2021

Differences in Attitudes Among Therapists in Suburban Versus Urban Settings Regarding Evidence-Based Treatments

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Abstract

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MS, Walden University, 2009

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Previous research has indicated that evidence-based treatments have proven effective in clinical trials. However, the transfer of desired outcomes from research settings to practice settings reflects a gap in the literature. Therefore, the purpose of this study was to examine whether differences exist between the attitudes of therapists who work in suburban versus urban settings and who do and not use evidence-based treatments in their attitudes toward evidence-based treatments and perceptions of treatment characteristics. The theoretical framework for this study was the theory of planned behavior. This quantitative study used the evidence-based practice attitude scale to assess therapist attitudes toward evidence-based treatments and the perceived characteristics of intervention scale to evaluate treatment characteristics' perceptions. A sample of 64 mental health therapists in New York State suburban and urban private practice settings, completed both assessment inventories. This nonexperimental quantitative study used eight two-way ANOVAs to examine whether differences exist between therapist attitudes in suburban versus urban settings toward evidence-based treatments and perceptions of treatment characteristics. The study results revealed no differences between therapists' perspectives in suburban versus urban settings toward evidence-based treatments and perceptions of treatment characteristics. Understanding the differences between the attitudes and perceptions of therapists in suburban versus urban settings can assist in creating treatments that can be tailored so that the outcomes in practice settings mirror effective results in clinical trials. Favorable treatments are typically implemented with fidelity which contributes to individual growth and leads to social change.

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Dedication

Walden University's mission statement involves promoting social change. With that in mind, I would like to dedicate my dissertation to my parents Mrs. Elmon Marie Kyle, whose belief in me remained steadfast from the first day of my life to the last day of hers; and Mr. Bennie Kyle, whose strength and support has always been unwavering. To my mom: "Mommy I did it, I finally did it". To my dad: "Daddy this is a present for your 100th birthday". Together as a family, we have gone from the sharecropper's fields to the doctor's office. Thank you both for everything I love you very much.

Acknowledgments

I would like to thank my wife Mrs. Janice Yvonne Kyle for the unconditional support she has given me throughout the years. Truth be told, I would not be where I am without her help. I would also like to thank all my family, friends, and acquaintances for any level of help, encouragement, and prayers they may have given. Finally, I would like to thank my committee Dr. Magy Martin and Dr. Patricia Loun as well as my academic advisor Dr. La Toya Johnson, for all their help as well as support and especially for believing in me despite the amount of time it took for me to complete the task.

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Chapter 1: Introduction to the Study

Epidemiological information indicates that almost 50% of the adolescents in the United States have had a diagnosable mental health disorder during their lives (Merikangas et al., 2010). Approximately one in 11 adolescents have a major depressive episode yearly (Mojtabai et al., 2016). Results from two nationally representative surveys of adolescents (N = 506,820) in Grades 8 through 12 in the United States, and national statistics on suicide deaths for ages 13 to18 years, indicate that adolescents' depressive symptoms, suicide-related outcomes, and suicide rates have risen between 2010 and 2015, particularly among females (Twenge et al., 2018). The rates of depression in adolescents are growing, and the lack of change in mental health interventions has contributed to an increasing number of adolescents with untreated depression (Mojtabai et al., 2016). Adolescents who reside in urban and suburban metropolitan settings frequently face life challenges that can contribute to mental health illness. The vulnerability for serious mental illnesses such as anxiety, mood, or addictive disorders is typically high in urban and suburban settings (Gruebner et al., 2017). Many adolescents who reside in urban and suburban settings are at risk for the same disorders but have distinct reasons. Suburban settings are at risk for suicide ideation due to school bullying as well as influences that include family conflict, alcohol, smoking, substance use, depression, and anxiety symptoms (Lardier et al., 2016). Researchers have also discovered that suburban settings are composed of a more homogeneous population consisting of middle-class or more affluent families ($120,000 per household/year and more), and many suburban adolescents smoke more, drink more, engage in hard

substances more often, and have greater rates of depression and anxiety than adolescents in urban settings (Marano, 2016). The adolescents who reside in urban settings face a different set of life challenges. Urban settings are composed of a more heterogeneous population and have mental health risk factors that include concentrations of low income, low education levels, low social support, and social segregation involving perceived minority status or ethnic group membership (Rapp et al., 2015). Investigators have found that residing in destitute environments has correlations with mental health disorders such as depression (Meyer et al., 2014). Comparing what therapists believe about treatments being used in suburban and urban settings could be useful in the development of future treatments. A comparison of therapist attitudes and perceptions about treatments being used in suburban versus urban settings would contrast therapists' attitudes about treatments being used with populations that are more homogeneous than with heterogeneous populations.

Evidence-based treatments have emerged to deliver service to adolescents in need, but despite their success in research settings, EBTs with adolescents in practice settings have not been fruitful (Prado et al., 2015). The lack of success with EBTs in practice settings represents a gap between clinical research and clinical care. Beidas and Kendall (2010) revealed that therapists have mixed attitudes about EBTs, which theoretical orientations or clinical experience may have influenced. Mental health therapists typically believe that most EBT studies involve homogeneous groups of participants (Southam-Gerow et al., 2012). These therapists believed that researchers have not established the desired results of EBTs in practice settings where patients are

more heterogeneous, distressed, complicated, and formidable to treat (Stewart et al., 2012). Researchers have suggested that therapists' attitudes toward evidence-based methods and doing things differently can have a notable effect on the implementation of contemporary treatments. Aarons et al. (2010) claimed that therapists' attitudes toward new treatments can affect implementation in several phases: (a) attitudes determine if a therapist will attempt an EBT; (b) the emotional element of an attitude can influence decisions on treatment implementation as well as use; and, (c) experiences can affect attitudes. Understanding the attitudes that affect treatments can help researchers identify the components necessary for positive outcomes. Previous research has investigated how therapist traits relate to their beliefs about EBTs, but few studies have concentrated on intervention characteristics that affect therapist attitudes (Barnett et al., 2017). Results from my study can be used to bridge a gap between research and practice. Researchers can use the results of this study to tailor treatments and implementation efforts to accommodate practitioners' skills and the needs of adolescents in suburban and urban settings. When researchers consider issues important to practitioners, the implementation of resulting evidence-based practices is more likely to succeed. Improving effective care for adolescents should increase the potential for positive social change.

Chapter 1 contains the background of the study, highlighting the gap in knowledge regarding therapists' attitudes towards EBTs. I then present a clear statement of the problem, the purpose of the study, and the research questions and hypotheses that will address the problem. The chapter concludes with a brief overview of the study, including its theoretical underpinnings, nature, assumptions, scope, delimitations,

limitations, and significance. Definitions of key terms appear throughout this study, and the chapter will conclude with a summary.

Background

Despite the development and success of innovative treatments in research settings, EBTs with adolescents in suburban and urban settings have not been productive (Prado et al., 2015). Because an urban setting has a more heterogeneous population about race, culture, education, and socio-economic status than a suburban setting (Rapp et al., 2015), the most effective approaches to treatments may differ depending on the setting. In this study I discuss the theoretical proposition chosen to guide the conversion of its research into practice. I reviewed the attitudes of therapists who are proponents and opponents of EBTs in practice settings. I examined the effects of the application of EBTs in practice settings will be examined, and I considered training for EBTs. Finally, I viewed the studies related to the research questions and reported the trends in adolescent mental health care.

The difference between the successful productivity of EBTs in research settings and the results of treatments in suburban and urban settings represents a gap between mental health research and practice. A significant factor contributing to this gap has been the scarcity of information on the adoption of EBTs with adolescents in practice settings (Lee et al., 2013). The gap in the literature includes (a) attitudes of therapists in suburban and urban settings that influence the implementation of EBTs with adolescents; and, (b) the therapist perceptions of treatment characteristics that influence how they work with adolescents in suburban and urban settings. I proposed to bridge these gaps by providing

an understanding of the attitudes of mental health therapists that contribute to the adoption of EBTs in suburban and urban settings. An examination of therapist perceptions of the characteristics of treatments they use with adolescents in suburban and urban settings will provide an understanding of the traits of treatments that will allow EBTs to have desirable outcomes in suburban and urban settings. The four subscales of Aarons' (2004) evidence-based practice attitude scale (EBPAS) measure therapists' attitudes: (a) intuitive appeal; (b) attitudes toward organizational requirements; (c) openness to change; and, (d) perceived divergence of usual practice with EBTs. Additionally, Cook et al., (2015) perceived characteristics of intervention scale (PCIS) measures four treatment characteristics. Cook et al., (2015) created the scale to assess health care providers' views of treatments, and the subscales include: (a) relative advantage, (b) task issues, (c) potential for reinvention, and (d) compatibility.

This study is necessary because it will provide information about therapists who are responsible for providing effective mental health care in suburban and urban metropolitan settings. Whereas both settings are parts of a city, the people who reside in these settings are different and may require an altered approach to treatment. Practitioners working in suburban and urban settings could use the results of this study to improve implementation efforts and help tailor treatments to accommodate the traits of therapists and the needs of the adolescents receiving service. Research has suggested that therapists are the key actors who can enhance the effectiveness of treatment implementation (Aarons et al., 2012). Understanding therapist attitudes toward EBTs and their perceptions of the characteristics of treatments is critical for positive outcomes.

Problem Statement

EBTs have not produced the same outcomes in practice settings as in controlled trials (Prado et al., 2015). Research has indicated that client results and therapist implementation results are lessened when treatments are provided in practice settings as opposed to research settings (Lau et al., 2018). The increasing number of adolescents facing mental health problems has led to urgent calls for the development of new treatments that are effective in practice settings. Danielson et al. (2019) note that the implementation of new treatments is heavily influenced by therapists' attitudes. Despite the many studies devoted to EBTs, information about the differences between therapist attitudes in suburban and urban settings toward EBT implementation, and perceptions of the treatment characteristics that affect therapist attitudes are sparse. The goal of the study was to shed light on these gaps in the literature.

Purpose of the Study

The purpose of this quantitative study was to examine whether differences exist between the attitudes of therapists who work in suburban versus urban settings and who do and do not use EBTs in their attitudes toward EBTs and perceptions of treatment characteristics. Quantitative research is an appropriate tool to examine and compare differences between subpopulations within a larger population (Creswell, 2003). I conducted the study to determine whether a significant difference exists between the independent variables in the study which were the practice settings (suburban which has a homogenous population versus urban which has a heterogeneous population) and the implementation of EBTs with two levels (yes and no). The dependent variables were

therapist attitudes toward EBTs measured by the four subscales of the EBPAS which include: (a) intuitive appeal, (b) organizational requirements, (c) openness to change, and (d) perceived divergence of usual practice with EBTs. Additional dependent variables were therapist perceptions of treatment characteristics measured by four subscales of the PCIS which included (a) relative advantage, (b) task issues, (c) potential for reinvention, and (d) compatibility. I considered race, work experience, theoretical orientation, occupational background, and training as covariates. I used these results to address the need for EBTs to produce the same outcomes in practice settings as in research settings.

Research Questions and Hypotheses

The following research questions and hypotheses guided the quantitative investigation.

RQ1: Are there are differences between the attitudes of therapists who work in suburban versus urban settings and who do and do not use EBTs in their attitudes toward the intuitive appeal of EBTs?

$H_0$1: There are no differences, as measured by the total EBPAS subscale score, between the attitudes of therapists who work in suburban versus urban settings and who do and do not use EBTs in their attitudes toward the intuitive appeal of EBTs.

$H_1$1: There are differences, as measured by the total EBPAS subscale score, between the attitudes of therapists who work in suburban versus urban settings and who do and do not use EBTs in their attitudes toward the intuitive appeal of EBTs.

RQ2: Are there are differences between the attitudes of therapists who work in suburban versus urban settings and who do and do not use EBTs in their attitudes toward the organizational requirements of EBTs?

$H_0$2: There are no differences, as measured by the total EBPAS subscale score, between the attitudes of therapists who work in suburban versus urban settings and who do and do not use EBTs in their attitudes toward the organizational requirements of EBTs.

$H_1$2: There are differences, as measured by the total EBPAS subscale score, between the attitudes of therapists who work in suburban versus urban settings and who do and do not use EBTs in their attitudes toward the organizational requirements of EBTs.

RQ3: Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their openness to change?

$H_0$3: There are no differences, as measured by the total EBPAS subscale score, between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their openness to change.

$H_1$3: There are differences, as measured by the total EBPAS subscale score, between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their openness to change.

RQ4: Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceived divergence of usual practice with EBTs?

$H_0$4: There are no differences, as measured by the total EBPAS subscale score, between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceived divergence of usual practice with EBTs.

$H_1$4: There are differences, as measured by the total EBPAS subscale score, between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceived divergence of usual practice with EBTs.

RQ5: Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the relative advantage of treatments?

$H_0$5: There are no differences, as measured by the total PCIS subscale score, between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the relative advantage of treatments.

$H_1$5: There are differences, as measured by the total PCIS subscale score between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the relative advantage of treatments.

RQ6: Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the task issues of treatments?

$H_0$6: There are no differences, as measured by the total PCIS subscale score, between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the task issues of treatments.

$H_1$6: There are differences, as measured by the total PCIS subscale score between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the task issues of treatments.

RQ7: Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the potential for the reinvention of treatments?

$H_0$7: There are no differences, as measured by the total PCIS subscale score, between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the potential for the reinvention of treatments.

$H_1$7: There are differences, as measured by the total PCIS subscale score between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the potential for the reinvention of treatments.

RQ8: Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the compatibility of treatments?

$H_0$8: There are no differences, as measured by the total PCIS subscale score, between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the compatibility of treatments.

$H_1$8: There are differences, as measured by the total PCIS subscale score between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the compatibility of treatments.

Theoretical Framework

The theoretical base for this study was Ajzen's (1991) theory of planned behavior (TPB). Many researchers have used TPB to investigate an immense range of behavior and is especially useful in applied settings (McEachan et al., 2011). The TPB connects beliefs with behavior; it can determine the variables that motivate health care professionals' behavior and predict a change in that behavior (Nilsen et al., 2012). According to the TPB, perceived behavioral control combined with behavioral intention help to predict behavioral achievement (Ajzen, 1991). The goal of the theory is to predict and explain human behavior (Ajzen, 1991), and because of this, TPB has been used as a foundation for analyzing the cognitive processes involved in clinical decision making and implementing EBTs (Nilsen, 2015). Because the TPB postulates that the antecedents of attitudes determine actions and intentions (Ajzen, 1991), the theory was useful to the results of this study to make conjectures about therapist attitudes toward the use of EBTs with adolescents in suburban and urban settings.

Nature of the Study

I used a quantitative approach. The research design allowed an examination of the differences between the attitudes of therapists who work in suburban versus urban settings and who do and do not use EBTs in their attitudes toward EBTs and perceptions of treatment characteristics. The settings and who do and do not use EBTs were the independent variables. The dependent variables included were therapist attitudes toward EBTs and perceptions of treatment characteristics. The covariates were gender, race, work experience, theoretical orientation, occupational background, and training. I used

Aarons' (2004) psychometrically validated EBPAS (Appendices A & B) and Cook et al., (2015) psychometrically validated PCIS (Appendix D) self-report survey instruments to gather data for this study. I garnered permission to use the EBPAS (Appendix A) and the PCIS (Appendix C) from the authors of the instruments. I composed a demographic questionnaire to gather data about sociodemographic and professional characteristics.

I invited participants from the Good Therapy (Good Therapy, 2019) and Psychology Today (Psychology Today, 2019) websites. These websites serve as a directory for licensed therapists to advertise their services. The websites also list the locations of the practices that allowed me to distinguish between suburban and urban settings. Participants completing the survey included male and female Caucasian, African American, and Hispanic therapists. Participating therapists who identified with a race not listed were classified as others. The therapists included psychologists with master's and doctoral training, clinical social workers, and licensed mental health counselors.

Definitions

Attitudes toward EBT. I identified Aarons' (2004) four domains of therapist attitudes towards the individual and organizational constructs that determine treatment implementation: (a) intuitive appeal, (b) attitudes toward organizational requirements, (c) openness to change, and (d) perceived divergence of usual practice from EBT. I also identified Cook et al., (2015) four constructs of perceived characteristics of interventions in the literature that affect the attitudes of therapists: (a) relative advantage, (b) task issues, (c) potential for reinvention, and (d) compatibility.

An *intuitive appeal* is an appeal of adopting an evidence-based treatment (Frambach & Scillewaert, 2002).

Attitudes toward organizational requirements are the extent that therapists will adopt and comply when new treatments are mandated (Garland et al., 2003).

Openness to change is the willingness to change (Anderson & West, (1998).

Perceived divergence of usual practice with research-based/academically developed interventions is the amount of deviation that occurs when a change has been recognized (Aarons, 2004).

Relative advantage is the degree to which an innovative treatment is considered superior to existing practices (Rogers, 1962).

Task issues are concerns about the innovative treatment that therapists need to be focused on to accomplish implementation (Greenhalgh et al., 2005).

Potential for reinvention is the ability to elaborate and modify the innovative treatment (Greenhalgh et al., 2005).

Compatibility is the innovative treatment's consistency with existing values, experiences, and needs of adopters and system (Rogers, 1962).

Evidence-based practice (EBP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (APA Task Force on Evidence-Based Practice with Children & Adolescents, 2008). EBP is a widespread idea that includes evidence-based treatments (EBTs) as well as evidence-based assessments (EBAs), which I used interchangeably throughout this study.

Implementation cliff is when a treatment is seldom implemented in community settings (Weisz et al., 2014).

Voltage drop is a non-beneficial implemented treatment (Chambers et al., 2013).

Assumptions

Assumptions Critical to the Study

An assumption that is important to the study was that participants who volunteered for the study did not have bias and that individuals who may be disgruntled with their practice did not refrain from participation.

Necessity of Assumptions

Another assumption was that the participants were familiar with the term *evidence-based practice* and answered the survey truthfully and to the best of their ability. These assumptions are necessary because was not possible to assess the integrity of each participant. A third assumption was that the EBPAS and the PCIS were appropriate measures for the identified variables. I made this assumption because of the scarcity of instruments designed to assess attitudes toward EBTs or perceptions of treatment characteristics that have been psychometrically validated (Rye et al., 2017).

Scope and Delimitations

Issue of Internal Validity

The four domains of therapist attitudes toward the implementation of EBT are critical aspects of the research problem addressed in this study. These aspects of therapist attitudes are the focus because of their importance about therapists' views of the individual and organizational constructs that determine treatment implementation

(Aarons, 2004). The four constructs of perceived treatment characteristics are also essential aspects of this study's research problem. These aspects of therapist perceptions of treatment characteristics are also the focus because they may serve to promote or be a roadblock for EBTs (Cook et al., 2015).

External Validity

The studied population consisted of therapists in private practices. Therapists in private practice do not have to administer treatments because of mandates that dictate eligibility for state or federal funding. Therefore, therapists in private practice can better control the treatments they want to use, whereas therapists who work for agencies must abide by the agency policies and mandates. For that reason, therapists from private practices that provide service to adolescents in the suburban and urban sections of the metropolitan areas were eligible. I also selected this population because they were the most accessible. The excluded population consisted of therapists in state agencies and public-school systems. The organizational complexities involved in gaining permission to conduct the study in those venues, along with the difficulty of accessing potential participants, made this population too impractical to study.

Scholars have employed numerous other theories related to this area of study, including the theory of reasoned action, social cognitive theory, and the theory of interpersonal behavior. Scholars have regularly applied all these theories to determine behavior change (Nielsen, 2015), I chose the TPB because of its focus on the antecedents of attitudes that affect actions and intentions.

Potential Generalizability

Generalizability may extend to comparable populations in other suburban and urban practice settings. The inclusion of state agencies that provide mental health services to adolescents could enhance the study.

Limitations

Limitations Related to Design or Methodology

I limited the study to private practices because it was easier for me to access them. Also, I had no control over which private practice would cooperate or the number of therapists who would participate. I also had no control over the individual response time of the participants once the survey has been circulated. I had no way to control the EBTs that the participating therapists use.

Limitations Related to Internal, External, and Construct Validity

The EBPAS is an efficient instrument with psychometric properties, but it measures a limited domain of attitude concepts (Rye et al., 2017). Also, the PCIS is described as generally unidimensional (Cook et al., 2015). Therefore, the perceived characteristic constructs it is measuring could be unidimensional.

Measures to Address Limitations

The study included only a narrow range of therapist attitudes and perceptions of treatment characteristics.

Significance of the Study

Significance to the Theory

The results of this study filled a gap in the literature by providing an understanding regarding the attitudes of therapists toward the adoption of EBTs with adolescents in suburban and urban practice settings, something previous studies have identified as a need in the field (Kozak et al., 2010). The analysis of these attitudes answered questions regarding the adaptability of EBTs to different subpopulations in suburban and urban settings (Southam-Gerow et al., 2012). Using the TPB as a foundation, the results from this study may help others make predictions about therapists' behavior and intention towards EBTs in these settings. This, in turn, may lead to the development of new ways to accommodate the varying requirements and traits of therapists in suburban and urban mental health agencies (Aarons et al., 2012).

Contribution to Practice

Therapists want to use methods that help provide successful treatment. When therapists are comfortable and confident with the treatments they administer, they use them without the need for a mandate or incentive. Because therapists have seldom used EBTs with adolescents in practice settings, it is important to understand the attitudes motivating them to implement or not to implement these innovative practices in community settings. The four domains that define the attitudes of therapists toward the adoption of EBTs provide insight into the development and implementation of new practices. The four perceived characteristics of interventions describe therapists' attitudes about the functionality of the EBT they are using. These eight variables affect

implementation for several reasons: (a) treatment must be appealing if the practitioner will implement them with fidelity; (b) despite requirements, some therapists may not comply with policy mandates; (c) therapists who are set in their ways need to have an openness to change; (d) divergence may occur when the practitioner identifies a difference between traditional practices and new methods; (e) innovative treatments that align with the clinical judgment of a therapist are considered compatible; (f) innovative treatments that practitioners can modify to fit the needs of the treatment environment have the potential for reinvention; (g) any concerns about an innovative treatment that requires attention for implementation are task issues; and (h) an innovative treatment has a relative advantage if it is more effective than the existing treatment. According to Simpson (2002), successful implementation of EBTs must consider the conditions in practice settings.

Significance to Social Change

Scholars acknowledge that habits are instinctive reactions to a set of circumstances established through the recurrence of behavior when the set of circumstances are present (Godin et al., 2008). Because a therapist's routine practice is notoriously hard to change, investigators contend that a therapist's habits are essential factors to understand when attempting to transition from one treatment to another (Nilsen et al., 2012). Integrating the habits that therapists consider effective with EBTs may incline them to use the new methods faithfully. Many therapists provide service in communities that are made up of ethnic/minority populations who might have difficulties engaging in treatment. Lau et al. (2018) suggested the possibility of EBTs presenting

more concerns than what is typically experienced in the treatment. Another concern is whether EBTs can meet the individual needs of the diverse populations residing in communities. Barnett et al. (2017) note how the rigidity of EBTs can make them too confining to meet individual needs. By obtaining a better understanding of therapist attitudes toward EBTs and the treatment characteristics that work best in particular settings, researchers can develop or modify treatments to assist the therapist's transition to something new.

Furthermore, an increased understanding could lead to the development of treatments that take into consideration engagement challenges with individuals from diverse populations, and that also allows some flexibility to accommodate individual needs. Providing information about what works best in practice settings can help develop EBTs that produce the same successful outcomes in practice settings as in research settings. If more therapists are willing to faithfully administer EBTs, more adolescents may receive effective and innovative care promoting positive social change. If more adolescents can feel that an EBT can help them, the more willing they may be to engage in treatment promoting positive social change. When an increased number of individuals are influenced by positive social change, it positively affects the communities where they reside. When an increased number of communities are influenced by positive social change, it positively affects society.

Summary

In this chapter, I recognized the need for evidence-based mental health interventions for adolescents in suburban and urban practice settings. I identified a

discrepancy between results in research settings and the outcomes in practice settings, which represented a major gap in the literature between science and practice. I noted several researchers who acknowledged the effects of therapist attitudes toward the implementation of EBTs. Moreover, I identified the problem posed by the scarcity of information about therapist attitudes toward the adoption of EBTs with adolescents in community settings. I posed research questions designed to investigate the four domains of therapist attitudes toward adopting EBTs and four constructs of therapists' perceptions of treatment characteristics in practice settings. I introduced the TPB as the study's theoretical base and defined its operational aspects. I also stated the research choices that shaped my focus and discussed the significance of the study.

In Chapter 2, I reviewed the existing literature regarding therapists' attitudes toward the adoption of EBTs in practice settings and identified the gaps in that knowledge. This included an explanation of the methods used to discover pertinent literature as well as a description of the theoretical framework used to frame the research questions, hypotheses, and data analysis interpretation. I also reviewed previous investigations associated with therapists' attitudes toward EBTs and the difficulties of implementing innovative practices in community settings. Lastly, I discussed the effects of training as a factor in the successful implementation of EBTs.

Chapter 2: Literature Review

Introduction

EBTs have not had the same results in practice settings as they have had in research settings (Prado et al., 2015). The literature has suggested that client results and the by-products of therapist implementation are not as effective in practice settings as they are in research settings (Lau et al., 2018). The purpose of this quantitative study was to examine whether differences exist between the attitudes of therapists who work in suburban versus urban settings and who do and do not use EBTs in their attitudes toward EBTs and perceptions of treatment characteristics.

The demand for effective interventions has strongly encouraged the development of new research-based methods (e.g. EBTs) (Chorpita et al., 2011). Using evidence-based methods as tools for treatment is a critical aspect of applying evidence-based practice (EBP). EBP is a method of operation that considers the most proven evidence attainable in decision making and determining procedures (Rousseau & Gunia, 2016). Numerous occupations apply EBP, but its roots are in the field of medicine in the 1980s when the objective was to advocate for the application of scientific evidence in physician education and clinical practice (Barenda & Briner, 2014). A productive application of EBP depends upon the possession of foundational and functional skills. Foundational skills involve common expertise as well as the knowledge needed to participate in all areas of EBP; functional skills are abilities obtained through education as well experience and knowledge, they relate to different actions such as evidence search and critical appraisal (Rousseau & Gunia, 2016).

The excitement in research circles around the productive psychological treatments for adolescents has diminished in recent years (Lee et al., 2013). Studies have indicated that treatments created and validated under controlled circumstances are ineffective at producing corresponding outcomes when therapists implement them in randomized controlled trials (Baker-Ericzen et al., 2010). Mental health scientists have recognized the dissonance between research and practice about treatment implementation and outcomes. When researchers create treatments that are seldom implemented in community settings, it is referred to as the *implementation cliff* (Weisz et al., 2014). Scholars refer to non-beneficial implemented treatments as a *voltage drop* (Chambers et al., 2013).

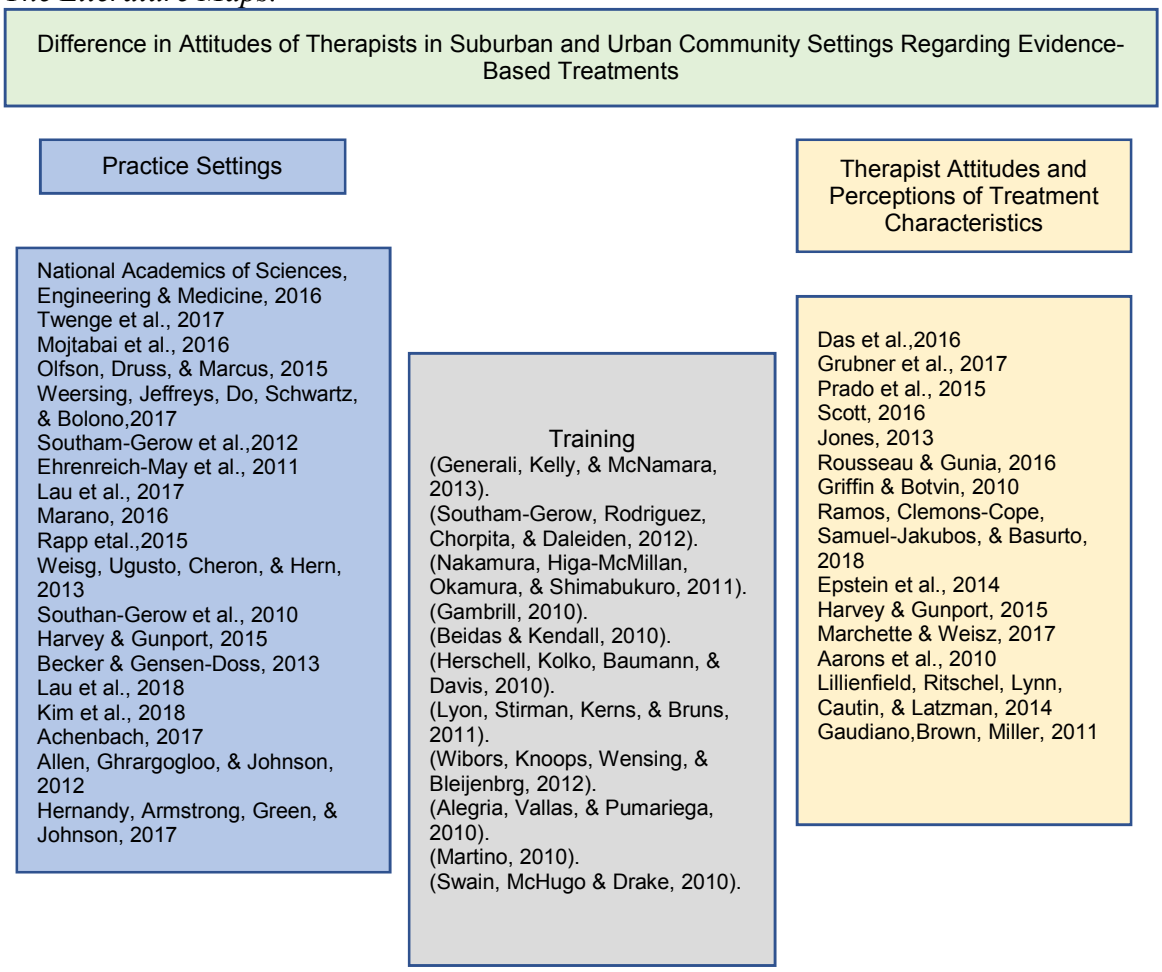
Some EBTs have proven effective in clinical trial settings. Still little information exists about using such EBTs with adolescents in practice settings where therapists want to implement treatments that are effective with diverse populations (Lee et al., 2013). The answers to this inquiry are important because the literature suggests that there is a persistent need for different psychological interventions due to the scarcity of productive results obtained by the most accomplished EBTs (Johnsen & Friborg, 2015). Supporters of EBTs have typically paid little attention to fundamental reasons why many psychologists in community settings have expressed concerns about applying the results from research in practice (Lillienfield et al., 2013). This disconnect between research and practice is a primary motivation for the study.

Information about therapists' thoughts about the application of EBTs in practice settings has recently become accessible. I undertook a review of selected literature to identify key factors involving therapists' attitudes toward the implementation of EBTs in

practice settings (Figure 1). I reviewed data from several peer-reviewed sources and chose several of those to summarize and integrate. In the rest of this chapter, I presented a comprehensive synopsis of the strategies that I used to search for relevant literature. I then described the results of that search, organized appropriately. I first addressed the theoretical framework. I then reviewed current work relating to therapist attitudes toward EBTs and their perceptions of treatment characteristics, the trends in adolescent mental health in addition to the challenges of implementing EBTs in suburban as well as urban practice settings, and the training options that are associated with EBTs. I also reviewed the ways that other researchers have approached assessing therapists' attitudes about EBTs. Finally, I summarized what has been discovered about therapists' attitudes toward EBTs and their perceptions of treatment characteristics in suburban and urban practice settings, and what remains to be studied.

Figure 1

The Literature Maps.



Literature Search Strategy

I conducted most searchers with two searches. When examining and framing the problem of assessing therapists' attitudes toward implementing EBTs in practice settings, I first searched the databases PsycARTICLES, PsycINFO, and SocINDEX. The second means of the literature review was thorough several databases available through the Walden University library including the Google Scholar database. The key research terms variations and combinations of the independent variables included those such as the

implementation of evidence-based treatments and practices in suburban as well as urban settings, evidence-based treatments in suburban as well as urban settings, and evidence-based treatments in practice settings. The key research terms variations and combinations of the dependent variables included those such as mental health therapists' attitudes about evidence-based treatments in practice settings, mental health therapists' attitudes about implementing evidence-based treatments in suburban as well as urban settings, and assessment of therapists' attitudes about evidence-based treatments for adolescents. I also used the terms evidence-based treatments in psychology, evidence-based treatments, and cultural competence, and the implementation of mental health evidence-based treatments with children and adolescents to gather additional relevant literature. The scope of the literature review includes studies published between 2010 and 2019. All results were restricted to peer-review studies and full-text articles, excluding dissertations. Virtually all inclusion factors include publication within the last 5 years.

Theory of Planned Behavior (TPB)

The ability to predict and explain the behavior of therapists effectively is critical to understanding what influences treatment implementation results. Psychological clinicians and researchers can use psychological theories to direct change from research into practice, comprehend what affects treatment implementation results, and assess implementation (Nilsen, 2015). The application of a theory guides procedures that pave the way for treatment implementation. Researchers have applied the TPB to analyze the factors that determine the change in clinical behavior (Nilsen et al., 2012). In this section,

I will review the origins of the TPB, its theoretical proposition, its rationale, how it has been applied in similar studies, and how it applies to this study.

Origins

The TPB, developed by Ajzen (1991), is a supplement to its predecessor, the theory of reasoned action (Ajzen & Fishbein, 1980). According to Ajzen (1991), the theory works to predict an individual's intention to behave in a certain way, at a specific time and place. It explains all conduct over which individuals can exercise self-control (Ajzen, 1991). The central factor in the TPB is behavioral intent—an individual's behavioral intentions depend on: (a) the individual's attitude regarding the probability that the behavior will have the anticipated result, and (b) the individual's subjective assessment of the risks and benefits of that result (Ajzen, 1991). In the TPB, behavioral attainment is contingent upon motivation (intention) as well as the ability (behavioral control) (Ajzen, 1991). TPB characterizes three forms of beliefs: (a) behavioral beliefs, which refer to beliefs about the probable consequences of the behavior, (b) normative beliefs, which refer to beliefs about the normative expectations of others, and (c) control beliefs which refer to the beliefs about the existence of elements that may promote or hinder the performance of the behavior (Ajzen, 1991). Behavioral beliefs generate an agreeable or disagreeable attitude toward the behavior, normative beliefs result in a perceived social pressure or subjective norm, and control beliefs become perceived behavioral control (Ajzen, 1991). Attitude toward the behavior, subjective norm and perception of behavioral control collectively guide the way to the creation of a behavioral intention (Ajzen, 1991). Typically, the more agreeable the attitude and subjective norm,

and the greater the perceived control, the more powerful the individual's intention to perform the behavior of interest (Ajzen, 1991).

Theoretical Proposition

Ajzen (1991), hypothesized that perceived behavioral control combined with behavioral intention could predict behavioral achievement. The author provided two reasons for this assumption: First, if intention remains constant, the effort used to bring a course of action to a fruitful outcome will probably grow (Ajzen, 1991). For example, if two people have equally strong intentions to learn to play tennis, and both attempt to accomplish that goal, the individual who is certain of becoming proficient at the task is more likely to persevere than the individual who doubts his or her ability. The second reason is that perceived behavioral control could frequently be applied as a replacement for a measure of actual control but doing so depends on the accuracy of perceptions (Ajzen, 1991). A precise prediction of behavior achievement depends on several conditions. First, it is essential that the measures of intention and perceived behavioral control be associated with and adaptable to the behavior that is to be predicted (Ajzen & Fishbein, 1977; Ajzen, 1988). In other words, it is necessary to evaluate the intentions and perceptions of control regarding the specific behavior of concern, and the described circumstances should be identical to those in which the behavior is to take place. For example, if the predicted behavior is to motivate the implementation of an EBT for adolescents, then the researcher must evaluate intentions to implement the EBT as well as the perceived control over implementing the EBT. The second condition for precise behavioral prediction is that intentions and perceived behavioral control must remain

constant during the time between the evaluation and monitoring of the behavior (Ajzen, 1991). Circumstances that happen incidentally may cause changes in intentions or in perceptions of behavioral control that impact the initial measures of the variables in unpredictable ways. The third condition for precise behavioral prediction involves the precision of perceived behavioral control, where perceptions of behavioral control genuinely mirror control that truly exists (Ajzen, 1991).

Definitions of Theoretical Constructs

Ajzen (1991) explained that the TPB consists of six constructs which, together, depict an individual's existing control over the behavior:

1.*Attitudes*—the degree to which an individual has an agreeable or disagreeable assessment of the behavior of interest; it involves an examination of the results of the performing behavior.

2.*Behavioral Intention*—the motivational elements that sway a given behavior, where the greater the intention to perform the behavior, the more likely the behavior will be performed.

3.*Subjective Norms*—the belief that most individuals endorse or oppose the behavior; the question of whether the peers and individuals of influence to the individual think that they should engage in the behavior.

4.*Social Norms*—the established codes of behavior in a group or individuals or larger cultural contexts; they are the social standards in a group of individuals.

5.*Perceived Power*—the perceived existence of elements that may promote or hinder the performance of behavior; it contributes to an individual's perceived behavioral control over each of those elements.

6.*Perceived Behavioral Control*—an individual's perception of the ease or challenge of performing the behavior of concern; it varies across circumstances and actions, which results in an individual having varying perceptions of behavioral control depending on the circumstance. The addition of perceived behavioral control is essentially the difference between the TPB and the theory of reasoned action; it was added because the first theory has limitations in handling behaviors over which individuals have incomplete volitional control.

Application in Similar Studies

According to Nilsen et al. (2012), applications of the TPB have allowed investigators to determine clinical behavior change involved in decision-making and implementation of EBTs. Godkin and Kok (1996) reviewed 56 studies that verified—either totally or partially—the efficacy of the TPB to explain intention or predict behavior. Their results indicated that the TPB could explain intension with perceived behavioral control being an attitude across health-related behavioral categories. In another study, Fields (2008) examined the TPB to determine the feasibility of its constructs for predicting therapists' inclusion of parents when treating youth. In their study, Dumitrescu, Wagle, Dogaru, and Manolescu (2011) tested the efficiency of the TPB to predict intention to improve oral health behaviors, attitudes toward oral health behaviors, and perceived behavioral control. Levy, Holttum, Dooley, and Ononaiye

(2016) explored the ability of the TPB to predict the intentions of trainee clinicians to use cognitive behavior therapy self-help materials routinely in their clinical practice. Their results suggested that the main constructs of the TPB were useful in predicting the intentions of trainees to use self-help materials routinely.

The rationale for the Theory

TPB is one of the most broadly tested models of factors that impact health-related behaviors (Cook & French, 2008). It has been especially useful in applied settings, and it has found many applications (McEachan et al., 2011). The TPB is precisely operationalized with guidelines regarding how to measure (Ajzen, 2006), analyze (Hankins, French, & Horne, 2000), and develop (Sutton, 2002) interventions using the theory (McEachan et al., 2011).

I propose to assess the attitudes of therapists that support and do not support the adoption of EBTs to gain knowledge about the obstacles to implementing EBTs with adolescents in suburban and urban community settings. Because the TPB can help explain the intentions of mental health therapists and predict their behavior, it can help determine how to change routine clinical behavior.

Application in This Study

I identified a gap in the existing literature between the implications of clinical research on EBTs and their implementation in the clinical practice of mental health therapists (Beidas et al., 2013). Individual intentions are frequently critical in the adoption of EBTs. Therefore, more information is needed about the cognitive mechanisms necessary to motivate a change in the approach of mental health therapists in

practice settings. Nilsen (2015) defined a theory as a set of principles that provide the understanding and an explanation for what impacts implementation results; thus, the TPB can assist in explaining the intentions of therapists to adopt EBTs. The ability to effectively explain and predict clinical behavior is important to professionals concerned with devising ways to change the behaviors of therapists regarding EBTs.

Literature Review Related to Key Variables

Despite the abundance of previous research on the issue, therapists have seldom used EBTs in practice settings (McHugh & Barlow, 2010). The implementation of EBTs in practice settings represents an innovation that therapists' attitudes toward the adoption of new treatments and practices may restrict or promote (Aarons et al., 2010). Therapists' attitudes toward EBTs have factored into the procedure and results of implementation (Aarons et al., 2012). Therapist's attitudes have influenced the basic course of action in starting new treatments and maintaining treatments within practice settings (Rye et al., 2017). To better understand the attitudes of therapists toward EBTs, it is important to evaluate the beliefs that dictate their actions. In this section, I will review therapist attitudes toward EBTs and perceptions of treatment characteristics as well as adolescent mental health and EBTs in practice settings. I will also examine the training options for EBTs.

Attitudes Toward EBTs and Perceptions of Treatment Characteristics

Therapist Attitudes Toward EBTs

The attitude of EBT proponents is that many therapists who work with adolescents are too liberal and apply the type of therapy they were taught to a variety of

situations instead of using an empirically supported treatment (Scott, 2016). Because EBP has promoted an evolution in how therapy is practiced, it has forced therapists to reconsider how they implement treatment. Proponents of EBTs have been interested in innovative techniques that work in practical settings. According to Prado et al. (2015), these innovative methods could reduce errors in clinical inference. EBTs have created a course of learning that has promoted the integration of established methods. The development of EBTs has stimulated the consolidation of proven results from different areas of research that has helped to create protocols for treatments and allows collaboration between developers and practitioners (Rousseau & Gunia, 2016). An increasing number of researchers have begun to examine treatments for adolescents in terms of their effective implementation in practice settings. Griffin and Botvin (2010) noted the considerable progress made in prevention programs for adolescent drug use. To address adolescent opioid use disorder (OUD) in Ohio counties, Ramos, Clemons-Cope, Samuel-Jakubos, and Basurto (2018) described and evaluated interventions that focused on prevention, screening as well as referral to treatment and treatment. To address the need for EBTs for adolescents with attention deficit hyperactivity disorder (ADHD), Epstein et al. (2014) highlighted the tremendous need to elevate the quality of care for adolescents with ADHD in community-based pediatric settings.

Some therapists who have reluctant attitudes desire more multiform adjustable methods that integrate techniques from several theoretical orientations (Harvey & Gumport, 2015). To enhance the process of decision making with EBTs, a transdiagnostic approach represents an alternative strategy (Marchette & Weisz, 2017).

The objective of the transdiagnostic approach is to apply one protocol to attend to multiple diagnostic problems utilizing one of three methods: (a) the core dysfunction approach focuses on multiple types of psychopathology by pointing out the common elements that are the foundation of the dysfunction and have been created to treat depression and anxiety at the same time; (b) the common elements approach attends to multiple types of psychopathology by combining therapeutic methods customarily applied for each, and maintains the advantages of manualized interventions while providing flexibility to create culturally sensitive treatment altered to the traits of the individual; (c) the principle-guided approach attends to multiple types of psychopathology by integrating core principles of therapeutic change that can be used with each, but with less itemized directions than other protocols, and can treat depression, anxiety, and conduct problems with adolescents (Marchette & Weisz, 2017).

Aarons et al. (2010) suggested that therapists with higher levels of education made more independent decisions about the use of EBTs because they had strong views about what establishes a useful treatment. Lillienfield, Ritschel, Lynn, Cautin, and Latzman (2014) studied sources of resistance to EBTs and revealed several therapists' beliefs that have created barriers toward implementing EBTs: (a) therapists feel they can identify patients' difficulties and treatment results impartially and without narrowmindedness; (b) therapists typically trust in their conception of human nature and use their judgment to present an explanation for choosing a treatment with little or no empirical validation; (c) therapists are prone to believe mistakenly that unvalidated treatments that have not been tested are treatments that do not work; and (d) therapists do

not feel confident in ideas that come from people who do not work in their environment. In an investigation involving 176 therapists of diverse backgrounds, Gaudiano, Brown, and Miller (2011) discovered that an intuitive approach to therapy correlated with negative attitudes toward EBTs. According to Lillienfield et al. (2014), many opponents of EBTs believed that (a) EBTs eliminate clinical judgment and mandate a cookie-cutter approach, (b) most EBTs require a manual which negatively impacts flexibility, (c) therapists have culturally established attitudes about certain EBTs, and (d) several patients have more than one concern and what works for one issue may not be suitable. The onset of several mental disorders occurs during adolescence, though they affect an individual's life during adulthood. Adolescence is a stage in life when people experiment with life situations and frequently make choices that can lead to harmful behaviors. Behaviors like impulsivity, self-harm, smoking, drinking, and drug use often occur during adolescence, which can lead to adult disorders (Das et al., 2016). Research suggests that half of the adult mental disorders begin before 18 years of age (Jones, 2013), and the occurrence of addictive as well as anxiety disorders are typically greater in urban settings (Grubner et al., 2017). Given the impact of mental disorders on the lives of adolescents, it is essential that researchers develop effective treatments and that therapists implement them. Therefore, researchers must explore the attitudes of therapists in practice settings that encourage or hinder the implementation of new treatment methods.

Therapist Perceptions of Treatment Characteristics

Therapists have different perceptions of various treatments (Lau et al., 2017). The literature has suggested that therapist's perceptions of treatment characteristics may sway

their attitudes about the treatment and may serve as an obstacle or a promoter of using it (Cook, Thompson, & Schnurr, 2015). As the use of EBTs increases across practice settings with diverse populations, it is important to comprehend how treatments created in research settings may need to be altered by the therapists using them in those practice settings (Chambers and Norton, 2016). The research suggests that EBTs do not have the same outcomes in practice settings as they do in research settings because therapists in practice settings have less training, less supervision, less feedback, and work in settings where there are less organizational supports (Lau et al., 2018). Therapists have a unique perception of various forms of EBTs. A critical part of enhancing EBT results in practice settings is comprehending the treatment characteristics that are related to many types of modifications (Lau et al., 2017). Therapists in practice settings have a good idea of the type of methods that work best with the individuals they treat. For example, innovative treatments that require manuals are often perceived as too restrictive to address the needs specific of different individuals (Barnett, et al., 2017). A therapist may appreciate research-based methods and have an open mind about trying new EBTs but may not like a specific EBT for numerous reasons (Cook, Thompson, & Schnurr, 2015). To better suit clients in practice settings, treatments that are created in research settings may need to be modified in practice settings where therapists use EBTs. Shanley, Bard, & Funderburk (2012) note that therapists are attracted to new treatments that they perceive as (a) more beneficial than what they are using, (b) that are harmonious with contemporary practices, (c) that are not difficult to present, (d) can be put into action slowly, and (e) and have results that can be easily seen.

Adolescent Mental Health and EBTs in Practice Settings

Trends in Adolescent Mental Health Care

The onset of several mental disorders occurs during adolescence, though they affect an individual's life during adulthood. Adolescence is a stage in life when people experiment with life situations and frequently make choices that can lead to harmful behaviors. Behaviors like impulsivity, self-harm, smoking, drinking, and drug use often occur during adolescence, which can lead to adult disorders (Das et al., 2016). Research suggests that half of the adult mental disorders begin before 18 years of age (Jones, 2013), and the occurrence of addictive as well as anxiety disorders are typically greater in urban settings (Grubner et al., 2017). Given the impact of mental disorders on the lives of adolescents, it is essential that researchers develop effective treatments and that therapists implement them. Therefore, researchers must explore the attitudes of therapists in practice settings that encourage or hinder the implementation of new treatment methods.

Analyzing trends in mental health care among adolescents, it has been debated that the initial eight years of an adolescent's life creates the basis for forthcoming life experiences and mental wellness (National Academics of Sciences, Engineering, and Medicine, 2016). Many adolescents have had difficulty coping with life circumstances. As a result, investigators foresee a critical situation advancing in mental health amongst adolescents nationally. Mental health concerns involving depression and suicide have become significant public health concerns (Twenge et al., 2017). The 12-month interval between major depressive episodes in adolescents has grown from 8.7% in 2005 to 11.3% in 2014 (Mojtabai et al., 2016). Olfson, Druss, and Marcus (2015) discovered that

the percentage of adolescents receiving any outpatient mental health service increased from 9.2% in 1996-1998 to 13.3% in 2010-2012, with significant increases in the application psychotherapy from 4.2% to 6.9% and psychotropic medications from 5.5% to 6.0%. In another update of evidence-based psychosocial treatments for adolescent depression, Weersing, Jeffreys, Do, Schwartz, and Bolano (2017) reviewed 42 randomized controlled trials. These studies included those published between 2008 and 2014 as well as a reevaluation of previously reviewed literature. The results of the review indicated that no treatment received a well-established status, and the foundation of evidence for treatment was reduced from previous reviews (Weersing et al., 2017).

EBTs in Practice Settings

EBTs for adolescents have typically concentrated on a particular childhood disorder, but many elements added to the disorder itself have impacted their effectiveness (Southam-Gerow et al., 2012). In practice settings, adolescents have had contrasting traits and come from various backgrounds. Consequently, they have responded to treatment differently or not at all. Researchers have shown that outcomes for adolescents who received service in practice settings were often different from those who were part of a research investigation because they had concerns involving child comorbidity and diverse backgrounds regarding culture and socioeconomic status (Ehrenreich-May et al., 2011). A critical act in developing treatment implementation results in practice settings is comprehending the determinants that are related to various types of modifications (Lau et al., 2017).

Suburban Settings Versus Urban Settings

In cities, an important distinction is that the suburban settings have typically homogenous populations with families that have a middle to high socioeconomic status (Grubner et al., 2017), and urban settings are typically heterogeneous where many families have diverse race/ethnicities with low income and education levels (Rapp et al., 2015). Furthermore, the literature suggests that adolescents who reside in suburban and urban settings are at a higher risk for serious mental illness (Rapp et al., 2015). In these settings, when the individuals engaged in counseling resembled the participants in an EBT study, there was a strong possibility that the treatment would have comparable results. However, when individuals were diverse and complex, a customary approach was sometimes more effective. Some investigations have discovered positive effects for EBTs (Weisz, Ugusto, Cheron, & Herrn, 2013), while others have found that EBTs were not more effective than a usual care approach (Southam-Gerow et al., 2010).

Despite the development of numerous innovative methods, the debate about the best treatments in practice settings for adolescents thrives. Because the evidence from clinical trials has seldom involved minority participants, disadvantaged participants, or participants with comorbid concerns, therapists who provide services for adolescents from a variety of backgrounds are skeptical about the outcomes of EBTs (Southam-Gerow et al., 2012). Additional concerns have included the attitude that EBTs hurt the therapeutic relationship and can be too structured and focused on the method (Harvey & Gumport, 2015). Becker and Jensen-Doss (2013) contended that EBTs might not lead to

more positive results. Client engagement difficulties faced during the implementation of multiple EBTs with diverse adolescents are a frequent challenge (Lau et al., 2018).

Furthermore, some researchers have suggested that support for imposed mandates to learn and implement multiple EBTs that are meant to improve the quality of service in practice settings frequently leads to burnout amongst therapists due to issues such as higher agency turnover and poorer client results (Kim et al., 2018). To help prevent burnout, Achenbach (2017) recommended evidence-based assessments (EBAs), which serve as a basis for EBP to advance intake, progress, and results in an orderly fashion. Allen, Ghrargozloo, and Johnson (2012) further suggested that therapists' attitudes toward EBTs are improved when knowledge of and training for EBTs are made available. To create and sustain a system change in children's mental health, grants made possible through the System of Care Expansion and Sustainability Cooperative Agreements sponsored by the Substance Abuse and Mental Health Administration (SAMHSA), have been critical in establishing wraparound mental health services that are family-driven, youth guided, community-based, and culturally as well as linguistically capable (Hernandez, Armstrong, Green, & Johnson, 2017).

Training Options for EBTs

To instill competence as well as confidence in therapists, and to assist in the transition of implementing something new, EBT training is critical. Education of trainees in the use of EBTs should include helping therapists to address concerns such as treatment selection, ethical practice, and application issues with scientific influence (Gambrill, 2010). Such education should serve the individual counseling needs and the

multicultural considerations of therapists and their clients (Generali, Kelly, & McNamara, 2013). Despite these considerations, some scholars have acknowledged critical distinctions between therapists in research investigations (who advocate for EBTs) and those who oppose their use, especially therapists in practice settings who have questioned the effectiveness of EBTs in practice environments (Southam-Gerow et al., 2010). Investigative studies have involved doctoral graduate students trained to work with specific populations, whereas therapists in practice settings have come from assorted mental health backgrounds and typically work with large caseloads, high productivity demands, and little to no supervision (Southam-Gerow et al., 2012). EBTs require service providers, who have been trained differently in their approach, to enhance and expand their knowledge. Many potential factors could influence the attitudes of therapists, such as their knowledge of and feelings about EBTs, formal education level, and therapeutic experience (Nakamura, Higa-McMillan, Okamura, & Shimabukuro, 2011).

Researchers have agreed that effective implementation of EBTs depends on training, but according to Beidas and Kendall (2010), workshops—the chief approach in use—have failed to change service provider conduct because they provide only passive primary training and limited follow-up training afterward. According to Herschell, Kolko, Baumann, and Davis (2010), alternative training options include: (a) treatment manuals and self-directed training; (b) intensive workshops which encompass observation and feedback during the training, as well as consultation or coaching after training; (c) pyramid training (e.g. train the trainer or cascading); and, (d)

multicomponent approaches (e.g. combinations of manuals, live sessions, expert consultation, monitoring of taped sessions, and booster training sessions).

Lyon, Stirman, Kerns, and Bruns (2011) recommended academic detailing, which consists of a trained EBT therapist consulting with the trainee in their work environment, and problem-based learning, which consists of combining collaboration between the trainer and trainee with self-directed learning by the trainee. Once training concludes, Lyon et al. (2011) suggested coaching in the form of a therapist skilled in the EBT who furnishes assessment and guidance. Southam-Gerow et al. (2012) suggested that training should also include therapist variables such as demographics like gender, race, previous training background, theoretical orientation, professional guild, and therapist attitudes. Investigators have validated the usefulness of taking the demographics of therapists into account. Many therapists have had doubts about EBTs because of issues such as the inflexibility of the manuals that govern them (Wibors, Knoops, Wensing, & Bleijenbrg, 2012). Other concerns have been the cultural compatibility of the treatment and the best way to administer EBTs in practice environments (Alegria, Vallas, & Pumariega, 2010).

Ultimately, it is therapists who must implement EBTs. According to Martino (2010), with proper training, therapists' confidence in their abilities to apply EBTs effectively typically improves. McHugh and Barlow (2010) argued that favorable outcomes for therapists in EBT training depend on an instructional balance between didactic training—techniques applied in data transfer, such as written materials as well as workshops—and skill training—the process of obtaining the expertise required to execute an intervention competently with conviction. In their investigation of the rates of

sustainability, Swain, Whitley, McHugo, and Drake (2010) discovered that 80% of mental health agency sites that utilized an implementation toolkit in addition to EBT trainers were able to maintain the EBT after two years.

According to Martino (2010), other innovative training options include distance learning and blended learning. Distance learning techniques are comprised of computer-assisted and web-based training as well as simulation programs that: (a) use an assortment of media to alter content to meet specific training requirements, permitting trainees to choose from a menu of learning modules; (b) allow trainees to control the arrangement and rate of the presentation; (c) allow trainees to replay the information as many times as necessary; (d) highlight built-in chances to practice newly acquired skills that occasionally include performance feedback; and, (e) offer standardized quality individualized training that has few geographic or temporal restrictions at a low cost (Martino, 2010). Blended learning consists of a combination of training methods and strategies that can include traditional methods such as reading manuals, workshops, and face-to-face supervision as well as distance learning methods (Martino, 2010). According to Martino, the best combination for a given program depends on the needs and interests of therapists, therapists' knowledge of multiple techniques, and therapists' ability to blend them. Blended learning usually involves arranging strategic elements over time, which are scheduled at the discretion of the trainer according to the preferences of the trainee (Martino, 2010).

According to Martino (2010), trainers should evaluate trainees at some point after the training has concluded, to determine whether (and to what degree) the training

impacts the skill level of the trainees. Martino reported that an observer should evaluate trainees using a rating scale that has been psychometrically validated. He further recommended inspecting the evidence of clients' responses to treatment, such as changes in symptoms or outcome data. Martino argued that observing the progress of trainees with standardized measures on a routine basis could assess how therapists implement EBTs and identify positive behavioral changes.

Studies Related to Research Questions

Ashcraft et al. (2011) examined the reliability and validity of the EBPAS (Aarons, 2004) and how therapist traits relate to attitudes toward EBTs. The researchers concluded that the four-factor model of the EBPAS, and the attitude that EBTs negatively affect the treatment process, correlated with relatively low openness to new treatments and with the attitude that EBTs do not produce positive results (Ashcraft et al. 2011). Two studies employed the EBPAS and the PCIS together to examine the general attitudes of therapists toward the EBT that they were using, as well as their perceptions of the treatment characteristics. In their study on EBTs in the context of a large-scale implementation of multiple practices in children's mental health, Lau et al. (2018) used the Openness and Divergence subscales from the EBPAS to examine the general attitudes of therapists toward EBTs and eight items from the PCIS. The researchers examined therapist perceptions of the EBTs being implemented. In a mixed-methods study that examined how intervention and implementation characteristics of six EBTs related to therapist attitudes, Barnett et al. (2017) used the Openness and Divergence subscales from the EBAS to assess the general attitudes of the therapists about the six EBTs.

Additionally, the researcher used four constructs from the PCIS (relative advantage, compatibility, complexity, and potential for reinvention) to examine therapist perceptions of the EBTs.

Summary and Conclusions

The literature reviewed fell into several main themes related to therapists' attitudes toward EBTs and perceptions of treatment characteristics. First, the literature has suggested that the implementation of new treatments is heavily influenced by therapists' attitudes (Danielson et al., 2019), and therapists' perceptions of treatments may sway attitudes about using treatments (Cook, Thompson, & Schnurr, 2015). Second, an important part of developing treatment outcomes in practice settings is understanding the determinants that are related to possible modifications (Lau et al., 2017). Third, therapists providing services for adolescents from diverse backgrounds in suburban and urban practice settings were skeptical about the outcomes of EBTs (Lau et al., 2018). In other words, the existing literature indicated that therapists have mixed attitudes toward EBTs in practice settings. Researchers also noted the need to examine EBT training as a method to provide therapists with the skills they need to implement new methods with fidelity (Gambrill, 2010). Despite the information presented, the scarcity of information about therapists' attitudes towards EBTs and the perceptions of treatment characteristics that affect therapist attitudes represent gaps in the literature.

I propose to help fill the gap by studying therapists' attitudes toward implementing EBTs with adolescents in suburban and urban practice settings. In those settings, variables such as client profile, therapist caseload, therapist background, and

therapist skill level are often unpredictable and may influence one's understanding of the challenges associated with implementing EBTs (Barnett et al., 2017). The knowledge gained from this study could help to correct and eliminate misconceptions that form barriers to EBT implementation with diverse adolescent populations in suburban and urban practice settings.

In chapter 3, I defined the study clearly, including the reasons for selecting a quantitative design, the variables, the sample population, the instrumentation, and the analysis that I will perform. I also described threats to validity and ethical requirements that will need to be met.

3: Methodology

Introduction

The purpose of this quantitative study using the EBPAS and the PCIS), was to examine the differences between the attitudes toward EBTs and perceptions of treatment characteristics of therapists who work in suburban versus urban settings and who do and do not use EBTs. I conducted the study to determine whether a significant difference exists between the independent variables in the study which are suburban settings versus urban settings, and the implementation of EBTs with two levels (yes and no). The dependent variables were four attitudes toward EBTs and four perceptions of treatment characteristics. Additionally, I analyzed the covariates race, work experience, theoretical orientation, occupational background, and training to determine whether a meaningful relationship is noted with the dependent variables. I will use these results to address the need for EBTs to produce the same outcomes in practice settings as in research settings.

This chapter is a description of the research method. I include the target population and description of the sample. I discuss in depth the collection of procedures. I also include information about data analysis, validity, and ethical procedures.

Research Design and Rationale

I used an online setting in this quantitative study to employ a non-experimental design. The variables in the research design were the following: the independent variables are therapists' practice settings (suburban versus urban), and EBT implementation (yes or no); the dependent variables were therapist attitudes toward EBTs measured by the four subscales of the EBPAS which include: (a) intuitive appeal, (b)

organizational requirements, (c) openness to change, and (d) perceived divergence of usual practice with EBTs. Supplemental dependent variables are therapist perceptions of treatment characteristics measured by four subscales of the PCIS which include (a) relative advantage, (b) task issues, (c) potential for reinvention, and (d) compatibility. Additionally, I will analyze the demographics race, work experience, theoretical orientation, occupational background, and training to determine whether a meaningful relationship exists with the dependent variables.

The design choice was consistent for using eight two-way ANOVAs to examine the differences between therapists who work in suburban versus urban settings and who do or do not use EBTs in their attitude toward EBTs and perceptions of treatment characteristics. Quantitative research is an appropriate tool to examine and compare differences between subpopulations within a larger population of subjects.

The study had several constraints, particularly regarding the lack of control:

•There was no control over which private practices would cooperate or the number of therapists who will participate.

•There was no control over the truthfulness of the individual response to the survey questions asked.

•There was no control over the cultural interpretation of what was asked, particularly about therapists from different cultures.

•There was no control over which EBTs therapists used.

The design was consistent with other research designs used in similar studies such as those conducted by Safran et al. (2011) and Safran et al., (2011), who surveyed to assess the attitudes of groups of therapists.

Methodology

Sampling and Sampling Procedures

For this study, the target population included therapists who provide services for adolescents in the surrounding suburban settings and the inner-city urban setting of the selected city in New York State. I administered the study via a questionnaire on the internet; therefore, the identified location of the participants varied. Therapists in private practice do not have to administer treatments because of mandates that dictate eligibility for state or federal funding. Therefore, therapists in private practice can better control the treatments they want to use, whereas therapists who work for agencies must abide by the agency policies and mandates. Therapists who are in private practice can choose the type of treatments they want to use whether it be evidence-based or a more traditional form of treatment. For that reason, therapists from private practices that provide service to adolescents and are in the suburban and urban sections of the area were eligible. I asked all participants to reveal whether they use or do not use EBTs, and both groups were eligible for participation. Because I was examining the differences in attitudes and perceptions of treatment characteristics between therapists in private practice who use and do not use EBTs, participants were not restricted to using EBTs or a specific EBT.

Type of Sampling Strategy

I randomly selected a sample of therapists from the Good Therapy (Good Therapy, 2019) and Psychology Today (Psychology Today, 2019) websites. These websites serve as a directory for licensed therapists to advertise their services. The websites also list the exact locations of the practices, which allowed me to distinguish between suburban and urban settings. As a supplemental question, I asked the therapists to disclose whether they use or do not use EBTs. I cluster sampled the responses from the two settings whether they do or do not use EBTs and then randomly selected the participants if more than the number needed for each group was available.

Inclusion Criteria

For inclusion in this study, participant foundational skills include expertise as well as knowledge and was reflected through the identified occupational background and training. Participant functional skills was reflected through the level of education, theoretical orientation, and at least 1 year of work experience. Participants must have been licensed, worked with adolescents, and trained in the EBT they were using if training was required.

Exclusion Criteria

For exclusion in this study, participants who were students, paraprofessionals, or not licensed were not eligible for participation.

Power Analysis

The G Power 3 statistical power analysis program (Faul et al., 2007), calculated the sample size, effect level, alpha level, and power level. Calculations from the

statistical power analysis program indicated a sample size of 116 participants with 29 participants in each of the four groups: the effect size was 0.25, the alpha level was .05, and the power level was .80.

Procedures for Recruitment, Participation, and Data Collection

I initially contacted participants by telephone with a follow-up e-mail reintroducing myself with an explanation for the surveys, the demographic questionnaire, and the letter of consent (Appendix E). I directed agreeable participants to a link to Survey Monkey, which I used to gather as well as store the data. Data collection included the participants completing the letter of consent, the EBPAS as well as the PCIS surveys, and the demographic questionnaire, which included questions about gender, years of service provision, race, level of education or years of college, primary discipline, theoretical orientation, professional status if they knew what an EBT was, if they were using an EBT, and if they had training for the EBT being used (Appendix F). Participants had 1 month to submit their surveys. After allowing 2 weeks for response time, I sent another email with a copy of the survey attached. Participants completed the survey via e-mail. I categorized responses from the demographic questionnaire into a demographic table.

Instrumentation and Operationalization of Constructs

The Evidence-Based Practice Attitude Scale (EBPAS)

I used Aarons' (2004) EBPAS to measure therapists' attitudes toward the adoption of EBTs (Appendices A and B). The EBPAS assesses four general attitudes toward the adoption of EBTs but does not ask about specific treatments (Stahmer &

Aarons, 2009). The EBPAS was an appropriate instrument for this study because it assesses variables that align closely with the attitudes I intended to study. Aarons (2004) has allowed researchers to reproduce and use EBPAS test content for research and educational purposes without seeking written permission.

The EBPAS is composed of 15 items measured on a 5-point Likert scale (Aarons, McDonald, Sheehan, & Walrath-Greene, 2007). The scale consists of four lower-order factors and a higher-order factor, or total scale that represents a respondent's global attitude toward the adoption of EBTs (Aarons et al., 2010). The *intuitive appeal* is critical because it influences the adoption of an EBT (Frambach & Scillewaert, 2002). *Attitudes toward organizational requirements* are about the variability of the extent to which therapists will adopt and comply when new treatments are mandated (Garland et al., 2003). Anderson and West (as cited in Aarons, 2004) recognized *openness to change* as a critical factor in the workplace that can influence change in mental health programs. *Perceived divergence of usual practice* from EBTs pertains to the amount of deviation that occurs when a change has been recognized (Aarons, 2004).

Of the 15 items, three relate to the requirements subscale, four relate to the appeal subscale, four relate to the openness subscale, and four relate to the divergence subscale (Aarons, 2004). Participants will need to specify the items that they agree to depict their attitudes about endorsing new or different methods of treatment. Choice of answers are as follows: 0 = not at all, 1= to a slight extent, 2 = to a moderate extent, 3 = to a great extent, and 4 = to a very great extent. The scoring for each subtest is established through

a calculation of the total score for the items that load on a given subscale (Appendix B) (Aarons, 2004).

Published Reliability and Validity Values

Aarons (2004) reported initial individual domain reliability scores as follows: appeal (.80), requirements (.90), openness (.78), and divergence (.59). Results of Aarons et al. (2010) indicated moderate-to-good internal consistency for the total score in two samples (Cronbach's $\alpha = .77$ and $\alpha = .79$) and subscale scores excluding divergence ($.78 < \alpha < .93$), with lower reliability estimates for divergence ($.59 < \alpha < .66$). About construct and convergent validity, Aarons et al. (2010) reported significant associations between EBPAS scores and mental health clinic structure and policies, organizational culture and climate, and leadership.

Previous Investigation

Aarons (2004) used the EBPAS to examine attitudes concerning a set of provider's differences and organizational characteristics. Participants included 322 public sector clinical service workers and 51 program managers from 51 programs in San Diego, California (Aarons, 2004). Rye et al. (2017) examined 420 instruments covering 48 different implementation constructs as part of the Society for Implementation Research Collaboration Instrument Review Project. They determined that the EBPAS has good psychometric properties and was recognized as psychometrically strong.

The Perceived Characteristics of Intervention Scale (PCIS)

I also used Cook et al.'s (2015) PCIS to measure therapists' attitudes about the characteristics of the EBT. Cook et al. developed the PCIS to assess the attitudes of

mental healthcare providers like psychologists, social workers, and psychiatrists. The PCIS applies to an array of treatments and may be suitable for innovations that are essentially not treatments, such as screening tools and clinical reminders (Cook et al., 2015). It is based on the perceived characteristic constructs of Rogers' (1962) Diffusion of Innovations with four additional constructs that were proposed by Greenhalgh et al. (2005). The constructs proposed by Rogers (1962) include relative advantage, compatibility, complexity, observability, and trialability. The additional constructs proposed by Greenhalgh et al. (2005) include the potential for reinvention, risk, task issues, nature of the knowledge required for use, and augmentation/technical support. In this study, four of the nine subscales from the PCIS will be used to assess therapist perceptions of the treatment they are using. The subscales include relative advantage, task issues, the potential for reinvention, and compatibility. *Relative advantage* determines the extent to which an innovative treatment is more effective than the practices being used (Rogers, 1962). *Task issues* identify the level of difficulty for implementation and determine if the innovative treatment improves the quality of work (Greenhalgh et al., 2005). *Potential for reinvention* identifies how well an innovative treatment can be altered to meet the needs of clients (Greenhalgh et al., 2005). *Compatibility* identifies how well an innovative treatment is aligned with therapist values (Rogers, 1962)

The PCIS is a unidimensional construct of EBP-specific perceptions which is composed of 20 items measured on a 5-point Likert scale, ranging from 1 (not at all) to 5 (a very great extent) (Cook et al., 2015). For this study, ten of the 20 items will be completed by the therapists in the sample. The PCIS is an appropriate instrument for this

study because it assesses variables that are not measured by the EBPAS that also align very closely with the attitudes that the researcher intends to investigate. Cook et al. (2015) have permitted to reproduce and use PCIS test content for research and educational purposes. (Appendices C & D).

Published Reliability and Validity Values

Cook et al. (2015) have reported that the PCIS is a reliable measure of perceived characteristics of interventions with some initial groundwork for its validity. The PCIS was used to evaluate two different EBTs, prolonged exposure (PE) and cognitive processing theory (CPT). Internal consistency for subscale scores range between very modest to very good for both EBTs which includes: relative advantage - PE ($\alpha = .55$), CPT ($\alpha = .80$); compatibility – PE ($\alpha = .81$), CPT ($\alpha = .87$); complexity - ($\alpha = .73$), CPT($\alpha = .85$); trialability – PE ($\alpha = .69$), CPT ($\alpha = .71$); observability – PE ($\alpha = .64$), CPT ($\alpha = .67$); potential for reinvention – PE ($\alpha = .81$), CPT - ($\alpha = .90$); task issues – PE ($\alpha = .68$), CPT ($\alpha = .80$); nature of knowledge – PE ($\alpha = .94$), CPT ($\alpha = .95$); and augmentation-technical support – PE ($\alpha = .83$), CPT ($\alpha = .88$) (Cook et al., 2015). Unidimensional model results of perceived characteristics for PE and CPT reveal a very modest evidence fit, whereas the multidimensional model for PE had a superior fit and CPT had a substantially better fit (Cook et al., 2015). About PE, the omega hierarchical for the general factor was .91 (Cook et al., 2015), and is considered consistent with a reliable measure (Resie et al., 2010). About CPT, the omega hierarchical for the general factor was .78 (Cook et al., 2015), and is slightly below the starting point for reliability recommended by Reise et al. (2010).

Previous Investigation

Cook et al. (2015) used the PCIS to examine therapist perceptions of two evidence-based psychotherapies for posttraumatic stress disorder (PTSD), prolonged exposure (PE), and cognitive processing theory (CPT). In the sample, 45% of the participants received training in PE and 70% received training in CPT (Cook et al., 2014). Participants included 215 Department of Veterans Affairs' residential treatment providers from 38 programs across the United States who completed online surveys (Cook et al., 2015). Of the 215 participants, 51.6% were psychologists, 29.8% were social workers, and 18.6% were psychiatrists, nurses, or other professionals (Cook et al., 2015). Investigation results indicated that the PCIS is a reliable measure of perceived characteristics of interventions with some initial support for the validity and may serve as an aid to improve the dissemination, implementation, and sustained use of EBTs (Cook et al., 2015).

Data Analysis Plan

Software

In this study, I used the Statistical Package for Social Science (SPSS) for hypothesis testing and descriptive statistics. To determine differences, I conducted 8 two-way ANOVAs to examine the differences between therapists who work in suburban vs urban settings and who do or do not use EBTs in their attitude toward EBTs and perceptions of treatment characteristics. The EBPAS measures four attitudes: (a) intuitive appeal, (b) organizational requirements, (c) openness to change, and (d) perceived divergence of usual practice with EBTs. The PCIS measures four treatment

characteristics: (a) relative advantage, (b) task issues, (c) potential for reinvention, and (d) compatibility.

Data Screening Procedures

To ensure that there is a homogeneity of variances for each of the groups of the two independent variables, I conducted Levene's test for homogeneity of variances. I also conducted a Wilk's test and a Q-Q plot to test the assumption of normality, Box's M test to test the multivariate homogeneity of variance-covariance matrices assumption, and I conducted a Run test to test the assumption of randomness. Additionally, I evaluated each hypothesis with a significance level of .05, which is the accepted significance level for social sciences. I undertook a review of the data analysis to identify key factors in analyzing the data (see data analysis table in Table 1.).

Table 1

Data Analysis Table

SPSS Statistical Software will be used to conduct 8 two-way ANOVAs

Between Therapist

Independent Variables

In Suburban Settings vs. Urban Settings

Who use EBTs vs. Who do not use EBTs

To Determine Differences Between

Dependent Variables

Attitudes Toward EBTs

1. intuition appeal
2. organizational requirements
3. openness to change
4. perceived divergence of usual practice

Perceptions of Treatment Characteristics

1. relative advantage
2. Task issues
3. Potential of reinvention of treatment
4. Compatibility

Frequency tables will be created for each demographic

Demographics

1. Race ethnicity
2. Gender
3. Work experience
4. Theoretical orientation
5. Educational background
6. Occupational background
7. Training

Research Questions and Hypotheses

The following research questions and hypotheses will guide the quantitative investigation.

RQ1: Are there are differences between the attitudes of therapists who work in suburban versus urban settings and who do and do not use EBTs in their attitudes toward the intuitive appeal of EBTs?

$H_0$1: There are no differences, as measured by the total EBPAS subscale score, between the attitudes of therapists who work in suburban versus urban settings and who do and do not use EBTs in their attitudes toward the intuitive appeal of EBTs.

$H_1$1: There are differences, as measured by the total EBPAS subscale score, between the attitudes of therapists who work in suburban versus urban settings and who do and do not use EBTs in their attitudes toward the intuitive appeal of EBTs.

RQ2: Are there are differences between the attitudes of therapists who work in suburban versus urban settings and who do and do not use EBTs in their attitudes toward the organizational requirements of EBTs?

$H_0$2: There are no differences, as measured by the total EBPAS subscale score, between the attitudes of therapists who work in suburban versus urban settings and who do and do not use EBTs in their attitudes toward the organizational requirements of EBTs.

$H_1$2: There are differences, as measured by the total EBPAS subscale score, between the attitudes of therapists who work in suburban versus urban settings and who

do and do not use EBTs in their attitudes toward the organizational requirements of EBTs.

RQ3: Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their openness to change?

$H_0$3: There are no differences, as measured by the total EBPAS subscale score, between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their openness to change.

$H_1$3: There are differences, as measured by the total EBPAS subscale score, between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their openness to change.

RQ4: Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceived divergence of usual practice with EBTs?

$H_0$4: There are no differences, as measured by the total EBPAS subscale score, between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceived divergence of usual practice with EBTs.

$H_1$4: There are differences, as measured by the total EBPAS subscale score, between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceived divergence of usual practice with EBTs.

RQ5: Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the relative advantage of treatments?

$H_0$5: There are no differences, as measured by the total PCIS subscale score, between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the relative advantage of treatments.

$H_1$5: There are differences, as measured by the total PCIS subscale score between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the relative advantage of treatments.

RQ6: Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the task issues of treatments?

$H_0$6: There are no differences, as measured by the total PCIS subscale score, between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the task issues of treatments.

$H_1$6: There are differences, as measured by the total PCIS subscale score between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the task issues of treatments.

RQ7: Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the potential for the reinvention of treatments?

$H_0$7: There are no differences, as measured by the total PCIS subscale score, between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the potential for the reinvention of treatments.

$H_1$7: There are differences, as measured by the total PCIS subscale score between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the potential for the reinvention of treatments.

RQ8: Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the compatibility of treatments?

$H_0$8: There are no differences, as measured by the total PCIS subscale score, between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the compatibility of treatments.

$H_1$8: There are differences, as measured by the total PCIS subscale score between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the compatibility of treatments.

The rationale for the Inclusion of Covariates

I made conclusions about the differences that exist between the suburban and urban settings based on the results of the analyses. Additionally, I identified distinctions and associations between the covariates and the dependents.

Interpretation of Results

I made conclusions about the differences that exist between therapists' attitudes toward EBTs and their perceptions of treatment characteristics in suburban and urban settings based on the results of the analyses. Additionally, I identified distinctions between the dependent variables and associations with the covariates.

Threats to Validity

Internal Validity

A threat to internal validity occurs if the variation of the dependent variable relates to causes other than the independent variable. One possible threat to internal validity is if participants do not respond truthfully. Another possible threat is if participants have limited knowledge about EBTs. A third possible threat is how the participant's level of fidelity with EBTs influences their beliefs.

External Validity

External validity pertains to the extent to which it is justified to associate the conclusions of this study to other circumstances. The results of this investigation could be viewed as a small reflection of therapists' attitudes towards EBTs who work in suburban and urban settings with diverse groups of adolescents.

Ethical Procedures

Ethical Issues in Research Problems

In conducting the study, I solicited private information such as beliefs, attitudes, and opinions. Participation in the survey was voluntary. A letter of consent accompanied the cover letter and survey questionnaires (Appendix E). I assigned responders who chose to participate a number to assure anonymity and confidentiality.

Ethical Issues in Institutional Permissions

I added information that is required to obtain IRB approval. This report included an ethics self-check that will confirm how the university's ethical standards have been met.

Ethical Issues in Research Questions and Purpose

I distributed the survey electronically by email to prospective participants with an introductory cover letter and informed consent form attached. In the introductory cover letter, I explained the purpose of the study and rationale for the questions. Honest responses require trust; to foster participant trust, I assured confidentiality and guaranteed that I will not share the information without the prior knowledge and consent of participants.

Ethical Issues in Data Analysis and Interpretation

I carefully considered the number of eligible participants and reported all pertinent data. I accurately reported statistically significant differences. I used appropriate terminology that precisely defined the data. I reported results fairly without bias, and all conclusions were supported by the data.

Ethical Issues in Writing and Disseminating Research

I took care to maintain sensitivity to cultural and social differences. I also made a conscientious effort to report research findings fairly and without bias.

Summary

In this chapter, I described the quantitative design of the proposed study. I explained that participants in the study would be licensed mental health therapists, including psychologists, clinical social workers, and mental health counselors. I described Aarons' (2004) EBPAS, which I will use to collect data, and demonstrated that its reliability and validity measures are acceptable. I additionally described Cook et al.'s (2015) PCIS, which I also used to collect data and report acceptable reliability measures. I also described the procedures for data collection and analysis, explained threats to validity, the ways I intended to mitigate them, and address ethical considerations.

In Chapter 4, I present the results of the study, including demographic characteristics of the sample, descriptive statistics, data analysis, and findings.

Chapter 4: Results

Introduction

The purpose of this study was to examine whether differences exist between the attitudes of therapists who work in suburban versus urban settings and who do and do not use EBTs in their attitudes toward EBTs and perceptions of treatment characteristics. RQ1 intended to determine whether differences existed in therapists' attitudes toward the intuitive appeal of EBTs. RQ2 aimed to determine whether differences existed in therapists' attitudes toward the organizational requirements of EBTs. RQ3 intended to determine whether differences existed in therapists' attitudes toward openness to change. RQ4 aimed to determine whether differences existed in therapists' attitudes in their perceived divergence of usual practice with EBTs. RQ5 intended to determine whether differences existed in therapists' attitudes toward the relative advantage of treatments. RQ6 aimed to determine whether differences existed in therapists' attitudes toward the task issues of treatments. RQ7 intended to determine whether differences existed in therapists' attitudes toward the potential for the reinvention of treatments. Finally, RQ8 aimed to determine whether differences existed in therapists' attitudes toward the compatibility of treatments. In this chapter, I report the characteristics of the obtained sample, the descriptive statistics for the study's variables, and the results of the tests of the study's hypotheses.

Data Collection

Time Frame and Recruitment

To comply with the federal laws and institutional policies related to research, the process to obtain permission to randomly select therapists from the Good Therapy (Good Therapy, 2019) and Psychology Today (Psychology Today, 2019) websites were granted by the Walden IRB. These websites served as a directory for licensed therapists to advertise their services. The websites also list the exact locations of the practices, which allowed me to distinguish between suburban and urban settings. Furthermore, the telephone numbers of the therapists were listed, which allowed me to either speak directly to the therapists or leave a message on their voice mail. I contacted a total of 500 therapists through e-mail with 250 contacts per-directory being placed at the Good Therapy (Good Therapy, 2019) and Psychology Today (Psychology Today, 2019) websites. Follow-up phone calls were made with 150 therapists.

Additionally, the invitation/consent letter was posted in five networking groups for counseling therapists listed on each of the Facebook and Linkedin social media websites. The period for the data collection began on 1/20/20 and ended on 6/14/20. I sent reminder e-mails to participants who were previously contacted every 2 weeks. There was a need for reminder e-mails because responses were slow.

Response Rate

As noted in Chapter 3, a G Power 3 statistical power analysis program (Faul et al., 2007) calculated the sample size, effect level, alpha level, and power level. The G Power 3 calculation determined a sample size of 116 participants with 29 participants in each of

the four groups. Data collection response was slow. After 13-weeks, I received 30 responses. After I made additional attempts to contact potential participants, I obtained total of 64 participants with suburban (n =32) versus urban (n =32) and EBTs- no (n =32) versus EBTs-yes (n =32). The four-group configuration consisted of participants in suburban/EBT-no (n = 16) and suburban/EBT-yes (n =16) versus urban/EBT-no (n =16) and urban/EBT-yes (n =16). The number of completed assessments yielded an N = 64 with a 55% response rate.

Discrepancies in Data Collection

After 20 weeks of data collection, the number of participants had increased to 44. Due to continued slow response, I made a request to the IRB to include using social media via Facebook and Linkedin to post the invitation/consent letter to improve data collection. The request was approved by the IRB and after 28 weeks, the number of participants increased to 64. Due to university time constraints, the data collection process had to be concluded before the recommended sample size could be obtained. Descriptive statistics are included in the results section, which contains a detailed description of the sample.

Demographic Characteristics

The total sample size was N = 64 participants who completed all the assessment instruments. I assessed demographic characteristics and included race/ethnicity, gender, work experience, theoretical orientation, educational background, occupational background, and training. Most of the participants in the total population (N= 64) were African American (46.9 %) and female (67.2%). The sample included licensed mental

health therapists consisting of psychologists, social workers, mental health counselors, and family counselors who work with adolescents. The level of education among the therapists ranged between BA/BS to PhD/PsyD. The frequency distribution of these variables is presented in Table 2. The table consists of the frequency and percentage for each variable. The four-group configuration of participants in suburban/EBT-no (n=16) consisted of African American females (31.25%), African American males (18.75%), Caucasian females (37.5%), and Caucasian males (12.5%).The mental health professions included psychologists (25%), mental health counselors (25%), social workers (25%), and family counselors (25%). Therapists who had EBT training (25%). The suburban/EBT-yes (n=16) consisted of African American females (25%), African American males (12.5%), Caucasian females (43.75%) Asian American males (12.5%), and Asian American females (6.25%). The mental health professions included psychologists (25%), mental health counselors (12.5%), social workers (18.75%), and family counselors (43.75%). Therapists who had EBT training (87.5%).The urban/EBT-no (n=16) consisted of African American females (12.5%), African American males (18.75%), Caucasian females (37.5%), Caucasian males (12.5%), Hispanic males (06.25%), Asian American males (6.25%), and (Asian American females (6.25%). The mental health professions included psychologists (18.75%), mental health counselors (12.5%), social workers (37.5%), and family counselors (31.25%). Therapists who had EBT training (43.75%). The urban/EBT-yes (n=16) consisted of African American females (43.75%), African American males (18.75%), Caucasian males (18.75%), Hispanic females (12.5%), and Asian females (6.25%). The mental health professions

included psychologists (12.5%), mental health counselors (43.75%), social workers (37.5%), and family counselors (06.25%). Therapists who had EBT training totaled (57.8%).

Table 2

Frequency Distribution of Demographic Characteristics of the Sample (N = 64)

Category	Frequency	Percent
Race		
White	24	37.5
Black	30	46.9
Hispanic	4	6.0
Asian	5	7.8
Other	1	1.6
Gender		
Male	21	32.8
Female	43	67.2
Years of Experience		
1-5	11	17.2
6-10	9	14.1
11-15	11	17.2
16-20	10	15.6
21+	23	35.9
Theoretical Orientation		
Behavioral	15	23.4
Cognitive Behavioral	34	53.1
Humanism	12	18.8
Feminism	2	3.1
Psychoanalysis	1	1.6
Education		
BA/BS	12	18.8
MA/MS	41	64.1
PhD/PsyD	11	16.6
Occupational Background		
Psychology	13	20.3
Social Work	21	32.8
Mental Health Counseling	14	21.9
Family Counseling	16	25.0
Evidence-Based Training		
No	27	42.2
Yes	37	57.8

Preliminary Data Assumptions

Once the data were collected, they were screened and processed through SPSS. Assumptions testing is presented in Table 3. A two-way ANOVA was conducted to examine the differences between the attitudes of therapists in suburban (*n = 16*) versus urban (*n = 16*) settings who do (*n* = 16) and do not (*n* = 16) use EBTs in their attitude toward the intuitive appeal of EBTs. Residual analysis was performed to test for

assumptions of the two-way ANOVA. Outliers were assessed by inspection of a boxplot; normality was assessed using Shapiro-Wilk's normality test for each cell of the design and homogeneity of variances was assessed by Levene's test. There were no outliers, residuals were normally distributed (p >.05), and there was homogeneity of variances (t test = .803).

A two-way ANOVA was conducted to examine the differences between the attitudes of therapists in suburban (n = 16) versus urban (n = *16)* settings who do (n = 16) and do not (n = 16) use EBTs in their attitude toward organizational requirements of EBTs. Residual analysis was performed to test for assumptions of the two-way ANOVA. Outliers were assessed by inspection of a boxplot; normality was assessed using Shapiro-Wilk's normality test for each cell of the design and homogeneity of variances was assessed by Levene's test. There were no outliers, residuals were not normally distributed (p = .025, p = .030), and there was homogeneity of variances (t test = .528).

A two-way ANOVA was conducted to examine the differences between the attitudes of therapists in suburban (n = *16)* versus urban (n = 16) settings who do (n = 16) and do not (n = 16) use EBTs in their attitude toward openness to change. Residual analysis was performed to test for assumptions of the two-way ANOVA. Outliers were assessed by inspection of a boxplot; normality was assessed using Shapiro-Wilk's normality test for each cell of the design and homogeneity of variances was assessed by Levene's test. There were no outliers, residuals were normally distributed (p > .05), and there was homogeneity of variances (t test = .491).

A two-way ANOVA was conducted to examine the differences between the attitudes of therapists in suburban (n = 16) versus urban (n = 16) settings who do (n = 16) and do not (n = 16) use EBTs in their attitude toward the perceived divergence of usual practice with EBTs. Residual analysis was performed to test for assumptions of the two-way ANOVA. Outliers were assessed by inspection of a boxplot; normality was assessed using Shapiro-Wilk's normality test for each cell of the design and homogeneity of variances was assessed by Levene's test. There were no outliers, residuals were not normally distributed (p = .036), and there was homogeneity of variances (t test = .958).

A two-way ANOVA was conducted to examine the differences between the attitudes of therapists in suburban (n = 16) versus urban (n = 16) settings who do (n = 16) and do not (n = 16) use EBTs in their attitude toward the relative advantage of treatments. Residual analysis was performed to test for assumptions of the two-way ANOVA. Outliers were assessed by inspection of a boxplot; normality was assessed using Shapiro-Wilk's normality test for each cell of the design and homogeneity of variances was assessed by Levene's test. There were no outliers, residuals were not normally distributed (p = .017, p = .021, p = .014, and p = .040), and there was homogeneity of variances (t test = .826).

A two-way ANOVA was conducted to examine the differences between the attitudes of therapists in suburban (n = 16) versus urban (n = 16) settings who do (n = 16) and do not (n = 16) use EBTs in their attitude toward the task issues of treatments. Residual analysis was performed to test for assumptions of the two-way ANOVA. Outliers were assessed by inspection of a boxplot; normality was assessed using Shapiro-

Wilk's normality test for each cell of the design and homogeneity of variances was assessed by Levene's test. There were no outliers, residuals were not normally distributed (p = .000, p = .005, p = .004, p = .048), and there was homogeneity of variances (t test = .685).

A two-way ANOVA was conducted to examine the differences between the attitudes of therapists in suburban (n = 16) versus urban (n = 16) settings who do (n = 16) and do not (n = 16) use EBTs in their attitude toward the potential for the reinvention of treatments. Residual analysis was performed to test for assumptions of the two-way ANOVA. Outliers were assessed by inspection of a boxplot; normality was assessed using Shapiro-Wilk's normality test for each cell of the design and homogeneity of variances was assessed by Levene's test. There were no outliers, residuals were not normally distributed (p = .004, p = .002, p = .002, and p = .000), and there was homogeneity of variances (t test = .599).

A two-way ANOVA was conducted to examine the differences between the attitudes of therapists in suburban (n = 16) versus urban (n = 16) settings who do (n = 16) and do not (n = 16) use EBTs in their attitude toward the compatibility of treatments. Residual analysis was performed to test for assumptions of the two-way ANOVA. Outliers were assessed by inspection of a boxplot; normality was assessed using Shapiro-Wilk's normality test for each cell of the design and homogeneity of variances was assessed by Levene's test. There were no outliers, residuals were not normally distributed (p = .001, p = .027), and there was homogeneity of variances (t test = .203).

Table 3

Assumptions Testing for Normality and Homogeneity of Variances

	Test of Normality			Levene's Test of Equality of Error Variances			
Suburban/Urban	Evidence-Based Treatment Statistic	Shapiro-Wilk					
				Levene Statistic	*df*1	*df*2	Sig
Suburban **(*n* = *32*)**	Intuitive Appeal	*df*	Sig	.331	3	60	.803
No (*n* = 16)		16	.169				
Yes (*n* = 16)		16	.358				
Urban **(*n* = *32*)**							
No (*n* = 16)		16	.157				
Yes (*n* = 16)		16	.255				
Suburban (*n* = *32*)	Organizational Requirements			.747	3	60	.528
No (*n* = 16)		16	.065				
Yes (*n* = 16)		16	.025				
Urban **(*n* = *32*)**							
No (*n* = 16)		16	.030				
Yes (*n* = 16)		16	.065				
Suburban (*n* = *32)*	Openness to Change			.815	3	60	.491
No (*n* = 16)		16	.098				
Yes (*n*= 16)		16	.752				
Urban **(*n* = 32)**							
No (*n*= 16)		16	.103				
Yes (*n* = 16)		16	.186				
Suburban (*n* = 16)	Divergence of Usual Practice			.102	3	60	.958
No (*n* = 16)		16	.597				
Yes (*n* = 16)		16	.769				
Urban **(*n* = *32)***							
No (*n* = 16)		16	.036				
Yes (*n* = 16)		16	.805				
Suburban (*n* = 32)	Relative Advantage			.298	3	60	.826
No (*n* = 16)		16	.017				
Yes (*n* = 16)		16	.021				
Urban **= (*n* = *32)***							
No (*n* = 16)		16	.014				
Yes (*n* = 16)		16	.040				
Suburban (*n* = 32)	Task Issues			.499	3	60	.685
No (*n* = 16)		16	.000				
Yes (*n*= 16)		16	.005				
Urba**n (*n* = 32)**							
No (*n* = 16)		16	.004				
Yes (*n* = 16)		16	.048				

Assumptions Testing for Normality and Homogeneity of Variances

	Test of Normality			Levene's Test of Equality of Error Variances			
Suburban/Urban	Evidence-Based Treatment Statistic	Shapiro-Wilk					
	Reinvention of Treatments	*df*	Sig	Levene Statistic	*df*1	*df*2	Sig
Suburban (*n* = 32)							
No (*n* = 16)		16	.004	.629	3	60	.599
Yes (*n* = 16)		16	.002				
Urban ***(n = 32)***							
No (*n* = 16)		16	.002				
Yes (*n = 16)*		16	.000				
Suburban (*n* = 32)	Compatibility			1.584	3	60	.203
No (*n* = 16)		16	.109				
Yes (*n* = 16)		16	.001				
Urban ***(n = 32)***							
No (*n = 16)*		16	.027				
Yes (*n* = 16)		16	.100				

Table 4. displays the means and standard deviations for the dependent variables included in the 8 hypotheses. These variables are the general domains of provider attitudes toward the adoption of EBTs and their perceptions of treatment characteristics. The variables include intuitive appeal, organizational requirements, openness to change, perceived divergence of usual practice, relative advantage, task issues, potential for reinvention, and compatibility.

Table 4

Descriptive Statistics: Means and Standard Deviation of Variable

Variable: Intuitive Appeal	EBTs	*M*	*(SD)*
Suburban (*n*=32)	No (*n* = 16)	5.44	(1.63)
	Yes (*n* = 16)	5.50	(1.41)
Urban (*n*=32)	No (*n* = 16)	5.56	(1.41)
	Yes (*n* = 16)	4.94	(1.48)
Variable: Organizational Requirements			
Suburban (*n* =32)	No (*n* = 16)	2.63	(0.96)
	Yes (*n* = 16)	2.50	(1.10)
Urban (*n* =32)	No (*n* = 16)	2.56	(0.81)
	Yes (*n* = 16)	2.38	(0.957)
Variable: Openness to Change			
Suburban (*n* = 32)	No (*n* = 16)	9.88	(2.70)
	Yes (*n* = 16)	10.06	(3.43)
Urban: (*n* = 32)	No (*n* = 16)	9.88	(3.32)
	Yes (*n* = 16)	9.188	(3.76)
Variable: Perceived Divergence of Usual Practice			
Suburban (*n* = 32)	No (*n* = 16)	7.13	(2.58)
	Yes (*n* = 16)	5.75	(2.35)
Urban (*n* = 32)	No (*n* = 16)	7.31	(1.99)
	Yes (*n* = 16)	7.13	(2.50)
Variable: Relative Advantage			
Suburban (*n* = 32)	No (*n* = 16)	6.19	(0.98)
	Yes (*n* = 16)	5.69	(1.08)
Urban (*n* = 32)	No (*n* = 16)	6.19	(1.11)
	Yes (*n* = 16)	6.31	(1.25)
Variable: Task Issues			
Suburban (*n* = 32)	No (*n* = 16)	7.31	(0.87)
	Yes (*n* = 16)	7.38	(1.09)
Urban (*n* = 32)	No (*n* = 16)	7.63	(0.98)
	Yes (*n* = 16)	7.19	(1.11)
Variable: Potential for Reinvention			
Suburban (*n* = 32)	No (*n* = 16)	6.50	(0.89)
	Yes (*n* = 16)	6.38	(0.81)
Urban (*n* = 32)	No (*n* = 16)	6.38	(0.81)
	Yes (*n* = 16)	6.44	(0.63)
Variable: Compatibility			
Suburban (*n* = 32)	No (*n* = 16)	7.31	(1.30)
	Yes (*n* = 16	7.56	(1.09)
Urban (*n* = 32)	No (*n* = 16)	7.63	(0.96)
	Yes (*n* = 16)	7.19	(1.11)

Results of Hypothesis Testing

Research Question 1

Table 5

Full Analysis Between Settings and EBTs on Intuitive Appeal

Intuitive Appeal	*df*	*F*	Sig	Partial Eta Squared
Settings	1	.346	.559	.006
EBTs	1	.572	.453	.009
Settings*EBTs	1	.854	.359	.014
Error	60			

A two-way ANOVA was conducted to examine the differences between the attitudes of therapists in suburban (n = 16) versus urban (n = 16) settings who do (n = 16) and do not (n = 16) use EBTs in their attitude toward the intuitive appeal of EBTs. Data are mean ± standard deviation unless otherwise stated. An analysis of the main effects for settings as well as EBTs was performed, which indicated that there were no statistically significant main effects of settings on intuitive appeal score $F(1, 60) = .346$, $ns = .559$, partial $n^2 = .006$, and there were no statistically significant main effects of EBT use on intuitive appeal score $F(1, 60) = .572$, $ns = .453$, partial $n^2 = .009$. The interaction effect between settings and EBTs on intuitive appeal was not statistically significant $F(1, 60) = .854$, $ns = .359$, partial $n^2 = .014$. The unweighted marginal means of "Intuitive Appeal" scores for settings (suburban/urban) and EBTs (no/yes) were 5.469 ±.263, 5.250 ±.263, 5.500 ± .263, and 5.219 ± .263, respectively. I failed to reject the null hypothesis for Hypothesis 1. Therefore, there were no differences.

Research Question 2

Table 6

Full Analysis Between Settings and EBTs on Organizational Requirements

Organizational Requirements	*df*	*F*	Sig	Partial Eta Squared
Settings	1	.152	.698	.003
EBTs	1	.423	.518	.007
Settings*EBTs	1	.017	.897	.000
Error	60			

A two-way ANOVA was conducted to examine the differences between the attitudes of therapists in suburban (n = 16) versus urban (n = 16) settings who do (n = 16) and do not (n = 16) use EBTs in their attitude toward organizational requirements of EBTs. Data are mean ± standard deviation unless otherwise stated. An analysis of the main effect for settings as well as EBTs was performed, which indicated that there were no statistically significant main effects of settings on organizational requirement score $F(1, 60) = .152$, $ns = .698$, partial $n^2 = .003$, and there were no statistically significant main effects of EBT use on organizational requirement score $F(1, 60) = .423$, $ns = .518$, partial $n^2 = .007$. The interaction effect between settings and EBTs on organizational requirements was not statistically significant $F(1, 60) = .017$, $ns = .897$, partial $n^2 = .000$. The unweighted marginal means of "Organizational Requirement" scores for settings (suburban/urban) and EBTs (no/yes) were 2.563 ±.170, 2.469 ±.170, 2.594 ± .170, and 2.438 ± .170, respectively. I failed to reject the null hypothesis for Hypothesis 2. Therefore, there were no differences.

Research Question 3

Table 7

Full Analysis Between Settings and EBTs on Openness to Change

Openness to Change	*df*	*F*	Sig	Partial Eta Squared
Settings	1	.276	.601	.005
EBTs	1	.090	.765	.002
Settings*EBTs	1	.276	.601	.005
Error	60			

A two-way ANOVA was conducted to examine the differences between the attitudes of therapists in suburban (n = 16) versus urban settings (n = 16) who do (n = 16) and do not (n = 16) use EBTs in their attitude toward openness to change. Data are mean ± standard deviation unless otherwise stated. An analysis of the main effects for settings as well as EBTs was performed, which indicated that there were no statistically significant main effects of settings on openness to change score $F(1, 60) = .276$, ns = .601, partial $n^2 = .005$, and there were no statistically significant main effects of EBT use on openness to change score $F(1, 60) = .090$, $ns = .765$, partial $n^2 = .002$. The interaction effect between settings and EBTs on openness to change was not statistically significant $F(1, 60) = .276$, $ns = .601$, partial $n^2 = .005$. The unweighted marginal means of "Openness to Change" scores for settings (suburban/urban) and EBTs (no/yes) were 9.969 ± .588, 9.531 ± .588, 9.875 ± .588, and 9.625 ± .588, respectively. I failed to reject the null hypothesis for Hypothesis 3. Therefore, there were no differences.

Research Question 4

Table 8

Full Analysis Between Settings and EBTs on Divergence of Usual Practice

Divergence of Usual Practice	*df*	*F*	Sig	Partial Eta Squared
Settings	1	1.744	.192	.028
EBTs	1	1.744	.192	.028
Settings*EBTs	1	1.007	.320	.017
Error	60			

A two-way ANOVA was conducted to examine the differences between the attitudes of therapists in suburban (n = 16) versus urban (n = 16) settings who do (n = 16) and do not (n = 16) use EBTs in their attitude toward perceived divergence of usual practice with EBTs. Data are mean ± standard deviation unless otherwise stated. An analysis of the main effects for settings as well as EBTs was performed, which indicated that there were no statistically significant main effects of settings on a perceived divergence of usual practice score $F(1, 60) = 1.744$, $ns = .192$, partial $n^2 = .028$, and there were no statistically significant main effects of EBT use on a perceived divergence of usual practice score $F(1, 60) = 1.744$, $ns = .192$, partial $n^2 = .028$. The interaction effect between settings and EBTs on a perceived divergence of usual practice was not statistically significant $F(1, 60) = 1.007$, $ns = .320$, partial $n^2 = .017$. The unweighted marginal means of "Perceived Divergence of Usual Practice" scores for settings (suburban/urban) and EBTs (no/yes) were 6.438 ± .418, 7.219 ± .418, 7.219 ± .418, and 6.438 ± .418, respectively. I failed to reject the null hypothesis for Hypothesis 4. Therefore, there were no differences.

Research Question 5

Table 9

Full Analysis Between Settings and EBTs on Relative Advantage

Relative Advantage	*df*	*F*	Sig	Partial Eta Squared
Settings	1	1.271	.264	.021
EBTs	1	.458	.501	.008
Settings*EBTs	1	1.271	.264	.021
Error	60			

A two-way ANOVA was conducted to examine the differences between the attitudes of therapists in suburban (n = 16) versus urban (n = 16) settings who do (n = 16) and do not (n = 16) use EBTs in their attitude toward the relative advantage of treatments. Data are mean ± standard deviation unless otherwise stated. An analysis of the main effects for settings as well as EBTs was performed, which indicated that there were no statistically significant main effects of settings on relative advantage score $F(1,60) = 1.271$, $ns = .264$, partial $n^2 = .021$, and there were no statistically significant main effects of EBT use on relative marginal means of "Relative advantage score $F(1, 60) = .458$, $ns = .501$, partial $n^2 = .008$. The interaction effect between settings and EBTs on relative advantage was not statistically significant $F(1, 60) = 1.271$, $ns = .264$, partial $n^2 = .021$. The unweighted Advantage" scores for settings (suburban/urban) and EBTs (no/yes) were 5.938 ± .196, 6.250 ± .196, 6.188 ± .196, and 6.000 ± .196, respectively. I failed to reject the null hypothesis for Hypothesis 5. Therefore, there were no differences.

Research Question 6

Table 10

Full Analysis Between Settings and EBTs on Task Issues

Task Issues	*df*	*F*	Sig	Partial Eta Squared
Settings	1	.061	.806	.001
EBTs	1	.550	.461	.009
Settings*EBTs	1	.978	.327	.016
Error	60			

A two-way ANOVA was conducted to examine the differences between the attitudes of therapists in suburban (n = 16) versus urban (n = 16) settings who do (n = 16) and do not (n = 16) use EBTs in their attitude toward the task issues of treatments. Data are mean ± standard deviation unless otherwise stated. An analysis of the main effects for settings as well as EBTs was performed, which indicated that there were no statistically significant main effects of settings on task issue score $F(1, 60) = .061$, ns = .806, partial $n^2 = .001$, and there were no statistically significant main effects of EBT use on task issue score $F(1, 60) = .550$, ns = .461, partial $n^2 = .009$. The interaction effect between settings and EBTs on task issues was not statistically significant $F(1, 60) = .978$, ns = .327, partial $n^2 = .016$. The unweighted marginal means of "Task Issue" scores for settings (suburban/urban) and EBTs (no/yes) were 7.344 ±.179, 7.406 ±.179, 7.469 ± .179, and 7.281 ± .179, respectively. I failed to reject the null hypothesis for Hypothesis 6. Therefore, there were no differences.

Research Question 7

Table 11

Full Analysis Between Settings and EBTs on Potential for Reinvention

Potential for Reinvention	*df*	*F*	Sig	Partial Eta Squared
Settings	1	.025	.875	.000
EBTs	1	.025	.875	.000
Settings*EBTs	1	.225	.637	.004
Error	60			

A two-way ANOVA was conducted to examine the differences between the attitudes of therapists in suburban (n = 16) versus urban (n = 16) settings who do (n = 16) and do not (n = 16) use EBTs in their attitude toward the potential for the reinvention of treatments. Data are mean ± standard deviation unless otherwise stated. An analysis of the main effects for settings as well as EBTs was performed, which indicated that there were no statistically significant main effects of settings on the potential for the reinvention of treatment score $F(1, 60) = .025$, $ns = .875$, partial $n^2 = .000$, and there were no statistically significant main effects of EBT use on the potential for the reinvention of treatment score $F(1, 60) = .025$, $ns = .875$, partial $n^2 = .000$. The interaction effect between settings and EBTs on compatibility was not statistically significant $F(1, 60) = .646$, $ns = .425$, partial $n^2 = .011$.The unweighted marginal means of the "Potential for the Reinvention of Treatment" scores for settings (suburban/urban) and EBTs (no/yes) were 6.438 ± .140, 6.406 ± .140, 6.438 ± .140, and 6.406 ± .140, respectively. I failed to reject the null hypothesis for Hypothesis 7. Therefore, there were no differences.

Research Question 8

Table 12

Full Analysis Between Settings and EBTs on Compatibility

Compatibility	*df*	*F*	Sig	Partial Eta Squared
Settings	1	.119	.732	.002
EBTs	1	.013	.909	.000
Settings*EBTs	1	.646	.425	.011
Error	60			

A two-way ANOVA was conducted to examine the differences between the attitudes of therapists in suburban (n = 16) versus urban (n = 16) settings who do (n = 16) and do not (n = 16) use EBTs in their attitude toward the compatibility of treatments. Data are mean ± standard deviation unless otherwise stated. An analysis of the main effects for settings as well as EBTs was performed, which indicated that there were no statistically significant main effects of settings on compatibility of treatments score $F(1, 60) = .119$, $ns = .732$, partial $n^2 = .002$, and there were no statistically significant main effects of EBTs use on compatibility of treatments score $F(1, 60) = .013$, $ns = .909$, partial $n^2 = .000$. The interaction effect between settings and EBTs on compatibility was not statistically significant $F(1, 60) = .646$, $ns = .425$, partial $n^2 = .011$. The unweighted marginal means of "Compatibility" of treatment scores for settings (suburban/urban) and EBTs (no/yes) were 7.438 ± .192, 7.531 ± .192, 7.469 ± .192, and 7.500 ± .192, respectively. I failed to reject the null hypothesis for Hypothesis 8. Therefore, there were no differences.

Summary

This examination has been conducted using a two-way ANOVA analysis. The study was trying to determine whether there are differences between the attitudes and perceptions of therapists in different metropolitan practice settings regarding EBTs and treatment characteristics. The attitudes were measured as intuitive appeal, organizational requirements, openness to change, and perceived divergence of usual practice. The perceptions were measured as relative advantage, task issues, potential for the reinvention of treatment, and compatibility. The practice settings in the investigation are a suburban practice setting ($n = 32$) that has a homogenous population versus an urban practice setting ($n = 32$) that has a heterogeneous population. The two-way ANOVA analyses revealed that there were no differences between the attitudes of therapists in suburban ($n = 16$) versus urban ($n = 16$) practice settings who do ($n = 16$) and do not ($n = 16$) use EBTs. Follow-up main effects procedures showed no statistically significant interactions throughout the analysis. In Chapter 5, a summary of the interpretation of the research questions will be discussed. Further, the recommendations based on the study's limitations, strengths, and implications of the study will be discussed. Additionally, Chapter 5 will also discuss positive social change related to individuals and the entire population studied.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to examine whether differences exist between the attitudes of therapists who work in suburban versus urban settings and who do and do not use EBTs in their attitudes toward EBTs and perceptions of treatment characteristics. The rationale for this study was based on the research that notes that the implementation of new treatments is heavily influenced by therapists' attitudes (Danielson et al., 2019). Many research articles focus solely on therapist attitudes toward EBTs and there is some research related to therapist perceptions of treatment characteristics. Chapter 5 also includes a discussion of the findings as related to the literature reviewed in chapter 2, the limitations of the study, and recommendations for future research.

Key Findings

After accessing the attitudes of therapists from diverse backgrounds in mental health, testing results revealed no differences between the attitudes of therapists who work in suburban versus urban practice settings who use and do not use EBTs. These attitudes included intuitive appeal, organizational requirements, openness to change, and perceived divergence of usual practice. There were also no differences between the attitudes of therapists in suburban versus urban practice settings who use and do not use EBTs in their perception of treatment characteristics. The perceptions tested included the relative advantage of treatments, task issues, the potential for the reinvention of treatments, and compatibility.

Interpretation of the Findings

Theoretical Framework

The TPB connects beliefs with behavior; it can determine the variables that motivate healthcare professionals' behavior and predict a change in that behavior (Nilsen et al., 2012). The central element in the TPB is behavioral intent which involves the individual's attitude regarding the probability that the behavior will have the anticipated result, and the individual's subjective assessment of the risks and benefits of that result (Ajzen, 1991). After reviewing 56 studies, Godkin and Kok (1996) reported that either partially or totally the TPB could explain intension or predict behavior. The literature notes that therapists in practice settings are interested in new treatments that they believe are (a) more beneficial than what they are using, (b) are harmonious with contemporary practices, (c) are not difficult to present, (d) can be put into action slowly, and (e) have results that can easily be seen (Henggeler, Lee, & Burns, 2002). Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceived divergence of usual practice with EBTs? *Perceived divergence of usual practice* is the amount of deviation that occurs when a change has been recognized (Aarons, 2004). Perceived divergence of usual practice correlates with the TPB because it focuses on the amount of deviation that occurs when a changed has been identified. By understanding the variables that influence the change in behavior, a speculation can be made about the amount of divergence that will occur from one's usual routine. The results of this study did not indicate that there are differences in the attitudes about perceived divergence of usual practice between the attitudes of therapists in

suburban versus urban settings who do and do not use EBTs. I believe the study's sample size was too small to find results.

Therapist Attitudes Toward EBTs

Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their attitudes toward the intuitive appeal of EBTs? An intuitive appeal is an appeal of adopting an EBT (Frambach & Scillewaert, 2002). Aarons (2004) developed the EBPAS to assess mental health providers attitudes toward the adoption of EBPs and used the measure to examine mental health provider attitudes toward the adoption of new treatments, interventions, and practices. The results of the study identified four dimensions of attitudes toward the adoption of EBPs: (a) intuitive appeal, (b) requirements, (c) openness, and (d) perceived divergence of usual practice with research-based/academically developed interventions (Aarons, 2004). In a later study that examined child welfare workers attitudes toward implementing EBP in a-mid Atlantic state, the results suggested that the EBPAS was able to measure workers' global attitudes and four attitude types toward EBP (Keyser et al., 2016). In another study where the EBPAS was used to assess the attitudes of youth residential facility administrators, the results confirmed that the factor structure of the EBPAS was a valid measure of attitude toward EBP among youth residential care providers (Ringle et al., 2019). The results of this study did not indicate that there are differences in attitudes about the intuitive appeal of treatments between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs.

Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their attitudes toward openness to change? *Openness to change* is the willingness to change (Anderson & West, 1998). The literature reveals that some therapists who have reluctant attitudes desire more multiform adjustable methods that integrate techniques from several theoretical orientations (Harvey & Gumport, 2015). The results of this study did not indicate that there are differences in attitudes about openness to change between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs.

Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their attitude toward the organizational requirements of EBTs? *Attitude toward organizational requirements* is the extent that therapists will adopt and comply when new treatments are mandated (Garland et al., 2003). The literature proposes that support for imposed mandates to learn and implement multiple EBTs that are meant to improve the quality of service in practice settings frequently leads to burnout amongst therapists due to issues such as higher agency turnover and poorer client results (Kim et al., 2018). The results of this study did not indicate that there are differences in attitudes about organizational requirements between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs.

Therapist Perceptions of Treatment Characteristics

Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the potential for the reinvention of treatments? *The potential for a reinvention of treatment* is the ability to

elaborate and modify the innovative treatment (Greenhalgh et al., 2005). The literature reports that as the use of EBTs increases across practice settings with diverse populations, it is important to comprehend how treatments created in research settings may need to be altered by the therapists using them in those practice settings (Chambers & Norton, 2016). The results of this study did not indicate that there are differences in perception about the potential for the reinvention of treatment between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs.

EBTs in Practice Settings

Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the relative advantage of treatments? *Relative advantage* is the degree to which an innovative treatment is considered superior to existing practices (Rogers, 1962). The literature suggests that therapist concerns have included the attitude that EBTs hurt the therapeutic relationship and can be too structured and focused on the method (Harvey & Gumport, 2015). The results of this study did not indicate that there are differences in perception about the relative advantage of treatments between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs.

Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the task issues of treatments? *Task issues* are concerns about the innovative treatment that therapists need to be focused on to accomplish implementation (Greenhalgh et al. 2005). The literature suggests that a critical act in developing treatment implementation results in practice

settings is comprehending the determinants that are related to various types of modifications (Lau et al., 2017). The results of this study did not indicate that there are differences in perception about task issues between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs.

Are there differences between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their perceptions toward the compatibility of treatments? *Compatibility* is the innovative treatment's consistency with existing values, and needs of adopters and system (Rogers, 1962). The literature points out that client engagement difficulties faced during the implementation of multiple EBTs with diverse adolescents are a frequent challenge (Lau et al., 2018). Additionally, because the evidence from clinical trials has seldom involved minority participants, disadvantaged participants, or participants with comorbid concerns, therapists who provide services for adolescents from a variety of backgrounds are skeptical about the outcomes of EBTs (Southam-Gerow et al., 2012). The results of this study did not indicate that there are differences in perception about the compatibility of treatments between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs.

Limitations of the Study

Internal Validity

In Chapters 1 and 3, I discussed some probable shortcomings that may arise during the execution of the study. A significant limitation involved the recruitment of therapists. Despite frequent e-mails, follow-up telephone calls, and utilizing social media, the data collection process remained slow and resulted in a smaller sample size than was

projected. Participation was dependent on a therapist's kindness and willingness to participate. Without some type of incentive, therapists were reluctant to participate. An additional limitation involved limited resources and time. With resources, I could have offered some form of incentive that would have helped to motivate participation. More time is needed because survey completion response time was slow and the repeated follow-up correspondence to individual therapists in private practice required more time than was available. Due to the difficulties of recruitment, it is possible that the cell sizes were too small and there was not enough power to find results.

External Validity

Whereas the participants in this study were working in real world settings, it is believed that the sample size was too small to reasonably generalize the findings from this study to the larger population. Additionally, situation effect factors such as the transition and adjustment of mental health services being provided virtually due to the COVID-19 pandemic limit generalizability of the findings.

Recommendations

In the future, if researchers wish to continue or replicate this study some recommendations may prove useful in expanding this body of research. Resources are necessary to offer some type of incentive for participation. It is difficult to solicit the help of therapists in private practice without compensating them for their time. Attempts to contact mental health therapists through the website directories without paying them for their time are frequently discouraged. When contact is established, potential participants are polite and encouraging, but they tend to fall short of following through with their

commitment to participate. Due to the slow data collection response, more time to collect data is also recommended to establish the desired sample size. The third recommendation is to expand the study to a mixed-methods study so the data collection process could include interviewing therapists. The qualitative addition to the study could provide critical information that offers more clarity and distinction about the differences between therapist attitudes towards EBTs and their perceptions of treatment characteristics in suburban versus urban practice settings.

Implications

The implications for social change include understanding the attitudes and perceptions of therapists that affect treatment, meeting the needs of diverse populations residing in communities, and understanding the need for flexible EBTs that can meet individual needs. Providing information about what works best in practice settings can help develop EBTs that produce the same successful outcomes in practice settings as in research settings. If the foundation of treatment has the characteristics that are favorable to the therapists who are intended to use them, there is a strong likelihood that therapists will implement them with fidelity. By understanding the attitudes that motivate therapists in suburban and urban practice settings to implement or not implement EBTs, new ways can be developed to accommodate the varying requirements and traits of therapists in suburban and urban practice settings. If more therapists are willing to faithfully administer EBTs, more adolescents may receive effective and innovative care promoting positive social change. If more adolescents can feel that an EBT can help them, the more willing they may be to engage in treatment promoting positive social change. When an

increased number of individuals are influenced by positive social change, it positively impacts the communities where they reside. When an increased number of communities are influenced by positive social change, it positively impacts society.

Conclusions

A sample of sixty-four therapists in private practice from suburban and urban metropolitan settings was randomly selected to participate in the study. The goal was to determine the difference between the attitudes of therapists in suburban versus urban settings who do and do not use EBTs in their attitudes toward EBTs and perceptions of treatment characteristics. The EBPAS (Aarons, 2004) was used to measure 4 general attitudes toward the adoption of EBTs, and the PCIS (Cook et al., 2015) was used to measure 4 perceived treatment characteristics. It was hypothesized that there are no differences between the attitudes of therapists who work in suburban versus urban settings and who do and do not use EBTs. The findings of this study suggest that there were no differences between the attitudes of therapists towards the adoption of EBTs and their perceptions of treatment characteristics in suburban versus urban metropolitan practice settings.

The number of adolescents in need of mental health care is growing. Due to a variety of life challenges, many adolescents who reside in suburban and urban metropolitan practice settings are at risk for the same disorders for different reasons. The need for mental health care is rising, but the lack of change in mental health treatment has contributed to many with untreated conditions (Mojtabai et al., 2016). Understanding the attitudes and perceptions that affect treatments can assist researchers in recognizing the

elements required for successful results. These identified components can be used to tailor treatments and implementation efforts to accommodate practitioners' skills and needs of adolescents in suburban and urban settings. Considering that therapists have many attitudes about EBTs and perceptions of treatment characteristics, only a few were examined in this study. As more beliefs are explored, similarities, as well as differences in attitudes and perceptions, may appear. Thereupon the beliefs that therapists in practice settings have in common can be used as a foundation with modifications that allow for differences in the development of future EBTs for adolescents who reside in suburban and urban settings.

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Appendix A: Evidence-Based Practice Attitude Scale

Version Attached: Full Test

PsycTESTS Citation: Aarons, G. A. (2004). Evidence-Based Practice Attitude Scale [Database record]. Retrieved from PsycTESTS. doi:http://dx.doi.org/10.1037/t01220-000

Instrument Type: Rating Scale

Test Format: 5-point Likert-type ranging from (0) Not at all to (4) To a very great extent.

Source: Aarons, G. A., Glisson, C., Hoagwood, K., Kelleher, K., Landsverk, J., Cafri, G., Research Network on Youth Mental Health. (2010). Psychometric properties and U.S. national norms of the Evidence-Based Practice Attitude Scale (EBPAS). *Psychological Assessment, 22*(2), 356-365. doi:10.1037/a0019188

Appendix B: Evidence-Based Practice Attitude Scale Items and Scoring Instructions

0 = Not at All; 1 = To a Slight Extent; 2 = To a Moderate Extent; 3 = To a Great Extent; 4 = To a Very Great Extent

Question (including subscale):

1. 3 - I like to use new types of therapy/interventions to help my clients.
2. 3 - I am willing to try new types of therapy/interventions even if I must follow a treatment manual.
3. 4 - I know better than academic researchers how to care for my clients.
4. 3 - I am willing to use new and different types of therapy/interventions developed by researchers.
5. 4 - Research based treatments/interventions are not clinically useful.
6. 4 - Clinical experience is more important than using manualized therapy/interventions.
7. 4 - I would not use manualized therapy/interventions.
8. 3 - I would try a new therapy/intervention even if it were very different from what I am used to doing.

For questions 9 – 15: If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if:

9. 2 - it was intuitively appealing?
10. 2 - it "made sense" to you?
11. 1 - it was required by your supervisor?
12. 1 - it was required by your agency?

13. 1 - it was required by your state?

14. 2 - it was being used by colleagues who were happy with it?

15. 2 - you felt you had enough training to use it correctly?

Upscale key: 1 = Requirements 2 = Appeal 3 = Openness 4 = Divergence

Appendix C: Email Correspondence Between Dr. Cook and Bennie Lamont Kyle

Regarding Use of PCIS

Dear Dr. Cook,

My name is Bennie Lamont Kyle. I am a doctoral student at Walden University, and I am writing my dissertation which is entitled "The Difference Between the Attitudes About Evidence-Based Treatments Between Therapists in Urban and Suburban Settings. A part of the study involves an assessment of the evidence-based treatments being used in private practice with adolescents and the client engagement challenges encountered by the therapists using them. I am writing you to request permission to use the Perceived Characteristics of Intervention Scale (PCIS) in my investigation. With your permission, data from the PCIS will help me to draw conclusions about evidence-based treatments that are being used by private practice therapists working with adolescents in urban and suburban settings. I would like to thank you in advance if you do allow me to use your instrument.

Sincerely,
Bennie Lamont Kyle

Of course, Bennie!

Do you need any information from me? Attached is the original paper and a copy of the measure with scoring. We have another paper using the PCIS and comparing it to the EBPAS; that one is in press in Psychological Services. Would you like to see the submitted word doc version?

Best of luck with your dissertation.

Joan
Joan M. Cook, Ph.D.
Associate Professor
Yale School of Medicine

Appendix D: Participant Invitation and Consent Letter

Dear Psychologist,

You are being asked to participate in a research study. The purpose of the study is to investigate the differences between the attitudes of therapists in urban and suburban settings who use and do not use evidence-based treatments with adolescents. This research is being conducted in partial fulfillment of the researcher's doctoral requirements at Walden University. As a prerequisite, Walden requires that participants give consent for participation in research prior to the circulation of the survey. If you choose to participate, please place an X next to the yes in the space provided at the bottom of the e-mail and return it to the e-mail address listed below.

You will be asked to complete a series of questions related to therapist attitudes toward evidence-based treatments and the characteristics of treatments that effect the attitudes of therapists. You will also be asked to answer some brief questions that pertain to your background and knowledge of evidence-based treatments. Your participation is voluntary. All data will be identified during analysis and reporting. All participants will receive a $10 Visa gift card as a small token of appreciation for their participation.

Thank you

Bennie Lamont Kyle

Name of participant _____

____ Yes, I will participate in the research study

Appendix E: Demographic Questionnaire

Please answer the following questions.

What is your gender?

How many years have you provided service?

What is your race/ethnicity?

What is your level of education?

What is your primary discipline?

What is your theoretical orientation?

What is your professional status?

What type of setting is your practice located in?

Do you know what an evidence-based treatment (EBT) is?

Are you using an EBT?

If you are using an EBT, have you had training for the EBT you are using?