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Leilani J. Hipol¹ and Brett J. Deacon¹

Abstract

Despite the well-established effectiveness of exposure-based cognitive-behavioral therapy (CBT) in the treatment of anxiety disorders, therapists have been slow to adopt CBT into their clinical practice. The present study was conducted to examine the utilization of psychotherapy techniques for anxiety disorders among community practitioners in a rural setting in order to determine the current status of the dissemination of CBT. A sample of 51 licensed psychotherapists from various mental health professions was recruited from online practice listings in the state of Wyoming. Participants completed a survey assessing their use of various psychotherapy techniques in the past 12 months for clients with obsessive-compulsive disorder, post-traumatic stress disorder, panic disorder, and social phobia. Nearly all psychotherapists reported providing CBT, and techniques such as cognitive restructuring, arousal-reduction strategies, and mindfulness were used by the vast majority of respondents. Therapist-assisted exposure was rarely utilized, and providers who delivered exposure therapy often did so alongside other techniques of questionable compatibility with this approach. Non-evidence-based techniques were frequently used, particularly by self-proclaimed anxiety specialists. Our findings highlight the successes

¹University of Wyoming

Corresponding Author:

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

Email: bdeacon@uwyo.edu

and failures of efforts to disseminate exposure-based CBT to community practitioners. Implications for clinical training and practice are discussed.

Keywords

dissemination, psychotherapy, CBT, anxiety disorders, evidence-based practice

Clinical trials have established the effectiveness of cognitive-behavioral procedures such as exposure to feared stimuli, elimination of safety behaviors, and cognitive restructuring in the treatment of anxiety disorders (Barlow, 2002). Exposure therapy in particular is the foundation of numerous effective cognitive-behavioral therapy (CBT) treatment protocols for posttraumatic stress disorder (PTSD; Schnurr et al., 2007), obsessive compulsive disorder (OCD; Foa et al., 2005), social phobia (Davidson et al., 2004), panic disorder and agoraphobia (Gloster et al., 2011), and specific phobias (Ollendick et al., 2009). Clinical practice guidelines published by the American Psychiatric Association (2012) and the National Institute for Clinical Excellence (2012) recommend exposure-based CBT approaches as first-line anxiety treatments. Relative to pharmacotherapy, exposure-based CBT typically produces similar short-term benefit and superior long-term maintenance of treatment gains (e.g., Barlow, Gorman, Shear, & Woods, 2000; Liebowitz et al., 1999). 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). However, despite its status as the most empirically supported psychological treatment for anxiety disorders, dissemination of exposure-based CBT has been largely unsuccessful.

Therapist surveys indicate that community practitioners, even those who self-identify as cognitive-behavioral in orientation, rarely use exposure-based treatments with their anxious patients (Frieheit, Vye, Swan & Cady, 2004). To illustrate, Becker, Zayfert, and Anderson (2004) found that fewer than 20% of doctoral-level psychologists reported using exposure therapy to treat clients with posttraumatic stress disorder (PTSD). Indeed, exposure was not widely utilized even among therapists with specialized training in this approach. These findings were replicated by van Minnen, Hendriks, and Olf (2010) in a survey of more than 250 trauma experts. Imaginal exposure was the least used treatment for PTSD, and respondents preferred both Eye Movement Reprocessing and Desensitization (EMDR) and supportive counseling to exposure therapy.

The underutilization of exposure therapy is not specific to PTSD. Freiheit et al. (2004) reported that Minnesota psychologists rarely provided interoceptive exposure, a key procedure in evidence-based CBT protocols for panic disorder (Barlow & Craske, 2007). Similarly, therapist-assisted in vivo exposure was rarely delivered to clients with OCD and social phobia despite its status as the central ingredient in empirically supported exposure-based CBT interventions for these disorders (e.g., Kozak & Foa, 1997; Heimberg & Becker, 2002). A German study found that although almost all therapists requested coverage for exposure therapy from OCD clients' health insurers, over 80% of their clients reported that no exposure component was used in their treatment (Böhm, Förstner, Kulz, & Voderholzer, 2008). Becker et al. (2004) found that fewer than 15% of trauma experts reported using exposure-based CBT when treating other anxiety disorders due to a lack of training.

There are numerous reasons why evidence-based treatments are resisted by practitioners, including concerns about negative effects on the therapeutic relationship, the inability to tailor treatment to client needs, and restriction of therapist creativity and innovation (Addis, Wade, & Hatgis, 1999). Exposure therapy is subject to a host of additional barriers to dissemination in the form of negative beliefs about this treatment (Deacon & Farrell, in press; Gunter & Whittal, 2010). Therapists may fear that clients will be unable to tolerate the distress exposure evokes and experience symptom exacerbation, drop out of therapy, or decompensate during particularly stressful exposure tasks. Practitioners may find it difficult to tolerate their own discomfort during exposure tasks and elect to deliver exposure in a less intensive manner, or not at all, in response to these concerns. These therapist barriers complicate efforts to disseminate exposure therapy and may explain the findings that (a) the majority of therapists with specialized training in exposure elect to forego this treatment (Becker et al., 2004), and (b) even therapists who use exposure often do so alongside arousal-reduction strategies designed to minimize anxiety symptoms (Freiheit et al., 2004).

The widespread failure to disseminate exposure-based CBT to mental health practitioners means that many clients with anxiety disorders receive non-evidence-based psychotherapies of lesser or unknown effectiveness (Goisman, Warshaw, & Keller, 1999; Stein et al., 2004). Clients seeking treatment for anxiety disorders frequently become victims of opportunity cost when they invest time, money, and effort in less beneficial therapies (Gunter & Whittal, 2010). Improving client access to evidence-based treatments in general, including exposure-based CBT for anxiety disorders, is an important public health priority. In order to improve future efforts to disseminate effective treatments for anxiety, it is necessary to understand the current practices of community therapists. This task is especially important in rural

settings removed from the universities and specialty clinics in which experts and training in exposure-based CBT are readily available.

The present study was conducted to examine the utilization of psychotherapy techniques for anxiety disorders among community practitioners in a rural setting in order to determine the current status of the dissemination of evidence-based CBT. Of particular interest was the use of exposure techniques relative to other CBT techniques (e.g., relaxation and cognitive strategies) and non-evidence based techniques from other psychotherapy traditions. Similar to Freiheit et al. (2004), we surveyed community practitioners about their use of specific psychotherapy techniques for different anxiety disorders (OCD, panic disorder, social phobia); the present study also assessed treatments for PTSD. This investigation builds upon previous research by surveying a representative community sample of clinicians from various mental health professions, as opposed to selecting samples of only psychologists (Freiheit et al., 2004) or trauma experts (Becker et al., 2004) who might be especially likely to practice in an evidence-based manner. In addition, the present study assessed use of non-evidence-based and pseudoscientific therapies in addition to techniques associated with CBT. Lastly, in order to inform future dissemination efforts the present study inquired about psychotherapists' interest in receiving additional training in CBT. We hypothesized that psychotherapists would report frequent utilization of CBT procedures in general but low utilization of exposure therapy. We further hypothesized that exposure therapy, when utilized by psychotherapists, would frequently be used concurrently with a large number of other CBT and non-evidence-based techniques. We also hypothesized that the utilization of non-evidence based practices would be frequent. Lastly, we hypothesized that therapists would report considerable interest in receiving additional training in CBT.

Method

Participants

Study participants were practicing psychotherapists in the state of Wyoming. Potential participants were identified through an online yellow pages database (www.dexknows.com), equivalent in content to the printed directory distributed to Wyoming residents, using the search terms "psychotherapist," "psychologist," "mental health services," "counseling," and "psychiatrist." These search criteria were selected in order to identify a broadly representative sample of all mental health practitioners without regard to their profession or work setting. The search was restricted to the 17 Wyoming cities with

a population greater than 5,000. All Wyoming psychotherapists with online practice listings ($N = 174$) were contacted via telephone to participate in the present study. The sample included therapists in private practice as well as individuals who worked at Veterans Administration hospitals, hospitals, clinics, and other organizations. The pool of potential participants was reduced to 143 after excluding disconnected and/or duplicate phone numbers ($n = 22$), as well as therapists who had not seen a client with an anxiety disorder in the previous 12 months ($n = 9$). Ninety-two phone numbers yielded no response to repeated telephone contacts. All 51 eligible therapists who responded to telephone solicitations agreed to participate.

The final sample consisted of 31 women and 20 men with a mean age of 53.6 years ($SD = 10.6$). Consistent with the population of Wyoming, the vast majority of participants were Caucasian (96.1%). Respondents included 15 psychologists, 14 licensed professional counselors, 13 licensed clinical social workers, 6 individuals who identified themselves as “psychotherapists,” 2 psychiatrists, and 1 licensed marriage and family therapist. Most participants ($n = 31$, 60.8%) indicated that their highest earned degree was a masters ($n = 31$); an additional 18 had earned a doctoral degree (35.3%; 14 Ph.D., 4 Psy.D.), and 2 (3.9%) had earned an MD. The most common work setting was private practice ($n = 38$; 74.5%), followed by community mental health center ($n = 5$), psychiatric hospital ($n = 4$), and various other settings ($n = 4$). The preponderance of therapists in private practice in the final sample was likely a consequence of three factors: (a) Wyoming has a relatively small number of universities, medical centers, and related organizations, (b) therapists within such organizations may have a fixed referral base and thus not personally advertise their services in the yellow pages, and (c) phone calls placed to therapists in organizational settings were generally screened by secretarial staff, whereas therapists in private practice were most often reached directly. All participants reported being licensed in the state of Wyoming; the average duration of licensure was 11.3 years ($SD = 9.2$). Most participants worked primarily with adults ($n = 37$), while fewer worked with both children and adults ($n = 10$) or with children primarily ($n = 4$). The majority of respondents ($n = 33$; 64.7%) described their theoretical orientation as cognitive-behavioral, either alone or in combination with other approaches. The average respondent reported that 31.5% ($SD = 22.7\%$) of his or her caseload was focused on treating clients with OCD, social phobia, panic disorder, and/or PTSD. Twelve therapists (23.5% of the sample; 5 psychologists, 4 counselors, 2 “psychotherapists,” and 1 social worker) advertised themselves to clients as a specialist in the treatment of one or more of these anxiety disorders.

Measure

The study measure was adapted from the 14-item survey used by Frieheit et al. (2004). The survey inquired about demographic/practice information and subsequently assessed the utilization of various techniques in the treatment of clients seen in the past 12 months with OCD, social phobia, panic disorder, and PTSD. Participants were asked whether or not they advertised themselves to clients as an anxiety specialist. Participants also were asked whether or not they used CBT in the treatment of clients with anxiety disorders, and if so, to indicate whether or not they endorsed each of six different reasons for using CBT. Participants who reported not using CBT were similarly asked about their endorsement of various reasons for this practice. Finally, participants were asked a series of questions about their interest in receiving additional training in CBT for anxiety disorders.

Participants were queried about their use of the following treatment techniques: (a) those central to empirically supported CBT protocols (e.g., exposure and response prevention), (b) other strategies often associated with CBT but less central to the treatment (e.g., breathing retraining, progressive muscle relaxation), (c) so-called “third-wave” (Hayes, Luoma, Bond, Masuda, & Lillis, 2006) CBT interventions (e.g., Acceptance and Commitment Therapy [ACT], Dialectical Behavior Therapy [DBT], mindfulness techniques), (d) commonly practiced non-CBT interventions (e.g., psychodynamic therapy, non-directive supportive psychotherapy), and (e) other therapies marketed to the local therapeutic community (e.g., EMDR, Thought Field Therapy [TFT], art therapy).

The present survey differed from that of Freiheit et al. (2004) in several respects. First, participants were asked to indicate whether or not they used various interventions with anxious clients in the past 12 months, rather than the extent to which they generally do so, and therapists who had not seen a client with a particular anxiety disorder in the past 12 months were excluded from responding. This decision to tie answers to recently seen clinical cases was made in the interest of increasing the accuracy of participants' retrospective recall. Second, the present measure included a number of techniques not assessed by Freiheit et al., including “third-wave” CBT-related interventions and non-evidence-based treatments. Third, the present survey assessed treatments provided to clients with PTSD in addition to OCD, panic disorder, and social phobia. Fourth, the present measure assessed participant interest in receiving training in CBT. A copy of the survey may be obtained by contacting the second author.

Procedure

The first author attempted to contact via telephone each psychotherapist identified in the initial online database search. When potential participants were reached, they were asked a screening question to ensure that they had treated at least one client with one of the four selected anxiety disorders in the past twelve months. Eligible participants who agreed to complete the survey were read a consent form that was signed by the first author and a witness to the conversation. Upon request, the consent form document was faxed or e-mailed to the participant. The survey was administered over the phone in approximately 15- 20 minutes. Data were recorded on hard copies of the survey and transferred into a statistical database for analysis. This study was approved by the University of Wyoming institutional review board.

Results

Interventions used to Treat Anxiety Disorders

All but one participant ($n = 50$; 98.0%) reported using CBT in the treatment of clients with anxiety disorders. Table 1 presents the frequency with which respondents reported using 19 different interventions in the past 12 months for patients with OCD, social phobia, panic disorder, and PTSD. Cognitive-behavioral techniques such as cognitive restructuring ($> 90\%$), elimination of safety behaviors ($> 70\%$), and arousal reduction techniques ($\geq 70\%$) were among the most commonly used procedures for each anxiety disorder. High utilization rates were also reported for non-directive supportive psychotherapy (range = 72.7% to 78.7%) and psychodynamic therapy (range = 50.0% to 57.6%). More than half of respondents reported using mindfulness techniques, ACT, and meditation for each anxiety disorder. Use of client self-directed exposure varied from 48.9% for PTSD to 69.7% for OCD. Therapist-assisted in vivo exposure was less often utilized (range = 19.1% to 33.3%) at rates comparable to that of non-evidence based techniques such as thought field therapy (range = 19.1% to 27.8%) and art therapy (range = 16.7% to 27.8%). Individual therapists tended to use the same techniques for each anxiety disorder. To illustrate, clinicians who provided therapist-assisted in vivo exposure for OCD were likely to do so for social phobia (100%), panic disorder (100%), and PTSD (87.5%).

Table 1. Percentage of Wyoming Psychotherapists Who Use Various Interventions to Treat Anxiety Disorders.

Intervention	OCD (n = 33)	Social Phobia (n = 30)	Panic Disorder (n = 35)	PTSD (n = 47)
Cognitive Restructuring	93.9%	96.7%	97.2%	93.6%
Mindfulness Techniques	75.8%	73.3%	80.0%	78.3%
Progressive Muscle Relaxation	75.8%	80.0%	77.8%	76.6%
Elimination of Avoidance and Safety-Seeking Behaviors	75.8%	80.0%	77.8%	74.5%
Non-Directive Supportive Psychotherapy	72.7%	76.7%	77.8%	78.7%
Breathing retraining	72.7%	70.0%	75.0%	76.6%
Client Self-Directed In Vivo Exposure	69.7%	66.7%	58.3%	48.9%
Meditation	63.6%	73.3%	77.8%	68.1%
Imaginal Exposure	63.6%	63.3%	63.9%	66.0%
Acceptance and Commitment Therapy	57.6%	63.3%	61.1%	55.3%
Psychodynamic Therapy	57.6%	50.0%	50.0%	51.1%
Motivational Interviewing	45.5%	56.7%	50.0%	53.2%
Dialectical Behavior Therapy	30.3%	23.3%	33.3%	34.0%
Therapist-Assisted In Vivo Exposure	27.3%	33.3%	27.8%	19.1%
Thought Field Therapy	24.2%	26.7%	27.8%	19.1%
Art Therapy	24.2%	16.7%	27.8%	27.7%
Eye Movement Desensitization and Reprocessing	15.2%	16.7%	22.2%	17.0%
Interoceptive Exposure	12.1%	16.7%	19.4%	8.5%
Hypnosis	12.1%	10.0%	19.4%	12.8%

Interventions used in Addition to Exposure

Responses from practitioners who reported using client self-directed exposure were examined in order to identify additional interventions used by clinicians who employ exposure therapy. These findings are presented in

Table 2. Use of Additional Interventions by Wyoming Psychotherapists Who Use Client Self-Directed in Vivo Exposure.

Intervention	OCD (n = 23)	Social Phobia (n = 20)	Panic Disorder (n = 21)	PTSD (n = 23)
Cognitive Restructuring	95.7%	100%	95.2%	100%
Mindfulness Techniques	82.6%	80.0%	90.5%	95.5%
Progressive Muscle Relaxation	78.3%	90.0%	85.7%	82.6%
Elimination of Avoidance and Safety-Seeking Behaviors	82.6%	90.0%	85.7%	91.3%
Non-Directive Supportive Psychotherapy	60.9%	70.0%	66.7%	69.6%
Breathing retraining	73.9%	70.0%	76.2%	82.6%
Therapist-Assisted In Vivo Exposure	39.1%	45.0%	38.1%	34.8%
Meditation	65.2%	70.0%	71.4%	69.6%
Imaginal Exposure	78.3%	75.0%	23.8%	82.6%
Acceptance and Commitment Therapy	47.8%	55.0%	47.6%	43.5%
Psychodynamic Therapy	52.2%	50.0%	52.4%	52.2%
Motivational Interviewing	43.5%	60.0%	57.1%	56.5%
Dialectical Behavior Therapy	34.8%	25.0%	42.9%	39.1%
Thought Field Therapy	26.1%	30.0%	33.3%	26.1%
Art Therapy	21.7%	15.0%	23.8%	26.1%
Eye Movement Desensitization and Reprocessing	21.7%	20.0%	28.6%	21.7%
Interoceptive Exposure	17.4%	25.0%	23.8%	13.0%
Hypnosis	17.4%	15.0%	14.3%	17.4%

Table 2. The pattern of utilization was generally comparable to that of all therapists in the study. Techniques such as cognitive restructuring (> 90%), elimination of safety behaviors (> 80%), and relaxation, breathing, and meditative strategies (> 60%) were among the most commonly used procedures. Fewer than half of therapists employing client self-directed exposure also provided exposure in a therapist-assisted manner; utilization of therapist-assisted exposure varied from 34.8% for PTSD to 45.0% for social phobia.

Non-evidence-based treatments such as psychodynamic therapy, non-directive supportive psychotherapy, thought field therapy, and art therapy were utilized with comparable frequency among clinicians who did or did not use client self-directed exposure.

Interventions used by Anxiety Specialists

Utilization of psychotherapy techniques was compared between therapists who did or did not advertise themselves to clients as a specialist in the treatment of anxiety disorders. The pattern of findings was generally similar across the four anxiety disorders (see Table 3). Compared to non-specialists, specialists were significantly more likely to report using the elimination of avoidance and safety-seeking behavior for OCD, $\chi^2(1) = 3.96, p = .05$, and interoceptive exposure for patients with each anxiety disorder (all p 's < .05). Anxiety specialists also reported significantly higher rates of utilizing thought field therapy for each anxiety disorder (all p 's < .05) than did non-specialists. Low statistical power due to the small sample size likely prevented several other comparisons from reaching traditional levels of significance (e.g., use of breathing retraining and EMDR). Notably, self-proclaimed anxiety specialists were less likely (albeit non-significantly) to use therapist-assisted in vivo exposure than non-specialists.

Reasons for Using Cognitive-Behavioral Therapy

Respondents who reported using CBT rated whether or not they endorsed six different reasons for doing so. Endorsement of these reasons was as follows: (a) personal experience indicates CBT is effective = 100%, (b) CBT is supported by research = 96.0% (c) CBT is consistent with clinical style of conducting therapy = 92.0%, (d) CBT is consistent with theoretical orientation = 90.0%, (e) CBT is recommended by supervisors/colleagues = 66.0%, and (f) CBT is consistent with the managed care approach = 62.0%.

Training in Cognitive-Behavioral Therapy

The vast majority (92.0%) of participants reported having received training in CBT for anxiety. Training experiences included professional workshops and/or conference education (80.4%), clinical supervision with an expert (72.5%), and graduate coursework (62.7%). Respondents also reported significant interest in receiving additional training in CBT for anxiety (78.4%). Few therapists (37.5%) reported having access to experts in their community

Table 3. Comparison of Interventions Used by Self-Identified Anxiety Specialists and Non-Specialists.

Intervention	OCD		Social Phobia		Panic Disorder		PTSD	
	Specialists (n = 9)	Non-Specialists (n = 24)	Specialists (n = 10)	Non-Specialists (n = 20)	Specialists (n = 9)	Non-Specialists (n = 26)	Specialists (n = 12)	Non-Specialists (n = 35)
Cognitive Restructuring	100%	91.7%	100%	95.0%	100%	96.2%	100%	91.4%
Mindfulness Techniques	77.8%	75.0%	70.0%	75.0%	70.0%	84.0%	75.0%	79.4%
Progressive Muscle Relaxation	77.8%	75.0%	70.0%	85.0%	80.0%	76.9%	75.0%	77.1%
Elimination of Avoidance and Safety-Seeking Behaviors	100%*	66.7%	90.0%	75.0%	90.0%	73.1%	91.7%	68.6%
Non-Directive Supportive Psychotherapy	55.6%	79.2%	70.0%	80.0%	70.0%	80.8%	66.7%	82.9%
Breathing retraining	55.6%	79.2%	50.0%	80.0%	60.0%	80.0%	66.7%	80.0%
Therapist-Assisted in Vivo Exposure	22.2%	29.2%	20.0%	40.0%	20.0%	30.8%	16.7%	20.0%
Client Self-Directed In Vivo Exposure	77.8%	66.7%	70.0%	65.0%	60.0%	57.7%	66.7%	42.9%
Meditation	66.7%	62.5%	70.0%	75.0%	70.0%	80.8%	66.7%	68.6%
Imaginal Exposure	66.7%	62.5%	50.0%	70.0%	50.0%	69.2%	75.0%	62.9%
Acceptance and Commitment Therapy	66.7%	54.2%	70.0%	60.0%	70.0%	57.7%	58.3%	54.3%
Psychodynamic Therapy	44.4%	62.5%	30.0%	60.0%	50.0%	50.0%	41.7%	54.3%
Motivational Interviewing	44.4%	45.8%	60.0%	55.0%	50.0%	50.0%	58.3%	51.4%
Dialectical Behavior Therapy	44.0%	25.0%	40.0%	15.0%	50.0%	26.9%	41.7%	31.4%
Thought Field Therapy	55.6%**	12.5%	50.0%*	15.0%	50.0%*	19.2%	41.7%**	11.4%
Art Therapy	22.2%	25.0%	20.0%	15.0%	30.0%	26.9%	16.7%	31.4%
Eye Movement Desensitization and Reprocessing	22.2%	12.5%	30.0%	10.0%	40.0%*	15.4%	33.3%	11.4%
Interceptive Exposure	33.3%*	4.2%	40.0%**	5.0%	40.0%*	11.5%	25.0%**	2.9%
Hypnosis	22.2%	8.3%	20.0%	5.0%	30.0%	15.4%	16.7%	11.4%

Note. * $p < .10$, ** $p < .05$ (Chi-Square test).

who provide training in CBT, and nearly all (97.5%) reported interest in attending affordable workshops in their community provided by experts in CBT for anxiety disorders.

Discussion

The present study was conducted to characterize Wyoming mental health professionals' use of psychotherapy techniques for clients with anxiety disorders. Nearly all survey respondents reported using CBT with their anxious clients and endorsed this approach because of personal experience and scientific evidence supporting its effectiveness. CBT techniques like cognitive restructuring, elimination of avoidance behavior, relaxation, and breathing retraining were frequently utilized. However, therapist-assisted exposure was rarely used despite its status as a critical ingredient in most evidence-based CBT protocols for anxiety disorders. Non-evidence-based techniques were frequently utilized alongside CBT interventions, and most therapists reported using a large number of techniques borrowed from different theoretical approaches in their treatment of anxious clients. Overall, the findings highlight the successes and failures of attempts to disseminate evidence-based treatment procedures for anxiety disorders to community therapists.

The form of CBT practiced by most Wyoming psychotherapists does not closely resemble that prescribed in evidence-based anxiety treatment manuals. Community practitioners frequently use non-disorder-specific interventions such as progressive muscle relaxation, breathing retraining, and meditation. Although these strategies are often associated with CBT, none are essential ingredients in most evidence-based CBT protocols for anxiety disorders (e.g., Foa & Rothbaum, 1998; Kozak & Foa, 1997). "Third wave" (Hayes et al., 2006) CBT interventions such as ACT and mindfulness techniques were used by a majority of therapists. DBT, an evidence-based treatment for borderline personality disorder (Lynch, Trost, Salsman, & Linehan, 2007) that has received little empirical attention as an anxiety treatment, was used by approximately one-third of therapists. The higher utilization rates of ACT and DBT relative to therapist-assisted exposure are notable given that both of these treatments emphasize exposure therapy (Eifert & Forsyth, 2005; Linehan, 1993). On a positive note, therapists reported frequent use of the elimination of safety behaviors and moderate use of client self-directed exposure, both of which are emphasized in most evidence-based CBT protocols. Taken together, our findings suggest that therapists surveyed in this study frequently use most CBT strategies *except* the one most emphasized in evidence-based CBT protocols – therapist-assisted exposure.

The present results are consistent with those of Freiheit et al. (2004) in highlighting the infrequent use therapist-assisted exposure relative to less central CBT techniques. Despite its status as a key ingredient in evidence-based CBT for social phobia and OCD, therapist-assisted in vivo exposure was used by a minority of therapists for these disorders. Interoceptive exposure, a central component of CBT for panic disorder, was used by less than 20% of therapists. Together with the findings of Freiheit et al. (2004), our results suggest that interoceptive exposure is the single least utilized evidence-based anxiety treatment. Imaginal exposure was used with similar frequency for each anxiety disorder despite the fact that this procedure is central to CBT for PTSD and is seldom included in the treatment of panic disorder and social phobia. Overall, the same group of primarily non-exposure-based strategies was used with remarkable consistency in the treatment of OCD, social phobia, panic disorder, and PTSD. In contrast to the distinctive set of disorder-specific techniques outlined in treatment manuals, Wyoming therapists appear to make little distinction in the interventions they use to treat the four anxiety disorders assessed in this study.

Why would therapists who primarily identify themselves as cognitive-behavioral in orientation, emphasize CBT techniques in their practice, and near-unanimously report using this treatment because of its effectiveness and research base, frequently eschew the most powerful CBT intervention for anxiety? Unfortunately, a powerful host of barriers serve to impede the dissemination of exposure therapy (Deacon & Farrell, in press; Gunther & Whittal, 2010; Olatunji, Deacon, & Abramowitz, 2009). These include lack of training, logistical problems (e.g., session length), workplace policies (e.g., prohibitions against traveling off-site with clients), and negative therapist beliefs about exposure (e.g., that it is unethical, intolerable, and harmful). It is also possible that community practitioners lack knowledge about the specific efficacy of exposure and response prevention relative to less central CBT interventions such as relaxation techniques. Clinical scientists have often developed and promoted cognitive-behavioral treatment packages that consist of numerous cognitive, arousal-reduction, and exposure-based techniques (e.g., Barlow & Craske, 2007), and exposure may be perceived as one of many CBT "tools" clinicians may utilize as opposed to the central active ingredient in treatment. Our findings highlight the need to focus on the dissemination of exposure therapy in particular, as opposed to other CBT techniques which are already utilized with considerable frequency. Doing so will require the development of innovative training methods designed to overcome the powerful barriers that discourage the use of this treatment (see Harned, Dimeff, Woodcock, & Skutch, 2011, for an example).

In addition to the utilization of exposure interventions per se, we were interested in examining the treatments psychotherapists used in conjunction with exposure. Our results suggest that when exposure is used, it is often employed alongside a variety of non-disorder-specific CBT techniques. Notably, most therapists who reported using client self-directed exposure reported using progressive muscle relaxation and breathing retraining with their anxious clients. Theorists have raised concerns that exposure and arousal-reduction strategies may be incompatible or perhaps even contradictory in some cases (e.g., Schmidt et al., 2000). Exposure encourages the evocation of intense and prolonged anxiety in order to promote distress tolerance, whereas relaxation strategies teach clients to minimize the intensity of their anxiety symptoms and run the potential risk of reinforcing the dangerousness and intolerability of anxiety itself (Abramowitz, Deacon, & Whiteside, 2010). Although few evidence-based CBT manuals for PTSD, OCD, panic disorder, or social phobia emphasize the concurrent use of exposure and arousal-reduction strategies, this practice appears to be the norm among practicing clinicians.

Wyoming therapists reported frequent use of non-evidence-based techniques. Non-directive supportive psychotherapy was used for each anxiety disorder by over 70% of therapists. Approximately half of survey respondents indicated using psychodynamic therapy. These techniques were frequently utilized alongside evidence-based CBT techniques such as client self-directed exposure and response prevention. Our findings indicate that most Wyoming psychotherapists often use a large number of techniques borrowed from different psychotherapy traditions with their anxious clients. To illustrate, the majority of therapists reported treating each anxiety disorder using (a) cognitive restructuring (a traditional CBT technique), (b) mindfulness techniques (a “third wave” CBT technique), (c) non-directive supportive psychotherapy (a client-centered technique), and (d) psychodynamic therapy. The “eclectic” practice of using evidence-based and non-evidence-based procedures from different theoretical orientations is concerning. Cognitive restructuring encourages the direct examination and modification of maladaptive thoughts, whereas mindfulness techniques teach clients to passively observe their thoughts without attempting to change them (Hayes, Strosahl, & Wilson, 1999). Non-directive supportive psychotherapy is antithetical to CBT’s emphasis on structure and pursuit of a specific agenda set by an expert therapist. Psychodynamic therapy encourages exploration of the past in order to gain insight into the origin of anxiety problems, whereas CBT focuses on present-day factors that maintain pathological anxiety. Although these characterizations are generalizations, it is evident that the anxiety treatments

provided by community therapists lack the conceptual clarity and emphasis on the delivery of theoretically compatible procedures outlined in evidence-based CBT protocols.

Non-evidence based treatments such as art therapy and TFT were used by a substantial minority of Wyoming psychotherapists. These techniques lack both theoretical plausibility and empirical evidence as anxiety disorder treatments, and their use among licensed mental health professionals is alarming. EMDR was used with comparable frequency as a treatment for PTSD (for which EMDR is considered an evidence-based treatment, albeit not without controversy; Herbert et al., 2000; Russell, 2008), and for the other anxiety disorders (for which EMDR is not an evidence-based intervention). Especially concerning is the observation that self-proclaimed anxiety specialists were significantly more likely than non-specialists to use TFT. Although the difference was not statistically significant, anxiety specialists also reported higher rates of EMDR use for each anxiety disorder than did non-specialists. These findings suggest that some therapists who advertise themselves to clients as anxiety specialists may do so because of their use of pseudoscientific treatments whose popularity and supposed effectiveness are influenced by exaggerated promotional claims and marketing tactics (e.g., Herbert et al., 2000). Unfortunately, our findings highlight the need for mental health consumers to be informed about evidence-based treatments for anxiety disorders so they may critically evaluate the claims of licensed mental health professionals in their community.

This study has a number of limitations. Assessing the utilization of psychotherapy techniques via retrospective recall introduces the possibility of error due to memory inaccuracy. We attempted to minimize this possibility by including only those therapists who had treated anxious clients within the past 12 months, and by tying their responses to the techniques used with clients seen during this time. Demand characteristics may have artificially inflated respondents' endorsement of techniques widely considered to be effective, such as those associated with CBT. The low utilization of therapist-assisted exposure is notable in the context of this limitation. For purposes of brevity the questionnaire items were concise, and as a result may have been open to interpretation by study respondents. For example, "imaginal exposure" may have been construed as (a) therapist-assisted exposure to a traumatic memory or distressing obsession, or (b) asking the client to imagine confronting a feared situation. It is likely that the relatively high utilization rates of imaginal exposure (> 60%) reflect a liberal interpretation of this technique. Our recruitment procedures did not allow us to contact Wyoming psychotherapists who did not advertise their practice in the telephone

directory, and therapists residing in towns with a population of less than 5,000 people were not included. The high percentage of therapists in private practice in our sample likely reflects the influence of our recruitment procedures as well as the distribution of therapists in a rural state with few large hospitals and specialty mental health clinics. Despite the relatively small sample size we estimate that the present study includes responses from more than 25% of all practicing mental health professionals in the state of Wyoming. Our approach of surveying all providers, rather than selecting only psychologists (e.g., Freiheit et al., 2004), likely provides a more accurate approximation of the mental health services accessible to most clients in community settings.

Overall, the present study paints a mixed picture regarding the dissemination of evidence-based treatments to community therapists. Encouragingly, most treatment providers described themselves as cognitive-behavioral and frequently emphasized CBT techniques in their practice. However, therapists rarely conducted exposures in session with their clients, and non-evidence based techniques with questionable compatibility with CBT were frequently utilized. Rather than providing CBT in place of unsubstantiated anxiety treatments, most treatment providers appear to have added non-specific CBT techniques to their intervention toolkits alongside traditional approaches such as psychodynamic therapy and non-directive supportive therapy. Pseudoscientific treatments were utilized with worrying frequency, particularly among clinicians who promote themselves as anxiety specialists. Treatment-seeking clients in Wyoming with OCD, PTSD, panic disorder, and social phobia will have little trouble finding therapists who claim to provide CBT, but will encounter considerable difficulty locating therapists who provide CBT in a manner that resembles that prescribed in evidence-based treatment manuals. Research is needed on the effectiveness of the less disorder-specific, primarily non-exposure-based form of CBT used by most practicing clinicians in community settings.

Ongoing efforts to disseminate evidence-based anxiety treatments to community practitioners should focus on promoting the use of theoretically-driven exposure-based CBT, while simultaneously discouraging the use of less effective CBT strategies and non-evidence-based techniques from other theoretical traditions. Fortunately, our results highlight considerable interest among Wyoming practitioners in receiving additional training in CBT, which may stem from a lack of access to CBT experts in rural communities. Our findings suggest that most community practitioners claim to provide "CBT" but do so in a manner that differs substantially from versions of CBT recognized as evidence-based among clinical scientists. As such, the term "CBT" may be sufficiently ambiguous as to render it largely devoid of meaning.

Rather than asking potential therapists whether or not they use CBT, informed treatment-seeking mental health consumers might be encouraged to ask, "What kind of CBT do you provide?"

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Author Biographies

Brett Deacon is an associate professor in the psychology department at the University of Wyoming. His research interests concern the nature of pathological anxiety as well as the development and dissemination of evidence-based treatments for anxiety.

Leilani Hipol graduated with a bachelor's degree from the University Wyoming in 2011. Her research interests involve the dissemination of evidence-based practices for anxiety disorders and other mental health problems.