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Identifying the organizational innovation-specific capacity needed for exposure therapy

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Abstract

Background: Current approaches to increasing the rates of clinician use of exposure therapy for anxiety disorders in community settings are limited. Research underscores the importance of addressing contextual variables to facilitate clinician use of evidence-based practices; however, no studies have identified the innovation-specific organizational capacity necessary to implement exposure therapy. Such work is critical to ensure that treatment-seeking individuals with anxiety receive effective care.

Methods: We used a two-step process to identify the innovation-specific organizational capacity necessary to deliver exposure. First, 24 leaders of specialty anxiety clinics in the United States (50% female, mean [*M*]age = 47.7 years) completed a survey about the organizational innovation-specific capacity (e.g., policies and procedures) they employ to support their providers in

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CONFLICT OF INTERESTS

Dr. Beidas receives consulting fees from the Camden Coalition of Health Providers and royalties from the Oxford University Press and other authors have no conflict of interests to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

All procedures performed were in accordance with the ethical standards of the 1964 Helsinki declaration and its later amendments. Written informed consent was obtained for all study participants.

delivering exposure therapy. Second, 19 community clinicians (79% female, M age = 42.9 years) reported on the extent to which these characteristics were present in their settings.

Results: In Step 1, specialty clinic leaders unanimously endorsed six organizational characteristics as essential and five as important within the areas of organizational policies, supervisory support, and peer clinician support. These characteristics were present in more than 90% of specialty clinics. In Step 2, therapists in community clinics reported these characteristics were minimally present in their organizations.

Conclusions: Specialty clinic leaders exhibited consensus on the innovation-specific organizational capacity necessary to implement exposure therapy. Identified characteristics were largely absent from community clinics. Developing fiscal, policy, or organizational strategies that enhance the organizational capacity within community settings may improve the patients' access to effective treatment for anxiety disorders.

Keywords

anxiety; evidence-based practice; exposure therapy; implementation science

Exposure therapy (“exposure”) is the key ingredient in cognitive-behavioral therapy (CBT) leading to improved outcomes for anxiety and related disorders (Abramowitz, 2013; Higa-McMillan, Francis, Rith-Najarian, & Chorpita, 2016). Less than 30% of clinicians in routine clinical settings regularly use exposure with their anxious clients (e.g., Becker, Zayfert, & Anderson, 2004; Becker-Haimes, Okamura et al., 2017; Cook, Biyanova, Elhai, Schnurr, & Coyne, 2010). Prior efforts to increase CBT use for anxiety have demonstrated success in increasing the use of strategies such as cognitive restructuring and relaxation (e.g., Becker, Becker, & Ginsburg, 2012; Hoyer et al., 2017) but little progress has been made in increasing clinician exposure use (Chu et al., 2015; Thomassin, Marchette, & Weisz, 2019). Exposure represents a unique challenge for implementation given its complexity (Garcia, 2017) and the tendency to evoke strong emotional reactions among clinicians (Pittig, Kotter, & Hoyer, 2018). Implementation strategies to increase exposure use are needed.

Insights from implementation science (i.e., the systematic study of how to integrate evidence-based practices [EBPs] into routine clinical settings; Eccles & Mittman, 2006) indicate that successful EBP implementation and sustainment requires addressing key contextual variables, such as organizational policies, culture, and climate (e.g., Damschroder et al., 2009). Much is known about the challenges that individual clinicians face when delivering exposure (e.g., negative attitudes, clinician anxiety, and practical barriers; e.g., Deacon et al., 2013; Farrell, Deacon, Dixon, & Lickel, 2013). Tools and training procedures to address clinician barriers exist (Becker-Haimes, Franklin, Bodie, & Beidas, 2017; Reid et al., 2017). However, little work has identified contextual variables critical for facilitating clinician exposure delivery (Becker-Haimes, Franklin et al., 2017). Work in this area primarily consists of empirical work linking broad facets of organizational culture and climate with trauma-based treatments that include exposure elements (Cook et al., 2015; Sayer et al., 2017) and qualitative work examining constraints of community organizations (Chu et al., 2015; Ringle et al., 2015).

Prior work has demonstrated that general organizational variables important for EBP implementation (e.g., proficient culture, implementation climate, and transformational leadership) are related to improved overall adherence to EBPs in community settings (e.g., Beidas et al., 2014; Cook et al., 2015; Farahnak, Ehrhart, Torres, & Aarons, 2019; Sayer et al., 2017; Williams, Glisson, Hemmelgarn, & Green, 2017). However, they are unrelated to clinician use of in vivo exposures (Becker-Haimes, Okamura et al., 2017). Implementation scientists have argued that in addition to supportive leadership capacity for EBP, it is critical for organizations to develop *innovation-specific* capacity for a given intervention (i.e., the human, technical, and fiscal conditions required for successful implementation of an intervention); this is thought to precede more traditionally studied organizational variables in mental health implementation such as implementation climate (Flaspohler et al., 2008; Scaccia et al., 2015; Wandersman et al., 2008). We hypothesize that there may be organizational characteristics *specific* to exposure (i.e., exposure-specific capacity) necessary to support clinician implementation that is distinct (e.g., policies allowing clients to be seen outside clinic rooms, team-oriented environments that facilitate confederate recruitment). Based on our work in community settings, we further hypothesized that such characteristics may be limited or absent in routine settings. Indeed, work with treatments including exposure has delineated that facets of clinic policy and the practice environment may be related to exposure use (Sayer et al., 2017). However, the concrete nature of this exposure-specific capacity is not known. Such work could facilitate the generation of implementation strategies aimed at enhancing organizational capacity to support exposure use and represents a critical next step for increasing rates of exposure use in routine clinical settings.

Guided by principles of the Interactive Systems Framework (Wandersman et al., 2008), we aimed to characterize the organizational exposure-specific capacity needed to implement exposure. We first surveyed leaders of specialty anxiety clinics about the organizational characteristics they employ to support their clinicians to use exposure and their perceptions about what is most important for supporting clinicians. Traditional implementation research often involves a mixed-methods inquiry into local contextual variables (e.g., organizational policies, culture, and climate of the settings in which implementation will occur) that may facilitate or impede successful EBP implementation in that setting to design implementation strategies (Powell et al., 2017). However, this approach is limited because it requires that respondents have familiarity with the intervention's complexity to accurately report on facilitators and barriers to its delivery. This may be particularly salient for exposure, given its low use outside of specialty clinics. Leaders in the field may have organically developed effective organizational strategies to train and support their clinicians to deliver exposure from which implementation efforts can learn.

Second, we gathered exploratory data from community clinicians on the presence of these organizational characteristics in nonspecialty settings (e.g., community mental health) seeking to implement exposure and examined whether these are related to clinician exposure use. While not all strategies used in specialty settings will automatically generalize to community contexts, identification of a set of homogenous "gold-standard" strategies used by experts that are variably present in community settings will provide a critical starting point upon which community implementation efforts can build. To our knowledge, no study

has attempted to gain insights into the tangible organizational processes used in specialty settings to inform the design of implementation strategies for complex psychosocial practices, like exposure, in community settings.

1 | MATERIALS AND METHODS

1.1 | Measure development

Given limited research in this area, no existing measure indexed organizational characteristics for supporting exposure. Developed for this study, the *Organizational Innovation-Specific Capacity for Exposure* (OISCE) survey assessed clinic leaders' perceptions of organizational policies and procedures ("characteristics") for supporting the use of exposure in their clinic. Items were guided by the Interactive Systems Framework (Wandersman et al., 2008) and were designed to represent possible human (e.g., supervisor and colleague factors), technical (e.g., organizational policies), and fiscal (e.g., organizational resources) conditions that may be uniquely necessary to support exposure. Item generation occurred iteratively. First, we reviewed existing studies examining barriers to exposure therapy (Chu et al., 2015; Ringle et al., 2015), which primarily have noted time and organizational policies prohibiting leaving the organization as organizational exposure barriers. We generated an additional 12 items based on our collective experiences delivering exposure therapy in five distinct specialty anxiety clinics and community mental health settings, and training and providing consultation to community clinicians on delivery of exposure therapy. This early draft was administered to a convenience sample of 28 community clinicians attending a local training on exposure therapy to examine face validity. Items on this early measure showed appropriate variability (full range) and feasibility, with no major issues with clinicians completing the measure. Independent experts in exposure and organizational psychology then reviewed the measure and items were modified per their recommendations (e.g., ensuring wording was consistent with the measurement of an organizational construct, breaking up items to maximize specificity). Based on this feedback, we added an item to assess overall organizational expectations for clinicians to use exposure, consistent with the construct of implementation climate (Ehrhart, Aarons, & Farahnak, 2014; Klein & Sorra, 1996), which has been previously linked with EBP broadly (e.g., Bonham, Sommerfeld, Willging, & Aarons, 2014). The final measure consisted of 17 items across five domains of interest: (a) supervisory support for exposure, (b) collaborations with others in the organization to deliver exposure, (c) organizational policies to facilitate exposure delivery, (d) organizational resources, and (e) organizational emphasis on exposure (Table 1).

1.2 | Participants and setting

1.2.1 | Primary aim: Specialty clinics—Participants were clinical leaders (i.e., clinical or executive directors) of 24 clinics that self-identified as specialty anxiety clinics (55% response rate). Half were female, with a mean (M) age of 47.7 years (standard deviation [SD] = 11.2, range = 32–69). Most leaders were clinical psychologists (75%); 75% reported CBT as their theoretical orientations (8.3% other). Clinics had diverse staffing models, with a mix of licensed psychologists (79%), unlicensed psychologists (50%), psychiatrists (25%), masters-level clinicians (63%), graduate students (54%), and "other"

(e.g., case managers; 8%). Seventy-five percent of respondents reported that the mission of their clinic included training future clinicians; 38% were affiliated with academic institutions. Most clinics (75%) reported that most of their clients paid for sessions out of pocket, 45% reported at least a portion of their clients paid with private insurance; three clinics reported any percentage of their clients paid via public insurance. There were no differences between contacted clinics that did and did not respond to the survey with respect to affiliations with academic centers, staff size, or whether they accepted insurance (all p s > .05).

1.2.2 | Exploratory aim: Community settings—Participants were 19 community clinicians in the Philadelphia region who had recently attended a workshop on exposure therapy (M age = 42.9, SD = 13.7; 79% female; 74% White, 11% Black, 5% Asian, 11% other; 5% Hispanic/Latinx). Clinicians were predominantly master's level providers (74%); 26% held doctorates in clinical psychology. Reported theoretical orientations varied: cognitive-behavioral (42%), eclectic (26%), humanistic/client-centered (11%), psychodynamic (5%), and family systems (11%); 5% did not disclose. Clinicians worked across 19 distinct clinical settings.

1.3 | Procedures

All procedures were reviewed by the University of Pennsylvania (specialty clinics) and Temple University (community clinics) Institutional Review Boards. All participants completed informed consent before participation.

1.3.1 | Specialty clinics—Purposive sampling identified specialty anxiety clinics within 25 miles of the top five most populous US cities according to the 2015 census (New York, Los Angeles, Chicago, Houston, and Philadelphia). Clinician names and their affiliated clinics were identified via the “therapist-finder” feature on the Anxiety and Depression Association of America website and subsequent internet searches. Research assistants searched for details of all affiliated clinics to determine study eligibility. Clinics were considered eligible if they: (a) self-identified as an anxiety specialty center or specialized in CBT for anxiety or related disorders, and (b) had at least three clinicians that provided services, consistent with the broader organizational literature. The final list comprised 44 clinics representing a mix of university or academic medical center-affiliated clinics and free-standing specialty clinics. This list was reviewed by three experts to ensure there were no major omissions. We applied principles of Tailored Design (Dillman, Smyth, & Christian, 2009) to design and obtain survey data from clinic leaders (clinical or executive directors) of identified clinics using the REDCap online survey platform (Harris et al., 2009). Clinic leaders were personally contacted by the first author and invited to participate by email. All leaders had the option to enter a lottery for a gift card. Leaders received up to three reminder emails to complete the survey.

1.3.2 | Community settings—Community clinician participants were drawn from a larger study examining the effect of different types of training in exposure therapy on exposure implementation. All participants completed a full-day workshop in exposure therapy, followed by 12 weeks of consultation. Following consultation (3 months after

workshop training), participants were administered questionnaires, including the OISCE. This sampling approach ensured that respondents adequately understood the construct of exposure therapy and allowed us to examine possible links between organizational characteristics within the context of “gold-standard” implementation strategies of training plus consultation.

1.4 | Measures

1.4.1 | Specialty clinic leader survey—Using a 5-point Likert scale, specialty clinic leaders were asked to rate how *important* each OISCE item was for supporting successful exposure delivery (*Not at all* = 0 to *Extremely* = 4) and how *true* each attribute was for their clinic (*Not at all* = 0 to *Extremely* = 4). Leaders were also asked to share additional organizational characteristics they perceived to be important to supporting clinician exposure use, and information about their supervisory practices related to exposure. Internal consistency for OISCE items was good ($\alpha = .87$). The leader survey also included a demographic questionnaire (e.g., theoretical orientation and education), and questions about organizational characteristics of their clinics (e.g., staffing and finance model) that were adapted from prior surveys (Schoenwald et al., 2008).

1.4.2 | Community clinician survey—Community clinicians were administered a version of the OISCE that asked how *true* each item was for their place of work. Internal consistency in this sample was excellent ($\alpha = .94$). Clinicians were also asked about supervision practices in their settings related to exposure and completed a demographic questionnaire. Finally, community clinicians self-reported on the number of in-session exposures they conducted “in a given week.”

2 | RESULTS

2.1 | Specialty clinic leadership

Table 1 shows specialty clinic leader ratings of the importance of the 17 OISCE items. Table 2 shows inter-item correlations. Except for one characteristic, average ratings for all items were greater than three on a 4-point scale, indicating that almost all items were rated “very important,” on average, for supporting clinicians to deliver exposure. Eleven out of the seventeen characteristics were identified as important by most of the leaders. Six were endorsed as universally important (rated “very” or “extremely” important by all leaders): (a) supervisors are knowledgeable about exposure, (b) supervisors help clinicians tailor exposure, (c) clinicians feel comfortable reaching out to others in the organization for help, (d) clinicians are allowed to leave the therapy room with clients during their session, (e) clinicians can hold therapy sessions outside of the therapy office (e.g., at client’s home), and (f) clinicians are able to schedule longer therapy sessions if needed. Five other characteristics were rated as “very” or “extremely” important for supporting clinicians by over 80% of leaders: (a) clinicians are willing to discuss exposure ideas with one another, (b) clinicians regularly reach out to others to ask them to help participate in exposure, (c) clinicians can leave organization premises with clients during their sessions to engage in exposure, (d) the organization facilitates access to needed stimuli for exposure, and (e) clinicians are expected to attempt to deliver exposure therapy to all clients with anxiety

disorders. Variability in inter-item correlations suggests OISCE items likely represent distinct constructs.

Only two leaders reported additional organizational characteristics beyond the 17 OISCE items were important for supporting clinicians to deliver exposure. One noted the importance of organizational policies related to informed consent about exposure. The other related to clinic financing: The presence of a large staff and trainee therapists offering lower-fee services helped offset barriers related to constraints placed by revenue targets, insurance companies (e.g., insurance not covering extended therapy sessions), and clients' financial status.

In terms of the *presence* of these characteristics in the surveyed clinics (how *true* each characteristic was; Table 3), all OISCE items but one (organization provides resources for clinicians to reward clients for exposure) were rated "very true," on average, by leaders. Of the 11 items identified as important for supporting clinicians to deliver exposure therapy by most leaders, all but one (clinicians regularly reach out to others in the organization to ask them to help participate in exposure) were rated universally present by over 80% of the sample of specialty clinics. Mean OISCE scores were higher for clinics that primarily served clients who paid out of pocket ($M = 3.83$) compared to those that accepted insurance ($M = 3.48$; $t = 2.99$, $p = .008$).

Finally, leaders reported on the supervision time that was dedicated to supporting exposure use. Nearly all ($n = 20$, 83%) reported they provided clinical supervision ($M = 4.2$ hr/week, $SD = 2.09$). Half of these supervisors reported that 26–50% of their supervision time was spent discussing or troubleshooting exposure specifically; eight reported more than half of their time was spent troubleshooting exposure. Only two reported less than a quarter of supervision was spent troubleshooting.

2.2 | Community clinicians

Table 3 shows mean OISCE scores for community clinicians alongside those reported by the specialty clinics. Community clinician ratings were lower than those reported by specialty clinics on all items ($p < .001$). With respect to supervisory practices related to exposure, 11 (58%) clinicians reported receiving regular supervision; only six reported that any supervision time was spent discussing exposure.

Finally, as an exploratory test of the hypothesis that OISCE scores would relate to therapist use of exposures, regression analysis examined the relationship between mean OISCE scores in the community sample with self-reported exposure use (number of exposures weekly; $M = 2.2$, range = 0–5). OISCE scores were positively associated with self-reported exposure use ($\beta = .34$) and explained 11.6% of the variance in exposure use, although the model only trended toward significance ($p = .17$), likely due to small sample size.

3 | DISCUSSION

Exposure is one of the most effective, yet least used, psychotherapy techniques. Innovative implementation strategies to close this study-to-practice gap are needed. This is the first

study to characterize the organizational innovation-specific capacity from the perspective of leaders of specialty anxiety clinics that may be required to successfully implement and sustain exposure. This is also the first to directly query leaders in the field about organizational strategies used to support clinicians to inform community implementation efforts. Leader ratings of the importance of organizational characteristics for supporting exposure indicated up to 11 possible organizational targets for implementation strategies. Our comparison community sample suggested major differences in organizational characteristics between specialty settings and community clinics. Our community sample suggested a possible link between these organizational characteristics and higher rates of exposure use, although more robust study of this hypothesis in a larger sample is needed.

As many of these organizational characteristics may be mutable targets, findings have implications for designing organizational implementation strategies to be tested in future studies. First, consistent with prior studies looking more broadly at implementation climate (e.g., Cook et al., 2015), leadership may benefit from fostering expectations and support related to use of exposure therapy. Organizational efforts could communicate to therapists that exposure is expected to be the first-line intervention for clients with an anxiety or related disorder (i.e., the default) relative to other treatment strategies (e.g., relaxation). One possible implementation strategy to address this would be to embed a drop-down item into the electronic health record for all clients with anxiety requiring clinicians to denote whether an exposure was conducted in-session or not. When clinicians opt not to conduct an exposure in each session with a client, they must document in their progress notes *why* they elected to not use exposure (i.e., an accountable justification decision support; Meeker et al., 2016).

Second, results point to the likely importance of involving and training clinical supervisors to adequately support providers to deliver exposure therapy. In addition, fostering an environment in which clinicians view exposure therapy as a “team-sport” where clinicians are comfortable with and regularly reach out to one another to problem-solve issues with exposure therapy may also be important. This is consistent with prior implementation work highlighting the importance of involving supervisors to support effective implementation (e.g., Dorsey et al., 2013). Of note, prior work demonstrates that less than half of a regular supervision hour in community settings typically focuses on clinical content (e.g., Dorsey et al., 2018). Data from our leader sample suggest that most supervisors in specialty settings spend a large percentage of their supervision meetings focused on exposure therapy *specifically*. Given high caseloads, administrative issues, and crisis management concerns that must also be addressed in community supervision (Accurso, Taylor, & Garland, 2011), it may not be feasible to expect community supervisors to dedicate a large portion of their weekly supervision hour to supporting clinicians to deliver exposure therapy. One possible specific implementation strategy to address this barrier for nonspecialty settings is to schedule a separate weekly or bi-weekly *group* supervision meeting that is exclusively focused on helping clinicians problem-solve and/or generate exposure ideas. This could also have a secondary benefit of facilitating a “team-sport” exposure environment and encouraging clinicians to reach out to one another to discuss challenges they experience related to exposure, while minimizing time away from billable activities.

Third, findings underscore the possible utility of organizations creating policies that allow clinicians to leave the organization premises to conduct exposures. While nearly all specialty clinics endorsed that an ability to leave the organization was important for supporting exposure, community clinicians routinely report this as a barrier (e.g., Chu et al., 2015; Ringle et al., 2015). One possible implementation strategy to address this issue, which was offered by one of the participating clinical leaders, would be to encourage organizations to consult with legal entities to add content to or adapt treatment consent forms to state that clients partaking in exposure understand that they may leave the setting of the organization with their clinician as a part of their treatment plan. If leaving the premises is not feasible even with such a solution (e.g., the organization legal team remains concerned about litigation, the surrounding clinic neighborhood is a high-crime area), it is crucial that clients should, at a minimum, be able to leave the therapy room during sessions to complete exposure. Furthermore, implementation efforts may need to focus on teaching clinicians strategies for bringing exposure stimuli into the therapy room (e.g., maximizing imaginal exposures, identifying video resources) to support clinicians to effectively deliver exposure within the constraints of their setting.

In addition to future research testing the efficacy of such organizational implementation strategies to strengthen exposure rates in community settings, it will also be critical to gather data on the acceptability, feasibility, and costs associated with these implementation strategies to determine which are the most useful and fiscally feasible targets for deployment to community settings. Substantially lower organizational supports were reported in our community sample, which generally serves more low-income populations or those on public insurance relative to specialty settings. Even among specialty clinics, results suggested higher organizational supports in specialty clinics that were primarily private pay compared to those that accepted insurance. Our study was unable to parse apart the extent to which differences between specialty and community clinics are primarily driven by financial considerations. However, the financial structure of clinics emerged in the open-ended leader survey items as possible drivers of organizational supports and has been more broadly recognized as a barrier to EBP use (Stewart et al., 2016). An important next step in this study will be to partner with community clinics to better understand the presence of these organizational characteristics, examine whether strengthening the organizational innovation-specific capacity for exposure improves clinician rates of exposure use, and determine the financial infrastructure necessary to implement and sustain this capacity.

Results should be interpreted in the context of limitations. While our survey had an overall good response rate (55%), our sample was relatively small. As our primary aim was to characterize the organizational characteristics of specialty clinics, we did not conduct formal psychometric analysis of the OISCE; future work should do so. Due to limited resources, we sampled for clinics in populous areas; clinics in rural settings may use alternative organizational strategies to support providers to use exposure. Additionally, our specialty clinic sampling identified clinics that self-identified as specialty anxiety clinics; while many of these clinics are affiliated with academic centers and have led anxiety treatment research, we did not select clinics based on use of exposure therapy or clinical outcome performance. We also did not ask leaders to report on the levels of care provided within their setting; while informal evaluation based on public information suggests most surveyed clinics represented

the outpatient setting, some clinics offer multiple levels of care (e.g., outpatient and intensive outpatient). Future work should examine how these organizational characteristics vary as a function of level of care. Our choice to use a survey method also has limitations. While our brief survey likely contributed to our high response rate, qualitative interviews might have yielded richer information on organizational supports used in specialty settings. The low number of clinics that noted “other” organizational characteristics in the final open-ended item of the survey lends support for the breadth of our survey items; however, future research might consider a mixed-methods approach.

4 | CONCLUSION

Converging evidence indicates little traction is likely to be gained in improving the long-term uptake of exposure without addressing contextual variables to support it. Characterizing the innovation-specific capacity needed for exposure is necessary to understand how to improve low rates of exposure use outside of specialty settings. We took a novel approach to generating potential implementation strategies to target these contextual variables in community settings by identifying the organizational strategies that leaders in the field employ to support exposure use. Results revealed organizational characteristics that may be mutable intervention points to improve rates of exposure. Findings point to implementation strategies to be tested in future studies.

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TABLE 1

Clinic leader perceptions about the importance of organizational characteristics to support exposure therapy in specialty clinics

Importance for supporting clinicians to deliver exposure		
M (SD)	Range	
Supervisory support for exposure		
1. Clinical supervisor(s) who are knowledgeable about exposures are readily available. ^a	3.95 (0.21)	3–4
2. Clinical supervisors are able to help clinicians tailor exposures to fit the needs of clients. ^a	3.90 (0.31)	3–4
Collaboration with others in the organization to deliver exposure		
3. Multiple clinicians (i.e., more than 2) in the organization conduct exposures with their clients.	3.55 (0.91)	1–4
4. Clinicians in this organization are expected to discuss exposure ideas with colleagues.	3.50 (0.74)	2–4
5. Clinicians in this organization are willing to discuss exposure ideas with colleagues. ^a	3.68 (0.65)	2–4
6. Clinicians feel comfortable reaching out to others in the organization to ask them to help participate in exposures for clients (e.g., asking for assistance with social anxiety exposures). ^a	3.82 (0.40)	3–4
7. Clinicians regularly reach out to others in the organization to ask them to help participate in exposures for clients (e.g., asking for assistance with social anxiety exposures). ^a	3.55 (0.96)	0–4
8. People in the organization are available to assist with exposures during the times clinicians see clients (e.g., other clinicians, front desk staff). ^a	3.59 (0.73)	2–4
Organizational policies		
9. Clinicians can go outside the therapy room with clients to engage in exposures. ^a	4.00 (0.00)	4–4
10. Clinicians can leave the premises of the organization with clients to engage in exposures. ^a	3.76 (0.54)	2–4
11. Clinicians can hold sessions in places other than their office as needed for exposures (e.g., client's home, school/work).	3.71 (0.46)	3–4
12. Clinicians have the flexibility to schedule a longer therapy session for clients if needed to complete an exposure. ^a	3.73 (0.46)	3–4
13. Clinicians have time outside of their scheduled sessions to prepare for exposures (e.g., to acquire materials, coordinate with school staff).	3.23 (0.97)	0–4
Organizational resources		
14. The organization facilitates access to needed stimuli for exposure (e.g., access to computers/speakers/YouTube to watch exposure-related videos, allowing printing of exposure-related images). ^a	3.77 (0.53)	2–4
15. The organization provides resources for purchasing exposure-related stimuli (e.g., plastic bugs for insect phobias, stuffed animals for dog phobias).	3.43 (0.81)	2–4

Importance for supporting clinicians to deliver exposure		
	<i>M (SD)</i>	Range
16. The organization provides clinicians access to and/or provides resources for rewards to give to clients to reinforce clients' use of exposures (e.g., prize box, games, snacks).	2.82 (1.44)	0–4
Organization emphasizes exposure (implementation climate for exposure)		
17. It is expected that clinicians will attempt to deliver exposure therapy to all clients with anxiety disorders on their caseload. ^a	3.73 (0.55)	2–4

Note: All items were rated on a 5-point Likert scale: *Not at all (0), Slightly (1), Somewhat (2), Very (3), Extremely (4).*

Abbreviations: *M*, mean; *SD*, standard deviation.

^a An item that was rated as “very” or “extremely” important by 80% or more of surveyed leaders for supporting clinicians to use exposure therapy.

TABLE 2

Inter-item correlations of specialty clinic leader ratings of the importance of organizational characteristics

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1	—																
2	.69 *	—															
3	.38	.18	—														
4	.45 *	.43	.21	—													
5	.58 *	.59 *	.39	.75 *	—												
6	.46 *	.25	.29	.65 *	.51 -	—											
7	.13	.00	.30	.13	.06	.65 *	—										
8	-.12	.02	.42	.39	.21	.39	.60 *	—									
9	~	~	~	~	~	~	~	~	—								
10	-.10	-.14	-.14	.05	.19	-.22	-.23	-.27	~	—							
11	-.14	-.21	.02	.41	.33	.23	-.09	.06	~	.71 *	—						
12	-.13	.15	-.08	.28	.18	-.02	-.19	-.07	~	.32	.39	—					
13	.05	.07	.18	.10	.20	.49 *	.68 *	.20	~	.19	.16	.36	—				
14	.33	.16	.37	.43 *	.62 *	.71 *	.44 *	.36	~	-.21	.18	-.07	.38	—			
15	.12	.39	.02	.64 *	.75 *	.26	-.011	.15	~	.47 *	.64 *	.61 *	.30	.36	—		
16	.28	.40	-.07	.45 *	.45 *	.44 *	.49	.42 *	~	.05	.05	.07	.41	.32	.65	—	
17	.30	.42	.31	.82 *	.82 *	.64 *	.11	.42 *	~	.10	.44 *	.26	.21	.60 *	.72 *	.36	—

Note: ~Correlation cannot be computed because there was no variability in item 9.

* $p < .05$.

TABLE 3

Presence of organizational characteristics in specialty clinics and community clinics, as rated by leaders and clinicians, respectively

	Specialty clinics (<i>n</i> = 24)		Community clinics (<i>n</i> = 19)		
	<i>M</i> (<i>SD</i>)	Range	<i>M</i> (<i>SD</i>)	Range	<i>t</i> Test
Supervisory support for exposure					
1. Clinical supervisor(s) who are knowledgeable about exposures are readily available. ^a	3.91 (0.29)	3–4	1.42 (1.47)	0–4	<i>t</i> (41) = 8.13 *
2. Clinical supervisors are able to help clinicians tailor exposures to fit the needs of clients. ^a	4.00 (0.00)	4–4	1.32 (1.29)	0–4	<i>t</i> (41) = 10.21 *
Collaboration with others in the organization to deliver exposure					
3. Multiple clinicians (i.e., more than 2) in the organization conduct exposures with their clients ^a	3.86 (0.47)	2–4	1.37 (1.12)	0–4	<i>t</i> (41) = 11.24 *
4. Clinicians in this organization are expected to discuss exposure ideas with colleagues.	3.45 (0.80)	2–4	0.95 (1.31)	0–4	<i>t</i> (41) = 7.72 *
5. Clinicians in this organization are willing to discuss exposure ideas with colleagues ^a	3.86 (0.35)	2–4	1.79 (1.18)	0–4	<i>t</i> (41) = 8.18 *
6. Clinicians feel comfortable reaching out to others in the organization to ask them to help participate in exposures for clients (e.g., asking for assistance with social anxiety exposures) ^a	3.86 (0.35)	3–4	1.79 (1.40)	0–4	<i>t</i> (41) = 6.99 *
7. Clinicians regularly reach out to others in the organization to ask them to help participate in exposures for clients (e.g., asking for assistance with social anxiety exposures).	3.41 (1.01)	0–4	1.11 (1.33)	0–4	<i>t</i> (41) = 6.45 *
8. People in the organization are available to assist with exposures during the times clinicians see clients (e.g., other clinicians, front desk staff).	3.29 (0.78)	2–4	1.32 (1.25)	0–4	<i>t</i> (41) = 6.33 *
Organizational policies					
9. Clinicians can go outside the therapy room with clients to engage in exposures ^a	3.95 (0.22)	3–4	1.63 (1.38)	0–4	<i>t</i> (41) = 8.13 *
10. Clinicians can leave the premises of the organization with clients to engage in exposures ^a	3.73 (0.88)	0–4	0.84 (1.39)	0–4	<i>t</i> (41) = 8.31 *
11. Clinicians can hold sessions in places other than their office as needed for exposures (e.g., client's home, school/work). ^a	3.64 (0.90)	0–4	0.63 (1.26)	0–4	<i>t</i> (41) = 9.13 *
12. Clinicians have the flexibility to schedule a longer therapy session for clients if needed to complete an exposure ^a	3.68 (0.57)	2–4	1.53 (1.26)	0–4	<i>t</i> (41) = 7.47 *
13. Clinicians have time outside of their scheduled sessions to prepare for exposures (e.g., to acquire materials, coordinate with school staff).	3.14 (0.99)	0–4	0.89 (0.94)	0–3	<i>t</i> (41) = 7.57 *
Organizational resources					
14. The organization facilitates access to needed stimuli for exposure (e.g., access to computers/speakers/YouTube to watch exposure-related videos, allowing printing of exposure-related images). ^{a, *}	3.91 (0.29)	3–4	2.00 (1.49)	0–4	<i>t</i> (41) = 6.15 *
15. The organization provides resources for purchasing exposure-related stimuli (e.g., plastic bugs for insect phobias, stuffed animals for dog phobias).	3.41 (1.10)	0–4	0.79 (1.08)	0–4	<i>t</i> (41) = 7.82 *

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	Specialty clinics (<i>n</i> = 24)		Community clinics (<i>n</i> = 19)		<i>t</i> Test
	<i>M</i> (<i>SD</i>)	Range	<i>M</i> (<i>SD</i>)	Range	
16. The organization provides clinicians access to and/or provides resources for rewards to give to clients to reinforce clients' use of exposures (e.g., prize box, games, snacks).	2.73 (1.52)	0–4	0.74 (1.10)	0–4	<i>t</i> (41) = 4.79 *
Organization emphasizes exposure (implementation climate for exposure)					
17. It is expected that clinicians will attempt to deliver exposure therapy to all clients with anxiety disorders on their caseload. ^a	3.73 (0.55)	2–4	0.42 (0.69)	0–2	<i>t</i> (41) = 17.52 *

Note: All items were rated on a 5-point Likert scale: *Not at all* (0), *Slightly* (1), *Somewhat* (2), *Very* (3), *Extremely* (4).

Abbreviation: *M*, mean; *SD*, standard deviation.

^a An item that was rated “very” or “extremely” true for their clinic by 80% or more of surveyed leaders.

* *p* < .001.