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Exposure Therapy Practices and Mechanism Endorsement: A Survey of Specialty Clinicians

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Studies have suggested that exposure is a key ingredient in the treatment of youth with anxiety disorders and obsessive–compulsive disorder (OCD), yet there are several barriers to the implementation of exposures. This may reflect the lack of detail in treatment protocols specifically outlining the delivery of exposure and the lack of consensus on treatment mechanism. The aim of this study was to learn how experts treating this population practice exposure treatment and conceptualize treatment mechanism on the basis of their responses on an Internet-based survey. Participants ($N = 65$) were licensed mental health clinicians who treated youth for primary OCD or for a primary anxiety disorder (generalized anxiety disorder, social phobia, social anxiety disorder) within the last year. Results indicated that exposure was widely practiced among our sample. Results on specific endorsements of exposure techniques and mechanism are reported, and clinical and research implications are discussed.

Keywords: clinician beliefs and practices, exposure therapy, anxiety, OCD, youth

Exposure-based treatment, such as cognitive–behavioral therapy (CBT), is considered a first-line intervention for anxiety disorders and obsessive–compulsive disorder (OCD) in children (Connolly, Bernstein, & The Work Group on Quality Issues, 2007; Foa et al., 1999, 2005; Geller, March, & The AACAP Committee on Quality Issues [CQI], 2012; Ollendick et al., 2009; Watson &

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Rees, 2008). Despite the clear efficacy of exposure-based treatment and the need for this treatment among youth with OCD and anxiety disorders, most of these children are unable to access efficacious treatment (Watson & Rees, 2008). In community settings, providers have difficulty implementing evidence-based treatment practices, and youth with anxiety and OCD rarely receive first-line treatments (Freiheit, Vye, Swan, & Cady, 2004; Stein et al., 2011, 2004; Young, Klap, Sherbourne, & Wells, 2001; Young, Klap, Shoai, & Wells, 2008). To date, no studies have examined the implementation or quality of exposure therapy in community settings for youth with OCD and anxiety disorders.

Although CBT treatment packages typically contain multiple components, exposures are thought to be critical for producing change in treatment (Kazdin & Weisz, 1998; Vande Voort, Svecova, Jacobson, & Whiteside, 2010). A feasibility randomized controlled trial dismantling CBT for childhood anxiety disorders found that parent-coached exposure therapy with an early emphasis on exposure produced better patient outcomes in fewer sessions compared to the anxiety management strategies typically taught during the initial sessions of CBT protocols (Whiteside et al., 2015). Compared to CBT for child anxiety, treatment packages for youth with OCD contain more exposure and tend to be more efficacious (Ale, McCarthy, Rothschild, & Whiteside, 2015). Although treatment packages for childhood anxiety disorders, such as the Coping Cat (Kendall, 1990), contain multiple other treatment ingredients (e.g., cognitive restructuring, relaxation), patient improvement tends to begin after the introduction of exposure (Kendall et al., 1997; Ollendick, 1995; Ollendick, Hagopian, & Huntzinger, 1991). The literature supports the use of exposure; however, even when therapists intend to provide exposure treatment, there are still substantial differences in therapist adherence to the delivery of exposure. In a web-based survey of clinicians practicing interoceptive exposure for panic disorder, Deacon, Lickel, Farrell, Kemp, and Hipol (2013) found substantial variability among therapists in reported exposure implementation.

There are several likely barriers to provider adaptation and implementation of exposures. One potential source of variation in therapist behaviors and outcomes during exposure-based treatments is the manner in which exposure is conducted. Although most treatment protocols specify the occurrence of exposure, none detail the way in which the therapist should conduct exposure. For example, manuals are unclear about the use of therapeutic techniques (e.g., cognitive restructuring), specific therapist statements (e.g., to increase anxiety), or optimization of exposure elements (e.g., variation in the setting of exposures) *during* exposure that might have a profound impact on the treatment efficacy. Lack of consensus about the best implementation of exposure along with unclear guidelines in most treatment manuals likely contributes to therapists' using other CBT treatment techniques more often (Hipol & Deacon, 2013).

Although there is currently a lack of data guiding therapist choice of technique during exposures, researchers have developed several theories about the mechanism of change in exposure-based treatment that can guide both clinical implementation and further research. These include habituation, cognitive, coping, inhibitory learning, and acceptance and commitment therapy (ACT) models (Arch & Abramowitz, 2015; Benito & Walther, 2015; Berman, Fang, Hansen, & Wilhelm, 2015; Conelea & Freeman, 2015; Twohig et al., 2015).

The habituation model posits that exposure reduces anxiety through habituation to feared stimuli and that the process of habituation is passive and internal (Abramowitz & Arch, 2014; Benito & Walther, 2015). The optimal exposure for this model includes (a) activating the fear, (b) minimizing behaviors that reduce anxiety (e.g., rituals, safety behaviors, avoidance), and (c) occurrence of habituation (anxiety reducing within and across exposure trials only when Conditions 1 and 2 are met; Benito & Walther, 2015). Research regarding the role of habituation in exposure-based treatments has been mixed (Craske et al., 2008). However, traditional measures of habituation have failed to consider the role of anxiety-reducing behaviors during exposures, potentially confounding the results of studies of habituation. For example, a reduction in anxiety due to a compulsion at the end of an exposure may be erroneously considered "habituation." Further research more precisely examining the role of habituation is warranted.

In the cognitive model, a decrease in maladaptive beliefs is thought to drive patient improvements (Berman et al., 2015). Maladaptive interpretations are modified through addressing the areas of responsibility or threat estimation, perfectionism or certainty, and overimportance or overcontrol of thoughts. The optimal therapeutic process therefore requires therapists to (a) set up exposures to facilitate belief disconfirmation and (b) encourage patient use of cognitive skills during exposure. The literature supports the efficacy of cognitive therapy for OCD and anxiety but does not address the role of cognitive techniques during exposure (Emmelkamp & Beens, 1991; Van Oppen et al., 1995; Wilhelm et al., 2009, 2005).

The coping model stresses the importance of replacing and reducing anxiety-provoking thoughts during exposure. Anxiety is actively reduced by increasing the patient's perceived level of self-efficacy (Kendall et al., 2005). Higher self-efficacy should yield a decrease in threat perception, which consequently reduces anxiety (Kendall et al., 2005). Kendall and colleagues (2005) suggested that the development of coping skills may be an important component to successful exposure treatment while working with anxious youth. The Coping Cat is a widely established CBT treatment manual for anxious youth that emphasizes coping skills (Kendall, 1990).

The inhibitory learning model suggests that the success of exposures is primarily due to violation of fear expectancy (Arch & Abramowitz, 2015). This model's foundation relies on the assertion that inhibitory learning occurs during exposure therapy (Craske et al., 2008; Craske, Liao, Brown, & Vervliet, 2012). The role of the therapist throughout the therapeutic process is to maximize the likelihood that inhibitory learning will occur by promoting tolerance of fear, disgust, and uncertainty. More specifically, this is achieved through therapist behaviors such as disconfirming negative expectancies, prompting variability in exposure context and stimuli, and encouraging patients to verbalize their feelings (Arch & Abramowitz, 2015). Previous studies have supported inhibitory learning as a foundational mechanism for fear extinction (Bouton, 1993; Bouton, Woods, Moody, Sunsay, & García-Gutiérrez, 2006; Vervliet, Craske, & Hermans, 2013), and multiple studies have supported components of the inhibitory learning model for the maintenance of treatment gains (e.g., Lang & Craske, 2000; Rowe & Craske, 1998). Additional articles by Craske and colleagues (2008, 2012) conjectured that long-term exposure therapy outcomes for OCD and anxiety disorders are a result of inhibitory learning, though this has yet to be tested.

Finally, the ACT model works by encouraging patients to live consistently with their values despite the discomfort that may accompany anxious thoughts (Twohig et al., 2015). This model encourages psychological flexibility through six foundational processes: accep-

tance, cognitive defusion, awareness of the present moment, self as context, values, and committed action. The therapist works to change patients' relationship with anxiety through acceptance of this internal experience rather than habituation to it. The therapeutic process in ACT relies on patients' willingness to accept anxious thoughts and feelings and not allow those feelings to change their course of behavior toward life values. Randomized trials of ACT that contained exposure have showed that this model is useful for treating anxiety disorders and OCD (Arch et al., 2012; Craske et al., 2014). Other research has found ACT without in-session exposure to also be useful for OCD and related disorders (Twohig et al., 2015). The literature has not yet explicitly investigated the combination of ACT with exposure with response prevention (ERP) for OCD. However, Twohig and colleagues (2015) suggested that ERP and ACT could be complementary models and should be investigated further.

Mechanisms of change and related therapeutic process variables theorized by each model have not been directly tested. However, given that each model emphasizes slightly different process variables, therapist endorsement of a given model might affect use of certain techniques during exposure. For example, a therapist using the coping model and conducting exposure may encourage the use of thought-challenging or repeated coping statements during exposure. Conversely, a therapist practicing with the habituation model during the same exposure would instead encourage or amplify anxious thoughts during exposure, with the goal of habituation as a passive process.

Attempts to disseminate exposure-based treatments have yielded mixed results (Beidas, Barmish, & Kendall, 2009; Sholomskas et al., 2005), potentially because there is a lack of data or expert consensus about the mechanism underpinning treatment. Understanding this mechanism may have profound implications for therapist behaviors during exposure. Furthermore, detailing key elements for producing change in treatment may help to address barriers to the use of exposure in community settings. The current study aims to understand beliefs regarding exposure mechanism and the relationship of those beliefs to implementation of exposure among anxiety and OCD specialists. Specifically, we report on clinician setting and practice characteristics, training experience, use of exposure, barriers to exposure use, endorsement of therapy techniques, and endorsement of exposure mechanism. We also examine the relation between mechanism endorsement and endorsement of specific therapy techniques. Furthermore, given differences in the emphasis of exposure typically included in treatment manuals for OCD compared with anxiety disorders, we describe any differences in use of specific techniques with patients presenting with OCD or anxiety disorders.

Method

Participants

Participants were 65 licensed mental health clinicians who treated children ages 5–17 for primary OCD or for a primary anxiety disorder (generalized anxiety disorder [GAD], social phobia [SP], social anxiety disorder [SAD]) within the last year. All respondents described their primary orientation as cognitive–behavioral. Additional demographic and practice information about participants is described in the Results section.

Participants were recruited from three sources: anxiety disorder specialty clinics, Anxiety and Depression Association of America (ADAA) conference programs, and the Association for Behavioral and Cognitive Therapies (ABCT) Special Interest Group (SIG) electronic mailing lists. This study aimed to survey anxiety specialists, defined as clinicians who primarily treat anxious patients or who work in a clinic that primarily treats anxious patients.

Measures

Participants completed an Internet-based survey designed to assess current practices related to the treatment of childhood anxiety disorders and OCD. Initial questions asked about type and frequency of disorders treated, as well as involvement in training in the use of exposures. Then, more-specific questions asked about treatment approaches, with a particular emphasis on use of exposures. The same set of questions was asked first about anxiety disorders (GAD, SP, and SAD) and then about OCD. Questions covered four primary domains, including techniques used during treatment (e.g., cognitive restructuring, in vivo exposure, relaxation), techniques used during exposure (e.g., choosing items from a hierarchy, limiting distraction, using relaxation), reasons for not using exposure (for some or all cases; e.g., exposures are not feasible for the child's symptoms, child was not motivated to participate in exposures), and reasons that children may benefit from exposures (i.e., theorized mechanisms). The survey also collected information regarding degree, practice type, geographical location, and training background. The survey was designed to allow participants to opt out of sections that were not relevant (e.g., clinicians who do not treat children with OCD were not required to complete the section about treating OCD). As a result of this formatting, the number of items varied depending on participants' responses.

Procedures

All procedures were approved by the Institutional Review Board. Participants were contacted via e-mail, either through their membership in professional organizations or through direct contact from researchers. Survey responses were collected between October 2013 and January 2014.

Recruitment occurred through several methods in an effort to reach a broad sample of anxiety specialists. Recruitment of ABCT SIG members was facilitated through SIG leaders, whose contact information was retrieved from the ABCT web site. A cover letter was sent via e-mail to all ABCT SIG leaders explaining the project and asking them to forward the survey link to the SIG electronic mailing list. Members of ADAA were recruited by reviewing conference programs from the previous 5 years (2009–2013). People who had given a symposium presentation on a topic related to child anxiety were contacted directly via the e-mail listed for them in the ADAA membership directory. Finally, anxiety specialty clinics were identified on the basis of the expertise of our clinicians and through consultation with colleagues specializing in anxiety or OCD treatment research at other institutions. Contact information for clinicians from anxiety specialty clinics was obtained through publicly available, published means (e.g., practice websites). In addition, e-mails sent to these clinicians requested their assistance in identifying other specialty clinics for continued recruitment.

The survey was hosted by surveymonkey.com and included a first page with consent language allowing participants to indicate

consent by clicking *yes.* Participants choosing *no* did not continue on to the rest of the survey. The remainder of the survey assessed current practices for the treatment of anxiety, as described in the Measures section. The survey was anonymous and took approximately 5–10 min to complete.

Results

Clinician Inclusion or Exclusion

Of $N = 87$ participants responding to the survey, those who did not complete at least 80% of questions ($N = 10$) were excluded. Given our focus on clinicians specializing in anxiety treatments for youth, we also excluded those who were recruited through a nonanxiety SIG and did not self-identify as working in an anxiety specialty setting ($N = 12$), leaving a total sample of $N = 65$. Due to the nature of recruitment, it was not possible to calculate the number of people who received the survey, so a response rate cannot be reported.

Clinician Setting and Practice Characteristics

Therapists reported working in a hospital or university setting most often (51.5%), followed by independent practice (31.8%) and community mental health clinics (4.5%). All clinicians described their primary orientation as cognitive–behavioral (100%). Therapists were asked to rank presenting patient problems on a 6-point scale ranging from 1 (*most frequently treated*) to 6 (*least frequently treated*). They reported treating GAD most frequently (M rank = 2.29, $SD = 1.33$), followed by SP (M rank = 2.72, $SD = 1.21$), OCD (M rank = 3.03, $SD = 1.92$), separation anxiety (M rank = 3.70, $SD = 1.26$), other anxiety disorders (M rank = 4.33, $SD = 1.34$), and other nonanxiety disorders (M rank = 4.92, $SD = 1.52$). On average, therapists reported 9.72 years ($SD = 8.79$, range = 1–35 years) of experience treating youth with OCD and/or anxiety disorders. On average, therapists reported treating 12.4 youth with OCD in the last year ($SD = 16.4$, range = 0–65) and 28.6 youth with anxiety in the last year ($SD = 25.4$, range = 0–100). Using a series of Bonferroni-corrected t tests and one-way analyses of variance, we explored the relationship of all clinician characteristics with other study variables. No significant relationships were found.

Clinician Training Experience

The majority of therapists (69.7%) reported that they do not currently provide training for others in the use of exposure. It is interesting that, of therapists working in training programs (e.g., doctoral or internship program, $N = 49$), 90.0% reported that the program does not provide formal training in the use of exposure for anxiety treatment. However, all except one therapist reported having received their own formal training in the use of exposure for treating anxiety (98.4%).

Clinician Exposure Use

A large majority of clinicians reported that they practice exposure with OCD patients (98.4%) and with anxiety patients (97.0%). For anxiety and OCD, most clinicians reported using exposure with 80%–100% of patients (see Figure 1), spending 40%–60% of session time on exposures (see Figure 2), and assigning exposure homework in 80%–100% of sessions (see Figure 3).

Clinician-Reported Barriers to Exposure Use

Although most clinicians reported using exposure most of the time and with most patients, reported barriers to exposure that were sometimes encountered in practice included lack of patient motivation, presence of comorbidities, patients who respond better to other techniques, patient prior experience with exposure that was unsuccessful, patient level of distress, and/or patient symptoms for which exposure is not feasible (see Table 1). Clinician free-text report of common exposure barriers also included family-level barriers (e.g., parent nonadherence; $N = 4$) and decision to use session time for other important interventions (e.g., psychoeducation, creating a behavior plan; $N = 3$).

Clinician Endorsement of Techniques

Table 2 presents a summary of techniques endorsed by clinicians both broadly and as part of exposure. Using McNemar's test, we found significant differences within clinicians for reported use of the following techniques in-session: cognitive restructuring, coping skills training, in vivo exposure, parent training, psychoeducation, and relaxation, depending on whether the patient's presenting problem is anxiety or OCD ($ps < .05$; see Table 2).

Clinician Endorsement of Exposure Mechanism

In order to assess clinician belief in a given exposure mechanism, we asked the following question: "Please read the following statement and indicate the choice that most closely matches your opinion: When children/adolescents with OCD benefit from exposure, it is because . . ." Answers included (a) "they have learned skills to actively reduce or cope with anxiety" (coping model), (b) "they have learned to fully experience the feeling of anxiety until it naturally diminishes" (habituation model), (c) "they have learned to fully experience the feeling of anxiety, but not necessarily until it naturally diminishes" (ACT), and (d) "they have evidence that feared consequences are unlikely to occur" (inhibitory learning/cognitive model). Given that only $N = 3$ clinicians endorsed the

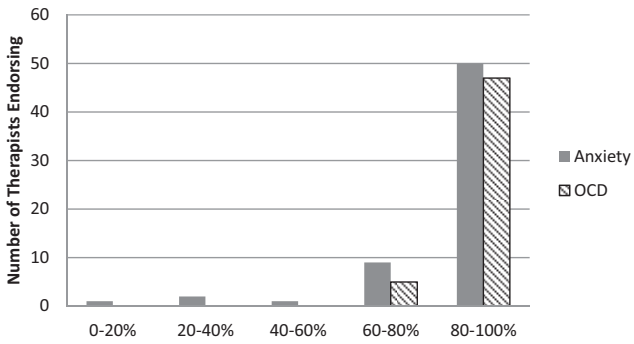

Figure 1. Percentage of anxiety and obsessive–compulsive disorder (OCD) patients with whom clinicians report using exposure.

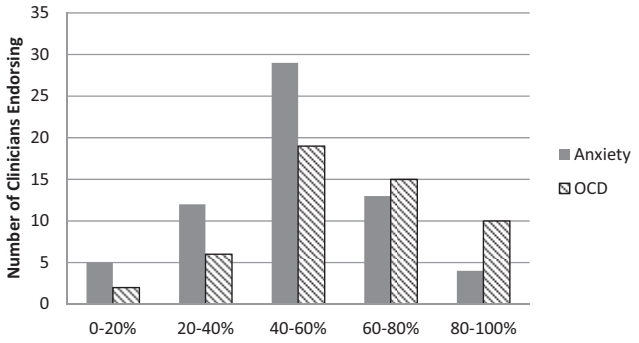

Figure 2. Percentage of session time for anxiety and obsessive–compulsive disorder (OCD) during which clinicians report using exposure.

ACT mechanism, we did not include that category in subsequent analyses.

We used binary logistic regression with dummy coding of exposure mechanism categories to test whether endorsement of an exposure mechanism predicted endorsement of a given technique.

Results for OCD. Mechanism endorsement significantly predicted "Prompting cognitive or coping tools," $\chi^2 = 7.45$, $p < .05$, such that those endorsing the coping mechanism were more likely to endorse this technique compared with those endorsing the inhibitory learning/cognitive mechanism ($b = 2.27$, $p < .05$). There were no other differences in technique on the basis of endorsement of exposure mechanism.

Results for anxiety. Mechanism endorsement significantly predicted "Ending the exposure after anxiety reduction," $\chi^2 = 7.53$, $p < .05$, such that those endorsing the habituation mechanism were more likely to endorse this technique compared to those endorsing the inhibitory learning/cognitive mechanism ($b = 1.73$, $p < .05$). Of marginal significance, mechanism endorsement predicted "Prompting cognitive or coping tools," $\chi^2 = 5.42$, $p = .07$, such that those endorsing the habituation mechanism were less likely to endorse this technique compared to those endorsing the coping mechanism ($b = 2.08$, $p < .05$). There were no other differences in technique on the basis of endorsement of exposure mechanism.

Discussion

This study aimed to better understand beliefs about and the implementation of exposure among clinicians specializing in the treatment of youth with anxiety and OCD. Given the historical split in treatment studies between OCD and anxiety disorders (Franklin et al., 2011; Freeman et al., 2014; Kendall, 1994; Kendall et al., 1997; Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008; Pediatric OCD Treatment Study [POTS] Team, 2004), we assessed use of techniques for OCD treatment and anxiety treatment separately. Our recruitment strategy was suc-

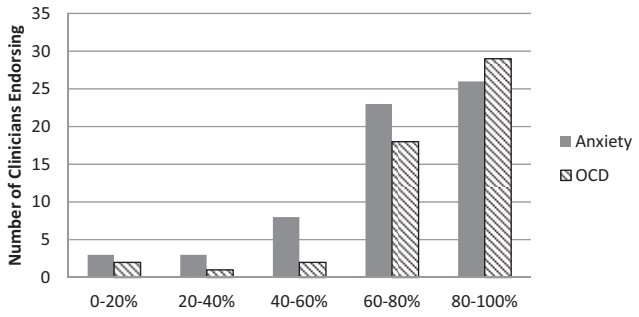

Figure 3. Percentage of sessions for anxiety and obsessive–compulsive disorder (OCD) during which clinicians report assigning exposure homework.

Table 1
Clinician-Reported Barriers to Exposure Use Among Clinicians Who Do Not Use Exposure With All Patients (OCD N = 47; Anxiety N = 55)

Barrier	% endorsing OCD	% endorsing anxiety
Patient is not motivated	36.1	49.1
Presence of nonprimary comorbidity that interferes with exposure	34.8	50.9
Patient who responds better to other techniques	37.3	50.9
Patient had prior unsuccessful experience with exposure	37.3	50.0
Patient becomes too distressed	37.3	53.3
Patient has symptoms for which exposure is not feasible	36.1	45.5

Note. Percentages are based on clinicians' reporting that the barrier "somewhat" or "strongly" contributes to the decision not to use exposure. OCD = obsessive–compulsive disorder.

Table 2
Percentage of Clinicians Using Therapeutic Techniques for Treatment of OCD and Non-OCD Anxiety Disorders

Technique	% endorsing OCD[a]	% endorsing non-OCD[b]
Techniques during session[c]		
Cognitive restructuring[d]	54.8	87.9
Coping skills training[d]	33.9	68.2
Imaginal exposure	54.8	63.6
In vivo exposure[d]	83.9	97.0
Parent training[d]	79.0	93.9
Psychoeducation[d]	80.6	93.9
Relaxation[d]	24.2	54.5
Necessary components of exposure[e]		
Using a hierarchy to select the exposure	80.3	94.8
Ending the exposure after anxiety reduction	55.7	64.5
Limiting distractions	63.9	64.5
Discourage ritualizing	78.7	
Prompting cognitive or coping tools	36.7	41.9
Prompting relaxation	10.0	16.1
Obtaining SUDS ratings	67.8	80.6
Providing reassurance	5.0	4.8
Maintain conversation throughout exposure	6.7	9.7

Note. OCD = obsessive–compulsive disorder; SUDS = Subjective Units of Distress.
[a] $N = 60$. [b] $N = 62$. [c] Therapists were asked, "Of the following list, please check the techniques you are likely to use with a child/adolescent who presents with primary OCD/non-OCD anxiety." [d] McNemar's test of $p < .05$. [e] Therapists were asked, "Of the components listed below, please indicate all of those that you include as a necessary component *during* an exposure for the treatment of child/adolescent OCD/non-OCD anxiety."

cessful in capturing a sample of specialized clinicians, as indicated by background, clinical orientation, patient population served, and endorsed use of exposure techniques. All clinicians in our sample reported a primary cognitive–behavioral orientation, which is consistent with the literature that CBT is the first-line treatment for anxiety disorders and OCD (Connolly et al., 2007; Foa et al., 1999, 2005; Geller et al., 2012; Ollendick et al., 2009; Watson & Rees, 2008). All but one therapist reported receiving formal training in the use of exposure for treating anxiety and OCD. Clinicians in our sample reported most frequently treating youth with anxiety or OCD compared to other disorders. An overwhelming majority endorsed the practice of exposure with anxiety and OCD patients. Consistent with the CBT model and with most CBT treatment manuals, the majority of clinicians reported spending a significant amount of time engaged in exposure during sessions (40%–60% of session time) and assigning exposure homework in most sessions (80%–100%) when treating patients with OCD or anxiety. Further, in vivo exposure was the most frequently endorsed technique used during treatment sessions. These rates of reported exposure utilization are encouraging in light of the strong evidence for exposure as a necessary treatment component for a positive treatment response when treating pediatric anxiety and OCD (Kendall et al., 2005). These findings are also consistent with previous literature reporting that exposure is the most common practice element in treatment protocols for anxiety (Chorpita & Daleiden, 2009).

Not surprisingly, the rates of reported exposure use in our sample were substantially higher compared to what is typically reported among nonanxiety-specialist community clinicians. To date, most research surveying community clinicians is based on clinicians who primarily treat adult populations. Surveys of nonspecialized community practitioners have indicated that use of exposure-based interventions is rarely used with anxious patients (Becker, Zayfert, & Anderson, 2004; Freiheit et al., 2004; Hipol & Deacon, 2013), and recent research based on electronic medical records also confirms that finding (Wolitzky-Taylor, Zimmermann, Arch, De Guzman, & Lagomasino, 2015). However, a more-recent survey of self-identified CBT clinicians indicated that the majority (85.5%) reported frequently using exposure exercises with OCD patients specifically (Scherr, Herbert, & Forman, 2015). This finding, together with the high rate of exposure utilization reported in our sample, may indicate that CBT clinicians are using exposure interventions more frequently. Perhaps CBT clinicians have become more aware of and comfortable with using exposure as dissemination and training efforts have increased. Although we did not have a comparison group of nonanxiety specialists, the rates of exposure use reported in our sample are in line with Hipol and Deacon's (2013) finding that anxiety specialists are significantly more likely to use exposure-based techniques than are nonspecialists.

The current results help elucidate specific techniques being used within anxiety and OCD treatment and provide a better understanding of how clinicians specializing in anxiety and OCD deliver exposure therapy. Results found that clinician utilization of CBT techniques, with the exception of imaginal exposure, significantly varied by whether therapists were treating OCD or non-OCD patients. When treating non-OCD patients, therapists reported more-frequent use of all techniques compared to when treating OCD patients, suggesting that clinicians used a variety of CBT techniques when treating generalized anxiety, social phobia, separation anxiety, and other anxiety disorders. One possible driver of this finding is the difference in OCD and anxiety disorder treatment protocols. Coping Cat (Kendall & Hedtke, 2006a, 2006b), a frequently used manual for treating pediatric anxiety, emphasizes the use of several cognitive–behavioral skills in addition to behavioral exposure, such as cognitive strategies, problem-solving, parental involvement, and relaxation training. On the other hand, OCD treatment manuals tend to focus primarily on ERP as the core treatment component, with other CBT techniques, such as parent training, included in some protocols (e.g., Freeman et al., 2012). Future studies should examine whether the utilization of techniques differ among non-OCD anxiety disorders.

Understanding therapist behaviors and the manner in which exposure is conducted is important because most treatment protocols do not detail the way in which a clinician should conduct exposures. It is interesting that there were no group differences between OCD patients and non-OCD anxiety patients in techniques clinicians reported to be necessary for exposure. In other words, clinicians in this sample seem to approach the delivery of exposure similarly whether they are treating OCD or anxiety disorders. Using a hierarchy to select an exposure, obtaining Subjective Units of Distress (SUDS) ratings, limiting distractions, ending the exposure after anxiety reduction, and discouraging ritualizing (OCD only) were the most frequently endorsed necessary components of exposure (greater than 50% reported). The question is then raised: Do therapists' behaviors and techniques used during exposure vary by their understanding of how exposure works?

To answer this question, we examined clinician use of specific techniques during exposure by their endorsement of exposure mechanism (e.g., habituation, coping, inhibitory learning/cognitive). Overall, results showed more similarities than differences in therapeutic techniques across endorsed exposure mechanisms for both OCD and non-OCD anxiety patients. There could be several reasons for this finding. Perhaps therapists' understanding of the way exposure works does not influence their behavior during exposure or they use the techniques taught to them in their training regardless of the underlying theory. It is also possible that these different theories of mechanisms of change share common core principles that tend to promote similar therapist behaviors during exposure, such as using a fear hierarchy, limiting distractions, and using SUDS. More minor differences may emerge through the nuances of each theory. One difference that emerged in this sample is whether the clinician endorsed prompting cognitive or coping strategies. For both OCD and non-OCD anxiety patients, there was a significant difference in the frequency of clinicians who endorsed this strategy by their understanding of exposure mechanism. Clinicians who endorsed a coping model ($N = 7$ for OCD patients; $N = 8$ for non-OCD patients) more frequently endorsed using cognitive/coping tools. This is not surprising given that the premise of this mechanism of change is to encourage children to actively cope or reduce anxiety during exposures. When splitting the sample on the basis of whether therapists primarily treated OCD versus anxiety disorders, there was a trend toward those primarily treating anxiety disorders to endorse the coping model, although this was not significant. Additionally, the estimated number of reported patients treated (OCD vs. anxiety) was not significantly related to therapists' mechanism endorsement. Another significant difference to emerge in this study was the timing of

when to end the exposure for anxiety disorders. Clinicians who endorsed an inhibitory learning/cognitive model ($N = 23$ for OCD patients; $N = 23$ for non-OCD patients) were less likely to end the exposure after anxiety reduction compared to clinicians endorsing the habituation ($N = 18$ for OCD patients; $N = 27$ non-OCD patients) or coping models. This finding is likely influenced by research by Craske and colleagues (2008) on inhibitory learning suggesting that there is limited evidence linking habituation and treatment outcome. Because the application of the inhibitory model to OCD is still in its infancy, this may explain why a significant difference in reports of habituation being necessary was found only for anxiety disorders and not for OCD patients. It is also important to consider that a limited sample size may have affected our ability to detect findings. Given that there were a small number of clinicians in each group, it is possible that additional differences would be found with a larger sample size.

This study has several important research and clinical implications. First, in vivo exposure was the most commonly reported treatment approach for OCD and non-OCD anxiety patients. Although this is not a surprising finding, it is interesting that we found that clinicians in this sample did not universally use exposure. This suggests that there are still barriers to exposure use even among those with anxiety expertise. We also found that, despite the majority of clinicians in our sample working in hospital or university settings, few were involved in providing formal training in exposure therapy, and most reported that their training programs did not provide specific training in the practice of exposure. More research is needed to clarify the barriers to both training and utilization of exposures. We also found that clinicians were more likely to use other CBT techniques in addition to exposure when treating patients with anxiety disorders, compared to OCD patients. Additional research is needed to better understand whether this difference is accounted for by specific disorders being treated (e.g., GAD, SP) or whether the finding is consistent across anxiety disorders. Results also have important implications for dissemination and understanding exposure delivery in practice. It is helpful for us to highlight strategies that, among clinicians with anxiety expertise, were more and less universally agreed upon during exposure. Over half of clinicians endorsed using a hierarchy to select the exposure, obtaining SUDS ratings, limiting distractions, ending the exposure after anxiety reduction, and discouraging ritualizing as necessary components of an exposure. Similarly, less than half of clinicians indicated that prompting cognitive/coping tools, prompting relaxation, providing reassurance, and maintaining a conversation throughout exposure were not necessary. There was variability in the sample and some evidence that certain therapists' behaviors during exposure may be influenced by their understanding of the exposure mechanism. These differences present challenges when considering how to most effectively train clinicians and disseminate information on how to conduct exposures. Additional research on mechanisms of change and specific therapist behaviors during exposure is needed.

Finally, limitations of this study should be considered. Although we attempted to categorize clinicians by endorsement of exposure mechanism through identifying the reason youth benefit from exposure, there are some limitations to this approach. The definitions and labeling of each mechanism may have missed the nuances and complexities of each model. Additionally, we did not have enough respondents to include ACT as a theoretical model. Given the recent popularity of ACT in the treatment of anxiety, future studies should consider this model when examining theoretical understanding of exposure. As previously mentioned, the small number of clinicians in each group may also have limited our ability to detect findings. This study would have benefitted from a larger sample size. We were also not able to report on the type of degree held by most of our sample, because the majority of clinicians did not respond to the question asking for their degree. It is not clear why this question was left unanswered by many, though it may have been that the question was at the end of the survey. We were also unable to obtain further information beyond diagnoses based on the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 1994) about the nature of the patients treated by these clinicians. In addition, although the goal of our study was to characterize the utilization of and beliefs about exposure among specialists in the treatment of youth anxiety and OCD, we did not have a comparison group of nonspecialists treating anxiety and OCD. This study recruited from a select sample of anxiety specialists, and the survey respondents were considered to be representative of that population. A comparison group would allow us to gain a better understanding of potential differences or similarities to barriers of utilizing exposure interventions. A final limitation is our reliance on self-report of clinicians about their own behavior. Therapist self-report has been the most common method for assessing practice patterns, yet research has shown that observers' ratings of therapist behavior in treatment sessions are typically not in concordance with self-report (Garland, Hurlburt, Brookman-Frazee, Taylor, & Accurso, 2010). Self-report is necessary to understand clinician beliefs about and understanding of how exposure works; however, our results regarding the actual interventions used during session would benefit from using both subjective and objective measures.

In summary, exposure for youth with anxiety and OCD appears to be the treatment of choice among specialists in the field. This is encouraging, and yet, even among this sample of anxiety and OCD specialists who adhere to a CBT framework, barriers to implementing exposure were noted. Clinicians in our sample seem to approach exposure with anxiety and OCD in generally the same manner even when they endorsed differing theories for the mechanism of change in exposure. At the same time, some differences in approach and variety of interventions used were found. Further research on the relationship between therapist beliefs and actual use of interventions can help improve training efforts.

References

Abramowitz, J. S., & Arch, J. J. (2014). Strategies for improving long-term outcomes in cognitive behavioral therapy for obsessive-compulsive disorder: Insights from learning theory. *Cognitive and Behavioral Practice, 21,* 20–31.

Ale, C. M., McCarthy, D. M., Rothschild, L. M., & Whiteside, S. P. H. (2015). Components of cognitive behavioral therapy related to outcome in childhood anxiety disorders. *Clinical Child and Family Psychology Review, 18,* 240–251. http://dx.doi.org/10.1007/s10567-015-0184-8

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Arch, J. J., & Abramowitz, J. S. (2015). Exposure therapy for obsessive-compulsive disorder: An optimizing inhibitory learning approach. *Journal of Obsessive-Compulsive and Related Disorders, 6,* 174–182. http://dx.doi.org/10.1016/j.jocrd.2014.12.002

Arch, J. J., Eifert, G. H., Davies, C., Plumb Vilardaga, J. C., Rose, R. D., & Craske, M. G. (2012). Randomized clinical trial of cognitive behavioral therapy (CBT) versus acceptance and commitment therapy (ACT)

for mixed anxiety disorders. *Journal of Consulting and Clinical Psychology, 80,* 750–765. http://dx.doi.org/10.1037/a0028310

Becker, C. B., Zayfert, C., & Anderson, E. (2004). A survey of psychologists' attitudes towards and utilization of exposure therapy for PTSD. *Behaviour Research and Therapy, 42,* 277–292. http://dx.doi.org/10.1016/S0005-7967(03)00138-4

Beidas, R. S., Barmish, A. J., & Kendall, P. C. (2009). Training as usual: Can therapist behavior change after reading a manual and attending a brief workshop on cognitive behavioral therapy for youth anxiety? *Behavior Therapist, 32,* 97.

Benito, K. G., & Walther, M. (2015). Therapeutic process during exposure: Habituation model. *Journal of Obsessive-Compulsive and Related Disorders, 6,* 147–157. http://dx.doi.org/10.1016/j.jocrd.2015.01.006

Berman, N. C., Fang, A., Hansen, N., & Wilhelm, S. (2015). Cognitive-based therapy for OCD: Role of behavior experiments and exposure processes. *Journal of Obsessive-Compulsive and Related Disorders, 6,* 158–166. http://dx.doi.org/10.1016/j.jocrd.2015.01.001

Bouton, M. E. (1993). Context, time, and memory retrieval in the interference paradigms of Pavlovian learning. *Psychological Bulletin, 114,* 80–99. http://dx.doi.org/10.1037/0033-2909.114.1.80

Bouton, M. E., Woods, A. M., Moody, E. W., Sunsay, C., & García-Gutiérrez, A. (2006). Counteracting the context-dependence of extinction: relapse and tests of some relapse prevention methods. In M. G. Craske, D. Hermans, & D. Vansteenwegen (Eds.), *Fear and learning: Basic science to clinical application*. Washington, DC: American Psychological Association.

Chorpita, B. F., & Daleiden, E. L. (2009). Mapping evidence-based treatments for children and adolescents: Application of the distillation and matching model to 615 treatments from 322 randomized trials. *Journal of Consulting and Clinical Psychology, 77,* 566–579. http://dx.doi.org/10.1037/a0014565

Conelea, C. A., & Freeman, J. B. (2015). What do therapists and clients do during exposures for OCD? Introduction to the special issue on theory-based exposure process. *Journal of Obsessive-Compulsive and Related Disorders, 6,* 144–146. http://dx.doi.org/10.1016/j.jocrd.2014.12.003

Connolly, S. D., Bernstein, G. A., & The Work Group on Quality Issues. (2007). Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders. *Journal of the American Academy of Child & Adolescent Psychiatry, 46,* 267–283. http://dx.doi.org/10.1097/01.chi.0000246070.23695.06

Craske, M. G., Kircanski, K., Zelikowsky, M., Mystkowski, J., Chowdhury, N., & Baker, A. (2008). Optimizing inhibitory learning during exposure therapy. *Behaviour Research and Therapy, 46,* 5–27. http://dx.doi.org/10.1016/j.brat.2007.10.003

Craske, M. G., Liao, B., Brown, L., & Vervliet, B. (2012). The role of inhibition in exposure therapy. *Journal of Experimental Psychopathology, 3,* 322–345. http://dx.doi.org/10.5127/jep.026511

Craske, M. G., Niles, A. N., Burklund, L. J., Wolitzky-Taylor, K. B., Vilardaga, J. C. P., Arch, J. J., . . . Lieberman, M. D. (2014). Randomized controlled trial of cognitive behavioral therapy and acceptance and commitment therapy for social phobia: Outcomes and moderators. *Journal of Consulting and Clinical Psychology, 82,* 1034–1048. http://dx.doi.org/10.1037/a0037212

Deacon, B. J., Lickel, J. J., Farrell, N. R., Kemp, J. J., & Hipol, L. J. (2013). Therapist perceptions and delivery of interoceptive exposure for panic disorder. *Journal of Anxiety Disorders, 27,* 259–264. http://dx.doi.org/10.1016/j.janxdis.2013.02.004

Emmelkamp, P. M., & Beens, H. (1991). Cognitive therapy with obsessive-compulsive disorder: A comparative evaluation. *Behaviour Research and Therapy, 29,* 293–300. http://dx.doi.org/10.1016/0005-7967(91)90120-R

Foa, E. B., Dancu, C. V., Hembree, E. A., Jaycox, L. H., Meadows, E. A., & Street, G. P. (1999). A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology, 67,* 194–200. http://dx.doi.org/10.1037/0022-006X.67.2.194

Foa, E. B., Hembree, E. A., Cahill, S. P., Rauch, S. A., Riggs, D. S., Feeny, N. C., & Yadin, E. (2005). Randomized trial of prolonged exposure for posttraumatic stress disorder with and without cognitive restructuring: Outcome at academic and community clinics. *Journal of Consulting and Clinical Psychology, 73,* 953–964. http://dx.doi.org/10.1037/0022-006X.73.5.953

Franklin, M. E., Sapyta, J., Freeman, J. B., Khanna, M., Compton, S., Almirall, D., . . . March, J. S. (2011). Cognitive behavior therapy augmentation of pharmacotherapy in pediatric obsessive-compulsive disorder: The Pediatric OCD Treatment Study II (POTS II) randomized controlled trial. *JAMA: Journal of the American Medical Association, 306,* 1224–1232. http://dx.doi.org/10.1001/jama.2011.1344

Freeman, J., Garcia, A., Benito, K., Conelea, C., Sapyta, J., Khanna, M., . . . Franklin, M. (2012). The Pediatric Obsessive Compulsive Disorder Treatment Study for Young Children (POTS jr): Developmental considerations in the rationale, design, and methods. *Journal of Obsessive-Compulsive and Related Disorders, 1,* 294–300. http://dx.doi.org/10.1016/j.jocrd.2012.07.010

Freeman, J., Sapyta, J., Garcia, A., Compton, S., Khanna, M., Flessner, C., . . . Franklin, M. (2014). Family-based treatment of early childhood obsessive-compulsive disorder: The Pediatric Obsessive-Compulsive Disorder Treatment Study for Young Children (POTS Jr)—A randomized clinical trial. *JAMA: Journal of the American Medical Association Psychiatry, 71,* 689–698.

Freiheit, S. R., Vye, C., Swan, R., & Cady, M. (2004). Cognitive-behavioral therapy for anxiety: Is dissemination working? *Behavior Therapist, 27,* 25–32.

Garland, A. F., Hurlburt, M. S., Brookman-Frazee, L., Taylor, R. M., & Accurso, E. C. (2010). Methodological challenges of characterizing usual care psychotherapeutic practice. *Administration and Policy in Mental Health and Mental Health Services Research, 37,* 208–220. http://dx.doi.org/10.1007/s10488-009-0237-8

Geller, D. A., March, J., & The AACAP Committee on Quality Issues (CQI). (2012). Practice parameter for the assessment and treatment of children and adolescents with obsessive-compulsive disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 51,* 98–113. http://dx.doi.org/10.1016/j.jaac.2011.09.019

Hipol, L. J., & Deacon, B. J. (2013). Dissemination of evidence-based practices for anxiety disorders in Wyoming: A survey of practicing psychotherapists. *Behavior Modification, 37,* 170–188. http://dx.doi.org/10.1177/0145445512458794

Kazdin, A. E., & Weisz, J. R. (1998). Identifying and developing empirically supported child and adolescent treatments. *Journal of Consulting and Clinical Psychology, 66,* 19–36. http://dx.doi.org/10.1037/0022-006X.66.1.19

Kendall, P. C. (1990). *Coping Cat manual*. Ardmore, PA: Workbook.

Kendall, P. C. (1994). Treating anxiety disorders in children: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 62,* 100–110. http://dx.doi.org/10.1037/0022-006X.62.1.100

Kendall, P. C., Flannery-Schroeder, E., Panichelli-Mindel, S. M., Southam-Gerow, M., Henin, A., & Warman, M. (1997). Therapy for youths with anxiety disorders: A second randomized clinical trial. *Journal of Consulting and Clinical Psychology, 65,* 366–380. http://dx.doi.org/10.1037/0022-006X.65.3.366

Kendall, P. C., & Hedtke, K. A. (2006a). *Cognitive-behavioral therapy for anxious children: Therapist manual* (3rd ed.). Ardmore, PA: Workbook.

Kendall, P. C., & Hedtke, K. A. (2006b). *The Coping Cat workbook* (2nd ed.). Ardmore, PA: Workbook.

Kendall, P. C., Hudson, J. L., Gosch, E., Flannery-Schroeder, E., & Suveg, C. (2008). Cognitive-behavioral therapy for anxiety disordered youth: A randomized clinical trial evaluating child and family modalities. *Journal*

of Consulting and Clinical Psychology, 76, 282–297. http://dx.doi.org/10.1037/0022-006X.76.2.282

Kendall, P. C., Robin, J. A., Hedtke, K. A., Suveg, C., Flannery-Schroeder, E., & Gosch, E. (2005). Considering CBT with anxious youth? Think exposures. *Cognitive and Behavioral Practice, 12,* 136–148. http://dx.doi.org/10.1016/S1077-7229(05)80048-3

Lang, A. J., & Craske, M. G. (2000). Manipulations of exposure-based therapy to reduce return of fear: A replication. *Behaviour Research and Therapy, 38,* 1–12. http://dx.doi.org/10.1016/S0005-7967(99)00031-5

Ollendick, T. H. (1995). Cognitive behavioral treatment of panic disorder with agoraphobia in adolescents: A multiple baseline design analysis. *Behavior Therapy, 26,* 517–531. http://dx.doi.org/10.1016/S0005-7894(05)80098-X

Ollendick, T. H., Hagopian, L. P., & Huntzinger, R. M. (1991). Cognitive-behavior therapy with nighttime fearful children. *Journal of Behavior Therapy and Experimental Psychiatry, 22,* 113–121. http://dx.doi.org/10.1016/0005-7916(91)90006-Q

Ollendick, T. H., Öst, L.-G., Reuterskiöld, L., Costa, N., Cederlund, R., Sirbu, C., . . . Jarrett, M. A. (2009). One-session treatment of specific phobias in youth: A randomized clinical trial in the United States and Sweden. *Journal of Consulting and Clinical Psychology, 77,* 504–516. http://dx.doi.org/10.1037/a0015158

Pediatric OCD Treatment Study (POTS) Team. (2004). Cognitive-behavior therapy, sertraline, and their combination for children and adolescents with obsessive-compulsive disorder: The Pediatric OCD Treatment Study (POTS) randomized controlled trial. *JAMA: Journal of the American Medical Association, 292,* 1969–1976. http://dx.doi.org/10.1001/jama.292.16.1969

Rowe, M. K., & Craske, M. G. (1998). Effects of varied-stimulus exposure training on fear reduction and return of fear. *Behaviour Research and Therapy, 36,* 719–734. http://dx.doi.org/10.1016/S0005-7967(97)10017-1

Scherr, S. R., Herbert, J. D., & Forman, E. M. (2015). The role of therapist experiential avoidance in predicting therapist preference for exposure treatment for OCD. *Journal of Contextual Behavioral Science, 4,* 21–29. http://dx.doi.org/10.1016/j.jcbs.2014.12.002

Sholomskas, D. E., Syracuse-Siewert, G., Rounsaville, B. J., Ball, S. A., Nuro, K. F., & Carroll, K. M. (2005). We don't train in vain: A dissemination trial of three strategies of training clinicians in cognitive-behavioral therapy. *Journal of Consulting and Clinical Psychology, 73,* 106–115. http://dx.doi.org/10.1037/0022-006X.73.1.106

Stein, M. B., Roy-Byrne, P. P., Craske, M. G., Campbell-Sills, L., Lang, A. J., Golinelli, D., . . . Sherbourne, C. D. (2011). Quality of and patient satisfaction with primary health care for anxiety disorders. *Journal of Clinical Psychiatry, 72,* 970–976. http://dx.doi.org/10.4088/JCP.09m05626blu

Stein, M. B., Sherbourne, C. D., Craske, M. G., Means-Christensen, A., Bystritsky, A., Katon, W., . . . Roy-Byrne, P. P. (2004). Quality of care for primary care patients with anxiety disorders. *American Journal of Psychiatry, 161,* 2230–2237. http://dx.doi.org/10.1176/appi.ajp.161.12.2230

Twohig, M. P., Abramowitz, J. S., Bluett, E. J., Fabricant, L. E., Jacoby, R. J., Morrison, K. L., . . . Smith, B. M. (2015). Exposure therapy for OCD from an acceptance and commitment therapy (ACT) framework. *Journal of Obsessive-Compulsive and Related Disorders, 6,* 167–173. http://dx.doi.org/10.1016/j.jocrd.2014.12.007

Van Oppen, P., De Haan, E., Van Balkom, A. J., Spinhoven, P., Hoogduin, K., & Van Dyck, R. (1995). Cognitive therapy and exposure in vivo in the treatment of obsessive compulsive disorder. *Behaviour Research and Therapy, 33,* 379–390. http://dx.doi.org/10.1016/0005-7967(94)00052-L

Vande Voort, J. L., Svecova, J., Jacobson, A. B., & Whiteside, S. P. (2010). A retrospective examination of the similarity between clinical practice and manualized treatment for childhood anxiety disorders. *Cognitive and Behavioral Practice, 17,* 322–328. http://dx.doi.org/10.1016/j.cbpra.2009.12.002

Vervliet, B., Craske, M. G., & Hermans, D. (2013). Fear extinction and relapse: State of the art. *Annual Review of Clinical Psychology, 9,* 215–248. http://dx.doi.org/10.1146/annurev-clinpsy-050212-185542

Watson, H. J., & Rees, C. S. (2008). Meta-analysis of randomized, controlled treatment trials for pediatric obsessive-compulsive disorder. *Journal of Child Psychology and Psychiatry, 49,* 489–498. http://dx.doi.org/10.1111/j.1469-7610.2007.01875.x

Whiteside, S. P., Ale, C. M., Young, B., Dammann, J. E., Tiede, M. S., & Biggs, B. K. (2015). The feasibility of improving CBT for childhood anxiety disorders through a dismantling study. *Behaviour Research and Therapy, 73,* 83–89. http://dx.doi.org/10.1016/j.brat.2015.07.011

Wilhelm, S., Steketee, G., Fama, J. M., Buhlmann, U., Teachman, B. A., & Golan, E. (2009). Modular cognitive therapy for obsessive–compulsive disorder: A wait-list controlled trial. *Journal of Cognitive Psychotherapy, 23,* 294–305. http://dx.doi.org/10.1891/0889-8391.23.4.294

Wilhelm, S., Steketee, G., Reilly-Harrington, N. A., Deckersbach, T., Buhlmann, U., & Baer, L. (2005). Effectiveness of cognitive therapy for obsessive-compulsive disorder: An open trial. *Journal of Cognitive Psychotherapy, 19,* 173–179. http://dx.doi.org/10.1891/jcop.19.2.173.66792

Wolitzky-Taylor, K., Zimmermann, M., Arch, J. J., De Guzman, E., & Lagomasino, I. (2015). Has evidence-based psychosocial treatment for anxiety disorders permeated usual care in community mental health settings? *Behaviour Research and Therapy, 72,* 9–17. http://dx.doi.org/10.1016/j.brat.2015.06.010

Young, A. S., Klap, R., Sherbourne, C. D., & Wells, K. B. (2001). The quality of care for depressive and anxiety disorders in the United States. *Archives of General Psychiatry, 58,* 55–61. http://dx.doi.org/10.1001/archpsyc.58.1.55

Young, A. S., Klap, R., Shoai, R., & Wells, K. B. (2008). Persistent depression and anxiety in the United States: Prevalence and quality of care. *Psychiatric Services, 59,* 1391–1398. http://dx.doi.org/10.1176/ps.2008.59.12.1391

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