unique demands of exposure therapy.

Therapists who believe that exposure therapy poses a risk management problem would benefit from the knowledge that the anxiety evoked during exposure sessions is generally tolerable, harmless, and no different from what clients are already experiencing. Reassuringly, there is no evidence to suggest that exposure is associated with an increased risk of litigation. Richard and Gloster (2007) searched the legal record for court cases involving exposure therapy. Their exhaustive search criteria did not reveal a single instance of litigation related to this treatment. Similarly, none of the 84 members of the Anxiety Disorders Association of America surveyed by Richard and Gloster reported knowledge of any legal action or ethics complaints regarding exposure. This survey approach, however, cannot rule out the possibility that relevant complaints have been filed, but dismissed or settled out of court. Lastly, we note that malpractice insurance carriers appear unconcerned with the use of exposure. Malpractice rates are much lower for psychotherapy than for many other healthcare providers, and we are not aware of any insurance companies that charge higher premiums for therapists who provide exposure therapy. In summary, the available evidence suggests that exposure is acceptably safe and tolerable, and that it carries little risk of actively harming clients (or their therapists).

Conclusions and Future Directions

Exposure-based CBT is the most evidence-based psychological treatment for pathological anxiety. Unfortunately, clients suffering from anxiety disorders are often unable to access this intervention owing to the widespread failure to disseminate it to practitioners. This chapter reviews the numerous and formidable barriers that prevent mental health practitioners from utilizing exposure therapy. However, the poor utilization of exposure is only part of the story, as a host of additional barriers may serve to reduce the efficacy of exposure therapy even when it is delivered by trained therapists.

Exposure therapy is a uniquely difficult treatment to disseminate. Strong, negative beliefs about this intervention are pervasive among mental health professionals. Despite its well-established efficacy, exposure is widely considered to be unethical, harmful, and intolerable for clients and therapists alike. Because of such beliefs, efforts to disseminate exposure therapy to practitioners likely require more than simple instruction in the nuts and bolts of the application of exposure techniques.

Clinical scientists continue to strive to improve the efficacy (e.g., Rapee, Gaston, & Abbott, 2009) and acceptability (e.g., Rachman, Radomsky, & Shafran, 2008) of exposure therapy, and will doubtless do so for the foreseeable future. However, the evidence base for existing exposure-based cognitive-behavioral therapies is now sufficiently well-developed that efforts at dissemination are proceeding in earnest (McHugh & Barlow, 2010). In the United States, the most prominent example is the widespread effort within the Veteran's Health Administration to train therapists in evidence-based psychotherapies for PTSD, including prolonged exposure therapy (Foa, Hembree, & Rothbaum, 2007). The Improving Access to Psychological Therapies

(IAPT) program in the United Kingdom is the most extensive dissemination effort in the world. In 2010, the Department of Health invested approximately £300 million (approximately \$435 million U.S. dollars) to train healthcare professionals in evidence-based treatments for depression and anxiety, and early clinical outcomes are impressive (Clark et al., 2009).

Empirical research on the nature and modification of therapist barriers to exposure has the potential to improve efforts to disseminate this treatment to mental health professionals. Future studies might address the following questions: (a) what are the negative beliefs about exposure therapy held by therapists?; (b) how do such beliefs affect whether or not, and how, therapists utilize exposure techniques in their practice?; (c) how do negative therapist beliefs about exposure affect client outcomes?; (d) what training strategies are most effective in modifying negative beliefs about exposure?; and (e) to what extent is the success of efforts to train practitioners in the competent delivery of exposure therapy contingent upon modification of negative beliefs about this treatment? Efforts to develop measurement tools for assessing therapist beliefs about exposure are underway, and researchers are beginning to tackle these questions in a systematic manner (e.g., Harned, Dimeff, Woodcock, & Skutch, 2011). Despite a host of practical and ideological barriers, substantial progress is being made in the dissemination of exposure-based treatments for anxiety disorders. We hope that the information presented in this chapter will encourage additional progress in the important effort to increase the availability of exposure-based CBT to clients with anxiety disorders.

References

- Abramowitz, J. S. (1996). Variants of exposures and response prevention in the treatment of obsessive-compulsive disorder: A meta-analysis. *Behavior Therapy, 27*, 583-600.
- Abramowitz, J. S., Deacon, B. J., & Whiteside, S. P. (2010). *Exposure therapy for anxiety: Principles and practice*. New York: Guilford Press.
- Addis, M. E., Wade, W. A., & Hatgis, C. (1999). Barriers to dissemination of evidence-based practices: Addressing practitioners concerns about manual-based psychotherapies. *Clinical Psychology: Science and Practice, 6*, 430-441.
- American Psychiatric Association (2011). American Psychiatric Association Practice Guidelines. Retrieved January 31, 2011, from:
<http://www.psychiatryonline.com/pracGuide/pracGuideHome.aspx>.
- American Psychological Association (2002). *Ethical principles of psychologists and code of conduct*. Available on the World Wide Web: <http://www.apa.org/ethics/>.
- APA Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*, 271-285.
- Baker, T. B., McFall, R. M., & Shoham, V. (2009). Current status and future prospects of clinical psychology: Toward a scientifically principled approach to mental and behavioral health care. *Psychological Science in the Public Interest, 9*, 67-103.
- Barlow, D. H., Gorman, J. M., Shear, M. K., & Woods, S. W. (2000). Cognitive-behavioral therapy, imipramine, or their combination for panic disorder: A randomized controlled trial. *Journal of the American Medical Association, 283*, 2529-2536.

- Barlow, D. H., Levitt, J. T., & Bufka, L. F. (1999). The dissemination of empirically supported treatments: A view to the future. *Behaviour Research and Therapy*, *37*, S147-S162.
- Becker, C., Zayfert, C., & Anderson, E. (2004). A survey of psychologists' attitudes toward utilization of exposure therapy for PTSD. *Behaviour Research and Therapy*, *42*, 277-292.
- Berke, D. M., Rozell, C. A., Hogan, T. P., Norcross, J. C., & Karpiak, C. P. (in press). What clinical psychologists know about evidence-based practice: Familiarity with online resources and research methods. *Journal of Clinical Psychology*.
- Böhm, K., Förstner, U., Külz, A., & Voderholzer, U. (2008). Versorgungsrealität der zwangsstörungen: Werden expositionsverfahren eingesetzt? *Verhaltenstherapie*, *18*, 18-24.
- Brown, A., Deacon, B. J., Abramowitz, J. S., & Whiteside, S. P. (2007). Parents' perceptions of pharmacological and cognitive-behavioral treatments for childhood anxiety disorders. *Behaviour Research and Therapy*, *45*, 819-828.
- Clark, D. M., Layard, R., Smithies, R., Richards, D. C., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy*, *47*, 910-920.
- Deacon, B. J. & Abramowitz, J. S. (2004). Cognitive and behavioral treatment for anxiety disorders: A review of meta-analytic findings. *Journal of Clinical Psychology*, *60*, 429-441.

- Deacon, B. J., & Abramowitz, J. S. (2005). Patients' perceptions of pharmacological and cognitive-behavioral treatments for anxiety disorders. *Behavior Therapy, 36*, 139-145.
- Foa, E., Hembree, E., & Rothbaum, B. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences, therapist guide*. New York, NY: Oxford University Press.
- Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape: Cognitive-behavioral therapy for PTSD*. New York, NY: Guilford Press.
- Franklin, M., Huppert, J., Garcia, A., Freeman, J., March, J., & Foa, E. (2004, November). *Therapist effects in a randomized controlled trial for pediatric OCD*. Poster session presented at the annual meeting of the Association for Advancement of Behavior Therapy, New Orleans, LA.
- Freiheit, S. R., Vye, C. Swan, R., & Cady, M. (2004). Cognitive-behavioral therapy for anxiety: Is dissemination working? *the Behavior Therapist, 27*, 25-32.
- Garb, H. N., & Boyle, P. A. (2003). Understanding why some clinicians use pseudoscientific methods: Findings from research on clinical judgment. In Lilienfeld, S. O., Lynn, S. J., & Lohr, J. M. (Eds.) *Science and pseudoscience in clinical psychology* (pp. 17-38). New York: Guilford Press.
- Goisman, R. M., Warshaw, M. G., & Keller, M. B. (1999). Psychosocial treatment prescriptions for generalized anxiety disorder, panic disorder, and social phobia, 1991-1996. *American Journal of Psychiatry, 156*, 1819-1821.
- Gray, M. J., Elhai, J. D., & Schmidt, L. O. (2007). Trauma professionals' attitudes toward and utilization of evidence-based practices. *Behavior Modification, 31*, 732-748.

- Gunter, R. W., & Whittal, M. L. (2010). Dissemination of cognitive-behavioral treatments for anxiety disorders: Overcoming barriers and improving patient access. *Clinical Psychology Review, 30*, 194-202.
- Harned, M. S., Dimeff, L. A., Woodcock, E. A., & Skutch, J. M. (2011). Overcoming barriers to disseminating exposure therapies for anxiety disorders: A pilot randomized controlled trial of training methods. *Journal of Anxiety Disorders, 25*, 155-163.
- Heuzenroeder, L., Donnelly, M., Haby, M. M., Mihalopoulos, C., Rossell, R., Carter R., et al. (2004). Cost-effectiveness of psychological and pharmacological interventions for generalized anxiety disorder and panic disorder. *Australia and New Zealand Journal of Psychiatry, 38*, 602-612.
- Hipol, L. J., & Deacon, B. J. (2010, November). *Dissemination of evidence-based practices for anxiety disorders in Wyoming: A survey of practicing psychotherapists*. Poster session presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, San Francisco, CA.
- Hunsley, J., & Di Giulio, G. (2002). Dodo bird, phoenix, or urban legend: The question of psychotherapy equivalence. *The Scientific Review of Mental Health Practice, 1*, 11-22.
- Kozak, M. J., & Foa, E. B. (1997). *Mastery of obsessive-compulsive disorder: A cognitive-behavioral approach*. San Antonio, TX: Graywind Publications.
- Litz, B. (2002, November). The use of PE: Clinical decision making. Paper presented at the 18th Annual Meeting of the International Society for Traumatic Stress Studies, Baltimore, MD.

- McHugh, R. K., & Barlow, D. H. (2010). The dissemination and implementation of evidence-based psychological treatments. *American Psychologist, 65*, 73-84.
- National Institute for Clinical Excellence (2011). Clinical Guidelines. Retrieved January 31, 2011, from: <http://guidance.nice.org.uk/CG>.
- Norton, G. R., Allen, G. E., & Hilton, J. (1983). The social validity of treatments for agoraphobia. *Behaviour Research and Therapy, 21*, 393-399.
- Olatunji, B. O., Cisler, J. & Deacon, B. J. (2010). Efficacy of cognitive behavioral therapy for anxiety disorders: A review of meta-analytic findings. *Psychiatric Clinics of North America, 33*, 557-577.
- Olatunji, B. O., Deacon, B. J., & Abramowitz, J. S. (2009). The cruelest cure? Ethical issues in the implementation of exposure-based treatments. *Cognitive and Behavioral Practice, 16*, 172-180.
- Persons, J. B., & Silberschatz, G. (1998). Are results of randomized controlled trials useful to psychotherapists? *Journal of Consulting and Clinical Psychology, 66*, 126-135.
- Pediatric OCD Treatment Study (POTS) Team (2004). Cognitive-behavior therapy, sertraline, and their combination for children and adolescents with obsessive-compulsive disorder: The Pediatric OCD Treatment Study (POTS) randomized controlled trial. *Journal of the American Medical Association, 292*, 1969-1976.
- Rachman, S., Radomsky, A., & Shafran, R. (2008). Safety behaviors: A reconsideration. *Behaviour Research and Therapy, 46*, 163-173.

- Rapee, R. M., Gaston, J. E., & Abbott, M. J. (2009). Testing the efficacy of theoretically derived improvements in the treatment of social phobia. *Journal of Consulting and Clinical Psychology, 77*, 317–327.
- Richard, D. C. S., & Gloster, A. T. (2007). Exposure therapy has a public relations problem: A dearth of litigation amid a wealth of concern. In Richard, D. C., S., & Lauterbach, D. (Eds.), *Comprehensive handbook of the exposure therapies* (pp. 409-425). New York: Academic Press.
- Rothbaum, B. O., & Schwartz, A. C. (2002). Exposure therapy for posttraumatic stress disorder. *American Journal of Psychotherapy, 56*, 59-75.
- Schmidt, N. B., Woolaway-Bickel, K., Trakowski, J., Santiago, H., Storey, J., Koselka, M., et al. (2000). Dismantling cognitive-behavioral treatment for panic disorder: Questioning the utility of breathing retraining. *Journal of Consulting and Clinical Psychology, 68*, 417-424.
- Slater, L. (2003). The cruelest cure. *New York Times*, November 3.
- Stein, M. B., Sherbourne, C. D., Craske, M. G., Means-Christensen, A., Bystritsky, A., Katon, W., Sullivan, G., & Roy-Byrne, P. P. (2004). Quality of care for primary care patients with anxiety disorders. *American Journal of Psychiatry, 161*, 2230-2237.
- Tavris, C. (2003). The widening scientist-practitioner gap: A view from the bridge. In Lilienfeld, S. O., Lynn, S. J., & Lohr, J. M. (Eds.) *Science and pseudoscience in clinical psychology* (pp. ix – xviii). New York: Guilford Press.

- Taylor, C. B., King, R., Margraf, J., Ehlers, A., Telch, M., Roth, W. T., & Agras, W. S. (1989). Use of medication and in vivo exposure in volunteers for panic disorder research. *American Journal of Psychiatry*, *146*, 1423-1426.
- van Minnen, A., Hendriks, L., & Olf, M. (2010). When do trauma experts choose exposure therapy for PTSD patients? A controlled study of therapist and patient factors. *Behaviour Research and Therapy*, *48*, 312-320.
- Weissman, M. M., Verdeli, H., Gameroff, M. J., Bledsoe, S. E., Betts, K., Mufson, L., et al. (2006). National survey of psychotherapy training in psychiatry, psychology, and social work. *Archives of General Psychiatry*, *63*, 925-934.
- Wolfe, R. M., Sharp, L. K., & Wang, R. M. (2004). Family physicians' opinions and attitudes to three clinical practice guidelines. *Journal of the American Board of Family Practice*, *17*, 150-157.
- Young, A. S., Klap, R., Shoai, R., & Wells, K. B. (2008). Persistent depression and anxiety in the United States. *Psychiatric Services*, *59*, 1391-1398.
- Young, A. S., Klap, R., Sherbourne, C. D., & Wells, K. B. (2001). The quality of care for depressive and anxiety disorders in the United States. *Archives of General Psychiatry*, *58*, 55-61.