



Dissemination of empirically supported treatments for anxiety disorders: Introduction to the special issue



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ABSTRACT

Effective exposure therapies for anxiety disorders have been available for half a century. Over that time we have made great strides increasing the potency of these powerful methods. Yet, most of us in practice still have a conversation like the following with our new patients: *Therapist*: “So what treatments have you had for your anxiety symptoms to date?” *Patient*: “I have seen numerous therapists over the last 10 years.” *Therapist*: “Great, so what did you do?” *Patient*: “We talked about things. And I learned relaxation and breathing techniques.” *Therapist*: “Did a therapist ever help you face your fears?” *Patient*: “What do you mean?” *Therapist*: “I mean did you directly confront feared situations, perhaps with your therapist outside the office?” *Patient*: “No, why, is that important?” This oft-repeated conversation highlights the disconnect between the well-established efficacy of exposure-based treatments for pathological anxiety and their inaccessibility to most anxious clients. This failure to successfully disseminate exposure-based empirically supported treatments is the motivation for this special issue. The articles that follow consider the causes of this dissemination failure, highlight areas of success, and offer constructive remedies for addressing this important public health problem.

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Anxiety disorders are the most common mental disorders in the United States and account for approximately one-third of all mental health care costs (Greenberg et al., 1999; Kessler et al., 2005). Fortunately, highly effective treatments are available that alleviate symptoms for most patients (Abramowitz, Whiteside, & Deacon, 2005; Deacon & Abramowitz, 2004; Gould, Otto, Pollack, & Yap, 1997; Gould, Otto, & Pollack, 1995; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010; Powers, Sigmarsson, & Emmelkamp, 2008; Rosa-Alcázar, Sánchez-Meca, Gómez-Conesa, & Marín-Martínez, 2008; Wolitzky-Taylor, Horowitz, Powers, & Telch, 2008). These exposure-based interventions are considered first-line treatments of choice by international guidelines (e.g. National Institute for Health and Care Excellence [NICE], Institute of Medicine). In fact, for some anxiety disorders they are the only recommended interventions. For example, in a comprehensive 2007 report, the *Institute of Medicine 2007* found that “the evidence is sufficient to conclude the efficacy of exposure therapies in the treatment of PTSD” (p. 97) but did not find sufficient evidence to support the efficacy of other pharmacologic treatments or psychotherapies.

Despite the overwhelming efficacy data, most people in the United States who suffer from anxiety disorders do not receive exposure therapy. To illustrate, only a small minority of therapists

and patients actually deliver or receive exposure therapy for anxiety (Becker, Zayfert, & Anderson, 2004; Freiheit, Vye, Swan, & Cady, 2004; Goisman, Warshaw, & Keller, 1999; Marcks, Weisberg, & Keller, 2009; Rosen et al., 2004). Indeed, most therapists do not conduct any exposure therapy. Bibliotherapy, medication, dynamic therapy, and cognitive therapy are all more commonly used than exposure (Freiheit et al., 2004; Goisman et al., 1999). Even among self-described cognitive-behavioral therapists, the use of therapist-assisted exposure is infrequent and occurs as often as the use of unsubstantiated treatments such as thought field therapy and art therapy (Hipol & Deacon, 2013). Thus, therapists have learned to report that they deliver empirically supported therapies for anxiety disorders, but in practice they omit the most important ingredient.

Although it is clear that effective treatments for anxiety disorders are either ignored or delivered suboptimally (without exposure), it is less clear why. In this issue we asked experts in the field to contribute articles that examined dissemination of empirically supported treatments for anxiety disorders. The resulting eight articles provide an innovative look at dissemination through novel strategies, research methods, and new ways of thinking altogether.

First, Franklin et al. (2013) describe expert-level competencies in the delivery of CBT for pediatric OCD. Their search for competencies resulted from site effects they observed during a clinical trial that were likely attributable to differences in therapist expertise

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(POTS, 2004). Identifying such competencies will be important for successful dissemination. Second, Harned, Dimeff, Woodcock, and Contreras (2013) examine barriers to adoption of exposure therapy methods in the context of a randomized controlled dissemination trial. Third, Farrell, Deacon, Kemp, Dixon, and Sy (2013) experimentally manipulated beliefs about exposure therapy and measured how therapists then delivered the treatment. Fourth, Deacon et al. (2013) describe the development and testing of a new 21-item Therapist Beliefs about Exposure Scale (TBES) and present evidence on the prevalence, consequences, and modifiability of common therapist reservations about exposure. Fifth, Farrell, Deacon, Dixon, and Lickel (2013) describe methods to modify therapist faulty negative beliefs about exposure to enhance optimal delivery. Sixth, McLean and Foa (2013) describe the strategies they use to successfully disseminate prolonged exposure therapy for PTSD. Seventh, Gallo, Comer, and Barlow (2013) describe direct-to-consumer marketing as a potential method of dissemination. Finally, Taylor and Abramowitz (2013) conclude with a summary and discussion of the articles presented in this issue.

This special issue aims to improve the dissemination of exposure therapies for anxiety disorders by diagnosing the causes of dissemination failure and highlighting innovative strategies (and success stories) for overcoming them. We hope researchers, educators, and practitioners will find within it effective strategies for addressing this critically important problem.

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