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Use of Evidence-Based Assessment for Childhood Anxiety Disorders in Community Practice

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Abstract

High quality assessment is essential to the delivery of effective treatment for childhood anxiety disorders. However, relatively little is known about how frequently child clinicians utilize evidence-based assessment (EBA) techniques in practice, and even less is known about the factors that influence EBA use in such settings. Thus, the current study presents data from a survey of 339 clinicians from a variety of professional backgrounds concerning their use of EBA for childhood anxiety disorders and explores issues preventing EBA implementation. Results indicated infrequent EBA use with clinicians citing practical barriers (i.e., time, access, knowledge, cost) and negative beliefs about EBA techniques (i.e., unhelpful) as issues preventing implementation. Implications for future EBA dissemination and implementation efforts are discussed.

Keywords

child; anxiety disorders; evidenced-based assessment; clinical practice

Anxiety disorders are among the most prevalent psychiatric diagnoses in youth (Demertzis & Craske, 2006), and if left untreated often lead to significant impairment (Beidel, Turner, Young, et al., 2007; Biggs, Sampilo, & McFadden, 2011; Mychailyszyn, Mendez, & Kendall, 2010) and additional psychopathology (Kendall, Settiani & Cummings, 2012; Woodward & Fergusson, 2001). Fortunately, our understanding of anxiety has improved dramatically over the past 25 years and evidence based treatments (EBTs) have demonstrated efficacy in treating this disorder (Kendall et. al., 2012). In general, EBT protocols are applied to specific diagnostic categories; meaning effective treatment is predicated on an accurate diagnosis (Jensen-Doss & Weisz, 2008; Pogge et. al., 2001). Thus,

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psychometrically sound, evidence-based assessment (EBA) is essential to the delivery of effective treatment (Mash & Hunsley, 2005).

Experts agree that structured diagnostic interviews represent the gold standard in EBA (Ehlert, 2007; Joiner et al., 2005; Schneider & Dopfner, 2004; Silverman & Ollendick, 2005). Compared to unstructured interviewing methods, structured interviews yield more objective data, increase the specificity of gathered information, and enable comprehensive evaluation of a range of diagnoses (Di Nardo, 1983; Edelbrock & Costello, 1990; Endicott, 1978). Moreover, patients have a positive attitude toward structured interviewing (Jonasson, Jonasson, Ekselius, & von Knorring, 1997; Newman, Walker, & Gettland, 1999; Marshall et al., 2001; Pinninti et al., 2003; Suppiger et al., 2009) and believe that this approach promotes the therapeutic relationship and enables therapists to better understand their patients' problems (Bruchmuller, Margraf, Suppiger & Schneider, 2011). Numerous interviews have been developed for reliable and valid diagnosis of anxiety disorders in youth, e.g., Anxiety Disorders Interview Schedule for Parents and Children (Silverman & Albano, 1996).

In addition to structured interviews, rating scales are an important component in EBA as they provide a cost-effective and efficient solution for identifying symptoms and tracking clinical change (Whiteside, Gryczkowski, Biggs, Fagen, & Owusu, 2012; Silverman & Ollendick, 2005). A number of valid and reliable rating scales have been developed for assessing childhood anxiety disorders (Silverman & Ollendick, 2005). Such scales demonstrate utility for child clinicians as they can be used to obtain data from multiple informants (e.g., children, parents, teachers) and capture information that might not have been reported by the child during clinical interview due to social desirability, embarrassment, or unwillingness to cooperate (Chorpita, Albano, & Barlow, 1996; Velting, Setzer, & Albano, 2004). Thus, rating scales can serve as an important supplement to structured interviews when providing an evidence-based approach to assessment.

Due to the importance of EBA in the delivery of effective psychotherapy, the degree to which structured interviews and rating scales are implemented in clinical practice is an important indication of the overall quality of services being offered (Hunsley & Mash, 2007). As such, studies exploring test usage among practicing clinicians have a long history within our field (e.g., Louttit & Brown, 1947) and have, unfortunately, provided considerable evidence that EBA is generally not implemented in clinical practice (e.g., Bruchmuller et al., 2011). However, relatively little research has explored child clinicians' use of EBA (Cashel, 2002; Kamphaus, Petoskey, & Rowe, 2000; Archer et al., 1991; Tuma & Pratt, 1982), and even less is known about how clinicians assess childhood *anxiety* (Jensen-Doss & Hawley, 2010).

Lack of knowledge about EBA use among child anxiety clinicians may be an example of the limitations of the traditional approach to dissemination and implementation (DI). Historically, DI efforts have involved unidirectional transmission of information about evidence-based practice (EBP; including assessment and treatment practices) from advocates (e.g., researchers, EBP developers) to behavioral health stakeholders (e.g., clinicians, policy makers; Beutler, Williams, Wakefield, & Entwistle, 1995). However, this approach does not yield information about the important contextual factors that influence

EBP use in clinical settings (Becker, Nakamura, Young & Chorpita, 2009). As such, early decisions regarding EBP DI were based on an incomplete understanding of clinical environments and generally failed to achieve widespread and sustainable adoption in such settings.

In response, collaborative approaches emphasizing a reciprocal exchange of information between EBP stakeholders and advocates about behavioral health innovations and clinical practice have become more common (Nadeem, Olin, Hill, Hoagwood & Horwitz, 2014). Such efforts have identified a number of practical and philosophical barriers to EBP implementation, and research suggests that attending to these issues improves the effectiveness of implementation efforts (Chorpita & Regan, 2009; Rogers, 2003; Stirman, Crits-Christoph, & DeRubeis, 2004). However, relatively little research has investigated barriers to implementation within the context of EBA (Bickman et al., 2000; Epstein, Langberg, Lichtenstein, et al., 2013; Garland, Kruse & Aarons, 2003; Bruchmuller et al., 2011; Jensen-Doss & Hawley, 2010).

To expand the understanding of EBA use in community settings, the current study surveys child therapists from a variety of disciplines about their use of EBA for anxiety, as well as their reasons for not implementing such practices. Given the findings of previous research in the adult literature and to a lesser extent, the child literature, we predicted that EBA use would be low overall. Considering prior research examining clinician characteristics and trends of general EBP use (Aarons, Hurlburt, & Horwitz, 2011; Beidas & Kendall, 2010; Jensen-Doss & Hawley, 2010; Rogers, 2003), we also hypothesized that PhD-level psychologists, recently graduated clinicians, and anxiety specialists would be more likely to use EBA. Finally, we collected brief qualitative data concerning clinicians' reasons for not implementing EBA.

Method

Participants

The sample consisted of 339 clinicians that reported providing outpatient treatment for childhood anxiety disorders. This same sample was also used to examine treatment practices in a study reported elsewhere (Whiteside, Deacon, Benito, & Stewart, 2016). Two hundred and sixty-five of the respondents provided their profession, which included social workers (SW; $n = 113$, 42.6%), doctoral level psychologists (PhD; $n = 49$, 18.5%; and PsyD; $n = 31$, 11.7%), masters degree licensed counselors ($n = 44$, 16.6%), and marriage and family therapists (MFT; $n = 28$, 10.6%). Just under half of the sample (44.6%) endorsed specializing in childhood anxiety disorders, which did not differ between professions. The respondents reported practicing for an average for 15.42 years ($n = 264$, $sd = 10.2$, range 1 to 43 years), with approximately 95% practicing for at least three years. Years of experience differed by profession with respondents holding a PsyD ($m = 10.81$) or degree in MFT ($m = 12.11$), being newer to the field than social workers ($m = 15.04$), PhD psychologists ($m = 17.80$), and masters level therapists ($m = 19.09$), $F(4, 259) = 4.69$, $p < .01$. The majority of the respondents endorsed multiple orientations ($m = 2.02$, $s.d. = 1.1$) with cognitive behavioral endorsed most frequently (81.4%), followed by family systems (54.8%), patient-centered (38.8%), eclectic (36.9%), and psychodynamic (27.0%).

Procedures

Clinicians were identified and recruited through a series of two electronic surveys. The first survey was used to identify therapists who work with anxious children. The survey was emailed directly to all psychologists and social workers that had supplied an email address to the state of Minnesota licensing boards and to all mental health professionals practicing within a regional health system ($n = 7,273$). A link to the survey was also included in email newsletters sent to the members of the statewide professional organizations for psychologists, social workers, and marriage and family therapists (e.g., Minnesota Psychological Association). An initial invitation and two reminders were sent through each channel. The survey inquired about the populations of patients to which the clinician provided treatment. Because the link was included in newsletters it is not known how many clinicians viewed the invitation. A total of 2,869 clinicians responded to the survey.

Among the respondents to the initial survey, 1,002 clinicians reported treating youth with anxiety disorders. Anxiety disorders were defined based upon the categorization of DSM-IV (the classification system in place during the study): generalized anxiety disorder (GAD), social phobia, specific phobia, panic disorder with or without agoraphobia, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD); and two anxiety disorders diagnosed in childhood (separation anxiety disorder and selective mutism). These are also the disorders covered by commonly used structured diagnostic interviews and rating scales (i.e., Silverman & Albano, 1996 and Birmaher et al., 1997 respectively). These clinicians were emailed a follow-up survey about their assessment (current study) and treatment practices (Whiteside, Deacon, Benito, & Stewart, 2016). A total of 339 respondents completed the questions regarding EBA and were included in the current study. An additional 66 began the survey, but did not complete enough items to be included in the current study. A response rate of 34% (339 of 1,002) is comparable to previous surveys (i.e., 27 to 30%; Addis & Krasnow, 2000; Becker, et al., 2004).

Measures

Demographic information—Respondents were asked to indicate their profession, theoretical orientation, number of years in practice, and the frequency with which they treated patients with each of the anxiety disorders. Respondents could endorse the following theoretical orientations: 1) CBT, including solely cognitive or behavioral approaches; 2) Psychodynamic, encompassing psychoanalytical, 3) Family systems, 4) Patient centered, including humanistic, supportive, Rogerian, and experiential approaches, and 5) Eclectic. Frequency treating children with each anxiety disorder was rated on a scale ranging from almost never (1) to very often (5). These ratings were averaged to form a single measure of the frequency treating any childhood anxiety disorder.

EBA usage—Respondents were asked four questions related to their use of EBA in their practice (Appendix A). To begin with participants were asked to indicate how often they used parent-report questionnaires, child-report questionnaires, and structured diagnostic interviews when assessing childhood anxiety disorders. Frequency of use was rated as Almost never (1), Rarely (2), Sometimes (3), Often (4), or Almost always (5). To aid descriptive analyses, the responses were dichotomized into frequent use (Often or Almost

always) and infrequent use (Almost never, Rarely, Sometimes) and combined into a single classification: a) Complete EBA Users - defined as frequent use of parent-report questionnaires, child-report questionnaires, and structured interviews; Partial EBA Users - defined as frequent use of only one or two of the tools; and c) Infrequent EBA Users - defined as infrequent use of all three techniques. Respondents that did not endorse using EBA were asked to enter reasons for not using EBA (free response).

Analytic Plan

Community use of EBA was initially examined through the frequency with which each technique was endorsed and the percentage of clinicians that fell into each category of EBA use. A series of analyses of variance with least significant difference post-hoc comparisons and a Chi-square analysis were used to examine the differences in EBA use by therapist profession. Differences in EBA use by therapist theoretical orientation was examined through a series of independent samples t-tests. Association of EBA use with years of experience and frequency of treating anxiety patients were examined through correlational and regression analyses. Reasons for not using EBA (i.e. qualitative data) were examined through methods of content analysis (i.e., systematic process of sorting and coding information based on themes; Neuendorf, 2001; Patton 1990). Thematic and content analysis strategies were used by three of the investigators (JCH, KVD, SPW) to identify predominant themes and to develop categories for coding qualitative data. A coding strategy was developed and two investigators (JCH, KVD) with experience in qualitative data analysis then coded all qualitative data. Consensus on key findings was achieved by the investigators.

Results

Community Use of EBA

Table 1 presents the frequency with which therapists endorsed using each EBA technique. For both of the rating scales, a similar percentage (approximately 40%) of therapists endorsed using them “rarely” to “almost never” as endorsed using them “often” to “very often.” In contrast, the majority of the sample (74%) endorsed using structured diagnostic interviews “rarely” or “almost never.” Approximately half of the sample was categorized as Infrequent EBA users, 10% as Complete EBA users, and the remainder as Partial users (Table 2).

Therapist Characteristics

Table 2 presents EBA use by profession. The use of EBA differed by profession for parent-report questionnaires, $F(4, 260) = 3.70, p < .01$; and child-report questionnaires, $F(4, 260) = 4.53, p < .01$; but not for structured interviews, $F(4, 260) = 0.39, p = .82$. Post-hoc comparisons indicated that PhD psychologists endorsed using parent-report questionnaires more frequently than masters degree licensed counselors, and social workers, while psychologists with a PsyD endorsed more use than masters degree licensed counselors, p 's $< .05$. Similarly, post-hoc comparisons indicated that PhD psychologists endorsed using child-report questionnaires more frequently than masters degree licensed counselors, marriage and family therapists, and social workers, while psychologists with a PsyD endorsed more use than masters degree licensed counselors, p 's $< .05$.

A chi-square analyses indicated that doctoral level psychologists (PhD and PsyD) were most likely to be Partial EBA Users (67.3% and 58.1%), while the other professions were most likely to be Infrequent EBA Users (50.0% to 63.6%), $X^2 = 21.67$, $p < 0.01$. A series of independent groups t-tests indicated that use of EBA was unrelated to endorsement of any theoretical perspective, all t 's < 1.8 , all p 's $> .07$. The correlation between EBA use and years of practice ($n = 264$) was small, but significant for parent-report questionnaires, $-.15$, $p < .05$; and child-report questionnaires, $-.15$, $p < .05$; but not for structured interviews, $.07$, $p = .27$. EBA use was significantly correlated with the frequency of working with anxious children for all EBA techniques ($n = 323$): parent-report questionnaires, $.22$, $p < .001$; child-report questionnaires, $.23$, $p < .001$; and structured interviews, $.30$, $p < .001$. Regression equations indicated that all associations remained significant when years of practice and frequency of work with children were entered simultaneously, all R^2 's $> .05$, all $Beta$'s $> .16$, all p 's $< .05$; the association between years of practice and use of structured interviews remained nonsignificant.

Reasons for not using EBA

Approximately half ($n = 173$; 51.0%) of the sample provided a comment in response to the open-ended question regarding reasons for not using EBA. Forty-one of these responses, 23.7%, were unrelated to the value of, or barriers to, using EBA. For example, some respondents that endorsed using EBA listed the measures they used while other respondents stated that other clinicians in their system provided EBA for their patients. The remaining comments were categorized into two themes with seven subthemes (Table 3).

The first theme, Barriers, captured comments regarding obstacles to using EBA, including the following subthemes: a) Time: insufficient time (e.g., "Time-consuming"); b) Access: lack of access to materials (e.g., "Lack of access to tools"); c) Knowledge: unfamiliarity with or lack training in EBA (e.g., "I was not aware nor trained in using those assessment tools"); and d) Cost: cost are prohibitive (e.g., "cost of use"). The second theme, Negative Beliefs, captured comments indicating negative beliefs about the potential benefits of EBA in clinical practice, including the following subthemes: a) Unhelpful: EBA techniques are not necessary for good clinical practice (e.g., "Believe interview skills are sufficient"); b) Patient burden: EBA techniques are burdensome on the patient/family (e.g., "Adolescents don't always want to fill them out"); and c) Interference: EBA techniques interfere with the therapeutic process (e.g., "Structured diagnostic interviews tend to interfere with development of therapeutic rapport..."). Qualitative comments could be coded into multiple categories.

Discussion

The current study extends prior research on practicing clinicians' use of EBA by demonstrating that less than 10% of therapists evaluating childhood anxiety disorders report frequently implementing full EBA evaluations when assessing their clients. Structured interviews demonstrated the lowest rates of reported implementation, whereas reports of rating scale use were more frequent, although rates were far from ideal (Hunsley & Mash, 2007; Mash & Hunsley, 2005). Greater frequency of rating scale use was influenced by

clinician-specific factors including possessing a PhD in psychology, being relatively earlier in one's career, and having more experience treating childhood anxiety. Overall, these results provide further confirmation of a well-documented gap between science and practice within the field of mental health, thus highlighting the need for continued work in DI of EBA in clinical service settings.

Beyond exploring EBA use among practitioners, the current study also fosters collaboration between EBA stakeholders and advocates by providing data concerning clinician-cited barriers to implementation. Overall, the data suggest that although many practitioners appear to be willing to implement EBA, practical barriers hinder their use in clinical settings. For example, clinicians expressed concerns about the practicality of EBA, citing barriers such as the time associated with the administration of such techniques. Accordingly, questionnaires, which often require relatively little time and expense for administration and interpretation were much more likely to be used than structured interviews. These results are consistent with a substantial body of research demonstrating that providers generally consider many EBA tools to be inordinately resource intensive for clinical use (Bruchmuller et al., 2011; In-Albon et al., 2008; Pinninti, Madison, Musser, & Rissmiller, 2003; Shear et al., 2000; Suppiger et al., 2009).

As such, implementation interventions may be more effective if efforts are made to address the practical barriers to using EBA clinically. Along these lines, researchers have recently employed statistical techniques (e.g., item response theory, Bayesian inference, and recursive partitioning) to develop comprehensive measures that are both accurate *and* efficient. For example, recent efforts have produced highly efficient protocols for structured interviews (Chorpita & Nakamura, 2008; Sheenan et al., 2010), evidence-based methods for easily integrating clinical data from children and parents (Ebesutani, Bernstein, Chorpita, & Weisz, 2012), and brief (yet, broad and psychometrically robust) tools for measuring clinical outcomes (Chorpita, Reise, Weisz, Grubbs, Becker & Krull, 2010). Given the utility that such measures offer in terms of providing clinicians with viable options for conducting high-quality clinical assessment, future efforts should continue to explore the application of novel statistical approaches in developing clinically feasible EBA tools.

Besides concerns about the time required for EBA, many clinicians cited additional practical barriers to implementation such as lacking access to EBA and the excessive cost of materials. Related to this point, prior research suggests that organizational support, especially the provision of evidence-based materials (i.e., increasing clinicians' access to EBPs by absorbing costs), is an important component of successful implementation interventions (Garland et al., 2013; Beidas & Kendall, 2010; Glisson et al., 2007). Thus, effective implementation efforts may require EBA advocates to extend their focus beyond individual clinicians and encourage organizational supervisors and administrators to foster a climate conducive to EBA use by providing clinicians with the necessary materials (Aarons et al., 2010).

However, addressing practical barriers alone may not be sufficient to achieve widespread and sustainable adoption of EBA in clinical settings. For example, the most frequently cited reason for not using EBA was the perception that such techniques are not clinically useful.

Unfortunately, these beliefs persist despite a program of research that establishes the utility of EBA (Hunsley & Mash, 2007; Mash & Hunsley, 2005). Thus, continued work is needed to identify the features of EBA technology that are most useful to clinicians and to leverage these features in improving EBA's relevance to clinical practice. Ideally, such efforts will produce measures that supplement, rather than replace existing practices (Becker, Nakamura, Young & Chorpita, 2009; Bracht et al., 1999; Martin et al., 1998; Rogers, 2003; Torrey, Lynde, & Gorman, 2005). Not only will this require collaboration between EBA advocates and stakeholders, but also substantial flexibility as the needs of particular clinicians likely depend on the nature of their practice. For example, the present results suggest that clinicians who assess childhood anxiety more frequently are also more likely to use anxiety-focused EBA techniques. Thus, effective implementation will likely require further understanding of the varied needs of clinicians to determine the ways in EBA technologies might be modified to accommodate diversity in the demands of clinical practice.

The current results also suggest that clinicians' training and education influence rates of implementation. For example, PhD-level psychologists and practitioners who had recently completed graduate training reported more frequent EBA use. These results may reflect the training offered in scientist-practitioner graduate programs, which has emphasized EBP, particularly in recent years (Karekla, Lundgren, & Forsyth, 2004; Crits-Christoph, Frank, Chambless, Brody, & Karp, 1995). Moreover, practitioners may develop entrenched, idiosyncratic practices as they gain clinical experience (Dawes, Faust & Meehl, 1989). Related to training/education, clinicians frequently cited lacking knowledge about EBA as a barrier to implementing such techniques. Given the impact that clinicians' education/training and knowledge of EBPs have on their propensity to adopt such practices (Frambach et al., 2002; Greenhalgh et al., 2004; Rogers, 2003), future implementation efforts should involve the development of training programs to engender knowledge (and use) of EBA among practitioners (especially those lacking scientist-practitioner oriented training). Fortunately, evidence-based guidelines for developing EBP training programs are available (Beidas & Kendall, 2010; Cheng & Ho, 2001).

A number of limitations to the current study need to be addressed. First, the methodological issues inherent in conducting any survey study (e.g., reporting bias, selection bias) may have skewed our results. Specifically, clinicians who chose to respond may have done so due to having particularly strong opinions about EBA and/or respondents may have answered the survey in such a way that they felt was desirable to the researchers. This limitation is particularly relevant given the relatively low response rate to the survey in general compounded by qualitative data being available for only half the sample. In addition, the survey that was distributed contained a small number of questions, thus potentially sacrificing the opportunity to gain additional information through the use of more items. For example, future research could examine the use of common assessment measures or the circumstances in which clinicians choose to use EBA tools. Finally, the conclusions warranted by the current study may be limited due to its relatively narrow focus on childhood anxiety. Although the results presented here are consistent with prior research exploring EBA use among practitioners, it remains unclear whether these findings generalize to assessment practices for other disorders and/or populations not explored in

previous studies. Despite these limitations, the current study provides valuable data concerning EBA use in clinical settings as survey respondents included a relatively large number of clinicians from varying professional backgrounds.

In summary, the current study suggests that although clinicians appear to be willing to implement EBA in practice, such techniques are not frequently used due to practical barriers (i.e., time constraints, lacking access and knowledge, prohibitive cost) and perceived lack of relevance to clinical practice. Thus, successful implementation may require continued effort to enhance the feasibility and utility of EBA in clinical practice, as well as clinicians' access to and knowledge of such practices. Of course the ultimate goal of such efforts is not to achieve effective EBA implementation in and of itself, but rather, to improve patients' access to high-quality care. Effective EBA implementation represents just one strategy aimed at achieving this ambitious goal.

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Appendix A

EBA usage Questions

In the past year, how often have you used the following assessment techniques to evaluate children and adolescents (aged 7 to 17) with anxiety?

- Had parents complete behavior rating scales (e.g., Behavioral Assessment System for Children, Spence Children's Anxiety Scale.)
- Had the child/adolescent complete behavior rating scales (e.g., Behavioral Assessment System for Children, Spence Children's Anxiety Scale).
- Administered a structured diagnostic interview (e.g., ADIS, SCID, MINI-KIDS)
- If you do not use the above assessment techniques regularly, what are some of the reasons that you do not?.

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Highlights

- 339 child anxiety therapists were surveyed regarding assessment practices.
- Only 10% were classified as users of regular evidence based assessment.
- Many reported rarely using ratings scales (40%) and diagnostic interviews (74%).
- Clinicians cited practical barriers and perceived lack of benefit as preventing use.

Table 1

Frequency of using evidence-based assessment to evaluate childhood anxiety disorders.

	Parent Rating Scales	Child Rating Scales	Structured Dx Interviews
Almost Never	101 (29.8%)	93 (27.4%)	200 (59.0%)
Rarely	37 (10.9%)	50 (14.7%)	51 (15.0%)
Sometimes	66 (19.5%)	67 (19.8%)	34 (10.0%)
Often	61 (18.0%)	66 (19.5%)	16 (4.7%)
Very Often	74 (21.8%)	63 (18.6%)	38 (11.2%)

Survey questions are presented in Appendix A.

Table 2

Use of EBA by profession

Specificity	Total	PhD	PsyD	MA	LMFT	SW
N	339	49	31	44	28	113
Parent-report	2.91 (1.5)	3.63 (1.4) ^a	3.32 (1.5) ^{ab}	2.52 (1.5) ^c	3.00 (1.5) ^{abc}	2.93 (1.5) ^{bc}
Child-report	2.87 (1.5)	3.57 (1.4) ^a	3.32 (1.3) ^{ab}	2.43 (1.4) ^c	2.75 (1.4) ^{bc}	2.89 (1.5) ^{bc}
Structured DI	1.94 (1.4)	2.08 (1.2)	2.03 (1.4)	1.75 (1.4)	1.93 (1.4)	1.99 (1.4)
Infrequent EBA	172 (50.7%)	12 (24.5%)	11 (35.5%)	28 (63.6%)	14 (50.0%)	59 (52.2%)
Partial EBA	135 (39.6%)	33 (67.3%)	18 (58.1%)	12 (27.3%)	12 (42.9%)	42 (37.2%)
Complete EBA	33 (9.7%)	4 (8.2%)	2 (6.5%)	4 (9.1%)	2 (7.1%)	12 (10.6%)

PhD = doctoral level psychologists; PsyD = psychologists with professional doctorate degree; MA = masters level professional counselors, LMFT = licensed marriage and family therapists, SW = social workers. Infrequent EBA = no EBA techniques used often or almost always; Partial EBA = one or two of child-, parent-report questions, or diagnostic interviews used often or almost always; Complete EBA = all three child-, parent-report questions, and diagnostic interviews used often or almost always. Different superscripts within rows denote means differ, $p < .05$.

Table 3

Reasons for not using EBA.

Theme	n	%
Barriers to use	75	56.8%
Time	18	13.6%
Access	33	25.0%
Knowledge	28	21.2%
Cost	14	10.6%
Negative Beliefs	66	50.0%
Unhelpful	64	48.5%
Pt. burden	5	3.8%
Interfere	4	3.0%
Total Responses	132	100%

Total Responses = All responses pertaining to reasons for not using EBA in clinical practice.

% = Percent of Total Responses

Responses could be coded into multiple categories