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Feasibility and acceptability of a toolkit to facilitate clinician use of exposure therapy for youth

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Abstract

Exposure therapy is a key element of cognitive-behavioral therapy for youth with anxiety. However, few clinicians outside of specialty anxiety clinics routinely use exposures with anxious youth. This study reports on the acceptability and feasibility of a clinician support toolkit for exposures with anxious youth in community settings. The toolkit was developed through an extensive literature review of exposure science and cited barriers to exposure therapy, with input from multiple experts in pediatric anxiety ($n = 10$). Acceptability and feasibility data was gathered via survey from 70 community clinicians attending a training on exposure therapy for youth. Qualitative data was collected from a subset of participants who used the toolkit with youth on their caseload for approximately one month. Survey data suggested that the toolkit was viewed highly favorably. Qualitative interviews indicated that the toolkit was viewed as a feasible therapeutic tool that positively impacted clinician motivation to use exposure. Primary challenges related to exposure use more generally, and included client and service setting barriers. Results suggested initial toolkit acceptability and feasibility. Future work to refine the toolkit and test its efficacy as an implementation strategy to increase clinician use of exposure therapy is warranted. Next steps include development of additional content in partnership with key stakeholders, and testing the toolkit's impact on increasing clinician use of exposure therapy.

Keywords

anxiety; exposure therapy; cognitive-behavioral therapy; implementation science; youth

Cognitive-behavioral therapy (CBT) routinely demonstrates efficacy in reducing anxiety symptoms in youth and *exposure* is the key mechanism through which CBT improves outcomes (Higa-McMillan, Francis, Rith-Naharian, & Chorpita, 2016; Kendall et al., 2006; Peris et al., 2015). However, despite the strongest empirical and theoretical support across multiple interventions and intervention targets (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012), exposure remains strikingly underused across routine clinical practice settings (Becker, Zayfert, & Anderson, 2004; Becker-Haimes et al., 2017; Borntrager, Chorpita, Higa-McMillan, Daleiden, & Starace, 2013; Trask, Fawley-King, Garland, & Aarons, 2016;

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Whiteside, Sattler, et al., 2016; Wolitzky-Taylor, Zimmermann, Arch, De Guzman, & Lagomasino, 2015). Exposure suffers from a “public relations problem” (Richard & Gloster, 2007), which has potentially contributed to this strongly supported intervention lagging behind implementation of other evidence-based interventions for youth (Borntrager et al., 2013; Trask et al., 2016). This is particularly problematic, as anxiety disorders are the most prevalent youth mental health conditions (Merikangas et al., 2010) and are associated with significant impairment and long-term sequelae if untreated (Kendall et al., 2010; Rapee, Schneiring, & Hudson, 2009).

While interventions based in evidence-based practice (EBP) have broadly faced challenges to widespread use and successful implementation (Becker, Smith, & Jensen-Doss, 2013; Gray, Joy, Plath, & Webb, 2013), exposure therapy is particularly challenging to implement for clinicians relative to other EBPs (Gola, Beidas, Antinoro-Burke, Kratz, & Fingerhut, 2016). Less than 10–33% of clinicians endorse using exposure with anxious youth (Hipol & Deacon, 2013; Whiteside, Sattler, et al., 2016). Clinicians opt for other treatment components, such as relaxation, over exposure (Becker, Becker, & Ginsburg, 2012; Becker-Haimes et al. 2017; Edmunds et al., 2014), or use relaxation and related strategies in conjunction with exposure, which is contrary to the goal of enhancing fear tolerance (Freiheit, Vye, Swan, & Cady, 2004). There are multiple unique barriers to the use of exposure in routine care, many of which are clinician-level barriers. *Knowledge/Attitudinal* barriers include clinician beliefs that exposure is harmful, unethical, or intolerable, as it involves intentionally encouraging youth to experience anxiety and distress (Deacon et al., 2013; Meyer, Farrell, Kemp, Blakey, & Deacon, 2014; Ringle et al., 2015; Whiteside, Deacon, Benito, & Stewart, 2016). Clinician anxiety about implementing exposure tasks is also predictive of less exposure use (Meyer et al., 2014; Schumacher et al., 2015). *Practical* barriers include the time and resources needed to prepare and carry out exposures (Chu et al., 2015; Farrell, Deacon, Dixon, & Lickel, 2013). While practical barriers such as lack of time likely impact EBP use generally, exposures require additional preparatory time to select clinically relevant exposures and accessible resources (e.g., confederates, exposure stimuli) to implement. *System and organizational* barriers specific to exposure that have been identified include clinic constraints on the time that can be spent on exposures in session, and potential restrictions on leaving the clinic to conduct exposures (Chu et al., 2015; Hipol & Deacon, 2013; Ringle et al., 2015). Given the many barriers to implementation, exposure therapy may require a higher level of implementation support relative to other EBP.

It is critical to develop implementation strategies to target these barriers and specifically promote the use of exposure. Traditional strategies to disseminate and implement EBP, such as provision of treatment manuals or providing clinicians with brief workshop trainings, are unlikely to lead to significant clinician behavior change (Beidas & Kendall, 2010; Herschell, Kolko, Baumann, & Davis, 2010). As a result, a number of implementation strategies are being studied to enhance implementation and sustainment of EBP, such as observation, feedback, and ongoing consultation with expert clinicians (Herschell et al., 2010). Early work suggests that these processes generally lead to higher rates of EBP implementation over time (Beidas, Edmunds, Marcus, & Kendall, 2012; Hanson, Self-Brown, Rostad, & Jackson, 2016; Lang, Franks, Epstein, Stover, & Oliver, 2015). However, data on the long-term effects of these strategies to specifically support exposure use are less encouraging. In

the few studies examining clinician use of exposure several years after implementation of CBT for youth anxiety, exposure was the least frequently used treatment strategy, with only one third of clinicians reporting use of exposure with their anxious clients several years after implementation (Chu et al., 2015; Edmunds et al., 2014).

Findings suggest a limitation of current approaches to increase the implementation and sustainment of clinician use of exposures for the treatment of youth anxiety. To expand the reach of evidence-based treatment for anxious youth, more research is needed around how to increase clinician uptake, implementation, and sustainment of exposure therapy in routine practice settings. An important first step in such research is to identify effective, cost-effective, and adaptable implementation strategies to specifically support the long-term use of exposure in routine clinical care. While effectively implementing exposure therapy will likely require multiple implementation strategies beyond traditional implementation supports (e.g., workshops, manuals; Beidas and Kendall, 2010) across multiple system levels, clinician factors have been cited as a key driver of exposure adoption (Becker-Haimes et al., 2017; Harned, Dimeff, Woodcock, & Contreras, 2013). While manuals and textbooks exist detailing exposure therapy application, to our knowledge, there is no existing resource that serves as an applied tool whose design was informed by the barriers to implementation experienced by clinicians in community settings. Combined with the high level of clinician barriers to the use of exposure cited in the literature, development of a clinician support tool may be an ideal first step toward addressing the complex challenge of exposure implementation.

To begin to address this critical challenge, we introduce the “*Resource for Exposures for Anxiety Disordered Youth* (READY)”. READY is a flexible, applied toolkit to support clinician use of exposure therapy designed primarily to target the practical barriers associated with exposure, and, to some extent, knowledge and attitude gaps. Toolkit-based implementation approaches have shown some success in the medical field (Septimus et al., 2016). Additionally, a recent study examining the use of a mixed media toolkit (e.g., DVD training, paper handouts) to enhance therapist use of engagement strategies in community mental health settings suggests that a toolkit approach can have a positive impact on therapist behavior (Haine-Schlagel et al., 2016), further supporting a toolkit as an appropriate intervention. To our knowledge, no work to date has attempted to directly intervene to specifically increase therapist use of exposure.

In this paper, we present quantitative and exploratory qualitative data examining acceptability and feasibility of the toolkit to practicing clinicians across multiple mental health settings. In addition to providing generalizable information about the potential utility of a toolkit like READY to facilitate exposure implementation, obtaining feedback from practicing clinicians is an important step in the development of such clinician support tools to increase their likelihood of use (Lyon & Koerner, 2016). As such, data obtained will be used to refine the toolkit to enhance the potential for widespread acceptability. We hypothesized that the toolkit would be viewed as acceptable and feasible, and that an electronic format (e.g., mobile app) would be preferable to a tangible tool. We also sought to identify characteristics of clinicians who may be more or less likely to use such a toolkit with their caseload. If only clinicians with characteristics similar to those most likely to

adopt EBP into their practice rate READY positively (e.g., those with a CBT theoretical orientation or positive attitudes toward EBP) the potential widespread utility of READY is likely to be minimal. Such work would also enable us to optimally target the toolkit to clinicians in the future. We therefore examined clinician characteristics associated with lower EBP use in prior studies (working in private practice, a non-CBT orientation, and negative attitudes toward exposures; Becker et al., 2013; Beidas et al., 2015) as predictors of perceptions of toolkit acceptability.

Method

Development of Toolkit Content

The toolkit was designed to target the most prevalent anxiety disorders seen in youth (separation anxiety, generalized anxiety, social anxiety; Merikangas et al., 2010), and specific phobias (natural environment, animal, blood injection injury, and emetophobia). Initial content development was informed by the underlying theory of exposures (e.g., Abramowitz, 2013; Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014) and cited barriers to exposure (e.g., Chu et al., 2015; Edmunds et al., 2014; Farrell et al., 2013; Gola et al., 2016). Table 1 provides an overview of READY content and how content maps on to cited barriers to exposure use by community clinicians in the literature. READY is composed of three sections: a knowledge/attitudes section, an exposure generation and planning section, and a supplemental materials section. In section 1, READY contains an overview of exposure therapy, a step by step guide to exposure, information on common challenges with implementing exposure therapy, and answers to frequently asked questions (i.e., misperceptions) about exposures. Section two consists of the majority of READY content and is designed to facilitate clinical delivery of exposure with minimal preparation time. This section is divided into a series of modules corresponding to each of the disorders targeted through READY. Each diagnostic module in section two contains a “Tips & Tricks” sheet that provides diagnostic-specific information on key things to assess, recommendations on how to enhance youth buy-in to treatment, and special considerations for exposure therapy (e.g., how to consider a client’s social skill level when completing social anxiety exposures). Each module also contains detailed lists of potential exposure exercises that are presented as individual cards that can be applied directly in session (“challenge cards”). The final section of READY consists of supplemental materials, including, links to pictures and media files, sample homework sheets, a Brave Bingo board, a sample session reward chart, and a list of materials to have on hand in the clinic setting.

Ideas generated for challenge cards were drawn from an extensive literature review, including previously published treatment manuals for youth anxiety (e.g., Albano & DiBartolo, 2007; Kendall & Hedtke, 2006), published articles on the application of exposure for youth (e.g., Kendall et al., 2006; Peterman, Read, Wei, & Kendall, 2015), published case studies (e.g., Heyne, Sauter, Ollendick, Van Widenfelt, & Westenberg, 2014; Peterman, Hoff, Gosch, & Kendall, 2015), in conjunction with clinical expertise. Recognizing that some exposures conducted within anxiety specialty clinics (e.g., going to the zoo to see or hold a snake, having a phlebotomist attend a therapy session to address blood-injection-injury fears) may not be feasible within the confines of an under-resourced clinic setting,

READY distinguishes exposures that can be done without any additional materials or confederates from those that require additional materials. Challenge cards in each diagnostic area include exposures that can be conducted feasibly in session without the need for additional materials or confederates. Whenever possible, when additional materials for exposures are needed (e.g., tongue twister poems, pictures of needles, plastic spiders), these are clearly demarcated on the challenge card and listed as good resources to have on hand in the office in the supplemental materials section. Exposures more suited to older youth (e.g., involving texting or social media) are marked as such. In addition, each diagnostic cluster includes exposure examples that range from easy, low-level exposure exercises to those that would be considered highly anxiety provoking that may feel uncomfortable to therapists less experienced with conducting exposures (for example, breaking a rule for a generalized anxiety exposure). Although cards at this advanced level may initially feel uncomfortable to therapists less experienced with conducting exposures, we included these to demonstrate that it is allowed, and in fact beneficial for treatment, to eventually (when the client is ready) engage in higher-level exposures. Figure 1 shows an example set of challenge cards.

Beyond generating exposure ideas, challenge cards are designed to serve several additional functions. Cards can be used to facilitate hierarchy building by asking clients to arrange challenges in order from easiest to hardest. Given emerging research suggesting that it may not be necessary to engage in exposures in a linear fashion from the bottom of the hierarchy to the top (Craske et al., 2014; Peterman et al., 2015), challenge cards do not need to be used in a particular order. For example, clinicians can select a handful of appropriate level exposure exercises that could potentially be completed in a single session and have the patient select one at random to complete. The design of the challenge cards was also intended to lend itself to the creation of “games” for younger youth, with rewards that could be used to increase motivation. For example, a number of exposure cards can be rearranged in a square to play “Brave Bingo”, with a game board included in the supplemental materials section. Finally, a subset of challenge task cards were designed to encourage youth to engage in their own treatment by asking them to contribute to exposure generation (“Create Your Own Challenge Task” and “Create Your Ultimate Challenge Task”). This is intended to promote buy in from youth, as well as potentially assist them in beginning to identify ways youth can create and self-direct in exposures.

After initial content generation, READY content was reviewed by multiple expert clinicians in youth anxiety disorders that practiced within specialty anxiety clinics ($n = 10$) to gain feedback on accuracy of content and comprehensiveness of exposure ideas. As a result of this feedback, additional content (e.g., additional challenge cards, supplemental materials) was added, resulting in a total of 130 challenge cards across the diagnostic categories.

Participants

Participants were 70 practicing clinicians who attended a state-sponsored day-long workshop on exposure therapy. Participants were largely female (74.3%) and Caucasian (70%), and were an average of 37.3 years old ($SD = 10.2$, Range = 25 – 65) and predominantly worked in the public sector (80%). Six clinicians were recruited from the larger sample to provide qualitative data about READY after using it for one month. Over

the follow-up, one clinician changed positions and stopped providing direct clinical services and one clinician was lost to follow-up, resulting in a final qualitative sample of 4 therapists (M age = 37.8, SD = 14.4; 100% Caucasian).

Procedures

Procedures were reviewed and considered exempt by the University of Pennsylvania Institutional Review Board. All participants were recruited from a day-long workshop on exposure therapy (total attendees = 88; 79.5% response rate). At the end of the training, workshop attendees were given a 30-minute presentation on READY, which included an overview of the concept and contents of the toolkit and a demonstration of sample Tips & Tricks Sheets and Challenge Cards. Anyone attending the workshop was eligible to participate in the study and all clinicians attending the workshop were offered a free PDF copy of the toolkit by email. Participants only completing the quantitative survey concluded their participation when they left the workshop.

Participants recruited to complete qualitative interviews were asked to use READY for a month with at least 2 clients on their caseload and participate in an additional survey, a brief consultation call, and a brief qualitative interview. Participation was offered to any interested participant who had completed the quantitative survey. Over a dozen attendees expressed interest in participating. Due to funding and resource constraints, six therapists were randomly selected from this larger pool of interested participants by pulling names out of a hat. Participants signed written consent forms and were given a physical copy of READY containing color materials and pre-cut challenge cards. Within one week of consent, clinicians completed a brief survey and participated in a 10–15-minute consultation call focused on providing ideas for identifying clients with whom the clinician could use exposure and how to incorporate READY into their clinical practice. Four weeks later, clinicians completed a brief, 30-minute semi-structured interview about clinician experience with READY. Interview questions solicited feedback on facilitators and barriers to READY use, the format and content of the toolkit and general facilitators and/or barriers to exposure therapy. All interviews were conducted by phone by the first author, and were audio recorded and later transcribed.

Measures

Demographic Questionnaire.—Participants completed a brief questionnaire about their demographic (e.g., age, gender) and professional (e.g., years of experience, theoretical orientation) characteristics. Participants also reported on their experience with treating youth anxiety.

READY Feedback Form.—All participants completed a 12-item feedback form adapted from prior studies assessing usability of new mental health technologies (Bruns, Hyde, Sather, Hook, & Lyon, 2016). The measure briefly describes READY's structure and contents. Participants rated their opinion of how useful aspects of the toolkit would be for their clinical practice, using a 4 point Likert scale (*Not Useful at All* to *Very Useful*). Participants also reported on how likely they would be to use READY if it were in a variety of formats (e.g., PDF, mobile app), using a similar 4-point scale.

Therapist Belief about Exposures Scale (TBES; Deacon et al., 2013).—The TBES is a 23-item measure that assesses therapist perceptions about the use of exposure. Participants rate each item on a 5-point Likert scale (*Strongly Disagree* to *Strongly Agree*); higher scores indicate more negative attitudes. This measure has previously shown a stable factor structure, excellent internal consistency, predictive validity, and sensitivity to change among a large sample of practicing clinicians; the average score in the validation sample was 34.0 ($SD = 17.5$; Deacon et al., 2013). The TBES demonstrated acceptable internal consistency in this sample ($\alpha = .83$). Scores were somewhat lower (i.e., more positive to exposure) than the original sample ($M = 28.58$, $SD = 9.25$).

Analysis Plan

Descriptive statistics characterized clinician perceptions of READY acceptability across the full sample. To better understand clinician reactions to READY and determine its potential for wide acceptability among practicing clinicians, we also examined whether clinician characteristics (self-rated experience treating anxiety, practice setting [community agency, private practice], CBT theoretical orientation, and caseload size) and attitudes on the TBES were related with responses on the READY Feedback form using multiple regression. To analyze toolkit feasibility and results of the qualitative interviews, a deductive content analysis approach (Elo & Kyngas, 2007) was selected for coding given *a priori* questions about the feasibility of READY application. A codebook was developed with 6 *a priori* codes: toolkit use, changes requested to READY, facilitators of READY, barriers to READY, toolkit use over time, and motivation to use READY or exposure. The number of clients with which each clinician reported using READY was also noted. Two coders (the first and third authors) independently coded each transcript and met to reconcile any discrepant codes. Any discrepancies in codes were resolved through open discussion; coders came to consensus on 100% of codes.

Results

Table 2 shows participant demographics and clinical characteristics for the full sample and the subset of participants who completed qualitative interviews. Participants had varied experience levels with the treatment of youth anxiety disorders; 31.4% endorsed “a lot” of experience and 38.6% endorsed “some” experience. Average years of full-time clinical experience for participants was 7.29 ($SD = 7.34$; Range = 0–41). The highest degree obtained for most clinicians was a master’s degree (91.4%). Clinicians reported an average caseload of 28 clients ($SD = 22$, Range = 0–100).

Acceptability

Overall, clinicians reported positive opinions of READY (see Table 3). Eighty-one percent ($n = 57$) of clinicians endorsed that READY would be “very useful” for their clinical practice; an additional 15.7% ($n = 11$) reported it would be “fairly useful” and 1 clinician (1.4%) said it would be “a little useful.” Over three-quarters (75.7%, $n = 53$) of clinicians reported they would be “very likely” to use READY with anxious clients on their caseload; 20% ($n = 14$) indicated they would be “fairly likely” and 1 clinician (1.4%) reported being “a little likely” to use READY.

Participants provided comparable answers when reporting on specific components of the toolkit: didactic content about exposures (80% “very useful”, 14.3% “fairly useful”, 0% “a little useful”) challenge cards (80% “very useful”; 12.9% “fairly useful”; 1.4% “a little useful”) and supplemental materials (84.3% “very useful”, 11.4% “fairly useful”, 0% “a little useful”). No clinicians endorsed any aspects of READY as “not at all useful”. With respect to the challenge cards specifically, 65.7% of clinicians ($n = 46$) reported they would be “very likely” to use the challenge cards and 30% ($n = 21$) reported being “fairly likely” to use the challenge cards. Two clinicians (2.9%) reported they would be “a little likely” to use the challenge cards.

When asked about the likelihood clinicians would use the toolkit across multiple media formats, over three-quarters of the sample reported being “very likely” or “fairly likely” to use a physical toolkit (61.4% very likely; 27.1% fairly likely), a single, downloadable PDF (67.1% very likely; 22.9% fairly likely), a series of downloadable PDF modules (64.3% very likely; 30.0% fairly likely), or an interactive website (57.1% very likely; 27.1% fairly likely). In contrast, only 37.1% of clinicians reported being “very likely” to use a mobile app version of READY and 20% fairly likely). A mobile app was the only version in which any individuals endorsed that they would be “not at all” likely to use (12.9%); 27.1 % said they would be “a little likely” to use an app.

Predictors of Clinician Acceptability

Results indicated no variables were significantly associated with ratings of toolkit usefulness (content, challenge cards, or overall) or likelihood of using the materials with anxious clients on their caseload (all $ps > .05$).

Toolkit Feasibility and Qualitative Interview Results

Descriptive results regarding clinician use of the toolkit and changes to READY participants requested are presented first to illustrate initial toolkit feasibility. We then present clinician reactions to and experiences with using the toolkit gathered during the qualitative interviews at one-month follow-up.

Toolkit Use.—All four participants reported using the toolkit with at least two clients on their caseload ($M = 4$; Range = 2–6). Overall, primary uses of the toolkit reported by participants included using as a reference ($n = 4$), using challenge cards to facilitate identification of appropriate clinical exposures ($n = 4$), and using challenge cards to build fear hierarchies (i.e., lists of feared situations ranked from least feared to most feared that guide exposure practice; $n = 3$). As one clinician shared, *“I think primarily the toolkit functions as a way to get you thinking, in the way that you need to think to do exposure therapy effectively. And so I think the challenge cards are a really good place to start.”* Only 1 clinician reported using the supplemental materials (e.g., pictures, video links, etc.). Two clinicians reported they had not used supplemental materials because they were not clinically relevant (e.g., were primarily for specific phobia), whereas the third did not have access to the internet to use the video examples. All clinicians reported using the generalized anxiety and social anxiety modules. Half of clinicians also pulled from various specific phobia modules, and one clinician used the separation anxiety module.

Changes Requested.

With respect to improvements to READY, clinicians primarily suggested changes to the physical layout (e.g., adding dividers for each diagnostic category) and requested that additional content be included. Three clinicians stated it would have been helpful to have challenge cards either laminated or available for online download to prevent wear and tear of materials. In terms of content, clinicians requested example hierarchies and fear thermometers, example exposures for panic disorder (e.g., interoceptive exposures) and obsessive-compulsive disorder. One clinician also noted that it would be helpful for her to have more guidance on imaginal exposures to circumvent some of the challenges of conducting in vivo exposures in and around her clinic setting.

Facilitators of READY Use.

All clinicians reported that READY was easy to use and that they benefited from the tangible nature of the toolkit and the challenge cards. READY was described as simple and straightforward. Clinicians specifically noted that having a physical resource greatly facilitated their use of READY. As one clinician remarked, *"I feel like I am more likely to go through something that I can hold in my hands than I am to go through my computer and look up things....I liked that it was a tangible thing and not electronic."* Clinicians also reported that READY helped facilitate their delivery of exposure therapy. For example, one clinician noted that READY helped her think outside of the box in developing exposures for her clients: *"There's some of them I looked at and was like, oh my gosh, I never would have suggested that or thought to use that as an exposure."* Another clinician shared that having READY as a reference enabled her to more effectively respond to client resistance and respond more effectively to clinical challenges related to exposure as they arose and respond more spontaneously to client resistance in session.

Barriers.

In general, few barriers were reported to READY use; primary barriers reported related to the use of exposure more broadly. The primary barrier reported by nearly all therapists was that the community mental health setting made it challenging to deliver exposure therapy. As one clinician stated, *"In community mental health, having a huge caseload and ridiculous paperwork expectations makes it hard to take the time to plan ahead. It was a challenge to be like, I'm seeing this client later today and I need to find five minutes to [collect materials]."* In addition to preparation time, one clinician noted that clinic restraints made it challenging for her to specifically use social anxiety exposures, although she had effectively problem-solved this by identifying a local store in which she could conduct social anxiety practice. Half the clinicians also noted client-related issues as a barrier to exposure. One clinician noted that inconsistent client attendance made it challenging to deliver exposure therapy, whereas another remarked that the complexity of client comorbidities requires clinicians to think beyond what was included in READY: *"You're going to have people whose anxieties are complicated and you're going to have to think more creatively to make the process fit. That again may be a reflection of being community-based because the people I work with have a really complicated array of problems."*

Toolkit Use Over Time.

All clinicians reported that when they first began using READY they relied on challenge cards as presented in the binder to help develop plans to deliver exposure (e.g., to develop hierarchies and select exposures for the clients to practice). Over time, clinicians were more apt to alter the use of cards to fit client needs. Half of participants reported moving toward intentionally using challenge cards to help normalize anxiety for clients: *“[Clients] think it’s cool that it’s ‘oh, this is in a notebook? I’m not the only one?’ It kind of gives them that feeling that oh, somebody thought of this, there’s other kids that have this kind of problem.”* Another clinician remarked that she used the challenge cards to help instill a sense of mastery for the client: *“I’d ask them from the very beginning of the easiest cards what they thought of them, [and they would say] ‘oh yeah, I could do that, I do that all the time.’ [And I’d say] ‘You’ve already got that mastered...look at that, you’ve already got two down.’”* After initially using the challenge cards to generate ideas for exposures, clinicians also began to develop their own exposure ideas tailored to their clients’ clinical presentation and make their own challenge cards. One clinician also commented that she had begun to use READY in her supervision of clinical interns, noting it that it was a useful resource for training others in exposure therapy.

Motivation.

All participants remarked that having READY as a resource helped motivate them to deliver exposure to their clients and served as a reminder to deliver exposures. As one clinician noted, *“A lot of times you go to a training or a workshop and get the information, but you don’t immediately have an opportunity to use it. So...having the toolkit, especially getting it at the end of the training day, did motivate me to look for opportunities to use it.”* Three clinicians also remarked on how once they began to use exposure therapy and saw a positive benefit for their clients, this enhanced their motivation to continue delivering exposure therapy to future clients: *“People just love [the challenge cards]. And I would have clients leaving really proud of themselves. And so, I’m thrilled. I’ve shared them with my colleagues. And one of my colleagues did some exposure with a client and said, ‘that’s what I needed to push myself and go out and try it,’ and I feel the same way.”* No clinicians reported a negative experience or READY having an adverse impact on their desire to use exposure.

Discussion

Given the substantial evidence-base for exposure as a core ingredient of CBT for anxiety disorders and the low rates of exposure use in routine clinical care settings, there is a need for implementation strategies targeted specifically to clinician use of exposure. *The Resource for Exposures for Anxiety Disordered Youth* (READY) was designed as a toolkit-based resource to increase clinician use of exposure and has the potential to serve as one such implementation strategy to address clinician-level practical and knowledge/attitude barriers to exposure. Results of this preliminary test of acceptability and feasibility suggested that READY was viewed as a highly acceptable tool among a large sample of practicing clinicians after recent training in exposure therapy. No examined clinician characteristics predicted ratings of acceptability, further supporting its acceptability,

although it is possible that limited variability in TBES scores precluded our ability to detect significant correlates. Follow-up qualitative data support initial feasibility for READY and suggest that READY may be useful at increasing the rates with which clinicians use exposure therapy for anxious youth.

Qualitative interviews provided additional insights into how READY was incorporated into clinical practice. READY was generally regarded as a feasible tool that assisted clinicians in effectively preparing for exposure therapy sessions. READY was designed to address multiple barriers that have been reported to the use of exposure therapy, with a primary emphasis on reducing the practical challenges associated with exposure and addressing knowledge and attitude gaps (Table 1). In general, clinicians reported using READY to address knowledge gaps, enhance their motivation to deliver exposure therapy, and easily develop ideas for effective exposures to implement in session, providing preliminary evidence for READY's ability to effectively target knowledge/attitudinal and practical barriers cited to exposure. In addition, one clinician noted that READY was a helpful supplement to supervision; thus, READY may help facilitate implementation of the active ingredient of CBT for anxiety for new clinicians.

Barriers to exposure perhaps not fully addressed by READY included the challenges of working within community mental health (most notably, little preparation time, as well as lack of internet resources to use certain supplemental materials) and complexities of certain client presentations. While this study was not able to thoroughly assess the extent to which these barriers truly impeded clinician ability to deliver exposure therapy (as all clinicians reported regular use of exposures with two or more anxious clients), barriers are consistent with those reported in prior work (Chu et al., 2015). It will be important for future work examining READY to better characterize these barriers to determine enhancements needed to the toolkit. In addition, these barriers highlight the potential need for adjunctive implementation strategies specific to exposure alongside READY to target these barriers that may best be facilitated at an organizational or systems level, which READY does not adequately address. For example, when seeking to implement exposure therapy, it may be important to intervene with administrators or policy-makers to develop the organizational capacity to facilitate sustainment of exposure therapy. Within an organization, efforts may need to be made to encourage administrators to relax clinic constraints that prohibit clinicians from doing exposures outside of the confines of the clinic. In addition, it may be necessary to intervene at an organizational level to foster a culture that recognizes exposure as a "team sport", emphasizing willingness of employees to serve as confederates in exposures, bring in their pets for specific phobia exposures, and allow time in group supervision to brainstorm creative ideas for exposures for complex clinical challenges. In addition, advocates for exposure therapy may benefit from working with policy makers to lobby for policy changes to incentivize use of exposure for anxiety (e.g., enhanced billing for sessions that include exposure therapy).

A primary aim of this study was to inform future refinement of the toolkit in preparation for formal testing of the toolkit's efficacy as an implementation strategy for exposure therapy. Results from both the quantitative survey and qualitative interviews provided important insights into next steps of READY development. In particular, feedback from participants in

this sample indicated a high preference for tangible supports, and general openness toward online resources. Perhaps most surprising was the relatively lower enthusiasm for a mobile app version for READY content, with the mobile app being the only option that any participants endorsed being not at all likely to use. Mobile apps and other online training resources are intuitively appealing to enhance widespread dissemination (Becker & Jensen-Doss, 2014; Kendall, Carper, Khanna, & Harris, 2015). While we did not formally hypothesize that a mobile app would be perceived as more acceptable to clinicians, we had a sense that an app would be intuitively appealing as a portable, accessible clinician tool. While this study did not formally contrast acceptability and feasibility of a web-based or mobile application format, this highlights the potential limitation of electronic resources for enhancing widespread uptake of exposure therapy. While technological tools intuitively speak to enhancing dissemination and implementation strategies, there may be limitations of such approaches for application in outpatient mental health contexts and underscores the utility and importance of up-front user testing with end-users (i.e., practicing clinicians) to determine optimal format of implementation supports (Lyon & Koerner, 2016).

Findings should be interpreted in the context of study limitations. While a study strength was a sample composed primarily of clinicians in community settings attending a state-sponsored workshop, it is possible they may represent a more motivated group of clinicians relative to that of the general pool of clinicians. We also did not collect data on acceptability and feasibility from the perspective of other relevant stakeholders, such as clients or agency administrators. While READY is designed primarily for use by individual clinicians, theoretical models of implementation highlight the importance of considering the multilevel nature of systems in which clinicians work to best understand implementation processes (e.g., Damschroder et al., 2009; Raghavan, Bright, & Shadoin, 2008). Future work would benefit from examining client and organizational factors that may impact the utility of READY. Additionally, interviews with clinicians about READY use were gathered from clinicians at a one-month follow-up; it is possible that READY use may drop off over time. Given the exploratory nature of the feasibility aim, our sample of clinicians completing qualitative interviews was relatively small. In addition, our use of brief consultation to keep participants engaged may limit generalizability; future work with READY will need to parse apart the need for consultation, as well as examine the necessity of a 1-day training versus other strategies (e.g., brief online workshops, multi-day trainings). Finally, it is possible that the subset of clinicians who completed qualitative interviews represented more motivated and engaged participants as compared to the larger sample. Given the sample size, we did not conduct statistical comparisons between qualitative participants and the larger sample; however, attitudes on the TBES were marginally more positive than those from the larger sample, suggesting that future qualitative work building on these findings would benefit from purposeful sampling to capture participants who reflect a wide range of attitudes toward exposure.

READY demonstrated initial promise as a potential useful implementation strategy to facilitate clinician implementation of exposure therapy. An important next step in this research is to formally test READY as an implementation strategy for exposure therapy implementation alone or in conjunction with additional implementation strategies, such as intervening to enhance organizational commitment to exposure (e.g., relaxing clinic

restraints on being able to leave the clinic to complete exposures, fostering a culture of exposure as a “team sport”). This could be done by comparing provision of READY to more traditional models of implementation (e.g., manual provision, workshops, consultation calls) on clinician use of exposure therapy. It will also be critical to conduct longer-term follow-up of clinicians’ use of READY to examine READY’s impact on clinician sustainment of exposure therapy. In addition, READY is an ideal candidate for testing various marketing approaches to determine how best to disseminate a toolkit like READY.

READY is currently undergoing additional content development and refinement in response to the feedback received by clinicians in this study. Specifically, we are now collaboratively (i.e., with community clinicians) developing content targeting obsessive-compulsive and panic disorders in response to queries from our partners. This will allow us to ensure that the final product is designed with our target end-users (community mental health practitioners) in mind. Long-term goals of this research are to determine if use of READY results in more effective uptake and sustainment of exposure therapy. Should this future work confirm that READY has a positive impact on clinician exposure use, the next step will be to facilitate the widespread uptake of the toolkit and study how to effectively scale-up READY in partnership with key stakeholders (e.g., identifying effective marketing strategies for widespread dissemination, development of a website to house materials). While we anticipate that READY will continue to evolve as it is further evaluated, it is available upon request from the first-author; we welcome the input of community clinicians on how we can continue to improve READY. We view READY as a dynamic toolkit with the capacity to advance with new scientific evidence that may emerge of relevance to clinicians.

READY represents one of the first steps in developing implementation strategies specifically aimed at increasing the uptake of exposure. READY was designed to explicitly map on to exposure barriers previously cited in the literature, and was developed in collaboration with multiple experts in pediatric anxiety. Most notably, READY was subjected to early end-user testing among a provider demographic that represents a key target of implementation efforts in mental health (i.e., masters’ level providers in community mental health settings; Robiner, 2006; Schoenwald et al., 2008) to prepare it for effective dissemination, which resulted in several recommendations for improvement. While READY represents an important step in a complex research agenda aimed at increasing clinician implementation and sustainment of exposure, there is still work needed to design comprehensive implementation strategies to ensure that anxious youth receive evidence-based care.

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Figure 1. Sample challenge cards for social anxiety disorder

Table 1.
Content of The Resource for Exposures for Anxiety Disordered Youth

Content	Intended function and purpose of content	Barrier addressed
<i>Introduction to Exposures</i>	Knowledge resource	<i>Knowledge/Attitudes</i>
<i>Exposure Guide</i>	Knowledge resource	<i>Knowledge/Attitudes</i>
<i>Frequently Asked Questions</i>	Dispel myths about exposure, normalize clinician anxiety	<i>Knowledge/Attitudes</i>
<i>“Tips & Tricks” sheets</i>	Offer diagnosis-specific exposure strategies	<i>Practical</i>
<i>Challenge cards</i>	Provide a range of exposure ideas, address lack of expert supervisor	<i>Practical, System/organizational gaps</i>
<i>Make your own challenge cards</i>	Promote collaborative approach, address lack of expert supervisor	<i>Practical</i>
<i>Supplemental materials</i>	Provide resources to reduce preparation time for exposures	<i>Practical</i>

Table 2.
Participant characteristics

	Full Sample (<i>n</i> = 70)	Qualitative Subset (<i>n</i> = 4)
Age, <i>M</i> (<i>SD</i>)	37.25 (10.18)	37.75 (14.41)
Female, <i>n</i> (%)	52 (74.3%)	4 (100%)
Race/Ethnicity ^a		
Caucasian, <i>n</i> (%)	49 (70.0%)	4 (100%)
Hispanic/Latino, <i>n</i> (%)	8 (11.4%)	0 (0%)
Asian/Pacific Islander, <i>n</i> (%)	6 (8.6%)	0 (0%)
African American, <i>n</i> (%)	5 (7.1%)	0 (0%)
Highest Degree Obtained		
Bachelor's, <i>n</i> (%)	2 (2.9%)	0 (0%)
Master's, <i>n</i> (%)	64 (91.4%)	4 (100%)
Doctoral, <i>n</i> (%)	2 (2.9%)	0 (0%)
Theoretical Orientation ^a		
CBT, <i>n</i> (%)	45 (64.3%)	3 (75%)
Psychodynamic, <i>n</i> (%)	3 (4.3%)	0 (0%)
Client Centered, <i>n</i> (%)	7 (10.0%)	0 (0%)
Family Systems, <i>n</i> (%)	7 (10.0%)	2 (50%)
Other, <i>n</i> (%)	20 (28.6%)	1 (25%)
Work Environment ^a		
Community Agency, <i>n</i> (%)	56 (80.0%)	3 (75%)
School or University, <i>n</i> (%)	7 (10.0%)	0 (0%)
Private Practice, <i>n</i> (%)	6 (8.6%)	1 (25%)
Other, <i>n</i> (%)	5 (7.1%)	0 (0%)
Therapist Belief about Exposure Scale, <i>M</i> (<i>SD</i>)	1.25 (.40)	1.07 (.26)

^aNote. Participants could endorse multiple categories; thus, totals may not sum to 100.

Table 3.
Average responses on the READY Feedback Form

	(<i>N</i> = 70) <i>M</i> (<i>SD</i> ; Range)	<i>n</i> , % reported “Very Useful/Likely”	<i>n</i> , % reported “Fairly Useful/Likely	<i>n</i> , % reported “A Little Useful/Likely”
Overall usefulness of toolkit	2.81 (.43; 1-3)	57, 81%	11, 15.7%	1, 1.4%
Likely to use toolkit with anxious clients	2.76 (.46; 1-3)	53, 75.7%	14, 20%	1, 1.4%
Usefulness of toolkit content	2.85 (.36; 2-3)	56, 80%	10, 14.3%	0% (0)
Usefulness of challenge cards	2.83 (.41; 1-3)	56, 80%	9, 12.9%	1, 1.4%
Usefulness off supplemental materials	2.88 (.33; 2-3)	59, 84.3%	8, 11.4%	0% (0)
Likely to use challenge cards	2.64 (.54; 1-3)	46, 65.7%	21, 30%	0% (0)

Note. Items are scored from 0 (not at all useful/very unlikely) to 3 (very useful/very likely). No clinician endorsed any aspect of READY as not at all useful or not at all likely to use.