ATTITUDES AND BELIEFS ABOUT EVIDENCE BASED PRACTICE
AMONG MASTERS IN SOCIAL WORK PRACTITIONERS AND
LICENSED CLINICAL SOCIAL WORKERS

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Katy Leanne Bandy
Emily Violet Thomas
June 2008
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ABSTRACT

Previous research has shown that the social work profession is often considered to be an "authority-based" profession that relies on lay knowledge and techniques (Rubin & Parrish, 2007; Gambrill, 2007; McNeill, 2006; Crisp, 2004). Social work ethics however, call for practice based on "recognized knowledge, including empirically based knowledge..." (National Association of Social Workers, 1996, p. 3). This lapse in understanding calls for an inquiry into MSW and LCSW attitudes and beliefs towards the use of evidence-based practices. According to Azjen and Fishbein's (1980) Theory of Reasoned Action, a person's attitude towards a certain behavior directly affects the likeliness that the behavior will occur.

This study utilized a survey instrument titled the "Evidence-Based Practice Attitude Scale" created by Gregory A. Aarons (2004). The survey was given to 59 MSWs and LCSWs working in the mental health setting during a staff meeting at Patton State Hospital. Their responses were analyzed using correlations, t-tests, frequencies and percentages using Aarons calculated subscales (2004).
The findings were that participants responded more positively than negatively to the subscales of Appeal and Openness. They also had somewhat positive attitudes towards Divergence, or willingness to diverge from usual practice to academically developed or research-based practices.

Contrarily, participant attitudes were more negative in the Requirements subscale, indicating that they were less enthusiastic about using EBPs required by supervisors or agencies.
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CHAPTER ONE

INTRODUCTION

Problem Statement

The issue of competent practice in the social work profession is one that social workers should be concerned with. Social workers are obligated to use the best knowledge available to help those who are vulnerable, oppressed and living in poverty but it is likely that practitioners often do not have the best resources once they leave the academic environment. Within this larger social problem of competence in practice there are practitioner attitudes and beliefs concerning the use of evidence-based practice (EBP).

Once a practitioner is bumped into the work place they rely on the knowledge they gained in their schooling; but what happens when new types of therapy and treatments are developed? If the practitioner does not have attitudes or beliefs that keep them up to date on evidence-based practice and new types of therapies they are likely to never learn about these new resources. This is where social work ethics come into play for the
practitioner’s attitudes and beliefs towards evidence based therapies.

The Code of Ethics of the National Association of Social Workers (NASW) confirms social workers’ ethical responsibilities as professionals: “Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics” (National Association of Social Workers, 1996, pp. 12). Though a new practitioner may adhere fairly well to this guideline, having just come out of the academic environment with the most recent knowledge, their attitudes and beliefs towards new types of therapy can change over time, or simply never develop further.

Anyone who is going to graduate school has to constantly stretch and change their attitudes and beliefs as they gain new knowledge and insight. The question is whether or not our educational policies prepare students for continual growth and interest in learning about new types of therapy and practice once they do not have their teachers to guide them.

The Educational Policy and Accreditation Standards of The Council on Social Work Education (CSWE) refers to
educational standards by saying, "The content prepares students to develop, use, and effectively communicate empirically based knowledge, including evidence-based interventions" (Council on Social Work Education, 2001, p. 4). Given these statements, it becomes clear how important it is for social workers to both practice competently and develop their personal attitudes and beliefs towards new ideas discovered by research. Competent practice can be fostered by making use of evidence-based practice which requires a certain attitude that fosters continued exploration of new types of therapies discovered through research.

The theory of reasoned action developed by Azjen and Fishbein (1980) asserts that a person's attitude towards a certain behavior directly affects the likeliness that the behavior will occur. This theory makes it clear that attitudes and beliefs of practitioners are a critical component in what type of therapy they will utilize, one they learned twenty years ago in graduate school or one published in the most recent journal.

In order to illustrate why competence in practice includes attitudes and beliefs that are open to the use of evidence-based practice one must understand why
evidence-based practice is important. Ethics that coincide with the use of evidence-based practice include commitment to the client's best interest, values-guided practice, goal-directed practice, accountability, and, as already mentioned, commitment to scientific standards of evidence (Rosen, 2003; Thyer & Wodarski, 2007).

As will be seen in the following chapters, evidence-based practice can incorporate these core ethics when used appropriately (Gambrill, 2007). If a practitioner does not have attitudes and beliefs that are open to the use of evidence-based practice, it could be argued that they are not practicing in a competent and ethical manner.

First one must ask whether or not there really is a problem with the competence of social work practice. In doing research it can be found that the social work profession is considered by many to be an "authority-based" profession, rather than a research-based profession (Rubin & Parrish, 2007; Gambrill, 2007; McNeill, 2006; Crisp, 2004). One author described that social work knowledge is based on "the opinions of other, tradition, pronouncements of

Because social and personal problems are the focus of social work professional concerns and similar problems might also exist in a practitioner’s personal life or the lives of those around them, they might enter the profession with already established lay understandings and ways to solve a particular issue. As a result, social workers have been accused of using lay knowledge and skills, instead of applying professional skills and knowledge (Rosen, 2003).

This reputation that social workers do not have open attitudes and beliefs towards evidence-based practice and instead rely on lay knowledge is not a positive one. Addressing this problem of competent practice includes addressing and analyzing practitioner attitudes. If the social work profession is going to claim to operate on ethics which require practitioners to use the best knowledge available, then it must do so.

A study that was conducted by Gambrill (2007) found that social workers want and expect their medical doctors to rely on scientific evidence when making decisions about their medical problems, but often do not have the
same standards for their own clinical practices (Gambrill, 2007; Pollio, 2007).

Other studies have found that social workers do not depend on evidence-based knowledge when selecting interventions for clients (Rosen, 2003; Jenson, 2005; McNeill, 2006). According to the Theory of Reasoned Action this would lead to the conclusion that social workers' attitudes towards evidence-based knowledge do not emphasize its importance.

Not only should social workers be concerned about utilizing evidence-based practice but educators should be enthusiastic about teaching evidence-based practice, clients should expect interventions that have been proven to be effective, and agencies should be training their employees in evidence-based practice continually in the work place.

The topic of evidence-based practice can be a controversial one and some argue that therapists do not need to have open and positive attitudes towards evidence-based practice. Because each individual is different and unique, a practitioner cannot expect a single solution or equation to work for everyone. There are many different evidence-based practices and each one
does not work the same in every situation. What can be understood in the social work profession is that certain techniques, as a general rule, work better than others for most people in a certain situation. This is the purpose of research, to find a general understanding for how things are most of the time.

It is important to understand more clearly some of the reluctance towards the use of evidence-based practice and that is why understanding attitudes and perceptions of MSWs and LCSWs can be useful. Perhaps graduate programs need to better communicate to future practitioners the understanding that though research does not provide "100% effective 100% of the time" solutions, it still guides us in a more competent direction.

If the field of social work begins to understand practitioner attitudes more clearly, it might be able to change social work practice in the realm of evidence-based practice. For example, practitioners, educators, and agencies will begin to understand what evidence-based practice truly is and the value it holds in the profession. More importantly clients will benefit because they will be provided with treatments that have
been proven to be successful in the majority of situations.

When looking at the use of evidence-based practice in the macro/policy realm there are many regulations for the field of social work which hold practitioners up to certain standards. State legislative mandate for example requires that a person wishing to be a school social worker must complete both an MSW program and a school social work program (Seeber, 2004). The state expects that through completing certain programs, practitioners will gain expertise in therapeutic standards. If the government is going to pay for programs or employees, they want to know they are paying for competent ones.

Another example of the need for competent practitioner standards is the hesitance from insurance companies to cover mental health treatment. Kennedy and Ramstad introduced "The Paul Wellstone Mental Health and Addiction Equity Act" (H.R. 1367) in March of 2007 which proposes "requiring group health plans that offer benefits for mental health and addiction to do so on the same terms as care for other diseases" (2007, p. 4).

It is because of the doubt in the reliability of mental health practitioners that bills like this have to
be enforced. If insurance companies and other large organizations had enough respect and trust for social work and its surrounding fields, the government would not have to force them to cover addiction treatment and other mental health needs like this. It is the responsibility of social workers to raise credibility in the eyes of the public by increasing practitioner standards and getting rid of the stereotype that social workers are practitioners of the anecdotal method.

The issue of competent practice at the micro level comes right down to the ethics mentioned earlier. If the field of social work truly aims to help the vulnerable, oppressed and those living in poverty then it should be concerned with the best possible resources and methods to treat clients. As service providers, mental health practitioners should not be like other businesses that value profit and yield more than quality. Human beings are not a commodity and each one deserves unique and sensitive treatment. Therapists should be aware of many types of evidence-based practice in order to know relatively well what type of therapy will suit each client best.
Purpose of the Study

The purpose of this study is to better understand the attitudes and beliefs about evidence-based practice among MSWs and LCSWs. Assessing the attitudes toward evidence-based practice can further the analysis of competent practice and perhaps help determine the extent to which social work is a profession based on research or anecdotal methods.

The rationale for addressing the issue of competent practice by asking practitioners about their attitude towards evidence-based practice is that practitioner viewpoints lead to an idea of whether or not they are using evidence-based practice, according to the Theory of Reasoned Action. Practitioner attitudes and opinions towards evidence-based practice can also give insight as to whether or not our schools and programs are adequately preparing practitioners for ethical and competent practice past their graduate school experience. It can also be seen whether or not evidence-based practice is deemed useful by practitioners and why this is.

By using a survey there is access to quantitative data. With quantitative data there is statistical measurement of MSW and LCSW opinions. The measurement
tool that was implemented was the "Evidence-Based Practice Attitude Scale" created by Aarons (2004). This tool consists of fifteen scaled questions about the practitioner's attitudes towards evidence-based practice and openness to new types of therapy.

This project is significant because it is not clear whether or not practitioner opinions about evidence-based practice are positive or negative. In order to dispel the stigma attached to the field of social work, practitioners must move away from anecdotal methods and lay methods of counseling and instead turn towards methods that have been statistically proven to be more successful with certain clients and issues.

In the literature review are two examples of areas in mental health in which evidence-based practice can be used, marital problems and post-traumatic stress disorder. The fact that not all evidence-based practices work for every person and that practitioners must be aware of the strengths and limitations of evidence-based practice will also be addressed.
Significance of the Project for Social Work

This study contributes to social work practice by improving the fund of knowledge about what therapist attitudes are towards evidence-based practice. In turn this knowledge can help the social work field grow and advance, providing better services for clients. If MSWs and LCSWs are already using evidence-based practice, then perhaps practitioners can learn to be more flexible with the application of certain types of therapy with certain clients. Perhaps practitioners need to be more open to adapting their repertoire of evidence-based practice to various settings.

Along with contributing to micro level practice, understanding practitioner attitudes towards evidence-based practice will also improve social work's standing at the macro and policy level of practice. Since social worker's deal with many large organizations from insurance companies to federal, state and local governments we have to maintain specific standards in addition to our own ethical standards.

If the field of social work expects to keep up in a world that is turning more and more to quality research, then it must use validated tools in the profession. This
study contributes to an already strong body of research that social work has built that helps the profession assess itself and its standards.

Because evidence-based practice and the broader social problem of competent practice is so expansive, this study will inform each stage of the generalist model. Evidence-based practices can be applied from assessment to termination and practitioners should be concerned with completing each step of the generalist model with the best tools and methods possible. Research based assessment instruments, types of therapy, intervention techniques and termination strategies are just a few of the ways evidence-based practice applies to the generalist model.

Since social work is a human service field, it cannot expect everything to be black and white but social workers can try to find the best solutions for various situations and move away from the archaic lay and anecdotal methods we are often known for.

Research Question: Among MSWs and LCSWs, what are the attitudes and beliefs toward Evidence-Based Practice?
CHAPTER TWO

LITERATURE REVIEW

Theory Guiding Conceptualization

To guide the conceptualization of this study, the theory of reasoned action was vital (Azjen & Fishbein, 1980). This theory asserts that a person's attitude towards a certain behavior directly affects the likeliness that the behavior will occur. This connection between attitude and behavior makes it clear that the attitudes and beliefs of practitioners are a critical component to what type of therapy they will utilize; one they learned twenty years ago in graduate school or one published in the most recent journal. By following the theory of reasoned action the results of a survey can be estimated as a predictor of behavior, at least to some extent.

Overview of Evidence-based Practice

Evidence-based practice (EBP) originated in medicine in the 1990s, and more recently in psychiatry, clinical psychology, and social work (Rosen, 2003). Currently, the Social Work Dictionary defines EBP as "the use of the best available scientific knowledge derived from
randomized controlled outcome studies, and meta-analyses of existing outcome studies, as one basis for guiding professional interventions and effective therapies, combined with professional ethical standards, clinical judgment, and practice wisdom" (Barker, 2003, p. 149). In other words, EBP brings together the best available research on a particular issue or intervention (e.g., marital problems, post-traumatic stress disorder), a client's unique values, circumstances and preferences along with the clinician's expertise (Thyer & Wodarski, 2007).

It is imperative to begin by distinguishing between Evidence-based Practice (EBP) and Evidence-based Treatments (EBT) (a.k.a. Evidence-based Interventions, Empirically-supported Interventions). EBP refers to a specific process, which will be discussed in more detail later, that includes more than just interventions or treatments that have attained empirical support. In other words, Evidence-based Treatments merely refer to those interventions that are well-established or efficacious in many cases (Woody, D'Souza, & Dartman, 2006).

If a practitioner decided to embark on the process of EBP, there are five steps that would be taken. First,
practitioners would transform their need for information into a question (e.g., What are the most effective treatments for helping couples in distress?). Second, practitioners would locate the best available research to answer the question. Third, practitioners would analyze the research in terms of its validity. Fourth, practitioners would bring together their critical appraisal with the client’s unique values, circumstances and preferences along with the practitioner’s clinical expertise. Finally, practitioners would assess their effectiveness in carrying out each step (Thyer & Wodarski, 2007).

Pollio (2007) proposes a few alternative practice principles for what he terms the art of evidence-based practice. First, Pollio states that practitioners need to be able to describe EBP clearly to their clients and help them understand why past implementation efforts of a particular intervention might have failed. Second, he explains that practitioners need to create a useful and realistic method to evaluate outcomes for themselves and their clients. Third, Pollio explains that practitioners need to have the ability to re-choose and refine treatments and systems of evaluation, based on an
increase in knowledge of the clients' situations and an increase in the clients' motivation to make changes. Last, he suggests that practitioners remain aware of pertinent evidence about specific treatments and incorporate new evidence into interventions, being critical consumers of all evidence.

Practitioners might ask themselves: "How do I evaluate the research literature in terms of the effectiveness of interventions?" After all, there is a hierarchy of evidence ranging from most likely valid or credible to the least reliable. On the high end of the scale is a methodical evaluation of all available research, published and unpublished, written in English and in other languages, provided by credible organizations like the Cochrane or Campbell Collaborations (Campbell Collaboration, 2000; Cochrane Collaboration, 1993). On the low end of the scale are expert opinions or consensus standards. In the middle of the hierarchy, going from most reliable to least reliable, are meta-analyses, large-scale multi-site randomized controlled trials, individual randomized controlled trials, quasi-experimental controlled trials, pre-experimental trials, single-subject research designs,
and qualitative outcome studies. Some other important factors to consider are whether the results have been replicated, whether the intervention is ethical, whether the intervention is applicable to a particular client, and whether the intervention is acceptable to the client (Thyer & Wodarski, 2007).

Crisp (2004) proposes a few more questions for practitioners to ask themselves when considering which research evidence to use:

- "Why am I using this evidence?" (p. 81).
- "Am I only using this evidence because it is readily available to me or because I believe it to be credible?" (p. 81).
- "Is the basis of this evidence methodically sound?" (p. 81).
- "Am I using this evidence without considering how apt it is for the context because it comes from an eminent source?" (p. 81).
- "To what extent do personal factors impinge on my evaluation of this evidence?" (p. 81).
- "Will others be convinced of this evidence?" (p. 81).
“Is it possible that there is more appropriate evidence? If so, do I have the resources (including time) to search for other evidence?” (p. 82).

“Are there reasons why this evidence cannot be applied?” (p. 82).

“Is it possible that this evidence has been superseded?” (p. 82).

As one can see from the preceding paragraphs, EBP is a complex process, not merely a simple choice about what treatment or intervention to use. It involves finding the best available research on a particular issue or intervention (e.g., marital problems, post-traumatic stress disorder), considering a client’s unique values, circumstances and preferences and finally taking advantage of a clinician’s expertise and evaluating outcomes.

Positive and Negative Viewpoints of Evidence-based Practice

Although the above concepts might seem simple and straightforward, in doing library research on EBP, the study concluded that there are numerous attitudes and perceptions about EBP. The study uncovered both positive
and negative views of EBP from various perspectives: social work pioneers, professionals, administrators, educators, researchers, The National Association of Social Workers (NASW), The Council on Social Work Education (CSWE), The National Institute of Mental Health (NIMH), The Substance Abuse and Mental Health Services Administration (SAMHSA), political officials, funding sources, and private foundations.

In relation to social work pioneers, Mary Richmond, Jane Addams, and Flexner all had beliefs grounded in EBP. Mary Richmond’s *Social Diagnosis* focused on the idea that evidence should be a basis for social work (Witkin & Harrison, 2001). Flexner questioned whether social work was a legitimate profession because of the “relatively weak integration between research and practice that characterized early social interventions” (Jenson, 2005, p. 131). And lastly, Jane Addams suggested that “systematic data collection and information processing were critical aspects of effective individual-level interventions and community practice strategies” (Jenson, 2005, p. 131).

Just as social work pioneers considered systematic data collection, recently Rubin and Parrish (2007)
systematically collected data for a national survey at the University of Texas at Austin, that measured views of Evidence-Based Practice Among Faculty in Master of Social Work Programs, it was determined that 73% of respondents view the EBP movement favorably or very favorably, although, the survey revealed a few negative perspectives.

There are various reasons for negative opinions of EBP. For example, certain individuals believe that evidence-based practice is "reductionistic and based on 'mindless' empiricism" and that it "denigrates clinical expertise, ignores patients' values and preferences, promotes a 'cookbook' approach to practice, is merely a cost-cutting tool, and leads to therapeutic nihilism" (Rubin & Parrish, 2007, p. 111). Other practitioners believe that EBP methods are "'likely to cramp the natural style of staff, and therefore, will lead to more harm than good'" (Pollio, 2007, p. 224). Some practitioners would even argue that EBP may "dissuade potentially creative practitioners from entering the field" (Witkin & Harrison, 2001, p. 295). All of these ideas completely overlook the basic principles of EBP.
described in the previous section (McNeill, 2006; Zlotnik & Galambos, 2004).

Another objection relates to the lack of evidence in certain areas of practice, but advocates for EBP argue that practitioners can still use the best available evidence and evaluate treatment outcomes (Pollio, 2007; Rubin & Parrish, 2007). Certain professionals and educators are also skeptical about EBP and its feasibility in the real world of practice. There are concerns about organizational policies that may not provide enough time, resources, and support to carry out the entire process of EBP; concerns about access to the Internet, books, and journals that are needed to find evidence; and concerns about having to follow strict treatment protocols, especially given the fact that a large percentage of clients drop out of treatment or are not consistent with attendance at therapy sessions (Rubin & Parrish, 2007). In addition, some practitioners complain about the restraints from bureaucracies at their employment sites (Gambrill, 2007).

At this point, the definition of EBP is hopefully clear, but many practitioners and educators still find the term puzzling and ambiguous. Additionally, there is
still debate in regards to evidentiary standards in evidence-based practice. The hierarchy described in the preceding section is currently being disputed (McNeill, 2006; Rubin & Parrish, 2007).

Another complaint about the EBP movement relates to obstacles with knowledge transfer (i.e., ability to attain research on evidence-based treatments) and translation (i.e., ability to understand research). As stated earlier, certain practitioners may not have access to the Internet, books, or journals, or may not have the time, support, and resources to research the evidence, especially given the vast amount and sometimes conflicted literature or information that is available on particular fields of practice.

In one study, 98.3% of socials workers listed time pressures as an obstacle to keeping up with professional literature (Crisp, 2004). Overall, the problem of knowledge dissemination may involve the practitioner (e.g., inexperience, lack of motivation, lack of time), the content of the information (e.g., too lengthy, confusing, contradictory), and the way of dissemination (e.g. hard to find/access, too much information) (Jenson, 2005; McNeill, 2006; Woody, D’Souza, & Dartman, 2006).
However, a few federal entities and independent researcher centers, such as the Substance Abuse and Mental Health Services Administration (SAMHSA), publish lists of effective programs in the National Registry of Evidence-Based Programs and Practices (Crisp, 2004; Jenson, 2005; Zlotnik & Galambos, 2004).

In contrast with the preceding negative viewpoints of EBP among social work professionals, a survey of Deans and Directors of CSWE-accredited Master’s in Social Work (MSW), which was conducted by University of Nebraska and Medical Center Aurora, found that informal faculty commitment to the goal of teaching EBP in the curriculum was much greater than program commitment. For example, there are only a small number of programs that teach EBP and EBT. One program’s curriculum includes the following: "an understanding and appreciation of evidence-based approaches; the ability to choose practice interventions supported by empirical evidence; a realization of the fact that many ‘social work theories and policies are research based’; the ability to deliver these interventions at all practice levels while keeping in mind the use of and possible need for adaptation of the interventions with various populations; and a capacity to
evaluate one’s intervention efforts objectively and to seek and find information through the use of reliable scientific databases when questions arise” (Woody, 2006, p. 471).

As was addressed in the problem formulation, the Council on Social Work Education (CSWE) and the National Association of Social Workers (NASW) both acknowledge the importance of using empirically supported interventions. In addition, respected social work organizations such as these, in collaboration with the National Institute of Mental Health (NIMH), are in the process of creating a CD-ROM curriculum support tool to encourage the teaching of EBP throughout the social work curriculum (Rubin & Parrish, 2007). And similarly, local, state, and federal policymakers, funding sources, and private foundations are all beginning to see the value in evidence-based treatments (Jenson, 2005). Certain social service organizations, especially those that are experiencing fiscal and resource crises, are also beginning to consider EBP in order to achieve accountability of interventions (Crisp, 2004).

As one can see, there is a vast array of both positive and negative perceptions about evidence-based
practice, some perspectives perhaps being misconceptions and others might be considered valid concerns.

Examples of Utilizing Evidence-based Practice

There are numerous psychosocial treatments that have proved to be effective with particular problems. In other words, if a problem exists in the world (e.g., marital dissatisfaction, trauma), it has the potential to be measured, in hopes of finding empirically supported interventions. Provided below are a few examples of using evidence-based practice, in relation to marital problems and post-traumatic stress disorder (PTSD) given that these are incredibly prevalent issues in our society.

First, the researchers transformed their need for information into questions: What are the most effective treatments for helping couples in distress? And what are the most effective treatments for helping people that are experiencing PTSD? Second, they located the best available research to answer the questions. For example, they read peer-reviewed journal articles and books written by credible authors. Third, the researchers analyzed the research in terms of its validity. Fourth, if they were actual practitioners they would have brought
together their critical appraisal with their clients' unique values, circumstances and preferences, and their clinical expertise. Finally, they would have assessed effectiveness in carrying out each step.

Marital Problems

In relation to the research step of evidence-based practice, the researchers found that five different treatments have proven to be effective: behavior couple therapy (BCT), cognitive-behavioral couple therapy (CBCT), integrative behavioral couple therapy (IBCT), emotionally focused couple therapy (EFCT), and insight-oriented couple therapy (IOCT) (Byrne, Carr, & Clark, 2004; Dattilio, 2001; Dattilio & Epstein, 2005; Epstein, 2006; Fisher & O'Donohue, 2006; Johnson & Greenman, 2006; Lopez, 1993; Snyder, Wills, & Grady-Fletcher, 1991; Snyder & Wills, 1989; Verseveldt, 2006).

Behavioral Couple Therapy

Behavioral Couple Therapy (BCT) is rooted in social exchange theory and social learning theory. The idea is that an individual's level of relationship satisfaction is contingent upon the ratio of positive to negative
experiences he or she has with his/her partner, and that partners form each other's behavior through the positive or negative consequences they provide for each other's acts (Fisher & O'Donohue, 2006). Behavioral exchange training (i.e., committing to perform more positive behaviors that his/her partner desires) and communication/problem solving skills training are the main components of BCT (Byrne, Carr, & Clark, 2004). Three studies confirmed the short and long-term effectiveness of behavioral couples therapy (Byrne, Carr, & Clark, 2004; Snyder, Wills, & Grady-Fletcher, 1991; Snyder & Wills, 1989).

**Cognitive-Behavioral Couples Therapy**

More than forty years ago, a man named Albert Ellis recognized the important role that cognition plays in marital problems, and developed rational emotive therapy (RET). He believed that individuals “hold irrational or unrealistic beliefs about his or her partner and relationship, and make extreme negative evaluations when the partner and relationship do not live up to such extreme expectations” (Dattilio & Epstein, 2005, p. 7). CBCT works to change partners' distorted or inappropriate cognitions (e.g., a shift from attributing a partner's
not doing the dishes as due to disrespect to attributing it to having a different idea of when the dishes need to get done), as well as to change inappropriate emotional responses. The belief is that an individual’s change in cognition may be all that is needed to increase happiness between partners, even when the partner’s behavior does not change (Fisher & O’Donohue, 2006). CBCT has undergone more controlled outcome studies than any other therapeutic model and there is considerable empirical evidence from treatment outcome studies that CBCT is effective in helping couples in distress (Dattilio & Epstein, 2005).

**Integrative Behavioral Couple Therapy**

Integrative Behavioral Couple Therapy (IBCT) focuses on interventions intended to increase partners’ acceptance of each other’s behaviors that are unlikely to change. The idea is that a large percentage of relationship unhappiness can be attributed to an individual’s lack of acceptance of particular partner characteristics that are for the most part unchangeable, and that attempts to pressure the partner to change will generally result in defensiveness and counterattacks. The practitioner would help the couple see the positive
aspects of their differences (Fisher & O’Donohue, 2006). A man named Richard B. Stuart developed the A-to-G of Integrative Therapy for Couples. His therapeutic interventions are created from an understanding of affective, behavioral, cognitive, developmental, environmental, family-of-origin, and genetic aspects of the couple’s interaction. He links the physiological, psychological, environmental aspects of behavior (Carlson & Kjos, 2002).

**Emotionally Focused Couples Therapy**

Emotionally Focused Couples Therapy (EFCT) is based on Bowlby’s attachment theory, which proposes that humans are born with a need for emotional attachment to nurturing others. Clinicians would assist partners in comprehending their own and each other’s negative emotional and behavioral responses that are evoked by attachment insecurity and help the couple develop more productive behavior toward one another that can fulfill their attachment needs. For example, the therapist might reframe partners’ negative behaviors as expressions of attachment needs and vulnerability (Byrne, Carr, & Clark, 2004; Fisher & O’Donohue, 2006; Johnson & Greenman, 2006;
Verseveldt, 2006). EFCT has proven to benefit couples in distress (Byrne, Carr, & Clark, 2004; Verseveldt, 2006). Insight-Oriented Couples Therapy

Last, Insight-Oriented Couples Therapy (IOCT) suggests that partners most likely experience emotional injuries in prior relationships that leave them with vulnerabilities (e.g., fear of being taken advantage of) and defensive strategies to protect themselves (e.g., not offering to help). A practitioner would help the couple distinguish between the past and present relationships (Fisher & O’Donohue, 2006). Studies have proven that IOCT produces positive changes in relationship functioning (Snyder & Wills, 1989; Snyder, Wills, & Grady-Fletcher, 1991).

Post-Traumatic Stress Disorder

In relation to Post-Traumatic Stress Disorder (PTSD), a clinician using EBP would need to know the different types of therapy to treat this specific problem. If a practitioner is treating someone with PTSD with a form of therapy meant to treat depression, the likelihood of recovery is not very strong (Fisher & O’Donohue, 2006). A mental health issue like PTSD has
many complex aspects such as psychogenic amnesia or cultural factors so it is important to understand the best EBTs to address the various symptoms. The type of EBT to use will also depend on whether the onset of PTSD is delayed or immediate (Fisher & O’Donohue, 2006).

For the acute phase of PTSD, evidence shows that the messages given to clients about their diagnosis is very influential. Since many of the early symptoms can be transient, it is important for a therapist to emphasize the likelihood of recovery rather than emphasizing the trauma (Fisher & O’Donohue, 2006).

If persistent symptoms do develop in a client, some studies show that short-term cognitive-behavior therapy can help reduce symptoms and deter a chronic course of PTSD (Hembree, Roth, & Bux, 2004). This is yet another example of how it is important to use the most effective therapy for the specific course of each mental illness.

Another type of therapy used is exposure-based psychotherapy and though this has been shown to be effective with some clients, Ehlers, Clark, and Dunmore (1998) found that some populations did not respond as well. They looked at rape victims and found that those whose memories of the event consisted of feelings of
mental defeat or no mental planning along with feelings of alienation and permanent change were less responsive to exposure-based therapy unless it was combined with cognitive restructuring (Ehlers et al., 1998). Cognitive restructuring refers to helping a client re-think automatic negative thoughts associated with the traumatic event. This emphasizes yet again the importance for the therapist to truly understand a client’s symptoms and choose an appropriate EBT to deal effectively with the issue.

Other interventions include Stress Inoculation Training (SIT), an intervention that combines relaxation, modeling, thought stopping, self-dialogue and role-playing (Fisher & O’Donohue, 2006). Another treatment that addresses experiential avoidance is Acceptance and Commitment Therapy (ACT) though it is still being researched (Fisher & O’Donohue, 2006).

Finally there is the possibility that a client may require medical treatment for PTSD. Selective serotonin reuptake inhibitors along with other mood stabilizers, antidepressants and benzodiazepines have been shown to be the most helpful for PTSD clients (Fisher & O’Donohue,
Despite the use of medications however, there is a high relapse rate once the medications are discontinued.

Using marital problems and PTSD, we have given different examples of EBTs to use. Undoubtedly there are many different EBTs for a therapist to choose from, but it is critical that practitioners keep in mind the importance of appropriateness and goodness of fit when considering the type of EBT to use with each client's unique set of symptoms.

Summary

This chapter began by discussing the theory of reasoned action, as a theory to guide conceptualization of this study. The chapter then went on to provide an overview of evidence-based practice, and positive and negative viewpoints about evidence-based practice. Furthermore, the chapter presented examples of utilizing evidence-based practice.
CHAPTER THREE

METHODS

Introduction

In this chapter the study design, sampling methods, data collection procedures, instrument, procedures, plan for protection of human subjects, and data analysis methods will be laid out.

Study Design

For this study, a cross-sectional survey format was used. The survey that was used measured the attitudes and beliefs about evidence-based practice among MSWs and LCSWs (Aarons, 2004). It was hypothesized that primarily positive attitudes and beliefs about evidence-based practice would be found among these practitioners.

The depth this study required could only be achieved through a quantitative research method because quantitative research provides the clearest expression of the thoughts and beliefs of participants. Quantitative research tends to provide clean and concise findings, which was beneficial for this study.
Sampling

The participants of this study were MSWs and LCSWs from Patton State Hospital. All were working in the mental health setting and Patton State Hospital employs a large number of mental health social workers.

Data Collection and Instruments

Data was collected using a 15-item survey entitled "Evidence-Based Practice Attitude Scale" created by Aarons (2004) (see Appendix A). The questions included in the instrument asked about feelings regarding the use of new types of therapy, interventions, or treatment all answered with interval scores. Along with this survey was a list of demographics questions (see Appendix D).

A review of the literature revealed that these types of questions are effective at targeting participants' attitudes and beliefs about evidence-based practice. The strength of this survey instrument is that it captures attitudes and beliefs in a clear way, but the weakness is that it does not offer personal depth on attitudes and beliefs of respondents.
Procedures

The data for this project was gathered using a fifteen-item survey which was handed out to the MSW and LCSW employees of Patton Hospital at the end of a monthly staff meeting to avoid coercion. Informed consent and debriefing statements were also given. Surveys were considered unusable if the respondent filled out less than 75% of the survey, though all were usable.

Protection of Human Subjects

For the protection of human subjects, participants were given an informed consent form (see Appendix B) which included the affiliation of the study along with the name of the supervisor connected to the study. Participant’s risks and benefits were explained along with the limits of confidentiality. It was made clear that participation in the study was optional and that they could choose to decline at any point. Any incomplete surveys or “drop-out” surveys were destroyed.

A debriefing statement was also be given after the surveys were collected (Appendix C). This statement included the contact number for the faculty supervisor should any of the participants have questions or
concerns. It also thanked them for their participation and explained the purpose of the study.

Data Analysis

Data was analyzed using one-way analysis of variance (ANOVA), correlations, t-tests, frequencies and percentages. Responses to each item were calculated into the same subscales used by Aarons; requirements, appeal, openness and divergence (2004). Subscales were scored by computing the mean score for all items in each subscale (Aarons, 2004).

Summary

This study used quantitative data in the form of a survey which was handed out to MSWs and LCSWs working in the mental health setting of Patton State Hospital. Using availability sampling it was possible to find a large enough sample of MSWs and LCSWs so that there was sufficient data to capture the attitudes and beliefs about EBP in a clear way.

Participants were given informed consent and debriefing. Since the survey was given out at the end of the staff meeting there was no coercion and all participants were given the option to deny the survey.
Once the data was collected each subscale was analyzed using ANOVA, correlations, t-tests, frequencies and percentages.
CHAPTER FOUR

RESULTS

Introduction

This chapter provides descriptive data on the sample of master level social workers from Patton State Hospital in Highland, CA, related to age, gender, years of experience as a master level social worker, and whether the participant had their LCSW. Furthermore, this chapter provides the mean scores and standard deviations of the four subscales which were Requirements, Appeal, Openness, and Divergence. Lastly, this chapter provides the results of the five research questions that were examined.
Presentation of the Findings

Table 1. Sample Characteristics

<table>
<thead>
<tr>
<th>Characteristics (N = 59)</th>
<th>N (%) or Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>17 (28.8)</td>
</tr>
<tr>
<td>Female</td>
<td>42 (71.2)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>20-30</td>
<td>14 (23.7)</td>
</tr>
<tr>
<td>31-40</td>
<td>14 (23.7)</td>
</tr>
<tr>
<td>41-50</td>
<td>17 (28.8)</td>
</tr>
<tr>
<td>51-70</td>
<td>13 (22.0)</td>
</tr>
<tr>
<td>Years of Experience as an MSW</td>
<td></td>
</tr>
<tr>
<td>0-10</td>
<td>29 (49.2)</td>
</tr>
<tr>
<td>11-20</td>
<td>12 (20.3)</td>
</tr>
<tr>
<td>21-30</td>
<td>4 (6.8)</td>
</tr>
<tr>
<td>LCSW</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>31 (52.5)</td>
</tr>
<tr>
<td>No</td>
<td>28 (47.5)</td>
</tr>
<tr>
<td>Requirements</td>
<td>6.8 (3.3)</td>
</tr>
<tr>
<td>Appeal</td>
<td>12 (2.6)</td>
</tr>
<tr>
<td>Openness</td>
<td>11 (2.7)</td>
</tr>
<tr>
<td>Divergence</td>
<td>4 (2.1)</td>
</tr>
<tr>
<td>Total Score</td>
<td>32.8 (4.8)</td>
</tr>
</tbody>
</table>

Sample Characteristics

Table 1 presents descriptive data on the sample of master level social workers from Patton State Hospital in
Highland, CA. Gender was disproportionately higher for females with the majority of participants being female with 71 percent and only 29 percent being male. This is common in the profession because the majority of social workers are female. Age was distributed almost evenly with, 24 percent between the ages of 20 and 30, 24 percent between 31 and 40, 29 percent between 41 and 50, and 22 percent were 51 and older. The majority of master level social workers had between zero and 10 years of experience as an MSW, 20 percent had between 11 and 20 years, and 7 percent had between 21 and 30 years. Having a licensed as a clinical social worker (LCSW) was almost equally distributed with social workers that held a LCSW at 53 percent and those without a LCSW at 48 percent.

The four main variables of interest were the subscales of the Evidence Based Practice Attitude Scale of Requirements, Appeal, Openness, and Divergence. Requirements refer to the extent to which the clinician would adopt a new practice if it was required by an agency, state, or supervisor. Appeal refers to the extent to which the clinician would adopt a new practice if it was intuitively appealing, made sense, could be used correctly, or was being used by colleagues who were happy
with it. Openness refers to the extent to which the 
clinician is generally open to trying new interventions 
and would be willing to try or use new types of therapy. 
Divergence refers to the extent to which the clinician 
perceives research-based interventions as not clinically 
useful and less important than clinical expertise. These 
subscales are important because they allowed the 
researchers to understand social workers’ attitude toward 
evidence-based practice in more depth, based on specific 
situations.

For the first three subscales, higher scores 
indicate a more positive attitude. For the last subscale, 
Divergence, a lower score indicates a more positive 
attitude. The mean scores were 6.8 (3.3) for Requirements, 
12 (2.6) for Appeal, 11 (2.7) for Openness, 4 (2.1) for 
Divergence, and for Total Score it was 33 (4.8). The mean 
score for Requirement was 6.8 (3.3) indicating that 
social workers had a somewhat negative attitude toward 
the adoption of new practices when they were required by 
their supervisors, state, or agency. The mean score for 
Appeal was 12 (2.6) indicating that social workers had a 
somewhat positive attitude toward the adoption of a new 
practice if it was intuitively appealing. The mean score
for Openness was 11 (2.7) indicating that social workers had a somewhat positive attitude toward the adoption of a new practice. The mean score for Divergence was 4 (2.1) indicating that social workers had a somewhat positive attitude toward the divergence from usual practices to academically developed or research-based practices.

For our first research question we were interested in examining whether years of experience as a master level social worker had any impact on the social worker’s attitude toward divergence. To answer our research question a one-way analysis of variance (ANOVA) was calculated. Results indicate that years of experience as a master level social worker does not have any impact on the social worker’s attitude toward divergence, $F(2, 42) = .501, p > .05$. This means that years of experience as a master level social worker did not have any impact on the way in which a clinician perceives research-based interventions compared to clinical expertise.

For our second research question we were interested in examining whether age had any impact on the social worker’s attitude toward divergence. To answer our research question a one-way analysis of variance (ANOVA)
was calculated. Results indicate that age does not have any impact on the social worker’s attitude toward divergence, $F(3, 54) = 1.275, p > .05$. This means that age does not have any impact on the way in which a social worker perceives research-based interventions compared to clinical expertise.

For our third research question we were interested in examining whether having a license had any impact on the social worker’s attitude toward requirements. To answer our research question a t-test was calculated. Results indicate that having a license does impact the social worker’s attitude toward requirements. On average, social workers without a license ($M = 6.64, SD = 4$) had a more negative attitude than social workers with a license ($M = 6.97, SD = 2.56$). This difference was statistically significant ($t = 5.07, .028$). This tells us that if LCSWs receive training in a therapy or intervention that is new to them, they would be more likely to adopt it if it was required by their supervisor, agency, or state.

For our last two-research question we were interested in examining social workers’ overall Appeal and Openness. To answer our research questions we looked at our descriptive data. Results indicate that master
level social workers had a somewhat positive attitude toward Appeal ($M = 12, SD = 2.6$) and Openness ($M = 11, SD = 2.7$).

Summary

This chapter presents results to the five research questions examined. First, the researchers found that years of experience as a master level social worker does not have any impact on the social worker's attitude toward divergence which is the extent that clinicians perceive research-based interventions as not clinically useful and less important than clinical expertise. Second, that age does not have any impact on the social worker's attitude toward divergence. Third, that having a license does impact the social worker's attitude toward requirements— the extent to which the clinician would adopt a new practice if it was required by an agency, state, or supervisor. And lastly, that master level social workers had a somewhat positive attitude adopting a new practice if it was intuitively appealing, made sense, could be used correctly, or was being used by colleagues who were happy with it (Appeal). As well as

46
being open to trying new interventions and would be willing to try or use new types of therapy (Openness).
CHAPTER FIVE

DISCUSSION

Introduction

This chapter discusses the research findings in more depth and analyzes some of the implications that were encountered. How the findings compare with previous research studies will also be discussed along with some of the limitations of this research.

Recommendations are also suggested for social work practice, policy and research in accordance with the findings of this study.

Discussion

Firstly, it is important to discuss the various scores for the four subscales used in this study. The first subscale was Requirements (Aarons, 2004). Using the Evidence-Based Practice Attitude Scale developed by Aarons, the Requirements subscale indicated likeliness to adopt new practices if required by an agency, state or supervisor.

Because the highest possible score for this subscale was 12, the respondents were moderately negative in their
attitude towards adopting new practice when it was a requirement.

This corroborates some of the findings in the literature. Gambrill found that some practitioners complained about the restraints from bureaucracies at their employment sites (2007). Understandably, negative feelings about agency requirements would affect clinician attitudes towards using new EBPs.

Because Patton State Hospital is highly regulated and managed, the results found with this group of therapists could be more highly sensitive to requirements. Mental health practitioners working in this setting might be more ‘fed up’ with requirements and thus responded more negatively.

This can be best illustrated when analyzing the next subscale, Appeal, which was concerned with respondent’s willingness to adopt a new practice if it were intuitively appealing, made sense, could be used correctly or was being used by colleagues who were happy with it. For this subscale the highest possible score would be 16. In contrast to the Requirements scale, respondents to this survey were much more positive in their attitudes according to Appeal.
This score indicates that masters level social workers have more positive attitudes towards certain EBTs based on personal appeal.

These findings go along with some of the literature review findings, specifically Pollio, who believes that EBP methods tend to "cramp the natural style of staff" leading to more harm than good (2007, p. 224). In this case, if a specific EBP is required by an agency, Pollio's assertion may hold true. Respondents at Patton State Hospital prefer to choose their EBTs based on their personal preferences/appeal so if they were required to use certain interventions, they might feel more restricted and resistant.

The third subscale, Openness, deals with the extent to which a clinician is open to trying new interventions or types of therapy (Aarons, 2004). This study's respondents had a score of 11 (2.7) which is a somewhat positive attitude of Openness since the highest possible score would be 16.

It can be concluded then, that masters level social workers are generally open to trying new EBPs. These results could be due to the agency culture at Patton
State Hospital or personal factors of the individuals who choose to work at a place like Patton State Hospital.

The final subscale, Divergence, is different because a lower score indicates a more positive attitude towards EBP (Aarons, 2004). Respondents scored 4 (2.1) which indicates masters level social workers feel fairly positive about diverging from usual practices towards academically developed or evidence-based practices.

In the literature review many studies were found that expressed the difficulty for clinicians in using EBP. These studies suggested that practitioners resisted new knowledge because of inexperience, lack of motivation or lack of time along with the problem of new information being too lengthy, confusing or contradictory not to mention difficult to find/access (Jenson, 2005; McNeill, 2006; Woody, D’Souza & Dartman, 2006).

According to the findings of this research however, clinicians claim to have little problem making a change towards new and developing EBPs, despite some of the potential aforementioned difficulties.

The literature review gave examples of studies that supported EBP and also resisted its use. These results support the studies showing that therapists prefer the
use of EBP. It could also be an indication that therapists working at Patton State Hospital have had more positive experiences with EBP and perhaps a broader sample would have provided less contradictive results.

The first research question looked at was how years of experience impacted attitudes towards EBP. This question was found not to be significant as years of experience had little impact towards EBP use.

This question was developed as an exploratory question and is not compared to any previous research findings. It was considered to be an important question because could have given an indication as to why the use of EBP is considered good by some and bad by others. Perhaps a clinicians years of experience changes their attitudes, or the academic program difference between modern MSW programs and programs completed 10 or 20 years ago.

According to the findings however, years of experience does not change the viewpoint about EBP. This could be a factor of the individual practitioners working at Patton State Hospital or even agency culture.
The second question concerned whether age had an impact on clinician attitudes towards the Divergence scale. This was also not found to be significant.

The question was developed with the consideration in mind that perhaps different life stages produced different practice theories or preferences. These results could again be a factor of individual differences or agency culture. It could also be an indication that it is not age that affects professional decision making but perhaps something else such as personal preference.

The third question examined whether or not having a license impacted attitudes towards EBP Requirements. This was found to be significant and social workers without a license had more negative attitudes when compared to social workers with a license.

The implication of this finding is that LCSWs feel more positive about accepting new EBPs that are required by their supervisor, agency or state when compared to unlicensed clinicians. Perhaps this can be understood by assuming that clinicians who choose to become licensed are already the type to accept requirements.

This conclusion would have to be further tested.
The two final research questions looked at the overall attitude of clinicians concerning the subscales Appeal and Openness, to determine the general attitudes and beliefs of MSWs and LCSWs towards adopting EBPs. It was hypothesized that these attitudes would be mainly positive and this hypothesis was confirmed.

Both of these scales returned fairly positive attitudes concerning the Appeal subscale and Openness subscale. These results were already discussed in comparison to the Requirements subscale and show that social work clinicians, as a whole, make their decisions about EBPs based on their intuitive appeal, clarity, ability to be used correctly and colleagues satisfied use of a certain EBP.

Overall, social work clinicians are generally open to trying new types of therapy and are willing to give new interventions a chance. This could be confined specifically to Patton State Hospital which has a unique agency culture. Mental health practitioners who choose to work at Patton State Hospital may all be similar because they prefer working with the specific types of clients treated in this setting. This could have been one reason for the findings.
Limitations

One of the primary limitations of this study was the sampling. All of the survey respondents were from the same agency and more diversity would have been better. Also a higher number of total respondents would have made the findings more valid.

Recommendations for Social Work Practice, Policy and Research

These findings suggest that the agency requirements for specific EBP use should somehow encompass clinician’s intuitive appeal more. Perhaps when an agency, supervisor etc. is creating policy towards EBP use, a system could be made to include clinician opinions. By using an open forum or procedure for open knowledge dissemination, perhaps clinicians could come to feel more positive and comfortable about agency requirements.

Since these findings suggest that clinicians are open to using new types of interventions but prefer to choose their EBPs based on appeal rather than requirements, perhaps agencies can develop ways to have more flexibility and choice for clinician EBP use.
There of course need to be standards, but offering an array of suitable EBPs to be used within agencies might lower clinician resistance and negative attitudes.

The significance of licensures positive effect on clinician attitude towards Requirements, could provide a suggestion for licensure requirements within agencies. If certain personalities are more attracted to licensure (presumably personalities that are more accepting of requirements), an agency desiring firmer EBP use requirements should thus have a standard for their employees to be licensed.

By doing this, an agency would be more likely to attract employees who are willing to comply with agency requirements. Likewise, if an agency wants clinicians who are more independent in their choice of EBP use, perhaps the agency should not require licensure.

The exact relationship between licensure and positive attitudes towards requirements would have to be more thoroughly analyzed however.

As mentioned earlier in this study social work ethics, call for practice based on "recognized knowledge, including empirically based knowledge..." (National Association of Social Workers, 1996, p. 3). This calls
for a re-analysis of social work ethics in agencies that are having difficulties with employees who resist the use of EBPs. Perhaps identifying the importance and need for validated treatment interventions could help with clinician hesitance toward agency requirements for EBP.

Conclusions

Overall, this study found that social work clinicians have a general openness to the use of new types of interventions and EBPs. Along with that, most respondents scored moderately high in the area of Appeal leading to the conclusions that social worker clinicians in general choose EBPs based on intuitive appeal, sensibility, ability to use it correctly and colleague use.

Along with these findings, clinicians held more negative attitudes towards EBPs that were required by a supervisor, agency or state. This was however different when comparing MSWs and LCSWs, who felt more positively towards EBP Requirements than MSWs.

The use of evidence-based practice is a complicated and controversial issue which will continue to be studied and examined. There will likely always be differing
opinions about its usefulness but the more the field of social work can understand clinician attitudes and beliefs towards EBP use, the more it can develop ways to improve services to clients.
APPENDIX A

SURVEY
Evidence-Based Practice Attitude Scale
EBPAS© Gregory A. Aarons, Ph.D.
Reference:

The following questions ask about your feelings about using new types of therapy, interventions, or treatments. Manualized therapy refers to any intervention that has specific guidelines and/or components that are outlined in a manual and/or that are to be followed in a structured/predetermined way.

Fill in the circle indicating the extent to which you agree with each item using the following scale:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at All</td>
<td>To a Slight Extent</td>
<td>To a Moderate Extent</td>
<td>To a Great Extent</td>
<td>To a Very Great Extent</td>
</tr>
</tbody>
</table>

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

For questions 9-15: If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if:
9. it was intuitively appealing?
10. it "made sense" to you?
11. it was required by your supervisor?
12. it was required by your agency?
13. it was required by your state?
14. it was being used by colleagues who were happy with it?
15. you felt you had enough training to use it correctly?
APPENDIX B

INFORMED CONSENT
INFORMED CONSENT STATEMENT

You are invited to participate in a research study that examines mental health practitioner attitudes about the use of Evidence-Based Practice (EBP). The purpose is to better understand how practitioners with masters in social work (MSWs) and licensure (LCSWs) perceive the use of new types of therapy. This study has been approved by the Department of Social Work sub-committee Internal Review Board of California State University San Bernardino.

You will be asked to complete a fifteen-item survey that should take no longer than five to ten minutes to complete. There are no foreseeable risks to participants taking part in this study.

All information gathered from this study will be confidential. Data will be made available only to persons conducting the study and will be kept in a locked box and destroyed once the study is completed. No reference will be made in oral or written reports that could link individual participants to the study.

If you have questions at any time about the study or the procedures you may contact the researchers or faculty supervisor Rosemary McCaslin at the CSUSB Social Work Department (909) 537-5507.

Your participation in this study is voluntary; you may decline participation without penalty. If you decide to participate, you may withdraw from the study at anytime without penalty. If you withdraw from the study before data collection is completed, your data will be destroyed.

When you have completed the survey, you will receive a debriefing statement describing the study in more detail. In order to ensure the validity of the study, we ask that you not discuss this study with other participants.

By placing a check mark below, I acknowledge that I have been informed of, and that I understand, the nature and purpose of this study, and I freely consent to participate. I also acknowledge that I am at least 18 years of age.

Place a check mark here: _____  Today's date: __________
APPENDIX C

DEBRIEFING STATEMENT
Debriefing Statement

Thank you for your participation in our study. The principal variable we are studying is MSWs and LCSWs attitudes toward the use of evidence-based practice and new types of therapies in order to better understand the field of social work practice. There was no deception used in the conduct of this study. If you have any questions concerning your participation, please contact the research supervisor, Rosemary McCaslin at (909) 537-5507.

Your responses on this survey were important and greatly appreciated. A report of this research should be ready for circulation by the end of September 2008 in the Pfau Library on the California State University San Bernardino campus. Thank you again for your participation.
Demographic Information

How many years of experience have you had as a master's level social worker? ____

Are you a licensed clinical social worker (LCSW)?
Yes ____ No ____

Do you have your PH.D or Doctorate in Social Work (DSW)?
Yes ____ No ____

Gender
Male ____ Female ____

Age ____

If you have a degree in something other than social work, please specify degree and years of experience: ____________
REFERENCES


ASSIGNED RESPONSIBILITIES PAGE

This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection: Combined Effort
   Assigned Leader: Emily Thomas
   Assisted By: Katy Bandy

2. Data Entry and Analysis:
   Team Effort: Emily Thomas & Katy Bandy

3. Writing Report and Presentation of Findings:
   a. Introduction and Literature
      Team Effort: Emily Thomas & Katy Bandy
   b. Methods
      Team Effort: Emily Thomas & Katy Bandy
   c. Results
      Team Effort: Emily Thomas & Katy Bandy
   d. Discussion
      Team Effort: Emily Thomas & Katy Bandy