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Pepperdine University

Graduate School of Education and Psychology

PSYCHOLOGY INTERNSHIP TRAINING IN EVIDENCE-BASED TREATMENTS FOR YOUTH WITH DISRUPTIVE BEHAVIOR PROBLEMS

A dissertation submitted in partial satisfaction of the requirements for the degree of

Doctor of Psychology

by

Nathan J. Balfanz, M.A.

October, 2012

Edward P. Shafranske, Ph.D., ABPP—Dissertation Chairperson

This clinical dissertation, written by

Nathan Balfanz

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

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DEDICATION

This is dedicated to my family, friends, and all my loved ones in between. Whether it was paid in tuition, love, laughter, or encouragement, thank you for all of your support along this journey.

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There are a number of people that I would like to recognize for their part in this dissertation process. First and foremost, I would like to extend my thanks to my committee members for their efforts and support in helping to shape the current research project. Dr. Edward Shafranske, you were willing to step in and chair this project when progress had reached a standstill, and for that I thank you. Dr. Carol Falender, your wisdom and passion for providing treatment services to the children of this world serves as a constant inspiration in my pursuit of becoming a child and adolescent-focused clinical psychologist. Dr. Carolyn Keatinge, I want to thank you for teaching me how to convey information and research findings in a way that is both meaningful and informative. To Dr. Bruce Chorpita, thank you for pointing me in the right direction with my research and providing me with an invaluable set of research information that served as the backbone for my project.   To my parents, thank you for all that you have done for me since day one-without the two of you, none of this would have been possible. To my friends, and you know who you are, thanks for not letting me take myself too seriously. And finally, to M.A., thank you for being my rock and my better half.

VITA

EDUCATION

Pepperdine University, Graduate School of Education and Psychology
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Doctor of Psychology in Clinical Psychology (Expected) October 2012
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Pepperdine University, Graduate School of Education and Psychology
Malibu, CA
Master of Arts in Clinical Psychology with a Marriage & Family Therapy Emphasis May 2008

Valparaiso University,
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CLINICAL EXPERIENCE

Children's Institute, Inc. (C.I.I.)
Los Angeles, CA
Psychology Intern September 2011-August 2012
Supervisor: George Bermudez, Ph.D.

- American Psychological Association (APA) accredited pre-doctoral training program
- Specializing in Early Childhood Mental Health
- Providing Child-Parent Psychotherapy (CPP) in a home-based treatment format for children (ages 0-5) and their caretakers
- Providing both individual and family-oriented psychotherapy in a home-based treatment format for pre-teens and adolescents and their families
- Serving as an early childhood mental health consultant for a pre-school aged classroom
- Providing group therapy and parenting skills services for fathers as part of the CII's "Project Fatherhood" program

The K & M Learning Center
Santa Monica, CA
Educational Specialist January 2008-Present
Supervisors: Melissa Mullin, Ph.D.; Karen Fried, L.M.F.T., Psy.D.

-- Conducting educational psychology-based interventions for children, ages 6-18, experiencing learning difficulties and disabilities that impede upon their academic and social growth
-- Reviewing child assessments for strengths and weaknesses, and creating a customized treatment program designed to meet specific intellectual and emotional needs
-- Attending individualized education plan (IEP) meetings to discuss with school representatives a student's classroom accommodations

Sharper Future
Los Angeles, CA
Doctoral Practicum Externship/Trainee August 2010-August 2011
Supervisor: Lea Chankin, Psy.D.

-- Conducted assessments and provided individual/group therapy for a forensic population experiencing mental health impairments and other unwanted behaviors
-- Administered specialized evaluations and tailored interventions for criminal sexual offenders both prior to adjudication and post-incarceration

Pepperdine University Counseling Center
Los Angeles, CA
Doctoral Practicum Externship/Trainee August 2009-August 2011
Supervisor: Joan Rosenberg, Ph.D.

-- Provided low cost, one-on-one psychotherapy for children and adults from the greater Los Angeles area
-- Conducted comprehensive psychological assessments for children

UCLA-Center for Assessment and Prevention of Prodromal States (CAPPS)
Westwood, CA
Doctoral Practicum Externship/Trainee July 2009-August 2010
Supervisor: Sandra DeSilva, Ph.D.

-- Conducted assessments and provided individual/group therapy for individuals demonstrating prodromal symptoms of psychosis
-- Assisted in developing a knowledge base for the prediction of future thought disorders in adolescents and young adults, and studied how brain functioning changes over time in those who develop psychosis as compared to those who do not

Children's Institute, Inc. (C.I.I.)
Los Angeles, CA
Marriage and Family Therapist Trainee/Doctoral Practicum Externship/Trainee January 2007-August 2009
Supervisor: Dr. Lukas Jaeggi

-- Provided individual and group therapy for children, ages 3-5, displaying severe emotional and behavioral problems often in response to a history of abuse, neglect, and displacement

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Pepperdine University
Malibu, CA
Student Athletics Tutor August 2006-May 2008
Supervisor: Kimberlee Rodriguez

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Marriage and Family Therapist Trainee August 2006-December 2007
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Merrillville, IN
Counselor January 2006-May 2006
Supervisor: Stanley Hughes, Ph.D.

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ASSESSMENT TRAINING

-- **Emotional & Personality Assessment**
  - MMPI-2; MCMI-III; MACI; TAT; HTP; DAP; Rorschach; Roberts-2
  - Test administration, interpretation, and report writing

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RESEARCH INTERESTS AND EXPERIENCE

-- Evidence-based treatment and best practices for children with disruptive behaviors

-- Trauma-focused treatment practices

-- Prodromal stages of development for psychosis in teens and young adults

RELEVANT EXPERIENCE

Our House-Grief Support Center
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Hult Education Center-Healthy Heroes
Peoria, IL
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H. Adams, M.D. Milestones Ranch Convention Center; Malibu, CA December 2007

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American Psychological Association Division 37, Student Member March 2012-Present
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Psi Chi, The International Honor Society in Psychology May 2006-Present

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June 2012

-- Awarded in recognition of those who demonstrate outstanding academic, social and personal achievements, and a commitment to working with the underserved

ABSTRACT

The implementation of evidence-based treatments (EBTs) has become a topic of significant debate amongst researchers and mental health practitioners alike. While current research has indicated a shift in attitudes amongst treatment providers for what constitutes as “best practices” in treating clients, less is known regarding the dissemination and teaching of EBTs for early career, training clinicians. The focus of this study was to take a closer look at clinical training in EBT strategies, specifically those for children and adolescents with disruptive behavior problems (DBPs). Sixty-four internship training directors and program representatives from American Psychological Association (APA) accredited and Association of Psychology Postdoctoral and Internship Centers (APPIC) approved child and adolescent-focused internships completed a survey developed specifically for the current study and based on previous research in the domain of EBT. A systematic review of the publicly accessible information presented on each eligible participant’s training agency website was also conducted in an attempt to compliment the data collected from the survey. The results of the study were consistent with previous findings from James and Roberts (2009) that supported placing a greater emphasis on training clinicians in EBTs, with the majority of participants noting specifically how training in EBTs helped to target treatments to diagnoses and ultimately lead to better client outcomes. Multiple concerns were also raised regarding the depth of an intern’s exposure to the EBT protocols being trained, the lack of funding and qualified supervisors required to administer the EBT training, as well as the real-world applicability of EBT practices. Limitations of the study included a small sample size, the potential for biases in those who responded to the survey, as well as limitations pertaining

to the research instrument, design, and methodology. Recommendations for future studies include conducting a more thorough examination of an agency's current and future plans for incorporating training in EBTs, conducting an in-depth analysis of an agency's website and online training handbook, as well as utilizing web-based surveys in addition to surveys distributed through United States Postal Service (USPS) mail as a way to increase the survey response rate.

Introduction

Disruptive or noncompliant behavior can be expected from young children and adolescents from time to time. It might involve a child stealing a piece of candy from the grocery store, two schoolmates getting into a fistfight on the playground, or a teenager sneaking out of the house after the curfew hour. It is only when children repeatedly demonstrate disruptive, rule-breaking acts, which violate the basic rights of others or society's expectations, that their behavior warrants clinical attention. Children and adolescents demonstrating disruptive behavior problems (DBPs) have been shown to carry an increased risk for jeopardizing the well-being of themselves and others by acting in an overly aggressive manner (Matthys, Cuperus, & Van Engeland 1999), develop more significant psychiatric disorders in adulthood (Robins & Price, 1991), as well as having an increased likelihood of violating social norms that often result in frequent and prolonged incarceration (Fergusson, Horwood, & Ridder, 2005).

Researchers and policymakers alike have conducted studies demonstrating how the actions of lifelong criminal offenders, who display a pattern of problematic, rule-breaking behaviors dating back to childhood, may result in societal costs that exceed millions of dollars when accrued over a lifetime. Not only do these problematic behaviors result in monetary costs to society, but they can also lead to a child or adolescent's social isolation and subsequent delays in social development, school failures, substance abuse problems, as well as future unemployment-even in those youth who may have managed to avoid the juvenile justice system. Mental health treatment can often be ineffective or inaccessible to those youth who need it the most, whether it be the result of a lack of accessibility to community resources, systemic issues related to

socioeconomic status, treatment noncompliance, or the like. Thus, the importance of suitable treatment interventions for such marginalized populations can have significant benefits for both the individual child and for society. In addition to providing necessary family and societal support, effective treatment interventions for youth with DBPs and their families are required, not only to curtail the child's current problematic behaviors, but also to prevent future behaviors that could prove costly for the child and those around him or her.

In years past, the plight of youth with DBPs like those seen in oppositional defiant disorder (ODD) and conduct disorder (CD) was bleak. Effective intervention approaches appeared to be nonexistent, since therapies such as long term psychotherapy and residential treatment did not result in verifiable behavioral change. However, more recently evidence-based practices (EBPs), including empirically supported treatments (ESTs), have been found to result in significant and sustainable behavior change. This development offers the hope of changing the downward trajectory of such youth, who are now able to receive adequate treatment. While empirical studies have demonstrated effectiveness, little is known about the dissemination and use of these treatments. Of particular interest is the extent to which training in such treatments is available. This dissertation aims to examine training in EBT strategies for youth with DBPs for psychologists. This study will investigate the status of training and supervised practice in EBTs for youth with DBPs in child and adolescent-focused clinical psychology internships.

Evidenced-Based Practices in Psychology (EBPP)

In an effort to ensure the effectiveness of psychotherapeutic treatment, the American Psychological Association ([APA], 2006) established a policy that requires psychologists to employ treatment interventions that meet the standards of evidence-based practice (EBP). The APA Presidential Task Force (2006, p. 273), described "evidence-based practice in psychology (EBPP)," to include, "The integration of best available research with clinical expertise in the context of patient characteristics, culture, and preferences." In other words, the intervention strategy utilized must be drawn from an empirically-supported research base (if available), be administered by a clinician well-trained in the treatment protocol, and maintain enough flexibility to account for the personal attributes and preferences of the client. The intention of this task force deliberation was to more closely examine what could be considered as sound clinical practice.

With the introduction of EBPP, an effective treatment could no longer be considered a "one-size-fits-all" technique, nor could a mental health provider rely solely on his or her intuition in providing treatment interventions that aimed to promote positive outcomes. As discussed above, ideally an identified treatment strategy will demonstrate reliability in the laboratory, while also maintaining enough flexibility to incorporate the preferences and characteristics unique to each client encountered in real-world clinical practice. This heightened standard for treatment is of particular importance when it comes to treating youth with DBPs, as such cases are often complicated by a variety of co-occurring disorders and other clinically relevant treatment issues.

Determining an appropriate treatment strategy for an individual who meets the *Diagnostic and Statistical Manual of Mental Disorders* ([DSM-IV-TR], American Psychiatric Association, 2000) criteria for disruptive behavior disorders like oppositional defiant disorder (ODD) and/or conduct disorder (CD) necessarily warrants the consideration of many factors. Henggeler and Sheidow (2003) advised clinicians and researchers alike to be aware of important caregiver and family factors that may exacerbate the deleterious effects of conduct problems (e.g. substance use, maternal age, caregiver psychopathology, family conflict management), as well as considering factors of peer influence (e.g. association with deviant peers, poor socialization skills) that can inhibit a youth's ability to effectively manage his or her misconduct. Including the involvement of the entire family unit in treatment, requiring the therapist to consider the cultural identity of the family members, identifying the personality and parenting styles of the child's primary caretakers, as well as considering the developmental level of the child have all been shown to contribute to treatment effectiveness (Eyberg, Nelson, & Boggs, 2008).

While the factors of clinician skill, treatment context, and client characteristics/ preferences are important ones to consider, a key component of EBPP involves understanding which strategies have received empirical support to treat the client's presenting symptoms. In the researcher's attempts at identifying the availability of EBTs as a starting point for working with children and adolescents with behavioral problems, two questions need to be answered:

- What treatments and practice components for youth with DBPs have received empirical support?

- How prevalent is training and practice of such treatments available in predoctoral internships in psychology?

The primary focus of this dissertation is to contribute to the research on the status of training for mental health providers in the domain of EBT strategies for youth with DBPs.

Background

This section provides the formal definitions for two primary disruptive behavior disorders found in children and adolescents: conduct disorder (CD) and oppositional defiant disorder (ODD). It also includes a discussion of the incidence and impact of the disruptive behaviors associated with CD and ODD, as well as an introduction to the EBTs for CD and ODD.

Definitions of Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD)

Conduct disorder (CD). According to the latest version of the DSM-IV-TR (2000, p. 98), CD is a psychiatric diagnosis observed in children and adolescents who demonstrate a pattern of behavior that either violates the rights of others or otherwise defies what would be considered as "age appropriate societal norms." Such behaviors can include repeated physical aggression towards people or animals, property destruction, theft, deceit, and/or a continued violation of rules set by parents, teachers, institutions, and the like. The International Statistical Classification of Diseases and Related Health Problems (ICD), a classification tool developed by the World Health Organization ([WHO],1992) to advance the universal classification and diagnosis of mental health disorders, refers to conduct-related disorders as "disorders characterized by a repetitive and persistent pattern of dissocial, aggressive or defiant conduct" that were "more severe

than ordinary childish mischief or adolescent rebelliousness" (p. 266). Litschge, Vaughn, and McCrea (2010, p. 22) provided a definition that usefully summarizes problematic conduct as "any of a range of behaviors that are related to such constructs as delinquency, aggression, violence, disruptive behavior, and externalizing disorders."

When assessing a child's conduct it is important to distinguish between isolated behaviors which are occasional and/or normative problematic behavior exhibited by many young children, and those behaviors by virtue of their nature or prevalence that surpass the threshold of clinical significance. To warrant a diagnosis of CD, a child must persistently demonstrate problematic behavior in three or more of the aforementioned domains listed in DSM-IV-TR over the course of a year, with at least one problematic behavior remaining consistent for the previous six months (2000, p. 98). A "Childhood-Onset Type" specifier is designated if at least one ongoing conduct problem occurred prior to age 10, while an "Adolescent-Onset Type" specifier is designated if there was no evidence of ongoing conduct problems before age 10.

Oppositional defiant disorder (ODD). The DSM-IV-TR (2000, p. 100) defines ODD as a psychiatric diagnosis observed in children and adolescents who demonstrate, "a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures." Some of the disruptive behaviors observed in children diagnosed with this disorder include easily losing one's temper, deliberately annoying others, arguing with and/or refusing to comply with the requests of adults, blaming others, exhibiting spiteful or vindictive behavior, as well as being easily angered or annoyed. While ODD is a disorder closely related to CD in that both may include instances of defiant or deceitful rule-breaking behavior, those behaviors observed in ODD are often considered

to be less severe than the aggressive and destructive nature of behaviors more frequently associated with CD. Therefore, while a child's symptoms may meet the criteria required to fulfill an ODD diagnosis, his or her symptoms may remain at a sub-threshold level of dangerousness for a CD diagnosis. To warrant a diagnosis of ODD, a child must repeatedly show four or more of the aforementioned behaviors as listed in the DSM-IV-TR for a time period of six months, without otherwise meeting criteria for CD or Antisocial Personality Disorder (2000, p. 102).

Clinical impairment. Children with DBPs consistent with diagnoses of either CD or ODD will often have significant impairments in maintaining healthy, positive interpersonal relationships with peers and family members alike. Hagen, Ogden, and Bjørnebekk (2011) noted how children who regularly demonstrate disruptive behaviors and their parents/caretakers can often become locked in a cyclical pattern of child misbehavior and the parental reinforcement of such behavior, which may perpetuate the problems encountered by the child, the family, and society as a whole. Such reinforcement may lead the child to believe that his or her disruptive behavior and the subsequent "problem child" label is self-fulfilling, while at the same time exasperated parents are left to wonder what they can possibly do to extinguish their child's misbehavior. In addition to such challenges, when treatment is finally sought out the noncompliance and defiant behavior regularly demonstrated by individuals presenting with DBPs often compromises the likelihood of maintaining a consistent adherence to even the best-designed treatment protocol (Burke, Loeber, & Birmaher, 2002).

The Incidence and Societal Cost of Youth with Disruptive Behavior Problems (DBPs)

Given the spectrum and severity of the rule-breaking behaviors that are included within the symptom criteria for disruptive behavior disorders, one can imagine the large-scale implications that may come as a result of a failure to appropriately intervene with this population. In an attempt to assess for the projected societal costs (i.e. costs related to the behavior of "career criminals," heavy drug abusers, and high school dropouts) of a young person demonstrating persistent antisocial behavior, Cohen (1998) estimated that as much as $1.7-$2.3 million dollars can potentially be spared by providing adequate, early intervention treatment for such high-risk youth.

A significant incidence of children with disruptive behavior disorders are found in a number of treatment settings across the world. Upon conducting a meta-analysis to observe the prevalence of conduct-disordered youth being referred for treatment, Loeber, Burke, Lahey, Winters, and Zera (2000) found that a range of 1.8%-16% of boys and 0.8-9.2% of girls in international community samples met the diagnostic symptom criteria for CD. The same study also found a range of 2.1-15.4% of boys and 1.5-15.6% of girls in various international samples who met diagnostic symptom criteria for ODD. Scott (2006) estimated that, on average, CD is prevalent in approximately 5% of the world's youth population. A primary concern for this population is the increased likelihood of encountering mental health issues that could persist into adulthood, as individuals who demonstrated significant conduct problems as children have been shown to develop a variety of psychiatric disorders as adults, including depression, substance abuse-related disorders, and in some cases, schizophrenia (Robins & Price, 1991).

As it was previously indicated, children exhibiting problems with disruptive behavior often have a variety of clinically relevant treatment concerns that extend beyond the disruptive behavior disorder diagnosis, including but not limited to: originating from families of low socioeconomic status (Lahey, Miller, Gordon, & Riley, 1999), comorbid conditions of attention deficit hyperactivity disorder ([ADHD], Gittelman, Mannuzza, Shenker, & Bonagura, 1985), anxiety disorders (Loeber & Keenan, 1994; Zoccolillo, 1992) and depressive disorders (Angold & Costello, 1993), substance abuse issues (Buydens-Branchey, Branchey, & Noumair, 1989), violent behavior (Loeber, Tremblay, Gagnon, & Charlebois, 1989; Trembley, Loeber, Gagnon, & Charlebois, 1991), as well as early pregnancy (Kovacs, Krol, & Voti, 1994; Zoccolillo & Rogers, 1991 [as summarized in Loeber et al., 2000]). Specific to ODD, over 92% of a nationally representative sample of adult participants from 2007 with a lifetime prevalence of ODD also fulfilled criteria for at least one other diagnostic disorder-generally anxiety, mood, and/or substance use disorders (Nock, Kazdin, Hiripi, & Kessler, 2007).

While the American Psychological Association (APA) has set a standard for treatment strategies of all mental health disorders to possess an empirically-supportive research base, making such research informed treatment of particular importance in treating disruptive behavior disorders given their complexity and impact on society as a whole is a necessity. In the following section, the qualifying criteria for a treatment strategy to be considered as receiving empirical support are identified, and the current status of EBTs for children and adolescents with DBPs is discussed.

The Movement Towards Evidence-Based Treatments (EBTs)

Motivated by a desire to enhance the position of psychotherapy as a scientific practice, researchers and clinicians such as McFall (1991) reevaluated the credibility of treatment practices that lacked a sufficient grounding in evidence-supported research, suggesting that clinicians delivering such services were failing to provide the patient with the necessary quality of care. In an attempt to support this and other similarly held positions, Chambless and Hollon (1998) advanced the concept of "empirically-supported treatment" (EST), which they defined as "clearly specified psychological treatments shown to be efficacious in controlled research with a delineated population" (p.8). The authors would go on to provide a more in-depth explanation of the criteria required for a treatment protocol to be considered empirically-supported; their summary of each criterion point is listed below:

- Comparison with a no-treatment control group, alternative treatment group, or placebo (a) in a randomized trial, controlled single case experiment, or equivalent time-samples design and (b) in which the EST is statistically significantly superior to no treatment, placebo, or alternative treatments or in which the EST is equivalent to a treatment already established in efficacy, and power is sufficient to detect moderate differences.
- These studies must have been conducted with (a) a treatment manual or its logical equivalent; (b) a population, treated for specific problems, for whom inclusion criteria have been delineated in a reliable, valid manner; (c) reliable and valid outcome assessment measures, at minimum tapping the problems targeted for change; and (d) appropriate data analysis.

- For a designation of efficacious, the superiority of the EST must have been shown in at least two independent research settings (sample size of 3 or more at each site in the case of single case experiments). If there is conflicting evidence, the preponderance of the well-controlled data must support the EST's efficacy.
- For a designation of possibly efficacious, one study (sample size of 3 or more in the case of single case experiments) suffices in the absence of conflicting evidence.
- For a designation of efficacious and specific, the EST must have been shown to be statistically significantly superior to pill or psychological placebo or to an alternative bona fide treatment in at least two independent research settings. If there is conflicting evidence, the preponderance of the well-controlled data must support the EST's efficacy and specificity. (Chambless & Hollon, 1998, p. 12)

EST criticisms. Following the introduction of objective standards for ESTs, some controversy ensued regarding what was gained versus what was lost as treatment strategies aimed to meet such rigorous research criteria. To begin with, multiple researchers including Bernal and Scharro-del-Rio (2001) posited that while utilizing treatment protocols with empirical evidence is better than using those without it, the uncertainty of a treatment's external validity in applying to a range of ethnic minority populations remained a concern. As the authors would go on to state, "We call upon the research, training, and practice communities to question the current paradigm's validity and consider working from more inclusive paradigms to develop and test theories, as well as evaluate the impact of treatments" (Bernal & Scharro-del-Rio, 2001, p. 337). Some criticized ESTs for using outcome assessment measures that were normed on European-

American populations and loosely translated into other languages, resulting in measures that were considered to be culturally inappropriate (Horrell, 2008). Mulder, Frampton, Joyce, and Porter (2003) suggested that research studies utilizing randomly-controlled designs to test ESTs often involved small, non-generalizable samples of participants as well as inconsistent reporting on treatment outcome effectiveness. From a financial standpoint, Goldfried and Wolfe (1996) warned that the dependence which outcome researchers placed on clinical trials to support treatments only served the interest of third-party payers and their emphasis on "fixed efficacy," while neglecting the best interests of the patients themselves (p. 1007). It was further indicated that a movement towards strictly utilizing only those treatments that meet an identifiable standard could result in managed care companies dictating a clinician's treatment approach solely on the basis of financial reimbursement (Duncan, 2002; Fensterheim & Raw, 1996). Treatment providers instructed to utilize only those protocols with an identified empirical base expressed concerns regarding a protocol's potential inability to meet the needs of clients whose cases involve such complex issues as diagnostic comorbidity or ethnic diversity, its restrictions on the flexibility and innovation of clinical practice, as well as questioning the feasibility of implementing a manualized treatment (Addis, Wade, & Hatgis, 1999). Wampold, Imel, and Miller (2009) noted that many EST designs utilized would rely solely on a diagnosis to guide the recommendations for treatment, a practice which they showed to have serious repercussions--specifically leading to inaccurate conclusions about a treatment's outcome effectiveness. An additional concern with the movement towards ESTs and their manualized treatment interventions was that the financial support necessary for treatment research would only be allocated towards the most frequently

occurring disorders (i.e. depression) at the expense of less frequently occurring disorders (i.e. social phobia) that nonetheless require sufficient treatment (Garfield, 1998).

From EST to EBT. As a result of the recognized shortcomings of determining a treatment protocol's suitability solely on its empirically-supportive base, the APA Presidential Task Force (2006) met to develop the more comprehensive concept of EBPP. Task force representatives noted that ESTs and EBPP were two separate but related concepts, stating: "ESTs are specific psychological treatments that have been shown to be efficacious in controlled clinical trials, whereas EBPP encompasses a broader range of clinical activities (e.g. psychological assessment, case formulation, therapy relationships)" (p. 273). Developing the concept of EBPP required treatment providers to recognize how treatment efficacy could depend on a number of factors besides the outcomes of controlled research designs, including but not limited to: the clinical skills of the treatment provider, the quality of the therapeutic relationship, and the personal attributes of the client in treatment. In accounting for these new treatment considerations, protocol designs saw a shift from the concept of ESTs to the more inclusive EBTs.

With the advent of EBPP, researchers such as Kazdin and Whitley (2006) were able to respond to some of the previously identified criticisms of ESTs through conducting large scale evaluations of treatment outcomes involving complex cases. Their research results suggested that clinical issues such as case complexity and comorbidity of disorders could be dealt with adequately in treatment, so long as the practitioner was mindful of the contextual considerations of the case (Kazdin & Whitley, 2006). Current researchers such as Whaley and Davis (2007) and La Roche and Christopher (2009) who studied manualized treatments specifically with minority populations remained hopeful

regarding a manualized treatment's effectiveness, noting that recent paradigm shifts towards EBPP have allowed for the closer examination of culturally relevant factors in treatment. More recently, Jackson, Alberts, and Roberts (2010) identified a general agreement amongst treatment providers that "dissemination is the most important area for focus to increase the availability and utility of evidence-based practice" (p.79). Some researchers believe that with a proper degree of refinement and specificity in defining symptom and treatment criteria, the field of psychology demonstrates the potential to create a universally acceptable, "hierarchically organized" framework of treatment operations (Schoenwald, Garland, Southam-Gerow, Chorpita, & Chapman, 2011, p. 339).

Regardless of one's position, achieving a better understanding of what is required of a treatment strategy to be classified as an EBT will help to inform the current research in its attempt to determine the extent to which of those treatments specific to children exhibiting DBPs are incorporated into predoctoral-level training programs.

EBTs for DBPs

As is often the case with therapeutic strategies that attempt to treat a specific domain of problematic behavior and/or maladaptive personality variables, EBTs for children with DBPs have been shown to possess a common set of essential features. Garland, Hawley, Brookman-Frazee, and Hurlburt (2008) examined eight treatment programs with a demonstrated empirical-base for effectively treating DBPs in youth ages 4-13 in an attempt to identify a group of common core elements amongst the treatment protocols. The researchers concluded that in terms of therapeutic content, treatment strategies for DBPs frequently included principles of positive reinforcement and effective limit setting, the enhancement of the parent-child relationship, problem-solving skills,

anger management, affect education, as well as anticipation and preparation for treatment setbacks.

With regards to the observable techniques utilized by the therapist in treating the population of interest, core technique elements included providing relevant psychoeducation and information materials, demonstrating how to deliver positive reinforcement as well as punishment, assigning homework, role-playing frequently encountered challenging scenarios, modeling behavior, as well as consistently reviewing treatment goals and progress with the client (Garland et al., 2008). Treatment strategies and techniques for disruptive youth can also be classified under interventions that are geared towards the child, as well as those that are geared towards the parent/caretaker, as research has demonstrated how parent-involved interventions often produce more positive treatment outcomes over interventions that are solely geared towards the child (Litschge et al., 2010).

For the purposes of the current study and its attempt at better understanding the extent to which training and implementation of EBTs for DBPs is available in predoctoral psychology internships, carefully devised lists of such treatments and their practice elements were formulated via a thorough review of the relevant research as well as expert consultation and included in a survey distributed to the directors and representatives of child-focused training programs across the United States. Many of the identified treatment protocols and their practice components involved the therapeutic content and technique elements described above. For a list of the treatment protocols and practice elements included in the survey, as well as for a reference to each treatment protocol, please refer to study survey listed in Appendix B.

Contemporary Thinking Regarding EBTs for Children and Adolescents

In recent attempts at determining the degree to which EBTs were taught in the various mental health fields of psychiatry, psychology, and social work, Weissman, Verdeli, Gameroff, Bledsoe, Betts, Mufson, Fitterling, and Wickramaratne (2006) conducted a brief survey of representatives from each of the fields and discovered from their responses that clinicians (particularly those from the psychology and social work domains) were continuing to receive training primarily in psychotherapeutic practices which lacked a strong evidence base by modern day standards. The authors were able to acknowledge that, "Although there may be justification for teaching treatment for which there is rather little empirical evidence, there is little justification for the exclusion of teaching psychotherapies when the evidence is robust" (p. 930). Weissman et al. (2006) would go on to suggest that factors such as hiring on more research faculty to clinical training programs and raising accreditation requirements for psychology and social work programs could help to accelerate the movement towards teaching exclusively those treatment practices with sound research support.

A study by James and Roberts (2009) that examined the current and future directions of clinical practice, research, and training specific to child and adolescent psychologists noted how the implementation of evidence-based practices (EBPs) for children and adolescents with mental health concerns has struggled to keep up with its ever-increasing demand. On the basis of the authors' appraisal of the current status of treatment in child and adolescent psychology, research results demonstrated a general consensus amongst treatment providers that suggested the incorporation of EBPs in clinical practice, research, and training was critical to the advancement of mental health

treatment for young people. Survey respondents highlighted the continued importance for the field to demonstrate real world applications of EBT strategies and research, as well as the importance of increasing the number of accessible, specialty training opportunities in EBTs for trainees, interns, and post-graduate professionals (2009). This feedback reinforced a previously formed position held by the APA Task Force on Evidence-Based Practice with Children and Adolescents (2008) who recommended that greater attention be paid to training model development and outcome research.

Despite the previously noted barriers related to effectively utilizing EBTs, it appears as though contemporary thinking within the field of clinical psychology remains in support of the movement towards incorporating treatments with a sound empirical base into everyday practice.

Study Purpose

James and Roberts (2009), based on their survey of 45 doctoral-level members within the field of clinical child and adolescent mental health, predicted a greater emphasis on training predoctoral trainees and interns in EBPs so as to "improve the ability of professional psychologists to be critical consumers of scientific findings" (p. 1017). In addition, they reported that survey respondents noted how current and future research that focuses on finding ways to prevent the incidence and societal effect of DBPs seen in children must remain a high priority for mental health professionals so as to enhance the effectiveness of child-focused treatment practices. The current study investigates the extent to which that prediction is being implemented by surveying the status of training and practice in EBTs for youth with DBPs in child and adolescent-focused clinical psychology internships.

In order to help achieve this research objective, a select list of EBTs and relevant practice components for youth with DBPs was developed. Training directors and program representatives of child- and adolescent-focused training programs from across the United States were surveyed to assess which treatment strategies and practice elements are included in their training program, as well as providing them with the opportunity to comment on the perceived advantages and disadvantages and challenges in implementing EBTs.

Research Objective

Simply stated, the primary objectives of the research are: (a) to assess the extent to which training in EBTs for youth with DBPs related to ODD and CD are incorporated in child- and adolescent-focused internship training programs in psychology in the United States; (b) to identify the treatment protocols and practice elements that are most frequently incorporated; and (c) to examine the attitudes of directors of training and program representatives about the advantages and barriers to providing training in EBT.

Method

The purpose of this study was to examine the availability of training in EBTs designed for children and adolescents with DBPs like those seen in ODD and CD at child and adolescent-focused psychology internship training programs in the United States.

Research Approach and Design

This study incorporated a survey approach to obtain self-report data of training directors and program representatives regarding the availability of clinical training in EBTs and their practice components. A survey approach was utilized for its potential to gather a significant amount of data in a brief period of time, while still allowing for participants to complete the measure at their own convenience and maintain their anonymity. Although, one should also consider that when using a survey approach, there exists the potential for response rates that may reflect a sampling bias in the survey's final results.

In addition to collecting data via the study's survey approach, a comprehensive search and review of each potential participant's agency website was also conducted in order to identify any explicit evidence of incorporating EBTs into their training or practice. The information gathered from the site search was utilized to compliment the data collected from the survey in order to provide a more comprehensive understanding of how EBTs are incorporated into the child and adolescent training agencies involved in the current study.

Participants

The participants were training directors and program directors of child and adolescent-focused psychology predoctoral psychology internships. As of March 2012, a total of 285 predoctoral psychology internship sites made up the list of eligible participants involved in the distribution of the survey (APPIC, 2012).

General characteristics of participants. A list of potential participants was identified from the Association of Psychology Postdoctoral and Internship Centers (APPIC) publically-accessible website (APPIC, 2012). The APPIC website provided a comprehensive, easily accessible list and information about predoctoral and postdoctoral-level training programs from sites across the United States and Canada. Programs included on the website were those that had received accreditation through the American Psychological Association (APA), Canadian Psychological Association (CPA) as well as a list of non-APA accredited internship training programs, which are members of APPIC. Directory search results were limited to APA-accredited and non-accredited training programs that listed both "Children" and "Adolescents" as "Major" populations referred for treatment and provided a mailing address for the site. After generating the results from the identified search criteria, the principal investigator arrived at a final list of 285 potential participants which were then entered into a spreadsheet with column headings for "Program Name," "Training Director," "Accreditation Type," "E-Mail Address," and "Mailing Address." The sample was non-discriminant with regards to gender, race, and socioeconomic status, while each participant was informed that their responses to the survey items were entirely anonymous.

Of the initial 285 survey packets that were mailed out, 64 (22.5%) participants responded; however, it is uncertain as to whether or not all 285 packets reached all of the potential participants. After the initial survey packet distribution, three surveys were returned to the investigator with a "return to sender" notification on the cover envelope. The investigator went back to review those addresses listed on the APPIC website for each site and discovered that two of the three sites had a newly listed address, while the third site address was unchanged. Two survey packets were sent out to the new addresses. The investigator did not attempt to resend the survey to the unchanged address, which reduced the final number of potential participants to 284. The final sample of 64 participants included 39 females and 25 males. With regards to racial/ethnic identification, 89.1% of survey participants identified as Caucasian, 3.1% as Hispanic, and 3.1% as Asian or Pacific Islander. One participant (1.6%) selected both American Indian/Alaskan Native and Caucasian categories. Under the "other" category, one participant (1.6%) wrote in "Hispanic/Caucasian," while another participant (1.6%) wrote in "Multi." When asked to identify their training program position, 81.3% of participants identified as a director of clinical training and 1.6% identified as a specialized program director. A variety of positions were identified under the "other" category, including "internship director" (6.3%), "training director" (%), "associate director" (1.6%), "division director, training" (1.6%), "director of internship training, primary therapist" (1.6%), and director of quality review and training" (1.6%). With regards to the time frame in which their doctoral degree was obtained, 82.8% of participants indicated that they had done so prior to the year 2002, while 17.2% obtained

their degrees in 2002 or later. Complete survey participant demographic information can be found in Table 1.

General characteristics of training sites. Of the 64 sites represented in the sample, 31.3% were classified by survey participants as community mental health centers, 17.2% as hospitals, 7.8% as child/adolescent psychiatric or pediatric clinics, 7.8% as private outpatient clinics, 7.8% as consortiums, and 6.3% as medical schools. Two survey participants (3.1%) identified as both a medical school and consortium, while another participant (1.6%) identified as a child/adolescent psychiatric or pediatric clinic, private outpatient clinic, and consortium. Ten survey participants responded as "other" sites; similar responses were collapsed under the categories of school/university setting (4.7%), non-profit agency (4.7%), residential treatment facility (3.1%), medical center (3.1%), and jail/forensic setting (1.6%). Final data on internship site settings can be found in Table 2, while participants' verbatim, write-in responses can be found in Table 3. When asked to report what percentage of their treatment population consisted of children or adolescents, thirty-one survey participants indicated 76-100%, sixteen participants indicated 26-50%, thirteen participants indicated 51-75%, and the remaining four participants indicated less than 25% of their treatment population served were children or adolescents. Results are displayed in Table 4.

Instrumentation

A survey instrument comprised of 12 items (see Appendix B) was developed for the current study. The first part of the survey was devoted to gathering demographic information, including the participant's gender and ethnicity, his or her current training program position, when the participant had received a doctoral degree, a description of

the participant's clinical training site, as well as what the approximate percentage of clients in the participant's setting were children or adolescents.

The second part of the survey elicited information about the nature of clinical training offered and attitudes towards the advantages and barriers to offering training in EBTs. The investigator drew from multiple sources in developing the items, including: (a) a review of the relevant research literature; (b) informal phone, e-mail, and in-person interviews with researchers and practitioners with expertise in the domain of EBTs for children and adolescents; and (c) results from consultation feedback. Four university-level researchers/professors of psychology or psychiatry and one graduate-level student in a doctoral-level clinical psychology program were contacted to provide evaluative comments to assess for clarity and identify areas of improvement for the survey. All five individuals provided their feedback via e-mail. A finalized version of the survey incorporating the feedback received was then distributed to five clinical psychologists employed by a child and adolescent-focused community mental health agency to assess for any final revisions that needed to be made, as well as to determine the length of survey administration. Four participants completed and returned a hard copy of the survey with written feedback. Survey administration was approximately 5-10 minutes; no survey items were altered or omitted as a result of the participants' feedback.

The first section following the demographic items focused on identifying the most frequently utilized EBT protocols that are currently in place for children and adolescents with DBPs. This section was developed by first conducting a comprehensive review of the relevant research in the field of EBTs as obtained through accessing the PsychINFO online research database. Different combinations of the following keywords helped to

provide information for the initial review of the literature: “Conduct Disorder,” “Oppositional Defiant Disorder,” “Empirically-Supported Treatment,” “Disruptive Behavior,” “Survey,” “Training,” and “Evidence-Based Treatment.” The survey developer then proceeded to contact Dr. Bruce Chorpita, a lead researcher in the field of EBT strategies for children as well as the program director for Child F.I.R.S.T., an online program designed to “identify, implement, adapt, and coordinate mental health treatments supported by the highest quality scientific research” for children and adolescents (Chorpita, 2012). Dr. Chorpita (personal communication, December 12, 2011) provided the survey developer with a list of 92 research article references citing 112 different treatment protocols with “Level 1 Best Support Evidence” for “Disruptive Behavior Problems” in children and adolescents, as indicated by the Child F.I.R.S.T. research database. The “Level 1 Best Support Evidence” qualifier is consistent with Chambless and Hollon’s (1998) criteria for treatment protocols with sufficient empirical support. The survey developer reviewed each of the 92 research articles by their title, abstract, population inclusion, treatment procedure, and outcome, and then numerically coded each research article in the order by which they were reviewed. After reviewing and coding all the articles, the developer created a spreadsheet with column headings for “Treatment Protocol Name,” “Research Article Number,” and “Total Number of Articles Cited.” After tallying the total number of articles cited for each treatment protocol, A list of the top five most frequently cited treatment protocols utilizing EBTs for children with DBPs was determined and reviewed by a panel of research experts and child treatment advocates in the field of EBTs, including Dr. Chorpita of the University of California, Los Angeles ([UCLA] personal communication, March 8, 2012), Michael Reding of

UCLA (personal communication, January 26, 2012), Dr. Timothy Fowles of the University of Delaware (personal communication, January 18, 2012), and Dr. Ann Garland of San Diego State University (personal communication, January 18, 2012). The list was finalized and included in the survey for distribution. Training program directors and staff were also provided with the opportunity to indicate which EBT protocols were incorporated into their training program that may not have been listed on the survey.

Following the list of formal treatment protocols, the second section of the survey focused specifically on commonly utilized practice components of EBT protocols for children and adolescents with DBPs. In developing the survey, it was understood that while a particular EBT protocol may not be utilized by the training programs surveyed, certain practice components of the previously identified protocols were likely to be included in most, if not all, child and adolescent treatment strategies. Using the same list of article references noted above, Dr. Chorpita's research team, Practicewise, LLC (2011) was able to code the most frequently utilized EBT practice components. Verbal consent was obtained from Dr. Chorpita to include the top 15 coded practice components in the current survey; the verbal consent was communicated to Matthew Fierstein, Dr. Chorpita's head research lab manager, who then communicated the consent to the study's principal investigator via e-mail (personal communication, March 8, 2012; see Appendix C). This list was reviewed by the same panel of experts previously indicated, finalized, and included in the survey for distribution.

In the final section of the survey, respondents were asked a series of multiple choice and write-in questions that provided them with the opportunity to express their thoughts and attitudes regarding the incorporation of EBTs in their training program

design (e.g. “What do you see as the barriers, if any, to training interns in EBTs?”). Items from this and other sections of the survey were modeled after a survey included in the Weissman et al. (2006) study on training in EBTs for professionals in the fields of psychiatry, psychology, and social work. Written consent was communicated from Dr. Weissman to the study’s principal investigator via e-mail (personal communication, March 6, 2012; see Appendix D).

Research Procedures

The following sections outline the recruitment process, human subjects protections, data collection, and the data analysis plan.

Participant recruitment. The principal investigator contacted via U.S. postal mail the directors of clinical training at child and adolescent focused APA-accredited and non-APA, APPIC approved doctoral training programs located in the United States. The investigator identified a list of the programs eligible for the survey from a publically accessible database found on the APPIC website. The names and mailing addresses of program training directors were obtained through reviewing the information page of each individual program site listing. Given that internship training programs generally offer multiple training rotations which are often supervised by other faculty and staff from the program, it was requested of each training director to pass the survey along to the program representative whom they believed to be the most appropriate individual to respond to a survey on training in child and adolescent treatment strategies. A survey packet was mailed to each potential participant that included: a letter of introduction and request for participation explaining the study’s purpose, participant anonymity, and the voluntary nature of the study (see Appendix E); a statement of informed consent which

described the consent procedures (see Appendix F); a hard copy of the survey; the contact information of the investigator responsible for developing the study; as well as a stamped, reply mail envelope. Participant recruitment spanned from May 22, 2012 to July 13, 2012.

A hard copy of the survey was included in a survey packet and delivered to all potential participants via United States Postal Service (USPS). The developer chose to send the survey by USPS mail in an attempt to ensure a larger number of respondents, given the understanding that training program directors are often overburdened with e-mails pertaining to their primary occupational roles and responsibilities. The hard copy survey was void of any identifying information, allowing participants to maintain anonymity in their responses. Potential study participants were sent a reminder document (see Appendix G) via e-mail 10 days following the initial distribution of the survey to remind them of their opportunity to participate had they not already done so. Upon distribution of the first reminder document, nine training directors responded with an "out of office" autoreply e-mail. The return dates for two of the site training directors had expired, indicating the potential for their e-mail accounts to no longer be active. One training director responded to the investigator indicating a change of site address, and a new survey packet was mailed to the new address. A second reminder document (see Appendix H) was sent via e-mail approximately 1 month following the initial distribution of the survey. Given that the distribution of a second reminder document had not been initially included in the investigator's initial methodology review, the investigator obtained written consent from the Graduate and Professional Schools IRB chairperson to distribute a second reminder. Upon dissemination of the second reminder document, 11

training directors responded with an “out of office” autoreply e-mail. One autoreply e-mail indicated that the recipient was no longer affiliated with the site and listed the e-mail contact information for the new training director; the e-mail reminder was then forwarded to the new director. E-mail addresses for the list of eligible training directors were obtained through reviewing the information page of each individual program site listing on the APPIC website.

Human subjects protection. Prior to beginning recruitment and data collection, an application to the Pepperdine University Graduate and Professional Schools Institutional Review Board (IRB) was submitted and approved. Approval guaranteed that the study follows the guidelines of the Belmont Report, U.S. Code of Regulations, DHHS (CFR) Title 45, Part 46: Entitled Protection of Human Subjects, and Parts 160 and 164: Standards for Privacy of Individually Identifiable Health Information and the California Protection of Human Subjects in Medical Experimentation Act. An expedited review was approved by the IRB, given that the study posed no more than minimal risk to participants. The approved Pepperdine IRB application can be found in Appendix I.

Consent for participation. Given that requiring the study participants to provide a documentation of consent would indirectly result in a request for identifying information and a subsequent violation of anonymity, the study investigator applied for a waiver of informed consent. A waiver of documentation of consent was requested by the investigator and approved by the IRB to allow for implied consent from the directors of clinical training and/or appropriate training program directors, indicating that the respondents demonstrate implied consent as a research participant by completing and returning the survey, as is stated in the statement of informed consent explanation.

Eligible participants were encouraged to respond to the survey and the summarized feedback gathered from the James & Roberts (2009) study, specifically that which suggested the importance of implementing EBT strategies. Potential participants were notified of the purpose and intent of the study, potential risks and benefits, as well as the procedure for accessing and responding to the online survey. Responding to the survey indicated a participant's confirmation that he or she understands the nature, risks, and benefits of the study, the participant's rights to confidentiality, steps being taken to ensure confidentiality, and the participant's right to refuse to participate or withdraw participation at any point.

Potential benefits and risks. Given that the participants in the current study were human subjects, certain benefits and risks of their participation were acknowledged so as to ensure the safety of each participant. While there were no direct benefits for one's participation in the study, a participant may have experienced some satisfaction in knowing that his or her participation could contribute to knowledge in the field of psychology.

Given the contents under study, i.e. information about the availability of training and attitudes towards the inclusion of EBTs in internship training, and the use of a survey design, the study posed no more than minimal risk to the research participant. Individuals interested in participating in the study encountered risks no greater than those of ordinary life, such that their responses to the survey items did not place them at risk for physical injury or criminal or civil liability, nor were they damaging to the individual's financial standing, employability, insurability, reputation, or stigmatizing of themselves or their training program. Further, given that no specific identifying information was

being collected, there was no risk of damaging the participant's or the training program's reputation or standing in the training community. A minimal risk that may have come as a result of participation in the study could have included possible boredom or discomfort in answering questions related to clinical training.

Data Analysis

Data collection and recording. The investigator mailed the internship training directors a survey, statement of informed consent, prepaid return envelope, and a cover letter which requested of them to respond to the items included in the survey. It should be noted that providing a significant number of participants from child and adolescent training internships listed in APPIC with an opportunity to respond to the survey may result in a potential sampling bias; training directors with a vested interest in EBT research and implementation or those eager to learn more about implementation may be over-represented in the study results.

The survey was entirely anonymous, and no names or code numbers were included on the survey or the demographic information sheet. Furthermore, no identifying information was included in the survey results other than distinguishing the nature of the program as a child and adolescent mental health treatment clinic, although it was noted that this information was already public knowledge. Once data collection was finalized, the principal investigator coded the responses to the surveys returned and entered them into their appropriate tables to be analyzed. To protect confidentiality, all hard copy surveys were kept in a locked office and container by the principal investigator, while all electronic, descriptive data files were stored on the investigator's

personal computer in a password-protected folder. After five years, all data will be destroyed.

Site search. In an attempt to compliment the data collected from the survey on the incorporation of EBTs in child and adolescent training agencies, as well as to compensate for a current survey response rate that was smaller than other studies surveying similar populations (Brooks, Mintz, & Dobson, 2004; James & Roberts, 2009; Scott, Ingram, Vitanza, & Smith, 2000; Scott, Pachana, & Sofronoff, 2011), the principal investigator conducted a systematic review of the publicly accessible information presented on each potential participant's training agency website. Website addresses for each training agency were obtained from the APPIC directory. Of the 285 child and adolescent-focused agencies listed, 28 agencies either did not list a website address, listed a website address with a broken hyperlink, or their agency was no longer listed in the APPIC database. These agencies were excluded from the review, resulting in a final sample of 257 agencies. The principal investigator reviewed the general agency website, the online predoctoral internship training program description, and the online predoctoral internship training program handbook (if available) for the following keywords: "evidence," "evidence-based," "EBT," and "best practices." Each aspect of the website was also reviewed for any indication of an intern's exposure to an EBT protocol, including those that may not have been specific to child or adolescent treatment populations. This step was taken in order to identify training agencies that may not have explicitly identified that the agency was incorporating EBTs but were able to identify the inclusion of at least one recognizable EBT in the agency overview. This also allowed for the investigator to better identify which specific EBT protocols were among the most

frequently advertised on child and adolescent training program websites. The agency websites were then reviewed for any indication of an intern's exposure to one of the five specific EBT protocols for children or adolescents with DBPs listed in the current study's survey. More specifically, the investigator searched for the following keywords: "Incredible Years," "Parent Child Interaction Therapy," "Multisystemic Therapy," "Problem-Solving Skills Training," and "Parent Management Training."

Data analysis. The study itself was descriptive in nature, thus descriptive statistics were used in the data analysis. Following collection of the data, analyses were performed in an attempt to determine any associations which seem to emerge. This study intended to contribute to our knowledge about the availability of and attitudes towards training in EBTs for children and adolescents with DBPs, as well as to better understand the manner in which EBTs are incorporated into training programs for predoctoral interns.

Results

The following sections present the survey data that was collected, as well as a summary of the information discovered from the systematic website review. Sixty-four surveys were completed and returned, and a descriptive data analysis was subsequently performed. In an effort to expand upon previous research studies that focused on the training and implementation of EBTs for children and adolescents, this study assessed the extent to which pre-doctoral internship programs provided their interns with training in EBTs for youth with DBPs related to ODD and CD, identified which specific EBT protocols and practice elements were being incorporated into predoctoral interns' training experiences, as well as observed what the internship training directors' thoughts and attitudes were regarding the provision of training in EBTs.

Identified EBT Protocols and Exposure Modes

In an attempt to identify the most frequently used EBT protocols for children and/or adolescents with DBPs, the investigator reviewed the previously conducted relevant research, as well as consulting with research experts from across the country who had demonstrated a significant interest in the domain of EBTs for children and adolescents. A list of five of the most commonly used EBTs specific to the population of interest was created, while also allowing for survey respondents to write in the names of other EBTs trained at their site. The exposure mode for each treatment was also of interest as an indicator of the depth and method of training, therefore respondents were also asked to indicate if the EBT was covered as a brief didactic exposure, an ongoing seminar, and/or supervised clinical experience.

Parent Child Interaction Therapy ([PCIT], Eyberg, 1988) was selected by survey participants as the most frequently incorporated protocol across exposure modes, as shown in Table 5. Of the 64 participants who responded to the survey, 24 indicated that their training program offered brief didactic exposure to PCIT, seven reported providing their interns with ongoing seminars specific to PCIT, while 17 participants reported providing supervised experience in PCIT. The Incredible Years (IY) Programs (Webster-Stratton, 1984) was the least incorporated EBT across exposure modes of the five identified EBP protocols, with only eight participants indicating that they provided interns with brief didactic exposure, two indicating that they provided ongoing seminars, and six participants indicating that they offered regular supervised experiences in the protocol. Figure 1 provides a graphic representation of the distribution of exposure mode across the five identified EBT protocols for children with DBPs.

Survey participants were also provided with an opportunity to write in any other EBT protocols that they incorporated into their internship training program, as well as identifying their protocol exposure modes. Trauma Focused Cognitive Behavioral Therapy ([TF-CBT], Cohen, Mannarino, & Deblinger; 2006), an EBT protocol for children and adolescents designed to help reduce emotional and behavioral challenges related to experiencing traumatic life experiences, received the most support across exposure modes. Five participants reported the use of brief didactic exposure to the protocol; five reported that they provided ongoing seminars; and nine participants reported that they exposed their interns to the protocol via supervised experiences. Each of the write-in treatment protocols identified by survey participants can be found in Table 6.

The survey data identifying the different EBT protocols included in internship training experiences was broken down into the three different exposure mode categories in order to conclude which mode of training was the most frequently utilized. Of the three categories included in Table 7, survey participants identified on 102 instances that they trained their interns in EBT protocols through supervised experiences, identified on 96 instances that they trained their interns through brief didactic exposures, while there were 45 instances where participants identified that they trained their interns via ongoing seminars. Figure 2 represents the distribution of the three different modes of exposure used in internship training. Supervised experiences (42.0%) and brief didactic exposures (39.5%) accounted for more than 80% of the modes through which interns are trained in EBT protocols, while training through ongoing seminars accounted for the remaining 18.5%. These results are noteworthy such that they provide a better framework for understanding the frequency and intensity by which interns are being trained in EBT protocols utilized by their agency. For example, one may note that despite being the most frequently utilized training exposure mode, less than half of the survey participants indicated that they used supervised experiences as a manner by which to train their interns in EBT protocols.

Of the previously identified EBT protocols for DBPs, PCIT proved to be the most frequently incorporated EBT protocol regardless of exposure mode at 54.7% of the 64 survey participants, followed by Parent Management Training ([PMT], Kazdin, 1985; 40.6%), Multisystemic Therapy ([MST], Henggeler, et al. 1986; 34.4%), Problem-Solving Skills Training ([PSST], Kazdin, Esveldt-Dawson, French, & Unis, 1987; 32.8%), and IY (18.8%). Of the most frequently indicated write-in responses, 14.1% of

the participants reported using TF-CBT while 7.8% reported using Dialectical Behavioral Therapy ([DBT], Linehan, 1993), an EBT protocol developed for adolescents and adults experiencing chronic feelings of anger/emptiness and chaotic interpersonal relationships most commonly associated with borderline personality disorder ([BPD], American Psychiatric Association, 2000).

Identified EBT Protocols Determined by Agency Website Review

In an attempt to compliment the data collected via the study's survey, the principal investigator conducted a systematic review of the publicly accessible program information presented on 257 of the 285 potential survey participant's training agency websites, with 28 agency websites being excluded as the result of an inaccessible website link. While the survey results were only able to provide data from 64 of the 285 potential survey participants, the agency website review was able to provide the investigator with information pertaining to training in EBTs for each program that was accessible via the internet.

While the results in Table 8 demonstrate a variety of EBT protocols being utilized, some inconsistencies were found between the percentage of agencies explicitly endorsing on their website the use of the 5 previously identified EBTs for DBPs and the percentages reported by survey participants. In comparing the information presented in Table 9 with the information presented in Table 8, exposure to PCIT (16.3%), IY (7.4%), PMT (5.8%), MST (3.9%), and PSST (3.1%) treatment protocols were all identified at a smaller percentage rate than what was reported by survey participants. A number of other EBT protocols were also identified in the principal investigator's review, with DBT (27.6%) and Motivational Interviewing ([MI], Miller, 1983; 8.9%), an EBT protocol for

adolescents and adults designed to help motivate clients to change behaviors that have become problematic, among the most frequently identified. This noteworthy finding suggests the frequency by which training in specific EBT protocols for children with DBPs that was reported by survey participants is inconsistent with the frequency by which those same EBT protocols are advertised on an agency's website. A comprehensive list of all the EBT protocols identified in the systematic review can be found in Table 8.

Figure 3 represents the percentage breakdown of the five previously identified EBTs for DBPs utilized across agencies from the data collected via the survey, while Figure 4 represents the data collected via the systematic review of the agency websites. Of the five previously identified EBTs, PCIT consistently emerged as the EBT with the highest frequency of use, representing 30.2% of the total survey participant response data as well as 44.7% of the total agency website data.

Most Commonly Used EBT Practice Components for Youth with DBPs

Given that exposure to a specific EBT protocol may not have been considered as part of an agency's formal internship training, survey participants were also provided with an opportunity to indicate which practice components of commonly used EBT protocols for children and adolescents with DBPs were incorporated into their intern training. One of the 64 participants elected not to respond to the survey item, while the remaining 63 participants responded to the item as it was intended. Of the 15 practice components eligible to be selected, 13 of them were endorsed by over 50% of the survey participants, with praise (87.5%), goal setting (84.4%), cognitive interventions (81.3%), and parent psychoeducation (81.3%) all endorsed by over 80% of the survey participants.

Commands (42.2%) and response cost (43.8%) were endorsed by the least number of participants with the exception of the individual participant write-in responses. These results suggest that despite whether or not internship programs are providing training in specific EBT protocols, there appears to be a general consensus amongst the survey participants as to which components of treatment for children with DBPs are the most useful. The 15 practice components and four write-in responses are listed in Table 10.

Identified Advantages and Barriers to Training Interns in EBTs

Survey participants were requested to identify what advantages (if any), as well as what barriers (if any) there were to training interns in EBTs. Of the 64 participants, 76.6% indicated that training interns in EBTs resulted in better client outcomes for treatment. In addition to promoting better client outcomes, 57.8% of participants identified training in EBTs to be helpful in targeting treatments to diagnoses, while 54.7% of participants identified that training in EBTs helped to facilitate the assessment of a program's effectiveness. Sixteen survey participants were also able to identify and write in other advantages to training in EBTs. Write-in responses were categorized and listed in Table 11, with each verbatim response listed in Table 12.

In addition to the multiple advantages to training interns in EBTs endorsed by survey participants, certain barriers to EBT training for interns were also noted. Over 50% of participants identified a lack of qualified supervisors to conduct the EBT training (56.3%) as a frequently encountered barrier. An endorsement rate of this magnitude will help to provide a framework for the discussion on why training in EBT protocols is not a more universally accepted practice for agencies and their treatment providers. Participants also recognized a lack of funding (32.8%) and time constraints (26.6%) as

other barriers to training interns in EBTs. Sixteen survey participants also identified and wrote in other barriers to training in EBTs. Write-in responses were categorized and listed in Table 13, with each verbatim response listed in Table 14.

On each of the survey items pertaining to either advantages or barriers to training interns in EBTs, participants were given the opportunity to select one or more response to each item. Table 15 shows that out of the 282 combined total response selections, 57.8% of the responses were recognized advantages to training in EBTs, while 42.2% of the responses were recognized barriers. Overall, 11 of the survey participants identified only advantages to training interns in EBTs, 4 participants identified only barriers, while the remaining 49 participants were able to identify at least one advantage and at least one barrier to training interns in EBTs. The most frequently endorsed advantages of promoting better client outcomes, targeting treatments to diagnoses, and helping to facilitate treatment progress, as well as the frequently identified barriers of a lack of qualified supervisors, a lack of funding, and time constraints are consistent with research findings from Norcross, Beutler, and Levant (2006) that center around the EBP debate.

Current and Future Plans for Incorporating Training in EBTs

Survey participants were asked, “If your program does not currently provide training in EBTs, do you have plans to do so in the future?” Table 16 shows that of the 64 survey participants, 34 of them did not provide a response to this survey item. Of the remaining participants, 21 indicated that they were currently in the process of providing training in EBTs, five indicated that they had no future plans of providing EBT training, while the remaining four participants indicated that they had future plans of doing so. Given that 34 survey participants did not provide a response to the item, further analysis

of the data was required to provide a better understanding of the status of training in EBTs. The principal investigator reviewed the participants' surveys for information that would help to offset the large number of non-responses to the survey item inquiring about an agency's plans for providing training in EBTs. Table 17 shows that 14 of the 34 participants who did not respond to the item had already identified that they incorporated training in at least one of the five previously identified EBTs for DBPs. Another 13 participants who had not responded already identified that they incorporated training in at least one of the five previously identified EBTs for DBPs, as well as at least 1 other EBT. Five of the participants who did not respond to the item pertaining to their plans for providing training in EBTs had already identified that they were training in at least one other EBT, while the remaining two participants gave no indication of providing training in EBTs. Overall, of the 34 participants who did not respond to the item pertaining to future plans for providing training in EBTs, 32 of them had already identified that training in an EBT protocol was a part of their agency's internship training program. Given such data findings, one could presume that participants elected not to respond to this item because they had already indicated that they were training their interns in at least one EBT protocol. A graphic representation of the survey participants' responses to items regarding current and future plans for training interns in EBTs can be found in Figure 5.

Through summating the data totals provided in Table 14, along with reviewing the 257 accessible agency websites, the principal investigator was better able to identify the extent to which training and practice in child and adolescent-focused EBT protocols are currently being incorporated into child and adolescent treatment agencies across the

country. Data from Table 18 shows that of the 64 participants who responded to the current survey, 87.5% indicated that their agency was currently incorporating EBTs in their training practices. In addition to this finding, Table 19 shows that the systematic review of each agency website found evidence of the incorporation of EBTs in clinical practices on 81.7% of the 257 websites.

Feedback from Survey Participants about EBTs

Upon completing the forced choice items, participants were provided with the opportunity to offer any additional comments they had regarding their attitudes towards EBTs, as well as their experiences with training and implementing EBTs into their agency practices. The 21 write-in responses were reviewed for consistencies found within the primary contents of each response. A number of participants responded to this item by further acknowledging the advantages and barriers of training and practice in EBTs. Multiple responses included a primarily supportive view of EBTs, with participants noting how EBTs were "central to service and training," and that EBTs were "becoming the standard of care." Some responses reinforced previously held positions about how EBT models "can sometimes be inflexible," and that "cost is the greatest barrier to implementation" of EBT protocols. A complete listing of the survey responses can be found in Table 20.

Discussion

This study examined the extent to which evidence-based treatments (EBTs) for children and adolescents with disruptive behavior problems (DBPs) are being incorporated into child and adolescent-focused clinical psychology internship training programs across the United States. The intent of the study was to expand upon previous research findings which reflected a movement towards extending the training of current and future clinicians to include EBTs. The research results were consistent with previous findings that supported placing a greater emphasis on training early career clinicians in EBT protocols, although the availability and adequacy of exposure methods to such EBT-focused trainings continues to be questioned.

Current study information gathered from the survey data and website review indicated that the vast majority of child and adolescent focused, predoctoral internship programs are currently incorporating EBTs into their clinical training practices in some capacity. A wide variety of child and adolescent-focused EBT protocols were identified by survey participants in addition to those found upon review of the accessible agency websites. Feedback from survey participants indicated that the majority of EBT training was being done via brief didactic exposures and supervised experiences, with multiple participants indicating that they elected to train their interns in EBT principles and components as opposed to training in formal treatment protocols. These findings helped to reinforce the general consensus of mental health clinicians from the James and Roberts (2009) study which predicted that training and practice in EBTs would continue to play a more integral role in the treatment of children and adolescents for years to come. Although, it should be noted that while participants from the previous study had predicted

a greater dissemination of specialty training in specific EBT protocols to be made available to trainees and practicing professionals, over half of the current study participants reported that a lack of qualified supervisors made the provision of formal training to interns in EBT protocols difficult. One of the current survey participants wrote, "Most if not all supervisors lack specific knowledge/training/ongoing practice of any specific model, therefore, the tendency is to teach via therapeutic 'principles' rather than EBTs," while a number of other participant responses also indicated providing training in evidence-based principles as opposed to their specific protocols. In considering the frequently identified barrier of a lack of qualified supervisors to provide EBT training, coupled with the multiple survey participant responses that emphasized training in evidence-based principles as opposed to formal protocols, one may question the extent to which formal EBT protocols for children and adolescents are being trained and administered as they were intended.

The extent to which EBT protocols are incorporated into agency training programs was further called into question after comparing the data gathered from the current study's survey with the data gathered from the principal investigator's systematic review of the agency websites. Of the five previously identified EBTs developed specifically for children with DBPs, a noticeably larger percentage of survey participants self-reported that they provided exposure to the identified EBTs when placed in comparison to what was found in the review of agency websites. While it could be posited that the systematic review of websites was incomplete in its attempt at providing an accurate portrayal of an agency's training methods or the extent of its training practices, the discrepancies found could also further indicate the tendency for directors of

clinical training programs to incorporate evidence-based principles as opposed to formal EBT protocols.

A recent study by Southam-Gerow, Rodríguez, Chorpita, and Daleiden (2012) suggested different ways to address concerns similar to those previously mentioned in this study. Specifically, the researchers noted how professional psychologists who represent a system of treatment could consider implementing quality and performance measurement tools for their team of service providers in an attempt to hold that system accountable for the provision of effective treatment-specifically EBTs which require some degree of fidelity to a specific treatment model. The researchers further suggest how a professional psychologist with a firm understanding of both the direct clinical services provided and the administrative and organizational factors of the system structure can be a strong asset in guiding and designing the implementation of EBT training and practices within that system (Southam-Gerow et al., 2012).

In addition to surveying training directors and program representatives about training in formal EBT protocols, the study also examined which EBT practice components were most frequently utilized in treating children with DBPs. The findings from this section of the survey were some of the more robust of the overall study, in that 13 of the 15 identified practice components of EBT protocols for children with DBPs were each endorsed by over half of training directors and program representatives who participated in the study. Delivering praise, setting goals, utilizing cognitive interventions, and providing psychoeducation to parents were among the most frequently trained EBT practice components recognized by survey participants. These results replicated the findings from a study conducted by Garland et al. (2008) which identified

principles of positive reinforcement, setting goals and reviewing progress, and providing relevant psychoeducation as some of the primary therapeutic components of treatment strategies for DBPs. The consistency amongst EBT treatment practice components for DBPs demonstrated over the years is promising, such that child and adolescent practitioners appear to be moving towards a general consensus as to which elements of treatment for children are the most useful in reducing disruptive behaviors.

Another factor to consider in trying to determine the extent to which training in EBTs is provided to predoctoral interns is to examine the exposure mode through which the training is provided. In the current study, survey participants were given the opportunity to identify whether training in the EBTs incorporated by their site was offered through brief didactic exposures, ongoing seminars, and/or supervised experiences. Results indicated that both training in supervised experiences and training in brief didactic exposures far outweighed training in ongoing seminars by a ratio of approximately 2:1. It was also noted though that despite being the most frequently endorsed exposure mode at 42%, less than half of the training program directors and program representatives in the study indicated that they used supervised experiences as a method by which to train their interns in EBT protocols. When taking this into consideration with the survey participants' frequently endorsed barrier of a lack of qualified supervisors to provide EBT training, the degree and frequency by which interns are being monitored in their provision of EBTs to clients becomes more questionable. Even fewer program directors and representatives reported providing their interns with EBT training via ongoing seminar, which could also suggest the potential for interns to primarily receive one-time training exposures and supervised experiences without the

periodic booster sessions to supplement the training as many protocols require. Although, it should also be noted that the current findings are hopeful such that previous study results indicated that the majority of clinical training programs did not require any formal training exposure to EBTs through didactics or clinical supervised experiences (Weissman et al., 2006).

The current study was able to extend the previous research on training in EBTs by allowing participants to expand upon how they considered training in EBTs to be advantageous for both clients as well as trainees, while also citing specific barriers that they felt needed to be resolved before training interns in EBTs could become a more universally accepted practice. The majority of survey participants agreed that training interns in EBTs would help target treatments to diagnoses and ultimately lead to better client outcomes. Although, survey data also reflected that nearly one-quarter of the survey participants refrained from selecting "better client outcomes" as a critical advantage to training interns in EBTs. Such a finding suggests that a significant percentage of the participant population may not consider EBTs to be more suitable for reducing a client's clinical symptoms, despite the breadth of research findings that suggest otherwise.

A finding such as this warranted a serious consideration of the number of barriers to training interns in EBT protocols as identified by the survey participants. Current participants identified a lack of general cultural appropriateness and inflexibility in the EBT model as barriers to training interns in EBT, which reinforced the position held by Addis, et al. (1999) who criticized manualized treatment protocols for their restrictions on the flexibility and innovation in clinical practice. A recent study by Jackson et al. (2010,

p. 80) noted that, as the field of child and adolescent treatment attempts to move towards closing the gap between scientific research and clinical practice, the ever-increasing population of children from different ethnic backgrounds living in the United States warrants a greater emphasis on child and adolescent practitioners to better understand "the unique and distinctive risks and skills that are common to children from different ethnic backgrounds." When taking this into consideration with the current research, it becomes more apparent that if such issues are not better addressed in the development and training of EBT protocols, the gap between research and practice may soon widen before moving any closer.

In addition to the previously identified barrier of a lack of qualified supervisors to provide EBT training, the current study participants also expressed concerns related to a lack of available funding or financial reimbursement for formalized treatment methods, concerns that have been expressed time and again in previous research studies (Duncan, 2002; Fensterheim & Raw, 1996; Goldfried & Wolfe, 1996). In reviewing the online websites devoted specifically to the 5 previously identified EBT protocols, the cost of training certification and the purchase of treatment manuals and practice materials appeared to demonstrate some correlation with the frequency by which each protocol was endorsed by survey participants. For example, PCIT, the treatment protocol most frequency cited by survey participants as being part of their training curriculum, provides training manuals and treatment practice materials at a purchase rate that is relatively more affordable when placed in comparison to the cost of training manuals and treatment practice materials for an EBT such as IY, a treatment protocol less frequently endorsed by survey participants ("PCIT International," 2012; "The Incredible Years," 2012). In

addition to the cost of purchasing the manuals and practice materials, the cost to either become a credentialed trainer or to hire a credentialed trainer to conduct an agency-wide training in any of the five identified protocols was shown to sometimes amount to over thousands of dollars. This helps to reinforce the position of those survey participants who noted that one of the greatest barriers to training interns in a specific EBT protocol was the lack of supervisors who were qualified to conduct the training. The study conducted by Southam-Gerow et al. (2012) reinforces some of these barriers by identifying how the implementation of EBT protocols into an agency model can be inhibited by the cost and the extent of training and supervision that is required for a particular EBT protocol. As the researchers stated,

> If multiple EBT models have different supervision requirements, tough decisions about balancing model adherence, productivity, and financial benefit may be required; these are exactly the sorts of decisions that professional psychologists will face as the clinical director, for example, of an agency attempting to implement an EBT. (Southam-Gerow et al., 2012, p. 5).

Overall, there were a number of both advantages and barriers to training interns in EBTs identified by the current survey participants, with a slightly greater consensus amongst participants identifying advantages to training interns in EBT protocols, both in terms of the volume of advantage responses as well as a greater degree of consensus amongst the advantages listed in the survey. As well, despite the number of barriers identified by survey participants, nearly 90% of the participant population indicated that their agency was currently incorporating EBTs into their internship training programs. This suggests a strong commitment on behalf of agencies and their training directors to

implement and disseminate EBT protocols in child and adolescent-focused clinical practice. While four survey participants refrained from identifying any advantages to training interns in EBTs, the remainder of survey participants was able to identify at least one (and often more than one) advantage to the practice. And while the support for EBT training and implementation persists, it would be of future interest to better understand the position of those training directors and program representatives who oversee a child and adolescent-focused training program but refrain from supporting the movement towards EBT in clinical research and practice. Future studies would also benefit from identifying ways by which to address the barriers of a lack of qualified supervisors for EBT training, the financial and timing costs of training and implementation of an EBT protocol, as well as the clinical and cultural appropriateness of an EBT protocol as the field moves towards making EBT a more universally accepted treatment practice.

Limitations and Other Directions for Future Research

The first identified limitation of the current study was the small sample size. While a thorough web review of nearly all the total child and adolescent internship sites initially identified was conducted to help compensate for the modest response rate, it is uncertain as to whether or not the review fully accounted for if and to what extent EBTs for children with DBPs were incorporated into each site's internship training program.

The small sample size may be due in part to the inability to contact participants directly. It was not known whether a survey packet reached its intended clinical training director or appropriate program representative, as the research procedure did not include obtaining confirmation of receipt in an effort to protect each participant's anonymity. The timing of subject recruitment also may have contributed to the small sample size. Both the first and second recruitment emails received a number of "out of office"

autoreply emails, thus the survey packet and subsequent reminders may have been overlooked upon the training director's return.

A second limitation relates to survey nonresponses. The difference between training directors and program representatives who decided to respond to the survey as opposed to those who did not may be correlated with the EBT subject content of the survey. As it was previously indicated, a debate over the research and implementation of EBTs continues to ensue within the field of applied clinical psychology. Training directors who advocate for the use of EBTs within their training programs may have been more likely to respond to a survey involving this topic, while those who are not in support of the implementation of EBTs may have chosen not to participate. Furthermore, the response sample is representative of predominantly Caucasian clinical training directors from community mental health agencies who completed their formal doctoral training over 10 years ago. A more diverse demographic sample may have provided different results, particularly given that evidence-based research and practice is a relatively modern concept of study, and EBT protocols have been highly scrutinized for their suggested lack of appropriateness with ethnic minority populations (Bernal & Scharro-del-Rio, 2001; Ho, McCabe, Yeh, & Lau, 2010).

Another limitation is related to the design of the survey instrument itself, specifically the item that assessed for future plans of incorporating training in EBTs (see Appendix B; survey item #11). Over half of the survey participants refrained from responding to this item, indicating that the item may be non-applicable or that it lacked a response category which would best represent their agency's current and/or future plans for training in EBTs. While it was determined that the majority of those participants

were already providing their interns with training in at least one EBT protocol and would likely continue to do so in the future, later studies incorporating the current research method may choose to divide this item into two parts; one part that asks directly whether or not a participant's training program currently provides EBT training, and a second part that asks if that program intends to provide EBT training in the future.

Other limitations relate to the research design and methodology. This study incorporated self-report methods that pertained to an agency's training program and design, which may lead to a social desirability bias or response set (Mitchell & Jolley, 2007), while also relying partially on a participant's capacity to present an objective representation of their training program design. With survey data being collected via USPS mail, the investigator was unable to control for whether or not the survey reached the recipient for which it was intended. In terms of the systematic review of the agency websites and training program designs, the investigator was able to collect data only on the EBT protocols that were explicitly stated on the agency website's and/or within a training program's handbook, with little to no knowledge of the depth of an intern's exposure to the EBTs identified. Future studies may wish to conduct a more in-depth analysis of an agency's website and online training handbook, as well as to utilize both USPS mail as well as web-based distributions of surveys as a way to help ensure they reach their intended recipients and ultimately increase the response rate.

Conclusion

The movement towards evidence-based practices in psychology (EBPP) has been the subject of a considerable amount of research, specifically within the past decade. Task forces as well as special interest groups and practicing researchers and clinicians have established the necessity for implementing EBPP into everyday treatment, although few studies have examined the frequency and extent to which new clinicians are being exposed to specific EBTs for children and adolescents as a part of their training experience. This study was important in that it helped to shed light on this issue by surveying first-hand the directors and program representatives of child and adolescent-focused agencies that provide formal training opportunities for predoctoral interns in the field of applied clinical psychology. Findings from the 64 clinical training directors and program representatives suggest that training for young clinicians in EBTs has continued to become a more recognizable and expected practice for clinical training programs across the country; although questions continue to persist related to the depth of EBT training that predoctoral interns receive, the availability of funding for EBT training and practice, as well as the real-world applicability and appropriateness of manualized treatment interventions developed under specific research conditions. Future research studies may want to look specifically at the current findings which identified a lack of qualified supervisors as the greatest barrier to training predoctoral interns in EBT protocols, as well as taking a closer look at the personal attitudes of training directors and service providers towards the training and implementation of EBTs to examine how they may influence an agency's clinical practices and program design. These findings help to contribute to the larger body of literature on research, training, and practice in EBTs.

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Table 1

Survey Participant Demographics (N=64)

Characteristic	*n*	%
Gender		
Female	39	60.9
Male	25	39.1
Racial/ethnic identification		
American Indian/Alaskan Native	0	0.0
Asian or Pacific Islander	2	3.1
African American	0	0.0
Hispanic	2	3.1
Caucasian	57	89.1
American Indian/Alaskan Native and Caucasian (selected both)	1	1.6
Other[a]		
Hispanic/Caucasian	1	1.6
Multi	1	1.6
Training program position		
Director of Clinical Training	52	81.3
Specialized Program Director (i.e. Early Intervention and Wellness Services)	1	1.6
Other[b]		
Associate Director	1	1.6
Director of Internship Training, Primary Therapist	1	1.6
Director of Quality Review and Training	1	1.6
Training Director	3	4.7
Division Director, Training	1	1.6
Internship Director	4	6.3
Year doctoral degree was obtained		
Prior to 2002	53	82.8
2002 or later	11	17.2

[a,b]Category includes verbatim responses.

Table 2

Internship Training Site Settings Reported by Survey Participants (N=64)

Setting Type	*n*	%
Community mental health center	20	31.3
Child/adolescent psychiatric or pediatric clinic	5	7.8
Private outpatient clinic	5	7.8
Medical school	4	6.3
Consortium	5	7.8
Hospital	11	17.2
Medical school/Consortium (checked both)	2	3.1
Child/adolescent psychiatric or pediatric clinic/Private outpatient clinic/Consortium (checked all three)	1	1.6
Other[a]		
Jail/Forensic Setting	1	1.6
Medical Center	2	3.1
Non-profit Agency	3	4.7
Residential Treatment Facility	2	3.1
School/University Setting	3	4.7

[a]Category combines verbatim responses involving similar response components.

Table 3

Write-In Responses to Internship Training Site Settings Identified by Survey Participants

Setting Type Category	Response[a]
Jail/Forensic Setting	1. Jail/forensic Outpatient
Medical Center	1. Medical Center 2. HMO
Non-profit Agency	1. Nonprofit 2. Non-profit Mental Health Agency 3. Multi-service non-profit mental health agency
Residential Treatment Facility	1. Residential treatment w/ 28 bed psychiatric residential treatment facility (PRIF) + Outpatient/aftercare 2. Residential Care
School/University Setting	1. School 2. Public school district 3. University outpatient clinic-psychological and educational

[a]Category includes verbatim responses.

Table 4

Total Percentage of Children or Adolescents Treated by Setting as Reported by Survey Participants (N=64)

Percentage	*n*	*%*
Less than 25%	4	6.25
26-50%	16	25.0
51-75%	13	20.3
76-100%	31	48.4

Table 5

Survey Participants' Reported Frequency by Exposure Mode of Training Sites Using Identified Evidence-Based Treatment (EBT) Protocols for Children with Disruptive Behavior Problems (DBPs)

Treatment	Brief Didactic Exposure	Ongoing Seminar	Supervised Experiences
The Incredible Years (IY) Programs (Webster-Stratton, 1984)	8	2	6
Parent Child Interaction Therapy (PCIT) (Eyberg, 1988)	24	7	17
Multisystemic Therapy (MST) (Henggeler, Rodick, Borduin, Hanson, Watson, & Urey, 1986)	16	3	7
Problem-Solving Skills Training (PSST) (Kazdin, Esveldt-Dawson, French, & Unis, 1987)	15	3	11
Parent Management Training (PMT) (Kazdin, 1985)	15	6	17

Table 6

Frequency by Exposure Mode of Training Sites Using Other EBT Protocols Identified by Survey Participants

Treatment	Brief Didactic Exposure	Ongoing Seminar	Supervised Experiences
Aggression Replacement Therapy (ART)	1		1
Barkley		1	1
Behavioral Parent Training			1
Bloomquist, M.L. (2006). Skills training for children with behavior problems: A parent and practitioner guidebook (revised). NY: Guilford Press		2	1
CBT-Exposure Response Prevention	1	1	1
Child Parent Psychotherapy/CPP	1	3	3
ChildFirst		1	1

Note. The exposure modes for responses identifying the same EBT protocol were combined under one protocol.

(continued)

Treatment	Brief Didactic Exposure	Ongoing Seminar	Supervised Experiences
Collaborative Problem Solving (Greene)	1	1	1
Coping Cat	2	1	4
DBT		2	3
Developmental Teaching Objectives Rating Form-Revised (DTORF-R)		1	1
Family Therapy-Strategic		1	1
Functional Family Therapy		1	1
HNC	1		1
Magic 123 (Phelan)	1		1
Managing and Adapting Program (MAP)		1	1
MDFT		1	1

Note. The exposure modes for responses identifying the same EBT protocol were combined under one protocol.

(continued)

Treatment	Brief Didactic Exposure	Ongoing Seminar	Supervised Experiences
Mindset Crisis Prevention Intervention	1		1
Multimodal Therapy (The Columbia Model)			1
Nurturing Parenting			1
Pathways-sexually maladaptive youth			1
Powersource-group			1
Seeking Safety (teen)			1
SFBFT		1	1
STEP-Parent Training			1
TADS	1		1
Trauma Focused CBT/TF-CBT	5	5	9
Triple P	2	1	2

Note. The exposure modes for responses identifying the same EBT protocol were combined under one protocol.

Table 7

Frequency of Exposure Modes to EBT Protocols Reported by Survey Participants

Mode	*n*	%
Brief Didactic Exposure	96	39.5
Ongoing Seminar	45	18.5
Supervised Experiences	102	42.0

Note. Final totals include data collected from previously identified EBT protocols for children with disruptive behavior problems (DBPs) as well as Other write-in responses to survey item #5.

Table 8

Survey Participants' Identified Use of EBT Protocols Without Specification of Exposure Mode (N=64)

Treatment	*n*	%
The Incredible Years (IY) Programs (Webster-Stratton, 1984)	12	18.8
Parent Child Interaction Therapy (PCIT) (Eyberg, 1988)	35	54.7
Multisystemic Therapy (MST) (Henggeler, Rodick, Borduin, Hanson, Watson, & Urey, 1986)	22	34.4
Problem-Solving Skills Training (PSST) (Kazdin, Esveldt-Dawson, French, & Unis, 1987)	21	32.8
Parent Management Training (PMT) (Kazdin, 1985)	26	40.6
Other		
Aggression Replacement Therapy (ART)	2	3.1
Barkley	1	1.6
Behavioral Parent Training	1	1.6
Bloomquist, M.L. (2006). Skills training for children with behavior problems: A parent and practitioner guidebook	2	3.1
CBT Exposure Response Prevention	1	1.6
Child Parent Psychotherapy/CPP	3	4.7
ChildFirst	1	1.6
Collaborative Problem Solving (Greene)	3	4.7
Coping Cat	4	6.3
DBT	5	7.8
Developmental Teaching Objectives Rating Form-Revised (DTORF-R)	1	1.6
Family Therapy-Strategic	1	1.6
Functional Family Therapy	1	1.6
Habit Reversal	1	1.6
HNC	1	1.6
Magic 123 (Phelan)	1	1.6
Managing and Adapting Program (MAP)	2	3.1
MDFT	1	1.6
Mindset Crisis Prevention Intervention	1	1.6
Multimodal Therapy (The Columbia Model)	1	1.6
Nurturing Parenting	1	1.6
Pathways-sexually maladaptive youth	1	1.6
Powersource-group	1	1.6
Seeking Safety (teen)	1	1.6

(continued)

Treatment	*n*	%
Other		
SFBFT	1	1.6
STEP-Parent Training	1	1.6
TADS	1	1.6
Trauma Focused CBT/TF-CBT	9	14.1
Triple P	3	4.7

Table 9

Specific EBT Protocols Indicated on Agency Websites (N=257)

Treatment	*n*	%
The Incredible Years (IY) Programs (Webster-Stratton, 1984)	19	7.4
Parent Child Interaction Therapy (PCIT) (Eyberg, 1988)	42	16.3
Multisystemic Therapy (MST) (Henggeler, Rodick, Borduin, Hanson, Watson, & Urey, 1986)	10	3.9
Problem-Solving Skills Training (PSST) (Kazdin, Esveldt-Dawson, French, & Unis, 1987)	8	3.1
Parent Management Training (PMT) (Kazdin, 1985)	15	5.8
Other		
Acceptance and Commitment Therapy (ACT)	12	4.7
Active Parenting	1	0.4
Aggression Replacement Training (ART)	4	1.6
Applied Behavioral Analysis (ABA)	15	5.8
Assertive Community Treatment (ACT)	9	3.5
Attachment Based Family Therapy (ABFT)	1	0.4
Behavior Activation Therapy (BAT)	3	1.2
Behavior Management Therapy (BMT)	1	0.4
Behavioral Couples Therapy (BCT)	2	0.8
Behavioral Interventions for Anxiety in Children with Autism (BIACA)	1	0.4
Brief Psychodynamic Therapy (BPT)	2	0.8
Brief Strategic Family Therapy (BSFT)	1	0.4
Child and Family Focused Cognitive Behavioral Therapy (CFF-CBT)	1	0.4
Child Parent Psychotherapy (CPP)	8	3.1
Cognitive Behavioral Analysis System Psychotherapy (CBASP)	1	0.4
Cognitive Processing Therapy (CPT)	10	3.9
Cognitive Remediation Treatment (CRT)	1	0.4
Collaborative Problem Solving (CPS)	1	0.4
Community Reinforcement and Family Training (CRFT)	1	0.4
Coping Cat	2	0.8
Coping Power	1	0.4
Crisis Oriented Recovery System (CORS)	1	0.4

(continued)

Treatment	*n*	%
Other		
Dialectical Behavioral Therapy (DBT)	71	27.6
Emotion Focused Couples Therapy (EFCT)	3	1.2
Exposure and Response Prevention (ERP)	6	2.3
Eye Movement Desensitization and Reprocessing (EMDR)	12	4.7
Family Based Therapy (FBT)	2	0.8
Family Focused Therapy (FFT)	5	1.9
Functional Analytic Psychotherapy (FAP)	1	0.4
Habit Reversal Training (HRT)	1	0.4
Harm Reduction Therapy (HRT)	1	0.4
Illness Management and Recovery (IMR)	2	0.8
Integrated Dual Diagnosis Treatment (IDDT)	1	0.4
Interactive Group Therapy (IGT)	1	0.4
Interpersonal Therapy (IPT)	11	4.3
LEGO Therapy	1	0.4
Life Space Crisis Intervention (LSCI)	2	0.8
Maudsley Approach	2	0.8
Mentalization Based Therapy (MBT)	1	0.4
Mindfulness Based Cognitive Therapy (MBCT)	2	0.8
Mindfulness Based Stress Reduction (MBSR)	1	0.4
Model Approach to Partnerships in Parenting (MAPP)	1	0.4
Motivational Enhancement Therapy-CBT (MET-CBT)	1	0.4
Motivational Interviewing (MI)	23	8.9
Multiple Dimensional Family Therapy (MDFT)	3	1.2
Narrative Therapy	6	2.3
People Empowering People (PEP)	1	0.4
Picture Exchange Communication System (PECS)	1	0.4
Pivotal Response Therapy (PRT)	1	0.4
Positive Behavior Support (PST)	1	0.4
Positive Parenting Program (Triple P)	4	1.6
Prevention and Relationship Enhancement Program (PREP)	1	0.4
Professional Assault Crisis Training (Pro-ACT)	2	0.8
Prolonged Exposure Therapy (PET)	7	2.7

(continued)

Treatment	*n*	%
Other		
Psychological First Aid (PFA)	1	0.4
Rational Emotive Behavior Therapy (REBT)	4	1.6
Relapse Prevention Therapy (RPT)	1	0.4
Relational Re-Enactment Systems Approach to Treatment (REStArT)	1	0.4
Seeking Safety	10	3.9
Self-Regulation Model	1	0.4
Short Term Psychodynamic Therapy for Depression	1	0.4
Skills Training in Affective and Interpersonal Regulation (STAIR)	1	0.4
`Social Communication, Emotional Regulation, Transactional Support (SCERTS)	1	0.4
Solution-Focused Therapy (SFT)	13	5.1
Stop Now and Plan (SNAP)	1	0.4
Structural Family Therapy (SFT)	6	2.3
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	1	0.4
Systematic Training for Effective Parenting (STEP)	1	0.4
Therapeutic Crisis Intervention (TCI)	1	0.4
Transference Focused Therapy (TFT)	1	0.4
Trauma Affect Regulation: Guide for Education and Therapy (TARGET)	1	0.4
Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)	38	14.8
Trauma Recovery and Empowerment Model (TREM)	1	0.4
Trauma Systems Therapy (TST)	3	1.2
Treating Adolescents Coping with Trauma (TACT)	1	0.4
Treatment and Education of Autistic and Related Communication-Handicapped Children (TEACCH)	1	0.4
Wellness Recovery Action Plan (WRAP)	1	0.4

Table 10

Survey Participants' Identified EBT Practice Components Utilized in Training of Interns

Practice Component	*n*	%
Praise	56	87.5
Commands	27	42.2
Monitoring	40	62.5
Time out	45	70.3
Goal setting	54	84.4
Differential reinforcement of behavior	35	54.7
Cognitive interventions	52	81.3
Modeling	48	75.0
Tangible rewards	41	64.1
Response cost	28	43.8
Therapist praise/rewards	41	64.1
Problem solving	51	79.7
Social skills training	51	79.7
Communication skills	49	76.6
Psychoeducational parent	52	81.3
Other[a]		
Alcohol and drug counseling	1	1.6
Support, insight, reflection	1	1.6
Role Play	1	1.6
Instructions	1	1.6
School based interventions	1	1.6

Note. One respondent indicated, "Question is not clear," and chose not to select any items.
[a]Category includes verbatim responses.

Table 11

Survey Participants' Identified Advantages to Training Interns in EBTs

Advantage	*n*	%
Better client outcomes	49	76.6
Ease of training	26	40.6
Targeted to diagnoses	37	57.8
Facilitates assessment of program effectiveness	35	54.7
Other[a]		
Allows for continuity of care	1	1.6
Applies theory	1	1.6
Empowers client to change	1	1.6
Ensures funding for treatment	1	1.6
Ensures treatment effectiveness	1	1.6
Helps guide clinician through treatment process	6	9.4
Provides clinician with treatment tools	3	4.7
Specific treatment goals are identified	2	3.1

[a]Category combines verbatim responses involving similar response components.

Table 12

Survey Participant's Write-In Advantages to Training Interns in EBTs

Advantage Category	Response[a]
Allows for continuity of care	1. If client moves from our setting (ip/residential) to another (op clinic) in agency, there is continuity of service and treatment
Applies theory	1. Links theory to practice
Empowers client to change	1. Proven effectiveness can empower client change process
Ensures funding for treatment	1. Only interventions that you can get funding for
Ensures treatment effectiveness	1. It works
Helps guide clinician through treatment process	1. Help beginning therapists know how to behave in providing treatment 2. Structured treatment 3. When able to articulate what working on with family and others 4. Ability to track progress 5. Interns learn about best practices and provide structure for tx 6. Facilitates assessment of clinician/trainee effectiveness
Provides clinician with treatment tools	1. Tools to utilize 2. Puts more "tools" in their toolboxes 3. Important tools for any well rounded child-clinical practitioner to know
Specific treatment goals are identified	1. Focused goals 2. Specificity of goals

[a]Category includes verbatim responses.

Table 13

Survey Participants' Identified Barriers to Training Interns in EBTs

Barrier	*n*	%
Too time-consuming	17	26.6
Funds unavailable	21	32.8
Do not have qualified supervisors	26	56.3
Too difficult to teach	4	6.3
Not culturally appropriate	10	15.6
Does not work in clinical practice	14	21.9
Lack of trainee interest	5	7.8
Lack of support of EBTs by clinical supervisors	6	9.4
Other[a]		
Billing/reimbursement challenges	2	3.1
Lack of access to resources	1	1.6
Lack of adherence to treatment protocol	2	3.1
Lack of administrative support	1	1.6
Lacks general appropriateness/flexibility	7	10.9
Staff turnover	3	4.7

[a]Category combines verbatim responses involving similar response components.

Table 14

Survey Participant's Write-In Barriers to Training Interns in EBTs

Barrier Category	Response[a]
Billing/reimbursement challenges	1. Insurance reimbursement is a hassle: 1) for group interventions; 2) for using unlicensed interns in providing care 2. At times we have too many EBTs we are following and then OMH mandates a new one to be used
Lack of access to resources	1. Resources/space (e.g. rooms with 1-way mirrors in some clinics)
Lack of adherence to treatment protocol	1. Lack of consistency at home setting makes it difficult to see progress 2. Resistance to change from comfort zone
Lack of administrative support	1. Lack of support by non-clinical supervisors (administrative faculty)
Lacks general appropriateness/flexibility	1. Not always appropriate-see John Norcross research 2. Not always appropriate in manualized form for working with young children. Needs adaptations, especially in bringing in play 3. Complex cases and multiple diagnoses often create difficulty implementing EBTs and fidelity; so we have to adapt interventions 4. You have to narrow client base to exclude children with really complex co-morbidities in order for trainers to see benefit (experienced practitioners can integrate EBTs in treatment of clients who typically present to tertiary care clinic) 5. Interns are trained in grad school but the direct clinical work is messy; people have complex and ever changing issues

(continued)

Barrier Category	Response[a]
Lack of general appropriateness/flexibility	6. Often is just a “package” of techniques already being done/known and can make sure everyone knows them leads to disappointments as often not conceptually based, have to modify so much 7. Unable to teach hidden common factors that make real differences
Staff turnover	1. Staff turnover is also a large issue/barrier to EBP training 2. Hard to reach “Train the Trainer” status, then staff leave. Expensive to train new staff. Also need ongoing training to update skills 3. Staff changes and so supervisor expertise changes

[a]Category includes verbatim responses.

Table 15

Total Combined Advantages and Barriers to Training Interns in EBTs Identified by Survey Participants

Category	*n*	%
Advantages	163	57.8
Barriers	119	42.2
Total	282	

Note. In survey item #9, "What do you see as advantages (if any) to training interns in EBTs?" and survey item #10, "What do you see as disadvantages (if any) to training interns in EBTs?" participants were given the option to select one or more responses per item. Category totals were determined by summating all the responses from each item.

Table 16

Survey Participants' Responses to Future Plans for Providing Training in EBTs (N=64)

Response	*n*	%
Yes	4	6.3
Currently in the process of doing so	21	32.8
No	5	7.8
Did not respond	34	53.1

Note. Survey item #11 pertaining to this table asked participants: "If your program does not currently provide training in EBTs, do you have plans to do so in the future?" Given that the majority of study participants elected not to respond, the principal investigator questioned the validity of this item and its response data.

Table 17

Secondary Analysis of Survey Participants' Responses to Future Plans for Providing Training in EBTs Combined with Data Extracted From Survey Item #7

	Possible Combinations of Responses from Survey Item #7			
Response	Identified EBT	Other EBT	Identified EBT + Other	No EBT
Yes	2	0	2	0
Currently in the process of doing so	7	0	12	2
No	1	0	0	4
Did not respond	14	5	13	2
Total	24	5	27	8

Note. Survey item #7 reads: "The following list presents some EBTs for children and/or adolescents with disruptive behavior problems. Please indicate the EBTs in which you offer training; check all that apply and indicate whether the EBT is: Covered as a Brief Didactic Exposure, an Ongoing Seminar, or consists of Supervised Experiences." Identified EBT= Previously identified EBT protocols for children with DBPs included in survey item #7; Other EBT= EBT protocols identified by survey participants in Survey Item #7.

Table 18

Survey Participants Indicating the Incorporation of EBTs in Their Training Practices (N=64)

Conclusion	*n*	%
Yes, survey participant is currently incorporating EBTs	56	87.5
No, survey participant is not currently incorporating EBTs	8	12.5

Note. Principal investigator inferred conclusions by summing the totals from Table 14.

Table 19

Results from Review of Websites Indicating the Incorporation of EBTs in Agency Practices (N=257)

Conclusion	*n*	%
Yes, review of website indicated incorporation of EBTs	210	81.7
No, review of website did not indicate incorporation of EBTs	47	18.3

Note. Of the 285 agencies in the original population pool, 28 agencies either did not list a website address, listed a website address with a broken hyperlink, or their agency was no longer listed in the APPIC database. These agencies were excluded from the review, resulting in a final sample of 257 agencies. Principal investigator inferred conclusions from a systematic review of each agency website, their online predoctoral internship training program description, and their online predoctoral internship training program handbook (if available).

Table 20

Survey Participants' Reported Attitudes and Experiences Regarding Training in EBTs

Response[a]	Primary Contents
1. Training supervisors (not clinicians) has been the hardest for us, as they typically believe they already know enough.	challenges of cooperation with training supervisors
2. Training in EBTs is best practices. Most if not all supervisors lack specific knowledge/training/ongoing practice of any specific model, therefore, the tendency is to teach via therapeutic "principles" rather than EBTs.	training in EBTs best practices, supervisors lack knowledge
3. EBTS are central to our service delivery and training philosophy.	EBTs central to service and training
4. General positive view. Having free online training like TF-CBT is beneficial. The cost factor for non-independent practitioners is prohibitive often.	positive view, cost factor prohibitive
5. We train primarily on evidence-based principles of behavior change (similar to question #8), and secondarily to specific models.	evidence-based principles before specific models
6. EBP can provide valuable information and tools which interns typically do not learn in schools. It behooves the field to teach such in training arenas, esp. w/ insurance co. demanding such at times.	EBP provide valuable information, benefits field
7. We implement programs informed by EBTs when unable/not fitting to use whole protocol e.g. DBT, ACT, Seeking Safety, Coping Cat, Triple P.	programs informed by EBTs, not whole protocol

[a]Category includes verbatim responses.

(continued)

Response[a]	Primary Contents
8. Your survey has raised my awareness re: some EBTs (PMT, MST, PCIT) in which we should make more effort to train interns.	more effort to train EBTs
9. EBT is becoming the standard of care	EBT as standard of care
10. Models can sometimes be inflexible. Research on which they are based is sometimes dubious.	models inflexible, research dubious
11. The cost is the greatest barrier to implementation.	cost greatest barrier
12. As our clinic grows, once thing in particular I look for are clinicians who have training in EBT's, and especially those which our current staff do not have.	prefer EBT trained clinicians
13. In order to get agency staff buy in, five years ago we needed a "bottom up" approach of holding "Town Meetings" in all parts of the approaches to share its benefits and thinking behind it.	need staff buy-in
14. We use Health Dynamics Inventory (HDI) as Behavioral Health Outcome i.e. Wojczyk and Saunders.	use outcome measures
15. We have several supervising clinicians who see very focused populations (e.g. young children with toileting problems, straightforward ADHD) and do the training in EBTs. Trainees can then implement these when seeing a more typical client population (e.g. children w/ co-morbid conditions such as ADHD, learning disabilities, anxiety disorder and toileting issues).	supervising clinicians train in EBTs

[a]Category includes verbatim responses.

(continued)

Response[a]	Primary Contents
16. There are many EBTs beyond what is listed. Limited funds are about training in general not specific to EBT.	limited funds for training
17. This is a very specific area of focus for EBT. We use EBT for a variety of diagnoses (e.g. depression, anxiety, panic, etc.) Have not really specialized in this area-we treat some children, but mostly adults.	use EBT for variety of diagnoses
18. Seems these are being made out to be new or special when really re-packaging what has been done for years in the field...research just catching up, but the use of these can restrict practice to be creative around case conceptualization from several points of view. Can include interns to use their case/diagnostic skills. Also doctoral interns are beyond "simple" techniques, more for Masters. But excellent for teaching basics.	EBTs excellent for teaching basics
19. We find matching clients who can benefit from a standard EBT are matched w/ younger trainees and complex clients are matched w/ experienced trainees. It works super well!!	match EBT to client, clinician expertise
20. EBT-based interventions are the only ones psychologists should be interested in implementing.	only EBTs should be implemented
21. We have IY and PCIT at the agency, but the time investment + cost is sometimes too prohibiting to train a staff member who will be with us only 1 year.	EBTs can be costly

[a]Category includes verbatim responses.

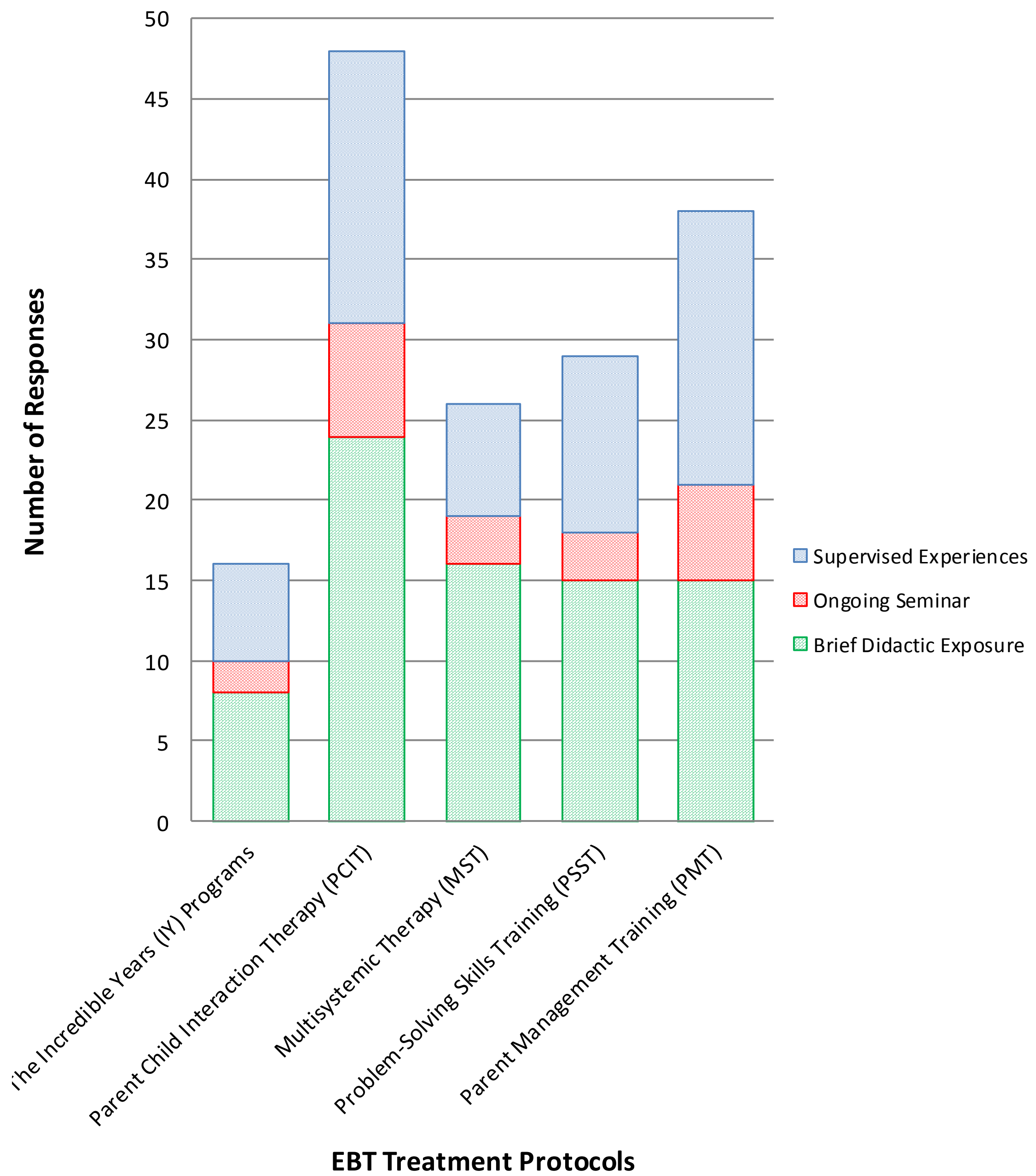

Figure 1. Survey participants' reported frequency by exposure mode of training sites using 5 previously identified evidence-based treatment (EBT) protocols for children with disruptive behavior problems (DBPs). Each survey participant was requested to indicate which of the 5 EBT protocols were incorporated into their training program, as well as indicating if the EBT was covered as a brief didactic exposure, an ongoing seminar, and/or a supervised experience.

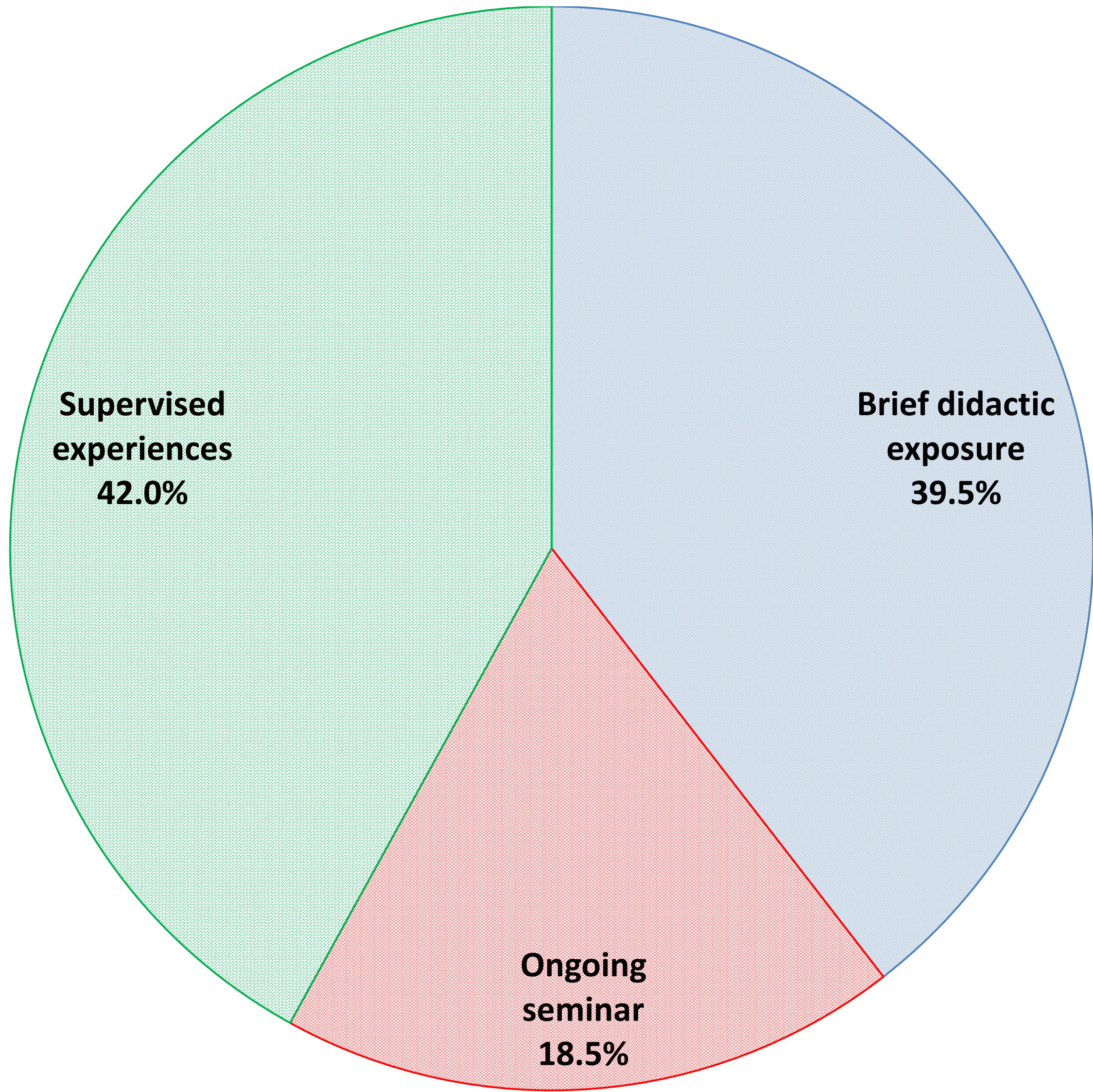

Figure 2. Percentage breakdown of exposure modes to EBT protocols as reported by survey participants.

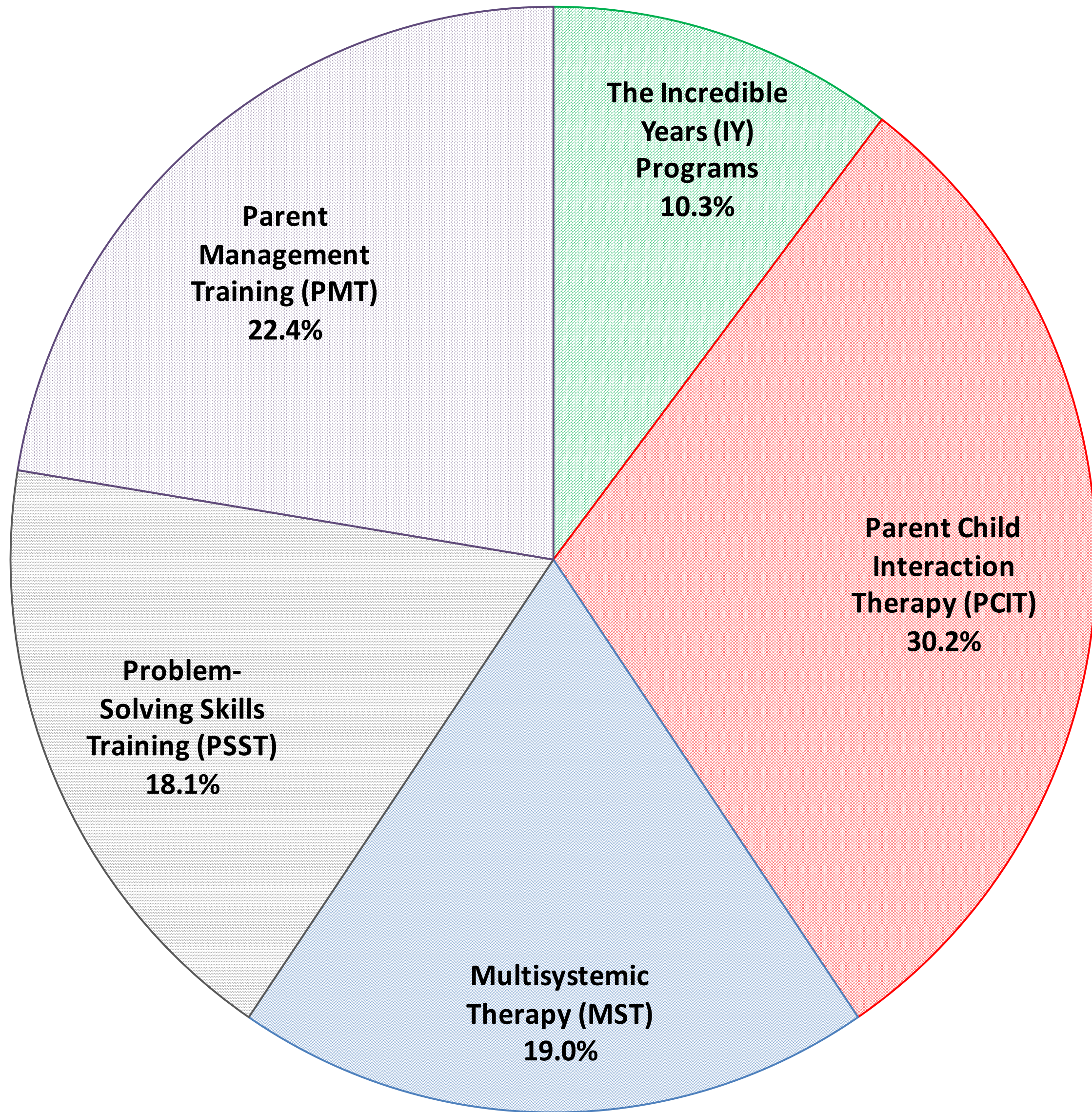

Figure 3. Percentage breakdown of 5 previously identified EBT protocols for children with DBPs utilized across agencies based on data collected via the study survey. Information presented in chart is to be compared to the information presented in Figure 4.

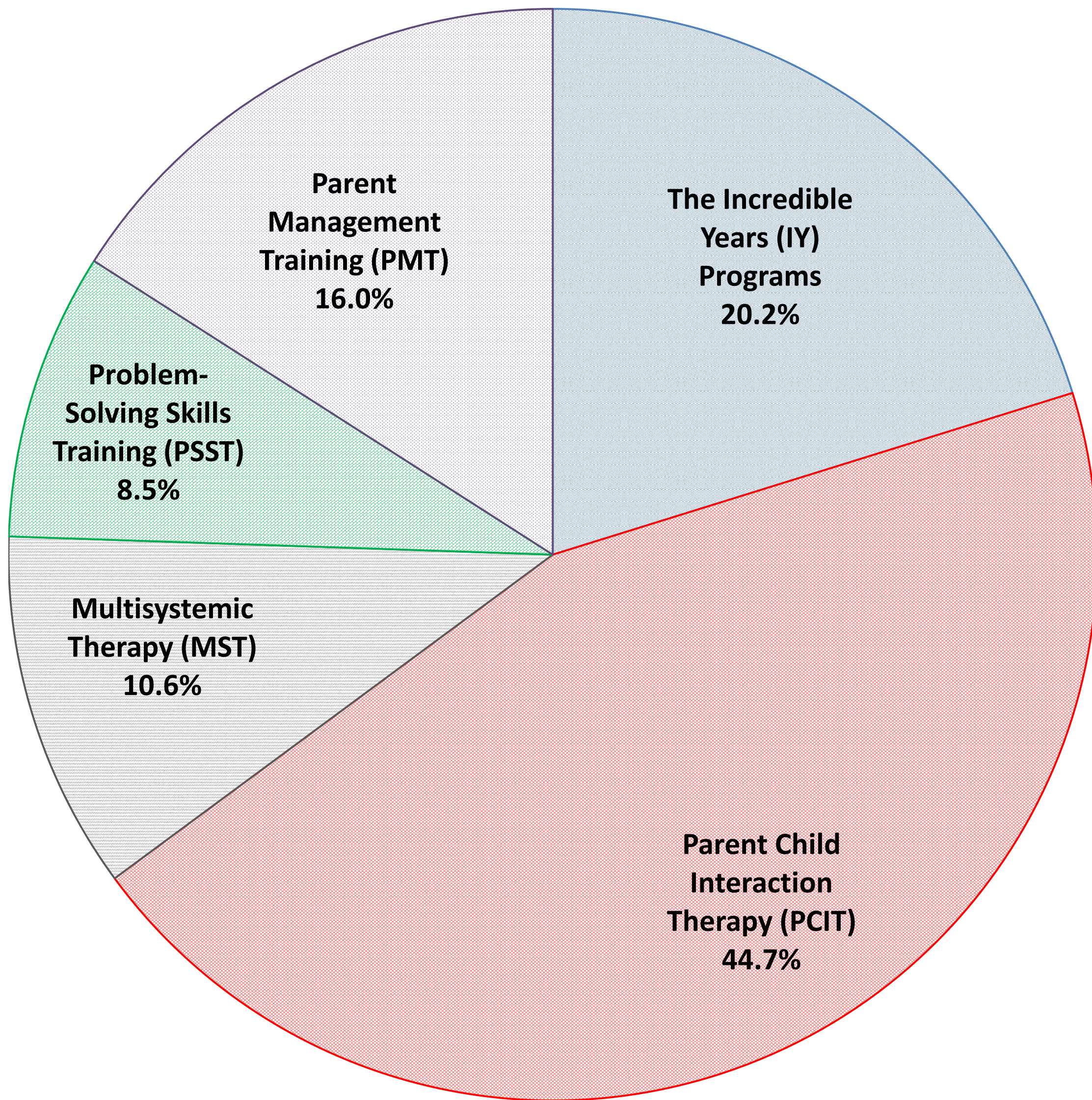

Figure 4. Percentage breakdown of 5 previously identified EBT protocols for children with DBPs utilized across agencies based on data collected via a systematic review of each agency website. Information presented in chart is to be compared to the information presented in Figure 3.

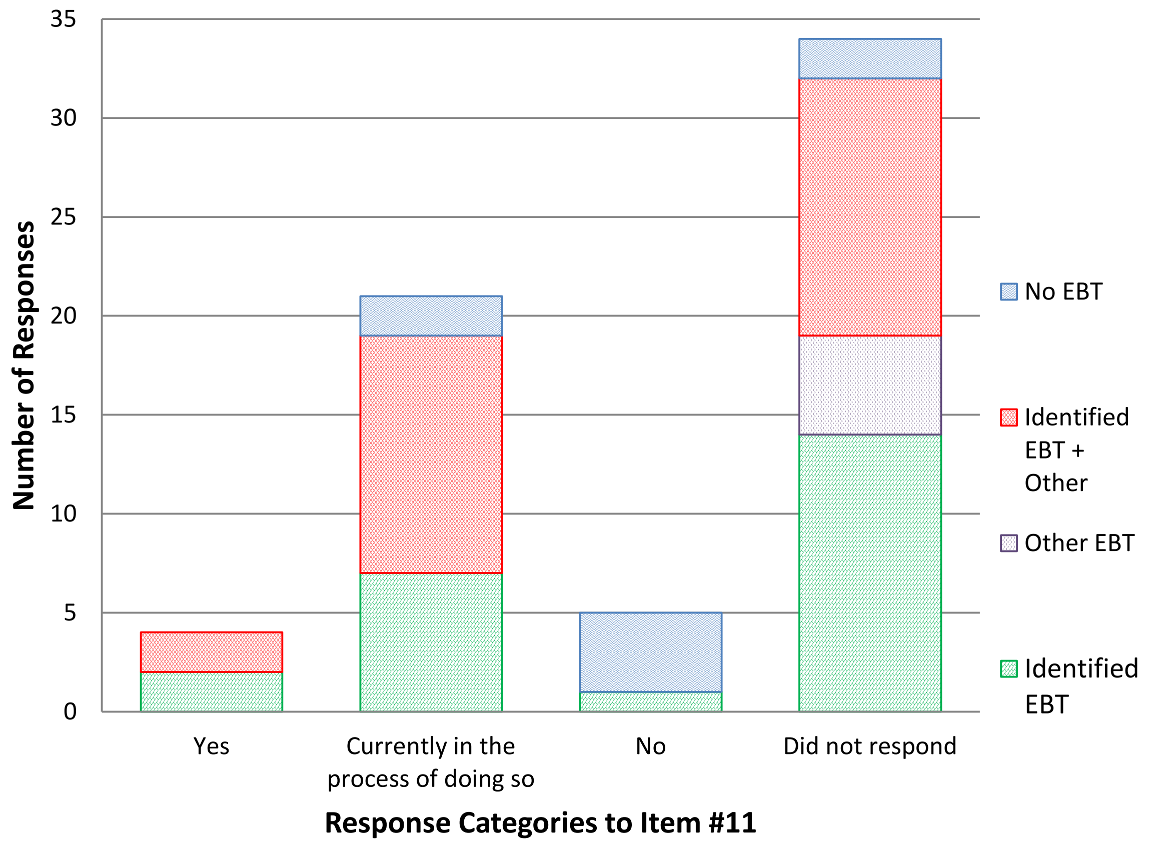

Figure 5. Secondary analysis of survey participants' responses to survey item #11("If your program does not currently provide training in EBTs, do you have plans to do so in the future?" combined with data extracted from survey item #7 ("The following list presents some EBTs for children and/or adolescents with disruptive behavior problems. Please indicate the EBTs in which you offer training; check all that apply and indicate whether the EBT is: Covered as a Brief Didactic Exposure, an Ongoing Seminar, or consists of SupervisedExperiences."). Identified EBT= Previously identified EBT protocols for children with DBPs included in survey item #7; Other EBT= EBT protocols identified by survey participants in survey item #7.

APPENDIX A

Literature Review

Author	Objective	Population	Research	Instrument	Conclusions
Addis, Wade, & Hatgis (1999)	Discuss practitioners' most common concerns, including (1) effects on the therapeutic relationship, (2) unmet client needs, (3) competence and job satisfaction, (4) treatment credibility, (5) restriction of clinical innovation, and (6) feasibility of manual-based treatments.	N/A	Literature Review/ Theoretical Discussion	N/A	Authors had concerns with treatments that are relatively structured and have been shown to be efficacious in controlled clinical trials. Authors debated whether cost issues should be given priority, indicating that it depends on the particular context and the research question. Authors suggested that many psychotherapy researchers are not well trained in evaluating cost-effectiveness.

American Psychiatric Association (2000)	Diagnostic manual for classifying mental disorders.	N/A	N/A	Diagnostic Manual	N/A
American Psychological Association (2012)	The mission of Division 12 is to encourage and support the integration of psychological science and practice in education, research, application, advocacy, and public policy, attending to the importance of diversity.	N/A	N/A	N/A	N/A

American Psychological Association Presidential Task Force on Evidence Based Practice (2006)	The APA 2006 Presidential Task Force on Evidence-Based Practice defines and discusses evidence-based practice in psychology (EBPP).	N/A	Task Force	N/A	Consensus was achieved among a diverse group of scientists, clinicians, and scientist-clinicians from multiple perspectives that EBPP requires an appreciation of the value of multiple sources of scientific evidence.
American Psychological Association Presidentail Task Force on Evidence-Based Practices for Children and Adolescents (2008)	The APA 2008 Presidential Task Force on Evidence-Based Practice providing focus on treatments specific to children and adolescents	N/A	Task Force	N/A	Greater attention be paid to training model development and outcome research, specifically for those treatments geared towards children and adolescents.

Angold & Costello (1993)	Reviewed research studies that examined the comorbidity and treatment options in the context of child and adolescent depression.	studies using standard interviews and DSM-III/DSM-III-R criteria.	Literature Review	N/A	A high rate of comorbidity exists in children and adolescents with major depressive disorder or dysthymia. In the majority of cases, ODD and CD were more common in depressed children than expected by chance, and the rates of other disorders in depressed children were higher than the rates of depression in those with depression.

Association of Psychological Postdoctoral and Internship Centers (2012)	Online database providing information for all registered predoctoral internship agencies across the United States and Canada.	N/A	N/A	Online Database	N/A
Bernal & Scharro-del-Rio (2001)	Determine alternatives on how to best contribute to treatment research of clinical utility with diverse populations.	N/A	Literature Review	N/A	Approach to science needs to be more inclusive of a diversity of approaches to inquiry. While it is clear that more efficacy, effectiveness, and other treatment outcome studies with communities of color are needed, a methodological pluralistic approach should guide these efforts.

Brooks, Mintz, & Dobson (2004)	Help determine the use and perceived effectiveness of diversity training methods as reported by Canadian internship training directors.	38 Canadian Clinical Psychology predoctoral internships	Survey	Internship Diversity Training Survey	Overall, it is clear that directors of internship training were attuned to the need to train psychology interns in issues of diversity. Training sites were most likely to encourage hands-on training methods and rated those methods as most effective for diversity training.

Burke, Loeber, & Birmaher (2002)	To review empirical findings on oppositional defiant disorder (ODD) and conduct disorder (CD) in an attempt to determine appropriate causal factors and treatment strategies.	N/A	Meta-Analysis	N/A	Convincing evidence of causal linkages remains elusive. It is apparent that there is not one single causative factor; thus it is not likely that one single modality will suffice to treat CD.

Buydens-Branchey, Branchey, & Noumair (1989)	Assessed the age of drinking onset and level of psychiatric disturbance in adult males to examine relationship potential.	218 male alcoholic psychiatric inpatients (aged 25-60 yrs).	Correlational Study	Structured Clinical Interview, Schedule for Affective Disorders and Schizophrenia	Early onset alcoholics exhibited hostile tendencies more frequently, and had a higher incidence of paternal alcoholism. Increased incidence of depression and suicidal tendencies was also observed in early onset alcoholics, as well as dysregulated mood and aggression control.

Chambless & Hollon (1998)	Attempt to describe the benefits of ESTs in controlled research, their usefulness, and their cost effectiveness relative to other alternative interventions.	N/A	Literature Review/ Theoretical Discussion	N/A	In evaluating the benefits of a given treatment, the greatest weight should be given to efficacy trials but that these trials should be followed by research on effectiveness in clinical settings and with various populations and by cost-effectiveness research.

Chambless & Ollendick (2001)	Summarize the work of several task forces to define, identify, and disseminate information about empirically supported psychological interventions from the U.S., U.K., and elsewhere, along with the list of treatments that have been identified as EST's.	N/A	Task Force/ Literature Review/ Theoretical Discussion	N/A	More research on effectiveness is clearly a priority if clinicians are to give credence to the value of ESTs. When treatment goals are concerned, little research was found on whether ESTs affect quality of life.
Chorpita (2012)	Online database that helps to provide treatment protocol options to help remedy a variety of child and adolescent presenting symptoms and behaviors.	N/A	N/A	Online Database	N/A

Cohen, Mannarino, Deblinger (2006)	Text outlining a systematic, cognitive-behavioral approach to treating children who have experienced traumatic events.	N/A	N/A	N/A	N/A
Cohen (1998)	Provides a list of potential benefits from "saving" a high-risk youth, by estimating the lifetime costs associated with the typical career criminal, drug abuse, and high-school dropout.	N/A	Literature Review/ Projection of Costs	N/A	Duplication eliminated between crimes committed by individuals who are both heavy drug users and career criminals results in an overall estimate of the "monetary value of saving a high-risk youth" of $1.7 to $2.3 million.

Duncan (2002)	Provides commentary of a 1936 article by S. Rosenzweig titled "Some Implicit Common Factors in Diverse Methods of Psychotherapy."	N/A	Theoretical Discussion	N/A	Suggests that psychotherapy abandon the empirically bankrupt pursuit of prescriptive interventions for specific disorders based on a medical model of psychopathology. Suggests it more important to conduct a systematic application of the common factors based on a relational model of client competence.

Eyberg (1988)	Describes in detail Parent-Child Interaction Therapy, a behavioral family therapy approach for the psychological treatment of preschool children and their parents.	N/A	Theoretical Discussion	N/A	Parent-Child Interaction Therapy has demonstrated successful treatment outcomes for a broad range of childhood problems.

Eyberg, Nelson, & Boggs (2008)	Article describes the EBT's and their evidence base and covers research on moderators and mediators of treatment outcome, as well as their clinical representativeness and generalizability of the studies.	16 studies targeting child/ adolescent disruptive behavior as the primary disorder were considered in this review.	Literature Review	N/A	Despite extensive treatment research on disruptive behavior since the initial review, still no single intervention emerges as "best." However, of the 6 parent training programs identified as evidence based, all but one were designed primarily for very young children (2-5). Also, of the 7 child training programs identified as EBT's, all but 1 were designed for older, elementary to high school age youth. The review provides support for both parent-training and child-training EBTs for youth with disruptive behavior.

Fensterheim & Raw (1996)	Challenges the stance that a clinical psychologist and clinical researcher are assumed to be one in the same.	N/A	Theoretical Discussion/ Literature Review	N/A	Authors suggested that the clinical psychologist/ clinical researcher model is unworkable due to the fact that clinical and research psychology are independent fields, each with its own problems and its own styles of thinking.

Fergusson, Horwood, Ridder (2005)	Objective is to extend research into the adult sequelae and development over time of childhood conduct problems.	Birth cohort of 1,264 New Zealand youth, assessed over a time span of 25 years.	Longitudinal Study	Rutter and Connors Parent and Teacher Questionnaires, Self-Report Delinquency Inventory, Revised Conflict Tactics Scale	Childhood conduct problems were associated with a wide range of adverse psychosocial outcomes (crime, substance use, mental health, sexual/partner relationships) even after controlling for confounding factors.

Garfield (1998)	Discusses the support and critiques for empirically supported treatments.	N/A	Theoretical Discussion	N/A	Concludes that too much of a focus on the forms of psychotherapy will have a tendency to diminish the importance of patient and therapist characteristics in producing positive treatment outcomes.

Garland, Hawley, Brookman-Frazee, & Hurlburt, (2008)	Purpose is to describe a new method for identifying common elements of EBP and to present common elements resulting from a systematic review of interventions for children with disruptive behavior problems and their parents.	Eight individual treatment programs with established efficacy for children ages 4-13 with disruptive behavior problems.	Systematic Literature Review	N/A	Identification of common core elements of EBP has important implications for efforts to characterize practice, as well as therapist training and implementation of EBP in community-based settings. Therapist training and ongoing supervision that builds on common elements of EBP could potentially improve the effectiveness of care overall.

Gittelman, Mannuzza, Shenker, & Bonagura (1985)	Identifies the diagnoses assigned to teenage and adult males whom were once identified as hyperactive in childhood.	101 15-23 year olds diagnosed as hyperactive at ages 6-12 yrs old compared to 100 controls.	Follow-Up Study	National Institute of Mental Health (NIMH) Diagnostic Interview Scale	Most common follow-up diagnoses were ADHD, conduct disorder, and substance use disorders, suggesting that studying psychiatric disorders in early and middle adolescence in males is likely to exaggerate the risk for maladjustment.

Goldfried & Wolfe (1996)	Discusses the importance of developing a new outcome research paradigm involving the collaboration of researcher and practicing clinician.	N/A	Theoretical Discussion	N/A	The discrepancy between clinical practice and research continues to be large. It is necessary for psychotherapy outcome research to move forward to allow for the generalizing of findings more faithfully to what is needed clinically.

Hagen, Ogden, & Bjornebekk (2011)	Assess the effectiveness of Parent Management Training in an existing service agency with a randomized controlled design.	Families of 112 Norwegian girls and boys with clinic-level conduct problems ranging in ages from 4-12; 75 families were retained at follow-up.	Effectiveness Trial	Treatment manuals from the Oregon Social Learning Center (Forgatch, 1994; Forgatch & Rains, 1997) translated and adapted to Norwegian conditions	From this study, the overall effectiveness of PMTO a year after treatment termination can at best be described as modest. Nevertheless, for clinicians and practitioners in the field, the results indicate that helping parents use effective disciplinary skills and supporting families in developing a sense of connectedness and cohesion may be particularly important in the therapeutic setting.

Henggeler, Rodick, Borduin, Hanson, Watson, & Urey (1986)	An early attempt at establishing the effectiveness of a multisystemic treatment modality.	57 delinquent adolescents receiving family ecological treatment, 23 delinquent adolescents receiving an alternative treatment, 44 developmental controls.	Effectiveness Study	Behavior Problem Checklist, Eysenck Personality Inventory	Adolescents who received family ecological treatment experienced significant decreases in conduct problems, anxious-withdrawn behaviors, immaturity, and association with delinquent peers. Relationships amongst family members were noted to be significant warmer; more frequent family interaction.

Henggeler & Sheidow (2003)	Provides an overview of evidence-based family treatments for adolescent conduct problems.	Literature on three family-based treatments for adolescent conduct problems identified as having empirical support: Functional Family Therapy, Multisystemic Therapy, and Oregon Treatment Foster Care.	Effectiveness Trial/Literature Review	N/A	Identified several similar features among FFT, MST, and OTFC that most likely account for treatment success. Validation and initial transport of three treatments to community-based programs have opened up new lines of research on the transport of evidence-based practices to community settings.

Ho, McCabe, Yeh, & Lau (2010)	Chapter in handbook on treating conduct problems in youth; specifically aims to provide an overview of a culturally specific evidence-base for ethnic minority youth with conduct problems	N/A	N/A	N/A	Ethnically-informed treatment practices will help clinicians to make treatment decisions that are both effective and culturally sensitive to their client.
Horrell (2008)	Reviews the current literature on the use of CBT with ethnic minority clients living in the United States.	12 studies examining the effectiveness of CBT for minority participants with psychological disorders.	Literature Review	N/A	CBT appears to be an effective treatment for use with clients from ethnic minority backgrounds.

Jackson, Alberts, Roberts (2010)	Contribute to the recent series of articles on specialties in *Professional Psychology Research and Practice*, and delineate the development, design and purpose of clinical child psychology.	N/A	Literature Review	N/A	The clinical child psychology specialty, encompassing a range of concepts and applications, developed within professional psychology meets the psychological needs of children, adolescents, and their families.

James & Roberts (2009)	Purpose was to survey the active members in the field of clinical child and adolescent psychology to identify the most important directions for the future of the field in the upcoming decade. Specifically, the study aims to identify the anticipated trends for clinical practice, research, and training in clinical child and adolescent psychology in the United States.	45 doctoral-level active members in the field of clinical child and adolescent criteria. Randomly selected from the following publicly accessible lists of clinical child and adolescent psychologist: American Board of Prof Psych (2007) list of diplomats in Clin. Child and Adolescent Psych, the National Register of	Exploratory/ Delphi survey	Survey	A two round Delphi system systematically predicted where the field is headed in the next 10 years in terms of clinical practice, research, and training. Predictions made are a consensus vision of what they view will happen based on current and past clinical experiences. These were then compared with the issues brought up by Kaufman et. al. (1989). In the comparison, several similar issues remained a high priority, while new, different issues also arose. See the discussion section of the article for a listing of these issues.

		Health Service Providers in Psych (2007) list of clinicians serving children and adolescents, Journal of Clin Child and Adolescent Psych (2007) masthead list of consulting editors, Society of Clin Child and Adolescent Psych (2005) list of grad program directors, and the Association of Psych				

		Postdoc and Internship Centers (2007) list of the directors of Clin Child and Adolescent Psych intern sites. The first 10 individuals on each randomly sorted list were then sent the informational email for the study.			

Kazdin (1985)	Text outlining an effective treatment approach to treating antisocial behavior in children and adolescents.	N/A	N/A	N/A	N/A
Kazdin, Esveldt-Dawson, French, & Unis (1987)	Examines the effects of cognitive-behavioral problem-solving skills training (PSST) and nondirective relationship therapy (RT) in the treatment of antisocial child behavior.	56 psychiatric inpatient children ages 7-13.	Effectiveness Study	Child Behavior Checklist (CBCL), School Behavior Checklist (SBCL), Therapist Evaluation Inventory, Child Evaluation Inventory (CEI)	PSST led to significantly greater changes than RT and no treatment. Suggests that cognitive-behavioral problem-skills training can effect changes in a seriously disturbed clinical population, on community-based measures, and that changes are sustained for at least up to 1 year.

Kazdin & Whitley (2006)	The present study tests the hypothesis that comorbidity and complexity of a case in child therapy influence the effectiveness of an EBT and that treatment is not likely to work or work very well with more complex cases. Four domains of complexity are explored; scope of child dysfunction, SES disadvantage of family, parent and family function, and obstacles in coming to treatment.	Children referred for oppositional, aggressive, and antisocial behavior were seen at an outpatient clinic for children and families. Two separate samples from the same clinic were used to test the hypotheses, namely those with ODD and those with CD. CD sample included 132 children (35 girls,	Effectiveness Trial	Families provided with Parent Management Training (PMT) or Problem Solving Skills Training (PSST)	Comorbidity among children with ODD or CD did not reduce or attenuate the effects of EBT. Children who varied in the number of comorbid disorders before treatment began were similar in their standing at the end of treatment in child antisocial behavior, problem behavior at home, or parent ratings across multiple symptom domains. Three of four domains to operationalize complexity of the case (child severity and scope of dysfunction, SES disadvantage, and parent/family functioning) were unrelated to treatment outcome or showed an effect opposite from what might be expected; greater complexity or adversity did not attenuate the effects of treatment. The fourth domain, barriers associated with treatment participation, was significantly associated with therapeutic change. Children from families who perceived barriers associated with treatment changed significantly less over the course of treatment than children from families who perceived fewer barriers.

		97 boys) and families, all consecutive cases who completed treatment. All 3 met criteria for CD, three groups were formed that varied in comorbidity: a) CD only (21), b) CD plus 1 other disorder (43), and c) CD plus 2 other disorders (68). ODD was not included as a comorbid disorder because of the diagnostic and			

		hierarchical relation of CD and ODD.			

Kovacs, Krol, & Voti (1994)	Investigated whether early onset depressive and conduct disorders and historical/familial variables increased the risk of teenage pregnancy among clinically referred girls.	83 girls, aged 8-13 years, repeatedly evaluated over 12 years.	Longitudinal/ Correlational Study	DSM-III, structured interview diagnostic scales	After adjusting for race, early onset conduct disorder represented a risk factor for teenage pregnancy amongst psychiatrically referred girls. May reflect behavioral dysregulation, delay in social-cognitive development, and misinformation about reproductive issues.

La Roche & Christopher (2009)	Contrasts the impact of two prominent research guidelines on the development of culturally sensitive psychotherapies: empirically supported treatments (ESTs) and evidence-based practice in psychology (EBPP).	N/A	Theoretical Discussion	N/A	Authors concluded that EBPP is more responsive to needs and characteristics of culturally diverse groups, ESTs also have their own strengths.
Lahey, Miller, Gordon, & Riley (1999)	Chapter in handbook of disruptive behavior disorders (DBDs); describes the methods that define epidemiology as they have been applied to DBDs and explains the roles played by population-based studies in identifying risk and protective factors.	N/A	N/A	N/A	N/A

Linehan (1993)	Training manual for clinicians working with clients demonstrating symptoms and behaviors indicative of borderline personality disorder.	N/A	N/A	Treatment manual	N/A
Litschge, Vaughn, & McCrea (2010	Identify and summarize treatment effects for children and adolescent conduct problems based on accrued meta analytic studies.	26 meta-analytic reviews composed of nearly 2000 studies from 1980-2007.	Systematic Literature Review	N/A	Results seemed to demonstrate evidence for equifinality. Effects are sturdy across a number of interrelated outcomes.

Loeber & Keenan (1994)	Examines the co-occurrence of conduct disorder (CD) and comorbid psychiatric diagnoses, as well as examining the influences of age and gender on patterns of comorbidity.	N/A	Literature Review/Correlational Study	N/A	Age and gender are considered as primary influences on patterns of comorbidity in CD. Although the risk of CD in girls is lower than that of boys, the risk for comorbidity of some disorders in girls appears higher than that for boys.
Loeber, Burke, Lahey, Winters, & Zera (2000)	Reviewed empirical findings on oppositional defiant disorder (ODD) and conduct disorder (CD).		Literature Review	N/A	Evidence supports a distinction between the symptoms of ODD and many symptoms of CD, but there is controversy about whether aggressive symptoms should be considered to be part of ODD or CD. Symptoms more serious, more atypical for child's sex, or more age-atypical appear to be prognostic of serious dysfunction. A proportion of children with ODD later develop CD, and a proportion of those with CD later meet criteria for antisocial personality disorder. ODD and CD frequently co-occur with other

					psychiatric conditions.
Loeber, Tremblay, Gagnon, Charlebois (1989)	Examines the progression of fighting behavior in elementary school children over time and associated factors.	170 kindergarten-aged children identified as "disruptive" by classroom teachers; followed up for four years.	Longitudinal Study	Classroom teacher assessments	Participants with high, stable fighting scores also scored high on nonaggressive antisocial acts at the end of 4 years; by age 9 stable high fighting was associated with single parent families.
Matthys, Cuperus, Van Engeland (1999)	Examines social problem-solving skills in psychiatrically defined aggressive boys.	48 boys with ODD/CD, 27 boys with	Comparative Study	Videotaped stimuli of problematic social	In ADHD boys, social problem-solving was affected only in encoding and generation of responses, whereas in ODD/CD and ODD/CD+ADHD boys social

		ADHD, and 29 boys with both disorders (ODD/CD+ ADHD) (all aged 7-12), 37 boys in a normal control group, 23 boys in a psychiatric control group with internalizing disorders.		situations	problem-solving was affected throughout the videotape viewing process.
McFall (1991)	Identifies the importance of integrating science and practice in clinical psychology; proposes that clinical psychologists adopt a manifesto aimed at advancing clinical psychology as an applied science.	N/A	Theoretical Discussion	N/A	Clinicians and researchers within the field must embrace the idea of building a science of clinical psychology in order to advance the field.

Miller (1983)	Creates a schematic diagram of the motivational interviewing treatment process and suggests a 6-step sequence for implementing motivational interviewing techniques.	N/A	N/A	N/A	Motivational interviewing succeeds by deemphasizing labeling and placing an emphasis on individual responsibility and internal attribution of change.
Mitchell & Jolley (2007)	Text designed to help students understand and learn to evaluate the internal, external, and construct validity of studies, while also assisting students with writing a research proposal.	N/A	N/A	N/A	N/A

Mulder, Frampton, Joyce, & Porter (2003)	To discuss the extent to which the results of randomized controlled trials (RCTs) in psychiatry can be generalized to clinical practice.	N/A	Literature Review/Theoretical Discussion		Randomized controlled trials remain the most robust design to investigate the effectiveness of treatments. They should be applied to important clinical questions, and carried out as far as possible with typical patients in the clinical conditions in which the treatment is likely to be used.

Nock, Kazdin, Hiripi, & Kessler (2007)	Examines the lifetime prevalence, onset, persistence, and correlates of ODD	3,199 adult respondents to the National Comorbidity Survey Replication	Survey/Empirical Study	National Comorbidity Survey	ODD is a common child- and adolescent-onset disorder associated with substantial risk of secondary mood, anxiety, impulse-control, and substance use disorders. Lifetime prevalence is estimated to be at 10.2% (11.2% of males, 9.2% of females).
Norcross, Beutler, & Levant (2006)	Text that addresses 9 fundamental questions in the debate on EBPs.	N/A	Textbook/Debate	N/A	N/A

PracticeWise, LLC. (2011)	Online database devoted to identifying appropriate treatments for a variety of child and adolescent presenting mental health symptoms and behaviors	N/A	N/A	Online Database	N/A
PCIT International (2012)	Online webstore providing pricing and descriptions for a variety of PCIT products.	N/A	N/A	N/A	N/A
Robins & Price (1991)	Examines effects of childhood conduct problems on 10 DSM-III psychiatric disorders.	8,377 men and 11,105 women	Interview/Empirical Study	Interview	Each of the 10 disorders showed an increase in prevalence with an increasing number of conduct problems.

Schoenwald, Garland, Southam-Gerow, Chorpita, & Chapman (2011)	Attempts to clarify terminology to describe and measure psychological treatment and consider what treatment adherence instruments can tell us about what happens in treatment.	11 adherence measurement methods for 14 evidence-based treatments for disruptive behavior problems in youth	Empirical Study/Qualitative/Literature Review	Adherence instruments for evidence-based treatments	Implications are considered for the definition of effective treatments and design and testing of strategies to measure and monitor their delivery.

Scott, Ingram, Vitanza, & Smith (2000)	Examines the current state of affairs of training in the practice of supervision in doctoral programs and predoctoral internship sites accredited by the American Psychological Association (APA)	123 program and training directions from counseling psychology, clinical psychology, and combined professional-scientific psychology programs accredited by the APA.	Empirical Study/Survey	Academic program survey, Internship site survey	Significant differences were found between training offered in counseling psychology programs compared to clinical psychology programs, and in university counseling center internship programs when compared to other types of internship sites. More extensive training in supervision found in counseling psychology programs and counseling center internship sites.

Scott (2006)	Chapter in "A Clinician's Handbook of Child and Adolescent Psychiatry," devoted specifically to the incidence and treatment of conduct disorder (CD)	N/A	N/A	N/A	N/A

Scott, Pachana, & Sofronoff (2001)	Identifies student experiences in postgraduate clinical programmes across Australian universities.	Students and directors from 35 APAC accredited postgrad clinical training programs	Survey	Survey	Students preferred practical, interactive, and competency based teaching and assessment to didactic, written, and exam-based alternatives. Programme directors responses reflected concerns with insufficient training places available, fewer clients accessing training clinics, and concerns related to adequate supervision and competency of students.

Southam-Gerow, Rodriguez, Chorpita, Daleiden (2012)	Reviews factors affecting the application of child/adolescent evidence-based treatments (EBTs) in community clinic settings.	N/A	Theoretical Discussion	Mental Health System Ecological Model	Researchers noted how professional psychologists who represent a system of treatment could consider implementing quality and performance measurement tools for their team of service providers in an attempt to hold that system accountable for the provision of effective treatment-specifically EBTs which require some degree of fidelity to a specific treatment model.

The Incredible Years: Frequently Asked Questions (2012)	Online website providing pricing, descriptions, and answers to frequently asked questions pertaining to the Incredible Years program.	N/A	N/A	N/A	N/A
Trembley, Loeber, Gagnon, & Charlebois (1991)	Identifies connections between fighting behavior and perceived level of classroom disruption	69 disruptive boys assessed at ages 6, 8, and 9	Longitudinal Study	Assessment of aggression	Aggression scales likely aggregate high-frequency fighters at high risk for stable disruptive, physically aggressive, and antisocial behaviors.

Wampold, Imel, Miller (2009)	Providing commentary on "The Dodo Bird, treatment technique, and disseminating empirically supported treatments," regarding what stands in the way of thoroughly disseminating evidence-based practices.	N/A	Literature Review	N/A	Notes that "evidence" goes beyond a simple observation of phenomena and needs to extend what observations are derived either from laboratory or naturalistic settings.
Webster-Stratton (1984)	Efforts to develop the Incredible Years curriculum and examine the usefulness of the videotape modeling component.	Mothers of 35 3-8 year old conduct-disordered children, assigned to three different treatment groups.	Comparative/ Follow-Up Study	Videotaped modeling program	Therapeutic efficiency of the videotape modeling group format was more cost-effective and provided treatment that lead to sustained improvements in child's behavior over time.

Weissman, Verdeli, Gameroff, Bledsoe, Betts, Mufson, Fitterling, & Wickramaratne (2006)	Determine the amount of EBT taught in accredited training programs in psychiatry, psychology (Ph.D. and Psy.D.), and social work and to note whether the training was elective or required and presented as a didactic (coursework) or clinical supervision.	Training directors (or their designates) from 221 programs (73 in psychiatry, 63 in PhD clinical psychology, 21 in Psy.D. psychology, and 64 in master's-level social work).	Exploratory/ Cross Sectional Survey	Survey	There is a considerable gap between research evidence for psychotherapy and clinical training.

Whaley & Davis (2007)	Illustrates the complementary nature of cultural competence and evidence-based practice in mental health services.	N/A	Theoretical Discussion	N/A	Stresses the importance of cultural adaptations of empirically supported treatments for mental health services in terms of research and practice with ethnic/racial minorities.
World Health Organization (1993)	International diagnostic manual for classifying disorders.	N/A	N/A	Diagnostic Manual	N/A

Zoccolillo (1992)	Identifies co-occurrence of conduct disorder with other psychiatric disorders in adulthood.	40 child and 73 adult general population studies of psychiatric disorder	Systematic Literature Review	N/A	Both depressive disorders and anxiety disorders co-occurred with CD and its adult outcomes for both sexes. Most women with CD and antisocial adult outcome also developed a depressive or anxiety disorder by early adulthood. For both sexes, increasing severity of antisocial behavior was associated with an increasing risk of an emotional disorder.

Zoccolillo & Rogers (1991)	Assesses treatment outcomes for hospitalized adolescent girls exhibiting symptoms of conduct disorder (CD).	55 adolescent girls aged 13-16 years with diagnoses of CD from a psychiatric hospital	Interview/ Empirical/ Follow-Up Study	Structured Clinical Interview for Diagnoses	Subjects' outcome at follow-up assessment was poor; 6% had died a violent death, the majority had dropped out of school, 1/3 were pregnant before age 17, half were rearrested, and many suffered traumatic injuries.

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Appendix B

Survey

TRAINING IN EVIDENCE-BASED TREATMENTS (EBTs) FOR CHILDREN WITH DISRUPTIVE BEHAVIOR PROBLEMS SURVEY*

1) What is your gender?
____ Male ____ Female

2) What is your race?
____ American Indian/Alaskan Native ____ Hispanic
____ Asian or Pacific Islander ____ Caucasian
____ African American ____ Other: __________

3) What is your current position within your training program?
___ Director of Clinical Training
___ Specialized Program Director (i.e. Early Intervention and Wellness Services)
___ Other: ____________________________

4) When did you obtain your doctoral degree?
____ Prior to 2002 ____ 2002 or later

5) Which best describes the setting of your internship site?
____Community Mental Health Center ____Medical School
____Child/Adolescent Psychiatric or Pediatric Clinic ____Consortium
____Private Outpatient Clinic ____ Hospital
____Other: Please describe: ____________________________________

6) Approximately what percentage of the clients in your setting are children or adolescents?
____less than 25% ____26%-50% ____51%-75% ____76%-100%

EVIDENCE-BASED TREATMENTS (EBTs)

7) The following list presents some EBTs for children and/or adolescents with disruptive behavior problems. Please indicate the EBTs in which you offer training; check all that apply and indicate whether the EBT is: Covered as a **Brief Didactic Exposure**, an **Ongoing Seminar**, or consists of **Supervised Experiences**

Treatment	Brief Didactic Exposure	Ongoing Seminar	Supervised Experiences
The Incredible Years (IY) Programs (Webster-Stratton, 1984)			
Parent Child Interaction Therapy (PCIT) (Eyberg, 1988)			
Multisystemic Therapy (MST) (Henggeler, Rodick, Borduin, Hanson, Watson, & Urey, 1986)			
Problem-Solving Skills Training (PSST) (Kazdin, Esveldt-Dawson, French, & Unis, 1987)			
Parent Management Training (PMT) (Kazdin, 1985)			
Other (please specify):			

EBT PRACTICE COMPONENTS**

8) Below are 15 of the most frequently used practice components for youth with disruptive behavior problems (Practicewise, LLC., 2011). Which of the following do you use with your interns? (Check all that apply)

___ Praise ___ Cognitive Interventions ___ Problem Solving

___ Commands ___ Modeling ___ Social Skills Training

___ Monitoring ___ Tangible Rewards ___ Communication Skills

___ Time Out ___ Response Cost ___ Psychoeducational-Parent

___ Goal Setting ___ Therapist Praise/Rewards ___ Differential Reinforcement Other Behavior

Other: _______________

ATTITUDES/PERSPECTIVES REGARDING EBTs

9) What do you see as advantages (if any) to training interns in EBTs? (Check all that apply)

Better client outcomes		Targeted to diagnoses	
Ease of training		Facilitates assessment of program effectiveness	
Other (please specify):		Other (please specify):	

10) What do you see as the barriers (if any) to training interns in EBTs? (Check all that apply)

Too time-consuming		Not culturally appropriate	
Funds unavailable		Does not work in clinical practice	
Do not have qualified supervisors		Lack of trainee interest	
Too difficult to teach		Lack of support of EBTs by clinical supervisors	
Other (please specify):		Other (please specify):	

11) If your program does not currently provide training in EBTs, do you have plans to do so in the future?
__ Yes __ Currently in the process of doing so __ No

12) Please offer any additional comments you may have regarding your attitudes towards EBTs and experiences with training and implementing EBTs into your training curriculum:

____

____

____

____

*****_Items_ #7, 9, 10, 11, 12 _used in this survey were adapted from:_

Weissman, M.M., Verdeli, H., Gameroff, M.J., Bledsoe, S. E., Betts, K., Mufson, L., Fitterling, H., Wickramaratne, P. (2006). National Survey of Psychotherapy Training in Psychiatry, Psychology, and Social Work. *Archives of General Psychiatry, 63*(8), 925-934. doi:10.1001/archpsyc.63.8.925

***This list of items was compiled from the following source:*

PracticeWise, LLC. (2011). Evidence-based youth mental health services literature database. Retrieved from http://www.practicewise.com

Thank you for completing the survey! For more information regarding this study or requests for a summary of the study results, please contact the investigator at: XXXXX.

APPENDIX C

B. Chorpita Permission Statement

Re: DISSERTATION FEEDBACK-Nathan Balfanz

XXXXX on behalf of Matthew Fierstein XXXXX

Sent: Friday, March 09, 2012 4:22 PM

To: Balfanz, Nathan (student)

Cc: Bruce F. Chorpita XXXXX

Hi Nathan,

Dr. Chorpita has given his verbal consent for you to use the practice element terms on your survey. Please let me know if you need anything else.

Matt

APPENDIX D

M. Weissman Permission Statement

RE: Request for National Survey...(2006)

Myrna Weissman XXXXX
Sent: Tuesday, March 06, 2012 11:16 PM

To: Balfanz, Nathan (student)

I am happy to hear our work was helpful to you. you might have a reference on the survey and your dissertation that says the survey was adapted from the the survey used in the following study and then reference our paper.

let me know your results when finished

Myrna M. Weissman PhD
Professor of Epidemiology and Psychiatry
XXXXX

APPENDIX E

Cover Letter

[Name
Title
Training Program
Address to be inserted]

Dear [Name to be added]:

My name is Nathan Balfanz, and I am a candidate in the Psy.D. Program in Clinical Psychology in the Graduate School of Education and Psychology (GSEP) at Pepperdine University. I am writing you today to request your participation in a research study in conjunction with my dissertation on internship training in evidence-based treatments (EBTs) for youth with disruptive behavior problems. You have been selected to participate in the research study given your position as training director or program director of a predoctoral internship psychology training program specializing in the treatment of children and adolescents listed in the 2012 APPIC directory. **Your participation would consist of answering questions on a brief 12-item survey, which should take between 5-10 minutes to complete.**

As someone who is devoted to the study and implementation of adequate treatment practices for today's youth, it is a primary research interest of mine to examine the extent to which the provision of effective treatment practices for children and adolescents is managing to keep up with its ever-increasing demand. With your participation, this survey study can help contribute to the latest research on EBTs for children and adolescents. You will find in this packet a statement of consent, the survey, as well as a reply mail envelope. If you are interested in participating in the study, please read through the statement of consent and fill out the survey to the best of your ability. Upon completing the survey, return it in the reply mail envelope addressed to myself as the principal investigator. The statement of consent is yours to keep.

If you think that you would not be the most appropriate program representative to complete this survey, please forward the survey to the program representative whom you believe to be most appropriate to respond to a survey on training in child and adolescent treatment.

Thank you in advance for your time and consideration of this request. Your timely response to this request is important to the success of the project and is greatly appreciated. If you have any questions or wish to receive a summary of the findings, please contact me at XXXXX. Also, should you have any questions you may contact my dissertation advisor, Edward Shafranske, Ph.D., ABPP, at XXXXX or XXXXX or Yuying Tsong, Ph.D., Chair, Graduate and Professional Schools IRB at (310) 568-5600.

Sincerely,

Nathan Balfanz, M.A.
Doctoral Candidate, Pepperdine University

Edward Shafranske, Ph.D., ABPP
Faculty Supervisor, Pepperdine University

APPENDIX F

Statement of Informed Consent

Introduction

This study and the following 12-item survey examine the use of evidence-based treatments (EBTs) for children and adolescents in psychology internship training, which include treatments that have received empirical support. This study is part of the dissertation scholarship conducted by Nathan Balfanz, M.A. and supervised by Edward Shafranske, Ph.D., ABPP, at the Psy.D. Program of Pepperdine University. Your participation in this study is voluntary; refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled. The survey itself will take approximately 5-10 minutes to complete. As a potential participant in this study, you are authorized to keep this statement of informed consent for your own records.

Consent to Participate

I understand that this study has been approved by the Pepperdine University Graduate and Professional Schools Institutional Review Board (IRB) and that my participation in this study is voluntary; refusal to participate will involve no penalty or loss of benefits to which I am otherwise entitled. I have been informed that the purpose of this study is to collect information and feedback regarding the use of evidence-based treatments (EBTs) for children and adolescents in psychology internship training, including treatments that have received empirical support. Further, I understand that my anonymity will be ensured because the survey information will be gathered with no identifying information requested and that identifying information about the internship will also not be requested. While there are no direct benefits to participants in the study, I understand that I may experience satisfaction in knowing that my participation will contribute to knowledge in the field of psychology. I understand that the study poses no greater than minimal risk of harm, for example, possible boredom or discomfort in answering questions related to clinical training. I understand that I may discontinue participation at any time and that it is recommended that I consult with a trusted colleague should I experience negative reactions when completing the survey.

I understand that by completing and returning the survey, I have indicated my voluntary consent to participate in this research. I understand that in an effort to maintain a potential participant's anonymity in the data collection process, the principal investigator has chosen not to require written documentation of consent. Further, I understand that if I wish to obtain more information regarding my rights as a research subject, including whether or not I would like to obtain documentation linking myself to the research (i.e. completion of a written informed consent form), I may contact the investigator at his e-mail address, XXXXX. I may also contact Dr. Edward Shafranske, Dissertation Chairperson, at XXXXX or XXXXX or Dr. Yuying Tsong, Chairperson of the Graduate and Professional Schools Institutional Review Board (GPS IRB) at Pepperdine University at (310) 568-5600 for further questions.

Principal Investigator: Nathan Balfanz, M.A.

APPENDIX G

Reminder Document

Greetings:

Approximately 10 days ago, you were sent a packet via U.S. postal mail requesting that you complete and return a survey on training in evidence-based treatments (EBTs) for children and adolescents with disruptive behavior problems. This is a friendly reminder to please take a moment to fill out this important survey.

The goal of the survey study is to examine in greater depth the extent to which predoctoral interns are being exposed to training in EBTs for children and adolescents with disruptive behavior problems over the course of their predoctoral internship year. Please take a moment to fill-out this survey and return the responses in the enclosed business reply envelope. Your participation is essential to further research in this important area of study. If you have already taken the time to complete and return the survey, please disregard this message.

Thank you for your time.

Sincerely,

Nathan Balfanz, M.A.
Doctoral Candidate, Pepperdine University

APPENDIX H

Second Reminder Document

Greetings:

Approximately one month ago, you were sent a packet via U.S. postal mail requesting that you complete and return a survey on training in evidence-based treatments (EBTs) for children and adolescents with disruptive behavior problems. This is a friendly reminder to please take a moment to fill out this important survey.

The goal of the survey study is to examine in greater depth the extent to which predoctoral interns are being exposed to training in EBTs for children and adolescents with disruptive behavior problems over the course of their predoctoral internship year. Please take a moment to fill-out this survey and return the responses in the enclosed business reply envelope. Your participation is essential to further research in this important area of study. If you have already taken the time to complete and return the survey, please disregard this message.

Thank you for your time.

Sincerely,

Nathan Balfanz, M.A.
Doctoral Candidate, Pepperdine University

APPENDIX I

Pepperdine IRB Application

PEPPERDINE IRB
APPLICATION FOR APPROVAL OF RESEARCH PROJECT

Date: **5/9/12** IRB Application/Protocol #: **P0412D09**

Principal Investigator: Nathan Balfanz

☐ Faculty ☐ Staff ☒ Student ☐ Other

School/Unit: ☐ GSBM ☒ GSEP ☐ Seaver ☐ SOL ☐ SPP

☐ Administration ☐ Other:

Faculty Supervisor: **Dr. Edward Shafranske** *(if applicable)*

School/Unit: ☐ GSBM ☒ GSEP ☐ Seaver ☐ SOL ☐ SPP

☐ Administration ☐ Other:

Project Title: Training in Evidence-Based Treatments for Youth with Disruptive Behavior Problems: A Survey of APA-Accredited and APPIC Approved Child and Adolescent-Focused Internships

Type of Project (Check all that apply):

☒ Dissertation ☐ Thesis
☐ Undergraduate Research ☐ Independent Study
☐ Classroom Project ☐ Faculty Research
☐ Other:

Is the Faculty Supervisor Review Form attached? ☒ Yes ☐ No ☐ N/A

Has the investigator(s) completed education on research with human subjects? ☒ Yes
☐ No

Please attach certification form(s) to this application.

Is this an application for expedited review? ☒ Yes ☐ No

If so, please explain briefly, with reference to Appendix C of the Investigator's Manual. **An expedited review is requested to the IRB, given that the research activities, including the survey design, pose no more than minimal risk to human subjects. Reasonable and appropriate protections will be implemented to reduce risks related to invasion of privacy and breach of confidentiality. Under the "Research Categories for Expedited Review" listed in Appendix C of the Investigator's Manual, the current research activities qualify under #7 such that the research employs a survey methodology.**

1. Briefly summarize your proposed research project, and describe your research goals and objectives: **In years past, the plight of youth with disruptive behavior problems like those seen in oppositional defiant disorder (ODD) and conduct disorder (CD) was bleak. Effective interventions approaches appeared to be nonexistent, since therapies such as long term psychotherapy and residential treatment did not result in verifiable behavioral change. However, more recently evidence-based practices (EBPs), including empirically supported treatments, have been found to result in**

significant sustainable behavior change. This development offers the hope of changing the downward trajectory of such youth, who are now able to receive adequate treatment. While empirical studies have demonstrated effectiveness, little is known about the dissemination and use of these treatments. Of particular interest is the extent to which training in such treatments is available. This dissertation aims to examine training in EBT strategies for youth with disruptive behavior problems for psychologists. This study will investigate the status of training and supervised practice in EBTs for youth with disruptive behavior problems in child and adolescent-focused clinical psychology internships.

The objectives of the research are: a) assess the extent to which training in EBTs for youth with disruptive behavior problems related to ODD and CD are incorporated in child- and adolescent-focused internship training programs in psychology in the United States; b) identify the treatment protocols and practice elements that are most frequently incorporated; and c) examine the attitudes of directors of training or program directors about the advantages, disadvantages, and challenges in providing training in EBT.

In order to meet these research objectives, a survey was developed, which includes a list of EBTs and their practice components, that assesses the availability of training in EBTs for children/adolescents and opinions about perceived advantages, disadvantages, and challenges in implementing EBTs. The survey was developed after reviewing the relevant research and corresponding with research experts in the field of child and adolescent treatment. The survey will be distributed to 285 internship training directors or program directors of child and adolescent-focused internships listed in the 2012 APPIC Directory. The study findings will provide important data on the availability of training in evidence-based practices.

2. Estimated Dates of Project:
From: **May 22, 2012** To: **May 22, 2013**

3. Cooperating Institutions and Funded Research. Circle and explain below; provide address, telephone, supervisor as applicable.

3.1 ☐Yes ☒ No This project is part of a research project involving investigators from other institutions.

3.2 ☐Yes ☒No Has this application been submitted to any other Institutional Review Board? If yes, provide name of committee, date, and decision. Attach a copy of the approval letter.

3.3 ☐Yes ☒ No This project is funded by or cosponsored by an organization or institution other than Pepperdine University.

Internal Funding (indicate source): **n/a**

External funding (indicate source): **n/a**

Funding Status: ☐ Funded ☐ Pending Explain, if needed: **n/a**

4. Subjects

4.1 Number of Subjects: **285 Ages: 21+**
Discuss rationale for subject selection. **A decision was made, in consultation with my dissertation committee, to recruit participation from the training directors or program directors from all child- and adolescent- internship programs (N=285) rather than to administer the survey to a sample of that population. To achieve a confidence level of 95% (5% margin of error) in a population of 285, the required sample size is approximately 165 respondents (The Research Advisors, 2006). It is believed that administrating the survey to program representatives from all programs will provide the best opportunity to obtain 165 completed surveys.**

The subjects are training directors or program directors of child and adolescent-focused predoctoral internship programs listed in the 2012 APPIC Directory. Directory search results were limited to those programs that listed both "Children" and "Adolescents" as "Major" populations referred for treatment, and provided a mailing address for the site.

The subjects will be instructed that if they think that they would not be the most appropriate program representative to complete this survey to forward the survey to the program representative whom they believe to be most appropriate to respond to a survey on training in child and adolescent treatment.

4.2 Settings from which subjects will be recruited. Attach copies of all materials used to recruit subjects (e.g., flyers, advertisements, scripts, email messages): **The principal investigator will contact via U.S. postal mail the directors of clinical training at child and adolescent focused APA-accredited and non-APA, APPIC approved doctoral training programs located in the United States. The investigator identified a list of the programs eligible for the survey from a publically accessible database found at: http://www.appic.org/directory/search_dol_internships.asp. The names and mailing addresses of program training directors were obtained through reviewing the information page of each individual program site listing. Given that internship training programs generally offer multiple training rotations which are often supervised by other faculty and staff from the program, it was requested of each training director to pass the survey along to the program representative whom they believed to be the most appropriate individual to respond to a survey on training in child and adolescent treatment strategies. A survey packet will be mailed to each potential participant that includes: a letter of introduction and request for participation explaining the study's purpose, participant anonymity, and the voluntary nature of the study; a hard copy of the survey; the contact information of the investigator responsible for developing the study; as well as a stamped, reply mail envelope.**

4.3 Criteria for inclusion and exclusion of subjects:
The subjects are training directors or program directors from internship programs that are (a) listed in the APPIC Directory as APA-accredited or non-accredited training programs; (b) internship program must identify “Children” and “Adolescents” as “Major” populations referred for treatment on its APPIC listing; and (c) internship program must have an accessible mailing address for its training director or program director in its APPIC listing. Potential subjects were excluded from the study if their training program was not in the United States, if their program did not identify both “Children” and “Adolescents” as “Major” populations for treatment, and/or if their program did not have an accessible mailing address for its training director or program director in its APPIC listing.

4.4 ☐Yes ☒No Will access to subjects be gained through cooperating institutions? If so, discuss your procedures for gaining permission for cooperating individuals and/or institutions, and attach documentation of permission. **You must obtain and document permission to recruit subjects from each site**.

4.5 ☐Yes ☒No Will subjects receive compensation for participation? If so, discuss your procedures. **n/a**

4.6 Describe the method by which subjects will be selected and for assuring that their participation is voluntary. **The principal investigator will contact the directors of clinical training at child and adolescent focused APA-accredited and non-APA, APPIC approved doctoral training programs located in the United States by mail (USPS). The investigator identified a list of the programs eligible for the survey from a publically accessible database found at: http://www.appic.org/directory/search_dol_internships.asp. The names and mailing addresses of program training directors were obtained through reviewing the information page of each individual program site listing. Given that internship training programs generally offer multiple training rotations which are often supervised by other faculty and staff from the program, it was requested of each training director to pass the survey along to the program representative whom they believed to be the most appropriate individual to respond to a survey on training in child and adolescent treatment strategies. A survey packet will be mailed to each potential participant that includes: a letter of introduction and request for participation explaining the study’s purpose, participant anonymity, and the voluntary nature of the study; an informed consent statement; a hard copy of the survey; the contact information of the investigator responsible for developing the study; as well as a stamped, reply mail envelope. The informed consent statement contains information regarding the research and the participant’s method for consent to participate. Each participant will be asked if he/she wants documentation linking the participant with the research. The participant’s wishes will govern whether or not their informed consent is to be documented. Participant recruitment will span from May 22, 2012 to May 22, 2013. A hard copy of the**

survey will be included in the survey packet and delivered to all potential participants via USPS. The developer chose to send the survey by mail in an attempt to ensure a larger number of respondents, given the understanding that training program directors are often overburdened with e-mails pertaining to their primary occupational roles and responsibilities. The hard copy survey is void of any identifying information, allowing participants to maintain anonymity in their responses.

5. Interventions and Procedures to Which the Subject May Be Exposed

5.1 Describe specific procedures, instruments, tests, measures, and interventions to which the subjects may be exposed through participation in the research project. Attach copies of all surveys, questionnaires, or tests being administered. **A hard copy of the survey will be included in a survey packet and delivered to all potential participants via United States Postal Service (USPS). The developer chose to send the survey by mail in an attempt to ensure a larger number of respondents, given the understanding that training program directors are often overburdened with e-mails pertaining to their primary occupational roles and responsibilities. The hard copy survey is void of any identifying information, allowing participants to maintain anonymity in their responses. If those recipients choose to participate in the study, they are requested to complete the survey included in the packet and mail it back to the principal investigator in the stamped, reply mail envelope also included. Given that requiring the study participants to provide a documentation of consent would indirectly result in a request for identifying information and a subsequent violation of anonymity, the study investigator has applied for a waiver of informed consent. A waiver of documentation of consent is requested to allow for implied consent from the directors of clinical training and/or appropriate training program directors, indicating that the respondents demonstrate implied consent as a research participant by completing and returning the survey, as is stated in the recruitment cover letter. Responding to the survey indicates a participant's confirmation that he/she understands the nature, risks, and benefits of the study, their rights to confidentiality, steps being taken to ensure confidentiality, and their right to refuse to participate or withdraw participation at any point. Potential study participants will be sent reminder documents via e-mail 10 days following the initial distribution of the survey to remind them of their opportunity to participate have they not already done so. E-mail addresses for the list of eligible training directors were obtained through reviewing the information page of each individual program site listing. If participants wish to receive feedback regarding the study, they are encouraged to contact the principal investigator directly in order to make this request. The survey itself as well as the reminder document are attached to this application. ADDENDUM: Due to an initial low response rate, and upon being granted permission by the Pepperdine IRB, the principal investigator sent out a second reminder email to training directors on 6/20/12.**

5.2 ☐Yes ☒No Are any drugs, medical devices or procedures involved in this study? Explain below. **n/a**

5.3 ☐Yes ☒No Are the drugs, medical devices or procedures to be used approved by the FDA for the same purpose for which they will be used in this study? Explain below. **n/a**

5.4 ☐Yes ☒ No Does your study fall under HIPAA? Explain below. **n/a**

6. Describe all possible risks to the subject, whether or not you consider them to be risks of ordinary life, and describe the precautions that will be taken to minimize risks. The concept of risk goes beyond physical risk and includes risks to the subject's dignity and self-respect, as well as psychological, emotional, and behavioral risk. Discuss the procedures you plan to follow in the case of adverse or unexpected events. **Given the contents under study, i.e. information about availability of training and attitudes towards the inclusion of EBTs in internship training, and the use of a survey design, it is the Principal Investigator's belief that the study poses no more than minimal risk to the research participant. Individuals interested in participating in the study would encounter risks no greater than those of ordinary life, such that their responses to the survey items would not place them at risk for physical injury or criminal or civil liability, nor would they be damaging to the individual's financial standing, employability, insurability, reputation, or be stigmatizing of themselves or their training program. Further, given that no specific identifying information is being collected, there is no risk of damaging the participant's or the training program's reputation or standing in the training community. Potential risks of participating in the current study include boredom. Participants are instructed that they may discontinue participation at any time, and it is recommended that they consult with a trusted colleague should they experience any discomfort when completing the survey.**

7. Describe the potential benefits to the subject and society. **While there are no direct benefits to individuals who participate in the study, a participant may experience satisfaction in knowing that his or her participation will contribute to knowledge in the field of psychology.**

8. Informed Consent and Confidentiality and Security of the Data

8.1 ☒Yes ☐No Is a waiver of or alteration to the informed consent process being sought? If yes, please attach the **Application for Waiver or Alteration of Informed Consent Procedures form.** If not, describe the ability of the subject to give informed consent. Explain through what procedures will informed consent be assured. **Subjects provide informed consent as indicated by completion and submission of the survey. Subjects also will receive a separate document outlining the informed consent information and procedures. A waiver of documentation of informed consent accompanies this application.**

8.2 Attach a copy of the consent form. Review the *Instructions for Documentation of Informed Consent* in Section VII.A of the Investigator Manual.

8.3 ☐Yes ☒ No Is the subject a child? If yes, describe the procedures and attach the form for assent to participate.

8.4 ☐Yes ☒ No Is the subject a member of another vulnerable population? (i.e., individuals with mental or cognitive disabilities, educationally or economically disadvantaged persons, pregnant women, and prisoners). If yes, describe the procedures involved with obtaining informed consent from individuals in this population.

8.5 If HIPAA applies to your study, attach a copy of the certification that the investigator(s) has completed the HIPAA educational component. Describe your procedures for obtaining Authorization from participants. Attach a copy of the Covered Entity's HIPAA Authorization and Revocation of Authorization forms to be used in your study (see Section XI. of the Investigator Manual for forms to use if the CE does not provide such forms). If you are seeking to use or disclose PHI without Authorization, please attach the **Application for Use or Disclosure of PHI Without Authorization** form (see Section XI). Review the HIPAA procedures in Section X. of the Investigator Manual. **n/a**

8.6 Describe the procedures through which anonymity or confidentiality of the subjects will be maintained during and after the data collection and in the reporting of the findings. Confidentiality or anonymity is required unless subjects give written permission that their data may be identified. **The cover letter includes "Your participation in this study is voluntary and no identifying information will be obtained regarding the study participants or training sites." No names or code numbers were included on the survey, results, or demographic information sheet.**

8.7 Describe the procedures through which the security of the data will be maintained.

Once data collection is completed, the principal investigator will code the responses to those surveys that were returned and enter them into an SPSS compatible spreadsheet. To protect confidentiality, all hard copy surveys will be kept in a locked container by the principal investigator, while all electronic, descriptive data files will be stored on the investigator's personal computer in a password-protected folder. After five years, all data will be destroyed.

I hereby certify that I am familiar with federal and professional standards for conducting research with human subjects and that I will comply with these standards. The above information is correct to the best of my knowledge, and I shall adhere to the procedure as described. If a change in procedures becomes necessary I shall submit an amended application to the IRB and await approval prior to implementing any new procedures. If any problems involving human subjects occur, I shall immediately notify the IRB

Chairperson. I understand that research protocols can be approved for no longer than 1 year. I understand that my protocol will undergo continuing review by the IRB until the study is completed, and that it is my responsibility to submit for an extension of this protocol if my study extends beyond the initial authorization period.