EVIDENCE-BASED PRACTICE AND POTENTIALLY HARMFUL TREATMENT IN CANADIAN THERAPISTS

by

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Abstract

Despite the abundance of research supporting evidence-based-practice (EBP), therapists are more likely to choose interventions based on intuition, training, and personal experience, rather than research (Gyani, Shafran, Myles, & Rose, 2014). One possible risk of not using EBP is that it leaves therapists open to the use of potentially harmful treatments (PHT) (Lilienfeld, 2007). Previous research has found that positive attitudes towards EBP are linked to intentions of using research to inform practice (Tasca, Grenon, Fortin-Langelier, & Chyurlia, 2014). While research about attitudes towards EBP and use of PHT are both growing respectively, there is a dearth of research supporting the relationship between attitudes towards EBP and use of PHT in Canadian therapists. This study explores attitudes towards EBP, use of PHT, and the relationship between EBP attitudes and PHT use in a sample of Canadian therapists. An online questionnaire was used to survey 152 practicing therapists, including registered counsellors and psychologists. Measures used include: the Attitudes Towards Evidence-Based Practice Scale-50 (EBPAS-50; Aarons, et al., 2012), a custom questionnaire assessing use of PHT, and questionnaires about education, practice, and personal demographics. Descriptive and inferential statistics were calculated. Results indicated that therapist factors like education, number of specializations, and caseload, independently related to certain domains of EBP attitudes, and to use of PHT. Moreover, specific dimensions of EBP attitudes related to use of PHT. In conclusion, this study confirms the association between negative attitudes towards EBP and using PHT in Canadian therapists. These findings also suggest that education, manageable caseloads, and limited specializations, may be important protective factors against negative attitudes towards EBP, and the use of PHT.
Preface

This thesis is an original intellectual product of the author, Nicole V. Thomson. The research project was conceptualized, designed, and researched by Master of Arts student, Nicole V. Thomson, with the support of research supervisor, Dr. Colleen Haney. All participant recruitment and data collection were completed independently by Nicole V. Thomson. Nicole V. Thomson performed data analyses with the support of Dr. Masoumeh Bejaei.

Partial results of this thesis were presented as a poster:


Ethics approval was obtained by The University of British Columbia Behavioural Research Ethics Board; certificate number H15-00392.
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Dedication

This thesis is dedicated to my family. To my Mom: you have always been there in so many ways; thank you. To my parents-in-law, can’t express how thankful I am for endless way you have helped. To my dad, though he’s no longer with me, continues to give me strength. And to James: I am the luckiest. Not only did I get to pursue my dream career; I got to with the encouragement and help of an amazing partner and best friend. I’m so grateful to have you and our girls by my side, and it fills me with joy to know they’re from such a loving and supportive family, from which they can pursue their dreams, too.

“The only test of truth is action based on the refusal to do harm…

…Truth is the end, love a means thereto.”

- Gandhi quote via Bondurant, J.V. Conquest of Violence
CHAPTER I

Introduction

Becoming a therapist is often seen as a calling to dedicate one’s life to helping others. Although therapists endeavour to help their clients, some treatments have been shown to produce worse than baseline functioning, and are therefore considered harmful (Lilienfeld, 2007). Research for informing treatment choice is plentiful; from case studies to clinical trials, an abundance of information exists to help therapists choose proven methods. However, previous literature indicates that many therapists do not rely on research to inform their practice, believing it to be inferior to clinical judgment, despite contrary findings (Gyani et al., 2014). Given the varied nature of well-intended therapists choosing treatments that could cause harm, further understanding about what informs treatment choice is crucial.

The primary aim of this study was to examine the relationships between therapist factors, attitudes towards Evidence-Based Practice (EBP), and use of Potentially Harmful Treatments (PHT). We tested the theory that therapists with more positive attitudes towards EBP are less likely to use a treatment that may cause harm. By exploring the potential influence of therapist variables such as degree type, populations served, and work environments, we hoped to highlight common strengths and barriers related to EBP attitudes and treatment choice. Although therapists ethically must intend to do no harm, there are complex educational, professional, and personal factors that may influence their attitudes, knowledge, and behaviour concerning treatment choice. We aimed to increase our understanding of these factors, in order to discover specific strengths and barriers that may impact client care, and contribute to supporting therapists in their efforts to best help their clients.
Ethics of Treatment Choice

It is clear that any therapist who intentionally causes harm to a client is acting unethically. It is less clear whether well-intended therapists who unknowingly use potentially harmful treatments (PHT) are acting unethically. Harm can be defined as: the worsening of symptoms, onset of new symptoms, “excessive dependency” on therapists, reluctance to try therapy in the future, and even physical harm (Lilienfeld, 2007). To examine the issue of ethical treatment choice, the following section references the fifth edition of the text “Ethics in counseling and psychotherapy: Standards, research, and emerging issues” by Welfel (2013), as well as the ethical guidelines of the Canadian Psychology Association (CPA) and the Canadian Counselling and Psychotherapy Association (CCPA).

Professional Competence. The first component of professional competence outlined by Welfel is “knowledge,” or understanding research and theory in the field of psychology (p. 84). Knowledge can be demonstrated by having a degree from an accredited program, and continuing education is recommended, if not mandated, by associations (2013, p. 85; Wise, 2008). CCPA’s code of ethics mentions continuing education for professional competence in its section on general responsibility (CCPA, 2007, p. 5); CPA’s code discusses continued education and keeping up with research under sections entitled competence and self-knowledge. It also discusses empirical support in the section entitled maximizing benefit (CPA, 2000, pp. 16-17).

“Skill” is the second component of competence to practice as outlined by Welfel. Skill can be further divided into clinical skills and technical skills (p 85). Clinical skills relate to common factors across therapies (from empathy and the therapeutic relationship to cultural competency), and technical skills relate to being able to choose appropriate interventions.
The third component of competence in practice is “diligence.” Diligent therapists prioritize client concerns, accurately assess presenting issues, consider their own strengths and limitations, and refer the client on if appropriate. Welfel goes on to discuss the level of training and supervision one must acquire to be considered “competent,” and states that most competent therapists will choose a focus, and cautions against therapists who claim to specialize in a great number of areas (p. 87).

Beneficence and Nonmaleficence. Beneficence is defined as proactively “promoting the client’s best interests”; nonmaleficence is defined as “not willfully harming clients, and refraining from actions that risk harm” (CPA, 2000, p. 16; CPPA, 2007, p. 2). Although professional competence is crucial, so are beneficence and nonmaleficence. For example, choosing a treatment backed by research may not be straightforward if information is unavailable or insufficient. Expecting therapists to only use treatments that meet the American Psychological Association’s strict criteria for an “empirically supported treatment” (EST) can be impractical or inappropriate. For example, EST has been criticized as favoring certain types of treatments, such as Cognitive therapies, which may not be appropriate for some clients (Dozois et al., 2014). For these reasons ethical codes include guidelines for ethically using treatments that are not EST.

Under the Principle of Responsible Caring, CPA’s code of ethics states that therapists should “monitor and evaluate the effect of their activities…” (CPA, 2000, p. 18) and “terminate an activity when it is clear that the activity carries more than minimal risk of harm and is found to be more harmful than beneficial, or when the activity is no longer needed” (section II.31). This is echoed by Welfel where, in relation to diligence, it is stated that treatment effectiveness is the best way to measure one’s competence, including evaluating outcomes of service (Welfel,
2013, p. 88; Spruill et al., 2004). Objectively monitoring client progress is important because therapists have difficulty detecting negative change, despite common assumptions that clinical judgment is sufficient for detecting change (Hatfield, McCullough, Frantz, & Krieger, 2010).

**Autonomy.** Both CPA and CCPA recommend that therapists limit their services to clients and services within their educational and professional experience (2000; 2007). Referral to more appropriate therapists is an option that must be considered any time competency to practice is in question. Numerous CCPA and CPA sections (CCPA A3 and B18; CPA II.8 and II.31) explain the preference for referring clients to more competent therapists, whenever possible (CCPA, 2007; CPA, 2000). Clients should be made aware of their options for referral to different therapists and options for relevant therapy techniques, so they can make informed autonomous decisions.

Ethical exceptions to referral may occur in a few situations; for example, if the client is aware that their therapist is new but has appropriate education and will be receiving supervision. Another example of when referral may not be appropriate is when there are no reasonable options for referral, for example when in a remote or rural location. In this case, if the therapist gains appropriate knowledge and commits to supervision (including distance supervision), it may be more ethical to proceed with treatment rather than refuse service. This would be in line with CPA’s section II.31 on *minimizing harm*, which states one should try to make reasonable arrangements for clients before terminating service (2000).

As with all ethical topics, understanding competence to practice can be complicated, and ethical decision making about whether a therapist is competent to practice requires the consideration of a number of factors. To provide ethical treatment, therapists must gain appropriate education, and work to maintain up-to-date knowledge about EBP in their
specializations. Although maintaining a highly competent practice may be challenging, providing services without appropriate training, and even inadvertently using potentially harmful treatments, is unethical. Limiting the number of areas one specializes in may allow clinicians to retain higher standards of treatment, while claiming to treat everything and anything may actually provide a warning against a therapist’s ability to practice competently in general.

Recently, a CPA based task force for EBP recommended that the CPA board of directors consider amending the Canadian Code of Ethics to be more direct about the importance of EBP (Dozois, et al., 2014). Currently, the Code’s section on responsible caring implies the use of EBP, but the code should include a clear and direct statement about EBP. Specifically, the update should include how clients must be clearly informed about relevant evidence-based options, and the therapists’ ability to provide them. Although this recommendation is based on the ethics of not doing harm to clients, there are many reasons it could be controversial.
CHAPTER II

Literature Review

The following literature review provides an overview of theories and findings related to therapists’ attitudes, knowledge, and behaviours towards EBP and PHT. For the purpose of the review, therapists include counsellors, psychologists, and social workers. Some researchers limit their definition of EBP to empirically supported treatments (EST). Others focus on specific areas of EBP, like client progress assessment, or research engagement. No retrievable Canadian studies specifically focus on gaining a comprehensive understanding of attitudes towards EBP, nor do any assess the prevalence of PHT. However, there have been Canadian studies concerned with other aspects of EBP, and international studies about treatment choices and attitudes towards EBP.

Evidence-Based Practice in Canada

In Canada, an effort is being made to bring attention to the need for EBP. In 2011, the Canadian Psychological Association (CPA) started a task force on the EBP of psychological treatments, and at the 2014 CPA national conference, a featured keynote address was presented on the current disconnection between science and practice in psychology, known as the “science-practice gap” (www.CPA.ca; Dozois, 2013). The Canadian Psychological Association also recently defined EBP:

“EBP of psychological treatments involves the conscientious, explicit, and judicious use of the best available research evidence to inform each stage of clinical decision-making and service delivery. This requires that psychologists apply their knowledge of the best available research in the context of specific client characteristics, cultural backgrounds, and treatment
preferences. Consistent with ethical codes and professional standards, EBP entails the monitoring and evaluation of services provided to clients throughout treatment.”

**Common Factors Theory**

Although the subject of EBP is gaining attention, amongst therapists there is debate and scepticism about the importance of choosing interventions with sufficient empirical support, because common factors (factors that are consistent across treatment types) have shown to play an important role in outcomes across different treatment types. One particular meta-analysis, which reviewed findings from a number of treatment comparison studies, is often cited during this debate (Wampold et al., 1997). To be included in Wampold’s analysis, studies were selected from four specific journals, published between 1970 and 1995, requiring an adequate effect size (to be compared to other treatments). The included studies also had to compare two or more treatments, each considered a “specific and bona fide” psychotherapy. A bona fide treatment was defined as a treatment “delivered by trained therapists, based on psychological principles, offered to the psychological community through professional manuals or books, or (must have) contained specific components.” Findings from this analysis revealed that efficacy was comparable across all included treatments, leading to the conclusion that the common therapeutic factors shared by all included treatments were likely sufficient for change.

While this study makes a convincing argument for the importance of common factors in bona fide therapies, the resulting statement: “therapeutic outcome differences may be attributed to client and therapist variables,” is often misunderstood to generalize to treatments that may not yet be established or meet the criteria of a bona fide therapy (Lilienfeld 2014; Wampold, 2001). Although results from the study demonstrate comparable results across supported treatments, it does not logically follow that all therapies, both supported and unsupported, are created equal.
Perhaps most importantly, common factor theory experts argue that their theory resides within the scope of EBP, not against it (Wampold & Imel, 2015).

**Potentially Harmful Treatments**

Without the caveat that common factors research only applies to well-established treatments, therapists may be under the false impression that their choice of intervention does not matter, and that all therapies are equally effective. Conversely, there are a number of interventions that have been shown to cause harm to clients (Lilienfeld, 2007). Potentially harmful treatments (PHT) have been operationally defined as: “Demonstrate(ing) harmful psychological or physical effects in clients or others (e.g., relatives); harmful effects are enduring and do not merely reflect a short-term exacerbation of symptoms during treatment; and harmful effects have been replicated by independent investigative teams” (Lilienfeld, 2007).

Lilienfeld identified several PHT by conducting a comprehensive literature search and critical evaluation. The PHT identified were rated as either Level I (probable harm for some individuals), or Level II (possible harm for some individuals). Treatments were categorized as Level II if evidence for harm was acquired from “quasi-experimental designs that have been replicated by at least one independent investigative team, or replicated single-case designs” (Lilienfeld, 2007). Level II treatments listed are: peer-group interventions for conduct disorder, and relaxation treatments for panic-prone patients.

Treatments were categorized as Level I if evidence for harm was acquired from “Randomly Controlled Trials (RCTs) that have been replicated by at least one independent investigative team, meta-analyses of RCTs, or the consistent and sudden emergence of low-base-rate adverse events following the introduction of therapy” (Lilienfeld, 2007). Ten treatments met the criteria for Level I. Of specific interest to our study, are: attachment therapies such as
“rebirth”, grief counselling for individuals with normal bereavement reactions, drug abuse and resistance education (DARE) programs, and critical incident stress debriefing (CISD).

**Attachment therapies.** Attachment therapies meet the criteria for a Level I PHT because of documented adverse events. Attachment therapies are based on the assumption that anger in children results from broken attachment bonds that can mend through techniques that may be considered abusive (Mercer, 2002). One type of attachment therapy, called “holding” can involve physically restraining a child until they maintain eye contact. Another type of attachment therapy is “rebirth”. The logic behind rebirthing is that a child may have been traumatized at birth, and must reenact being born, by being wrapped in blankets, and squeezed or sat on to simulate birth. Tragically, several children have died during rebirthing sessions (Mercer, 2002). To the author’s knowledge, no RCTs have been conducted on the efficacy of attachment therapies, and no positive effects have been supported by research.

**Grief counselling for normal bereavement reactions.** Lilienfeld included grief counselling for normal bereavement reactions based on a meta-analysis of 23-grief therapy RCTs, conducted by Neimeyer (2000). Neimeyer’s analysis showed that 38% of grief therapy clients ended up with lower functioning than non-treatment control groups. When Neimeyer further compared outcomes for clients who had “traumatic” compared to “normal” grief reactions; 17% of the traumatic group, and 50% of the normal group were worse off after grief therapy.

Labeling grief counselling for normal bereavement reactions as a PHT was met with some criticism. Authors Larson and Hoyt responded to Lilienfeld, stating that they found his conclusions about grief counselling to be overly pessimistic (2007). They challenged the statistical methods used in Neimyer’s analysis, and cited a different report with different outcomes (Fortner, 1999). Lilienfeld and co-author Bonanno then replied with a critique of
Larson and Hoyt’s sources, and a warning about the dangers of overselling a treatment that may lead to worse outcomes (2008). Larson and Hoyt responded again, stating that several of their conclusions had been mischaracterized (2008). They also discussed how grief-counselling studies are diverse when it comes to important moderator variables, making it hard to generalize effect size across studies. They concluded by agreeing with Lilienfeld and Bonanno about more research being needed (Larson & Hoyt, 2008).

Based on the available research, grief counselling for normal bereavement reactions does fit the criteria for a potentially harmful treatment. Arguing that it is not harmful if a therapist has expertise about which clients and circumstance it is safe to use on, does not change that it has been shown to have the potential to do harm. Nevertheless, it remains a treatment that has the potential to do harm.

**Drug Abuse and Resistance Education (DARE) Programs.** School based drug intervention programs, such as DARE, have been researched considerably. Some may argue that, because DARE programs are extensively researched, they are evidence-based. However, a literature review revealed that much of the support for DARE is taken from small sections of large studies, with otherwise no effects (Gorman & Huber, 2009). Lilienfeld cites RCTs and meta-analyses of RTCs, with outcomes that suggest these programs may actually increase substance use (Lynam et al., 1999; MacKillop, Lisman, Weinstein, & Rosenbaum, 2003; Werch & Owen, 2002). Research supporting school based drug prevention programs include caveats to consider protective factors against drug use, like parent involvement and anti-drug media campaigns (Montoya, Atkinson, & McFaden, 2003).
Critical Incident Stress Debriefing (CISD). CISD is an intervention for reducing posttraumatic stress and anxiety symptoms, involving in-depth discussion about highly stressful events directly after they occur (Lohr, Hooke, Gist, & Tolin, 2003). Some studies have found that CISD participants do not improve more than controls (Litz, Gray, Bryant, & Adler 2002; Rose, Brewin, Andrews, & Kirk, 1999). Furthermore, several studies found CISD participants had worse posttraumatic stress or anxiety symptoms at follow-up, compared to their non-treatment counterparts (McNally, Bryant, & Ehlers, 2003; Rose, Bisson, & Wessely, 2001; Sijbrandij, Olff, Reitsma, Carlier, & Gersons 2006; van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002). Counter arguments have included criticizing previous research for applying CISD outside of the contexts it was intended for: groups of people working high-risk jobs together (Hawker, Durkin, & Hawker, 2011).

Sexual Reorientation/ Reparative Therapy (RT). Psychology’s history of pathologizing gender and sexual diversity has been acknowledged as harmful (Anderson & Holland, 2015). Although not included in Lilenfeld’s 2007 paper about PHT, Reparative Therapy (RT) (also referred to as Conversion Therapy, or “Sexual orientation change efforts”) qualifies as a harmful treatment. One survey of 1,632 former RT clients revealed that less than 4% felt any change in their sexuality, 42% reported no positive gains, and 37% reported moderate to severe harm (Bradshaw, Dehlin, Crowell, Galliher, & Bradshaw, 2015).

One of the few papers cited in support of RT, included 200 previous clients of an RT therapist (Spitzer, 2003). Most of the participants reported experiencing some desired changes in their sexual orientation. Nine years later, the author published a formal apology to the gay community for the harm his article may have caused, emphasizing that previous findings could not be generalized; because his participants were “highly motivated” individuals who self-
selected to partake in the study (Spitzer, 2012). Regardless of research for or against RT, efforts to change sexual orientation are now acknowledged as so harmful and inappropriate, that there have been legal bans, and calls for further bans on RT (Byne, 2016).

**Research on Potentially Harmful Treatments.**

Lilienfeld noted several methodological issues with identifying PHT in the literature, including: increases in variance in treatment control groups compared to no treatment control groups, possible improvement and deterioration differences across symptom domains, multiple forms of client harm that may not be assessed, harm to friends or relatives which may not be assessed, assumptions about possible long term improvements despite short term deterioration, missing information from participants who drop out of treatment studies, ethical issues around replicating studies if the treatment may cause harm, and vast differences in the strength of evidence that can be found for different treatments.

However hard to identify, drawing attention to PHT is important for the safety and progress of clients. Despite this importance, there is a lack of research on the prevalence of therapists using PHT. However, one 2012 study of 400 licensed clinical social workers focused on comprehensively assessing which treatments were being used, and included Lilienfeld’s conception of PHT (Pignotti & Thyer, 2012). Participants responded to an online survey that assessed their use of “Novel Unsupported Therapies” (NUST), Conventional Unsupported Therapies (CNUST), Empirically Supported Treatments, and Unclassified Treatments. Authors defined NUSTs as “Interventions that lack adequate empirical support and yet make unsupported claims for their efficacy” and excluded new interventions in the process of being researched that do not make unsupported claims. CNUSTs were defined as unsupported therapies that are not new, but conventional.
The survey revealed that, while 97.5% of the social workers had used an EST within the past year, 75% also reported using some type of NUST, and 60% had used approximately 1 type of CNUST in the last year. Although social workers with a Cognitive Behavioural Therapy (CBT) orientation rated research evidence as more important than other participants, when it came to the reasons interventions were chosen, clinical experience was generally rated as more important than research.

The study was a voluntary self-report questionnaire for social workers in the US. The limitations of this type of design include the reliability of participant recall about treatment use in the past year, the generalizability to those who chose not to participate, and the possible tendency to over report the use of EST. As the study deliberately focused on Social Workers, it is worth noting that results may also not generalize to other types of therapists like counsellors or psychologists.

**Barriers to Evidence-Based Practice**

Evidence-based practice (EBP) can be considered a defense against the use of PHT. However, there are many barriers, or factors that make it difficult, for therapists to maintain an EBP. Systemically, training opportunities for EBP do not currently keep up with the advancements being made by research (Lyon et al., 2011). Place of work can also impact EBP, as therapists’ perception of stress within their organization has been significantly associated with greater barriers to implementing new EBP (Lundgren, Chassler, Amodeo, D'Ippolito, & Sullivan, 2012).

A recent Canadian study explored barriers to using research in practice, surveying 68 clinicians (from a variety of professions, with a variety of degree types) who planned on attending a conference on therapy practice research networks (Tasca et al., 2014). Using an
online survey distributed to all conference attendees, the authors assessed therapists’ intention to use research, and their subjective attitudes, norms, and perceived behavioural control, and found that each trait was independently related to therapists’ intentions to use research to inform their practice. Attitudes uniquely accounted for the largest percentage (25%) of the variance in intentions, with subjective norms at 14%, and perceived behavioural control at 8%.

The limitations of this study were the small sample size, and the measure being novel and relatively brief (only 14 items). Because the participants were conference attendees, they may have also had a greater than average interest in research. Nevertheless, the authors found their research to be consistent with previous findings by health care providers, and the study is relatively unique because it assesses both barriers and intentions to use EBP while adding to the limited understanding we have about EBP use by Canadian therapists.

Although Canadian research on EBP is relatively rare, the topic seems to be of increasing interest. A 2014 survey of 1,668 Canadian psychologists focused on the use of progress monitoring measures (PMs) (Ionita & Fitzpatrick, 2014). PMs are assessment tools used systematically to monitor clients repeatedly throughout treatment, and are a simple way of bringing evidence into practice (Overington & Ionita, 2012). The survey found that over two-thirds of respondents were unfamiliar with progress monitoring measures, and only 12% were using any of these measures (Ionita & Fitzpatrick, 2014). Objectively monitoring client progress is important because therapists have difficulty detecting negative change, despite common assumptions that clinical judgment is sufficient for detecting change (Hatfield, McCullough, Frantz, & Krieger, 2010).

A lack of information or education about EBP appears to be a major barrier to the use of EBP. A 2007 study asked 37 APA members to respond to an online survey with open-ended
questions about barriers to EBP. The respondents indicated 84 barriers, with the most common being a lack of training, and negative attitudes towards EBP (Pagoto et al., 2007). The researchers also noted a general confusion between EBP and empirically supported treatments (EST).

**Evidence-Based Practice vs. Empirically Supported Treatments**

It is important to differentiate between EBP and EST. One of the simplest explanations for the difference between EBP and EST was offered by the APA’s Presidential Task Force on Evidence-Based Practice (2006): EBP starts with considering the individual client and their circumstances and asks what research can be applied; EST starts with a treatment and asks what clinical problems it has been shown to help with (p.273).

EBP may involve considering a range of relevant evidence to fit unique circumstances, while an EST is an intervention that has met specific criteria set by the American Psychological Association’s Society for Clinical Psychology (Division 12) (Thomason, 2010). To meet criteria as a well-established treatment, an intervention must be manualized, specific to a population, and meet the following two criteria: it must contain at least two studies by different investigators, or a series of single case studies with good experimental designs; it must have been found to be superior to another treatment, a psychological placebo, or a pill, or statistically equivalent to an already established treatment (Chambless & Hollon, 1998).

Although it is important to know the difference between EBP and EST, it is worth noting that using an appropriate EST qualifies as EBP. Because specific research on barriers to EBP is limited, and EST can be EBP, it is worth including recent and relevant research on barriers to using EST. A qualitative study published in 2012 involved interviewing 25 independently practicing therapists, highlighting specific reservations they had about EST. The therapists were
concerned about external validity and applicability of research findings, using manuals in treatment, and that “nonpsychologists would use EST lists to dictate practice” (Stewart, Stirman, & Chambless, 2012). Time and financial barriers concerned nearly all participants. Clinicians suggested they might be interested in EST, if the treatments could be integrated into their current frameworks, and if resources for learning EST were improved. Positive interest in EST was also expressed, as some saw value in treatments with research support, and understood the benefit of using measurement rather than intuition to assess how clients are helped. Clinicians also had alternative ways of improving their practice, reporting that they valued “clinical experience, peer networks, practitioner-oriented books, and (some) continuing education” (Stewart, Stirman, & Chambless, 2012).

To gain a better understanding of resistance to EBP, Lilienfeld and colleagues performed an in depth analysis concerning EBP attitudes (2013). The authors systematically reviewed survey data from peer reviewed articles about therapists’ attitudes towards EBP, and identified six specific factors as underlying sources of resistance:

(1) Naïve realism (concluding that client change is due to an intervention rather than a competing explanation); (2) misconceptions about human nature (like assuming a problem originated from an unrecalled early experience); (3) statistical misunderstanding about the “application of group probabilities to individuals”; (4) placing the burden of proof on skeptics instead of the advocates of untested therapies; (5) misunderstanding the definition of EBP; and (6) “pragmatic, educational, and attitudinal obstacles”, like navigating the often over-technical EBP literature (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013).
To summarize the literature, the problem with the science-practice gap is both ethical and practical. While EBP is a possible solution to the gap between research and practice, therapists face barriers to EBP. Therapists may be unaware of potentially harmful treatments, given the misconception that common factors render treatment choice inconsequential (Wampold, & Imel, 2015). Therapists, like all people, are also prone to errors in judgment, trusting intuition and personal experience over objective measures of change (Gyani et al., 2014). Although therapist attitudes are often considered the main barrier to EBP, these attitudes are complex, and influenced by a number of internal and external factors. Even practicing therapists who positively regard EBP can be caught in a balancing act, where they must “develop and maintain a personally effective therapeutic voice, translate multiple streams of evidence into meaningful interventions, offer safe and confidential therapeutic relationships, and practice in the real world” (Goodheart, 2004). Despite the complexity of applying research to practice, progress is being made to understand the multi-dimensional barriers to EBP, continuously bringing us one step closer to our goal of ensuring that our clients receive the best help possible.

Statement of the Problem

Some argue that common factors (factors consistent across therapies) impact treatment more than intervention choice, and therefore treatment choice is less important; however numerous interventions have been shown to cause harm to clients (Lilienfeld, 2007; Wampold, 2001). Although evidence-based practice (EBP) can help therapists choose appropriate treatments, preventing use of potentially harmful treatments (PHT), therapists report being more likely to rely on intuition, training, and personal experience than research when selecting interventions (Gyani et al., 2014). The disconnection between available research and its clinical application is known as the science-practice gap. The science-practice gap is an important issue
for clients, educators, researchers, policy makers, and therapists. Within this gap between research and practice, is the potential to do unintended, unethical, harm to our clients. By examining attitudes towards EBP and use of PHT amongst Canadian therapists, the present study hopes to help address the science-practice gap.
CHAPTER III

Current Study

Limitations to previous research on the science-practice gap include a lack of Canadian samples, a lack of comprehensive EBP attitudes measures, and the absence of assessing the use of PHT. To address these limitations, we surveyed a Canadian sample, used a comprehensive measure of EBP attitudes, and inquired about the use of PHT. Having attended to these limitations, the primary aim of this study was to explore Canadian therapists’ attitudes towards EBP, and the use of PHT. Further, we examined the potential relationships between EBP, PHT, and therapist differences on personal and professional domains. We hope to contribute to the field of counselling by highlighting therapist concerns, strengths, and the barriers to using EBP.

Research Questions and Hypotheses

Research Question One: Are therapist characteristics related to EBP attitudes?

*Hypothesis 1:* Therapists with higher or more diverse caseloads, or publicly funded practices will perceive EBP as more burdensome on the Burden subscale of the EBPAS-50, than those with lower case loads, less diverse, or private practices (Aarons et al., 2012).

*Hypothesis 2:* Therapists who endorse CBT as an orientation will have a more favourable view of EBP on the EBPAS-50, than therapists who do not (Pignotti & Thyer, 2012).

Research Question Two: Are therapist characteristics associated with using potentially harmful treatment (PHT)?

*Hypothesis 3:* Compared to therapists who do not use PHT, therapists who use PHT will report less education, less experience, a higher caseload, and more clinical specializations.

Research Question Three: Are EBP attitudes associated with using PHT?
**Hypothesis 4:** EBPAS-50 scores will indicate significantly more negative attitudes towards EBP amongst those who have used at least one PHT in the past two years, compared to those who have not.

**Method**

**Design and Procedure**

The present study used a quantitative, cross-sectional survey design. To survey Canadian therapists about themselves and their practice, we created an online questionnaire using Qualtrics survey software. Prior to distribution, three MA level counselling students piloted the survey for completion time and clarity.

Participants were recruited from advertisements posted on email lists of organizations such as the Canadian Counselling and Psychotherapy Association, and the Canadian Psychological Association (Appendix A). Organizations who agreed to help would distribute our advertisement (Appendix B). Individuals who wished to participate could follow an internet link to our secure online questionnaire, which was created using Qualtrics survey software (Appendix C - F). To participate, therapists must have self-reported having graduate degrees related to counselling or psychology, or be in such training, and have seen clients within the past twelve months. Data collection spanned several months. Out of 210 participants who began the survey, we excluded data from participants who did not complete enough of our questionnaire; specifically we excluded 56 participants who did not fully complete the EBPAS-50, leaving 154 remaining participants.

Although in-person surveys may secure higher completion rates, putting our survey online allowed us to invite therapists from across Canada to participate at their convenience. Participation was voluntary, anonymous, and participants could quit at any time. Participants
were also able to access information about ethics approval, and researcher contact information. The survey took approximately 15 - 25 minutes to complete. At the end of the survey, participants were given the option to follow a link to a separate secure form and enter into a gift card draw.

**Assessments and Measures**

*Attitudes towards Evidence-Based Practice Scale-50 (EBPAS-50).* (Appendix D). The EBPAS-50 was designed to measure therapists’ attitudes towards implementation of EBP in service provider and mental health settings (Aarons, et al., 2012). It is a self-report measure, with 50 items on a 5-point scale (zero to four; not at all, slight extent, moderate extent, great extent, very great extent). Items can be summed according to twelve subscales, or (after five specific subscales are reverse scored) all can be summed for a total score. (Table 3.1)

**Table 3.1 EBPAS-50 Subscale descriptions.**

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requirements</td>
<td>Would adopt new treatment if required by supervisor, agency, or province</td>
</tr>
<tr>
<td>Appeal</td>
<td>Would adopt new treatment if intuitive, colleagues endorsed it, training provided</td>
</tr>
<tr>
<td>Openness</td>
<td>Willing to try new therapies, try therapies by researchers, and follow manuals</td>
</tr>
<tr>
<td>Divergence*</td>
<td>Would not use manualized treatment, knows better than researchers</td>
</tr>
<tr>
<td>Limitations*</td>
<td>Believes EBP reduces alliance, is not individualized, and is too simple</td>
</tr>
<tr>
<td>Fit</td>
<td>Would use a new therapy if clients wanted it, and it fit with existing approach</td>
</tr>
<tr>
<td>Monitoring*</td>
<td>Prefers to work without oversight and monitoring</td>
</tr>
<tr>
<td>Balance*</td>
<td>Competence is more important than approach; therapy is more art than science</td>
</tr>
<tr>
<td>Burden*</td>
<td>Does not have time to meet obligations, learn anything new, or fit in EBP</td>
</tr>
<tr>
<td>Security</td>
<td>Believes learning an EBP will help keep one's job, or obtain a new job</td>
</tr>
<tr>
<td>Support</td>
<td>Would learn new treatment if support, credits, or training were provided</td>
</tr>
<tr>
<td>Feedback</td>
<td>Views supervision and feedback as helpful and enjoyable</td>
</tr>
</tbody>
</table>

*Note: EBPAS-50: Evidence-Based Practice Attitude Scale-50 Item Version. * Indicates a subscale that gets reverse scored before being summed into the mean total score.*

The EBPAS-50’s internal consistency has been reported as .77 - .92, and factor correlations have been reported as small, from .01 to .56 (Aarons, et al., 2012). The original
version of the Evidence-Based Practice Attitude Scale (EBPAS) contained the first four subscales (fifteen items), which remain in the EBPAS-50 (EBPAS; Aarons 2004). The EBPAS has demonstrated its validity and reliability in a number of studies (Aarons 2004; Aarons 2006; Aarons et al. 2007; Aarons, McDonald, Sheehan, & Walrath-Greene, 2007; Keyser, Harrington & Haksoon, 2016).

*Interventions Checklist.* (Appendix E). A checklist of treatments was assembled for the current study, to assess knowledge and use of Potentially Harmful treatments (PHT). The list was originally constructed based on previous PHT research. Three peer-reviewed articles that contained comprehensive lists of PHT were used as an initial source (Lilienfeld, 2007; Norcross, 2006; Pignotti & Thyer, 2012). To keep our list brief and appropriate for current Canadian therapists, the previously established lists were combined and adapted in the following way:

- PHT that may have been identified since 2007 were searched for via a literature search conducted in the method outlined by Lilienfeld (2007). We ended up adding sexual reorientation therapy to our list.
- The Internet was searched for the prevalence of each treatment amongst Canadian therapists, in order to eliminate treatments not relevant to our sample. Many treatments from previous research were eliminated during this step. One challenge we ran into, was that some therapists advertised that they work with “attachment” or “sexuality”, without naming specific treatments. For that reason, we wanted to retain certain controversial treatments, to assess for prevalence in Canada over the past 2 years.
- To minimize time burden for participants, the final checklist was edited to include five PHT: Critical Incident Stress Debriefing, Drug Abuse Resistance Education (DARE) programs,
Grief Counselling for normal bereavement reactions, Re-birthing/ Attachment therapies, and Sexual Reorientation / Reparative therapy.

**Participants**

Two hundred and ten participants began the survey, 154 finished and were included in the analysis, making the completion rate 73.33%. (Table 3.2).

**Table 3.2 Participant Demographics**

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>116</td>
<td>76.82</td>
</tr>
<tr>
<td>Men</td>
<td>31</td>
<td>20.53</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>2.65</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 - 30</td>
<td>20</td>
<td>13.16</td>
</tr>
<tr>
<td>31 - 40</td>
<td>44</td>
<td>28.95</td>
</tr>
<tr>
<td>41 - 50</td>
<td>35</td>
<td>23.03</td>
</tr>
<tr>
<td>51 - 60</td>
<td>38</td>
<td>25.00</td>
</tr>
<tr>
<td>61 - 70</td>
<td>15</td>
<td>9.87</td>
</tr>
<tr>
<td><strong>Province</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alberta</td>
<td>22</td>
<td>14.77</td>
</tr>
<tr>
<td>British Columbia</td>
<td>51</td>
<td>34.23</td>
</tr>
<tr>
<td>Manitoba</td>
<td>5</td>
<td>3.36</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>2</td>
<td>1.34</td>
</tr>
<tr>
<td>Newfoundland &amp; Labrador</td>
<td>2</td>
<td>1.34</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>11</td>
<td>7.38</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>1</td>
<td>0.67</td>
</tr>
<tr>
<td>Ontario</td>
<td>48</td>
<td>32.21</td>
</tr>
<tr>
<td>Quebec</td>
<td>2</td>
<td>1.34</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>3</td>
<td>2.01</td>
</tr>
<tr>
<td>Yukon</td>
<td>1</td>
<td>0.67</td>
</tr>
<tr>
<td>Not currently in Canada</td>
<td>1</td>
<td>0.67</td>
</tr>
</tbody>
</table>

**Professional Demographics**

In addition to standard demographic information, participants provided details about their education, practice, specializations, and professional development. Descriptive statistics were calculated.
Education. Therapists’ most recent degrees were Masters \( (n = 89) \), Doctorates \( (n = 59) \) and “other” \( (n = 2) \) (Figure 3.1). Participants with PhDs could specify clinical \( (n = 39, 25.32\%) \), or counselling psychology \( (n = 6, 3.90\%) \). Counselling MEd \( (n = 15, 9.74\%) \), counselling MA \( (n = 37, 24.03\%) \), and clinical psychology MA \( (n = 15, 9.74\%) \) degrees were all represented. Amongst Masters programs, 69.7\% were two-year, and 30.3\% were three-year programs.

Seventy-two (46.75\%) participants described their graduate programs as ascribing to a "scientist-practitioner" model, and 120 (77.92\%) participants reported being taught about EBP. Only seventeen (11.04\%) indicated that neither description applied to their program. The disparity of reported practicum or internship hour requirements was notable; with the range being 0 – 4000 hours, with a mean of 816.10 hours, and a standard deviation of 786.19 hours.

Practice context. Participants indicated if they had been practicing for 0 - 5 \( (n = 63) \), 6 - 10 \( (n = 34) \), 11 - 20 \( (n = 35) \), or over 20 years \( (n = 22) \) (Figure 3.2). More therapists worked in urban \( (n = 124, 81.58\%) \), compared to rural settings \( (n = 22, 14.47\%) \), and private \( (n = 88, 57.5\%) \), compared to public practices \( (n = 65, 42.7\%) \).

Figure 3.1

\[ \text{Latest Degree} \]

2% Masters
39% Doctorate
59% Other

Figure 3.2

\[ \text{Years Practicing} \]

14% 0 - 5
41% 6 - 10
23% 11 - 20
22% 20 +

\text{Figure 3.1 Pie Chart showing Participants’ latest degree level, using percentages.}
\text{Figure 3.2 Pie Chart showing Participants’ years practicing therapy, using percentages.}
Within the public sector: 32 (20.8%) worked in nonprofit or social service agencies, 32 (20.8%) in post-secondary settings, 23 (14.9%) in hospitals, thirteen (8.4%) in rehabilitation centers, twelve (7.8%) in outpatient clinics, eight (5.2%) in public schools, eight (5.2%) in residential care/ halfway houses, and three (1.9%) in correctional facilities.

**Therapy specializations.** Participants were queried on three dimensions of specialization: client populations, theoretical orientations, and clinical issues (Table 3.3). For each dimension, participants were shown a list of possible specializations (including “other”) and asked to select and rank as many as relevant. The mean number of client population specializations was 3.25 ($SD = 1.56$), with the most frequent population being “Adult” ($n = 131, 85.06\%$). The mean number of theoretical orientation specializations was 3.58 ($SD = 1.77$), with the most frequent theoretical orientation being Cognitive Behavioural Therapy ($n = 115, 74.68\%$). The mean number of clinical issue specializations was 6.02 ($SD = 3.14$), with the most frequent clinical issue being Anxiety ($n = 132, 85.71\%$).

**Professional Development.** To get a sense of participants’ professional development habits, we asked about participation in a number of activities over the past two years. Results showed our sample attending a mean 2.24 ($SD = 2.11$) professional conferences, 3.36 ($SD = 2.26$) therapy workshops, and belonging to 2.53 ($SD = 1.46$) professional associations. Participants reported reading a mean 4.25 ($SD = 3.05$) research articles per month, and using "other" professional development tools, like books and webinars. When asked why they keep up with research, participants indicated clinical interest ($n = 148, 96.10\%$), academic interest ($n = 104, 67.53\%$), and research interest ($n = 53, 34.42\%$).
Table 3.3 Specialization Frequencies.

<table>
<thead>
<tr>
<th>Client Populations</th>
<th>n</th>
<th>%</th>
<th>Theoretical Orientations</th>
<th>n</th>
<th>%</th>
<th>Clinical Issues</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>131</td>
<td>85.06</td>
<td>CBT</td>
<td>115</td>
<td>74.68</td>
<td>Anxiety</td>
<td>132</td>
<td>85.71</td>
</tr>
<tr>
<td>Adolescents</td>
<td>90</td>
<td>58.44</td>
<td>Experiential</td>
<td>59</td>
<td>38.31</td>
<td>Depression</td>
<td>125</td>
<td>81.17</td>
</tr>
<tr>
<td>Groups</td>
<td>62</td>
<td>40.26</td>
<td>Humanistic</td>
<td>59</td>
<td>38.31</td>
<td>Trauma</td>
<td>87</td>
<td>56.49</td>
</tr>
<tr>
<td>Couples</td>
<td>58</td>
<td>37.66</td>
<td>Integrative</td>
<td>57</td>
<td>37.01</td>
<td>Grief</td>
<td>71</td>
<td>46.10</td>
</tr>
<tr>
<td>Children</td>
<td>57</td>
<td>37.01</td>
<td>Narrative</td>
<td>41</td>
<td>26.62</td>
<td>PTSD</td>
<td>67</td>
<td>43.51</td>
</tr>
<tr>
<td>Older Adults</td>
<td>54</td>
<td>35.06</td>
<td>Behavioural</td>
<td>40</td>
<td>25.97</td>
<td>Anger</td>
<td>57</td>
<td>37.01</td>
</tr>
<tr>
<td>Families</td>
<td>48</td>
<td>31.17</td>
<td>Interpersonal</td>
<td>35</td>
<td>22.73</td>
<td>Personality Disorders</td>
<td>48</td>
<td>31.17</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Systemic</td>
<td>35</td>
<td>22.73</td>
<td>Addictions</td>
<td>38</td>
<td>24.68</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Psycho-dynamic</td>
<td>32</td>
<td>20.78</td>
<td>OCD</td>
<td>30</td>
<td>19.48</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Existential</td>
<td>29</td>
<td>18.83</td>
<td>Sleep Issues</td>
<td>27</td>
<td>17.53</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Feminist</td>
<td>19</td>
<td>12.34</td>
<td>Career</td>
<td>24</td>
<td>15.58</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other</td>
<td>31</td>
<td>20.13</td>
<td>Culturally Diverse</td>
<td>24</td>
<td>15.58</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>LGBTQ Clients</td>
<td>23</td>
<td>14.94</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Spirituality</td>
<td>23</td>
<td>14.94</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Psychotic Disorders</td>
<td>22</td>
<td>14.29</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Eating Disorders</td>
<td>21</td>
<td>13.64</td>
</tr>
</tbody>
</table>

*Note. N = 152. CBT = Cognitive Behavioural Therapy; PTSD = Posttraumatic Stress Disorder; OCD = Obsessive Compulsive Disorder; LGBTQ = Lesbian Gay Bisexual Transgender Queer.*

**Excluded Participants.** Participants were included in our final analyses if they had completed the EBPAS-50. Because therapists were asked about their professional demographics before the EBPS-50, we can compare included and excluded participants on a number of variables.

Included participants specialized in significantly more client populations ($M = 3.25, SD = 1.56$), compared to excluded participants ($M = 2.47, SD = 2.09, t(76.72) = -2.51, p = 0.014$); more theoretical orientations ($M = 3.58, SD = 1.77$) compared to excluded participants ($M = 2.43, SD = 2.26, t(80.75) = -3.46, p = 0.001$); and more clinical issues ($M = 6.02, SD = 3.14$), compared to excluded participants ($M = 3.61, SD = 3.39, t(91.62) = -4.65, p < 0.001$). Included and excluded participants did not differ significantly on years practicing ($p = 0.90$) or practice location ($p = 0.7$).
Relevance to Counselling Psychology

Expanding knowledge about Canadian therapists’ attitudes towards EBP and use of PHT is both timely and relevant to counselling psychology. As support and demand for EBP continues to rise in Canada, it is important to investigate which personal and professional factors contribute to use of EBP, as this may illuminate barriers and supports to using EBP, leading to recommendations for researchers, educators, and policy makers. Similarly, given the controversy around the rise of EBP, it is important to investigate whether EBP may be protective against PHT.

It is vital to share any findings of PHT being used in Canada. Raising awareness, encouraging further investigation, and exploring solutions for reducing potential harm to all Canadians seeking therapy is not only important for clients and therapists, but it is critical information for educators and policy makers, for economical and moral reasons. In summary, this study will help inform therapists, educators, and policy makers about attitudes towards EBP, current use of PHT, and the possible relationship between EBP attitudes and PHT, contributing to an under-researched area in Canadian counselling psychology.
CHAPTER IV

Results

Measure Means and Correlations

Interventions Checklist. To assess the prevalence of PHT in our sample, participants were shown a list of treatments, and asked if they had used them in the past two years (Table 4.1).

Table 4.1 Frequency of Potentially Harmful Treatments used in the past 2 years.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grief Counselling for normal bereavement reactions</td>
<td>57</td>
<td>37.01</td>
</tr>
<tr>
<td>Critical Incident Stress Debriefing</td>
<td>20</td>
<td>12.99</td>
</tr>
<tr>
<td>Re-birthing/ Attachment therapies</td>
<td>3</td>
<td>1.95</td>
</tr>
<tr>
<td>DARE programs</td>
<td>3</td>
<td>1.95</td>
</tr>
<tr>
<td>Sexual Reorientation / Reparative therapy</td>
<td>2</td>
<td>1.30</td>
</tr>
</tbody>
</table>

Note. N = 152. DARE = Drug Abuse Resistance Education

Attitudes towards Evidence-Based Practice Scale-50. To assess whether our sample’s EBPAS-50 scores are consistent with previous research, inter-correlations are presented (Table 4.2). Scores on the EBPAS-50 are correlated in the directions expected based on previous research (Aarons et al., 2012).

Research Question One

The primary research question asked if therapist characteristics related to EBP attitudes. We compared mean EBPAS-50 scores against a number of individual therapist factors using independent samples t-tests and correlations.

Hypothesis One. The first hypothesis stated that therapists with publicly funded practices or higher caseloads would perceive EBP as more burdensome than those with private practices or lower caseloads (Aarons et al., 2012).
### Table 4.2

Descriptive Statistics and Inter-correlations for the EBPAS-50 subscales and total.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Requirements</td>
<td>–</td>
<td>.337***</td>
<td>.198*</td>
<td>-.166*</td>
<td>-0.11</td>
<td>.208*</td>
<td>-0.09</td>
<td>-0.13</td>
<td>-0.06</td>
<td>.252**</td>
<td>.270**</td>
<td>-.06</td>
<td>.523**</td>
<td>2.26</td>
<td>1.11</td>
</tr>
<tr>
<td>2. Appeal</td>
<td>–</td>
<td>.427***</td>
<td>0.02</td>
<td>0.10</td>
<td>.557***</td>
<td>.08</td>
<td>.273**</td>
<td>0.11</td>
<td>0.06</td>
<td>.317**</td>
<td>0.08</td>
<td>.381**</td>
<td>2.84</td>
<td>0.72</td>
<td></td>
</tr>
<tr>
<td>3. Openness</td>
<td>–</td>
<td>-.16</td>
<td>0.00</td>
<td>.294***</td>
<td>0.01</td>
<td>-0.07</td>
<td>-0.05</td>
<td>.241**</td>
<td>.417***</td>
<td>.193*</td>
<td>.483**</td>
<td>2.22</td>
<td>0.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Divergence</td>
<td>–</td>
<td>.586***</td>
<td>.178*</td>
<td>.386***</td>
<td>.590***</td>
<td>.325***</td>
<td>-.241**</td>
<td>-.280**</td>
<td>-.08</td>
<td>-.676**</td>
<td>1.08</td>
<td>0.77</td>
<td></td>
<td></td>
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<tr>
<td>5. Limitations</td>
<td>–</td>
<td>0.14</td>
<td>.312***</td>
<td>.416***</td>
<td>.379***</td>
<td>-0.14</td>
<td>-0.11</td>
<td>-0.04</td>
<td>-.625**</td>
<td>0.78</td>
<td>0.89</td>
<td></td>
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<td></td>
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<tr>
<td>6. Fit</td>
<td>–</td>
<td>0.13</td>
<td>.301***</td>
<td>-0.06</td>
<td>-0.07</td>
<td>.191*</td>
<td>0.05</td>
<td>.257**</td>
<td>2.99</td>
<td>0.54</td>
<td></td>
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<tr>
<td>7. Monitoring</td>
<td>–</td>
<td>.333***</td>
<td>0.11</td>
<td>-.210**</td>
<td>-.09</td>
<td>-.247**</td>
<td>-.471**</td>
<td>1.04</td>
<td>1.02</td>
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<td></td>
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<tr>
<td>8. Balance</td>
<td>–</td>
<td>0.03</td>
<td>-.246**</td>
<td>-0.13</td>
<td>0.09</td>
<td>-.423**</td>
<td>2.53</td>
<td>0.71</td>
<td></td>
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<tr>
<td>9. Burden</td>
<td>–</td>
<td>0.14</td>
<td>0.07</td>
<td>-0.13</td>
<td>-.350**</td>
<td>0.62</td>
<td>0.64</td>
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<tr>
<td>10. Security</td>
<td>–</td>
<td>.493**</td>
<td>.208*</td>
<td>.471**</td>
<td>1.46</td>
<td>1.02</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>11. Support</td>
<td>–</td>
<td>.272**</td>
<td>.567**</td>
<td>2.46</td>
<td>0.95</td>
<td></td>
<td></td>
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<tr>
<td>12. Feedback</td>
<td>–</td>
<td>.323**</td>
<td>3.07</td>
<td>0.81</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>13. Total</td>
<td>–</td>
<td>2.69</td>
<td>3.83</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tbody>
</table>

Note: $n = 152$. EBPAS-50: Attitudes Towards Evidence-Based Practice Scale – 50 item. * $p < .05$; ** $p < 0.01$; *** $p < 0.001$. For subscales 1 (Requirements), 2 (Appeal), 3 (Openness), 6 (Fit), 10 (Security), 11 (Support), and 12 (Feedback), higher scores indicate more positive attitudes towards EPB. For subscales 4 (Divergence), 5 (Limitations), 7 (Monitoring), 8 (Balance), and 9 (Burden), higher scores represent more negative attitudes towards EBP; these subscale scores are reversed for calculating total score.
Contrary to previous findings, there were no significant differences between therapists in private \((M = 2.66, SD = 0.36)\) compared to public practices \((M = 2.73, SD = 0.39, t(141) = -1.26, p = 0.21)\) on the EBPAS-50, including the Burden subscale \((t(150) = -4.64, p = 0.64)\). However, client hours per week and number of specializations were associated with negative attitudes on a number of EBPAS-50 subscales. (See Table 3.1 - EBPAS Subscale Descriptions). Direct therapy hours per week were positively associated with Divergence \((r = 0.21; p = 0.009)\), and Limitations \((r = 0.16; p = 0.05)\). Number of client type specializations (i.e. children, couples, groups) also related to EBPAS-50 scores; as number of client population specialties increased, so did subscale scores for Divergence \((r = 0.26; p = .001)\), Limitations \((r = 0.17; p = 0.03)\), and Balance \((r = 0.19; p = 0.02)\). Similarly, number of clinical issue specialties (i.e. anxiety, depression, trauma) positively related to Divergence \((r = 0.16; p = 0.05)\), Limitations \((r = 0.21; p = 0.009)\), and Balance \((r = 0.21; p = 0.01)\). Number of clinical issue specialties also correlated positively with Fit \((r = 0.24; p = 0.003)\), and negatively with Burden \((r = -0.19; p = 0.02)\); indicating more positive attitudes towards EBP.

**Hypothesis Two.** The second hypothesis stated that those with a CBT orientation would have a more favorable view of EBP than others (Pignotti & Thyer, 2012). This hypothesis was confirmed in our sample (Figure 4.1). Significant EBPAS-50 differences included: Divergence \((t(152) = 2.65, p = 0.01)\), Limitations \((t(152) = 3.01, p = 0.003)\), Balance \((t(88.60) = 2.18, p = 0.03)\), Burden \((t(54.18) = 2.73, p = 0.01)\), and Requirements \((t(150) = -2.25, p = 0.03)\).

Additionally, CBT specialists had higher total EBPAS-50 scores \((M = 2.74, SD = 0.36)\) than others \((M = 2.54, SD = 0.38, t(141) = -2.73, p = 0.01)\), indicating more positive EBP attitudes.
Figure 4.1

Figure 4.1. Radar Chart illustrating mean EBPAS-50 subscale scores for those who did vs. did not select CBT as a theoretical orientation. Note. N = 152. EBPAS-50: Attitudes Towards Evidence-Based Practice Scale – 50 item. * p < .05; ** p ≤ 0.01. Appropriate subscales were reversed: higher numbers (outer circle) indicate more favourable EBP attitudes.

Research Question Two

The second research question asked if therapist characteristics were associated with using potentially harmful treatment (PHT). Independent samples t-tests and chi-square tests of independence were performed to examine PHT use differences between groups.

Hypothesis Three. The third hypothesis was that education and experience would negatively relate, while higher caseloads and more specializations would positively relate, to PHT use.
A chi-square test of independence was used to examine the relation between PHT use and education. The relationship was significant ($\chi^2(1) = 8.30, p = 0.004$), with more MA level therapists using at least one PHT compared to PhD level therapists (Figure 4.2).

**Figure 4.2**

![Bar Graph - distribution of Potentially Harmful Treatment use and Latest Degree.](image)

Mann-Whitney tests indicated years of practicing therapy did not differ based on using or not using PHT, $U = 2517.00, z = -1.30, p = 0.20$. However, compared to therapists who did not use PHT, participants that used PHT reported specializing in significantly more client populations ($U = 2146, z = -2.67, p = 0.007$); theoretical orientations ($U = 2044.00, z = -3.03, p = 0.002$), and clinical issues ($U = 2305.50, z = -2.03, p = 0.04$) (Figure 4.3). They also saw significantly more clients per week ($U = 2201, z = -2.40, p = 0.02$) (Figure 4.4).
Research Question Three

Our third research question inquired about the relationship between EBP attitudes and use of PHT. Independent samples t-tests were used for between group comparisons.

Hypothesis Four: The fourth hypothesis was that negative attitudes towards EBP would be higher amongst those who used at least one PHT, compared to those who had not.

As expected, several differences in EBPAS-50 scores were found (Table 4.3). Having used a PHT was related to scoring higher on Divergence (i.e. agreeing that they know better than researchers), Limitations (i.e. agreeing that EBP is too limited for many clients), Balance (i.e. agreeing that therapy is more of an art than a science), and total EBPAS-50 score.
Table 4.3
Means, SD’s, and t-tests for EBPAS-50 scores by Potentially Harmful Treatment Use

<table>
<thead>
<tr>
<th>Measure</th>
<th>No PHT (n=109)</th>
<th>Used PHT (n=43)</th>
<th>t(df)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>1. Requirements</td>
<td>2.35</td>
<td>1.16</td>
<td>2.13</td>
<td>1.04</td>
</tr>
<tr>
<td>2. Appeal</td>
<td>2.84</td>
<td>0.77</td>
<td>2.84</td>
<td>0.66</td>
</tr>
<tr>
<td>3. Openness</td>
<td>2.20</td>
<td>0.68</td>
<td>2.25</td>
<td>0.66</td>
</tr>
<tr>
<td>4. Divergence</td>
<td>0.93</td>
<td>0.69</td>
<td>1.31</td>
<td>0.84</td>
</tr>
<tr>
<td>5. Limitations</td>
<td>0.63</td>
<td>0.79</td>
<td>1.00</td>
<td>0.98</td>
</tr>
<tr>
<td>6. Fit</td>
<td>2.94</td>
<td>0.55</td>
<td>3.06</td>
<td>0.53</td>
</tr>
<tr>
<td>7. Monitoring</td>
<td>1.01</td>
<td>0.99</td>
<td>1.09</td>
<td>1.07</td>
</tr>
<tr>
<td>8. Balance</td>
<td>2.38</td>
<td>0.73</td>
<td>2.77</td>
<td>0.61</td>
</tr>
<tr>
<td>9. Burden</td>
<td>0.58</td>
<td>0.59</td>
<td>0.68</td>
<td>0.71</td>
</tr>
<tr>
<td>10. Security</td>
<td>1.57</td>
<td>1.06</td>
<td>1.29</td>
<td>0.94</td>
</tr>
<tr>
<td>11. Support</td>
<td>2.46</td>
<td>0.97</td>
<td>2.45</td>
<td>0.91</td>
</tr>
<tr>
<td>12. Feedback</td>
<td>3.12</td>
<td>0.76</td>
<td>2.99</td>
<td>0.87</td>
</tr>
<tr>
<td>Total</td>
<td>2.75</td>
<td>0.36</td>
<td>2.61</td>
<td>0.38</td>
</tr>
</tbody>
</table>

Note: n = 152. ** p ≤ 0.01. * p < .05. EBPAS-50: Attitudes Towards Evidence-Based Practice Scale – 50 item.
CHAPTER V

Discussion

The purpose of this study was to explore potential relationships between Canadian therapists’ demographics, attitudes towards evidence based practice, and use of potentially harmful treatments. The following discussion includes commentary on the outcome of each hypothesis tested. Results will be discussed in relation to previous literature, current study limitations, and future research recommendations.

Hypotheses Discussion

Hypothesis One. The first hypothesis was that therapists with publicly funded practices or higher caseloads would perceive EBP as more burdensome than those with private practices or lower case loads (Aarons et al., 2012).

Our study found no significant EBPAS-50 differences based on having a private or public practice. Although previous research indicated higher EBPAS-50 Burden scores in public practices, there are a few possible reasons we did not replicate these findings. First, much of the previous research on EBP attitudes was conducted in the United States (US). Previous research suggests mental health needs may be better met in Canada than the US (Vasiliadis, Lesage, Adair, Wang, & Kessler, 2007; Volland, 2014). Despite some clear differences, further research is needed, especially given ever changing political and medical systems in both countries.

A second reason some findings were not replicated is that many previous studies assessed EBP attitudes in mental health workers or social workers. These professions may differ from Clinical and Counselling psychology in ways that impact EBP attitudes, such as having less choice over therapy hours per week, client clinical issues, client populations, and interventions. Additionally, a US study of graduate programs found that social work programs had less EBP
training requirements than psychiatry or psychology based therapy programs, with a majority (61.7%) of MSW programs not making EBP training a requirement (Weissman, Verdeli, Gameroff, Bledsoe, Betts, Mufson, et al., 2006). Future research could investigate further differences by comparing EBP attitudes across mental health professions.

The second part of hypothesis one asked about the relationship between EBP attitudes and caseload. Indeed, our study found that as caseloads got higher (more client hours per week) or more diverse (more specialization types), negative attitudes towards EBP increased in several domains. Specifically, client hours per week were positively associated with the EBPAS-50 subscales of Divergence (“I know better than researchers”) and Limitations (“EBP is too simplistic”). Specializing in more types of clients (i.e. specializing in adults, children, couples, and groups) also related to EBPAS-50 Divergence and Limitations, as well as Balance (“…therapy is more of an art than a science”).

Specializing in more clinical issues (i.e. anxiety, depression, anger, trauma) related to more negative views of EBP, as indicated on the Divergence, Limitations, Balance, and Burden (“I can’t meet my other obligations”) subscales. However, scores on the Fit subscale (would adopt an EBP if “your clients wanted it”) were significantly higher in those who specialize in a greater number of clinical issues, indicating a more positive attitude towards adopting an EBP if it was a good “fit” for them or their clients. While unexpected, reporting a greater number of issue specializations may relate to an adaptability that is also reflected in willingness to be flexible with treatment approach. Future research could explore mediators between attitudes and caseload.

*Hypothesis Two.* The second hypothesis was that CBT specialists would have a more favorable view of EBP than others (Pignotti & Thyer, 2012). This was confirmed in our sample, with CBT
specialists indicating significantly more positive attitudes towards EBP on the following EBPAS-50 subscales: Divergence, Limitations, Balance, Burden, and Requirements, as well as EBPAS-50 total score.

This hypothesis was expected for a number of reasons. CBT is considered an Empirically Supported Treatment (EST), which is an EBP by definition. Also, many of the questions on the EBPAS-50 ask about attitudes towards constructs inherent in CBT, such as willingness to use treatment manuals, or receive supervision or monitoring. However, non-CBT therapists being significantly more “Divergent”, was not necessarily expected. It is possible that therapists who do not align with structured therapies like CBT may feel defensive about their treatment choices, or disillusioned by the EBP movement. Future research could explore mediators between treatment choices and divergent EBP attitudes.

Hypothesis Three. The third hypothesis was that education and years of experience could be protective against the use of PHT, while higher caseloads, and more clinical specializations would be risk factors for PHT. This Hypothesis was confirmed with education, but not experience. MA level therapists used PHT at a rate of 33.68% compared PhD level therapists at a rate of 22.32%; rates of PHT use did not differ based on years practicing.

One possible explanation for the education based differences is that more PhD level therapists were from the Clinical Psychology branch of therapy, and more MA level therapists from the Counselling branch of therapy. Clinical psychology has historically followed a medical model approach to mental health, and is associated with diagnosing mental disorders in a standardized manner, which lends well to quantitative research and treatment standardization. Counselling psychology is more often associated with taking a systemic or holistic view of mental health, which can make client issues and treatment less straightforward to operationalize,
study, and standardize. While both systems have value, it is important for educators, clients, and therapists to be aware that PhD level education may be protective against use of PHT. Future research could specify if differences between Clinical and Counselling psychology relate to EBP or PHT use, and more importantly whether those differences relate to treatment outcomes.

The second part of hypothesis three considered whether higher caseloads or more specializations might translate to less professional competency. Indeed, therapists who reported seeing more clients per week, or specializing in higher numbers of client, orientation, or issue specializations were more likely to have used a PHT and indicate certain negative attitudes towards EBP. This finding lends support to recommendations for best practices made by ethics committees and psychology associations. Therapists are told to receive proper training and supervision before treating specialized issues or populations, and that we should keep up with best practice recommendations for our specialties. Claiming many different areas of competency may indicate lower standards of practice for each, being unable to keep up with new findings, and falling into the “science-practice gap”.

A counter argument could be raised, that those with many specialties may work from a perspective that focuses more on common factors, or relationship based psychology, which can effect change across issues, populations, and orientations. Perhaps focusing more on the therapeutic relationship, and less on categorizing ourselves and clients, is a good approach, and perhaps this perspective comes with less favorable attitudes towards EBP. However, it is important to recall Wampold’s common factors theory, and the debate against pitting common factors against EBP. Indeed, if having more specialties and less positive attitudes towards EBP was harmless, we would not also find a greater use of PHT. Follow up research could examine
this theory by testing if EBP attitudes mediate the association between number of specializations and use of PHT.

*Hypothesis Four.* The final hypothesis was that therapists who used PHT would have significantly worse attitudes towards EBP, compared to those who did not use PHT. Indeed, those who used PHT indicated more negative attitudes towards EBP on several EBPAS-50 subscales, and overall. This finding suggests that negative attitudes towards EBP can relate to using treatments that may be harmful to clients.

For educators, our research highlights the need for including formal training about EBP. One predictable criticism of this recommendation is that common factors in therapy have been found to be very important, and education around building therapist competence with common factors like relationship building is, of course, essential. However, the fact that common factors are important for treatment outcomes does not negate that supporting treatment intervention choices with research is absolutely necessary.

The current study confirms that therapists using PHT hold more negative attitudes towards EBP than those who do not, as evidenced by significantly higher scores on the EBPAS-50 Divergence subscale ($p < 0.01$). The Divergence subscale measures the most adversarial attitudes towards EBP: “I know better than academic researchers how to care for my clients,” “Research based treatments/ interventions are not clinically useful,” “Clinical experience is more important than using manualized therapy/ treatment”, and simply “I would not use manualized therapy/ interventions”. While these findings appear to provide a quick explanation for the use of PHT, that some therapists simply think they know better than researchers, we should be cautious about reaching this conclusion. Most problematically, it ignores other
significant relationships between PHT and EBPAS-50 subscales: Limitations ($p = 0.01$) and Balance ($p < 0.01$).

The EBPAS-50’s Limitations subscale includes statements like “Evidence-based practice is not useful for clients with multiple problems” and “Evidence-based practice is too narrowly focused.” Scoring higher on Limitations suggests that EBP is not meeting the diverse needs of some therapists. One possibility is that therapists who see many clients, or many types of clients may find EBP too overwhelming or limited. Accordingly, post hoc analyses of our data found that higher Limitations scores correlated with more client hours per week ($r = 0.16; p = 0.05$), more client population specialties ($r = 0.17; p = 0.03$), and more clinical issue specialties ($r = 0.21; p = 0.009$).

**Limitations**

An initial limitation of our study was how we recruited participants. By advertising through counselling and psychology associations, we reached an audience of therapists who may be more interested in current therapy standards than those who would not receive correspondence from therapy associations. Further, the type of therapist who volunteers their time to contribute to research likely has more positive attitudes towards EBP. Because our study had self-selecting participants, it may not be generalizable to all Canadian therapists.

Another limitation was a lack of participant diversity. Of the participants included in the analysis, the majority identified as women ($n = 116, 76.82\%$). However, our distribution of gender may be representative of therapists in Canada. For example, a 2013 study of 538 Canadian practitioners had 74% women, and a 2014 study of 1,668 Canadian psychologists had 70% women. Not producing a French version of our survey also limited the generalizability by
excluding French-speaking therapists. Follow up research could include both French and English surveys.

Our study also suffered from the limitations generally associated with self-report measures, such as over reporting of positively perceived variables (like use of EBP), and difficulty accurately recalling details (like how many clients one sees per week). Follow up research on EBP and PHT in Canadian therapists could address these limitations by varying participant recruitment, reaching a more geographically diverse sample of therapists, and varying data collection methods.

Finally, needing to construct our own measure of PHT use resulted in many limitations. Only including a list of treatment names, without further context or definition, means that level of harm we really assessed is debatable. For example, participants were asked to simply select if they had used Critical Incident Stress Debriefing in the past 2 years, but the literature specifies that CISD is specifically harmful when used incorrectly (for example, with individuals instead of groups). Similarly, “grief counselling for normal bereavement reactions” may have been a confusing item. By leaving such an item without context, it is assumed that participants recognize specific differences between “grief counselling” and other types of counselling, as well as what constitutes a “normal” bereavement reaction. Further defining treatment context, and inquiring about knowledge of appropriate use, could clarify our findings.

PHTs like Sexual Reorientation Therapy, or Rebirthing are easier to accept as harmful, due to infamous cases of harm, and research presented by Bradshaw and colleagues (2015), and by Mercer (2002). However, for treatments such as grief counselling for normal bereavement reactions, or CISD, context and knowledge matters. Perhaps therapists who are using these treatments are considering the cultural context and personal preferences of the client, an
important component of CPA’s definition of EBP. Conversely, other therapists could be using a
gold standard empirically supported treatment, without taking into consideration the client’s
culture or preferences, making that established treatment, potentially harmful.

**Implications**

**Research Implications.** The present study was, to the author’s knowledge, the first to examine
attitudes towards EBP and use of PHT amongst Canadian therapists. We demonstrated an
association between negative attitudes towards EBP, and use of PHT in Canada. We confirmed
that certain therapist traits (like seeing more clients and reporting more specializations) relate to
both negative EBP attitudes and using PHT. We were also surprised to find that years of
experience were not protective against PHT use.

Throughout the discussion section, we proposed explanations for why specific domains
of EBP attitudes relate to certain therapist factors, and why particular therapist factors relate to
PHT use. An important next step may be to examine whether EBP attitudes generally mediate
the relationship between therapist variables and use of PHT. If so, it would lend further support
to clarifying and strengthening EBP requirements and education. More broadly, coming up with
a theoretical model to explain directionality between therapist traits, EBP, PHT, could be helpful
for making targeted practical recommendations.

A number of participants in our study indicated using PHTs, which warrants further
investigation about PHT use in Canada. As mentioned, our assessment of PHT use had
limitations. Re-assessing the prevalence of PHT using diverse and improved methods is an
important next step. Future studies could aim to gather more detailed information about the
specific context and applications of PHTs. For example, a qualitative study could investigate
treatment decision making, in the context of anticipating or avoiding harm. It is possible that
many participants who indicated using a PHT either misunderstood the item, or has enough knowledge and expertise to be practicing in an appropriate way, for example, considering treatment preferences and including progress monitoring.

Expanding on therapists’ use and understanding of EBP is also important. Specifically, assessing the component of EBP that includes considering “the context of specific client characteristics, cultural backgrounds, and treatment preferences” (Dozois, 2013). It may be that common factors such as being mindful of client preferences could be more protective against harmful outcomes than treatment choice, specifically for treatments that have only been proven harmful in specific contexts. A number of other future research recommendations are made throughout the discussion section.

**Practical Implications.**

In addition to future research recommendations, our findings have a number of implications for educators, policy makers, therapists and clients. For educators and policy makers, it is important to note differences we found between MA and PhD level therapists: Masters level therapists had more negative attitudes towards EBP, and were more likely to use PHT. It is important to consider how philosophies and clients may differ between MA and PhD level therapists, leading to valid reasons for differences in treatment approach. However, it remains an ethical obligation for therapists to implement EBP as much as possible.

To address education-based discrepancies in EBP attitudes and PHT, universities, licensing associations, and insurance companies could formally require training in EBP at the MA level. The ability for attitudes towards EBP to change through education was demonstrated in a 2014 study on PsyD students (Bearman, Wadkins, Bailin, & Doctoroff, 2014). Attitudes improved in two separate cohorts, one that took the course as a requirement, and one that took it as an elective. Students with a BA as their highest degree had larger gains than students with an
MA as their highest prior degree. These findings highlight the association between lower education level and poorer EBP attitudes, but also provide evidence that improvement can be seen across education levels.

For therapists, we want to highlight that having a higher number of specializations was associated with both PHT and negative attitudes towards EBP, respectively. CPA and CCPA have existing recommendations that include proper training and supervision as key components of being competent to practice. If we decide to treat more populations and issues, it gets harder to maintain these training and supervision standards, and harder to maintain higher standards of practice. Our study provides evidence that supports a common concern: treating everything and anything may provide a warning against a therapist’s ability to practice competently.

A few of our findings have implications for clients and agencies looking to hire EBP friendly therapists. First, according to our findings, it may be important to consider education level more than years of experience, as degree type related to EBP attitudes and PHT use, but years of practicing did not. Second, therapists who included CBT amongst their theoretical orientations had generally more positive attitudes towards EBP.

Specialties and other differences aside, all therapists should be mindful of the scope of research supporting their own practice. As a field, we should aim to be cautious of the manufactured debate between either being competent with common factors in therapy, or rigidly adhering to empirically supported treatments. Basing one’s practice on evidence can and should include a strong therapeutic relationship, where individual client needs are considered. Whether that means following current research, continuing education, or including progress-monitoring measures in a novel treatment, evidence-based practice is an important tool that can help us as therapists, as we fulfill our calling to help others.
References


Hoyt, W. T., & Larson, D. G. (2008). A realistic approach to drawing conclusions from the


Appendices

APPENDIX A: Recruitment Contact Letter

UBC
THE UNIVERSITY OF BRITISH COLUMBIA

___, 2015

Name
Title
Organization

Dear _____,

My name is Nicole Thomson. I am a graduate student at the University of British Columbia, working towards my Master of Arts Degree under the supervision of Dr. Colleen Haney, in the Department of Educational and Counselling Psychology, and Special Education. The purpose of this letter is to briefly explain my thesis project, and ask for your permission and assistance distributing an invitation for your members or email list subscribers to participate in our study.

The aim of my thesis is to investigate Canadian therapists’ (masters or doctorate level counsellors and psychologists) opinions and experience around incorporating evidence into practice. As this is an under researched area in Canada, the study will produce important information about possible practice differences amongst therapists. The information collected from this study has implications for understanding possible supports or barriers to using evidence in practice, and informing future research on under supported treatments.

The survey consists of an ~15 minute online questionnaire, is completely anonymous and confidential. Participants will be offered entry into a draw for one of three $50 Amazon.ca gift cards, via a separate webpage.

Information will be collected securely via Qualtrics (http://www.qualtrics.com/security-statement/), and stored on secure servers only accessible by the named researchers (Dr. Haney and N. Thomson).

If you agree to distribute our study to your members, please reply to this email indicating your agreement. You will then be sent a description and link to the study to share with members.

Should you have any questions or concerns, you may contact Nicole Thomson at n.thomson@alumni.ubc.ca.

If you have any concerns about the treatment or rights of study participants, you may contact the UBC Behavioural Research Ethics’ Research Subject Information Line at 604-822-8598.

Your organization’s participation in this study is highly valued and appreciated, as hearing the opinions of your members is extremely important to us. Thank you for considering our request.

Sincerely,

Dr. Colleen Haney
Nicole Thomson

Faculty of Education
Department of Educational and Counselling Psychology, and Special Education
2125 Main Mall
Vancouver, BC, Canada, V6T1Z4
Phone 604 822 0242
Fax 604 822 3302
www.ecps.educ.ubc.ca

Counselling Psychology • Human Development • Learning and Culture
Measurement, Evaluation and Research Methodology • School Psychology • Special Education
APPENDIX B: Recruitment Poster

You are invited to take part in a study exploring Canadian therapists’ experiences & opinions about the strengths or limitations of applying research to practice.

What Is Involved?
You will be asked to complete an anonymous online survey that takes ~ 15 minutes. The survey asks about you and your opinions as a therapist, no risks are expected.

Why participate?
This is one of very few studies examining Canadian Therapists’ opinions and experience around incorporating evidence into practice.

We hope to produce important information that contributes to improving the field of therapy in Canada, so the contribution of therapists like you is essential and greatly appreciated.

Participants will also be offered entry into a draw for one of 3 $50 Amazon.ca gift cards.

Who is eligible to participate?
Therapists (with an MA, MEd, PhD, or PsyD in Counselling or Clinical Psychology), currently seeing clients in Canada.

The study is located at:
https://ubcarts.eoi.qualtrics.com/SE/?SID=SV_eX0VscNSjBvARv5
If you wish to participate, click or copy and paste the link into your browser, and follow instructions.

Clicking on the study link or contacting us in no way commits you to participate.
If you do decide to participate you can quit at any time.

If you would like more information, please contact graduate student researcher, Nicole Thomson at:

The Title of this project is “Practice Characteristics of Canadian Therapists” | The principle investigator is Dr. Haney in the Department of Educational and Counselling Psychology, and Special Education at the University of British Columbia | Ethical concerns about the study may be directed to UBC’s Behavioural Research Ethics Board at 604-822-8590.
APPENDIX C: Informed Consent and Practice Demographics

Introduction

*Practice Characteristics in Canadian Therapists*

**Study Information:**

The following study is being conducted as part of Nicole Thomson's M.A. thesis, under the supervision of Dr. Colleen Haney, at the University of British Columbia's Department of Educational and Counselling Psychology, and Special Education.

**Study Purpose:**

The aim of our study is to explore Canadian therapists' practice characteristics and experiences incorporating research into practice.

We are interested in your thoughts and opinions as a practicing therapist in Canada. Learning about your experience is very important to us, and your openness is greatly appreciated.

**Study Requirements:**

- Completing an ~15 minute survey
- Being trained as a masters or doctorate level counsellor or psychologist

**Confidentiality:**

The survey is completely confidential, there will be no records identifying participants, and you will remain anonymous.
If you choose to enter the prize draw (for 1 of 3 $50 Amazon.ca gift cards), you will be redirected to a new page, and your email address will not be connected to your survey responses.

Information will be collected securely via Qualtrics (http://www.qualtrics.com/security-statement/), and stored on secure servers only accessible by researchers Dr. Haney and N. Thomson.

The findings from this study may be used in future research presentations and publications, though no identifying information will be shared.

**Potential Risk:**

There is no expected risk to participating in this study. You may quit at any time. If you do not feel comfortable answering a question, you may skip it. However, after you submit the completed survey, it will not be possible to withdraw your contribution.

**Questions or Concerns:**

If you have any questions or concerns about the study, please contact graduate student researcher Nicole Thomson at [email protected] or Dr. Haney at [email protected]

If you have any concerns about your treatment or rights as a research participant, you may contact the Research Subject Information Line at the UBC Office of Research Services at 604-822-8598.

**Please indicate if you agree to participate:**

Agree
Disagree

If you meant to hit "disagree" please close the study at this time.
If you meant to hit "agree" please change your response and continue
At times, this survey asks about Evidence-Based Practice, defined as "...involv(ing) the conscientious, explicit, and judicious use of the best available research evidence to inform each stage of clinical decision-making and service delivery." (CPA Task Force for EBP, 2014).

This definition is not limited to the "Empirically Supported Treatments" that have met specific APA research standards.

**Practice**

Years of practicing therapy

5 and under
6 - 10
11 - 20
21 and above

I am currently registered as a(n) (select all that apply)

RCC
CCC

R. Psyc
Other (i.e. other registration, or student. Please specify)

Workplace setting(s) (select all that apply)

Public practice
Private practice

Private school (K-12)
College or University
Hospital                  Residential care / halfway house
Nonprofit or social service agency  Outpatient clinic
Rehabilitation center or agency  Correctional facility or prison
Public school (K-12)  Other(s) (please specify)

**Clientele**
(Please drag applicable choice(s) into the box, and rank)

<table>
<thead>
<tr>
<th>Items</th>
<th>Clientele</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td></td>
</tr>
<tr>
<td>Adolescents</td>
<td></td>
</tr>
<tr>
<td>Adults</td>
<td></td>
</tr>
<tr>
<td>Older adults</td>
<td></td>
</tr>
<tr>
<td>Couples</td>
<td></td>
</tr>
<tr>
<td>Families</td>
<td></td>
</tr>
<tr>
<td>Groups</td>
<td></td>
</tr>
<tr>
<td>Other(s) (please specify)</td>
<td></td>
</tr>
</tbody>
</table>

**Specialization(s)**
(Please drag applicable choice(s) into the box, and rank)

<table>
<thead>
<tr>
<th>Items</th>
<th>Specialization(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions</td>
<td></td>
</tr>
<tr>
<td>Anger</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
</tr>
<tr>
<td>Career concerns</td>
<td></td>
</tr>
<tr>
<td>Culturally diverse clients</td>
<td></td>
</tr>
</tbody>
</table>
Depression
Grief
Eating Disorders
LGBTQ clients
OCD
Personality Disorders
Psychotic Disorders
PTSD
Sleep issues
Spirituality
Trauma
Other(s) (please specify)

Regarding your top ranked specialization: please briefly explain the intervention or treatment(s) that you most often use.

For example "CBT - Exposure therapy (for anxiety)" or "career / values exploration exercises taken from ______ (for career concerns)"

Theoretical Orientation(s)
(Please drag applicable choice(s) into the box, and rank)

<table>
<thead>
<tr>
<th>Items</th>
<th>Orientation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural</td>
<td></td>
</tr>
<tr>
<td>Cognitive Behavioural</td>
<td></td>
</tr>
<tr>
<td>Existential</td>
<td></td>
</tr>
</tbody>
</table>
Experiential (i.e. Emotion Focused)
Feminist
Humanistic
Interpersonal
Narrative
Psycho-dynamic or Analytical
Systemic
Integrative
Other(s) (please specify)

Do you have a specific approach or any special considerations when working with culturally diverse clients?

When working with clients of specific or minority cultures, how helpful do you think it is to (please slide to rate)

<table>
<thead>
<tr>
<th>Not helpful</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be from the same culture as client</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have education in cross cultural counselling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gain or have knowledge about the client's culture (outside of sessions)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have a specific approach or any special considerations when working with clients from the LGBTQ community?
When working with clients from the LGBTQ community, how helpful do you think it is to (please slide to rate)

Not helpful     0     1     2     3     4  Very helpful

Also be a member of the LGBTQ community

Have education specific to gender and sexuality

Gain or have knowledge about the client’s specific identity (outside of sessions)

You typically learn interventions from:
(Drag and rank all that apply)

<table>
<thead>
<tr>
<th>Items</th>
<th>Learning from</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical experience</td>
<td></td>
</tr>
<tr>
<td>Colleagues</td>
<td></td>
</tr>
<tr>
<td>Treatment manuals</td>
<td></td>
</tr>
<tr>
<td>Workshops</td>
<td></td>
</tr>
<tr>
<td>Supervised training</td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
</tr>
</tbody>
</table>

Do you conduct a unique form of therapy, that you or your colleagues developed?

Yes
No

Please share a bit about your unique treatment

Please share any specific credentials or qualifications you have received (i.e. "Certified _______ Therapist")

Click to write

N/A

Roughly, how do you spend your time on an average work week?
(Please slide each choice to represent the ~ # of hours per week)

<table>
<thead>
<tr>
<th>Hours / Average Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

Seeing clients in therapy

Administration

Conducting research

Teaching

Supervising other therapists

Other (please specify)

In the past 2 years, approximately how many
(Slide to respond)
Professional conferences attended?

Therapy workshops attended?

Academic articles read in an average month?

Professional associations belonged to?

Other professional development?

Please share name(s) of conference(s) attended

Please share name(s) of workshop(s) attended

Please drag and rank any reason(s) you typically try to keep up with research

<table>
<thead>
<tr>
<th>Items</th>
<th>Your reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical interest (i.e. learning about specific clients or clinical issues)</td>
<td></td>
</tr>
<tr>
<td>Academic interest (i.e. keeping up with my field)</td>
<td></td>
</tr>
<tr>
<td>Research interest (i.e. keeping up with my research area)</td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX D: Attitudes Towards Evidence-Based Practice Scale - 50 Item

Please share name(s) of the professional association(s) you belong to (i.e. "CPA / Canadian Psychological Association")

EBPAS-50

The following questions ask about your feelings about using new types of therapy, interventions, or treatments.

Manualized therapy refers to any intervention that has specific guidelines and/or components that are outlined in a manual and/or that are to be followed in a structured/predetermined way.

Evidence-based practice refers to any intervention that is supported by empirical research.

Choose the number indicating the extent to which you agree with each item:

<table>
<thead>
<tr>
<th></th>
<th>0 Not at all</th>
<th>1 Slight extent</th>
<th>2 Moderate extent</th>
<th>3 Great extent</th>
<th>4 Very great extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>I like to use new types of therapy/interventions to help my clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am willing to try new types of therapy/interventions even if I have to follow a treatment manual</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>I know better than academic researchers how to care for my clients</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
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<td>4</td>
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<td>------------------------------------------</td>
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</tr>
<tr>
<td>I am willing to use new and different</td>
<td></td>
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<tr>
<td>types of therapy/ interventions developed</td>
<td></td>
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<td></td>
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<tr>
<td>by researchers</td>
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<tr>
<td>Research based treatments/</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>interventions are not clinically useful</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Clinical experience is more important</td>
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<tr>
<td>than using manualized therapy/treatment</td>
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<tr>
<td>I would not use manualized therapy/</td>
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<tr>
<td>interventions</td>
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<tr>
<td>I would try a new therapy/ intervention</td>
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<tr>
<td>even if it were very different from what</td>
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<tr>
<td>I am used to doing</td>
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</tbody>
</table>

**If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if:**

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>It was intuitively appealing?</td>
<td></td>
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<tr>
<td>It “made sense” to you?</td>
<td></td>
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<tr>
<td>It was required by your supervisor?</td>
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<tr>
<td>It was required by your agency?</td>
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<tr>
<td>It was required by your province?</td>
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<tr>
<td>It was being used by colleagues who</td>
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</tr>
<tr>
<td>were happy with it?</td>
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<tr>
<td>You felt you had enough training to use</td>
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<tr>
<td>it correctly?</td>
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<td></td>
</tr>
</tbody>
</table>

**If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if:**
<table>
<thead>
<tr>
<th></th>
<th>0 Not at all</th>
<th>1 Slight extent</th>
<th>2 Moderate extent</th>
<th>3 Great extent</th>
<th>4 Very great extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your clients wanted it</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You knew more about how your clients</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>liked it</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>You knew it was right for your clients</td>
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<tr>
<td>You had a say in which evidence-based</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>practice was used</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You had a say in how you would use the</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>evidence-based practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It fit with your clinical approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It fit with your treatment philosophy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Choose the number indicating the extent to which you agree with each item:**

<table>
<thead>
<tr>
<th></th>
<th>0 Not at all</th>
<th>1 Slight extent</th>
<th>2 Moderate extent</th>
<th>3 Great extent</th>
<th>4 Very great extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence-based practice detracts from</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>truly connecting with your clients</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Evidence-based practice makes it harder</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>to develop a strong working alliance</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Evidence-based practice is too simplistic</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence-based practice is not useful for</td>
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</tr>
<tr>
<td>clients with multiple problems</td>
<td></td>
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<td></td>
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<tr>
<td>Evidence-based practice is not useful for</td>
<td></td>
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<td></td>
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<tr>
<td>families with multiple problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence-based practice is not</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>individualized treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence-based practice is too narrowly</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>focused</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>0 Not at all</td>
<td>1 Slight extent</td>
<td>2 Moderate extent</td>
<td>3 Great extent</td>
<td>4 Very great extent</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
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<td>-----------------</td>
<td>-------------------</td>
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</tr>
<tr>
<td>I prefer to work on my own without oversight</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I do not want anyone looking over my shoulder while I provide services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My work does not need to be monitored</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I do not need to be monitored</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am satisfied with my skills as a therapist/case manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A positive outcome in therapy is an art more than a science</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Choose the number indicating the extent to which you agree with each item:**

<table>
<thead>
<tr>
<th>Item</th>
<th>0 Not at all</th>
<th>1 Slight extent</th>
<th>2 Moderate extent</th>
<th>3 Great extent</th>
<th>4 Very great extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy is both an art and a science</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My overall competence as a therapist is more important than a particular approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t have time to learn anything new</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can’t meet my other obligations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t know how to fit evidence-based practice into my administrative work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence-based practice will cause too much paperwork</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning an evidence-based practice will help me keep my job</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Learning an evidence-based practice will help me get a new job</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Learning an evidence-based practice will make it easier to find work</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I would learn an evidence-based practice if continuing education credits were provided</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I would learn an evidence-based practice if training were provided</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I would learn an evidence-based practice if ongoing support was provided</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I enjoy getting feedback on my job performance</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Getting feedback helps me to be a better therapist/case manager</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Getting supervision helps me to be a better therapist/case manager</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**EBP - extra questions**

Choose the number indicating the extent to which you agree with each item:

| I consider my practice to be "evidence-based" | 0 | 1 | 2 | 3 | 4 |
| Research from outside of Canada is relevant for my clients | 0 | 1 | 2 | 3 | 4 |
### APPENDIX E: Interventions Checklist

<table>
<thead>
<tr>
<th></th>
<th>0 Not at all</th>
<th>1 Slight extent</th>
<th>2 Moderate extent</th>
<th>3 Great extent</th>
<th>4 Very great extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using evidence in practice is an ethical responsibility</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>I routinely use established measures to monitor client progress</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Training in evidence-based practice should be mandatory for therapists</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
</tbody>
</table>

### List of Interventions

The following section asks you to categorize a number of therapeutic interventions.

### Category Definitions:

- **Potentially Harmful:** "Demonstrate(ing) harmful psychological or physical effects in clients or others (e.g., relatives)" and "...not merely reflect(ing) a short-term exacerbation of symptoms during treatment" (Lilienfeld 2007)

- **Unsupported:** Benefit claims are currently unsupported by research

- **Supported:** Benefit claims are supported by research

- **Unfamiliar:** You have not heard of this treatment

Briefly consider each intervention and select the category you think is most fitting.

Also indicate if you have used the treatment in the past 2 years.
<table>
<thead>
<tr>
<th>Treatment</th>
<th>Potentially Harmful</th>
<th>Unsupported</th>
<th>Supported</th>
<th>Unfamiliar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body Centered Psychotherapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Motivational Interviewing for Substance Dependence</td>
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<tr>
<td>Emotional Freedom Technique</td>
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<tr>
<td>Critical Incident Stress Debriefing</td>
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<tr>
<td>Rebirthing- Attachment Therapy</td>
<td></td>
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<tr>
<td>DARE (Drug Abuse Resistance Education) Programs</td>
<td></td>
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<tr>
<td>Family-Based Treatment for Anorexia Nervosa</td>
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<tr>
<td>Healing Touch or Therapeutic Touch</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Reiki</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Prolonged Exposure Therapy for PTSD</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Dream Interpretation or Analysis</td>
<td></td>
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<tr>
<td>Grief counseling for normal bereavement reactions</td>
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<tr>
<td>Psychodrama</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Reorientation / Reparative therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal Therapy for Depression</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

All Demographics
APPENDIX F: Education and Personal Demographics

Education

Latest Degree:

- MEd - Counselling Psychology
- MA - Counselling Psychology
- MA - Clinical Psychology
- PhD - Clinical Psychology
- PsyD
- Other (please specify)
- PhD - Counselling Psychology

How many hours of supervised therapy were required in your program?

Institution you received your degree from (optional)

Please select all that apply

- My program self described as ascribing to a "scientist-practitioner" model
- I was taught about evidence-based practice in my program
- None of the above

My program was described as a

- 2 year Masters
- 3 years Masters
- Other
Demographics

Age:
- 20 - 30
- 31 - 40
- 41 - 50
- 51 - 60
- 61 - 70
- 71 and above
- Prefer not to say

Gender:
- Female
- Male
- Preferred label (please specify)

Cultural identity (please select all that apply):
- Canadian
- First Nations
- White / European
- Black / African
- Chinese
- Japanese
- Korean
- East Indian
- Middle Eastern/Arab
- Other(s) (please specify)
Province:

Location of therapy practice:
Urban
Rural
Other

Closing page

The following Survey was about Evidence Based Practice & Practice Characteristics of Canadian therapists

Do you have any additional comments about evidence-based practice, being a therapist in Canada, or the survey in general?

Submitting your responses now indicates that you AGREE to participate in this survey.

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