NON-TRADITIONAL THERAPY FORMATS: WOULD CLINICIANS IMPLEMENT GUIDED SELF-HELP?

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ABSTRACT OF THE DISSERTATION

Non-Traditional Therapy Formats: Would Clinicians Implement Guided Self-Help?

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The current study evaluated knowledge of and attitude towards a scalable, novel therapy format (Guided Self-Help; GSH) among evidence-based clinicians who treated one or more of the following disorders: panic disorder, major depressive disorder, bulimia nervosa, binge-eating disorder, and generalized anxiety disorder. A total of 155 out of 256 individuals recruited online and at professional conferences were eligible after completing a screening questionnaire. The subsequent study survey assessed whether clinicians had experience utilizing GSH, measured their confidence in defining GSH, evaluated their ability to define it, and asked whether clinicians would hypothetically utilize GSH with a fictional client. The fictional client presented to each clinician had a diagnosis that matched the clinicians’ specialization. Additionally, each case’s presentation was determined from a literature review of the average profiles of individuals recruited in GSH trials.

Analyses indicated that clinicians predicted their knowledge of GSH with an average confidence of 50.41%, and that less than 10% of individuals had ever implemented GSH as a stand-alone treatment (i.e., not as an adjunct to standard therapy). Additionally, after reading fictional vignettes of client cases, the average hypothetical use of GSH was approximately 50%. Exploratory analyses indicated that hypothetical use
was predicted by two subscales of the Evidence-Based Practice Attitudes Scale: Openness and Appeal.

Study findings suggest that evidence-based clinicians do not uniformly know of or endorse the use of this low-level intervention for mild to moderate cases of anxiety, depression, eating disorders (bulimia nervosa and binge eating disorder) or panic disorder. Analyses indicate that some of this variation may be predicted by a willingness to learn new treatments as well as knowledge of and training in such interventions. In fact, lack of training in GSH was one of the most frequently endorsed barriers to implementing GSH in clinical practice ($n = 99, 64\%$).

The current findings have implications for future studies on the dissemination and implementation of treatments like GSH in the United States, which have a greater potential for scalability. For example, it may be useful to investigate whether openness to new interventions as well as their appeal are modifiable factors in order to promote the use of such treatments in the United States. Additionally, measuring openness among clinicians may help health systems identify groups of clinicians who are more likely to implement novel delivery models of therapy. Finally, it may be important to incorporate scalable interventions into graduate programs as part of clinical training.
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Introduction

The Treatment Gap

Although many evidence-based treatments have been identified through rigorous efficacy and effectiveness trials, access to these treatments remains insufficient (Kazdin & Blase, 2011). Many studies have documented a significant “treatment gap,” which refers to the discrepancy between those in need of treatment and those who receive it (Kessler et al., 2001; Kohn, Saxena, Levav, & Saraceno, 2004). This gap results from many factors, such as the affordability of treatments, the location of treatment services, and the number of providers trained in delivering a treatment (Kazdin & Blase, 2011). However, research evaluating the magnitude of the treatment gap indicates that simply increasing the number of trained clinicians would not sufficiently address this gap (Kazdin & Blase, 2011). In the United States, approximately 164 million people will experience a mental health problem (Kazdin, 2018), and the majority of these individuals will not receive treatment. This may be associated with multiple factors, such as insurance status, living in a rural area (e.g., Wang et al., 2005) and stigma (e.g., Nadeem et al., 2007). In other countries with fewer resources, up to 90% of individuals do not receive treatment for psychiatric conditions (Patel et al., 2010). To reduce the burden of mental illness, clinical psychologists might consider changes in both research and practice, which include the expansion of criteria through which treatments are evaluated (e.g., is the magnitude of symptom reduction the only outcome considered?) as well as the formats through which clients can access services (i.e., can therapy be delivered in a different way?).

Novel Delivery Models
Novel methods of delivery may be distinguished from traditional practices in several ways (Kazdin & Blase, 2011). The dominant model for delivering psychotherapy often consists of one-to-one sessions, face-to-face contact between a therapist and client, the provision of therapy by a highly trained, specialized, and often expensive provider, and/or the delivery of treatment in a clinical or university setting (Kazdin & Blase, 2011). Thus, alternative therapy formats might seek to change the provider-to-client ratio (e.g., group therapy administered by one clinician), deliver therapy virtually or by telephone, task-shift specified clinical work to lower-level providers, deliver a smaller “dose” of treatment, provide treatment in non-traditional settings among other changes, and deliver interventions immediately as they are needed (Kazdin, 2018).

**Guided Self-Help**

Although there are a host of treatments that have been developed that meet some of these criteria, one example of a researched format is guided self-help (GSH). GSH is distinct from current standard practices in several ways. Overall, GSH is defined as a treatment in which individuals help themselves, or self-administer a treatment, with the support of another person (e.g., therapist; National Collaborating Centre for Mental Health UK, 2011), and is considered a “low intensity” intervention. GSH is program-led, meaning that clients follow a manual or workbook specified to their diagnosis which is communicated via paper or computerized format (National Health Service, 2018). There are no studies that evaluate which specific format is best. In 2017, the World Health Organization listed GSH as one of three scalable interventions of interest for communities affected by adversity. One reason GSH is scalable is because it has the potential to reduce a treatment’s reliance on specialist providers for delivery (World
Health Organization, 2017), either by task-shifting this type of treatment to a lower-level provider or by reducing clinician’s overall time in treating a psychiatric disorder.

There is no formal definition of GSH. However, the manner in which it is studied provides some helpful distinctions from standard therapy. Firstly, GSH differs from pure self-help in that clients are often directed to self-help materials by a treatment provider who checks in with the client to assess their progress and answer questions (e.g., Falbe-Hansen et al., 2009). Although evidence-based clinicians often follow treatment manuals, GSH is distinct from such therapist-led interventions where the treatment provider guides the content of a session. In GSH, clients receive some form of contact with a therapist which may be in person or via technology (e.g., telephone or e-mail; Cuijpers & Schuurmans, 2007), and is primarily geared towards facilitating their use of the program (National Health Service, 2018a). Such guidance may include addressing questions about the instructions in the manual, its content, or helping clients address any issues that arise with following the program (Cuijpers & Schuurmans, 2007; Gellatly et al., 2007).

Additionally, although it is possible to administer GSH for a secondary problem in conjunction to standard therapy for a primary problem, GSH is studied as a stand-alone treatment or implemented as a treatment option within stepped care. Thus, GSH would not involve a suggestion of pure self-help materials without follow-up or guidance.

There are numerous advantages to utilizing GSH. Contact between the clinician therapist and the client may be reduced in terms of time (e.g., a clinician therapist can now attend to two clients in one hour or have reserved slots within their standard care for GSH clients). Given that GSH may be delivered face-to-face or remotely (e.g., via technology), this treatment modality has the potential to increase access to treatment
among individuals who may be unable to attend weekly, hour-long sessions or do not have access to transportation. Indeed, the National Institute for Health and Care Excellence (NICE) suggests the use of GSH for clients with specific psychiatric disorders who decline a full course of an evidence-based treatment (e.g., social anxiety disorder; NICE, 2013). Additionally, research demonstrates that GSH may be provided by less-specialized and potentially less-expensive providers who benchmark results obtained by doctoral-level providers (e.g., Zandberg & Wilson, 2013) or by other formats such as group CBT (e.g., Bailer et al., 2003).

In considering GSH or other non-traditional therapy formats (e.g., telehealth), some providers may wonder whether such formats would eventually dominate standard practice. Utilization of a treatment model that incorporates GSH as a potential treatment, however, does not imply that clinicians should strictly implement GSH. Additionally, some treatments may have varying degrees of scalability (World Health Organization, 2017) and could be utilized in addition to standard care as treatment options (Falbe-Hansen et al., 2009; Lucock, Kirby, & Wainwright, 2011). For example, a clinic may consider offering GSH to low-severity clients as a first step in treatment, which resembles the implementation model utilized by a national program called Improving Access to Psychological Treatments (IAPT) in the UK (Clarke et al., 2009; Clarke, 2011). Such models have the potential to reach more people in a timely fashion and at reduced costs. Analyses on the cost effectiveness of GSH versus standard cognitive-behavioral therapy (CBT) for eating disorders, for example, suggests that although CBT may be more effective overall, it is significantly more costly than GSH for its benefits (Lynch et al., 2010; König et al., 2018).
To date, GSH has been studied in several populations such as individuals with generalized anxiety disorders (e.g., Furmark et al., 2009), panic disorder (Schneider 2005), depression (Gellatly et al., 2007), and eating disorders (e.g., Bailer et al., 2003; Banasiak et al., 2005; Zandberg & Wilson, 2013). This treatment format has demonstrated efficacy in certain populations (e.g., generalized anxiety disorder, mild to moderate unipolar depression, bulimia nervosa, binge-eating disorder) but is not supported as a first line treatment for other conditions (e.g., severe depression). Although GSH has been implemented in stepped-care programs around the world, the systematic study of utilization of GSH practices in the United States is sparse. The majority of research is additionally focused on the efficacy of GSH in reducing symptoms, feasibility, and client acceptability versus the implementation of GSH.

**GSH for Anxiety Disorders**

According to the NICE guidelines (2013), following psychoeducation, individuals with generalized anxiety disorder who do not see improvement from psychoeducation alone may receive low intensity interventions such as individual GSH. NICE (2013) recommends the utilization of GSH as one possible treatment for mild to moderate panic as well as for social anxiety disorder should clients decline a course of individual CBT. Such recommendations assume that clinicians assess other factors (e.g., substance use, for which MI would be an initial step).

Numerous studies have evaluated the effectiveness of GSH for anxiety disorders such as generalized anxiety disorder, social anxiety disorder, and panic disorder. Trials often combine social anxiety disorder, panic disorder, and generalized anxiety disorder as treated diagnoses. Generally, effect sizes for GSH for the anxiety disorders range from
moderate to large (e.g., van’t Hof et al., 2009), although many of the trials that test GSH have compared its use to treatment-as-usual and a wait-list control. Even so, it is possible that GSH could be offered as an option to clients if providers are considering scalability. Meta-analysis comparing traditional, face-to-face therapy with GSH interventions for anxiety or depression found that both therapy formats were comparable at post-intervention and one-year follow up (Cuijpers et al., 2010), with essentially no difference between the two formats ($d = -.02$).

Several trials indicate a reduction in symptoms of anxiety following use of GSH. For example, a randomized clinical trial comparing an online course with and without automated internet emails for generalized anxiety disorder, depression, social anxiety disorder, and panic disorder found that for individuals with elevated symptoms, automated e-mails during the program uniquely helped reduce symptoms as measured by the Patient-Health-Questionnaire-9 item (PHQ-9) and the Generalized Anxiety Disorder 7-item scale (GAD-7; Titov et al., 2013). Berger et al. (2014) compared the effects of internet-based GSH generalized to various anxiety disorders or specific to social anxiety disorder, panic disorder, and generalized anxiety disorder diagnoses with a waitlist control. Therapists in this trial had masters-level degrees and provided feedback via e-mail messages. Compared to baseline scores, clients experienced significant reductions in symptoms at post treatment and 6-month follow up ($d = .80$ for tailored, $d = .82$ unstandardized). Clients also reported being “somewhat” to “very satisfied” with the treatment.

Trials evaluating GSH for generalized anxiety disorder have found that it is superior to a waitlist (Paxling et al., 2011; Titov et al., 2013) and that it is comparable to
face-to-face interventions (e.g., Cuijpers et al., 2010). For instance, a study by Paxling and colleagues (2011) found that an 8-week online CBT course facilitated by clinicians via e-mail led to significant reductions as measured by their primary outcome, the Penn-State-Worry-Questionnaire, as well as other indices of anxiety (e.g., Beck Anxiety Inventory, State Trait Anxiety Inventory) compared to a waitlist control ($d > .80$ in favor of guided CBT). Guidance in this trial averaged 10 to 15 minutes per week per client. Such reductions either continued to improve or were maintained at 1- and 3-year follow-up.

A feasibility study by Kenwright et al., (2001) demonstrated that computerized GSH reduced panic disorder symptom severity for individuals compared to treatment provided entirely by a nurse-clinician in a behavioral psychotherapy unit. Additionally, clients spent 86% less time and required half of the sessions provided by treatment entirely guided by nurses. Following pilot trials of GSH for panic disorder (Kenwright et al., 2004), Schneider and colleagues (2005) randomized 68 individuals to receive a computer aided GSH protocol for agoraphobia with or without panic, social phobia, or specific phobia. This protocol compared two GSH protocols: minimal CBT, a protocol that included instructions for relaxation but provided no information about exposure, versus exposure based GSH. Regarding guidance, individuals received 6 phone or e-mail contacts with a clinician with 2 follow-up contacts. Findings demonstrated that individuals who received either program improved at post-test. However, at 14 weeks, individuals in the exposure-based condition improved significantly more on five of ten measures. Similar to full-protocol CBT trials, 29% of individuals dropped out of
treatment. Overall, this study demonstrates that GSH programs with different levels of contact are effective with this population.

Another trial compared 10 traditional sessions to 10 sessions of self-help with minimal contact with a therapist and found that the two treatments were similarly effective at reducing multiple measures of behaviors and cognitions associated with panic disorder, as well as improving quality of life and function (Carlbring et al., 2005). Additionally, 80% of individuals in the GSH protocol experienced remission compared to 67% receiving in-person treatment.

Trials testing treatment specific to social anxiety disorder indicate that this disorder, in particular, is amenable to self-administered intervention with or without minimal guidance from a therapist (e.g., Berger et al., 2011). Furmark et al. (2009) found that although GSH was more effective than pure self-help aided by group discussions, both of these treatments reduced symptomatology among individuals with SAD. Post-treatment to follow-up effect sizes were highest for bibliotherapy aided by group discussions ($d = .99 - 1.06$) and internet delivered CBT ($d = .99 - .98$) compared to both bibliotherapy ($d = .74 - .75$) and internet applied relaxation ($d = 0.77 - 0.84$).

Titov and colleagues (2009) found that supplementing a completely computer-based, self-help treatment protocol with automated reminders improved adherence to this protocol and reduced symptoms in individuals with social anxiety disorder compared to the same treatment without weekly phone calls. Similarly, individuals in a trial by Berger et al. (2011) experienced significant reductions in social anxiety symptoms within all treatment arms: unguided internet-based self-help, internet GSH with weekly feedback e-mailed by a therapist, and pure self-help with option to step up to internet GSH with
email or telephone guidance. Nordgreen et al. (2012) evaluated moderators of treatment outcome has demonstrated that for individuals with social anxiety disorder, baseline severity of social anxiety disorder symptoms but not co-morbid depressive symptoms would indicate the use of guided versus unguided self-help. The effect size of change in symptoms in the GSH arm was 0.97 at post-test and 1.19 at follow-up. This study also demonstrated that credibility of pure-self-help predicted an increase in symptoms reduction, indicating the importance of a client’s buy-in for this particular low-intensity intervention.

**GSH for Depression**

NICE guidelines include GSH based on CBT principles for mild to moderate depression. Research has found that several GSH protocols are effective in the treatment of major depression. For instance, a trial by Williams et al. (2013) recruited individuals with a score of 14 or greater on the Beck Depression Inventory II (BDI-II) and randomly assigned them to receive CBT-GSH from a psychology graduate student compared to treatment as usual within their primary care setting. Treatment as usual included monitoring by a physician, the potential to be prescribed an anti-depressant, and the ability of a primary care physician to recommend specialist services as recommended by the United Kingdoms’ guidelines. Individuals in the GSH arm received a total of three 40-minute sessions to support their use of the GSH protocol. The primary outcome of the study was scores on the BDI-II at 4 months.

Results from this trial indicated that individuals receiving GSH reported clinically meaningful reductions in symptoms as measured by the BDI-II. A total of 42.6% of individuals recovered at 4 months, compared to 24.5% in treatment-as-usual. When
examining a longer follow-up period, the treatment effect difference between GSH and
treatment as usual was 5.26 points on the BDI-II at 4 months in favor of GSH and 5.44 at
12 months. This difference reduced to 3.51 at 4 months and 2.68 at 12 months when
missing data was imputed.

Other studies provide support for a variety of GSH formats in the treatment of
depression. Vernmark et al. (2010) demonstrated that administering internet-based CBT
with minimal support yielded similar results to tailored e-mail therapy with less self-help
components. Although both protocols within Vernmark et al. (2010) demonstrate the use
of novel delivery models, the ability to utilize either treatment provides options for
increasing the ability to reach more clients.

Brown & Lewinsohn (1984) randomized individuals with depression to receive
treatment via a class format, standard individual sessions, or a treatment in which clients
received minimal contact from providers, and a delayed control arm. Results
demonstrated that all active interventions were superior to delayed treatment for reducing
symptoms of depression. A computerized format of CBT combined with motivational
interviewing for mothers of children enrolled in Headstart also demonstrated reductions
in depression (Sheeber et al., 2012). Mothers with elevated symptoms of depression were
recruited. Participants in the intervention arm had an average BDI score of 26 and those
in the delayed intervention arm had an average BDI score of 25. Mothers received
weekly phone coaching of 15 to 20 minutes per module. Results from this trial
demonstrated that mothers experienced significant reductions in symptoms as measured
by the PH-Q-9 after the intervention (Hedges’ $g = 0.89$), which were maintained 12
weeks post-intervention.
Berger et al. (2011) compared guided and unguided self-help for depression. This study found that both treatments were effective compared to a wait list, but that GSH resulted in a greater effect size than unguided self-help \( (d = .66) \) when compared to wait-list \( (d = 1.14) \). Watkins et al. (2011) studied the effects of concreteness training and relaxation training in the format of GSH for individuals with depression within a primary care setting. Both treatments led to significant reductions in depressive symptoms compared to treatment as usual, and there were no differences between the two treatments. These are only several studies that demonstrate the support for GSH in mild to moderate depression.

**GSH for Eating Disorders (Bulimia Nervosa and Binge Eating Disorder)**

Several studies have evaluated the effects of GSH on binge-eating disorder and bulimia nervosa utilizing a manual, *Overcoming Binge Eating* (Fairburn, 1995) that was designed to be used either as pure self-help or with the guidance of another person (e.g., therapist). This protocol consists of psychoeducation followed by a structured CBT-based protocol covering modules or “steps,” which include self-monitoring of meals, alternatives to binge-eating, regular eating, problem solving, how to address dieting and body image concerns, and relapse prevention. Clients approach each “step” or technique in the protocol and are instructed to move on to the subsequent step only after mastering the current one.

Trials have tested the GSH version of this protocol against control and active intervention groups. Compared to a wait-list condition, research demonstrates that pure and guided-self-help lead to significantly greater rates of abstinence from binge-eating (Carter & Fairburn, 1998). A randomized clinical trial compared behavioral weight-loss,
GSH, and a control treatment in 90 individuals with binge-eating disorder (Grilo & Masheb, 2005). In this trial, GSH consisted of six, bi-weekly sessions with a therapist that lasted approximately 15 to 20 minutes each. Results demonstrated that although no treatment was helpful for weight reduction, individuals who received the GSH protocol experienced greater rates of remission in BED diagnoses than behavioral weight-loss and the control condition (Grilo & Masheb, 2005).

Regarding the scalability of GSH, a proof-of-concept trial by Zandberg & Wilson (2013) demonstrated that, after training with an expert provider, a master’s level clinician could feasibly train newer graduate students to deliver a GSH version of CBT for bulimia nervosa, binge-eating disorder, and eating disorder not otherwise specified. This study reported that approximately 42% of participants had ceased binge-eating altogether at post-test, which increased to approximately 47% at a 1-month follow-up. Additionally, 63.2% received diagnostic remission. Thus, therapists trained by a master’s level clinician could yield significant symptom reductions utilizing a GSH protocol, highlighting an additional benefit to utilizing GSH.

Other trials of GSH for binge-eating disorder have evaluated the efficacy of support provided via the internet (Carrard et al., 2011; Sánchez-Ortiz et al., 2011) as well as a GSH protocol based in dialectical behavior therapy (Masson, von Ranson, Wallace, & Safer (2013). For example, a trial by Sánchez-Ortiz et al., (2011) found that individuals with BN and subthreshold eating disorders who received an internet-based CBT protocol aided by e-mail support improved at 3- and 6-month follow-up compared to those in waitlist control. Additionally, a trial by Masson and colleagues (2013) found that, compared to wait-list, DBT-GSH led to greater reductions in binge eating at post-
treatment \((d = .79)\) and higher rates of abstinence from binge-eating at a 6-month follow-up. Additionally, baseline to follow-up assessments within the treatment arm demonstrated significant reductions in overall symptoms as measured by the Eating Disorder Examination-Questionnaire \((d = 1.38)\).

**Limitations of the Research on GSH**

Several limitations should be noted regarding the research on GSH for eating disorders, depression, and anxiety disorders. Some data suggests that the populations utilized in GSH clinical trials may have less severe symptomatology than treatment-seeking individuals. A meta-analysis by Coull & Morris (2011) noted that GSH for anxiety and depression was often studied in individuals recruited via media advertisements, which they argued are less clinically representative than clients seeking treatment at a clinic or hospital. Gellatly et al., (2007) reported similar findings in a meta-analysis of moderators of effectiveness of GSH for depression, in which treatment outcomes for GSH were more favorable within non-clinical settings.

Additionally, more research is needed to identify moderators of GSH treatment outcome for various disorders. For anxiety and depressive disorders, research shows that pre-treatment symptom severity moderates the effects of GSH, such that those with higher symptom severity benefited more when utilizing GSH versus self-help without guidance (Titov et al., 2013). For eating disorders, a trial comparing GSH treatment completers to non-completers indicated that individuals who dropped out often had higher levels of weight concern and depression at pre-treatment (Jones et al., 2013). Of the 28 individuals who dropped out of treatment in this trial, approximately a third reported needing more guidance and a quarter indicated they were not ready to change.
Carrard et al., (2011) similarly also found that higher levels of weight concern were associated with treatment drop out in addition to higher levels of drive for thinness. More controlled trials in clinical populations for the anxiety, depressive, and eating disorders should evaluate whether pre-treatment severity affects outcome and further clarify symptom severity thresholds for implementation. Finally, with respect to eating disorders, rapid response is a moderator of GSH treatment outcome for binge-eating disorder (Wilson, 2010).

Limitations of GSH Implementation and Barriers to Utilization

There are several limitations and barriers to the implementation of GSH in clinical practice. Regarding the logistics of GSH, clients need access to materials via the internet or through an initial meeting with a treatment provider. Additionally, treatment often requires the ability to read and write. Although these concerns have received some attention through trials (e.g., testing GSH within older populations for whom transportation is more difficult; Landreville, Gosselin, Grenier, Hudon, & Lorrain, 2016), more research is needed understand which therapy formats could address such barriers.

Another potential limitation of utilizing GSH is that its practice would still require the assessment techniques that occur prior to traditional therapy in order to ensure that clients do not initiate a treatment targeted towards an incorrect diagnosis (Cuijpers & Schuurmans, 2007). Relatedly, many trials of GSH evaluate its implementation within a primary care setting or as part of a larger model of stepped-care. Such settings could yield different outcomes to private practice, given the organizational support of a larger team.

Additionally, certain symptoms of the disorders themselves could minimize adherence to the protocol. For example, symptoms of depression, such as difficulty
concentrating, anhedonia, loss of energy, and active suicidal ideation, could present difficulties for clients self-administering materials with minimal guidance. Several trials evaluating the efficacy of GSH for depression often excluded individuals who score highly on such symptoms (e.g., Williams et al., 2013). Thus, clinicians may have to screen their clients based on such factors prior to considering GSH. Regarding the anxiety disorders in general, research has demonstrated that although specific measures of anxiety decrease with treatment, quality of life often does not significantly improve (e.g., Paxling et al., 2011).

Studies have sought to understand whether or not drop-out from GSH is higher than rates found for traditional therapy practice. Several studies show that drop-out is comparable to that observed in standard CBT protocols (Schneider et al., 2005; Cuijpers et al., 2010). Regarding the long term-effectiveness of GSH, Coull and Morris (2011) found that studies on GSH for anxiety and depression yielded more favorable results at post-treatment versus follow-up. Additionally, this format may not be suitable for certain mental disorders. In a population with obsessive compulsive disorder, Lovell et al. (2017) found that individuals receiving GSH compared to standard care did not improve based on a clinically significant criterion defined prior to treatment. Additionally, this research demonstrated that GSH was cost-effective compared to standard care at 12 months and not sooner.

**Are clinicians using GSH or would they consider it?**

Despite the availability of GSH, several basic questions remain unanswered about practitioners’ beliefs about and utilization of GSH. The first question is whether or not therapists are aware of this treatment modality and if they understand its correct
implementation. A study of clinicians in the UK, for example, found that many clinicians utilize pure-self-help (i.e., unguided treatment manuals) as an optional addition to treatment that clients may or may not have the option to view during standard therapy (MacLeod, Martinez, & Williams, 2008). However, there is little research on clinician knowledge of and attitudes toward GSH in the United States. MacLeod et al., (2008) conducted their research within the UK, in which the NICE guidelines recommend the use of GSH as part of stepped-care model. With data from this study, the researchers were able to observe changes among utilization of self-help compared to two previous surveys of clinician attitudes toward self-help interventions. Overall, they observed a decrease in clinicians who felt that clients were less satisfied with self-help interventions than with a therapist, which fell from 73.1% to 62.9% across 5 years. Additionally, they found an increase in the number of clinicians recommending self-help materials, although this was not specific to GSH, across this time period.

Utilization of GSH in the United States, however, may be distinct given that clinical decision-making may not occur within a stepped-care system. Further, there may be less explicit education on a variety of treatments focused on scalability. For example, Weisz, Ng, and Bearman (2014), found that of 51 accredited graduate training programs associated with the Academy of Psychological Clinical Science, only three (5.89%) programs offered courses in dissemination and implementation. Although GSH is often based in CBT and could be taught in full treatment courses or learned via other methods (e.g., practicums, research), the format of GSH is a facet related to dissemination (i.e., in that GSH is scalable) and implementation (i.e., the role of the therapist is different in
GSH than in standard therapy) of ESTs, and thus, might be included in courses focused on dissemination and implementation.

Finally, it is unclear whether clinician therapists who are familiar with GSH would implement this treatment with clients for whom treatment could very much be efficacious. For example, given that treatment costs may be reduced with less extensive protocols, clinicians may be weary of potential pressures to implement GSH with all clients versus those who are fit for this treatment. Additionally, research demonstrates that the effects of GSH may vary according to treatment setting (i.e., community versus clinic; Delgadillo, 2018). Thus, clinicians may believe that their populations are less appropriate candidates for GSH.

The current study was designed to address the following aims within a sample of clinicians practicing in the United States: 1. To understand clinician knowledge of guided self-help (GSH); 2. To evaluate current GSH utilization practices among clinicians; 3. To evaluate hypothetical utilization of GSH for a case in which GSH may be indicated. Given that research has demonstrated that therapists often recommend self-help materials as optional resources to supplement a course of individual therapy (MacLeod, Martinez, & Williams, 2009), we included items to assess whether clinicians viewed GSH as a stand-alone treatment protocol that included guidance. To ensure that clinicians did, indeed, understand the manner in which GSH has been studied, they were asked whether GSH consisted of optional reading not monitored by the clinician and if, compared to traditional hour-long sessions, contact between client and their providers was minimized in this treatment format.

Secondary Exploratory Analyses
Exploratory aims involved examining clinician factors (versus client factors) that influence the utilization of GSH—primarily evidence-based practice attitudes (Aarons, 2004). Attitudes fall into four primary domains: 1. intuitive appeal of EBP; 2. likelihood of adopting EBP when required; 3. Openness to new practices; 4. perceived divergence of usual practice with research-based interventions (Aarons, 2004). Several additional clinician factors—years in clinical practice, identity as a clinician, identity as a researcher, and frequency of waiting lists within clinicians’ work settings were examined as potentially relevant predictors of hypothetical GSH utilization.
Method

Participants

Participants were recruited through flyers shared at professional conferences, professional listservs, and online postings. Additionally, the principal investigator randomized all APA accredited programs and emailed 80 DCTs and/or clinic directors the survey link to ask if they were interested in sharing with colleagues and/or students. The survey link was open to all participants and could be shared by individuals who viewed the link. A total of 256 clinicians completed five questions in the survey screener. After completing the screener, 155 clinicians were eligible and directed to the survey.

Participants were eligible on the bases of being 18 years or older, providing therapy in the United States, and self-reporting the provision of evidence-based treatments for major depressive disorder, generalized anxiety disorder, binge eating disorder, bulimia nervosa, and/or panic disorder. Participants were excluded on the bases of endorsing an eclectic theoretical orientation to clinical practice, which was the most common reason for rule-out ($n = 76$). The current sample consisted primarily of clinicians who were licensed practitioners ($n = 51$, 32.9%) and those undergoing clinical training as students ($n = 84$, 54.2%). The average age of the sample was 31.92 ($SD = 8.88$, See Table 1 for descriptive statistics on clinician characteristics).

Although clinicians could report up to three highest degrees obtained, the most frequently endorsed degrees were PhDs ($n = 58$, 37.42%), followed by MAs ($n = 45$, 29.03%; consult Table 2 for list of degrees earned and currently sought by participants). The majority of clinicians worked in outpatient settings ($n = 148$, 95.48%). The most frequently reported settings for work were as follows: Academic Medical Centers ($n =$
47, 30.32%); University Clinics (n = 45, 29.03%); Private Practice (n = 27, 17.42%; see Table 3 for full list of settings in which clinicians reported delivering care).

Materials

The current study was implemented in a survey compiled using Qualtrics software (2019; See Appendix A for all survey materials).

Clinician Characteristics

Clinicians were asked to report the following information: age, licensure status, highest degree earned, status as a student and pending academic degree, nature of work-setting and percentage of time as a professional or student seeing clients. Additionally, clinicians were asked the extent to which they identified as a “clinician” on a scale of 1 to 5 (1 = not at all, 5 = to a very great extent), and the extent to which they identified as a “researcher” on the same scale. The survey asked clinicians to list the approximate years of experience they had in delivering therapy. Finally, clinicians were asked how frequently their practice and/or practices had waitlists, the regularity of current case supervision, and whether or not they accepted insurance for the provision of services.

Clinician Specialization

Clinicians were asked to indicate which disorders they treated from a list including panic disorder, major depressive disorder, eating disorders (binge eating disorder and bulimia nervosa), and generalized anxiety disorder. If a clinician selected more than one disorder, they were asked to rank the disorders they treated according to their specialization. This ranking was used to determine which client vignette the clinician would read in later section of the survey, such that the client diagnoses within the vignette matched the clinician’s specialization.
**Lifetime Utilization of GSH**

Clinicians were asked whether or not they had ever utilized GSH with a client or had training in GSH. Although it is possible to administer GSH for a secondary problem in conjunction with a full course of therapy for a primary diagnosis, the current study was interested in whether clinicians had utilized GSH as a stand-alone treatment, and thus, a third question addressed the isolated use of GSH in a client’s treatment.

**GSH Knowledge**

Participants were asked several questions regarding GSH.

Measure 1: Confidence: To assess knowledge of GSH, clinicians were first asked how confident they were in defining what GSH on a continuous scale from 0 to 100.

Measure 2: For a second measure of clinician knowledge, clinicians provided a free-response explanation of GSH. Free-response definitions were graded by the principal investigator for consisting of the following elements: a) a client works independently through written or computerized material b) with the help of a therapist or another person, c) the therapist/guiders reviews progress and outcomes. If clinicians stated in their free response that they had never heard of GSH, they received a zero on free-response portions. Segments a, b, and c were allotted 20 points if present in the clinician’s answers and followed by two true or false questions. The true or false questions were related to the following aspects of GSH: that contact between the therapist or guider is minimized compared to standard therapy and that GSH does not consist of optional readings that are not monitored by clinicians. The true/false questions were also allotted 20 points if correct for a total of 100 possible points.
Measure 3: A third measure of knowledge of GSH involved isolating the responses to true and false, where each question was worth 50 points of a possible total of 100 points.

**The Evidence-Based Practice (EBP) Attitudes Scale (Aarons, 2004)**

Clinicians were additionally administered the 15-item evidence-based practice (EBP) attitudes scale which consists of four subscales: intuitive appeal of EBP ($\alpha = .80$), likelihood of adopting EBP when required ($\alpha = .90$), openness to new practices ($\alpha = .78$), and perceived divergence of usual practice with research-based interventions ($\alpha = .59$). Items are rated on a 5-point likert scale (0 = *not at all*, 5 = *to a very great extent*).

Previous research indicates that the EBPAS demonstrates reliability across subscales and total scale score that is moderate to excellent (Aarons et al., 2010).

**Information about GSH**

After answering questions about themselves and their familiarity with and training and GSH, therapists were provided with a brief definition of GSH. This definition was taken from the UK’s National Health Service website which provides details on GSH and its distinction from pure self-help (National Health Service, 2018). They were also provided with a definition compiled by the principal investigator as well as a short summary of research on its efficacy extracted from published clinical trials.

**Client Vignette**

Client vignettes were presented to clinicians. Regardless of diagnoses, client/patient characteristics aligned with averaged profiles of clients treated in clinical trials based on several factors: age, duration of illness, severity, employment status, and comorbidity. Individuals who treated eating disorders were randomized to receive a
vignette for a client who had symptoms of either binge-eating disorder or bulimia nervosa, but not both. This presentation was randomized given that there are few isolated trials of individuals with either diagnoses. Client vignettes were not identical to each other, although all vignettes indicated that individuals had mild to moderate cases of a particular diagnoses. There was only one vignette presented per diagnoses. Given that GSH trials were not consistent across diagnoses on a client’s average age, duration of illness, and symptoms, vignettes did not present identical information.

**Hypothetical Utilization**

Clinicians were asked how likely they would be to utilize GSH for the client described in the vignette, which they rated on a scale of 0 to 100. Additionally, they were asked to provide a text response indicating the factors they considered in making their decision. Clinicians text responses were analyzed for themes utilizing qualitative data analysis techniques (Renner & Taylor-Powell, 2003), which involved data reduction (reducing text responses to isolate meaningful information related to our research questions) and the identification of patterns and themes via content and thematic analyses.

**Barriers**

Clinicians were provided a checklist of possible barriers to GSH asked to identify any factors that might impede their use of GSH with clients at in their current clinical practice. A majority of barriers were taken from research that documents potential concerns. The principal investigator included some barriers with mixed or non-existent support in the literature (e.g., that GSH leads to higher drop-out rates, [Cuijpers et al., 2010]; that GSH implementation is not acceptable to clients [e.g., Sheeber et al., 2012]).
Other barriers in this list have been supported by research (e.g., that GSH is less efficacious for and should not be considered for clients with active and severe suicidal ideation [van Spijker et al., 2014]). Finally, some barriers were constructed in areas for which research is unclear or pending (e.g., therapist preference for GSH; therapist training in GSH).

**Non-traditional Therapy Formats**

Finally, clinicians were asked which non-traditional therapy formats they currently utilize (See Appendix B, page 72 for list of formats). Clinicians were asked to only endorse their use of a format if it was utilized for all sessions in a treatment course (i.e., they were asked to endorse “therapy via phone” if all sessions were conducted over the phone versus phone sessions that supplemented or replaced standard therapy sessions).

**Procedure**

Clinicians were directed to a link to the screening questions, after which eligible participants were directed to the full survey. The survey was administered via Qualtrics and lasted approximately 10 to 15 minutes. The current study did not record IP addresses to maintain participant confidentiality. Following survey completion, clinicians were directed to a separate, confidential link in which they could provide personal information to enter to win a raffle for one of five gift cards.
Results

Sample Characteristics Relevant to Analyses

Of the 155 clinicians who began the survey, 141 progressed to the end of the survey. On average, clinicians completed 96% of the survey. Clinicians reported specializing in the following disorders: Major Depressive Disorder ($n = 60$, 39.22%), Panic Disorder ($n = 34$, 22.2%), Generalized Anxiety Disorder ($n = 39$, 25.5%), and Eating Disorders ($n = 20$, 13.07%). Overall, clinicians reported a mean of 11.41 ($SD = 49.39$) years of experience in delivering psychotherapies and spent approximately half of their time delivering therapy within the context of their work ($M = 49.12$, $SD = 26.25$).

Clinicians reported that, on average, their practices had waitlists approximately half of the time ($M = 3.28$, $SD = 1.47$). When asked how much they identified as a clinician, participants reported a mean of 3.75 ($SD = .92$) and as researchers an average of 3.26 on the same scale ($SD = 1.2$). Additionally, a total of 124 clinicians reported regularly receiving case supervision ($n = 46$, 30.5%), and the majority did not accept insurance for the provision of therapy ($n = 80$, 53%) or reported that they accepted it for certain clinical settings/services but not others ($n = 25$, 16.1%).

Guided Self-Help

Lifetime Utilization

A total of 29 clinicians (19.1%) reported ever having used GSH and 22 (14.5%) of the total sample reported having received training in it. Of the 29 clinicians who utilized GSH, 17 had received training in it. Of the 29 clinicians who implemented GSH in the past, approximately half of them ($n = 14$, 48.3%) reported using it alone in the treatment of a disorder and not in addition to another treatment ($n = 15$, 51%).
Clinician Knowledge of GSH

On average, clinicians reported that they were 50.41% confident in their ability to accurately define the GSH treatment modality ($M = 50.41$, $SD = 33.3$). Our second measure of knowledge, combining true or false questions with a qualitative evaluation of clinician’s free response revealed that clinicians earned an average score of 49.78%. No clinician reported outcomes review as part of their definitions. Thus, when scoring for this component (i.e., outcomes review), clinicians were given credit if they referred to the therapist role as one who helped clients with accountability, progress, pacing, and/or remaining on track with the treatment materials. A Pearson Correlation indicated that all three indices of knowledge were significantly correlated with each other (See Table 14 for these correlations).

When asked whether GSH consisted of optional reading not monitored by a clinician, 34.9% ($n = 56$) incorrectly stated that this was true of GSH. Additionally, when asked whether contact between clients and providers was minimized in GSH compared to that of traditional 45 to 60-minute sessions, 33 (23.2%) clinicians incorrectly stated that this was false. After allotting 50 points to each correct true or false question as an isolated measure of objectively quantified knowledge, clinicians scored an average of 68.66% out of a 100.

Hypothetical Utilization of GSH

A preliminary analysis of variance demonstrated that there were no difference in hypothetical use by disorder specialization, $F(3,126) = .216$, $p = .54$. Across diagnoses, therapists stated that, on average, they were 53.62% ($n = 130$, $SD = 29.05$) likely to consider utilizing GSH with the client for whom they read the vignette. Additionally,
they reported a 51.41% ($SD = 30.20$) probability of utilizing GSH prior to starting a lengthier treatment protocol.

**Do Clinician Factors Predict GSH Utilization?**

*Evidence-based practices attitudes scale (EBPA; Aarons, 2004).*

Clinicians’ average rating of the likelihood of adopting an intervention based on requirements was 2.86 ($SD = .88$), where 3 equals “To a Great Extent.” Regarding how likely clinicians were to adopt a new EBT based on intuitive appeal, clinicians reported an average rating of 2.83 ($SD = .73$). When measuring how open clinicians were to innovation, clinicians reported an average score of 2.86 ($SD = .62$). Finally, when asked how likely individuals were to adopt a new EBT if it diverged from their current practice, clinicians reported and average rating of 3.59 ($SD = .39$), where 4 equals “To a Very Great Extent.” The average total of the four subscales for clinicians was a 3.04 ($SD = .43$; See Table 8 for correlations among subscales of the EBPA). We had fairly similar measures of reliability across the four subscales to Aarons (2004; Requirements $\alpha = .86$, Appeal $\alpha = .82$, Openness $\alpha = .77$, Divergence $\alpha = .50$) with Divergence demonstrating the weakest measure of reliability.

An exploratory multiple linear regression was conducted to understand whether clinician factors predicted hypothetical use of GSH. The four subscales of the EBPA (i.e., likelihood of adopting EBP when required, intuitive appeal of EBP, openness to new practices, and perceived divergence of usual practice with research-based interventions) were entered into the regression in a step-wise fashion. There was a significant relationship between the Openness subscale of the EBPA ($p < .01$) and hypothetical utilization ($\beta = 13.70$, 95%, CI: 5.99, 21.4). Additionally, a model including the
Openness and Appeal subscales (p < .01) of the EBPA was also significant in predicting hypothetical use ($\beta = 8.04$, 95%, CI: 1.24, 14.85, p < .05). The model with including the Openness and Appeal Subscales yielded a medium effect size ($r^2 = .166$, $f^2 = .199$).

Additionally, we entered the following variables into the model to control for possible confound in the prediction of hypothetical use of GSH: years of clinical experience, identity as a clinician, identity as a researcher, and frequency of waiting lists within clinicians’ work settings. The same models (1. Openness; 2. Openness and Appeal) remained significant after controlling for covariates (See Tables 9 and 10 for significant models).

**Qualitative Data Analysis**

Table 11 demonstrates the themes extracted from clinician’s free response to a question asking them what factors led them to make their decision about hypothetically utilizing GSH with the fictional client. Aspects regarding the client and the clinician emerged. Several of these themes were demonstrated in the percentage of clinicians who endorsed barriers to implementing GSH in clinical practice on a checklist. The most frequently endorsed barriers were not having enough training in GSH ($n = 99$), not knowing enough about GSH ($n = 85$), and the possibility that clients would fare better with greater face-to-face contact with a treatment provider ($n = 17$; See Table 12 for list of endorsed barriers to implementing GSH in clinical practice).

**Use of Non-Traditional Therapy Formats**

The most widely used non-traditional therapy format among clinicians was teletherapy via video conferencing ($n = 43$) followed by brief interventions within
primary care ($n = 27$; See Table 13 for list of non-traditional therapy formats clinician reported currently utilizing).
Discussion

The current study demonstrates that evidence-based clinicians had approximately 50% confidence in their ability to define GSH and that a majority of participants had never received training in GSH (85.5%). Approximately 19% of the sample had utilized GSH and less than 10% of those in our total sample had administered it as a stand-alone treatment. This suggests that a majority of evidence-based clinicians in the United States may not be receiving consistent training in novel therapy formats such those based in self-help or are not utilizing a breadth of treatment delivery formats for which there is evidence to support use with certain populations.

Although no formal definition of GSH exists and it is unclear how much or little guidance is necessary for an intervention to be considered GSH, this study attempted to assess qualitative knowledge of GSH by forming a set of criteria for the definition of GSH based upon the available literature. Qualitative analyses assessing 5 domains of GSH knowledge indicated that clinicians were approximately 50% accurate in defining GSH. This knowledge was slightly higher when only examining answers to two true or false questions generated from the literature. The results regarding knowledge may be due to lack of training in GSH, which was frequently endorsed by clinicians as a barrier to implementation in clinical practice (65.87%), as well as the lack of a clear definition in the literature.

In addition to assessing experience with and knowledge of GSH, the current study found that clinicians were potentially divided in recommending GSH for the cases presented to them in the vignettes, whose severity, function, and illness duration were modeled after average cases seen in GSH trials. In visually examining the frequency of
hypothetical use of GSH among clinicians, the distribution appears to be bimodal. Thus, instead of a bell curve resulting in an average of 50%, the data visually indicates a cluster of individuals considering GSH with a low likelihood of 0 to 20% and a second cluster of individuals recommending it with a higher likelihood of 60 to 80% (i.e., bimodal distribution). This may indicate an important division among this particular sample—one that consists of clinicians whom endorse evidence-based treatments—in considering the use of low-intensity interventions such as GSH. The exploratory analyses aimed to better understand hypothetical consideration of GSH with clients for whom GSH would likely be efficacious.

The current study found that the Openness and Appeal subscales from the EBPA emerged as predictors of hypothetical use of GSH after controlling for four other variables. The Openness subscale captures whether clinicians enjoy learning new interventions, are willing to try new protocols developed in research, and are willing to learn new interventions even though they are different from what they are accustomed to implementing (Aarons, 2004). The Appeal subscale captures how likely clinicians are to use a new therapy if the treatment intuitively makes sense to them, if colleagues who use a therapy are happy with it, and if they felt they had enough training to use an intervention correctly (Aarons, 2004). The appeal subscale has similarities to some of the endorsed barriers to the utilization of GSH, such as lack of knowledge and training. Such findings may be related to lines of research demonstrating that adaptability as it relates to work may be a function of both conscientiousness and openness to experience (LePine et al., 2000).
Although reticence in hypothetically considering GSH could be understood in terms of potential weaknesses in GSH treatment studies (e.g., comparing GSH to waitlist versus an active control; effect size deterioration at long-term follow-up), clinicians’ responses to why they made their decisions did not often cite this as a reason. In fact, only 6 clinicians endorsed weak evidence for GSH as a barrier to its implementation. Instead, severity of the client emerged as a theme for barriers to GSH implementation. For example, two clinicians (out of 20 whom reported eating disorders as their specialization) listed symptom frequency of binge eating and purging within the context of bulimia nervosa as one of their explanations for not recommending GSH. It is indeed possible that in clinical practice individuals with moderate levels of binge-eating and purging would warrant a higher level of monitoring compared to milder cases. However, the studies that evaluate GSH have found that it can be effective for this level of symptom frequency (Bailer et al., 2004).

Although the literature on GSH validates concerns over treatment design and efficacy (i.e., many studies compare GSH to waitlist), GSH may fulfill important criteria regarding reach and scalability. If GSH is reserved for mild to moderate cases of certain psychiatric disorders, it is possible to supervise less specialized individuals in therapy (e.g., Berger et al, 2013). Our qualitative data analysis indicates that clinicians often cite lack of training in GSH as a reason for not choosing to implement it. Providing training in these therapies could therefore lead to greater GSH utilization.

Examination of qualitative theses related to consideration of GSH for a possible patient, individuals weighed evidence along with many factors surrounding the client (e.g., severity, risk, function, preference) and themselves as clinicians (e.g., ease of
transferring their current skills, insurance reimbursement, training, knowledge). Many individuals stated that they were well versed in gold-standard treatments for the diagnoses listed in our survey, and do not understand why they would consider using GSH instead. Although this data does not quantitatively define which of those factors are considered most important, we failed to find a consistent pattern regarding reach and scalability as factors in a clinician’s decision-making around treatment intervention. Only one clinician referred to scalability by describing the potential for using GSH with the fictional client to make better use of finite resources, and five clinicians (3.22%) described hypothetically using GSH as part of stepped care.

Finally, the current study asked clinicians whether or not they were implementing other novel treatment formats, such as providing care in an integrated setting, conducting therapy entirely over the internet, etc. Such information was sought in order to evaluate what scalable interventions have the greatest chance of uptake within mental health services in the United States. The most frequently endorsed non-traditional therapy format was telehealth via video conferencing. This suggests that clinicians may be interested in some versions of therapy that have a wider potential to reach individuals, or that requirements have affected utilization practices (e.g., utilization of telemental health has increased with the VA initiative to offer these services; “Telemental health for Veterans,” 2019).

**Limitations and Future Directions**

The sample recruited within this study consisted of individuals who identified as evidence-based clinicians, treated 5 specific psychiatric disorders, practiced in the United States, and denied an eclectic orientation to clinical practice. Although these criteria
served the study’s goal of evaluating the knowledge, lifetime, and hypothetical use of GSH within a confined sample of individuals likely invested in remaining informed about research, it is possible that clinicians who identify as eclectic could be interested in nontraditional therapy formats. It is also possible that individuals in other parts of the world would have differing attitudes towards treatments like GSH. If the goal of new branches within clinical psychology is to ensure the successful implementation of tested interventions and to broaden the reach of interventions amongst providers, then understanding where there is overlap between all providers may lead to developments that increase client access to effective resources.

The current study relied on online, non-random sampling. Given the online format, it is difficult to verify the nature of certain qualitative responses. For example, when clinicians state that therapists who deliver GSH assess progress, the word “progress” may refer to a number of areas related to a client’s treatment, such as reading of materials, learning of skills, symptom severity, quality of life, etc. Thus, studies in the future should seek to utilize methodologies that strengthen this assessment, such as allowing for more extensive interviews and a number of randomized raters in assessing clinicians’ knowledge of GSH. Additionally, the definition of GSH is not objectively stated in any particular reference. Although this is true, our study indicates that clinicians understand it is shorter than traditional therapy but do not understand the role of the clinician with respect to this treatment modality.

A strength of the survey development relied on analyzing studies for average profiles of individuals in randomized clinical trials of GSH for anxiety, depression, eating disorders, and panic disorder. However, the current study did not stratify sampling to
account for potential differences in hypothetical use of GSH by disorder treated. Thus, clinician’s hypothetical use of GSH could be influenced by factors specific to distinct psychiatric diagnoses.

Additionally, given the nature of online data collection, participant attrition towards the end of the survey left us with fewer datapoints to have proper statistical power to compute a multiple linear regression with four predictor variables to detect a small effect size. We attempted this exploratory regression despite missing data, which yielded a medium effect size (model 1 $r^2 = .16$, model 2 $r^2 = .2$). However, our findings that openness and appeal were largely predictors of uptake of GSH should be interpreted with caution and only used as hypothesis-building information. Future studies should consider other methodologies to reduce the probability of survey fatigue, and recruit utilizing methods that are stronger in assessment of knowledge/attitudes.

Another characteristic of our sample that should be noted is that approximately half of participants identified as students. The current study may, thus, reflect a population of individuals who have yet to learn about new formats for delivering therapies. This study did not explicitly examine other methods through which clinicians were being trained in alternative therapy formats such as practicum experiences or research. Alternatively, the current study might instead include individuals who are most open to adopting new strategies given less training in therapies to date, and it is possible that hypothetical use of GSH is even less likely in more experienced practitioners. Additionally, it is surprising that clinicians listed an average waitlist only half of the time. Such frequency might not reflect most clinical practices or hospitals, given that the majority of clients do not have access to treatment in the United States, and data has
shown that 94 million Americans report experiencing a wait of one week or longer when seeking mental health services (Dampier, 2018).

The current study only evaluated clinician knowledge of and attitudes towards GSH. This is only one of many interventions with the potential for scalability. There are several studies that demonstrate that interventions lose some efficacy once they are scaled up or when administered outside of highly controlled research trials (e.g., Weisz et al., 2013) and this could be true of GSH. Additionally, there is some evidence to suggest that a client’s belief in the efficacy of a treatment affects outcomes for pure self-help (e.g., Nordgreen, 2012), which may indicate that were clinicians interested in recommending GSH, their portrayal of the treatment might be particularly important (e.g., Kazdin, 2018).

The current study did not ask what materials were offered to individuals on a practitioner’s waitlist. Such questions could provide important insights into whether clinicians are offering materials such as GSH much in the manner that they have been studied: in comparison to treatment as usual or a waitlist. In some ways, a lack of interest in these formats beyond this sample may mirror the process of resistance to adopting evidence-based practices among clinicians as a whole. If it is possible to understand what leads to a willingness to change practices amongst evidence-based providers in the delivery of scalable interventions—whether adoption is related to clinician factors or certain logistical demands—then this knowledge could be applied to increasing utilization of EBPs within the broad field of clinical psychology.

**Future Directions**
Many of the findings in the current study are descriptive in nature. Although the data do not directly address predictions about who is likely to utilize a treatment format that is more scalable, descriptive data from this project could inform future research on identifying whether uptake of these types of formats are likely within the field of clinical psychology, or if individuals are interested in supervising others to implement similar therapy formats (i.e., task-shifting GSH to less expensive providers for the treatment of mild to moderate cases of certain psychiatric disorders). Similarly, future studies might select clinicians who are currently utilizing scalable interventions in their practice and understand attitudes based on current versus hypothetical use.

Regarding GSH as a treatment format, clinicians’ qualitative data indicate they are weighing new approaches such as GSH against both their training in other evidence-based approaches and the efficacy of GSH versus protocols they currently deliver. Given these concerns, trials testing alternative therapy formats might consider treatment designs that include simpler decision trees in determining who is appropriate for GSH among clinicians who are open to GSH and find it appealing to learn and implement. Instead of only developing an intervention with one outcome in mind, Kazdin (2017) suggests that research should additionally consider how these treatments could and would be utilized as part of an expansion of delivery models. Simplifying the process of selecting an intervention may follow such advice.

**Implications for Research Design and Training**

Kazdin (2017) proposes that psychologists consider factors related to dissemination and implementation in research design and intervention development, particularly if they wish to create interventions that will work in real-world settings or be
able to meet the demand for services. This could include an intervention’s potential for reach, scalability, and affordability. Some of these factors would demonstrate the comparative effectiveness of interventions when administered outside of randomized clinical trials. For example, it is possible that a more complex intervention has efficacy that is similar enough to a less complex intervention that could be delivered more easily outside of a research context.

Additionally, researchers could consider the expansion of settings in which interventions may be delivered, such as those settings that individuals already frequent (e.g., a grocery store), the feasibility and flexibility of their interventions to be adapted to the context of diverse settings, and the option for individuals to reach desired outcomes from a choice of interventions (Kazdin, 2017). GSH is only one example of the manner in which we can adapt current evidence-based treatments to meet these criteria. Future studies could examine attitudes towards some of the more widely endorsed non-traditional therapy formats such as brief interventions in special settings and telehealth.

Considering the reach of evidence-based treatments, however, may currently be secondary to the goal of increasing the implementation of evidence-based practices among the broad field of clinicians delivering treatment (see Lilienfeld et al. 2013 for a discussion of barriers to evidence-based practice). Clinicians’ qualitative responses for offering GSH suggest that they may not be considering scalability and reach in their decision making. As proposed in Weisz et al. (2013), it may be useful to identify clinicians who are interested in reach within the broad field of dissemination and implementation and create specialty tracks within clinical training to further the implementation of EBTs as well as the adoption of scalable interventions.
References


### Table 1

*Demographics and Clinician Factors*

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<th>M</th>
<th>SD</th>
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<th>%</th>
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<td>conducting therapy</td>
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*Note.* This table describe clinician factors measured by the survey.
### Table 2

**Degree Type Earned and Sought by Participants**

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<th>Degree Type</th>
<th>Highest Degree Earned</th>
<th>Terminal Degree Sought</th>
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<td>n</td>
<td>(%)</td>
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<td>(0.65%)</td>
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<td>MA</td>
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<tr>
<td>PsyM</td>
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<td>(4.52%)</td>
</tr>
</tbody>
</table>

**Note.** This table shows the frequency of highest degree earned by participants and terminal degree sought by participants who reported a student status.
**Table 3**

*Setting of client/patient care*

<table>
<thead>
<tr>
<th>Setting</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic Medical Center</td>
<td>47</td>
<td>(30.32%)</td>
</tr>
<tr>
<td>College Counseling Center</td>
<td>10</td>
<td>(6.45%)</td>
</tr>
<tr>
<td>Community Mental Health Clinic</td>
<td>24</td>
<td>(15.48%)</td>
</tr>
<tr>
<td>Department of Psychiatry</td>
<td>13</td>
<td>(8.39%)</td>
</tr>
<tr>
<td>Group Practice</td>
<td>9</td>
<td>(5.81%)</td>
</tr>
<tr>
<td>Hospital (Psychiatric)</td>
<td>15</td>
<td>(9.68%)</td>
</tr>
<tr>
<td>Hospital (General)</td>
<td>15</td>
<td>(9.68%)</td>
</tr>
<tr>
<td>Primary Care</td>
<td>7</td>
<td>(4.52%)</td>
</tr>
<tr>
<td>Private Practice</td>
<td>27</td>
<td>(17.42%)</td>
</tr>
<tr>
<td>School Setting (K-12)</td>
<td>3</td>
<td>(1.94%)</td>
</tr>
<tr>
<td>Telemedicine; Telepsychiatry</td>
<td>17</td>
<td>(10.97%)</td>
</tr>
<tr>
<td>University</td>
<td>12</td>
<td>(7.74%)</td>
</tr>
<tr>
<td>University Clinic</td>
<td>45</td>
<td>(29.03%)</td>
</tr>
<tr>
<td>Veterans Affairs</td>
<td>19</td>
<td>(12.26%)</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>(5.81%)</td>
</tr>
</tbody>
</table>

*Note.* This table demonstrates the settings in which clinicians conduct clinical work. “Other” consisted of 1 clinician in the following categories: Army Hospital; Clinical treatment trial, home-based delivery; Interdisciplinary rehabilitation center for brain injury; Juvenile justice diversion program; Military Treatment Facility; Military treatment hospital; Military, DOD clinic; Outpatient multispecialty medical group; Private.
### Table 4

**Level of client/patient care**

<table>
<thead>
<tr>
<th>Level</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>148</td>
<td>95.48</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>15</td>
<td>9.68</td>
</tr>
<tr>
<td>Partial Hospital</td>
<td>5</td>
<td>3.23</td>
</tr>
<tr>
<td>Inpatient Unit/Residential</td>
<td>21</td>
<td>13.55</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>2.58%</td>
</tr>
</tbody>
</table>

*Note.* This table demonstrates the level of care in which clinicians provide clinical services. “Other” consisted of 1 clinician in the following categories: Inpatient medical; Medical stabilization; Research patients meeting OP level of care; Research program.
### Table 5

*Disorders Treated by Clinicians*

<table>
<thead>
<tr>
<th>Specialization</th>
<th>$n$</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic Disorder</td>
<td>34</td>
<td>22.2%</td>
</tr>
<tr>
<td>Major Depressive Disorder</td>
<td>60</td>
<td>39.2%</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>20</td>
<td>13.1%</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>39</td>
<td>35.5%</td>
</tr>
</tbody>
</table>

*Note.* This table demonstrates the disorders clinicians reported specializing in treating.
### Table 6

**Field of Clinicians’ Degrees**

<table>
<thead>
<tr>
<th>Field</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Child Psychology</td>
<td>12</td>
<td>7.74</td>
</tr>
<tr>
<td>Clinical Health Psychology/Health Psychology/Behavioral Medicine</td>
<td>11</td>
<td>7.10</td>
</tr>
<tr>
<td>Clinical Psychology</td>
<td>115</td>
<td>74.19</td>
</tr>
<tr>
<td>Clinical School Psychology/School Psychology/Educational Psychology</td>
<td>2</td>
<td>1.29</td>
</tr>
<tr>
<td>Community Psychology</td>
<td>1</td>
<td>0.65</td>
</tr>
<tr>
<td>Counseling</td>
<td>3</td>
<td>1.94</td>
</tr>
<tr>
<td>Counseling Psychology</td>
<td>1</td>
<td>0.65</td>
</tr>
<tr>
<td>Developmental Psychology</td>
<td>1</td>
<td>0.65</td>
</tr>
<tr>
<td>Medicine (specialize in Psychiatry)</td>
<td>1</td>
<td>0.65</td>
</tr>
<tr>
<td>Mental Health Counseling</td>
<td>1</td>
<td>0.65</td>
</tr>
<tr>
<td>Neuropsychology</td>
<td>3</td>
<td>1.94</td>
</tr>
<tr>
<td>Neuroscience/Cognitive and/or Behavioral Neuroscience</td>
<td>1</td>
<td>0.65</td>
</tr>
<tr>
<td>Psychology</td>
<td>20</td>
<td>12.90</td>
</tr>
<tr>
<td>Social Work</td>
<td>1</td>
<td>0.65</td>
</tr>
</tbody>
</table>

*Note.* This table demonstrates the fields in which participants had earned or were currently pursuing degrees. The majority of clinicians worked in the field of clinical psychology.
**Table 7**

*Clinician Utilization Practices of GSH*

<table>
<thead>
<tr>
<th>Type or Use/Training</th>
<th>n</th>
<th>%</th>
<th>M(SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime (yes/no)</td>
<td>29</td>
<td>19.1</td>
<td></td>
</tr>
<tr>
<td>Lifetime (GSH alone)</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime (GSH in addition to another treatment)</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>22</td>
<td>14.5</td>
<td></td>
</tr>
<tr>
<td>Hypothetical (rated 0-100)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likelihood of use with client</td>
<td></td>
<td></td>
<td>53.62 (29.05)</td>
</tr>
<tr>
<td>Likelihood of use prior to longer treatment protocol</td>
<td></td>
<td></td>
<td>51.41 (30.20)</td>
</tr>
</tbody>
</table>

*Note.* This table demonstrates the percentage of clinicians who reported prior training in GSH and their utilization practices.
Table 8

Evidence-Based Practice Attitudes Scale: Correlations

<table>
<thead>
<tr>
<th>Scale</th>
<th>M(SD)</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Requirements</td>
<td>2.86 (.88)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Appeal</td>
<td>2.38 (.73)</td>
<td>.34**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Openness</td>
<td>2.83 (.63)</td>
<td>.20*</td>
<td>.33**</td>
<td></td>
</tr>
<tr>
<td>4. Divergence</td>
<td>3.04 (.39)</td>
<td>.23**</td>
<td>-.07</td>
<td>.13</td>
</tr>
</tbody>
</table>

*Note.* This table demonstrates the correlations among the four subscales of the EBPA: Requirements, Appeal, Openness, and Divergence. Correlations with 1 asterisk are significant at the .05 level. Correlations with 2 asterisks are significant at the .01 level.
Table 9

*Multiple Linear Regression with Subscales from EBPA*

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized</th>
<th>Standardized</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>6.711</td>
<td>11.116</td>
</tr>
<tr>
<td>Openness</td>
<td>16.449</td>
<td>3.781</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>-8.530</td>
<td>12.723</td>
</tr>
<tr>
<td>Openness</td>
<td>13.700</td>
<td>3.897</td>
</tr>
<tr>
<td>Appeal</td>
<td>8.044</td>
<td>3.441</td>
</tr>
</tbody>
</table>

*Note:* The above table demonstrates the results of an exploratory multiple linear regression evaluating clinician factors as predictors of the hypothetical use of GSH. Predictors in this model included the four subscales of the EBPA.
Table 10

*Multiple Linear Regression including Covariates*

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized</th>
<th>Standardized</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>B</td>
<td>t</td>
</tr>
<tr>
<td>1</td>
<td>(Constant)</td>
<td>4.710</td>
<td>11.327</td>
<td>.416</td>
</tr>
<tr>
<td></td>
<td>Openness</td>
<td>17.050</td>
<td>3.846</td>
<td>.369</td>
</tr>
<tr>
<td>2</td>
<td>(Constant)</td>
<td>-12.947</td>
<td>13.066</td>
<td>-991</td>
</tr>
<tr>
<td></td>
<td>Openness</td>
<td>14.261</td>
<td>3.919</td>
<td>.308</td>
</tr>
<tr>
<td></td>
<td>Appeal</td>
<td>8.894</td>
<td>3.484</td>
<td>.216</td>
</tr>
</tbody>
</table>

*Note:* The above table demonstrates the results of an exploratory multiple linear regression evaluating clinician factors as predictors the hypothetical use of GSH.

Predictors in this model included the four subscales of the EBPA, clinician identity, researcher identity, years of experience in clinical practice, and frequency of waitlists.
**Table 11**

*Explanations for hypothetical use of GSH*

<table>
<thead>
<tr>
<th>Categories</th>
<th>Subcategories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td></td>
</tr>
<tr>
<td>Preference</td>
<td>Affordability; Barriers to Access; Greater Therapist Contact</td>
</tr>
<tr>
<td>Function</td>
<td>Overall Functioning; Cognitive Functioning</td>
</tr>
<tr>
<td>Severity</td>
<td>Symptoms; Duration; Comorbidities; Treatment History</td>
</tr>
<tr>
<td>Risk</td>
<td>Suicidal Ideation; Medical management</td>
</tr>
<tr>
<td>Engagement</td>
<td>Motivation; Buy-in</td>
</tr>
<tr>
<td>Clinician</td>
<td></td>
</tr>
<tr>
<td>Preference</td>
<td>Maximizing efficacy by utilizing current gold standard treatments; Ease of Modifying Current Knowledge to Deliver GSH</td>
</tr>
<tr>
<td>Knowledge and Competence</td>
<td>Knowledge; Training/Experience in GSH; Confidence in Delivery of GSH; Access to Materials for GSH; Length of Treatment</td>
</tr>
<tr>
<td>Logistical Barriers</td>
<td>Current setting of work; Infrastructure; Insurance Reimbursement</td>
</tr>
<tr>
<td>Evidence</td>
<td>Independent Review of Literature Needed; Evidence-Base; Study Design and Samples involved in GSH Trials</td>
</tr>
<tr>
<td>Strategies</td>
<td>Therapeutic Strategies (e.g., exposure) Require Greater Guidance</td>
</tr>
</tbody>
</table>
### Table 12

*Barriers to Implementing GSH in Clinical Practice*

<table>
<thead>
<tr>
<th>Barrier</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I do not have training in GSH</td>
<td>99</td>
<td>63.87%</td>
</tr>
<tr>
<td>2. I do not know enough about GSH</td>
<td>85</td>
<td>54.84%</td>
</tr>
<tr>
<td>3. Patients/Clients might fare better with greater face-to-face contact with a treatment provider</td>
<td>71</td>
<td>45.81%</td>
</tr>
<tr>
<td>4. Patients/Clients might not like GSH</td>
<td>58</td>
<td>37.42%</td>
</tr>
<tr>
<td>5. Most of my patients have important co-morbidities to consider before using GSH</td>
<td>58</td>
<td>37.42%</td>
</tr>
<tr>
<td>6. Many of my clients report suicidal ideation</td>
<td>56</td>
<td>36.13%</td>
</tr>
<tr>
<td>7. Most patients/clients would be too severe for this type of treatment</td>
<td>35</td>
<td>22.39%</td>
</tr>
<tr>
<td>8. I do not know how to bill for GSH</td>
<td>30</td>
<td>19.35%</td>
</tr>
<tr>
<td>9. Patients/Clients are likely to drop out of GSH</td>
<td>29</td>
<td>18.71%</td>
</tr>
<tr>
<td>10. I primarily work with adolescents who need greater guidance</td>
<td>24</td>
<td>15.48%</td>
</tr>
<tr>
<td>11. My clients often have comorbid personality Disorders</td>
<td>22</td>
<td>14.19%</td>
</tr>
<tr>
<td>12. It would be difficult for me to help a client with minimized contact</td>
<td>19</td>
<td>12.26%</td>
</tr>
<tr>
<td>13. I would not get to know my patient/client using GSH</td>
<td>18</td>
<td>11.61%</td>
</tr>
<tr>
<td>14. My clients have low social functioning</td>
<td>16</td>
<td>10.32%</td>
</tr>
<tr>
<td>15. Other (please specify)</td>
<td>14</td>
<td>9.03%</td>
</tr>
<tr>
<td>16. GSH would not be an effective intervention</td>
<td>7</td>
<td>4.52%</td>
</tr>
<tr>
<td>17. The literature on the efficacy of GSH is weak</td>
<td>6</td>
<td>3.87%</td>
</tr>
<tr>
<td>18. I do not agree with GSH principles</td>
<td>2</td>
<td>1.29%</td>
</tr>
<tr>
<td>19. It would be difficult to administer GSH</td>
<td>2</td>
<td>1.29%</td>
</tr>
</tbody>
</table>

*Note.* This table reports endorsed barriers to the utilization of GSH in clinical practice.
Table 13

*Non-traditional Therapy Formats Utilized by Clinicians*

<table>
<thead>
<tr>
<th>Format</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy via video conferencing</td>
<td>43</td>
<td>27.75%</td>
</tr>
<tr>
<td>Brief interventions within primary care</td>
<td>27</td>
<td>17.42%</td>
</tr>
<tr>
<td>Therapy via phone (all sessions over phone)</td>
<td>19</td>
<td>12.26%</td>
</tr>
<tr>
<td>Other (Please Specify)</td>
<td>5</td>
<td>3.23%</td>
</tr>
<tr>
<td>Therapy via smart-phone app (all sessions over app)</td>
<td>4</td>
<td>2.58%</td>
</tr>
<tr>
<td>Therapy in a non-traditional setting (e.g., church, coffee shop,</td>
<td>3</td>
<td>1.94%</td>
</tr>
<tr>
<td>grocery store)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy via e-mail (all sessions over e-mail)</td>
<td>1</td>
<td>0.65%</td>
</tr>
</tbody>
</table>

*Note.* This table provides a list of other non-traditional therapy formats endorsed by clinicians. The most commonly endorsed non-traditional therapy formats were therapy via video-conferencing and brief interventions within primary care.
Table 14

*Correlations between Three Indices of Knowledge*

<table>
<thead>
<tr>
<th>Index</th>
<th>M(SD)</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Confidence</td>
<td>2.86 (.88)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. True/False</td>
<td>2.38 (.73)</td>
<td>.201*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Five Domains</td>
<td>2.83 (.63)</td>
<td>.409**</td>
<td>.652**</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* This table demonstrates the correlations among the three measures of knowledge of GSH which include a clinician’s confidence in defining GSH, their score on true/false items in isolation, and the combination of true/false items with qualitatively measured free-response answers in defining GSH. Correlations with 1 asterisk are significant at the .05 level. Correlations with 2 asterisks are significant at the .01 level.
Figure 1

*Exploratory Multiple Linear Regression (Predicted Values)*

![Graph showing predicted values from regression equation including Openness and Appeal (R² = .166)](image)

*Note.* This graph demonstrates the predicted use of GSH based on a significant regression model accounting for the Openness and Appeal Subscales of the Evidence-Based Practice Attitudes Scale.
Acknowledgement of Previous Publications

None
Appendices

Appendix A: Screening Questions

This is the screening portion of the study. Responses are required for this part of the survey to determine eligibility. If you do not wish to participate, please close your browser window.

1. Are you 18 years of age or older?
   a. Yes
   b. No

2. Do you currently provide therapy to clients/patients in the United States? (Please respond regardless of whether you are licensed or not.)
   a. Yes
   b. No

3. Do you provide evidence-based treatments? (e.g., cognitive-behavioral therapy, dialectical behavioral therapy, acceptance and commitment therapy, motivational interviewing, etc.)
   a. Yes
   b. No

4. Do you treat one or more of the following disorders:
   - Major Depressive Disorder
   - Eating Disorders (binge-eating disorder or bulimia nervosa)
   - Panic Disorder
   - Generalized Anxiety Disorder
   a. Yes
   b. No

5. In terms of your theoretical orientation, would you describe yourself as “eclectic”? 
   a. Yes
   b. No
Appendix B: Survey
Welcome to the study! You are eligible based on the screening questions! After completing the survey, you will be given a link to enter the raffle.

Please fill out the following demographics:

1. How old are you?

2. Are you a licensed clinician?
   a. Yes
   b. No
   i. If participant is a licensed clinician:
      1. What type of license do you have? (e.g., LPA, LPN, LMFT, LPC, MD, DO, PA, LP)

3. What is your highest degree earned? (Select up to 3.)

   a. AA
   b. AB
   c. AS
   d. BA
   e. BAH
   f. BFA
   g. BSc
   h. BSW
   i. C Psych
   j. Clin Psych
   k. D Clin Psy
   l. DBH
   m. DMFT
   n. DO
   o. DPhil
   p. DrPH
   q. DSW
   r. EdD
   s. EdS
   t. GED
   u. High School Diploma
   v. JD
   w. MA
   x. MBA
   y. MCJ
   z. MD
   aa. MDiv
   bb. MEd
   cc. MFT
   dd. MHS
   ee. MLS
   ff. MPA
   gg. MPAS
   hh. MPC
   ii. MPH
   jj. MPych
   (Clin)
   kk. MS
   ll. MSc
   mm. MS
   nn. MSN
   oo. MSSA
   pp. MSSW
   qq. MSW
   rr. No Degree
   ss. PhD
   tt. PsyD
   uu. PsyM
   vv. ScD
   ww. SciD
   xx. Undergrad
   yy. Other
   (Please Specify)

4. Are you currently a student?
   a. Yes
   b. No
   i. If participant is a student:
1. What terminal degree are you pursuing?

   a. AA
   b. AB
   c. AS
   d. BA
   e. BAH
   f. BFA
   g. BSc
   h. BSW
   i. C Psych
   j. Clin Psych D
   k. D Clin Psy
   l. DBH
   m. DMFT
   n. DO
   o. DPhil
   p. DrPH
   q. DSW
   r. EdD
   s. EdS
   t. GED
   u. High School
   v. JD
   w. MA
   x. MBA
   y. MCJ
   z. MD

   aa. MDiv
   bb. MEd
   cc. MFT
   dd. MHS
   ee. MLS
   ff. MPA
   gg. MPAS
   hh. MPC
   ii. MPH
   jj. MPsysc
   h (Clin)
   kk. MS
   ll. MSc
   mm. MSED
   nn. MSN
   oo. MSSA
   pp. MSSW
   qq. MSW
   rr. No Degree
   ss. PhD
   tt. PsyD
   uu. PsyM
   vv. ScD
   ww. ScD
   ciD
   xx. Underg rad
   yy. Other
   (Please Specif y)____
   ___

5. In what type of setting do you conduct clinical work with patients/clients? Select all that apply.

   a. Academic Medical Center
   b. College Counseling Center
   c. Community Mental Health Clinic
   d. Department of Psychiatry
   e. Group Practice
6. In which level of care do you conduct clinical work? (Select all that apply.)
   a. Outpatient
   b. Intensive Outpatient
   c. Partial Hospital
   d. Inpatient Unit/Residential
   e. Other (Please Specify)

7. Approximately what percentage of your work activities is spent doing clinical work? (continuous marker)
   0 10 20 30 40 50 60 70 80 90 100

8. How much do you identify as a clinician?
   a. Not at all
   b. To a Slight Extent
   c. To a Moderate Extent
   d. To a Great Extent
   e. To a Very Great Extent

9. How much do you identify as a researcher?
   a. Not At All
   b. To a Slight Extent
   c. To a Moderate Extent
   d. To a Great Extent
   e. To a Very Great Extent

10. Approximately how many years of experience do you have providing therapy?

11. Which of the following disorders do you treat? (Select all that apply)
a. Panic Disorder
b. Depression
c. Eating Disorders (Binge-Eating Disorder and/or Bulimia Nervosa)
d. Generalized Anxiety Disorder

i. If participant ranked two or more disorders:

1. Please rank the disorders in terms of your specialization in treating them.

   a. Panic Disorder
   b. Depression
   c. Eating Disorders (Binge-Eating Disorder and/or Bulimia Nervosa)
   d. Generalized Anxiety Disorder

12. In what field is your terminal degree? (limited to 3)

   a. Allied Health and Science
   b. Anthropology
   c. Biochemistry
   d. Biological Psychiatry
   e. Biology
   f. Biopsychology
   g. Chemistry/Organic Chemistry
   h. Clinical Child Psychology
   i. Clinical Health
      Psychology/Health
      Psychology/Behavioral Medicine
   j. Clinical Psychology
   k. Clinical School Psychology/School Psychology/Educational Psychology
   l. Cognitive Psychology/Cognition and Neural Systems
   m. Community Psychology
   n. Counseling
   o. Counseling Psychology
   p. Criminal Justice
   q. Developmental Psychology
   r. Experimental Psychology
   s. Forensic Psychology
   t. Intellectual and Developmental Disabilities
   u. Judgment and/or Decision Making
   v. Law
   w. Learning and Behavior
   x. Marital Family Therapy
   y. Medicine (do not specialize in Psychiatry)
   z. Medicine (specialize in Psychiatry)
   aa. Mental Health Counseling
   bb. Neuropsychology
   cc. Neuroscience/Cognitive and/or Behavioral Neuroscience
   dd. Nursing
   ee. Nursing Assistant
   ff. Osteopathic Medicine
   gg. Pathology
   hh. Pharmacy
   ii. Physician Assistant
   jj. Political Science
   kk. Psychology
   ll. Quantitative Psychology
13. How often does your clinical practice have a waiting list?
   a. Never
   b. Sometimes
   c. About half of the time
   d. Most of the time
   e. Always

14. Do you regularly receive case supervision?
   a. Yes
   b. No

15. Do you accept insurance for provision of therapy?
   a. Yes
   b. No
   c. Sometimes (e.g., Yes at one site, No at another.)

16. How confident are you in defining what guided self-help is?
   Not Confident      Neutral      Very Confident
   0     10    20      30     40   50    60    70    80   90   100

17. Have you received any training in guided self-help (GSH)?
   a. Yes
   b. No

18. Have you ever utilized guided self-help (GSH) with a patient/client?
   a. Yes
   b. No

19. Did you provide guided self-help alone (i.e., not in addition to traditional 45-60 minute sessions for a client)?
   a. It was used in addition to another treatment
   b. It was used alone

20. If you were to explain to a patient/client what guided self-help (GSH) is, what would you say to them? (Write as little or as much as you believe to be informative.)
Please answer the following true/false questions.

21. GSH consists of optional reading for clients that is not monitored by a clinician.
   a. True
   b. False

22. Compared to traditional 45- to 60- minute outpatient therapy session, contact between therapists and clients is minimized in GSH.
   a. True
   b. False
EVIDENCE-BASED PRACTICE ATTITUDE SCALE (Aarons, 2004)

Instructions: The following questions ask about your feelings about using new types of therapy, interventions, or treatments. Manualized therapy, treatment, or intervention 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 or predetermined way. Indicate the extent to which you agree with each item using the following scale.

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23. I like to use new types of therapy/interventions to help my clients.
24. I am willing to try new types of therapy/interventions even if I have to follow a treatment manual.
25. I know better than academic researchers how to care for my clients.
26. I am willing to use new and different types of therapy/interventions developed by researchers.
27. Research based treatments/interventions are not clinically useful.
28. Clinical experience is more important than using manualized therapy/interventions.
29. I would not use manualized therapy/interventions.
30. 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:

31. it was intuitively appealing?
32. it “made sense” to you?
33. it was required by your supervisor?
34. it was required by your agency?
35. it was required by your state?
36. it was being used by colleagues who were happy with it?
37. you felt you had enough training to use it correctly?
Please read the following information about guided-self-help:

Guided self-help is a low-intensity intervention. In guided self-help, a patient/client is the one who administers a treatment protocol with the help of a clinician. Contact with the clinician is focused on helping the client follow the protocol, reviewing the client's progress throughout treatment, and reviewing outcomes. A clinician may provide this contact in person, via e-mail, via phone, etc. Guided self-help often includes psycho-education as well as skills specific to CBT (e.g., self-monitoring, problem-solving). The contact between provider and client is minimized (e.g., each phone-call/session is often less than 30 minutes but varies in length in clinical trials).

The literature on guided-self-help demonstrates that it significantly reduces symptoms compared to wait-list, treatment-as-usual, and may obtain similar results to lengthier treatments for mild to moderate generalized anxiety disorder, panic disorder, bulimia nervosa, binge eating disorder, and depression. It is included as one of several recommended low-intensity interventions in stepped-care models of treatment delivery following the assessment of certain factors (severity, client's preference, co-morbid substance-use disorders).
If Depression is clinician’s specialization:

Please read the following vignette about a client who is diagnosed with depression:

Irene is a 37 year-old woman who has struggled with several symptoms that warrant a diagnosis of major depressive disorder. She remembers first feeling depressed in her mid 20s and has "struggled on and off with depressive episodes." She stated that she typically has weeks where she feels incredibly “low” and has loss of interest in her hobbies, which include gardening and shopping. She says that she typically has difficulty sleeping, feels as though she is a failure, and cannot seem to get anything done as she cannot concentrate. She reports breaks in between her low moods in which she can remember feeling better. After providing her with the Beck Depression Inventory-II (1996), she reports a score in the moderate category. She has been cleared of any potential confounding medical conditions. She has no history of suicidal ideation, mania, substance or alcohol-use disorder, or other co-morbid psychological disorders, and is currently employed.

If Panic Disorder is clinician’s specialization:

Please read the following vignette about a client who is diagnosed with panic disorder:

Irene is a 39-year-old woman who has struggled with several symptoms that warrant a diagnosis for panic disorder. Her symptoms began 11 years ago following her move to a new city. She stated that during her panic attacks her heart races, she sweats, she feels as though she cannot breathe, and she becomes dizzy. She said that after her first panic attack, she felt as though she was “losing my [her] mind” and has been terrified of having more panic attacks ever since. After administering the several questionnaires (e.g., the Body Sensations Questionnaire, the Agoraphobic Cognitions Questionnaire; Chambless, 1984), Irene is diagnosed with moderate Panic Disorder. She has been cleared of any potential confounding medical conditions. She has no history of suicidal ideation, mania, substance or alcohol-use disorder, or other co-morbid psychological disorders, and is currently employed.

If Generalized Anxiety Disorder is clinician’s specialization:

Please read the following vignette about a client who is diagnosed with generalized anxiety disorder:

Irene is a 38-year-old woman who is struggling with symptoms that warrant a diagnosis of generalized anxiety disorder. She states that she cannot remember a day in the last 20 years where she was not worried about multiple things all day. Irene reports being extremely exhausted all of the time, feeling that her body is constantly tense, becoming irritable, and having difficulty concentrating. She additionally reports worrying at night and having difficulty sleeping. She has stated that this has made her relationships difficult, particularly with her significant other who wishes she could just "let things go." Several indices of anxiety including the GAD-7 (Generalized Anxiety Disorder-7 item measure) indicate she has moderate generalized anxiety disorder. She has been cleared of any potential confounding medical conditions. She has no
history of suicidal ideation, mania, substance or alcohol-use disorder, or other co-morbid psychological disorders, and is currently employed.

If Eating Disorders are clinicians specialization vignette regarding either Bulimia Nervosa or Binge Eating Disorder is randomized:

Please read the following vignette about a client who is diagnosed with binge-eating disorder:

Irene is a 42-year-old woman who has struggled with several symptoms that warrant a diagnosis for binge-eating disorder. She recalls first struggling with her symptoms in her late 20s. She stated that 4 times a week, she typically experiences a loss of control over eating and can consume a family size bag of chips, a pint of ice-cream, and half of a large pizza in one sitting. Irene typically eats past her experience of feeling full, eats this food quickly, and does so alone given that it leads her to feel shame. She has never attempted to compensate for this by exercising, vomiting, or using laxatives or diuretics. She is currently overweight and has a BMI of 28 kg/m2. She reports a 4 out of 6 on weight concerns on the Eating Disorders Examination (Fairburn et al., 2008). Her symptoms warrant a diagnosis of moderate binge-eating disorder. She has been cleared of any potential confounding medical conditions. She has no history of suicidal ideation, mania, substance or alcohol-use disorder, or other co-morbid psychological disorders, and is currently employed.

Irene is a 28-year-old woman who has struggled with several symptoms that warrant a diagnosis for bulimia nervosa. She recalls first struggling with her symptoms around the age of 20. She stated that 4 times a week, she typically experiences a loss of control over eating and can consume a family size bag of chips, a pint of ice-cream, and half of a large pizza in one sitting. Irene typically engages in purging following her binge-eating. She is currently normal weight and has a BMI of 23.17 kg/m2. She reports a 4 out of 6 on weight and shape concerns on the Eating Disorders Examination (Fairburn et al., 2008). The frequency of her binge-eating and purge episodes fall into the moderate category for severity. She has been cleared of any potential confounding medical conditions. She has no history of suicidal ideation, mania, substance or alcohol-use disorder, or other co-morbid psychological disorders, and is currently employed.
38. How likely are you to consider using guided self-help (GSH) for this client?

Unlikely       Neutral       Likely
0  10  20  30  40  50  60  70  80  90  100

39. Please explain why you made your decision regarding your use GSH for this particular client.
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

40. How likely are you to consider utilizing guided self-help (GSH) with this client prior to starting a lengthier treatment protocol?

Unlikely       Neutral       Likely
0  10  20  30  40  50  60  70  80  90  100

41. What factors might prevent you from using guided self-help (GSH) with any patient/client at your practice (not simply the patient/client you have read about)? (Select all that apply.)

a. Patients/Clients might not like GSH
b. Patients/Clients might fare better with greater face-to-face contact with a treatment provider
c. Patients/Clients are likely to drop out of GSH
d. I do not agree with GSH principles
e. GSH would not be an effective intervention
f. It would be difficult for me to help a client with minimized contact
g. Most patients/clients would be too severe for this type of treatment
h. I do not know enough about GSH
i. I do not have training in GSH
j. I do not know how to bill for GSH
k. I would not get to know my patient/client using GSH
l. Most of my patients have important co-morbidities to consider before using GSH
m. I primarily work with adolescents who need greater guidance
n. Many of my clients report suicidal ideation
o. My clients often have comorbid personality Disorders
p. My clients have low social functioning
q. The literature on the efficacy of GSH is weak
r. It would be difficult to administer GSH
s. Other (please specify) ________________
42. Do you use any of the following non-traditional therapy formats? Please select only if they are used alone, and not as an adjunct to standard, 45-60 minute sessions.

   a. Therapy via phone (all sessions over phone)
   b. Therapy via e-mail (all sessions over e-mail)
   c. Therapy via e-mail and phone (all sessions either by phone or e-mail)
   d. Therapy via smart-phone app (all sessions over app)
   e. Brief interventions within primary care
   f. Therapy via video conferencing
   g. Therapy in a non-traditional setting (e.g., church, coffee shop, grocery store)
   h. Other (Please Specify) _______________

43. How did you hear about this survey?

   a. Conference
   b. Online posting
   c. Email
   d. Flyer
   e. Other (Please Specify) _______________

44. If you feel we did not ask you something important, please let us know in the box below:
Appendix C: Scale

EVIDENCE-BASED PRACTICE ATTITUDE SCALE ITEMS AND SCORING INSTRUCTIONS

Instructions: The following questions ask about your feelings about using new types of therapy, interventions, or treatments. Manualized therapy, treatment, or intervention 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 or predetermined way. Indicate the extent to which you agree with each item using the following scale.

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