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# **Dissemination of Exposure Therapy and Factors Associated with Mental Health Professionals' Use of Exposure Therapy in Norway**

Graduate thesis in the Clinical Programme in Psychology  
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Trondheim, December 2018

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## Preface

This project was conducted between January and December 2018, and represents our graduate thesis for the Clinical Programme in Psychology at the Norwegian University of Science and Technology. We were curious to investigate the dissemination of exposure therapy after a compelling lecture held by our supervisor Leif Edward Ottesen Kennair. With valuable help from both our supervisor and Kyrre Svarva we developed an online survey in the beginning of 2018, and collected our data from April to August 2018. We have contributed equally to all parts of the project. We have collaborated in every step of the process, including initial preparations, development and distribution of the survey, data analysis, and writing this dissertation. The process has been fascinating, challenging and incredibly educating. This experience has taught us a great deal of the do's and don't's when developing a survey, and allowed us to refresh our knowledge of statistics and use of SPSS. Moreover, throughout this process we have become increasingly motivated to publish these findings as a scientific article and are determined to accomplish this goal.

We contacted every district psychiatric centre (Distrikt psykiatrisk senter) and child and adolescent speciality mental health service (Barne- og ungdomspsykiatrisk poliklinikk) in Norway, as well as numerous other private and public mental health providers—amounting to around 200 mental health providers in total. This process was time consuming and required continuous follow-up from us. We appreciate everyone who helped us distribute the survey and everyone who agreed to partake in our project, especially those who lent us their enthusiasm and support. We would like to thank Kyrre Svarva and Mons Bendixen for their help throughout this project. Additionally, we would like to extend our gratitude to Brett J. Deacon for enthusiastically allowing us to use and translate his version of the Therapist Beliefs about Exposure Scale. We would especially like to express our gratitude to our supervisor Leif Edward Ottesen Kennair for his superb guidance, availability, support and patience. He has been as enthusiastic about this project as we have. Finally, we would like to thank each other for such a great partnership and the mutual effort we have committed to this project.

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## Table of Contents

Preface.....	i
Abstract.....	v
Introduction.....	1
Clinical Guidelines.....	2
Lack of Dissemination of Exposure Therapy .....	2
Barriers to the Dissemination of Exposure Therapy.....	3
Ethical Considerations .....	6
Current Study: Aims, Hypothesis and Predictions .....	7
Method .....	11
Procedure .....	11
Participants.....	11
Measures .....	12
Data Analysis .....	16
Results.....	18
Use of Exposure Therapy and Core Exposure Techniques .....	18
Negative Beliefs about Exposure.....	26
Discussion.....	31
Use of Exposure Therapy and Core Exposure Techniques .....	31
Negative Beliefs about Exposure.....	36
Limitations and Future Research .....	40
Practical Implications.....	42
Conclusion .....	43
References.....	44
Appendix.....	53



Abstract

Despite the large body of empirical evidence supporting the efficacy of exposure therapy for anxiety disorders, several studies have found that few therapists actually use exposure therapy when treating patients with anxiety disorders. The aim of the present study was to investigate the dissemination of exposure therapy and factors associated with mental health professionals' use of exposure therapy in Norway. A sample of 419 Norwegian mental health professionals from various professional backgrounds completed an online survey about their use of therapeutic approaches when treating clients with specific phobias, panic disorder, agoraphobia, social phobia, obsessive-compulsive disorder or post-traumatic stress disorder; during the last six months. The survey also included questions about use of specific core exposure techniques and factors hypothesised to influence use of exposure therapy. The majority of participants reported using exposure therapy often, however less than one third reported using core exposure techniques such as habituation and behavioural experiments. Endorsing a cognitive, behavioural and/or metacognitive orientation and acquired knowledge about exposure therapy were the most important predictors of more use of core exposure techniques. While the most important predictor of less use of core exposure techniques was endorsement of perceived contraindications for use of exposure therapy. The results suggest that the majority of Norwegian mental health professionals may appear to provide exposure therapy in a manner that is insufficient. Implications for the clinical training of therapists and the educational programmes for clinical psychologists in Norway are discussed.





## Introduction

Anxiety disorders, including panic disorder, social phobia, agoraphobia, specific phobia, obsessive-compulsive disorder, and post-traumatic stress disorder are ranked as the most common mental health issues globally (World Health Organization, 2017). A recent systematic review of 87 prevalence studies across 44 countries found that at any given time one in 14 people around the world has an anxiety disorder and that one in nine people will experience an anxiety disorder in a given year (Baxter, Scott, Vos, & Whiteford, 2013). Anxiety disorders have a life-time prevalence of nearly 30%, they typically debut at an early age (as early as six years old; Merikangas et al., 2010) and the course is often chronic-recurrent (Kessler, Ruscio, Shear, & Wittchen, 2010).

Cognitive behavioural therapy (CBT) is considered the preferred evidence-based treatment for anxiety disorders as supported by several large scale meta-analyses (Carpenter et al., 2018; Deacon & Abramowitz, 2004; Olatunji, Cisler, & Deacon, 2010; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010; Stewart & Chambless, 2009). CBT has also demonstrated favourable long-term outcomes for anxiety disorders in adults and youths in effectiveness studies where treatment was delivered in community settings, emphasising that CBT is beneficial outside of efficacy trials (DiMauro, Domingues, Fernandez, & Tolin, 2013; Kodal et al., 2018). CBT for anxiety disorders aims to alter maladaptive beliefs about the likelihood and true cost of anticipated harms by utilising various cognitive (e.g. cognitive restructuring) and behavioural (e.g. exposure) techniques (Wells, 1997). Meta-analytical findings highlight the latter, positing that behavioural interventions, particularly exposure, constitute a critical ingredient in the treatment of anxiety disorders (Deacon & Abramowitz, 2004). When referring to CBT's effectiveness in the treatment of anxiety disorders, exposure techniques are found to be the key catalyst for the reduction of anxiety (Craske et al., 2009; Peterman, Read, Wei, & Kendall, 2015) and allotting a large proportion of treatment sessions to exposure has been associated with greater improvement in treatment outcomes (Solem, Hansen, Vogel, & Kennair, 2009). Correspondingly, a novel meta-analysis found larger effect sizes for CBT treatments using primarily exposure techniques than those including both cognitive and exposure techniques, and only cognitive techniques (Carpenter et al., 2018). Parallel to this clinical research there exists a theoretical debate about how to classify exposure in the CBT framework, namely if exposure can be said to be purely behavioural when it can be understood as a cognitive intervention (e.g. through testing appraisals) with behavioural consequences (i.e., habituation). However, while such theoretical inquiries and research can offer explanations about how and why exposure works and instigate ways to

improve treatment, it is the effectiveness of exposure in the treatment of anxiety disorders that sets the framework for the current study.

CBT aimed towards anxiety disorders is often termed exposure-based cognitive behavioural therapy or exposure therapy (ET) due to the importance of exposure techniques in reducing anxiety (Meyer, Farrell, Kemp, Blakey, & Deacon, 2014). ET aims to reduce anxiety through new learning experiences that modify pathological cognitive fear structures. Exposure is proposed to alter pathological cognitive fear structures by first activating these structures and providing new information that disconfirms the unrealistic associations in the structures (e.g., not checking the oven will not lead to the house burning down) (Kaczurkin & Foa, 2015). Exposure can take several forms including exposure in vivo (i.e., exposure to objects, people, places or situations), imaginal (i.e., exposure to mental images, thoughts or memories) or interoceptive exposure (i.e. exposure to physical sensations). Furthermore, behavioural experiments can also be viewed as an exposure intervention (Kaczurkin & Foa, 2015).

### **Clinical Guidelines**

In line with the substantial support for the use of ET, several national guidelines for clinical practice recommend ET as the treatment of choice for anxiety disorders, including the American (American Psychological Association [APA] 2011), the British (National Institute for Clinical Excellence, 2011), the Danish (Sundhedsstyrelsen, 2007) and the Swedish (Socialstyrelsen, 2017) guidelines. Furthermore, the reference guide BMJ Best Practice recommends ET for panic disorder and agoraphobia (Sawchuk & Veitengruber, 2017), social phobia (Sawchuk, Veitengruber, Olatunji, & Welch, 2017), specific phobia (Freidl & Zakarin, 2017), obsessive-compulsive disorder (OCD; Seibell, Pallanti, Bernardi, Hughes-Feltenberger, & Hollander, 2017), and post-traumatic stress disorder (PTSD; Zammit, Hoskins, & Lewis, 2017). The Norwegian Directorate of Health advises clinicians to follow the Swedish, Danish, American and British guidelines, as well as the guidelines set by BMJ Best Practice, as the Norwegian guidelines for treatment of anxiety disorders have not been updated since 2000 (K. I. Gravbrøt, Senior Advisor, Dept. of Mental Health and Substance Abuse, Norwegian Directory of Health, February 13th 2018, personal communication; Helsebiblioteket, 2013; Helsetilsynet, 2000).

### **Lack of Dissemination of Exposure Therapy**

Despite the empirical support for ET, several studies find that few therapists use ET when treating patients with an anxiety disorder. To illustrate this, an American study found that only 17% of therapists used exposure in the treatment of PTSD (Becker, Zayfert, &

## DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

Anderson, 2004). Van Minnen, Hendriks, and Olf (2010) mirrored these findings when they surveyed 250 trauma experts in Belgium and the Netherlands and found ET to be the least utilised treatment method. The lack of dissemination of ET is not limited to PTSD: Hipol and Deacon (2013) found that ET was used by less than 30% of therapists when treating patients with PTSD, OCD, social phobia, and panic disorder. Similarly, a study surveying 684 behavioural therapists in Germany found that therapists included exposure in slightly less than half (46.8%) of their treatments when treating patients where the principal diagnosis was an anxiety disorder (Pittig & Hoyer, 2017). Additionally, Freiheit, Vye, Swan, and Cady (2004) found that therapists who reported using CBT in treatment of patients with OCD, panic disorder, and social phobia rarely utilised therapist-assisted in-vivo, imaginal, or interoceptive exposure. Similar findings have been reported for the treatment of anxiety in children: Whiteside, Deacon, Benito, and Stewart (2016) found that only 40% of therapists reported using exposure techniques when treating anxiety disorders in children. Böhm, Förstner, Külz, and Voderholzer (2008) interviewed patients with OCD and found that, from the patient's perspective, only 16.2 % reported that exposure had been included in prior treatment. Additionally, only 19% recalled creating a hierarchical list of their OCD-symptoms—which is considered a standard component in ET (Forsyth, Barrios, & Acheson, 2007).

### **Barriers to the Dissemination of Exposure Therapy**

In the past 10-15 years there has been an increased attention on factors associated with the implementation of ET when treating anxiety disorders to investigate its use or lack thereof (Deacon & Farrell, 2013). Specifically, studies have sought out potential barriers to the dissemination of ET. Research on barriers to the dissemination of ET has widely focused on aspects associated with therapists (Deacon & Farrell, 2013), while few studies have included factors related to the workplace and/or patients. Harned, Dimeff, Woodcock, and Contreras (2013) found that factors related to the therapist were the primary barriers to the utilisation of ET, while patient-related or organisational factors (e.g., therapists' self-reports on the practicability of ET in the work place) acted as barriers to a lesser extent.

**Profession and higher degree level.** Studies have found that therapists with a higher degree level (i.e., PhD psychologists) provide ET and endorse exposure techniques to a greater extent than therapists with shorter degrees, that is master's degree licenced counsellors, marriage and family therapists, and social workers (Harned et al., 2013; Whiteside et al., 2016).

**Theoretical orientation.** Studies have demonstrated mixed findings concerning the association between therapists' theoretical orientation and use of ET. Harned et al. (2013) found no association between a cognitive and/or behavioural orientation and use of exposure. However, Whiteside et al. (2016) found that therapists who identified as purely CBT-therapists or endorsed CBT as well as another perspective used exposure techniques more often than therapists who endorsed another theoretical orientation(s), with pure CBT-therapists ranking highest.

**Experience and training.** There is some disagreement on whether experience and training in ET is associated with greater use of ET. Some studies find that therapists who have more experience and training in treating anxiety disorders with ET use exposure more frequently (Sholomskas et al., 2005; van Minnen et al., 2010). Additionally, studies have found that therapists who received training in exposure during their initial qualification use exposure more frequently when treating anxiety disorders in routine care (Broicher, Gerlach, & Neudeck, 2017; Pittig & Hoyer, 2017). However, another study found that less than half of therapists with training in ET for PTSD reported using imaginal exposure to treat at least half of their PTSD patients, and nearly one third of therapists reported that they never use imaginal exposure (Becker et al., 2004).

**Negative beliefs about exposure.** In recent years, negative beliefs and attitudes towards exposure have been identified as a significant barrier to the dissemination of ET (Olatunji, Deacon, & Abramowitz, 2009). Negative beliefs include beliefs that exposure will cause symptom exacerbation (Olatunji et al., 2009), harm to the patient or increased risk of litigation (Richard & Gloster, 2007), or drop-out (van Minnen et al., 2010). Due to its deliberate provocation of anxiety, ET can be perceived as inherently unethical (Deacon & Farrell, 2013). In a similar vein, studies have demonstrated that therapists view exposure as unbearable to the patient (Feeny, Hembree, & Zoellner, 2003), solely applicable in research settings and ineffective in routine care (Becker et al., 2004). Meyer et al. (2014) found that therapists exclude patients from ET based on patient characteristics that do not reliably predict negative outcomes from ET. For instance, Meyer et al. (2014) found that the most commonly endorsed reason for excluding a patient from ET was a comorbid psychotic disorder. However, several studies have found that patients with schizophrenia benefit from ET to treat social phobia (Halperin, Nathan, Drummond, & Castle, 2000; Kingsep, Nathan, & Castle, 2003), and PTSD (Christopher Frueh et al., 2009). In addition, perceived contraindication have been associated with less use of ET (Meyer et al., 2014; Becker et al., 2004). Deacon, Farrell, et al. (2013) surveyed 637 therapists and found that the average therapist had a

moderate degree of negative beliefs about ET. In the same study, several demographic variables were associated with negative beliefs: age was positively correlated to negative beliefs; women tended to endorse negative beliefs to a greater extent compared to men; therapists with a PhD reported significantly less endorsement, so did self-described anxiety specialists; and clinical psychologists reported significantly less endorsement compared to counselling psychologists, social workers, counsellors, marriage and family therapists and pastoral counsellors. Waller, D'Souza Walsh, and Wright (2016) also found that clinical psychologists endorsed less negative beliefs than other professions, specifically psychiatrists, nurses, and social workers. Additionally, recent studies have found that training in ET reduces negative beliefs about exposure (Farrell, Deacon, Dixon, et al., 2013; Farrell et al., 2016; Harned, Dimeff, Woodcock, & Skutch, 2011).

Negative beliefs have been associated with administering exposure in an overly cautious manner, causing sub-optimal delivery (Deacon, Farrell, et al., 2013; Harned et al., 2013; Whiteside et al., 2016). Deacon, Farrell, et al. (2013) found that even therapists who identified themselves as exposure therapists held negative beliefs about ET and, in turn, were more cautious in its delivery. Specifically, Harned et al. (2013) found that negative attitudes towards exposure predicted therapists reassuring their clients of safety during the exposure task, terminating the exposure task prematurely and ineffectively addressing patients' avoidance behaviour. Whiteside et al. (2016) found that therapists who were concerned about the potential harm induced by exposure were more likely to emphasise breathing techniques when delivering exposure tasks to patients with panic disorder. In their experimental study Farrell, Deacon, Kemp, Dixon and Sy (2013) found that participants who had received basic training in ET followed by information containing negative beliefs about exposure were overall more cautious in their delivery than those who had received training with information containing positive beliefs. They created a less ambitious exposure hierarchy, selected a less anxiety-provoking task, and attempted to minimise client anxiety during exposure. How therapists deliver ET is considered to play a critical role in treatment outcome (Farrell, Deacon, Dixon, & Lickel, 2013) and a less intense and client self-directed delivery attenuates its effectiveness (Blakey & Abramowitz, 2016; Deacon, Kemp, et al., 2013).

**Sensitivity to distress.** As exposure engages the therapist to actively provoke anxiety and distress within their patient, it is considered fundamental that therapists are able to tolerate their own distress during exposure (Deacon & Farrell, 2013). Subsequently, therapists' sensitivity to distress, own anxieties and insecurities in tolerating their patient's distress has been found to impede the use of exposure in routine care (Levita, Duhne, Girling,

& Waller, 2016; Schare & Wyatt, 2013). Anxiety sensitivity has also been found to be associated with negative beliefs about exposure (Deacon, Farrell, et al., 2013).

Schumacher et al. (2014) measured the physiological stress levels in both patients and novice therapists, during and after exposure sessions. They found that patients and therapists experience similar levels of distress. Schumacher et al. (2015) replicated these findings with experienced therapists. However, in both studies, stress response was not associated with the patients' nor therapists' satisfaction with the exposure session; indicating that therapist's physiological stress in itself does not cause inadequate exposure (Schumacher et al., 2014; Schumacher et al., 2015). Scherr, Herbert, and Forman (2015) introduced the concept of "experiential avoidance": Under use of exposure is "related to therapist discomfort with and avoidance of the temporary increase in distress that patients often experience during exposure therapy, and the secondary distress that this may cause in therapists themselves" (p. 21). Notably, experiential avoidance encompasses therapists' and patients' distress, and how therapists seek to minimise or avoid both. Scherr et al. (2015) found that therapists high on experiential avoidance allotted less time to exposure in sessions. Summarised, sensitivity to distress appears to be a considerable barrier to the dissemination of exposure by instigating avoidance towards (optimal) exposure and reinforcing negative beliefs about exposure.

### **Ethical Considerations**

Both the APA and the Norwegian Psychological Association (Norsk psykologforening; NPF) stress the importance of evidence-based practice in psychology, defined as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2006, p. 273). The "Policy Statement on Evidence Based Practice in Psychology" approved by the APA in 2005 and adopted by the NPF in 2007 states that "EBPP promotes effective psychological practice and enhances public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention" (APA, 2006, p. 271). The importance of evidence-based practice is also emphasised by the Norwegian government as health professionals in Norway are obligated by law to document if they use treatment interventions that are not in line with treatment guidelines (Forskrift om pasientjournal, 2000), which all follow the principle of evidence-based practice (Helsedirektoratet, 2012).

The policy statement also notes that an essential aspect of clinical expertise is a scientific attitude towards clinical work by integrating the best research evidence in order to provide services that have a high probability of achieving the goals of treatment. A scientific

attitude is characterised by “openness to data, clinical hypothesis generation and testing, and a capacity to use theory to guide interventions without allowing theoretical preconceptions to override clinical or research data” (APA, 2011, p. 277). The use of scientific research in clinical practice has been addressed in recent research. Cook, Biyanova, Elhai, Schnurr, & Coyne (2010) surveyed 2607 therapists in Canada and the U.S. regarding what influenced their clinical practice and found that significant mentors, books, training in graduate school, and informal discussions with colleagues were the most highly endorsed influences on current practice, while empirical evidence had little influence. Similarly, Gyani, Shafran, Myles, and Rose (2014) surveyed 736 therapists in the UK and found that research had little influence on therapists’ clinical decision-making and theoretical orientation compared to other factors (e.g., clinical experience and supervisors). Therefore, excluding patients from ET based on assumptions that have little empirical support or opting out of ET in favour of less evidence-based methods due to therapists’ individual barriers may imply a disregard to the policy statement. Moreover, it nuances the lack of dissemination of ET as an ethical issue: Are we not doing our patients a considerable disservice when we withhold them from the most effective treatment method?

### **Current Study: Aims, Hypothesis and Predictions**

In light of past research, the aim of the current study was to investigate the dissemination of ET in Norway. To our knowledge, no previous research has explored the dissemination of ET among Norwegian mental health professionals. In line with the overall aim of the current study, we intended to investigate the following research questions: (1) What treatment methods do Norwegian mental health professionals use in the treatment of anxiety disorders (i.e., panic disorder, social phobia, agoraphobia, specific phobia, obsessive-compulsive disorder, and post-traumatic stress disorder), and (2) what influences the use of ET among Norwegian mental health professionals in the treatment of anxiety disorders? When examining use of ET, the authors also wished to examine potential group differences. Additionally, seeing as negative beliefs have been highlighted in recent research, the current study also aimed to examine potential group differences in negative beliefs and factors that may influence negative beliefs. Hypotheses and predictions are listed below: These were formulated on a theoretical or empirical basis. For topics where there does not exist sufficient theoretical or empirical information we composed specific research questions.

**Use of exposure therapy and core exposure techniques.** Seeing as core exposure techniques are inherently a large part of conducting ET, we expected the following:

## DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

H1a. Frequency of use of ET and frequency of use of core exposure techniques will be highly positively associated.

H1b. Predictors of frequency of use of ET will also predict frequency of use of core exposure techniques.

### **Group differences in frequency of use of exposure therapy.**

H2a. Anxiety specialists will report more frequent use of ET compared to participants who are not anxiety specialists.

H2b. Clinical psychologists will report more frequent use of ET compared to other professions.

H2c. Participants who primarily work in the public health sector will report more frequent use of ET compared to participants who primarily work in a private practice.

We expect that anxiety specialists will report greater use of ET based on the aforementioned studies by Becker et al. (2004) and Hippol and Deacon (2013). The regional public health sector in Norway includes specialised OCD-treatment units where treatment is provided by professionals with extensive training in treating OCD (Helsedirektoratet, 2015, March 12). In the current study we viewed participants with current or previous experience in such units as anxiety specialists. The hypothesis regarding professions is based on above-mentioned studies (Harned et al., 2013; Whiteside et al., 2016). Additionally, the hypothesis regarding therapists in the public health sector was based on the study by Gyani et al. (2014), that found that therapists working in the public health sector in the UK were more likely to use empirical evidence when making clinical decisions.

***Exploratory research questions.*** We wanted to investigate differences between clinical psychologists in Norway. Previous research has not compared therapists who work with children and adolescents with therapists who work with adults in regard to use of ET.

Thus, we wanted to investigate whether there was a significant difference between:

RQ1. Clinical psychologists based on where they received their degree (i.e., either Trondheim, Oslo, Tromsø, Bergen, or abroad) in reported frequency of use of ET?

RQ2. Participants who work primarily with adults and participants who primarily work with children and adolescents in reported frequency of use of ET?

### **Predictors of frequency of use of exposure therapy.**

H3. Factors that are expected to predict more frequent use of ET: (a) having a clinical or psychiatric specialisation (i.e., higher degree level), (b) larger degree of cognitive, behavioural and/or metacognitive theoretical orientation, (c) greater competence in ET, and (d) greater number of anxiety patients in routine care.



H4. Factors that are expected to predict lower reported frequency of use of ET: (a) greater endorsement of negative beliefs about exposure, (b) greater endorsement of perceived contraindications, and (c) higher sensitivity to distress within the therapeutic context.

Hypotheses concerning predictors of use of ET was based on aforementioned research regarding higher degree level (Harned et al., 2013; Whiteside et al., 2016), theoretical orientation (Whiteside et al., 2016), negative beliefs about exposure (Deacon, Farrell, et al., 2013; Farrell et al., 2016; Harned et al., 2013; Meyer et al., 2014; Olatunji et al., 2009; Whiteside et al., 2016), perceived contraindications (Becker et al., 2004; Meyer et al., 2014), sensitivity to distress (Harned et al., 2013; Levita et al., 2016; Schare & Wyatt, 2013; Scherr et al., 2015), and experience and training in exposure (Broicher et al., 2017; Pittig & Hoyer, 2017; Sholomskas et al., 2005; van Minnen et al., 2010). As one study found that a higher implementation climate (i.e., employees' shared perceptions that the adoption, implementation, and use of evidence based treatments is expected, rewarded, and supported by the organization) was associated with increased use of exposure (Becker-Haimes et al., 2017), we chose to include experience and training in ET, as well as the implementation climate, in our conceptualisation of competence. With regard to higher degree level, we considered a formal specialisation to reflect a higher degree level. We expected that a greater number of anxiety patients would positively predict use of ET based on the study by Becker et al. (2004), which found that therapists who had treated a large number of patients with PTSD endorsed greater use of ET compared to therapists who had treated less patients with PTSD.

### **Group differences in negative beliefs about exposure.**

H5a. Women will report greater endorsement of negative beliefs about exposure therapy compared to men.

H5b. Clinical psychologists will report lower endorsement of negative beliefs compared to other professions.

H5c. Anxiety specialists will report lower endorsement of negative beliefs compared to participants who are not anxiety specialists.

H5d. Participants who primarily work in the public health sector will report lower endorsement of negative beliefs about exposure compared to private practitioners.

Hypotheses concerning gender, professions and anxiety specialists are based on research by Deacon, Farrell, et al. (2013) and Waller et al. (2016), as outlined previously. Additionally, we expected therapists in the public health sector to report less negative beliefs about exposure based on the study by Gyani et al. (2014) which indicated that therapists in the public health sector had a more positive attitude toward research.

**Exploratory research questions.** As was the case with use of ET, we wanted to investigate whether there was a significant difference between:

- RQ3. Clinical psychologists based on where they received their degree (i.e., either Trondheim, Oslo, Tromsø, Bergen, or abroad) in endorsement of negative beliefs?
- RQ4. Participants who work primarily with adults and participants who primarily work with children and adolescents in endorsement of negative beliefs?

**Predictors of negative beliefs about exposure.**

- H6. Factors that are hypothesised to predict greater endorsement of negative beliefs about exposure: (a) greater sensitivity to distress within the therapeutic context, (b) age, and (c) greater endorsement of perceived contraindications.
- H7. Factors that are hypothesised to predict lesser endorsement of negative beliefs about exposure: (a) having a clinical or psychiatric specialisation (i.e., higher degree level), (b) larger degree of cognitive, behavioural and/or metacognitive theoretical orientation, and (c) greater competence in ET.

The anticipated predictors of negative beliefs about exposure are based on aforementioned studies regarding age (Deacon, Farrell, et al., 2013), higher degree level (Deacon, Farrell, et al., 2013), anxiety sensitivity (Deacon, Farrell, et al., 2013), perceived contraindications (Meyer et al. 2014), and training and experience (i.e., competence; Farrell, Deacon, et al., 2013; Farrell et al., 2016; Harned et al., 2011). Previous research has not explicitly investigated whether CBT-theoretical orientation is associated with lower endorsement of negative beliefs about exposure, although Whiteside et al. (2016) found that use of non-CBT interventions (e.g., psychodynamic therapy) is associated with more negative beliefs about exposure and a non-CBT theoretical orientation. Nevertheless, we assumed that endorsing a CBT-theoretical orientation would theoretically imply less negative beliefs about exposure, seeing as ET is rooted in CBT.

**Exploratory research questions.** We have not found any studies investigating whether there is an association between the number of anxiety patients in therapist's clinical practice and negative beliefs about exposure. Thus, we ask:

- RQ5. Does the total proportion of anxiety patients in clinical practice predict endorsement of negative beliefs about exposure?

## Method

### Procedure

The project was approved by the Norwegian Centre for Research Data (ref.nr. 59967). An online survey assessing self-reported use of ET for anxiety disorders and various barriers hypothesised to impact the dissemination of ET (see appendix), was developed and sent to mental health professionals in Norway. In an attempt to obtain a diverse and nationally representative sample of Norwegian mental healthcare professionals, all district psychiatric centres (“Distrikt psykiatrisk senter”, DPS), and child and adolescent specialty mental health services (“Barne- og ungdomspsykiatrisk poliklinikk”, BUP) in Norway were contacted by phone or email by the authors. The aforementioned institutions were requested to distribute the online survey via email to all therapists in their workplace. Private practitioners were also included in the sample, they were found by web search and contacted by email. The online survey was also distributed through closed facebook groups for health professionals. All participants were informed that participation was voluntary, and that their responses would remain anonymous. The respondents did not receive any reward for their participation. Some participants requested to receive the results of the study, which the authors agreed to do.

### Participants

A total of 423 participants completed the online survey. Three participants were deleted from further analysis due to either not having a clinical position (e.g., secretary) or missing responses on nearly all items. One additional participant was removed due to inconsistency in answers and being a non-genuine outlier. The final sample consisted of 419 practitioners from numerous mental health professions who provide psychotherapy to clients in Norway. Mean age was 41.2 ( $SD = 10.94$ , range = 24-75). The majority of the participants were female ( $n = 283$ ; 67.5%), 32.0% ( $n = 134$ ) were male and 0.5% ( $n = 2$ ) chose the alternative “other opinion of gender”. The distribution of health professions was as follows: clinical psychologist ( $n = 302$ ; 72.1%), physician ( $n = 37$ ; 8.8%), nurse ( $n = 31$ ; 7.4%), social worker ( $n = 23$ ; 5.5%), pedagogue ( $n = 14$ ; 3.3%) and other ( $n = 12$ , 2.9%). A greater part of the participants had a clinical or psychiatric specialisation ( $n = 270$ ; 64.4%), while 32.7% ( $n = 137$ ) did not have a clinical or psychiatric specialisation, and 2.9% ( $n = 12$ ) were missing. Participants reported that they had been practicing as a therapist for an average of 10.23 years ( $SD = 8.44$ , range = 0-45). Of the 418 respondents who provided information about their primary patient group, the vast majority answered that they primarily had adult patients ( $n = 294$ , 70.3%). 29.2% ( $n = 122$ ) reported children and adolescents as their primary patient

## DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

group, while two respondents (0.5%) specified elderly as their primary patient group. Participants mostly worked in a public institution, hospital or medical centre ( $n = 401$ , 95.7%). A small minority were private practitioners ( $n = 14$ ; 3.3%), while three of the participants (.7%) worked in a private practice with a public contract license, and one participant (0.2%) was missing. Respondents were asked to rate which theoretical orientation was most characteristic of their therapeutic work, and the distribution was as follows: cognitive therapy ( $n = 122$ ; 29.1%), eclectic/integrative ( $n = 77$ ; 18.4%), psychodynamic therapy ( $n = 50$ ; 11.9%), metacognitive therapy ( $n = 35$ ; 8.4%), short-term psychodynamic psychotherapy ( $n = 29$ ; 6.9%), behavioural therapy ( $n = 23$ ; 5.5%), mentalisation-based therapy ( $n = 18$ ; 4.3%), emotion focused therapy ( $n = 17$ ; 4.1%), mindfulness-based therapy ( $n = 8$ ; 1.9%), psychoanalytic therapy ( $n = 6$ ; 1.4%), dialectic behavioural therapy ( $n = 5$ ; 1.2%), humanistic therapy ( $n = 4$ ; 1%), interpersonal therapy ( $n = 4$ ; 1%), eye movement and desensitisation and reprocessing (EMDR;  $n = 4$ ; 1%), schematic therapy ( $n = 3$ ; 0.7%), existential therapy ( $n = 1$ ; 0.2%), and other ( $n = 13$ , 3.1%). In addition, 416 participants provided information about which type of therapy they typically provide. Most respondents answered individual therapy ( $n = 377$ ; 90.6%), while 5.3% ( $n = 22$ ) said group therapy, 3.8% ( $n = 16$ ) said family therapy, and one (0.2%) participant answered couple's therapy.

### Measures

**Therapist Beliefs about Exposure Scale (TBES: Deacon, Farrell, Kemp, Dixon, Sy, Zhang & McGrath, 2013).** The TBES was used to assess therapists' negative beliefs about exposure. The TBES consists of 21 statements and respondents are asked to rate to what extent they agree with negative beliefs about exposure in regard to its ethicalness, tolerability, safety and effectiveness. Respondents rated on a 5-point scale ranging from 1 (Disagree strongly) to 5 (Agree strongly). Total scores range from 0 to 84; higher scores indicate greater endorsement of negative beliefs about exposure. Deacon, Farrell, et al. (2013) found that the TBES displayed a clear single-factor structure, normal distribution in a large and diverse sample of therapists, excellent internal consistency ( $\alpha = .95$ ), exceptionally high test-retest reliability after six months ( $r = .89$ ), and criterion validity (Deacon, Farrell, et al., 2013). The internal consistency in the current sample was excellent ( $\alpha = .89$ ). The TBES was administered with permission from Brett J. Deacon (personal communication via email, February 14th, 2018). We translated the original version to Norwegian (see appendix). Out of the 21 items in the scale, all but one retained their original meaning in the Norwegian translation. The item "Compared to other psychotherapies, exposure therapy increases the risk

that the therapist will be sued for malpractice” (Deacon, Farrell, et al., 2013, p. 775) was adjusted to better suit the Norwegian health care system as it is uncommon in Norway for patients to file a lawsuit if they feel they have received insufficient treatment or been victim to malpractice. In consequence, we adjusted the item to a culturally equivalent procedure, namely filing a formal complaint to the county governor (Norwegian: “fylkesmann”).

**Perceived Contraindications (PCI).** This measure is an altered version of The Broken Leg Exception Scale (BLES: Meyer, Farrell, Kemp, Blakey & Deacon, 2014). The authors altered the name of the scale in order maintain a clear distinction between the original Broken Leg Exception Scale and the altered version included in this study. The BLES was developed to assess various reasons why therapists might exclude certain patients from ET, and is based on the presumption that therapists opt out of ET due to an expectation that particular patient characteristics predict negative treatment outcome. The BLES contains 25 patient characteristics and respondents are asked to rate the likelihood of the therapist electing to not provide ET based on the respective characteristics. The respondents rate on a 4-point scale ranging from 0 (Very unlikely) to 3 (Very likely), with higher scores indicating greater likelihood to exclude patients with particular characteristics. The BLES demonstrated a normal distribution and excellent internal consistency ( $\alpha = .93$ ). Higher scores on the BLES were also associated with greater endorsement of negative beliefs about exposure, measured by the TBES (Meyer et al., 2014). Meyer et al. (2014) found that the most frequently endorsed reasons to exclude patients from ET were a patient’s comorbid psychotic disorder, emotional fragility, reluctance to participate in ET, and comorbid substance use disorder, respectively. In the current study we chose to only include these four items due to survey length limitations. We translated the items to Norwegian, and rephrased the instructions to ask respondents to rate the likelihood of whether they would provide ET to a patient with the respective characteristic. We chose to do so in order to clarify the instructions for the respondents by avoiding the use of double negatives as present in the original version. We reversed the scale to range from 0 (Very likely) to 3 (Very unlikely) so that higher sum scores reflect greater likelihood to exclude patients with particular characteristics, as was used by Meyer et al. (2014). Total scores for the adjusted scale range from 0 to 12. The adjusted scale demonstrated low internal consistency ( $\alpha = .62$ ), however mean inter-item correlation was .30.

**Sensitivity to Distress Scale (SENS).** Nine questions were constructed for measuring therapists’ sensitivity to distress within the therapeutic context. Our conceptualisation includes therapists’ avoidance of distress. Two aspects of sensitivity to distress were included: (1) avoiding talking about topics or doing things in sessions because it might distress the

patient and (2) avoiding talking about topics or doing things in sessions because it might distress the therapist. Respondents rated their level of sensitivity to distress by indicating to what degree a statement applied to them on a 5-point scale ranging by from 0 (Does not apply to me at all) to 4 (Applies to me very much). Higher scores reflect greater sensitivity to distress. The authors used the mean score as the total score for the scale, with a range from 0 to 4. Item number three and seven (see appendix) were excluded from the final scale because results from preliminary analysis demonstrated that the items had low item-total correlations (.006 and -.075) and reduced the Cronbach's alpha by .08. The final scale with seven items had a Cronbach's alpha of 0.82.

**Frequency of use of exposure therapy for anxiety disorders.** Self-reported use of ET for anxiety disorders was assessed by asking respondents to indicate the frequency with which they used ET in treatment of anxiety disorders on a 7-point scale from 0 (Never) to 6 (Always). Higher scores indicate more frequent use. Participants were also asked to indicate how often they used other therapeutic approaches in the treatment of anxiety disorders (see appendix for full list).

**Frequency of use of core exposure techniques.** Four items were developed to assess the use of core exposure techniques in ET. Participants were asked to rate on a 7-point scale from 0 (Never) to 6 (Always), how often they used the following techniques when practicing ET: (1) make an anxiety hierarchy with the patient, (2) carry out the exposure sessions themselves, (3) apply behavioural experiments, and (4) apply habituation. Higher scores indicate more frequent use of core exposure techniques. The mean score was used as the total score for the scale, ranging from 0 to 6. Respondents who did not use ET were instructed to choose the alternative "Not relevant" (coded missing). The scale had a Cronbach's alpha of 0.74.

**Competence in exposure therapy.** Seven items were used to assess competence in ET. Four different aspects of competence were measured: (1) whether respondents had learned about ET, (2) self-rated competence in ET, (3) to what extent respondents viewed their professional community as competent in ET, and (4) to what extent respondents experienced support to utilise ET from their professional community. The first aspect of competence was represented by four items: Whether respondents had learned about ET through (i) education, (ii) further education, (iii) seminars, and/or (iv) supervision. Participants responded to the four items by choosing 'Yes' (coded 1) or 'No' (coded 0), total scores ranging from 0 to 4 with higher scores reflecting greater acquired competence in ET. This variable was labelled Competence 1, and was defined as acquired knowledge about ET.

## DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

The three remaining aspects (2-4) were represented by one item each (i.e., three items in total). Participants responded to each item by rating to what degree a statement applied to them on a 5-point scale from 0 (Does not apply to me at all) to 4 (Applies to me very much), with higher scores reflecting greater competence within each aspect. The three items demonstrated an acceptable internal consistency ( $\alpha = .74$ ), and were therefore merged into one variable labelled Competence 2. This variable was defined as a combined measure of self-rated competence and perceived competence and support to use ET in professional community. The mean score was used as the total score for the variable, with a range from 0 to 4.

**Theoretical orientation.** In an effort to survey the participants' theoretical orientation, participants were asked to rate which theoretical orientation characterised their therapeutic work the best. Respondents could select up to three theoretical orientations from 1 to 3, with 1 being the most characteristic of their therapeutic work. Participants could select between 14 different theoretical orientations (see appendix) and were also given the option to select "Other" if they wished to specify a theoretical orientation outside of the orientations provided. EMDR and schematic therapy were added to the list after preliminary analysis. 22 respondents had not rated their selected theoretical orientations in ascending order, for example some had only rated 2 and 3 or 1 and 3. These responses were adjusted so that the numbers appeared in ascending order. For example, if theoretical orientations were rated 2 and 3 respectively, the responses were adjusted so that 2 became 1 and 3 became 2.

Theoretical orientation was operationalised in several different ways. For the descriptive statistics participants were clustered according to the theoretical orientation they had rated as number 1. For further data analysis respondents were clustered according to the degree they endorsed a cognitive, behavioural and/or metacognitive orientation. This was done by first grouping participants according to what degree they endorsed a cognitive, behavioural, and metacognitive orientation, respectively. For example, if a respondent rated cognitive therapy as the most characteristic of their therapeutic work (i.e., rated as "1") their response was recoded as 2. If cognitive therapy was rated as the second or third orientation characteristic of their therapeutic work (i.e., rated as "2" or "3") their response was recoded as 1. Responses not including cognitive therapy (i.e., missing) were coded 0. After recoding all responses, degree of cognitive, degree of behavioural, and degree of metacognitive orientation were merged into one variable. This variable was labelled Degree of CBM (cognitive-behavioural-metacognitive) and ranged from 0 (i.e., respondent has not selected any of the three orientations) to 4 (i.e., respondent has selected all three orientations).

**Total proportion of anxiety patients (TPAP).** Total proportion of anxiety patients (TPAP) in clinical practice was measured by asking the participants to rate how often they had patients with one or more of the following anxiety disorders in treatment, based on the last six months: (1) specific phobias, (2) social phobia, (3) agoraphobia, (4) panic disorder, (5) obsessive-compulsive disorder, and (6) post-traumatic stress disorder. Frequency was rated on a 7-point scale from 0 (Never) to 6 (Always), with higher scores indicating greater number of anxiety patients in clinical practice. Mean scores were used as the total score for the scale, also ranging from 0 to 6. Internal consistency for TPAP was acceptable ( $\alpha = .72$ ).

### Data Analysis

The data analysis consisted primarily of descriptive statistics, between-group differences, correlation analysis, and regression analysis. Preliminary analysis was conducted to ensure that no assumptions of the respective statistical tests were violated. In cases where the preliminary analysis raised concern, the authors tested various transformations to see if the transformed variable produced any significant differences. Descriptive statistics were used to identify the most frequently used therapeutic approaches when treating anxiety disorders, the most frequently used core exposure techniques when treating anxiety disorders, and the most commonly agreed upon negative beliefs about exposure.

Independent samples t-test and one-way between-groups analysis of variance (ANOVA) were used to test for hypothesised group differences with regard to use of ET and negative beliefs about exposure. In order to examine differences in frequency of reported use for each therapeutic approach in treatment of anxiety disorders, a one-way repeated measures ANOVA was conducted. Effect sizes were calculated and reported: Cohen's  $d$  for each independent samples t-test, eta-squared ( $\eta^2$ ) for each one-way between-groups ANOVA, and partial eta-squared ( $\eta_p^2$ ) for the one-way repeated measures ANOVA. The authors followed the guidelines proposed by Cohen (1988) and Richardson (2011) when interpreting effect sizes: Cohen's  $d$  were interpreted as either small (0.2), moderate/medium (0.5) or large (0.8); eta-squared and partial eta-squared were interpreted as either small (.01), moderate/medium (.06) or large (.14).

Preliminary correlational analysis using the Pearson correlation coefficient was conducted in order to test whether hypothesised variables were significantly related to the dependent variable before subsequent regression analysis. Only variables that were significantly correlated to the dependent variable were included in the multiple linear regression analysis. A correlational analysis was also conducted to check whether participants



## DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

who reported using ET as their therapeutic approach when treating anxiety disorders also reported using core exposure techniques specifically. For the multiple linear regression analysis, the authors chose to enter the independent variables hierarchically in order to control the effect of certain predictors in each step of the regression analysis. Hierarchical regression analysis was conducted to test the predictive strength of hypothesised variables on frequency of use of ET, frequency of use of exposure techniques, and negative beliefs about exposure. In order to test whether predictors for frequency of use of exposure therapy also predicted frequency of use of core exposure techniques, the same independent variables were included in the preliminary correlational analysis for frequency of use of core exposure techniques as was included for frequency of use of ET. However, for the subsequent hierarchical regression analysis, only variables that were significantly correlated to the dependent variable were included.

## Results

### Use of Exposure Therapy and Core Exposure Techniques

Approximately half of the participants ( $n = 207$ ; 54.3%) reported that they always or very often used ET when treating patients with anxiety disorders. A repeated measure ANOVA indicated that the participants reported using ET significantly more often than other therapeutic approaches when treating anxiety disorders,  $F(9.16, 2299.16) = 128.19, p < .001$ . This difference represented a large effect,  $\eta_p^2 = .34$ . Mauchly's test indicated that the assumption of sphericity had been violated,  $\chi^2(90) = 639.19, p < .001$ . In turn, degrees of freedom were corrected using the Greenhouse-Geisser estimates of sphericity,  $\epsilon = .71$ . The Greenhouse-Geisser correction was used as it is recommended when the sphericity estimate ( $\epsilon$ ) is less than .75 (Field, 2014). The three most frequently used therapeutic approaches after ET, from highest to lowest, were cognitive therapy without exposure, eclectic/integrative, and metacognitive therapy. Participants' relative frequency of use of and overall mean frequency of use for each therapeutic approach are presented in Figure 1. Only 27.7% ( $n = 98$ ) of the respondents who reported using ET to any degree (regardless of frequency) answered that they always or very often implemented habituation and only 32.5% ( $n = 117$ ) reported that they always or very often implemented behaviour experiments. Participants' relative frequency of use and overall mean frequency of use for each core exposure technique are presented in Figure 2. Less than 50% of participants reported that they always or very often use each core exposure technique. This difference in reported frequency of use of ET and reported frequency of use of core exposure techniques was also demonstrated by a moderate, however bordering to large, correlation between the variables,  $r(358) = .49, p < .001$ . This was inconsistent with H1a.

**Specialised OCD treatment unit.** A one-way ANOVA indicated a significant difference in frequency of use of ET between participants based on their experience in OCD-units (current, previous, never), *Welch's*  $F(2, 46.47) = 71.32, p < .001, \eta^2 = .07$ . Post-hoc comparisons using Games-Howell tests, found that participants who currently work in an OCD unit ( $M = 5.67, SD = .48$ ) use ET significantly more often than participants who previously worked ( $M = 4.64, SD = 1.22$ ; mean difference = 1.03, *CI*: 0.35 to 1.71,  $p < .05$ ) and participants who had never worked in an OCD unit ( $M = 4.21, SD = 1.44$ ; mean difference = 1.46, *CI*: 1.17 to 1.75,  $p < .05$ ). Both differences represented a large effect ( $d = 1.11$  and  $d = 1.36$ ). However, participants who had previously worked in an OCD-unit did not use ET significantly more often than participants who had never worked in an OCD-unit ( $p > .05$ ). Hence, the results are partially consistent with H2a.

DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

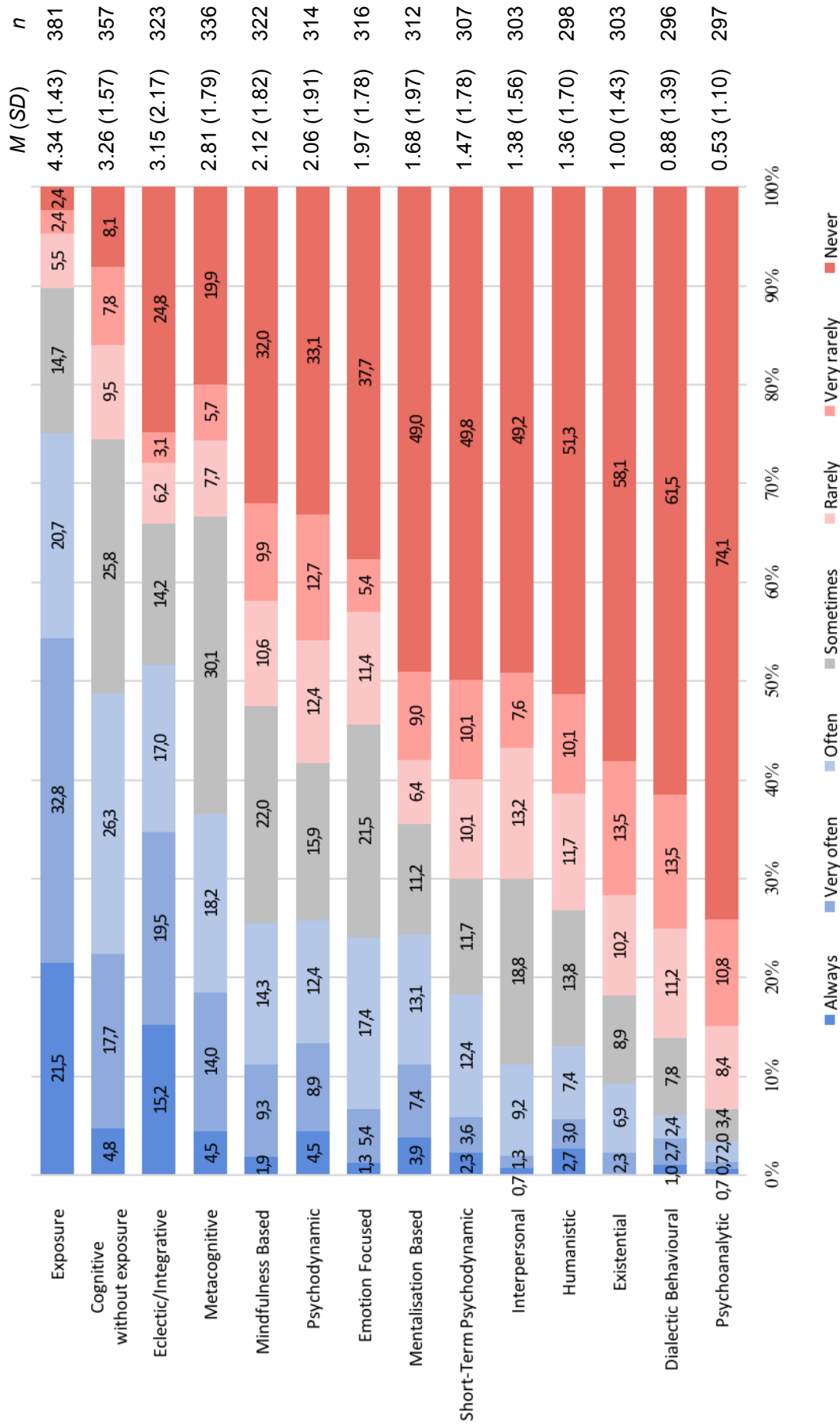


Figure 1. Therapists' relative use of therapeutic approaches in the treatment of anxiety disorders. Therapeutic approaches are listed in order of highest to lowest mean frequency of use, on a scale ranging from 0 (Never) to 6 (Always). Mean frequency, SD and n for each item are shown to the right of each bar. Numbers inside bars indicate percentage for each response per item.

## DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

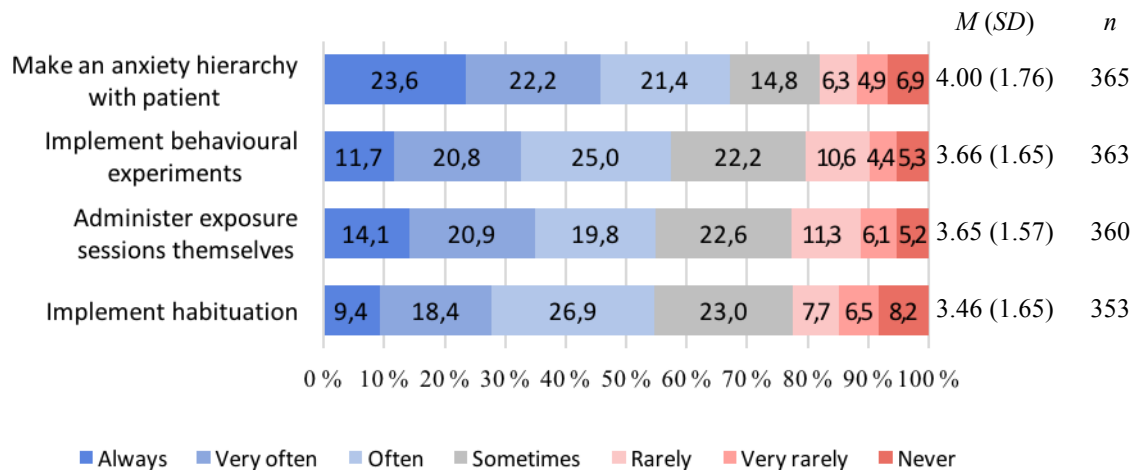


Figure 2. Practitioners' relative use of core exposure techniques. Items are listed in order of highest to lowest mean frequency of use, on a scale ranging from 0 (Never) to 6 (Always). Mean frequency, *SD* and *n* for each item are shown to the right of each bar. Numbers inside bars indicate percentage for each response per item.

**Place of education.** With regard to RQ1, a one-way ANOVA indicated a significance difference in frequency of use of ET depending on where clinical psychologists received their degree,  $F(4, 274) = 3.58, p = .007, \eta^2 = .05$ . Post-hoc comparisons using the Tukey HSD test, indicated that not all group differences were significant. Specifically, clinical psychologists who received their degree in Bergen ( $M = 4.83, SD = 1.24$ ), reported using ET significantly more often than clinical psychologists who received their degree in Oslo ( $M = 3.98, SD = 1.58$ ; mean difference = 0.84,  $CI: -1.55$  to  $-0.14, p < .05$ ) or abroad ( $M = 4.14, SD = 1.54$ ; mean difference = 0.69,  $CI: 0.32$  to  $1.35, p < .05$ ). These differences represented, respectively, a moderate effect ( $d = .60$ ) and small, bordering to moderate, effect ( $d = .49$ ).

**Primary patient group.** An independent-samples t-test was conducted to answer RQ2. The test found that practitioners primarily treating children and adolescents ( $M = 4.72, SD = 1.19$ ) use ET significantly more often than practitioners primarily treating adults and older adults ( $M = 4.18, SD = 1.49$ ),  $t(247.96) = -3.71, p < .001$ . The magnitude of the difference in means (mean difference = .54, 95%  $CI: 0.25$  to  $0.82$ ) was small ( $d = .40$ ).

**Non-significant group differences.** Inconsistent with H2b, a one-way ANOVA showed no significant difference between professions (i.e., clinical psychologists, physicians, nurses and social workers) in frequency of use of ET. The groups "pedagogues" and "occupation otherwise specified" were too small to be included in the analysis. An independent-samples t-tests found no significant difference in frequency of use of exposure between practitioners primarily working in private practices and practitioners primarily

## DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

working at a public institution, hospital or medical centre. This was inconsistent with H2c.

**Predictors of use of exposure therapy.** A hierarchical multiple regression analysis was run with Frequency of Use of ET as the outcome variable in order to ascertain the significance and influence of hypothesised predictors on Frequency of Use of ET. Correlational analysis (see Table 1) indicated that all hypothesised predictors were significantly related to Frequency of Use of ET, except having or not having a clinical or psychiatric specialisation (Specialisation). This was inconsistent with H3a, and the variable was excluded from the regression analysis. Preliminary analysis indicated that the assumption of homoscedasticity was not met. Thus, the regression analysis was rerun using a bootstrap estimation approach with 1000 samples.

**Table 1**

*Pearson Correlation Matrix for Frequency of Use of ET and Independent Variables (N = 367-419)*

Variables	1	2	3	4	5	6	7	8	9
1. Use of ET									
2. TPAP	.20***								
3. Degree of CBM	.31***	.08							
4. TBES	-.39***	-.09	-.38***						
5. PCI	-.30***	-.02	-.23***	.42***					
6. SENS	-.16**	-.13*	-.13**	.30***	.11*				
7. Competence 1	.41***	.22***	.30***	-.31***	-.12*	-.16**			
8. Competence 2	.58***	.15**	.31***	-.26***	-.21***	-.16**	.46***		
9. Specialisation	.02	.09	-.07	.04	.11*	-.12*	.19***	.07	

*Note.* TPAP = Total Proportion of Anxiety Patients, Degree of CBM = Degree of Cognitive-Behaviour-Metacognitive orientation, TBES = Therapists Beliefs about Exposure Scale, PCI = Perceived Contraindications for use of ET, SENS = Sensitivity to Distress Scale, Competence 1 = Acquired Knowledge about ET, Competence 2 = Self-Rated Competence, and Competence and Support to use of ET in professional community.

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$ .

Degree of Cognitive-Behaviour-Metacognitive orientation (Degree of CBM) and Sensitivity to Distress (SENS) were entered at stage one of the regression. Therapist Beliefs about Exposure (TBES) and Perceived Contraindications for use of ET (PCI) were entered at stage two. Total Proportion of Anxiety Patients (TPAP); Acquired Knowledge about ET

## DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

(Competence 1); and Self-Rated Competence, and Competence and Support to use of ET in professional community (Competence 2) were entered at stage three. The variables were entered in this order to control for the potential influence participants' degree of cognitive, behavioural and/or metacognitive orientation and sensitivity to distress have on perceived contraindications for use of ET and negative beliefs about exposure. The competence variables and Total Proportion of Anxiety Patients were entered last as it was deemed probable that these variables are influenced by all the above-mentioned variables. The results of the regression analysis are summarised in Table 2.

**Table 2**

*Summary of Hierarchical Regression Analysis for Predictors of Use of ET (N = 360)*

Predictors	<i>B</i>	<i>SE B</i>	$\beta$	<i>p</i>	<i>R</i> <sup>2</sup>	$\Delta R^2$
Step 1					.109***	.109***
Constant	4.09	0.17		.001***		
Degree of CBM	0.34	0.06	.30	.001***		
SENS	-0.27	0.11	-.12	.015*		
Step 2					.201***	.092***
Constant	5.37	0.27		.001***		
Degree of CBM	0.21	0.06	.19	.001***		
SENS	-0.10	0.11	-.05	.354		
PCI	-0.10	0.03	-.16	.002**		
TBES	-0.03	0.01	-.24	.001***		
Step 3					.420***	.219***
Constant	1.66	0.41		.001***		
Degree of CBM	0.07	0.05	.06	.182		
SENS	0.08	0.09	.04	.375		
PCI	-0.07	0.03	-.12	.006**		
TBES	-0.02	0.01	-.18	.001***		
Competence 1	0.13	0.07	.10	.039		
Competence 2	0.82	0.10	.43	.001***		
TPAP	0.17	0.07	.11	.012*		

*Note.* Standard errors are based on 1000 bootstrap samples. Degree of CBM = Degree of Cognitive-Behaviour-Metacognitive orientation, SENS = Sensitivity to Distress Scale, PCI = Perceived Contraindications for use of ET, TBES= Therapist Belief about Exposure Scale, Competence 1 = Acquired Knowledge about ET, Competence 2 = Self-Rated Competence, and Competence and Support to use of ET in professional community, TPAP = Total Proportion of Anxiety Patients.

\**p* < .01, \*\**p* < .05, \*\*\**p* < .001.

The results of the hierarchical multiple regression revealed that at stage one, Degree of CBM and Sensitivity to Distress contributed significantly to the regression model,  $F(2, 358) = 21.81, p < .001$ , and explained 10.9% of the variance in Frequency of Use of ET. Consistent with H4a and 4b, adding Therapist Beliefs about Exposure and Perceived Contraindications for use of ET to the model in stage two explained an additional 9.2% of the variance in Frequency of Use of ET, and this change in  $R^2$  was significant,  $F(2, 356) = 20.47, p < .001$ . Lastly, the addition of Acquired knowledge about ET; Self-rated Competence, and Competence in and Support to use of ET in professional community; and Total Proportion of Anxiety Patients in stage three explained an additional 21.9% of the variance in Frequency of Use of ET, and the change in  $R^2$  was significant,  $F(3, 353) = 44.41, p < .001$ . This was consistent with H3c and H3d. The final regression model with all seven predictors was significant,  $F(7, 353) = 36.46, p < .001$ , and explained 42% of the variance in Frequency of Use of ET. However, in the final model, neither Degree of CBM, Sensitivity to Distress nor Acquired Knowledge about ET were significant predictors of Frequency of Use of ET. This was inconsistent with H3b, H4c and H3c. The most important predictor of Frequency of Use of ET was Self-Rated Competence, and Competence and Support to use of ET in professional community.

**Predictors of use of core exposure techniques.** A three stage hierarchical multiple regression analysis was conducted with Frequency of Use of Core Exposure Techniques as the dependent variable in order to test H1b. Preliminary correlational analysis (see Table 3) indicated that all hypothesised predictors were significantly related to Frequency of Use of Core Exposure Techniques, except Specialisation. This variable was therefore excluded from the regression analysis.

Degree of Cognitive-Behavioural-Metacognitive orientation (Degree of CBM) and Sensitivity to Distress (SENS) were entered at stage one of the regression. Therapist Beliefs about Exposure (TBES) and Perceived Contraindications for use of ET (PCI) were entered at stage two. Acquired Knowledge about ET (Competence 1); Self-Rated Competence, and Competence and Support to use of ET in professional community (Competence 2); and Total Proportion of Anxiety Patients (TPAP) were entered at stage three. The variables were entered in this order based on the same rationale as for the regression analysis for Frequency of Use of ET. The same regression model was applied in order to compare independent variables with regard to their predictive strength on Frequency of Use of ET and Frequency of Use of Core Exposure Techniques.

DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

**Table 3**

*Pearson Correlation Matrix for Frequency of Use of Core Exposure Techniques and Independent Variables (N = 348-419)*

Variables	1	2	3	4	5	6	7	8	9
1. Core Exposure Techniques									
2. TPAP	.17**								
3. Degree of CBM	.30***	.08							
4. TBES	-.30***	-.09	-.38***						
5. PCI	-.28***	-.02	-.23***	.42***					
6. SENS	-.15**	-.13*	-.13**	.30***	.11*				
7. Competence 1	.28***	.22***	.30***	-.31***	-.12*	-.16**			
8. Competence 2	.32***	.15**	.31***	-.26***	-.21***	-.16**	.46***		
9. Specialisation	-.03	.09	-.07	.04	.11*	-.12*	.19***	.07	

*Note.* TPAP = Total Proportion of Anxiety Patients, Degree of CBM = Degree of Cognitive-Behaviour-Metacognitive orientation, TBES = Therapists Beliefs about Exposure Scale, PCI = Perceived Contraindications for use of ET, SENS = Sensitivity to Distress Scale, Competence 1 = Acquired Knowledge about ET, Competence 2 = Self-Rated Competence, and Competence and Support to use of ET in professional community, Specialisation = Having or not having a clinical or psychiatric specialisation.  
\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$ .

The regression analysis revealed that at stage one, Degree of CBM and Sensitivity to Distress contributed significantly to the regression model,  $F(2, 340) = 18.25$ ,  $p < .001$ , and accounted for 9.2% of the variation in Frequency of Use of Core Exposure Techniques. Introducing Perceived Contraindications for use of ET and Therapist Beliefs about Exposure in stage two explained an additional 6.3% of the variation in Frequency of Use of Core Exposure Techniques and this change in  $R^2$  was significant,  $F(2, 338) = 12.63$ ,  $p < .001$ . The addition of Acquired Knowledge about ET; Self-Rated Competence, and Competence and Support to use of ET in professional community; and Total Proportion of Anxiety Patients in stage three explained an additional 5.5% of the variation in Frequency of Use of Core Exposure Techniques, and this change in  $R^2$  was also significant,  $F(3, 335) = 7.81$ ,  $p < .001$ . The independent variable that contributed the most to the variation in Frequency of Use of Core Exposure Techniques was Perceived Contraindications for use of ET. When all six independent variables were included in stage three, Therapist Beliefs about Exposure, Self-Rated Competence, and Competence and Support to use of ET in professional community, Total Proportion of Anxiety Patients, and Sensitivity to Distress were not significant



## DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

predictors of the dependent variable, although Therapist Beliefs about Exposure was just was just above the alpha level of .05 ( $p = .060$ ). This was inconsistent with H1b. The final regression model was significant,  $F(7, 335) = 13.08$ ,  $p < .001$ , and explained 21.5% of the variation in Frequency of Use of Core Exposure Techniques. The results of the regression analysis are summarised in Table 4.

**Table 4**

*Summary of Hierarchical Regression Analysis for Predictors of Frequency of Use of Core Exposure Techniques (N = 343)*

Predictors	B	SE B	$\beta$	p	R <sup>2</sup>	$\Delta R^2$
Step 1					.097***	.097***
Constant	3.52	0.15		.001***		
Degree of CBM	0.27	0.05	.27	.001***		
SENS	-0.24	0.10	-.13	.013*		
Step 2					.160***	.063***
Constant	4.45	0.24		.001***		
Degree of CBM	0.19	0.05	.19	.001***		
SENS	-0.119	0.10	-.06	.227		
PCI	-0.10	0.03	-.18	.001**		
TBES	-0.02	0.01	-.15	.013*		
Step 3					.215***	.055***
Constant	2.88	0.45		.001***		
Degree of CBM	0.13	0.05	.13	.016*		
SENS	-0.04	0.10	-.02	.693		
PCI	-0.10	0.03	-.18	.001**		
TBES	-0.01	0.01	-.11	.060		
Competence 1	0.17	0.07	.15	.009**		
Competence 2	0.20	0.11	.10	.072		
TPAP	0.12	0.07	.09	.076		

*Note.* Degree of CBM = Degree of Cognitive-Behaviour-Metacognitive orientation, SENS = Sensitivity to Distress Scale, PCI = Perceived Contraindications for use of ET, TBES= Therapist Belief about Exposure Scale, Competence 1 = Acquired Knowledge about ET, Competence 2 = Self-Rated Competence, and Competence and Support to use of ET in professional community, TPAP = Total Proportion of Anxiety Patients.

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$ .

### Negative Beliefs about Exposure

Relative agreement to each negative belief is shown in Figure 3. For 12 of the 21 items, rates of agreement were below or around 10%. However, for the remaining 9 items, 15% to 49% of participants agreed or agreed strongly with negative beliefs expressing either too much distress for the patient during or because of exposure, exposure is only superficially effective, or concerns that are practical or personal for the therapist when using exposure. The mean TBES sum score was 24.12 ( $SD = 11.85$ , range 0-81).

**Gender.** Consistent with H5a, an independent-samples t-test found that men ( $M = 22.23$ ,  $SD = 10.80$ ) had significantly lower TBES sum scores than women ( $M = 25.02$ ,  $SD = 12.26$ ;  $t(405) = 2.23$ ,  $p = .03$ , two-tailed); however it represented a small-sized effect,  $d = .24$ .

**Profession.** A one-way ANOVA found a significant difference between practitioners based on profession,  $F(3, 380) = 4.09$ ,  $p = .007$ ; however the difference represented a small effect,  $\eta^2 = .03$ . Consistent with H5b clinical psychologist ( $M = 22.97$ ,  $SD = 11.56$ ) had the lowest TBES sum scores compared to physicians ( $M = 24.59$ ,  $SD = 11.27$ ), nurses ( $M = 25.42$ ,  $SD = 9.63$ ), and social workers ( $M = 31.35$ ,  $SD = 9.31$ ). Two groups, pedagogues and occupation otherwise specified, were too small to be included in the analysis. Post-hoc analysis using Games-Howell test found that only two groups differed significantly: Clinical psychologists scored lower on the TBES compared social workers (mean difference =  $-8.39$ , 95%  $CI$ :  $-14.13$  to  $-2.63$ ,  $p = .002$ ). This difference represented a moderate effect,  $d = 0.73$ .

**Specialised OCD treatment unit.** A one-way ANOVA found a significant difference between practitioners who currently work in a specialised OCD treatment unit, have previously worked in a specialised OCD treatment unit, and practitioners who have never worked in a specialised treatment unit,  $Welch's F(2, 39.66) = 84.7$ ,  $p < .00$ , yielding a large effect size,  $\eta^2 = .17$ . Post-hoc analysis using Games-Howell test found that all groups were significantly different from each other. Participants who currently work in an OCD unit ( $M = 8.37$ ,  $SD = 6.50$ ) had significantly lower TBES sum scores than participants who had never worked in an OCD unit ( $M = 25.88$ ,  $SD = 11.00$ ; mean difference =  $-17.50$ , 95%  $CI$ :  $-20.81$  to  $-14.20$ ,  $p < .001$ ), yielding a very large effect size ( $d = 1.94$ ); and participants who had previously worked in an OCD unit ( $M = 15.98$ ,  $SD = 12.43$ ; mean difference =  $-17.50$ , 95%  $CI$ :  $-20.81$  to  $-14.20$ ,  $p < .001$ ), yielding a moderate effect size ( $d = 0.77$ ). Participants who had previously worked in an OCD unit had significantly lower TBES sum scores than participants who had never worked in an OCD unit (mean difference =  $-9.89$ , 95%  $CI$ :  $-16.52$  to  $-3.27$ ,  $p = .003$ ), yielding a large effect size ( $d = 0.84$ ). These differences are consistent with H5c.

DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

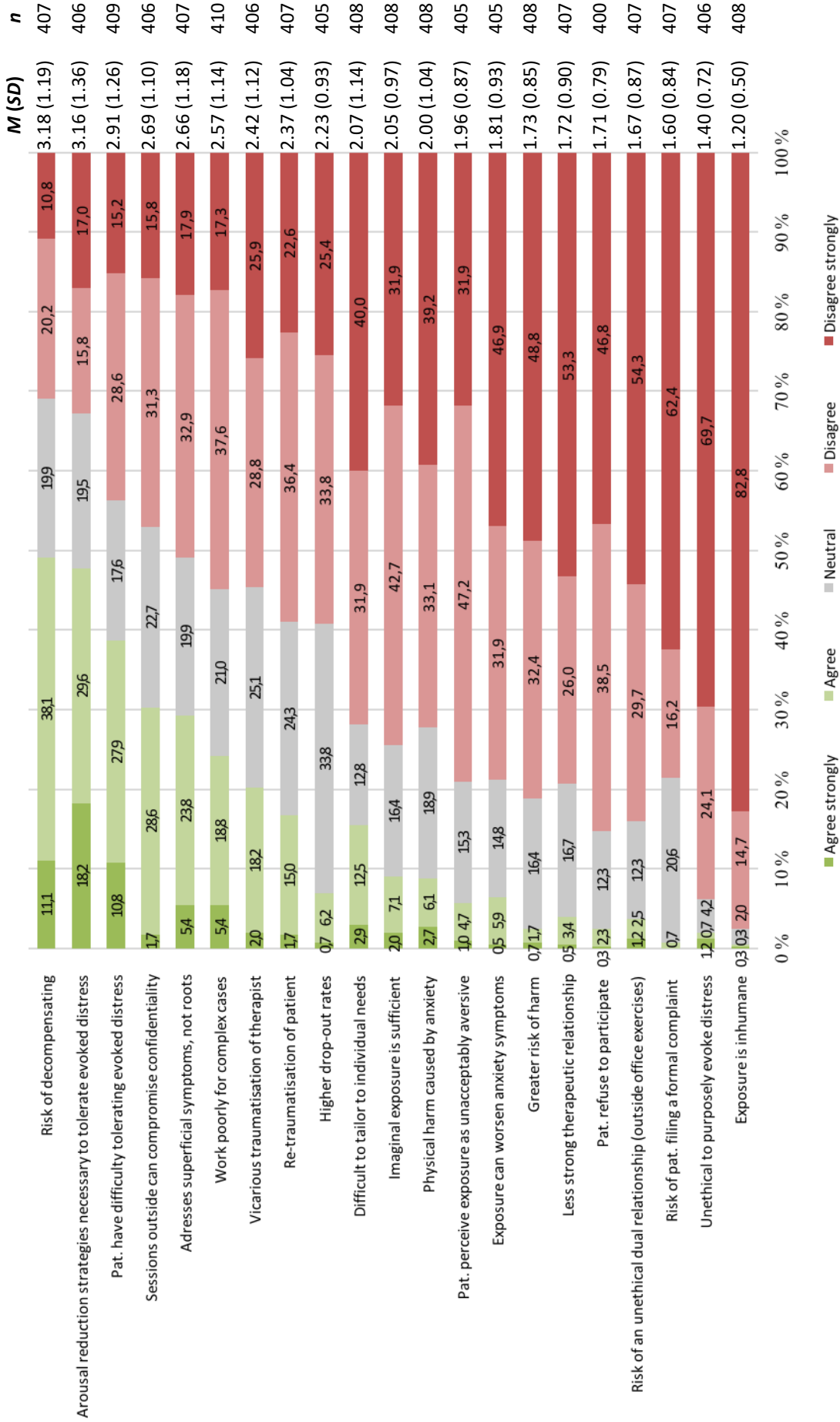


Figure 3. Therapists' relative agreement to negative beliefs about exposure. Items are ordered from highest to lowest mean agreement, on a scale ranging from 1 (Disagree strongly) to 5 (Agree strongly). Mean frequency, SD and n for each item are shown to the right of each bar. Numbers inside bars indicate percentage for each response per item

**Place of education.** With regard to RQ3, a one-way ANOVA found a significant difference in TBES sum scores between clinical psychologists based on where they received their degree in clinical psychology; either Oslo, Bergen, Trondheim, Tromsø, or abroad;  $F(4, 291) = 6.37, p < .001$ , this difference represented a moderate effect,  $\eta^2 = .08$ . The TBES sum scores for place of education, from lowest to highest, were as follows: Trondheim ( $M = 17.94, SD = 10.41$ ), Bergen ( $M = 21.19, SD = 12.50$ ), Tromsø ( $M = 23.34, SD = 11.40$ ), Oslo ( $M = 24.71, SD = 9.29$ ), abroad,  $M = 27.08, SD = 11.55$ . However, post-hoc analysis using Tukey's HSD test found that not all group differences were significant. Clinical psychologists with a degree from Trondheim scored significantly lower on the TBES than those with a degree from Oslo (mean difference =  $-6.76$ , 95% *CI*:  $-12.41$  to  $-1.13$ ,  $p = .01$ ) or abroad (mean difference =  $-9.13$ , 95% *CI*:  $-14.47$  to  $-3.79$ ,  $p < .001$ ). These differences represented a moderate effect ( $d = 0.69$ ) for the former and a large effect ( $d = .83$ ) for the latter. Additionally, clinical psychologists with a degree from Bergen scored significantly lower on the TBES than those who received their degree abroad (mean difference =  $-5.89$ , 95% *CI*:  $-10.86$  to  $-.92$ ,  $p = .011$ ). This difference represented a small, however bordering to large, effect,  $d = 0.49$ .

**Non-significant group differences.** Independent-samples t-tests found no significant difference in TBES sum scores between respondents primarily working in private practice and practitioners primarily working at a public institution, hospital, or medical centre (inconsistent with H5d); nor between practitioners who work with adults and practitioners who work with children and youth (RQ4).

**Predictors of negative beliefs about exposure.** A hierarchical multiple regression analysis was conducted to test our hypotheses regarding predictors of Therapist Beliefs about Exposure. Preliminary correlation analysis (see Table 5) revealed that the variables Specialisation (inconsistent with H7a) and Total Proportion of Anxiety Patients (RQ5) were not significantly correlated to the dependent variable and were in turn not included in the regression analysis. Therefore, six independent variables were included in the stage three hierarchical regression analysis with Therapist Beliefs about Exposure as the dependent variable.

The regression analysis revealed that at stage one, Sensitivity to Distress, Degree of Cognitive-Behavioural-Metacognitive orientation, and Age contributed significantly to the regression model,  $F(3, 390) = 39.38, p < .001$ , and accounted for 23.2% of the variation in Therapist Beliefs about Exposure. This was consistent with H6a, H7b and H6b. Introducing Perceived Contraindications for use of ET (PCI) in stage two explained an additional 8.7% of the variation in Therapist Beliefs about Exposure and this change in  $R^2$  was significant,  $F(1,$

## DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

389) = 49.93,  $p < .001$ . This was consistent with H6c. The addition of Acquired Knowledge about ET (Competence 1); and Self-Rated Competence, and Competence and Support to use of ET in professional community (Competence 2) in stage three explained an additional 3.9% of the variation in Therapist Beliefs about Exposure, and this change in  $R^2$  was also significant,  $F(2, 387) = 11.79, p < .001$ . This was consistent with H7c. However, Self-Rated Competence, and Competence and Support to use of ET in professional community (Competence 2) was not a significant predictor of Therapists Beliefs about Exposure, which was inconsistent with H7c. The independent variables contributed to the variation of Therapist Beliefs about Exposure in the following order, from highest to lowest: Perceived Contraindications for use of exposure therapy, Degree of Cognitive-Behavioural-Metacognitive orientation, Sensitivity to Distress, Competence 2, and Competence 1. The final regression model was significant,  $F(6, 387) = 36.10, p < .001$ , and explained 35.9% of the variation in TBES.

**Table 5**

*Pearson Correlation Matrix for Therapist Belief about Exposure and Independent Variables (N = 369-419)*

Variables	1	2	3	4	5	6	7	8	9
1. TBES									
2. PCI	.42***								
3. SENS	.30***	.11*							
4. Degree of CBM	-.38***	-.23***	-.13**						
5. Competence 1	-.31***	-.12*	-.16**	.30***					
6. Competence 2	-.26***	-.21***	-.16**	.31***	.46***				
7. Specialisation	.04	.11*	-.12*	-.07	.19***	.19**			
8. TPAP	-.09	-.02	-.13*	.08	.22***	.15**	.09		
9. Age	.16**	.15**	-.09	-.14**	.08	.02	.58***	.03	

*Note.* TBES = Therapist Beliefs about Exposure Scale, PCI = Perceived Contraindications for use of ET, SENS = Sensitivity to Distress Scale, Degree of CBM = Degree of Cognitive-Behavioural-Metacognitive orientation, Competence 1 = Acquired Knowledge about ET, Competence 2 = Self-Rated Competence, and Competence and Support to use of ET in professional community, TPAP = Total Proportion of Anxiety Patients.  
\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

**Table 6**

*Summary of Hierarchical Regression Analysis for Variables Predicting Therapist Beliefs about Exposure (N = 393)*

Predictors	<i>B</i>	SE <i>B</i>	$\beta$	<i>p</i>	<i>R</i> <sup>2</sup>	$\Delta R^2$
Step 1					.232***	.232***
Constant	17.25	2.56		.001***		
SENS	5.05	0.83	.27	.001***		
Degree of CBM	-3.23	0.45	-.33	.001***		
Age	0.16	0.05	.15	.001**		
Step 2					.320***	.087***
Constant	9.37	2.65		.001***		
SENS	4.51	0.79	.25	.001***		
Degree of CBM	-2.63	0.43	-.27	.001***		
Age	.113	0.05	.105	.015*		
PCI	1.51	0.21	.31	.001***		
Step 3					.359***	.039***
Constant	14.03	3.37		.001***		
SENS	4.12	0.77	.22	.001***		
Degree of CBM	-2.09	0.44	-.21	.001***		
Age	0.14	0.05	.13	.002**		
PCI	1.44	0.21	.29	.001***		
Competence 1	-2.34	0.52	-.21	.001***		
Competence 2	0.12	0.76	.008	.874		

*Note.* TBES = Therapist Beliefs about Exposure Scale, SENS = Sensitivity to Distress Scale, Degree of CBM = Degree of Cognitive-Behavioural-Metacognitive orientation, PCI = Perceived Contraindications for use of ET, Competence 1 = Acquired Knowledge about ET, Competence 2 = Self-Rated Competence, and Competence and Support to use of ET in professional community.

\**p* < .05, \*\**p* < .01, \*\*\**p* < .001.

## Discussion

### Use of Exposure Therapy and Core Exposure Techniques

The aim of the present study was to consider the dissemination of ET in Norway. Results suggests that Norwegian therapists very often provide ET, with 54.3% stating that they always or very often use ET, and only 4.8% stating that they very rarely or never use ET when treating anxiety disorders. We expected that therapists who reported using ET would report corresponding use of core exposure techniques, defined as therapist-assisted exposure, anxiety hierarchy, habituation and behaviour experiments. However, our findings suggest that participants implement these techniques to a much lesser degree. Less than one third reported always and very often using behavioural experiments and habituation (in vivo, imaginal and interoceptive exposure), just above one third reported always or very often providing therapist-assisted exposure and just above half reported always or very often making an anxiety hierarchy with patients. This raises the question about what techniques therapists implement when they use ET if they rarely use core exposure techniques during treatment sessions.

Past research on implementation of ET and CBT for anxiety disorders suggests that therapists favour cognitive strategies (e.g., problem solving, identifying emotions and automatic thoughts), client-guided exposure, and arousal reduction strategies (e.g., breathing and relaxation exercises) (Becker-Haimes et al., 2017; Farrell et al., 2013; Freiheit et al., 2004; Hipol & Deacon, 2013; Scherr et al., 2015; Whiteside et al., 2016). It is plausible that Norwegian therapists also favour cognitive strategies, especially considering that cognitive therapy without exposure was reported as one of the most frequently used approaches after ET in the current study, with 22.5% stating that they always or very often used this approach. The low use of core exposure techniques may implicate that the majority of Norwegian therapists provide ET in a manner that appears to be insufficient, as exposure-based interventions (in vivo, imaginal and interoceptive exposure and behaviour experiments) constitute a critical component in the treatment of anxiety disorders (Craske et al., 2009; Peterman et al., 2015). In addition, therapist-assisted exposure has been found to be more effective than client-guided exposure (Abramowitz, 1996; Gloster et al., 2011). Furthermore, non-exposure CBT interventions have been found to be negatively related to use of exposure interventions (Becker-Haimes et al., 2017; Vande Voort, Svecova, Jacobson, & Whiteside, 2010), and including non-exposure CBT interventions in the treatment of anxiety does not improve effectiveness (Adams, Brady, Lohr, & Jacobs, 2015; Ale, McCarthy, Rothschild, & Whiteside, 2015; Carpeneter et al., 2018; Deacon & Abramowitz, 2004; Vande Voort et al.,

2010; Whiteside et al., 2015). Prior research also demonstrates that therapists incorporate an array of interventions from a variety of theoretical orientations when treating anxiety (Freiheit et al., 2004; Hipol & Deacon, 2013; Whiteside et al., 2016). In the current study, 34.7% reported they always or very often select an eclectic approach when treating anxiety. This may be of concern, as techniques from different theoretical orientations may be incompatible or even contradictory. In addition, implementing techniques across theoretical orientations may crowd out exposure-based techniques. However, since we did not ask about the use of specific techniques other than core exposure techniques we do not know exactly what specific techniques (and their respective theoretical underpinnings) therapists incorporate in their eclectic approach.

Regarding what influences use of ET and use of core exposure techniques, we were surprised to find that predictors of use of ET did not similarly predict use of core exposure techniques as we had hypothesised. Self-rated competence, perceived competence and support to use ET in the professional community was the most important predictor for use of ET. This is consistent with existing research: A greater implementation climate for use of evidence-based practice in the work place has previously been associated with increased use of ET (Becker-Haimes et al., 2017), as has self-rated competence in a new study (Pittig, Kotter, & Hoyer, in press). Surprisingly acquired knowledge about ET was not a significant predictor of use of ET. For use of core exposure techniques, our results were the opposite: Acquired knowledge was a significant predictor while self-rated competence, perceived competence and support to use ET in the professional community was not a significant predictor. Existing research indicates that experience and training in ET are associated with greater use of ET for anxiety disorders (Broicher et al., 2017; Pittig & Hoyer, 2017; Sholomskas et al., 2005). Moreover the competence facet that predicted the use of ET did not predict use of core exposure techniques and vice versa. One possible interpretation of our diverging results is that acquired knowledge is more important for the use of specific techniques: Learning about ET will entail a better understanding of the rationale behind ET, what constitutes its most key elements, and specifically how to conduct exposure. Overall, the current study suggests that therapists elect ET more often when they view themselves and their professional community as competent in and supportive of the use of ET. However, while this aspect of competence may influence what therapy method is selected, acquired knowledge about ET is perhaps a more important influence on what techniques therapists implement when they use ET.



## DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

In line with our hypothesis and prior research, higher endorsement of negative beliefs about exposure predicted lower use of ET (Becker et al., 2004; Deacon & Farrell, 2013; Feeny et al., 2003; Olatunji et al., 2009; Richard & Gloster, 2007; van Minnen et al., 2010; Whiteside et al., 2016). Surprisingly and inconsistent with prior research (Deacon, Farrell, et al., 2013; Whiteside et al., 2016), negative beliefs did not predict use of core exposure techniques. Although use of core exposure techniques was not directly predicted by negative beliefs, one can speculate whether negative beliefs about exposure contribute to the use of non-exposure based interventions. Additional research is needed to explore the relationship between negative beliefs about exposure and use of specific ET and CBT-techniques, as well as non-CBT techniques. Interestingly, greater endorsement of perceived contraindications for use of ET negatively predicted both use of ET and of core exposure techniques, and was the most important predictor overall for the latter. It is possible that negative beliefs about exposure and perceived contraindications have a reciprocal relationship: Greater endorsement of an array of negative beliefs may strengthen perceived contraindications, which in turn can reinforce negative beliefs. This interpretation is supported by the strong association between negative beliefs and perceived contraindications in the current study and in previous research (Meyer et al., 2014). To illustrate, ET may be perceived as less safe, ethical, effective, or tolerable if used with certain patients, for example patients with a comorbid psychotic disorder. Altogether, negative beliefs presumably have an impact on use of exposure-based interventions when they pertain to patients that are perceived as unsuitable for ET, while other negative beliefs about exposure are perhaps not as decisive for use.

The current study found that the more frequently therapists have patients with anxiety in routine care the more frequently they use ET. This is consistent with previous research on the use of ET for PTSD and our hypothesis (Becker et al., 2004). However, contrary to our hypothesis, having had many anxiety patients in clinical practice did not increase use of core exposure techniques. It is plausible that the proportion of anxiety patients a therapist has in treatment is a reflection of how knowledgeable they are in ET, as supported by the significant correlation between acquired knowledge in ET and total proportion of anxiety patients. The association may also be reciprocal: Therapists who acquire more knowledge in ET choose to work with anxiety patients more often than those who have less acquired knowledge, and frequently having anxiety patients inclines therapists to acquire more knowledge about ET. This association may explain why total proportion of anxiety patients did not uniquely predict use of core exposure techniques, yet it may contribute to the use of core exposure techniques

through its association with acquired knowledge in ET. These findings highlight the role of specific experience and training in ET.

Previous research has demonstrated mixed results with regard to what influence theoretical orientation has on use of ET (Harned et al., 2013; Whiteside et al., 2016). In the current study, degree of cognitive, behavioural and/or metacognitive orientation was no longer a significant predictor for use of ET when competence and total proportion of anxiety patients in clinical practice were accounted for. One way to interpret our results is to view theoretical orientation as the basis for other factors, such as perceived contraindications for use of ET, negative beliefs about exposure, and competence in ET. In this way, the impact of theoretical orientation on use of ET expresses itself through these predictors. This interpretation is supported by the fact that higher degree of cognitive behavioural and/or metacognitive orientation was a significant predictor of lower endorsement of negative beliefs about exposure. Nevertheless, degree of cognitive, behavioural and/or metacognitive orientation was a significant predictor of use of core exposure techniques. This is consistent with Whiteside et al. (2016) who found that a CBT-orientation was associated with greater use of exposure technique. Summarised, these findings indicate that theoretical orientation has a direct positive influence on the use of core exposure techniques and perhaps indirectly promotes greater use of ET through its effect on other predictors.

Sensitivity to distress in the therapeutic context was a significant predictor of use of ET and use of core exposure techniques in the first step of the regression analysis, but was not significant in subsequent steps. This result was surprising as we anticipated it to be a significant predictor based on previous research stating that therapists' sensitivity to distress has been found to impede use of ET (Deacon & Farrell, 2013; Levita et al., 2016; Pittig et al., in press; Schare & Wyatt, 2013). Inconsistency with existing research may possibly be explained by how sensitivity to distress was measured, as well as target sample. In our study, sensitivity to distress was measured with reference to the general therapeutic context, regardless of therapeutic approach, while other studies have specifically focused on the therapeutic context of ET (e.g., Pittig et al., in press). The possible contribution of this factor can be interpreted as an underlying factor influencing other predictors, as it was initially significant for both use of ET and use of core exposure techniques. One may postulate that sensitivity to distress in the general therapeutic context may tap into therapists' personalities.

In the current study, we expected that obtaining a formal specialisation would be equivalent to obtaining a PhD with regard to its influence on use of ET or core exposure techniques. Previous research has found an association between higher degree level and

greater use of ET and has highlighted that therapists with a PhD use ET the most (Harned et al., 2013; Whiteside et al., 2016). However, we found that having or not having a clinical or psychiatric specialisation was not significantly associated with use of ET nor core exposure techniques. Our findings indicate that obtaining a formal specialisation is not equivalent to obtaining a PhD with regard to its influence on use of ET or core exposure techniques. A possible interpretation of our finding is that obtaining a PhD may provide more insight into evidence-based treatment methods, which perhaps is not the case when obtaining a clinical or psychiatric specialisations.

With regard to group differences for use of ET, our results indicate that anxiety specialists (i.e., therapists with work experience in an OCD-unit) use ET more frequently than other therapists, which is consistent with our hypothesis and previous research (Becker et al., 2004; Hipol & Deacon, 2013). However, one should note that our results are limited to therapists working in specialised OCD-treatment units. Interestingly, we found that the difference was only significant for practitioners currently working in an OCD-unit; practitioners who have previously worked in an OCD-unit did not report using ET significantly more than practitioners who have never worked in an OCD-unit. One may argue that therapists who currently work in an OCD-unit use ET more frequently because of a positive implementation climate, entailing support to use ET from colleagues in the OCD-unit and their shared experience with using ET. As a consequence of moving to a different workplace that may not endorse ET, therapists do not use ET as often when treating anxiety. Furthermore, practical barriers may be less prevalent in OCD-units compared to other work places. Another interpretation is that therapists leave OCD-units because they prefer other treatment methods or patient groups over ET and patients with OCD.

Use of ET amongst clinical psychologists varied significantly based on educational background both within and between universities in Norway and universities abroad. One can wonder whether these differences are in part influenced by differences in the respective universities': academic profile, course content and attitudes toward ET, manual-based approaches, and evidence-based practice. Universities in Norway have academic freedom protected by law (Universitet- og høyskoleloven, 2007, §1-5), which allows them to adopt their own academic profile. The authorisation system in Norway exists to ensure patients' safety by assuring that clinical psychologists meet the requirements of the public authorities to practice (Helsepersonelloven, 1999, §48, §73). For that reason, the authorisation system, as well as the NPF's policy statement on evidence-based practice, work to coordinate the professional competence of clinical psychologists so that patients receive evidence-based

treatment. However, our findings insinuate that clinical psychologists' educational background might influence whether their patients receive evidence-based treatment or not.

We also found that therapists who work primarily with children and adolescents reported using ET more frequently than therapists who primarily work with adults. One can speculate that a contributing factor to this difference is that children and adolescents are not as verbally, cognitive or emotionally developed as adults. In turn, therapists working with children and adolescents may to a greater extent use behavioural interventions compared to other interventions that more heavily depend on the patient's cognitive and verbal skills.

The results of the current study did not indicate any significant difference in use of ET between professions. This is inconsistent with previous research (Harned et al., 2013; Whiteside et al., 2016) and our hypothesis. Our sample may not be entirely representative of the distribution of mental health professionals in Norway seeing as a substantial majority (72%) consisted of clinical psychologists, which could partially explain why the current study is inconsistent with previous research. Inconsistent findings may also be due to differences in educational content and authorisation requirements for professions within Norway and across countries.

We did not find any difference between practitioners primarily working in private practices and practitioners primarily working at a public institution, hospital or medical centre. Although prior research has found that therapists who work in the public health sector are more likely to use research when making clinical decisions compared to private practitioners (Gyani et al., 2014), this may not be applicable to the use of ET. However, the number of private practitioners was quite small in our sample and is perhaps not representative for the proportion of private practitioners amongst mental health professionals in Norway. In turn, more research is needed to investigate the potential differences in anxiety treatment between therapists in the public health sector and private practitioners in Norway.

### **Negative Beliefs about Exposure**

The current study found that the most commonly agreed upon negative beliefs about exposure were in regard to patients' inability to tolerate the distress evoked by exposure, the need for anxiety reduction strategies in response to evoked distress, limited effectiveness for complex cases and underlying roots, and practical or personal concerns for the therapist when using exposure. Negative beliefs about the ethicalness and safety of exposure were to a lesser extent prominent in our sample. These findings are similar to the original American study conducted by Deacon, Farrell, et al. (2013) when the TBES was first constructed and the

recent German study by Pittig et al. (in press). This suggests that not only are negative beliefs about exposure present amongst Norwegian mental health professionals, but concerns about exposure's tolerability and effectiveness may constitute the main components in therapists' negative beliefs as they are shared amongst therapists in different health care systems (U.S., Germany and Norway). These negative beliefs reflect a real obstacle in the treatment of anxiety disorders as they convey that anxiety is in fact dangerous and should be avoided and that ET, a well-supported treatment, will not provide sufficient help. Overall agreement to negative beliefs was lower than what Deacon, Farrell, et al. (2013) reported, but similar to the average level of agreement reported by Pittig et al. (in press). This may indicate that therapists in the U.S. display greater endorsement of negative beliefs than therapists in Europe, however more studies in the U.S. and Europe are needed to support this postulation.

Although we did not have hypotheses regarding specific beliefs, we were surprised to find that therapists were more concerned with exposure causing vicarious traumatisation of the therapist than re-traumatisation of the patient, especially as Deacon, Farrell, et al. (2013) and Pittig et al. (in press) reported the opposite finding. Research on the topic suggests that trauma-related problems are rare amongst therapists who work extensively with trauma (Brady, Guy, Poelstra, & Brokaw, 1999; Ghahramanlou & Brodbeck, 2000). Additionally, therapists who work with trauma do not report higher levels of mental health problems (van Minnen & Keijsers, 2000) or increased difficulties in coping with the demands of their work (Sabin-Farrell & Turpin, 2003) compared to other therapists. Summarised, although vicarious traumatisation may be a genuine concern, it is probably not as likely or as burdensome as some therapists might anticipate or fear.

Most of the anticipated predictors demonstrated a significant influence on endorsement of negative beliefs about exposure, and were nearly identical in terms of predictive strength with the exception of age. Having a clinical or psychiatric specialisation was not significantly related to negative beliefs. This is inconsistent with Deacon, Farrell, et al. (2013), who found that higher degree level was associated with less negative beliefs. Seeing as acquired knowledge about ET was a significant predictor, it is likely that learning about ET specifically is more important than a general increase in education level. Our findings are supported by previous research on the positive impact training in ET has in reducing negative beliefs about exposure (Farrell, Deacon, Dixon, et al., 2013; Farrell et al., 2016; Harned et al., 2011; van Minnen et al., 2010). It is also possible that therapists' main professional background (e.g., clinical psychology, medicine, social work, or nursing) plays a more influential role on therapists' beliefs about exposure than obtaining a clinical or

psychiatric specialisation. Combined with the finding that clinical psychologists reported the lowest endorsement of negative beliefs, one can speculate whether the course content in the different professional backgrounds contributes to therapists' attitudes towards ET.

In line with our hypothesis and consistent with Meyer et al. (2014) perceived contraindications for use of ET was a significant predictor of greater endorsement of negative beliefs. Perceived contraindications was the strongest predictor of negative beliefs. This suggests that perceiving ET as not appropriate for certain patient groups may strengthen overall negative beliefs, while perhaps specifically heightening negative beliefs about exposure's suitability (e.g., "works poorly for complex cases").

Consistent with our hypothesis and previous research (Deacon, Farrell, et al., 2013), sensitivity to distress within the therapeutic context predicted greater endorsement of negative beliefs. With our measurement of sensitivity to distress, we found that it is the therapist's avoidance of potentially distressing topics or tasks, irrespective of target patient and therapeutic method, that contributes to negative beliefs about exposure. This is an important nuance as it entails that sensitivity to distress is adverse when the anticipated distress is perceived as something that should be, and in turn is, avoided. When distress is perceived as something to avoid, it is no surprise that therapists hold negative beliefs about a therapeutic method that actively addresses and activates anxiety. Furthermore, one can postulate that holding negative beliefs may provide justification for the avoidance of distressing topics or tasks. For example, negative beliefs regarding perceived negative consequences of distress evoked by exposure, such as physical harm (patient) or vicarious traumatisation (therapist), may validate avoidance of potentially distressing topics or tasks. In a similar vein, negative beliefs about perceived negative consequences of distress may also prompt the therapist to include interventions or modify interventions in order to reduce the level of distress in the therapeutic context. This may explain why sensitivity to distress and negative beliefs were not significant predictors of use of core exposure techniques, yet they may predict the use of non-exposure based interventions in combination with exposure (e.g., breathing exercises), or modifying exposure interventions so that they are less distressing for the patient and/or therapist (e.g., allowing patient to execute safety behaviours during exposure). This explanation is supported in existing research: Sensitivity to distress and negative beliefs have been found to predict cautious delivery of exposure in a myriad of ways (Farrell et al., 2016; Harned et al., 2013; Whiteside et al., 2016).

Consistent with our hypothesis, degree of cognitive, behavioural and/or metacognitive orientation predicted less endorsement of negative beliefs about exposure. Although

Whiteside et al. (2016) found that use of non-CBT techniques is associated with negative beliefs, no previous studies to our knowledge have specifically tested the influence of theoretical orientation on beliefs about exposure. In light of our findings, one may argue that endorsing a cognitive, behavioural and/or metacognitive orientation would imply greater understanding of the rationale behind exposure, its mechanisms and effectiveness, which in turn would dispute negative beliefs. This assumption is supported by the significant correlation between degree of cognitive, behavioural and/metacognitive orientation and competence in ET, both in the form of acquired knowledge and therapists' self-rated competence and perceived competence in and support to use ET from the professional community. However, only acquired knowledge about ET was a significant predictor of less endorsement of negative beliefs. These findings suggest that learning about ET helps to refute negative beliefs, while competence in and support to use ET taps into self-perceptions and evaluations that do not directly appertain to therapists' attitude towards exposure.

In line with our hypothesis and previous research (Deacon, Farrell, et al., 2013), age predicted negative beliefs. Although one can suspect that older therapists are schooled in the psychotherapeutic methods prominent during their initial degree and subsequent training, its potential influence on other predictors was already controlled for. This indicates that age influences negative beliefs through factors that we have not investigated. This may be considered in future research.

The majority of our hypothesised group differences were supported and are consistent with previous research (Deacon, Farrell, et al., 2013): Women reported greater endorsement of negative beliefs than men, clinical psychologists reported lower endorsement than other professions, as did anxiety specialists (i.e., experience in an OCD-unit). Deacon, Farrell, et al. (2013) propose that women's higher levels of empathetic concern could explain the gender difference in negative beliefs (Davis, 1980, as cited by Deacon, Farrell, et al., 2013). Farrell, Deacon, Kemp, et al. (2013) further found empathic concern to predict cautious delivery of exposure. Although we found that clinical psychologists had the lowest scores on the TBES, the only significant difference was in comparison to social workers. This is in line with previous research with regard to degree length (Deacon, Farrell, et al., 2013): The clinical psychology degree in Norway has a duration of six years, compared to three years for social workers. Our finding is also consistent with Waller et al. (2016) who found that clinical psychologists reported lower endorsement of negative beliefs than other professions. However, comparing our sample with the American sample in Deacon, Farrell, et al. (2013) and the British sample in Waller et al. (2016) has its limitations seeing as the authorisation

requirements to become a clinical psychologist in the U.S. are not equivalent to the Norwegian requirements, and the same can be said for other professions. This limits the generalisability of our findings. Taking this into consideration, our findings nevertheless indicate that amongst mental health professionals in Norway, clinical psychologists reported the least negative beliefs about exposure.

Additionally, we found clinical psychologists with a degree from Bergen or Trondheim reported significantly less negative beliefs compared to clinical psychologists with a degree from a university abroad. Clinical psychologists with a degree from Trondheim also reported significantly less negative beliefs compared to clinical psychologists with a degree from Oslo. These findings are consistent with the anticipated association between beliefs about exposure and use of ET: Clinical psychologists with a degree from Bergen or Trondheim also reported the most frequent use of ET. However, whereas clinical psychologists with a degree from Trondheim displayed the least endorsement of negative beliefs, clinical psychologists with a degree from Bergen use ET the most (although not significantly more than clinical psychologists with a degree from Trondheim). As previously mentioned, there may be other factors which we have not investigated that are related to the universities' degree programme and professional community that influence the beliefs about exposure; for instance, attitudes and course content in manual-based psychotherapies and evidence-based treatments. Nevertheless, these findings suggest that place of education contributes both to differences in how ET is perceived and whether ET is used in future clinical work.

Our results indicated no significant difference in endorsement of negative beliefs between therapists who work primarily with children and adolescents and therapists who primarily work with adults. Inconsistent with our hypothesis but similar to the results for use of ET, we found no significant difference between practitioners primarily working in private practices and practitioners primarily working at a public institution, hospital or medical centre. Whereas Gyani et al. (2014) found that therapists who work in the public health sector are more positive toward research than private practitioners are; these findings are not necessarily applicable to attitudes toward exposure.

### **Limitations and Future Research**

The results of the current study should be interpreted in the context of study limitations. Firstly, we have measured self-reported use of ET and core exposure techniques. This might not be an accurate measure of use seeing as other research has shown that self-



reported practice and direct observation of practice are not always correlated (Hurlburt, Garland, Nguyen, & Brookman-Fraze, 2010). In addition, there seems to be a discrepancy between therapists' and patients' experience in terms of what psychotherapeutic interventions have been included in treatment (Böhm et al., 2008). Correspondingly, self-report surveys might overestimate the use of ET and core exposure techniques. The discrepancy between self-reported use of ET and core exposure techniques also demonstrates that self-reported use can be measured in several ways: The authors argue that future research should focus even more on specific techniques to more precisely assess what therapists are doing when treating patients with anxiety. In particular, surveying specific techniques, both core exposure techniques and other techniques (i.e., CBT and non-CBT techniques), allows for an evaluation of whether exposure is conducted in an optimal manner. Moreover, when asked about specific techniques in this survey, participants were presented with short descriptions that may be interpreted differently by participants. Future research would benefit from the use of operational definitions of therapeutic techniques when conducting self-report surveys.

Another limitation of the current study is that we assessed therapists' practice across a range of anxiety disorders for which ET is the treatment of choice. Although prior research has found endorsement of exposure techniques and use of ET to be consistent across anxiety disorders (Freiheit et al., 2004; Hipol & Deacon, 2013; Pittig et al., in press; Whiteside et al., 2016), focusing on use and techniques for specific anxiety disorders may provide added information about the dissemination of ET. For example, a therapist who uses EMDR may provide imaginal exposure to PTSD-patients, but not report use of exposure.

The variables included in the current study explained 21.5% of all variance for use of core exposure techniques and 42% of all variance for use of ET. This suggests that there are other factors not included in this study that might influence use of ET and especially use of core exposure techniques. The present study focused primarily on therapist-related factors, as research indicates these factors are the primary barriers to the use of ET (Harned et al., 2013). However, other studies have demonstrated the influence of barriers of practicability (e.g., not having time for long exposure exercises or exercises outside office; Pittig et al., in press). This aspect should be included in future research as it is plausible that restrictions, for instance productivity requirements, time and recourses per patient represent significant barriers to the use of ET for practitioners working in the public sector. In addition, considering that ET is a manual-based approach, it might be beneficial to include attitudes toward manual-based psychotherapy, especially as psychotherapy manuals have been met with some criticism among practitioners (Carroll & Nuro, 2002).

### **Practical Implications**

The significant influence of several factors demonstrates the need for a multilevel approach targeting both individual and systemic barriers in the effort to optimise dissemination of exposure-based interventions in the treatment of anxiety disorders. One implication from the current study is that strategies to increase use of ET should focus on the implementation climate within the work place (i.e., support to use ET). The current study supports previous research that emphasises the importance of sufficient training in exposure, both in terms of the rationale behind and effectiveness of exposure and how to conduct exposure to produce optimal treatment outcome (Gunter & Whittal, 2010). The inconsistency between reported use of ET and core exposure techniques in the current study suggests that interventions to enhance dissemination of ET should especially focus on core exposure techniques, namely behavioural experiments and therapist-assisted in vivo, imaginal, or interoceptive exposure. For instance, studies show that explicitly addressing negative beliefs and perceived contraindications during training increases and improves use of exposure (Farrell, Deacon, Dixon, et al., 2013; Farrell, Deacon, Kemp, et al., 2013; Farrell et al., 2016). This is in line with the present findings, which indicate that perceived contraindications have a negative impact on use of core exposure techniques. Although such interventions can improve the dissemination of ET, they are somewhat limited to therapists who specifically seek training in ET or are encouraged to do so by their workplace or professional community.

In order to address a wide range of mental health professionals, we propose that interventions should be included during their initial qualification. Previous research has found that therapists who receive training in ET during their initial qualification use exposure more frequently when later treating anxiety disorders in routine care (Broicher et al., 2017; Pittig & Hoyer, 2017). Encouragingly, one study found that inexperienced psychology students can successfully learn to treat patients with OCD using ET (Solem et al., 2009); illustrating that exposure can readily be taught to and effectually implemented by mental health professionals independent of clinical training and experience. Although specific training in ET during initial qualification will likely improve the dissemination of exposure, it is perhaps not feasible across professions. There may not be time nor capacity to provide such training in shorter degrees, such as nursing and social work, and the same can be said for medical degrees where the purpose is to educate general medical practitioners. Working to increase focus on evidence-based treatment, clinical research, and the potential drawbacks of choosing less empirically supported treatment methods may prove a better interdisciplinary intervention that is more readily implemented during mental health professionals' initial

qualification. This may help to reduce the general lack between research and clinical practice, which in turn could improve the dissemination of ET.

Previous research has indicated that supervisors play a particularly influential role in therapists' clinical decision-making (Gyani et al., 2014). In turn, increasing supervisors' knowledge of evidence-based treatments and its role in clinical decision-making can be a possible avenue for improving the use of empirical evidence when selecting psychotherapeutic interventions. Interventions that are directed towards supervisors may be especially influential for therapists who are acquiring a clinical or psychiatric specialisation.

With reference to clinical psychologists, we found that use of ET and endorsement of negative beliefs about exposure varied based on where participants had received their degree. As previously mentioned this may indicate that the provided treatment to patients with anxiety is somewhat dependent on the course content and training provided by the respective universities. An implication of this finding is that it might be preferable to coordinate educational programs for clinical psychologists in Norway in order to assure that patients with anxiety are offered the same treatment options regardless of therapists' educational background and that treatment is based on the principle of evidence-based practice.

### **Conclusion**

The current study demonstrates that most Norwegian mental health professionals report using ET often in the treatment of anxiety disorders, however only a minority report using core exposure techniques. Moreover, the present findings suggest that therapists may provide ET in a manner that is insufficient, due to a lack of emphasis on core exposure techniques. Instead, therapists presumably favour non-exposure techniques, such as cognitive strategies and arousal reduction strategies. Our findings also highlight the contribution of several factors for the use of ET in the treatment of anxiety disorders: Negative beliefs about exposure and perceived contraindications for use of ET were the most prominent barriers, while acquired knowledge, self-rated competence and perceived competence and support in professional community were the most important factors for increasing use of core exposure techniques. Furthermore, the results of the current study give rise to practical implications with regard to the education and training of mental health professionals and the educational program for Norwegian clinical psychologists. In sum, our findings suggest a lack of dissemination of ET among Norwegian mental health professionals that should be addressed in order to assure that patients with anxiety disorders are offered the most effective and empirically supported treatment.

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Appendix



### Valg av terapeutisk tilnærming i angstbehandling

Formålet med denne spørreundersøkelsen er å kartlegge terapeuters behandlingsvalg i møte med angstlidelser, og å identifisere faktorer som er med på påvirke valg av terapeutisk tilnærming. Dette gjør vi for å få bedre innsikt i hvordan norsk helsepersonell behandler angstlidelser. Resultatene fra undersøkelsen vil bli brukt i vår hovedoppgave ved profesjonsstudiet i psykologi ved NTNU.

NB: Vi ønsker *bare* svar fra deg som er ansatt i en terapeutstilling og som driver psykologisk behandling.

Det er frivillig å delta, og all informasjon vil bli behandlet konfidensielt. Datamaterialet vil bli anonymisert ved prosjektslutt, senest ved utgangen av 2018. Resultatene vil bli presentert slik at ingen enkeltpersoner kan gjenkjennes. Du samtykker i å delta ved å svare på spørsmålene og sende dem inn ved å klikke på «Ferdig» på siste side.

Det tar ca. 20 minutter å svare. Har du spørsmål kan du kontakte Nora V. Svihus (412 15 962) eller Maya G. T. Nærland (473 42 401).

Takk for at du er villig til å delta!

Maya G. T. Nærland og Nora V. Svihus  
psykologstudenter

Leif Edward Ottesen Kennair  
professor/psykologspesialist og daglig ansvarlig  
Tlf. 955 57 004

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Vennligst svar på alle spørsmålene i én økt.  
Bryter du av underveis, må du starte på nytt.

#### Bakgrunnsinformasjon

Kjønn:

- Kvinne
- Mann
- Annen oppfatning av kjønn

## DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

Alder:

Yrke:\*

Dette spørsmålet må besvares, fordi svaret er avgjørende for hvilke spørsmål du får.

- Lege
- Psykolog
- Sykepleier
- Sosionom
- Annen utdanning:

Har du psykiatrisk eller klinisk spesialisering?

- Ja
- Nei

Hvor ble du uteksaminert som psykolog?

- Oslo
- Bergen
- Trondheim
- Tromsø
- Utlandet

Hvor jobber du primært?

- Offentlig institusjon / sykehus / medisinsk senter
- Privatpraktiserende
- Privatpraktiserende med hjemmel

Hvem jobber du primært med?

- Voksne
- Barn og ungdom
- Eldre

Er du del av et OCD-team?

- Ja, er i et OCD-team nå
- Nei, men har vært det før
- Nei, har aldri vært i et OCD-team

Hvor mange år har du vært ansatt i en terapeutstilling?

Hvor lenge har du arbeidet som terapeut?

	År	Måneder
Oppgi antall år og måneder, evt. bare år eller bare måneder:	<input type="text"/>	<input type="text"/>

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## Klinisk praksis

Hvilke(n) teoretisk(e) orientering(er) beskriver din terapeutiske tilnærming best?

Ranger inntil 3 orienteringer fra 1-3, hvor 1 er mest beskrivende.

	1	2	3
Psykodynamisk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kortidsdynamisk psykoterapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psykoanalytisk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kognitiv terapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Atferdsterapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Metakognitiv terapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Humanistisk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interpersonlig terapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emosjonsfokusert terapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eksistensiell psykoterapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mindfulnessbasert terapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mentaliseringsbasert terapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dialektisk atferdsterapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eklektisk/integrativ	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Annet (beskriv i feltet nedenfor)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Hva består ditt kliniske arbeid primært av?

- Individualterapi
- Gruppeterapi
- Parterapi
- Familierapi

I løpet av *de siste 6 månedene*, har du hatt pasient(er) med én eller flere av disse diagnosene i behandling?  
Spesifikke fobier, agorafobi, sosial fobi, panikklidelse, tvangslidelse, posttraumatisk stresslidelse.\*

Dette spørsmålet må besvares, fordi svaret er avgjørende for hvilke spørsmål du får.

- Ja
- Nei

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## Behandlingsvalg i møte med angstlidelser

Følgende spørsmål tar utgangspunkt i dine behandlingsvalg i møte med følgende angstlidelser: Spesifikke fobier, agorafobi, sosial fobi, panikk lidelse, tvangslidelse og posttraumatisk stresslidelse.

I noen av spørsmålene brukes begrepet «eksponeringsbehandling». Med dette menes behandling som innebærer bruk av eksponeringsteknikker i form av habituering og atferdsekspeserimenter.

Med utgangspunkt i *de siste 6 månedene*, hvor ofte har du pasienter med disse diagnosene i behandling?

	Alltid	Svært ofte	Ofte	Av og til	Sjelden	Svært sjelden	Aldri
Spesifikke fobier	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Agorafobi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sosial fobi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Panikk lidelse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tvangslidelse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Posttraumatisk stresslidelse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Hvor ofte bruker du følgende terapeutiske tilnærminger ved behandling av angstlidelser?

	Alltid	Svært ofte	Ofte	Av og til	Sjelden	Svært sjelden	Aldri
Eksponeringsbehandling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kognitiv terapi uten eksponering	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psykodynamisk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Korttidsdynamisk psykoterapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psykoanalytisk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Metakognitiv terapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Humanistisk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interpersonlig terapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emosjonsfokusert terapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eksistensiell psykoterapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mindfulnessbasert terapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mentaliseringsbasert terapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dialektisk atferdsterapi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Her er to spørsmål om hvordan du anvender eksponeringsbehandling gitt at dette er valgt behandlingsmetode. Bruker du andre metoder enn eksponeringsbehandling, velger du «ikke relevant».

	Alltid	Svært ofte	Ofte	Av og til	Sjelden	Svært sjelden	Aldri	Ikke relevant
Hvor ofte lager du angsthierarki med pasienten din i tilfeller hvor du bruker eksponeringsbehandling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hvor ofte utfører du eksponeringsbehandlingen selv?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hvor ofte bruker atferdsekspeserimenter?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hvor ofte anvender du habitueringsprinsipp?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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## Kompetanse innenfor eksponeringsbehandling

Har du ...

	Ja	Nei
lært om eksponeringsbehandling i løpet av din utdanning?	<input type="radio"/>	<input type="radio"/>
lært om eksponeringsbehandling gjennom spesifikk videreutdanning?	<input type="radio"/>	<input type="radio"/>
lært om eksponeringsbehandling på kurs?	<input type="radio"/>	<input type="radio"/>
fått veiledning innen eksponeringsbehandling?	<input type="radio"/>	<input type="radio"/>

Hvor godt eller dårlig stemmer følgende utsagn for deg?

	Stemmer svært godt	Stemmer nokså godt	Verken / eller	Stemmer nokså dårlig	Stemmer svært dårlig
Jeg har kompetanse på bruk av eksponeringsbehandling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jeg er i et fagmiljø som har kompetanse på bruk av eksponeringsbehandling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jeg er i et fagmiljø som støtter bruk av eksponeringsbehandling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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## Therapist Beliefs about Exposure Scale (norsk oversettelse)

Her er en rekke påstander om eksponeringsbehandling for angstlidelser. Med eksponeringsbehandling menes behandling som tar i bruk eksponeringsteknikker i form av habituering og/eller atferdseksperimenter.

Hvor enig eller uenig er du i hver påstand?

	Svært enig	Delvis enig	Verken / eller	Delvis uenig	Svært uenig
De fleste pasienter har vansker med å tolerere ubehaget fremkalt under eksponeringsbehandling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eksponeringsbehandling retter seg ikke mot underliggende årsaker ved en angstlidelse, men adresserer heller overfladiske symptomer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eksponeringsbehandling fungerer dårlig for komplekse saker, som for eksempel når pasienten har flere diagnoser	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sammenlignet med andre terapeutiske tilnærminger, fører eksponeringsbehandling til høyere frafall ("dropout")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eksponeringssesjoner som foregår utenfor terapirommet øker risikoen for en uetisk dobbeltrelasjon til pasienten	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Det er vanskelig å skreddersy eksponeringsbehandling til pasientens individuelle behov	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sammenlignet med andre terapeutiske tilnærminger, er eksponeringsbehandling assosiert med en mindre sterk terapeutisk relasjon	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Å be pasienten om å diskutere traumatiske minner i eksponeringsbehandling kan retraumatisere pasienten	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

Det er uetisk av terapeuter å intensjonelt fremkalle ubehag hos pasienten	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pasienter kan dekompensere (dvs., miste mental og/eller atferdsmessig kontroll) under svært angstprovoserende eksponeringssesjoner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Svært enig	Delvis enig	Verken / eller	Delvis uenig	Svært uenig
Eksponeeringssesjoner som foregår utenfor terapirommet kan gå på bekostning av taushetsplikten	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avspenningsteknikker, som f. eks pusteøvelser, er ofte nødvendige for at pasienter skal kunne tolerere ubehaget fremkalt i eksponeringsbehandling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sammenlignet med andre terapeutiske tilnærminger, er det høyere risiko for at pasienten skades i eksponeringsbehandling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
De fleste pasienter opplever at eksponeringsbehandling gir et uakseptabelt ubehag	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eksponeeringsbehandling forårsaker ofte en forverring av pasientens angstsymptomer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Å be pasienten om å diskutere traumatiske minner i eksponeringsbehandling kan medføre sekundær traumatisering av terapeuten	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pasienten kan utsettes for fysisk skade som følge av egen angst (f.eks, bevissthetstap), under svært angstprovoserende eksponeringssesjoner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Imaginær eksponering er tilstrekkelig, eksponering for fryktede stimuli i den virkelige verden er sjeldent nødvendig	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eksponeeringsbehandling er inhumant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
De fleste pasienter nekter å delta i eksponeringsbehandling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sammenlignet med andre terapiformer, er eksponeringsbehandling forbundet med en økt risiko for at pasienten sender klage til fylkesmannen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Her er noen pasientrelaterte kjennetegn som terapeuter av og til anser som betydningsfulle for om man vurderer eksponeringsbehandling som egnet for pasienten.

Ranger sannsynligheten for at du tilbyr eksponeringsbehandling til en pasient basert på hvert enkelt kjennetegn.

	Svært usannsynlig	Noe usannsynlig	Noe sannsynlig	Svært sannsynlig
Pasienten har en komorbid psykoselidelse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pasienten er emosjonelt sårbar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pasienten er motvillig mot å delta i eksponeringsbehandling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pasienten har en komorbid ruslidelse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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## DISSEMINATION OF EXPOSURE THERAPY IN NORWAY

Her er noen utsagn om deg som terapeut i en terapeutisk setting, uavhengig av behandlingsmetode og pasientgruppe.

Hvor godt eller dårlig stemmer hvert utsagn for deg?

	Stemmer svært godt	Stemmer nokså godt	Verken /eller	Stemmer nokså dårlig	Stemmer svært dårlig
Jeg synes det er ubehagelig å fremkalle negative følelser hos pasienten min	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jeg synes det er ubehagelig å gjøre pasienten min engstelig	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Noen ganger må pasienter tåle å møte sine vondeste følelser for å oppleve bedring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jeg mener at man må unngå å vekke ubehagelige følelser hos pasienten for at den terapeutiske relasjonen ivaretas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jeg unngår av og til å gjøre ting i behandling fordi det vil være ubehagelig for pasienten	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jeg unngår av og til å prate om tema i behandling fordi det vil være ubehagelig for pasienten	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jeg pleier å forklare pasienten rasjonale bak den valgte behandlingsmetoden	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jeg unngår av og til å gjøre ting i behandling fordi jeg synes det er ubehagelig	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jeg unngår av og til å prate om tema i behandling fordi jeg synes det er ubehagelig	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

For å sende inn svarene dine og samtykke i å delta i undersøkelsen, klikker du på «Ferdig».

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