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Frequency and Predictors of Manual Use and Evidence-Based Psychological Interventions Among Clinicians Treating Eating Disorders in British Columbia

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Frequency and Predictors of Manual Use and Evidence-Based Psychological Interventions Among Clinicians Treating Eating Disorders in British Columbia

by

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Abstract

Several evidence-based psychological interventions (EBPIs) exist for eating disorders (EDs). Yet, these interventions and manuals are underutilised in clinical practice. This study described psychological interventions British Columbia (BC) clinicians used to treat EDs and examined factors associated with manual and EBPI use. Participants were recruited from a list of 1,530 potential participants created for this study by identifying clinicians listing online that they treat EDs, as well as through social media advertisement and snowball recruitment. One hundred and twenty-six community counsellors and psychotherapists providing psychological intervention to individuals with EDs across BC described their ED clients, psychological interventions used, and their training. To examine predictors of EBPI and manual use, these participants provided demographic information and completed measures of affect, intolerance of uncertainty, and attitudes toward treatment manuals. Overall, 8% of respondents indicated that they often used manuals in their clinical work. Use of EBPIs by clinicians for treatment of anorexia nervosa, bulimia nervosa, and binge eating disorder ranged from 2%-15%. Logistic regression analyses identified two factors associated with manual use included: negative attitudes toward manuals were associated with infrequent use of manuals, whereas positive attitudes toward manuals were associated with increased likelihood of manual use. Unexpectedly, logistic regression analyses did not identify any factors that significantly predicted of EBPI use. The low uptake of EBPIs for the treatment of EDs suggests that ED client may be receiving suboptimal care, highlighting the need for future work to address barriers to EBPI use. Future research should explore beyond clinician characteristics and investigate how external and intervention factors may impact the adoption and implementation of EBPIs and manuals in ED treatment.

Keywords: eating disorders; evidence-based psychological interventions; protocol-based approaches; empirically supported treatments; therapist drift

Preface

This thesis is original, unpublished, independent work by the author, D. Bajaj. The research described in this thesis was approved by the Conjoint Faculties Research Ethics Board at the University of Calgary, certificate number REB22-0661 on November 22, 2023, for the project "Use of Evidence-Based Psychological Interventions Among Clinicians Treating Eating Disorders Across British Columbia".

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List of Abbreviations

AN	Anorexia nervosa
APA	American Psychological Association
ARFID	Avoidant/restrictive food intake disorder
ATMQ	Attitudes to Treatment Manuals Questionnaire
BED	Binge eating disorder
BC	British Columbia
BN	Bulimia nervosa
CBT	Cognitive behavioural therapy
CFIR	Consolidated Framework for Implementation Research
CI	Confidence interval
CPA	Canadian Psychological Association
DSM-5	Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition
EBPI	Evidence-based psychological interventions
ED	Eating disorder
FBT	Family-based treatment
IPT	Interpersonal psychotherapy
IUS-12	Intolerance of Uncertainty Scale-12
OSFED	Other specified feeding or eating disorder
PANAS	The Positive Affect and Negative Affect Schedule
RCT	Randomized controlled trials

RO DBT	Radically open dialectical behaviour therapy
SD	Standard deviation
SE	Standard error
SPSS	Statistical Package for the Social Sciences
UFED	Unspecified feeding or eating disorder
VIF	Variance inflation factor

Predictors of Manual Use and Evidence-Based Psychological Interventions Among Clinicians Treating Eating Disorders Across British Columbia

Eating Disorder Classification

Eating disorders (EDs) are characterized by disturbances in body image and disordered eating (American Psychiatric Association, 2013) that can be life-threatening (Crow et al., 2009; Treasure et al., 2020) and are associated with poor quality of life (Hay et al., 2017) and numerous physical complications such as anemia, electrolyte imbalances, compromised reproductive health, cardiovascular impacts such as low heart rate, low blood pressure, and even sudden cardiac death (Voderholzer et al., 2020). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) outlines diagnostic criteria for EDs, including anorexia nervosa (AN), bulimia nervosa (BN), binge-eating disorder (BED), and avoidant/restrictive food intake disorder (ARFID). The DSM-5 also describes the diagnoses of other specified feeding or eating disorder (OSFED) and unspecified feeding or eating disorder (UFED) under the category of EDs.

AN is characterized by severe restriction of food often leading to low body weight, and overvaluation of weight. Similarly, BN is defined by undue influence of weight or shape on self-evaluation, as well as recurrent binge-eating episodes (i.e., consuming an objectively large amount of food while experiencing a loss of control), and weight-controlling behaviour (i.e., compensatory behaviour such as vomiting, excessive exercise, fasting, use of laxatives, etc.). Recurrent binge-eating episodes without regular compensatory behaviour characterize BED. In contrast, food avoidance and restriction characterize ARFID, but, in contrast to AN, there is no body image disturbance. Individuals not fully meeting eating disorder criteria are often classified

with OSFED, which includes atypical anorexia nervosa, subthreshold bulimia nervosa, subthreshold BED, and others.

Evidence-based Psychological Interventions for Eating Disorders

Several treatments for EDs have been identified as *evidence-based psychological interventions (EBPIs)* (Kazdin et al., 2017; Waller, 2016). EBPIs refer to those with efficacy at reducing symptoms, demonstrated via rigorous randomized controlled trials (RCTs) compared to control or active treatment conditions (Chambless et al., 1996), whereas *evidence-based practice* integrates EBPIs with clinician judgment and patient values (Dozois et al., 2014). Specifically, evidence-based practice is conceptualized as a 'three-legged stool' consisting of the best research evidence, clinical expertise, and patient values, preferences, characteristics, and circumstances (Spring, 2007). Tolin (2014) and the Canadian Psychological Association's (CPA) Presidential Task Force on evidence-based practice of psychological treatments (Dozois et al., 2014) concluded that evidence-based practice should integrate the selection of empirically supported treatments using research evidence while considering patient characteristics and clinician judgment.

Criteria for EBPIs have been subject to debate and has been updated over time. Chambless et al., (1996) criteria for *well-established* treatments are met through either (a) at least two between-group design experiments demonstrating superior efficacy for a treatment compared to a pill, psychological placebo, or another treatment, or demonstrating equivalent efficacy to an established treatment with adequate statistical power (approximately 30 per group) or (b) at least nine single case design studies demonstrating efficacy by using good experimental designs and comparing the treatment to another treatment. In all these cases, the treatments must have been conducted using treatment manuals, characteristics of participants must be outlined,

and efficacy must have been demonstrated by at least two different investigators. Criteria for *probably efficacious* treatments are met by (a) at least two experiments demonstrating efficacy compared to a waiting list control group, or (b) one ore more studies meeting criteria for well-established treatments except independent investigation by other researchers, or (c) at least three single case designs using good treatment designs, comparing the treatment to another treatment using treatment manuals, and describing their client samples (Chambless and Hollon 1996).

Tolin and colleagues (2015) proposed a new model to evaluate empirically supported treatments that assesses efficacy and effectiveness of treatments, such as treatment success in non-research settings, with complex patients, and that have utility in the real world. Tolin et al. (2015) defined *strong research support* as ranging from moderate (i.e., a few studies which have some limitations and no major flaws, some variation between groups, or there is a large confidence interval for the summary estimate) to high-quality empirical evidence (i.e., range of studies without major limitations, little variation between treatments, and narrow confidence intervals for test statistic) for a treatment that also improves symptoms or outcomes, does not have high risk of harm, and reasonable use of resources.

In this study, we defined EBPIs by the lists maintained by Division 12 of the American Psychological Association (APA). APA Division 12 is the Society of Clinical Psychology and professional home for clinical and health service psychologists that aims to integrate "clinical psychological science and practice in education, research, application, advocacy, and public policy" (Society of Clinical Psychology, 2022). The Division 12 website (https://div12.org/diagnoses/) identifies several treatments as having the best research evidence for several psychological disorders, including AN, BN, BED. Although similar guidelines exist (e.g., The National Institute of Clinical Excellence Standards in the United Kingdom), other

guidelines also list pharmacological interventions and do not provide information on strength of evidence supporting the listed interventions (Tolin et al., 2015). The treatments listed on the Division 12 website (Table 1) are identified as having strong research support if they meet Chambless et al., (1996) criteria for well-established treatments or Tolin et al. (2015) criteria for moderate to high quality evidence. Treatments listed on Division 12's website are classified as having modest research support if they meet Chambless et al., (1996) criteria for probably efficacious treatments.

Table 1

Evidence based psychological interventions listed on Division 12's website for anorexia nervosa, bulimia nervosa, and binge eating disorder.

Treatments	Anorexia nervosa	Bulimia nervosa	Binge-eating disorder
Radically open dialectical behavior therapy for disorders of overcontrol (RO-DBT)	Modest support	*	*
Family-based treatment (FBT)	Strong research support for adolescents	Modest research support for adolescents	*
Cognitive-behaviour therapy (CBT)	Modest research support for post hospitalization relapse prevention	Strong research support	Strong research support
Interpersonal therapy	*	Strong research support	Strong research support

Note. * Denotes that no treatment is listed for this specific disorder on Division 12's website.

Treatment manuals or protocols provide standardized and focused approaches to therapy with specific skills and techniques that have proven to be effective through RCTs (Wilson, 2007). There are treatment manuals available for the aforementioned EBPIs (Fairburn, 2008; Lock and Le Grange, 2015; Lynch, 2018; Weissman et al., 2017). The literature suggests that protocol-based approaches tend to outperform clinician judgment in predictive tasks, selecting

interventions, assessment interpretation, and case formulation (Garb & Boyle, 2015; Grove et al., 2000; Meehl, 1954; Sarbin, 1943). Garb and Boyle (2015) cite errors in reasoning, such as confirmation bias and hindsight bias, as sources of errors in judgment and overconfidence in clinicians, consequently leading to erroneous decision-making. Thus, an overreliance on subjective clinical judgment and therapist anxiety when choosing and applying treatments can lead patients to receive treatments that are not the most effective (Waller, 2009). When evidence is available for treatment of specific psychological disorders, some researchers and clinicians argue EBPIs with the best available evidence should be used for individuals receiving psychological treatment, as opposed to treatments with insufficient or no available evidence (Wilson & Shafran, 2005; Dozois et al., 2014). Yet, most community clinicians report not using EBPIs when treating EDs, despite research evidence demonstrating their efficacy (von Ranson & Robinson, 2006; von Ranson et al., 2013). Relying solely on clinician judgment to choose a treatment may sometimes undermine treatment goals and EBPI use (Waller, 2016), highlighting the importance of adhering to manualized approaches.

Research-Practice Gap

Several studies have established that EBPIs in the treatment of EDs are not in frequent use (Haas & Clopton, 2003; Mulkens et al., 2018; Mussell et al., 2000; Simmons et al., 2008; von Ranson & Robinson, 2006, von Ranson et al., 2013). The disconnect between what is shown to be efficacious through empirical research and what is done in practice is the *research-practice gap* (Lilienfeld et al., 2015). The research-practice gap in EDs is well established (e.g., Kazdin et al., 2017; Lilienfeld et al., 2013; Maine et al., 2016; von Ranson, 2017). The use of non-EBPIs can mean that patients receive ineffective treatment (Waller, 2016).

There are several reasons why EBPIs are not adopted into clinical practice. The Consolidated Framework for Implementation Research (CFIR) provides a framework to understand and influence implementation through five domains: the intervention, inner and outer setting, the individuals involved, and the process through which implementation is accomplished (Damschroder et al. 2009). The first domain (the intervention) focuses on characteristics of the intervention such as adaptability, cost, and complexity. The inner setting includes factors such as structural characteristics of the organization, culture, and readiness for implementation, while the outer setting includes patients' needs and resources, funding, and resources outside the organization, and external policies. The fourth domain describes characteristics of individual implementers (in this case, ED clinicians) such as knowledge and beliefs about the intervention, self-efficacy, and personal attributes. The final domain, the implementation process, consists of factors such as planning how to carry out an effective implementation, executing the implementation as outlined by the plan, reflecting, and evaluating the implementation. The present study focused on the individual domain by investigating therapist characteristics and their association with use of EBPIs.

There is a dearth of studies examining the use of EBPIs among community clinicians. Community clinicians have varying levels of training and credentials, and may include psychologists, social workers, nurse practitioners, counselors, physicians, occupational therapists (Magel et al., 2021; von Ranson et al., 2013; von Ranson & Robinson, 2006), as well as others who have little or no training, such as those without a bachelor's degree (von Ranson et al., 2013). In a survey of community clinicians across Alberta, von Ranson and colleagues (2013) identified infrequent use of EBPIs. For instance, half of the clinicians reported using both unsupported and addictions-based approaches, such as the 12-step model, at least some of the

time. This is alarming since, to the best of our knowledge, no RCTs have been conducted evaluating the efficacy of these treatments.

Therapist Drift

The phenomenon whereby clinicians fail to deliver EBPIs that they have been trained in, or fail to deliver EBPIs adequately even when resources permit, is referred to as *therapist drift* (Waller, 2009). Over two-thirds of ED practitioners internationally have demonstrated knowledge of EBPIs for EDs, yet reported infrequent use of EBPIs in practice (Wallace & von Ranson, 2012; Waller, 2009). However, even when clinicians report using EBPIs, they often omit key elements and do not adhere to treatment protocols. For example, clinicians using CBT to treat ED clients often used specific CBT techniques infrequently and often in conjunction with unsupported addiction-based approaches (von Ranson and Robinson, 2006; von Ranson et al., 2013). Similarly, Waller et al. (2012) found that clinicians using CBT to treat EDs often did not adhere to treatment protocols and used CBT techniques selectively. These findings indicated that clinicians were not using EBPIs as recommended by treatment manuals and practice guidelines.

Clinicians reporting use of FBT in ED treatment also employ techniques that are not included in treatment protocols (Kosmerly et al., 2015). In fact, the literature describes a trend in ED treatment in which there is a scarcity of clinicians using manuals (Brown & Nicholson Perry, 2018; Kosmerly et al., 2015, 2015; Tobin et al., 2007; von Ranson et al., 2013), despite manualized psychotherapy protocols having demonstrated greater efficacy in improving disorder symptoms (Addis & Waltz, 2002; Linardon et al., 2017; Zipfel et al., 2014). In a national survey of United States clinicians treating various psychological disorders, few reported using manuals (Becker et al., 2013). Likewise, in an international survey of ED clinicians, Wallace and von Ranson (2011) found that only 30.5% of clinicians reported using treatment manuals when

treating patients with BN. In a recent study, only half of clinicians using CBT to treat BN and BED reported using manuals (Brown & Nicholson Perry, 2018). This departure from treatment protocols can have widespread negative implications for both the clinician and patient, including wasted time and resources, diminishing the patient's confidence in improvement, and can even aggravate the patient's concerns and push them further away from recovery (Waller, 2009). In addition to understanding the frequency of EBPI use in ED treatment, research is needed to clarify if EBPIs are being used as recommended. If EBPIs are not being used as evaluated in research, they may have limited efficacy and may reduce benefits to patients.

Factors Influencing the Use of Evidence-Based Psychological Interventions

Beliefs and Attitudes

In their review, Speers and colleagues (2022) synthesized several factors associated with therapist drift generally, including therapist knowledge, attitudes towards research, therapist anxiety, clinical experience, therapist age, theoretical orientation, critical thinking, personality traits, and cultural competency. However, research on why community clinicians treating EDs underutilize EBPIs is scarce. In a review, Waller (2016) identified three reasons explaining the limited use of EBPIs in the treatment of EDs. First, he identified service-centered reasons, including difficulties implementing new treatments due to resistance from other staff members with opposing views and service provider policies. Second, he described patient-centred reasons, such as patient values. Third, he described clinician-centered reasons including inadequate training, as well as negative attitudes toward manuals and clinicians erroneously believing treatments they specialize in are more effective than they are. Likewise, von Ranson et al. (2013) found clinicians to endorse limited training in EBPIs as the most common reason for infrequent use of EBPIs. In another study, Waller et al. (2013) found clinicians with positive views of

treatment manuals as providing helpful information and structure, while those with negative views of manuals as being less useful and being forced upon them by third-party insurance companies. It is necessary to acquire further insight on why the uptake of EBPIs and manuals is limited if we are to effectively treat ED patients. Likewise, investigation of factors associated with infrequent EBPI as well as manual use will help inform dissemination efforts to increase the adoption of EBPIs among practitioners.

Anxiety

A systematic review on therapist drift described therapist anxiety as a major contributor to the underutilization of EBPIs and manuals, where clinicians do not use treatments due to clinicians' worries about causing anxiety in their clients, leading clinicians to feel anxious (Speers et al., 2022). Specifically, amongst clinicians treating EDs in the United Kingdom, anxious clinicians were less likely to use empirically-supported CBT techniques such as asking patients to complete food diaries, employ structured eating, and participate in behavioral experiments when treating adults with EDs (Waller et al., 2012). Other studies (e.g., Mulkens et al., 2018; Turner et al., 2014) have focused on the cognitive factor of trait anxiety, such as intolerance of uncertainty (Koerner et al., 2006) or the inability to tolerate uncertainty. Intolerance of uncertainty can be divided into two facets, including prospective anxiety (inability to tolerate ambiguity or unpredictability) and inhibitory anxiety (inability to initiate action due to uncertainty). Both these facets have been associated with non-use of EBPIs. For instance, in a study of Dutch clinicians, clinician intolerance of uncertainty was associated with differences in CBT techniques employed when treating individuals with EDs (Mulkens et al., 2018). For example, clinicians with greater inhibitory anxiety were less likely to use exposure or behavioural experiments and were more likely to continue seeing clients who refused to use food

diaries. Mulkens et al. (2018) hypothesized that clinicians with greater inhibitory anxiety did not use necessary techniques due to ambiguity about the outcome. In another study, prospective anxiety was associated with greater worries about elements of manualized CBT, where cognitive and exposure-based techniques of CBT and inhibitory anxiety was associated with concerns about treatment motivation or ending among clinicians treating EDs (Turner et al., 2014). Similarly, clinicians with higher clinical anxiety scores using FBT were more likely to omit key elements of treatment, such as weighing clients less frequently than recommended (Kosmerly et al., 2015). As such, therapist anxiety appears to be an important contributor to therapist drift. However, Waller and colleagues (2012) did not find an association between therapist anxiety and the use of manuals. Waller et al., (2013) found that clinicians with higher depression scores also demonstrated greater negative attitudes toward the use of manuals in ED treatment. In this study, Waller and colleagues (2013) focused on clinical levels of anxiety and depression. As such, there is a need for further investigation of dispositional traits such as clinician anxiety and depression during treatment delivery to inform potential interventions targeting barriers to EBPIs and manual use.

Age

Speers and colleagues (2022) found that younger clinicians were more likely to use EBPIs. Similarly, in Wallace and von Ranson's (2011) study, younger clinicians were more likely to use manuals when treating individuals with BN. Yet, in one study, clinician age was linked to practitioner attitudes toward manuals use, in that older practitioners were less likely to view manuals as negatively impacting the therapeutic process (Waller et al., 2013). However, other studies (e.g., Kosmerly et al., 2015; Waller et al., 2012) did not replicate links between age and the use of EBPIs and manuals in the field of EDs. Speers et al. (2022) suggest that clinician

age and clinician experience are separate constructs underscoring the need for further research to delineate and understand the relationship between age and use of EBPIs and manuals.

Knowledge and Training

Therapist education level has been positively associated with treatment fidelity, use of EBPIs, and willingness to use EBPIs (Campbell et al., 2013; Patterson Silver Wolf et al., 2018; Speers et al., 2022; Wallace & von Ranson, 2011). Specifically, clinicians with lower levels of education tended to employ non-EBPIs when treating EDs, compared to more highly educated clinicians (Wallace & von Ranson, 2011). Notably, training of ED clinicians is quite varied and of concern, as many clinicians appear to be ill-equipped to treat ED patients. For instance, in a survey of Alberta clinicians treating EDs, about 15% reported having had no specific training in ED treatment (von Ranson et al., 2013).

Clinicians may not be using manualized EBPIs for several reasons. First, manualized approaches are often time restricted (i.e., the number of therapy sessions are predetermined prior to the beginning of the first session) in RCTs for pragmatic reasons such as cost and feasibility, and to improve internal validity, which may not meet their clients' needs in everyday practice (De Geest & Meganck, 2019). Next, there may not be an EBPI that meets the exact needs of their client or an available EBPI that has been researched and validated for their client's group. For example, Tolin et al. (2015) describes a scenario where a clinician must select a treatment for "...impoverished African-American man with a presenting complaint of depression, as well as a significant drinking problem". In this case, it is likely no EBPI exists for this client that addresses the racism and poverty he experiences, and how that intersects with his depression and substance use, leading the clinician to adapt the EBPI to meet their patient's needs. Despite these limitations of manualized EBPIs, Tolin et al. (2015) argue that the first step to evidence-based

practice is identifying EBPIs that have efficacy for a certain problem and then potentially adapting this scientific information based on clinician judgment and patient characteristics. Thus, the present study focused on the first leg of evidence-based practice and explored what treatments were being used to treat EDs.

Limitations of Previous Research

There is a lack of consensus in the literature on the influence of clinician anxiety and age on the use of manuals and EBPIs in the field of EDs. In addition, the influence of clinicians' depressed mood on use of EBPIs has largely been neglected (for an exception, see Waller et al., 2013). Therefore, further investigation of the association between clinician emotional traits and characteristics and the uptake of EBPIs and manuals is needed to inform potential targets to increase the adoption of EBPIs.

Whereas previous research has examined the use of EBPIs among community clinicians treating EDs across Alberta (von Ranson et al. 2013), this research has not been extended to other geographical locations. Further research should decipher if von Ranson and colleagues' (2013) findings generalize across jurisdictions and time, which may aid in our understanding of factors associated with use of EBPIs. Given the potential impact of EBPIs on patient outcomes, it is important to replicate and extend previous research in Alberta in other jurisdictions.

Purpose of the Present Study

The aim of the current study was to investigate to what degree clinicians in British Columbia (BC) treating EDs were using manuals and EBPIs, as well as factors associated with their uptake. We aimed to identify clinicians' primary treatment approaches, and clinician characteristics—such as attitudes, age, intolerance of uncertainty, mood, and training background—that were associated with use of EBPIs and manuals. We used two logistic

regression models to determine which aforementioned factors predicted use of manuals (Model 1) and use of EBPIs (Model 2). This study explored the degree to which treatment approaches differed depending on the client's diagnosis (as done by von Ranson et al., 2013). This study aimed to contribute to a growing body of literature on the use of EBPIs in ED treatment to inform future dissemination efforts of EBPIs by identifying correlates related to their utilization.

Method

Power Analysis

To estimate sample size for logistic regression analyses, an a priori power analysis was conducted using G*Power software. A total sample size of 131 participants was required for 95% power to detect a medium effect (using an estimated odds ratio of 2.10) for practical significance (i.e., a result that would have at least some explanatory or use in the real world; Funder & Ozer, 2019).

Recruitment

Eligible participants included BC clinicians who had provided psychotherapy or counselling to at least one individual with an ED in the last 12 months. Participants were recruited from a list of psychotherapists created for this study. The list of psychotherapists comprised names and any available contact information for various professionals, including psychologists, social workers, counsellors, medical doctors, and other mental health professionals advertising online that they provided psychotherapy for EDs. The list was constructed by gathering names (between approximately May-July 2022) of clinicians listed on (a) government and agency websites; (b) provincial professional association websites; (c) websites listing resources and clinician referrals; (d) and web-based searches (e.g., filtering clinicians stating on professional websites that they treated EDs). For example, Psychology

Today (https://www.psychologytoday.com/ca), an online resource for individuals seeking psychological services, allows individuals to browse therapists according to several criteria. We filtered this source by restricting geographical location to BC and issue to eating disorders. We included those from this resulting search in our list of potential participants. Participants not on the list of psychotherapists were recruited through advertisements posted on social media sites (Instagram, Facebook, and Twitter), on lab member's social media profiles, and through the National Eating Disorder Information Centre's research listings, as well as snowball recruitment.

The final list of psychotherapists included 1,530 individuals. We attempted to contact all individuals for whom we had contact information. However, we did not reach all participants (i.e., phone numbers not in service or emails that bounced). If a phone number was available, potential participants were contacted by phone initially and screened for eligibility. If we were unable to reach individuals directly, a voicemail and email were sent (if email address was available), describing the study and eligibility criteria, and providing a link to participate. If we did not have a potential participant's phone number, participants were sent an email only. Participants received up to two reminder emails at 1-week intervals if they did not respond to the initial contact or complete the survey. We attempted to contact 1,432 individuals from the list of psychotherapists. Overall 1,055 individuals were sent a link to the survey via email if: (a) an email address was available from the list, (b) if they were deemed eligible to participate over the phone and subsequently provided an email address, or (c) if they expressed interest in participating in the study through social media or snowball recruitment. Of those sent an email link to the survey. One hundred fifty-six individuals (14.7%) responded to the survey. Of the 156 respondents, 126 individuals met eligibility criteria assessed in the survey (i.e., having treated at least one individual with an eating disorder in the last 12 months). The sample of clinicians is

comparable to BC residents in terms of age and ethnicity, as outlined in the 2021 Canadian Census (Statistics Canada, 2023).

Procedure

Ethics. Ethics approval for this project was obtained from the University of Calgary Conjoint Faculties Research Ethics Board. The certificate of approval identification number is REB22-0661.

Eligibility. The eligibility criterion for this study was having provided psychotherapy or counselling to at least one individual with an ED in the past 12 months. For individuals who answered their phone, an eligibility screening was conducted via telephone and, if interested and eligible, they were sent a link to complete the study. Others received a voicemail and/or email with information and a link to the study. Prospective participants provided informed consent to participate prior to starting survey (see Appendix A for informed consent form). The survey was administered via Qualtrics.com, a secure, web-based survey platform. Data were collected during the third year of the COVID-19 from approximately December 2022 to May 2023. Participants were asked to reflect on the treatment of their ED clients over the past year, which included the height of the pandemic (2021-2022)Participants were not renumerated for completing the survey.

Measures

An online survey (Appendix C), adapted from von Ranson et al., Magel et al., (2013), and Kosmerly et al. (2014), was used for this study. The survey took approximately 30 minutes to complete and consisted of five parts: (1) questions regarding clinicians' ED clients and specific training for working with ED patients; (2) specific psychotherapeutic approaches used and specific CBT and FBT techniques used; (3) perceived barriers and facilitators to use of EBPIs; (4) familiarity with ARFID (e.g., a new diagnosis); and (5) demographic information on

age, ethnicity, gender, and education (Appendix D). Although the survey assessed questions relating to clinician familiarity with and the treatment of ARFID, use of specific CBT and FBT techniques, barriers and facilitators of EBPI use, these measures were not analyzed in the present study.

Intolerance of Uncertainty Scale (Carleton et al., 2007). The IUS-12 (see Appendix E) is 12-item self-report measure of trait anxiety with two subscales, with seven items assessing Prospective Anxiety (i.e., fear of future or unpredictable events) and five items assessing Inhibitory Anxiety (i.e., uncertainty inhibiting action). Items are rated on a 5-point Likert scale from 0 (not at all characteristic of me) to 5 (entirely characteristic of me). Items are summed to yield a total score (possible range 12-60), Prospective Anxiety (possible score range 7-35), and Inhibitory Anxiety (5-.25).Example items of Prospective Anxiety include "Unforeseen events upset me greatly" and "A small, unforeseen event can spoil everything, even with the best of planning". Sample items of Inhibitory Anxiety include, "Uncertainty keeps me from living a full life." and "When it's time to act, uncertainty paralyzes me". The IUS-12 has previously demonstrated strong internal consistency (Cronbach's alpha = .91) and convergent validity with the original 27-item scale (r = 0.96; Carleton et al., 2007). The IUS-12 has demonstrated adequate internal consistency in a sample of clinicians (Cronbach's alpha = .89 for the Prospective Anxiety scale and .85 for the Inhibitory Anxiety scale; Turner et al., 2014). This measure has been used in previous studies examining therapist anxiety in the treatment of eating disorders (Hernandez Hernandez & Waller, 2021; Mulkens et al., 2018; Turner et al., 2014). McDonald's omega was calculated to measure internal consistency. In this sample, McDonald's omega was .83 for Prospective Anxiety and .83 for Inhibitory Anxiety.

The Positive Affect and Negative Affect Schedule (D. Watson et al., 1988). The PANAS (see Appendix F) is a 20-item measure of positive and negative affect and was used to assess each clinician's mood. Participants rate how much they have felt each emotion over the past week, "Indicate the extent you have felt this way over the past week," on 5-point scale ranging from 0 (very slightly or not at all) to 5 (extremely). The Positive Affect scale includes emotions such as "enthusiastic" and "proud", while the Negative Affect scale included items such as "guilty" and "upset". Items scores were summed to give total Positive Affect and Negative Affect scores (possible ranges 10-50). The PANAS has demonstrated strong internal consistency among therapists (Cronbach's alpha = .91 for the positive affect scale and .90 for the negative affect scale; Chui et al., 2016). McDonald's omega in the current study was .85 for Positive and .89 for Negative Affect.

The Attitudes to Treatment Manuals Questionnaire (Addis & Waltz, 2002). The 52-item ATMQ (see Appendix G) assesses four categories: clinician demographic characteristics, treatment manual expertise, attitudes toward treatment manuals, and beliefs about treatment manuals. This questionnaire has been validated for use with doctoral-level psychologists (Addis & Waltz, 2002) and has demonstrated acceptable internal consistency (Cronbach's alpha: .79-.92) with eating disorder clinicians with qualifications ranging from bachelor's to doctorate degrees (Waller et al., 2013). Likewise, this measure has been used in previous studies evaluating eating disorder clinician's attitudes toward use of manuals (Waller et al., 2013). The Experience scale is comprised of nine items and uses a variety of response scales. Attitudes and Beliefs are rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree) with 17 and nine items, respectively. The Attitudes scale yields two factors, Negative Processes and Positive Processes. Mean scores of 10 items yield the Negative Process scale and mean

scores of seven items yield the Positive Processes scale. The Negative Process factor includes items such as that manuals are viewed as impeding the therapeutic relationship and therapists' flexibility and freedom such as, "Using a treatment manual undermines clinical creativity and artistry" and "Using a treatment manual makes a therapist think more about sticking to the manual than the needs of the individual client". The Positive Process factor included items that relate to manuals' ability to enhance therapeutic outcomes such as, "Following a treatment manual will enhance therapeutic outcomes by ensuring that the treatment being used is supported by research" and "Treatment manuals, if used appropriately, will enhance the average outcomes of clients treated in psychotherapy." McDonald's omega was .74 for Positive Processes and .95 for Negative Processes.).

Use of Manuals and EBPIs. Clinicians reported on their frequency of manual use in their clinical work on item 16 of the ATMQ, "How often do you use treatment manuals in your clinical (non-research) work?". Use of manuals in clinical work was dichotomized by categorizing those who reported using manuals in their clinical work, 'rarely,' 'sometimes', and 'often' into 'yes' (n = 68) and 'never' responses into the 'no' (n = 30) category. None of the respondents indicated they used treatment manuals almost exclusively in their clinical work. Participants provided open-ended responses on their use of treatments for each specific eating disorder (see Question 28 of the survey). Respondents reporting more than one primary approach were not classified. The author dichotomized the use of EBPIs by categorizing those who indicated they had used at least one EBPI (as listed on Division 12's website) to treat either AN, BN, or BED as 'yes' (n = 20). Respondents who did not report using at least one EBPI for these disorders were categorized as 'no' (n = 60).

Data Analysis

Data were analyzed using SPSS, Version 29 (IBM Corp, 2022). Missing data were not replaced, resulting in varying sample sizes across analyses. Descriptive statistics were used to describe the sample and measures. Logistic regression analyses were performed to predict dependent variables (use of EBPIs and manuals).

Results

Sample Demographics

Participants included 126 clinicians in BC. Participant demographic information is presented in Table 2. Participants' mean age was approximately 45 years old (range: 27-76 years). Most participants identified as White/European descent and as women.

Table 2

Sociodemographic Characteristics of Clinicians

Gender (*n* = 109)	*n*	%
Women	90	82.6
Men	12	11.0
Non-binary	4	3.7
I prefer not to answer	2	1.8
Fluid/genderqueer	1	0.9
Age in years (*n* = 95)	*M*	*SD*
	45.41	10.61
Ethnicity (*n* = 117)	*n*	%
White/European	92	78.6
South Asian	10	8.5
East Asian	3	2.6
I prefer not to answer	3	2.6
African/Caribbean	2	1.7
Latin American	2	1.7
Metis	2	1.7
First Nations	1	0.9
Middle Eastern/West Asian	1	0.9
Other	1	0.9

Descriptive Statistics

Mean, standard deviations, and range of scores for clinicians' anxiety (IUS-12), affect (PANAS), and attitudes toward manuals in this sample are presented in Table 3.

Table 3

Descriptive Statistics for the Intolerance of Uncertainty Scale-12 (IUS-12), the Positive Affect and Negative Affect Schedule (PANAS), and the Attitudes Toward Manuals Questionnaire (N = 89-99)

Variable	*M*	*SD*	*Range*
Intolerance of Uncertainty Scale-12			
Prospective Anxiety	13.94	4.80	7.00-26.00
Inhibitory Anxiety	6.80	2.45	5.00-15.00
Positive Affect and Negative Affect Schedule			
Positive Affect	34.07	5.78	21.00-50.00
Negative Affect	16.92	5.73	10.00-40.00
Attitudes Toward Manuals Questionnaire			
Negative Processes Scale	3.09	0.88	1.10-4.80
Positive Processes Scale	3.06	0.56	1.57-4.86

Eating Disorder Client Characteristics

Clinicians were asked to describe characteristics of the clients with eating disorders they had treated (Table 4). Participants could offer multiple responses; thus, sums exceed 100%. Clinicians in the present study had experience treating a range of EDs. In addition, clinicians reported having treated a diverse range of ED clients in terms of ethnicity, age, and gender. Out of 123 respondents, most (84.6%) identified their primary treatment setting as outpatient. Seventy-five percent of 121 respondents reported not collaborating with other professionals in providing ED treatment.

Table 4

Characteristics of Clinicians' Eating Disorder Clients

	M	*SD*
Percent ED clients of clinicians' typical caseload (n = 123)	26.74%	28.72

Types of EDs ever treated (n = 124)	n	%
Binge eating disorder	103	83.1
Bulimia nervosa	99	79.8
Anorexia nervosa	89	71.8
Other specified feeding and eating disorder	82	66.1
Unspecified eating disorder	78	62.9
Avoidant restrictive food intake disorder	64	51.6
Other	9	7.3
I prefer not to answer	3	2.4

Ethnicity of ED clients clinicians have ever treated (n = 105)	n	%
White/European	91	86.7
East Asian	43	41.0
First Nations	42	40.0
South Asian	30	28.6
Middle Eastern/West Asian	24	22.9
African/Caribbean	22	21.0
Metis	22	21.0
Latin American	18	17.1
Southeast Asian	15	14.3
Filipino	13	13.3
I do not know	7	6.7
I prefer not to answer	4	3.8
Inuit	2	1.9
Other	1	1.0

Gender of ED clients clinicians have ever treated (n = 106)	n	%
Female	87	82.1
Male	56	52.8
Transgender	49	46.2
Fluid/genderqueer	48	45.3
Non-binary	47	44.3
Two spirit	11	10.4
I do not know	8	7.5
Other	3	2.8
I prefer not to answer	2	1.9

Client age group clinicians have ever treated (n =119)	n	%
Adults (age 18-64)	113	95.0
Adolescents (age 13-17)	85	71.4
Children (age 12 and under)	27	22.7
Seniors (age 65 and older)	21	17.6
I prefer not to answer	1	0.8

Note. ED = eating disorder.

Clinician Education and Training

Of the 102 individuals that reported on their highest level of education, most reported having a master's degree (88.2%), others reported a doctoral or professional degree (8.8%), and a few reported having a bachelor's degree (1.9%). Five (3.2%) of 107 respondents elected not to answer this question. The average years of graduate school completed by participants was 3.25 (*SD* = 2.18; range 0-15). On average, clinicians had completed their most advanced degree a decade ago (*M* = 10.0 years; *SD* = 8.5; range = 0-42 or 1981-2023). Clinicians reported an average of 11.3 years in clinical practice (*SD* = 8.9; range 0-42) after completing graduate school. The mean number of years participants had been providing psychotherapy or counselling to ED patients, excluding graduate school, was 10 years (*SD* = 8.5; range 0- 40 years). Of the 108 individuals that responded to this question., 70.4% indicated they were registered under the BC Health Professions Act, which oversees 30 practitioner groups (see https://bchealthregulators.ca/health-regulation-in-bc/regulated-health-professions). On the other hand, 20.4% reported they were not registered or chartered, and 10 (6.4%) preferred not to answer. Of 105 respondents, most (94.3%) reported direct patient contact as their predominant professional activity; others reported teaching (1.9%), consulting (1.9%), and other (4.8%). "Other" responses included clinical supervision and leadership (1.0%), and supervision of other practitioners (1.0%). Most participants (82.9%) reported private practice was their primary employment setting (see Table 5 for a list of primary employment settings). The types of training clinicians had received for treating EDs is presented in Table 6 (the total exceeds 100% as participants could indicate more than one response). Frequent "Other" responses included addictions training and experience, anecdotal experience, lived/personal experience, podcasts, research experience, and more. Almost all of 123 respondents reported their clinical work with

ED patients included psychotherapy or counselling (99.2%), while one participant indicated their work did not (0.8%).

Table 5

Clinicians' Primary Employment Setting (*N* = 105)

Employment setting	*n*	%
Private practice	87	82.9
Community clinic/agency	9	8.6
Other	6	5.7
Primary/secondary school	2	1.3

Table 6

Clinicians' Training in Eating Disorder Treatment (N = 121)

Types of training in eating disorders	*n*	%
Reading books	103	85.1
Workshop or seminar attendance	99	81.8
Part of graduate clinical training	71	58.7
Formal supervision by colleagues (regularly scheduled meetings)	65	53.7
Informal supervision by colleagues (ad hoc meetings)	62	51.2
Viewed tapes	52	43.0
Intensive training provided by workplace	29	24.0
Other	32	26.4

Psychotherapeutic Approaches Used when Treating Individuals with Eating Disorders

Of 123 participants that responded to this question, most reported individual therapy (87.8%), followed by group therapy (4.1%), family therapy (4.1%), "other" (3.3%), and marriage/couples therapy (0.8%) was their primary treatment modality. Primary approaches for treating individuals with EDs are presented in Table 7. Frequent other primary responses included emotion-focused therapy, internal family systems, somatic therapy, and more. EBPIs were infrequently endorsed as clinician's primary approach to treating eating disorders (see Table 7). The most important reason for using this treatment approach is presented in Table 8.

Participants provided open-ended responses on their primary approach used for each specific ED type (Table 9). Participants reported using a wide range of approaches to treat each ED. Approximately 15% of respondents reported use of at least one of the three EBPIs listed by Division-12 for AN. Thirteen percent of respondents reported having used CBT for BED, and 14% and 2% respectively reported having used CBT and FBT for BN. None of the participants reported using IPT for BED or BN.

Table 7

Primary Psychotherapeutic Approach Endorsed by Clinicians Treating People with Eating Disorders (*N* = 109)

Primary approach	*n*	%
Other	23	21.1
Cognitive behavioural therapy	20	18.3
Dialectical behaviour therapy	12	11.0
Acceptance and commitment therapy	8	7.3
Eye movement desensitization and reprocessing	8	7.3
Integrative therapy	7	6.4
Narrative therapy	5	4.6
Family-based treatment	4	3.7
Psychoeducation	3	2.8
Radically open dialectical behaviour therapy	3	2.8
Family therapy	2	1.8
Motivational interviewing	2	1.8
Psychodynamic therapy	2	1.8
Psychoeducation for family/carers	2	1.8
Solution-focused therapy	2	1.8
Supportive therapy	2	1.8
Cognitive remediation therapy	1	0.9
Maudsley Anorexia Nervosa Treatment for Adults	1	0.9
Play therapy	1	0.9
Self-disclosure	1	0.9

Table 8

Clinicians' Most Important Reason for the Primary Psychotherapeutic Approach Used for Treating Individuals with Eating Disorders (*N* = 108)

Reason	*n*	%
Clinical experience indicates effectiveness	33	30.6
Supported by research	24	22.2
Flexible; can be tailored to individual clients' needs	23	21.3
Received training in this approach	11	10.2
Consistent with own theoretical orientation	7	6.5
Recommended by supervisors/colleagues	4	3.7
Compatible with own clinical style of conducting therapy	4	3.7
Other	1	0.9
I prefer not to answer	1	0.9

Table 9

Clinicians' Use of Treatment Approaches for Specific Eating Disorder Diagnoses

	Treatment approach *n* (%)				
	Anorexia nervosa (*n*= 69)	Bulimia nervosa (*n*= 71)	Binge-eating disorder (*n* = 76)	Other specified feeding and eating disorder (*n* = 46)	Unspeci-fied feeding or eating disorder (*n* = 45)
Acceptance and commitment therapy	5 (7.3)	3 (4.2)	5 (6.6)	2 (3.5)	1 (2.2)
Brain spotting	0 (0)	1 (1.4)	0 (0)	0 (0)	0 (0)
Coaching/Recovery coaching	1 (1.5)	1 (1.4)	1 (1.3)	2 (3.5)	1 (2.2)
Cognitive-behavioural therapy (CBT)/CBT-enhanced	8 (11.6)*	10 (14.1)*	10 (13.2)*	7 (15.2)	6 (13.3)
Dialectical behaviour therapy	4 (5.8)	10 (14.1)	4 (5.3)	3 (6.5)	5 (11.1)
DBT-radically open	2 (2.9)*	0 (0)	0 (0)	0 (0)	0 (0)
Emotion focused therapy	2 (2.9)	2 (2.8)	1 (1.3)	2 (3.5)	1 (2.2)
Emotion focused family therapy	2 (2.9)	1 (1.4)	1 (1.3)	0 (0)	0 (0)
Eye movement desensitization and reprocessing	0 (0)	1 (1.41)	1 (1.3)	0 (0)	0 (0)
Family-based treatment	2 (2.9)*	2 (2.8)*	0 (0)	1 (2.2)	0 (0)
Internal family systems therapy	1 (1.5)	2 (2.8)	6 (7.9)	2 (3.5)	2 (4.4)
Integrative treatment	4 (5.8)	4 (5.6)	4 (5.3)	2 (3.5)	3 (6.7)
Intuitive eating	0 (0)	0 (0)	1 (1.3)	0 (0)	0 (0)
Lifespan integration	0 (0)	0 (0)	1 (1.3)	0 (0)	0 (0)
Maudsley Model of Anorexia Nervosa Treatment for Adults	1 (1.5)	0 (0)	0 (0)	0 (0)	0 (0)

Meal support	1 (1.5)	0 (0)	0 (0)	0 (0)	0 (0)
Motivational interviewing	1 (1.5)	1 (1.4)	1 (1.3)	0 (0)	0 (0)
Narrative therapy	2 (2.9)	2 (2.8)	2 (2.6)	1 (2.2)	1 (2.2)
Polyvagal therapy	1 (1.5)	1 (1.4)	1 (1.3)	1 (2.2)	1 (2.2)
Psychoeducation	0 (0)	1 (1.4)	0 (0)	0 (0)	0 (0)
Sand tray or sand play	2 (2.9)	0 (0)	0 (0)	1 (2.2)	0 (0)
Supportive therapy	1 (1.5)	1 (1.4)	1 (1.3)	1 (2.2)	1 (2.2)
2 responses indicated	14 (20.3)	17 (23.9)	20 (26.3)	11 (23.9)	14 (31.1)
3 or more responses indicated	11 (15.9)	9 (12.7)	11 (14.5)	6 (13.0)	5 (11.1)
Other	4 (5.8)	2 (2.8)	5 (6.6)	4 (8.7)	4 (8.9)

Note. Evidence-based psychological interventions are denoted by *. No EBPIs were listed for other specified feeding and eating disorder and unspecified feeding or eating disorder on the Division 12 website.

Clinicians' Experience with Treatment Manuals

Clinicians reported on their experience using treatment manuals (see Appendix H). Of the 106 individuals who responded to this question, most respondents (85.6%) in our sample had heard of psychotherapy treatment manuals. One hundred and three participants reported on their use of manuals in clinical practice, where few respondents (8.7%) indicated they used treatment manuals regularly in their practice with patients with EDs. Most participants (40.8%) of 103 respondents reported their feelings toward use of manuals in clinical practice were somewhat strong.

Clinician's attitudes toward treatment manuals

In our sample, the mean score on the Negative Processes scale was 3.09 (*SD* = 0.88; range 1.10-4.80) and 3.06 (*SD* = 0.56; range 1.57-4.86) on the Positive Process scale. Item rating of these scales are reported in Appendix I.

Predictors of Manual Use

Binominal logistic regression analyses were performed to predict the likelihood of clinicians using manuals in their clinical work and use of EBPIs. Independent variables included

in these models were prospective anxiety, inhibitory anxiety, negative affect, positive affect, mean negative attitudes toward manuals, mean positive attitude toward manuals, highest level of education, and age. All continuous variables were linearly related to the logit of the dependent variables (use of manuals and EBPIs), as assessed by the Box-Tidwell (1962) procedure, meeting the linearity assumption of logistic regression. Significance for this procedure was assessed by using a significance value of $p < .001$. Multicollinearity of independent variables was assessed using variance inflation factor (VIF) values. The data met the assumption of absence of multicollinearity, as all VIF values were below 10.

All eight of the predictors were included in both models. The logistic regression model for use of manuals (see Table 10) was statistically significant $\chi^2(8) = 22.51$, $p = .004$. The Nagelkerke R^2 suggested the model explained 38.3% of the variance and correctly predicted 81.3% of the cases. Two of the eight predictor variables were statistically significant: mean Negative Attitudes toward manuals and mean Positive Attitudes toward manuals. Those with more negative attitudes toward manuals had 0.30 times the odds of using a treatment manual (i.e., were less likely to use a manual), whereas having a greater positive attitude toward manuals was associated with 5.14 times the odds of using manuals. By contrast, the model for predictors of EBPIs was not statistically significant, $\chi^2(8) = 3.96$, $p = .0.861$ (see Table 11).

Table 10

Logistic Regression Analyses Predicting Clinicians' Use of Manuals with Eating Disorder Clients

Predictor	*B*	*SE*	*Wald*	*df*	*p*	*Odds Ratio*	*95% CI*
Prospective Anxiety	-0.06	0.09	0.45	1	.508	0.95	0.80-1.12
Inhibitory Anxiety	-0.11	0.16	0.468	1	.494	.90	0.63-1.23

Negative Affect	.0.10	0.07	1.81	1	.179	1.11	0.96-1.01
Positive Affect	-0.01	0.01	0.99	1	.319	.99	0.98-1.01
Negative Attitudes toward Manuals	-1.21	0.48	6.35	1	.012	0.30	0.16-0.76
Positive Attitudes toward Manuals	1.64	0.77	4.48	1	.034	5.14	1.13-23.44
Age	0.04	0.03	1.81	1	.178	1.045	0.98-1.11
Highest level of education	1.61	1.07	2.24	1	.134	4.98	0.61-40.67

Table 11

Logistic Regression Analyses Predicting Clinicians' Use of Evidence-Based Psychological Interventions for Eating Disorders

Predictor	*B*	*SE*	*Wald*	*df*	*p*	*Odds Ratio*	*95% CI*
Prospective Anxiety	-0.02	0.09	0.72	1	.788	0.97	0.82-1.16
Inhibitory Anxiety	0.05	0.18	0.09	1	.761	1.06	0.74-1.50
Negative Affect	--0.05	0.06	0.77	1	.379	0.95	0.84-1.07
Positive Affect	-0.00	0.01	0.33	1	.567	.996	0.98-1.01
Mean Negative Attitudes toward Manuals	0.26	0.46	0.31	1	.580	1.29	0.52-3.21
Mean Positive Attitudes toward Manuals	-0.15	.70	0.04	1	.835	0865	0.22-3.39
Age	-0.03	0.04	0.82	1	.367	0.97	0.90-1.04
Highest level of education	-0.20	0.83	0.06	1	.810	0.82	0.16-4.19

Discussion

A few studies have examined the use of EBPIs for EDs among community clinicians in Alberta and Calgary (Magel et al., 2020; von Ranson & Robinson, 2006; von Ranson et al., 2013). The present study aimed to extend von Ranson and colleagues' (2006, 2013) work by examining the use of EBPIs among community clinicians treating EDs in BC, as well as identify predictors of EBPI and manual use. We identified two cross-sectional predictors of manual use: positive attitudes toward manuals were associated with their use and negative attitudes toward manuals were associated with less use. As such, it appears that attitudes toward treatment manuals are associated with their use.

One hundred twenty-one clinicians reported on the types of training they received for treating individuals with EDs. Clinicians indicated receiving formal training in ED treatment such as formal supervision, graduate school training, attending workshops and seminars, as well as informal training including reading books, informal supervision, and viewing tapes. A few clinicians indicated their training for EDs was based on personal experience. Although personal experience can provide important insight and compassion for patients, it is alarming that clinicians are relying on personal experience to treat EDs. It is unclear if clinicians relayed solely on personal experience when treating EDs or used personal experience in their clinical decision making. Future work should investigate how clinicians treating eating disorders balance the three legs of evidence-based practice, namely, EBPIs, clinician judgment, and patient characteristics, when selecting treatments for ED clients. Increased education on EBPIs may reduce clinicians' reliance on personal experience when treating individuals with EDs.

Psychotherapeutic Approaches Used for Treating Individuals with Eating Disorders

In this sample, the primary psychotherapeutic approaches used for treating EDs varied. Few clinicians endorsed using EBPIs, as defined by Chambless and Hollon (1998) and Tolin et

al., (2015) criteria on EBPIs, as their primary approach for treating EDs. Approximately 20% of clinicians reported CBT was their primary approach for treating eating disorders, which is consistent with previous studies (22.9%; von Ranson et al., 2013). Further, only a few clinicians had used EBPIs for each specific eating disorder. These results are consistent with other studies which have found 6% to 35% of clinicians use EBPIs for eating disorder treatment (Tobin et al., 2007; Wallace & von Ranson, 2011; Waller, 2016).

Although EBPIs play a critical role in evidence-based practice and patient care, there are several challenges that may explain why clinicians are not using these treatments. During the COVID-19 pandemic, there was an increase in number of diagnoses and hospitalizations in youth with AN and atypical AN across Canada (Agostino et al., 2021). This increase in EDs may have left clinicians in a unique predicament, in which clinicians who had not treated EDs before may have found themselves taking on ED clients. Further, clinicians may not have the tools or resources to employ EBPIs generally or during the pandemic, which may potentially explain their underutilization. Clinicians may not be using EBPIs due to other barriers, such as limited training in specific treatments, cost of training, feasibility of treatments in practice, as well as system-level barriers in the outer and inner settings of the CFIR including structures of organizations or limited funding and resources to adopt EBPIs

In addition, clinicians may not be using EBPIs as they may not believe EBPIs are meeting the needs of their clients, such as the severity of their client's ED or their client's characteristics, such as age or racial group. Clinicians may not find treatments to be meeting the needs of their clients due to several limitations that still exist in ED research. Particularly with EDs, these limitations include lack of data on treatments, that available evidence is usually limited by heterogenous samples and inconsistent efficacies, as well as limited understanding of

factors that influence treatment to optimize care (Peterson et al., 2016). Further, clinicians do not always have access to training in these EBPIs for EDs to provide effective treatment. To bridge the research-practice gap, Peterson and colleagues suggest that researchers ensure their samples match clinical populations in terms of comorbidities, ethnicity, and socioeconomic status.

Predictors of Use Manuals and EBPIs for Treatment of Eating Disorders

Like von Ranson and colleagues' (2013) findings, most participants in this study had a master's degree. However, the proportion of those with a master's degree vastly differed from von Ranson's sample in Alberta. We had a significantly larger proportion of master's degree clinicians than in von Ranson et al.'s study. The differences in educational attainment are unexpected, as psychologists in BC are licensed at the doctoral level, while in Alberta they are licensed at the master's level. As such, we had expected a larger proportion of clinicians with doctoral degrees treating eating disorder patients. Although we attempted to recruit a diverse group of clinicians, our sample included fewer psychologists than von Ranson and colleagues' samples, which may explain the different proportions of educational degrees.

Approximately 69% of respondents reported having used manuals in their clinical work at some point. The rates of manual use among BC clinicians treating eating disorders were lower than those previously reported by eating disorder specialists in the United Kingdom (Waller et al., 2013). For instance, Waller and colleagues (2013) found that approximately 90% of clinicians had used manuals in their clinical work at some point. However, the results from the present study were similar to findings by Becker et al. (2013), who found that approximately 50% of mental health clinicians in the United States had used manuals in their practice. ED specialists may be using manuals in their practice to a greater extent than community clinicians in BC treating EDs.

Two cross-sectional predictors of use of manuals in clinical work were identified: positive and negative attitudes toward manual use. Clinicians with positive attitudes toward manuals were more likely to use manuals compared to clinicians with negative attitudes towards manuals, who were less likely to use manuals. As such, manual use is related to clinicians' attitudes toward treatment manuals. Yet, the present study did not identify any statistically significant predictors of use of EBPIs among clinicians treating EDs. The findings from the present study may suggest that correlates of EBPIs and manual use are distinct.

In our sample, clinician age did not significantly predict manual use. This is different from other samples that have reported greater use of manuals among younger ED clinicians (Wallace and von Ranson, 2011) and mental health clinicians (Becker et al., 2013). For instance, Wallace and von Ranson (2011) found clinician age was a significant predictor of manual use among eating disorder specialists treating BN. On a related note, Speers et al. (2022) identified ten studies examining clinician age and use of empirically supported treatments which included use of manuals, adherence to manuals, and fidelity to empirically supported treatments for psychological disorders. In their systematic review, they found contradictory evidence between clinician age and adherence, whereby some studies identified a significant relationship between age and use of empirically supported treatments, while others found no relationship. The present study did not find a statistically significant association between age and manual use or use of EBPIs, which may suggest the association between clinician age and therapist drift may not be robust. Future research should explore if therapist drift is associated with clinician experience or age to determine if age and experience or similar or separate constructs.

Waller and colleagues (2013) examined the association between emotional factors and attitudes toward manuals among eating disorder specialists in the United Kingdom. Like Waller

et al. (2013), we found that most clinicians had heard of treatment manuals. In addition, Waller et al. (2013) found clinicians with lower levels of depressed mood tended to have more positive attitudes toward manual use. The present study extended their work by examining positive and negative affect using the PANAS, as well as attitudes toward manuals as predictors of manual use among clinicians treating individuals with EDs. Future research should consider if those with negative attitudes towards manuals can adopt more positive attitudes, and if changes in attitudes toward manuals are associated with increased uptake of EBPIs in ED treatment. Previous research has found education to be associated with manual use. For instance, among eating disorder professionals treating BN, clinicians with a Ph.D. or Psy.D. in clinical psychology were more likely to use a manual (Wallace & von Ranson, 2011). The present study did not find education level to be a significant predictor of manual use. This finding may be due to low power due to the small sample size of participants who had professional degrees (n = 5).

Currently, counselling is not a regulated profession in BC, and anyone can provide "psychotherapy." The low uptake of EBPIs among BC clinicians may provide support to encourage enhanced oversight of counsellors in BC (Martin et al., 2013). The province has recently announced they will be working toward regulating counsellors and psychotherapists (see https://www.ccpa-accp.ca/british-columbia-regulation/). This oversight may reduce the risk of harm to clients (Martin et al., 2013) by ensuring clinicians have competences in evidence-based practice to increase use of manuals and use of EBPIs.

In their systematic review, Speers and colleagues (2022) concluded that therapist anxiety was one of the most robust predictors of therapist drift. For example, among ED therapists, greater anxiety was associated with non-adherence to CBT manuals for EDs (Mulkens et al., 2018). Although previous research has found clinician anxiety to be a robust factor associated

with non-adherence and infrequent use of empirically supported treatments, the results of this study did not find prohibitory or inhibitory anxiety to be a significant predictor of manual use or use of EBPIs. Previous studies of clinician anxiety and manual use with ED patients have used samples from the Netherlands (Mulkens et al, 2018) and the United Kingdom (Waller et al., 2012). The previous studies only included CBT clinicians and adherence to CBT techniques, whereas our study included a range of treatment approaches and overall use of manuals. As such, we investigated use of manuals and EBPIs more broadly, which may explain why we did not find clinician anxiety to be a significant predictor in our sample. It could be that clinician anxiety is related to specific techniques in CBT such as use of food diaries. Future research should consider the role of mediating factors on the relation between therapist anxiety and therapist drift, such as training level. It could be that anxious clinicians may have fewer years of experience, leading them to feel distressed when following certain techniques of manualized approaches such as exposures. As such, it is important for training programs to ensure that clinicians have competencies in EBPIs and follow manualized approaches.

Implications

Findings from the present study are important for implementation science. Several studies have identified evidence-based psychological interventions for EDs. Further, APA Division 12 has outlined several EBPIs with the most scientific rigor for AN, BN, and BED on their website. Yet, most clinicians fail to use these EBPIs, as shown in the current study. The present study identified potential barriers to manual use from the individual domain of the CFIR framework such as clinicians' negative attitudes toward manuals. Future research should evaluate if and how individual factors such as negative attitudes toward manuals interact with other domains of the CFIR to impact adoption and implementation of EBPIs. In addition, more research is required on

how each level of the CFIR may be preventing EBPIs for EDs being adopted into practice. To expand, at there may be characteristics about the intervention itself such as cost or adoptability that may be limiting its adoption. Factors at the inner and outer setting such as funding and resources within and outside the organization may also be limiting EBPI use and are important considerations for future research. Another important and understudied area related to evidence-based practice is how characteristics of the individual (i.e., client) such as personal attributes may relate to underutilization of EBPIs.

Previous research has found that manualized treatments are associated with better outcomes for psychological disorders (Cukrowicz et al., 2011) and eating disorders (see Wallace and von Ranson, 2011). However, the present study found that among the clinicians that responded to the survey, few clinicians in BC treating EDs are using manuals in their clinical work, regularly. This study found negative attitudes toward manuals predicted non-use of manuals, whereas positive attitudes predicted use of manuals, cross-sectionally. To increase the uptake of manuals, it will be important for future research to determine how to make negative attitudes toward manuals more positive among community clinicians. For instance, if clinicians' negative attitudes are addressed by ensuring treatment manuals tend to fit real-world patients, clinicians may be more inclined to use manuals. It will be important for future research to work toward changing negative attitudes toward manuals to potentially increase their use, and subsequently improve patient outcomes.

The present study found that most clinicians in BC were not using EBPIs when treating individuals with EDs. As such, it appears clients may not be receiving the best available treatments and optimal care. To ensure that clients with EDs are receiving the best possible care and maximizing their chances of recovery, EBPI uptake needs to be increased. Importantly,

Division-12's website only listed four EBPIs for the treatment of EDs. As such, clinicians may not be using EBPIs due to the limited availability of EBPIs for EDs. The present study did not identify any predictors of EBPI use. Future work should examine barriers and facilitators of EBPI use to potentially impact their use.

Study Strengths and Limitations

The present study has several strengths. First, we created a large list of potential participants through various sources throughout BC, and we contacted most participants on this list, allowing us to include a large sample of clinicians. Second, to the best of our knowledge, this is the third study to examine the use of EBPIs for EDs amongst Canadian community clinicians. This study allowed for the investigation of psychotherapies being used to treat EDs among community clinicians, whereas most previous studies have focused on ED experts. Third, we expanded on von Ranson et al.'s work by using logistic regression models to explore clinician characteristics as predictors for use of EBPIs and manuals.

Limitations of the present study include the use of self-report data. Although the survey was anonymous, participant responses may have been impacted by social desirability bias and demand characteristics, which may mean our survey results are an overrepresentation of EBPI and manual use. Participant interpretation of questions may have also impacted our findings (e.g., we did not include English-speaking fluency as an eligibility criterion; we did not define key terminology for participants such as counselling, psychotherapy, or treatment manuals). In addition, participants may have could have interpreted the following question, "How strong are your attitudes and feelings about the role of treatment manuals in clinical practice" to mean positive or negative feelings. Further, those who chose to participate may have differed from those who did not participate in the survey, and those who were hesitant to report on their use of

treatments may have elected not to participate. Another limitation of the present study included the group size in the logistic regression model of predictors of EBPI use, whereby the group of clinicians using EBPIs may have been too small to detect a medium effect. Although we attempted to recruit a large and diverse sample of ED clinicians across BC, our sample may not reflect all clinicians. The association between positive attitudes and manual use should be interpreted with caution, as the wide confidence interval is suggestive of a lack of precision of this estimate. Finally, this study used a cross-sectional design which limits our ability to infer a temporal relationship between predictors and outcomes (i.e., manual and EBPI use).

Other limitations of the current study relate to the use of Division 12's list of EBPIs. First, it is unclear how up to date Division 12's list of EBPIs is. For instance, there is preliminary evidence for the treatment of ARFID in children using FBT (Lock et al., 2019), and CBT for children and adolescents (Thomas et al., 2020), as well as for adults (Thomas et al., 2021). However, the current literature on these treatments is not reflected in this list. It is unclear how often Division 12 updates their list of EBPIs.

Evidence-based practice is a process involving integration of clinician judgment, client characteristics, and research evidence when clinicians make decisions to optimize care (Dozois et al., 2014). The present study focused on the use of EBPIs for the treatment of eating disorders among BC mental health clinicians and did not consider clinician judgment or characteristics of clients. When using EBPIs, clinicians should consider client characteristics. For instance, FBT has demonstrated efficacy for children and adolescents with AN. Future research should consider how client characteristics such as age, ethnicity, comorbidity, gender, and more are considered by clinicians when selecting treatments.

Conclusion

In this sample, we found that very few BC clinicians used EBPIs to treat EDs. The present study focused on the individual domain of the CFIR by investigating if clinician characteristic such as clinician age, education, intolerance of uncertainty, mood, positive and negative attitudes toward manuals are associated with manual and EBPI use among clinicians treating EDs in BC. Logistic regression analyses found that positive attitudes toward manuals were associated with their use, while negative attitudes toward manuals were associated with infrequent use of manuals. Changing clinicians' perceptions of manuals may increase their use. To ensure ED clients are receiving optimal care, it will be important to increase uptake of EBPIs and adherence to manuals. Future research should explore how other domains of the CFIR such as intervention characteristics, resources within and outside an organization, and implementation processes are associated with EBPI and manual use among clinicians treating EDs to potentially increase their use.

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Appendix A
Informed Consent Document

Name of Researcher, Faculty, Department, Telephone & Email:
Deepika Bajaj, BA Deepika Bajaj, Faculty of Arts, Department of Psychology, email: deepika.bajaj@ucalgary.ca
Supervisor:
Dr. Kristin von Ranson, Professor, Department of Psychology, tel: (403)-220-7085, email: kvonrans@ucalgary.ca
Title of Project:
Survey of British Columbia Eating Disorder Clinicians
Sponsor:
Unfunded

This consent form, a copy of which has been given to you, is only part of the process of informed consent. If you want more details about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The University of Calgary Conjoint Faculties Research Ethics Board has approved this research study.
Participation is completely voluntary, and anonymous/confidential

Purpose of the Study
The purpose of this study is to examine what psychological treatments clinicians are using to treat individuals with eating disorders.

What Will I Be Asked to Do?
If you choose to participate in the study, you will answer questions on the secure website, Qualtrics.com. Questions relate to your treatment practices, mood, and wellbeing, as well as your age, gender identity, and ethnicity. Studies involving humans now routinely collect information on race and ethnic origin as well as other characteristics of individuals because these characteristics may influence how people respond and allow us to better understand our sample. Providing this information is voluntary, and you do not have to answer any questions you do not wish to or any questions that make you feel uncomfortable. This study will take you approximately 30 minutes to complete online.

We will ask for your email address so we may communicate with you regarding the study. You need to know that emails sent to some webmail services (e.g., Gmail, Hotmail, etc.), may be stored/routed outside of Canada (for example, in the United States) and governed by foreign laws. All the information you provide to us will be kept completely confidential. Providing your

email address means that you voluntarily agree and give your consent for the study team to use email to communicate with you.

Your participation in this study is completely voluntary. You have the right to refuse to participate in this study without any penalty. If you decide to participate in this study, you may choose to withdraw from the study at any time without any negative consequences. You are free to decline to answer any and all questions.

What Type of Personal Information Will Be Collected?
We will protect your confidentiality by ensuring your survey responses are not connected to any identifiable information you provide (e.g., names, email addresses). If you choose to receive a summary of study findings and/or be contacted for future studies, we will ask for your email address at the end of the survey. Email addresses will be saved separately from survey responses to ensure individual responses remain anonymous. Electronic databases will be stored indefinitely on secure Qualtrics.com and University of Calgary servers. Any presentations will include only group data.

Are there Risks or Benefits if I Participate?
There are no direct risks or benefits associated with participation in this study. However, there is a chance that you may experience mild, transient distress when answering questions about your anxiety. You will not be identifiable in any reports of the study. You do not have to answer any questions that upset you or you do not wish to.

If you are experiencing emotional distress or discomfort in relation to any aspect of this study, you may wish to contact one of the following resources:

1) Crisis Lines:
   a) Vancouver Crisis Centre: 604-872-3311 or toll-free 1-866-661-3311
   b) Fraser Health Crisis Line: 604-951-8855 or toll-free 1-877-820-7444
2) Family Services of Greater Vancouver: 604-731-4951; www.fsgv.ca
3) Oak Counselling Services Society: 604-266-5611; www.oakcounsellingservices.com
4) Simon Fraser University Health and Counselling: Burnaby campus: 778.782.4615, Vancouver campus: 778.782.5200, Surrey campus: 778.782.5200 https://www.sfu.ca/students/health.html
5) Simon Fraser University Clinical Psychology Centre: 778-782-4720; https://www.sfu.ca/psychology/clinical-psychology-centre.html
6) University of British Columbia Psychology Clinic: 604-822-3005; http://clinic.psych.ubc.ca/

What Happens to the Information I Provide?
If you wish to withdraw from the study at any point, you may simply close your browser window. It will not be possible to withdraw your data after you have submitted any responses because we will not be able to identify which responses are yours, as the survey is anonymous.

Researchers are increasingly required by granting agencies and journals to make their data accessible in a research repository, known as open access data. Thus, your deidentified research

data (which means your name, and other identifiers have been removed) may be deposited into a publicly accessible location at the time of publication. This can enhance the transparency of the research data and allows for external validation and fraud control, but also allows other to access the data for re-analysis of this study to do other kinds of analyses in the future, beyond what you are consenting to in this study. Also, this future use of your data may not be subject to oversight by a research ethics board, and thus the data may be publicly shared and used in currently unknown ways. The data collected in this survey may be used in research investigations in the future.

Study findings may be presented at academic conferences or published in academic journals. Participants will not be personally identifiable in any presentation of the findings. At the end of the survey, you will be asked if you would like to receive a summary of study findings and/or be contacted for future studies. If a positive response is indicated for this question, you will be taken to a new confidential Qualtrics survey site to provide your email address, so your email address cannot be linked to your survey responses.

Consent

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason.

- Agreeing to participate in this study indicates that you consent to participate in this study.
- You do not waive any of your legal rights by participating in this study.

☐ No, I do not wish to take part in this study.
☐ Yes, I wish to participate in this study.

Questions/Concerns

If you have any questions or concerns about the study, you may contact the principal investigator, Dr. Kristin von Ranson (kvonrans@ucalgary.ca), or the study coordinator, Deepika Bajaj (deepika.bajaj@ucalgary.ca).

If you have any concerns about the way you've been treated as a participant, please contact the Research Ethics Analyst, Research Services Office, University of Calgary at 403.220.6289 or 403.220.8640; email cfreb@ucalgary.ca. A copy of this consent form has been given to you to keep for your records and reference. The investigator has kept a copy of the consent form.

Appendix B

Recruitment Material

Phone Recruitment Script

Thank you so much for taking the time to speak with me. My name is _____. I'm a graduate assistant (or research assistant) at the University of Calgary. You have been identified as a provider involved in the treatment of eating disorders, and we are thus seeking your participation in a research study. We acknowledge that you are a busy professional, but your participation in this survey may help improve the future treatment of eating disorder patients.
I would like to ask you some questions about the types of clients to whom you provide treatment as well as the types of treatments you provide. Our study is examining the types of treatment that patients presenting with an eating disorder are receiving from clinicians across British Columbia.

1.0 Do you treat individuals with eating disorders such as anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), avoidant restrictive food intake disorder (ARFID), other specified feeding or eating disorders (OSFED), or unspecified feeding or eating disorder (UFED)?
____ Yes [1] ____No [0]

1. Do you currently provide psychotherapy or mental health counselling in British Columbia.

____ Yes ____ No

1. Have you provided psychotherapy or counselling to a patient with an eating disorder in the last 12 months in British Columbia?
   i. ____ Yes ____ No

IF NO TO ANY: Unfortunately, only healthcare professionals meeting these criteria are eligible for this study. Thank you for your time.

IF YES: Great, you are eligible to participate in our study. I will send you an email with a link to complete a 30-minute confidential survey.
IF YES: ask for email address _____ and send link to survey_

We will send you a reminder email next week if you haven't completed the survey. Thank you for your time and I hope you have a great day.

Email Recruitment Script

Dear *Participant Name*

My name is _____. I am a graduate student at the University of Calgary. You have been identified as a provider involved in the treatment of eating disorders, and we are thus seeking your participation in a research study. Specifically, we request that you complete a confidential, 30-minute online survey that explores the types of treatment that patients with an eating disorder are receiving from clinicians across British Columbia. We acknowledge that you are a busy professional, but your participation in this survey may help improve the future treatment of eating disorder patients. If you are interested in participating in our study, please follow the link below to complete the confidential survey.

This study has been approved by the University of Calgary Conjoint Faculties Research Ethics Board (#xxxxxxx).

Follow this link to the Survey:
(Link will be provided)

Or copy and paste the URL below into your internet browser:
(Link will be provided)

Please do not hesitate to get in touch if you are having any issues completing the survey or have any questions.

Thank you for your time!

Kind regards,
Deepika Bajaj, BA (master's student)
Dr. Kristin von Ranson, Ph.D, R. Psych. (Supervisor)

Deepika Bajaj
Study Coordinator
Eating Behaviors Lab | University of Calgary
Phone: (403) 210-9438| Email: Deepika.bajaj@ucalgary.ca | eatinglab@ucalgary.ca

Appendix C
Clinician Survey

Eligibility Questionnaire

1. Do you treat individuals with eating disorders such as anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), avoidant restrictive food intake disorder (ARFID), other specified feeding or eating disorders (OSFED), or unspecified feeding or eating disorder (UFED)?
    - Yes
    - No
2. Do you currently provide psychotherapy or mental health counselling in British Columbia?
    - Yes
    - No
3. Have you provided psychotherapy or counselling to a patient with an eating disorder in the last 12 months in British Columbia?
    - Yes
    - No

Eating Disorder Patient Questions

4. Was an eating disorder a focus of treatment?
    - Yes
    - No
    - I prefer not to answer.
5. Do you make a formal, DSM-5 diagnosis for each of your clients with an eating disorder (i.e., anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant restrictive food intake disorder (ARFID), other specified feeding or eating disorders (OSFED), or unspecified feeding or eating disorder (UFED)?
    - Yes
    - No
    - I prefer not to answer.
6. Please select the types of eating disorders you treat. Select all that apply.

    ☐ Anorexia Nervosa (AN). There are three essential features of anorexia nervosa: persistent energy intake restriction; intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain; and a disturbance in self-perceived weight or shape.

    ☐ Bulimia Nervosa (BN). There are three essential features of bulimia nervosa: recurrent episodes of binge eating (Criterion A), recurrent inappropriate compensatory behaviors to prevent weight gain (Criterion B), and self-evaluation that is unduly influenced by body shape and weight (Criterion D). To qualify for the

diagnosis, the binge eating, and inappropriate compensatory behaviors must occur, on average, at least once per week for 3 months (Criterion C).

☐ Binge Eating Disorder (BED). The essential feature of binge-eating disorder is recurrent episodes binge eating that must occur, on average, at least once per week for 3 months (Criterion D). An "episode of binge eating" is defined as eating, in a discrete period of time, an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances (Criterion A1). An occurrence of excessive food consumption must be accompanied by a sense of lack of control (Criterion A2) to be considered an episode of binge eating. Binge eating must be characterized by marked distress (Criterion C) and at least three of the following features: eating much more rapidly than normal; eating until feeling uncomfortably full; eating large amounts of food when not feeling physically hungry; eating alone because of feeling embarrassed by how much one is eating; and feeling disgusted with oneself, depressed, or very guilty afterward (Criterion B).

☐ Avoidant Restrictive Food Intake Disorder (ARFID). Avoidant/restrictive food intake disorder replaces and extends the DSM-IV diagnosis of feeding disorder of infancy or early childhood. The main diagnostic feature of avoidant/ restrictive food intake disorder is avoidance or restriction of food intake (Criterion A) manifested by clinically significant failure to meet requirements for nutrition or insufficient energy intake through oral intake of food. One or more of the following key features must be present: significant weight loss, significant nutritional deficiency (or related health impact), dependence on enteral feeding or oral nutritional supplements, or marked interference with psychosocial functioning.

☐ Other Specified Feeding or Eating Disorder (OSFED). This category applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class. Examples of presentations that can be specified using the “other specified” designation include the following: 1) Atypical anorexia nervosa 2) Bulimia nervosa (of low frequency and/or limited duration) 3) Binge-eating disorder (of low frequency and/or limited duration) 4) Purging disorder 5) Night eating syndrome.

☐ Unspecified Feeding or Eating Disorder (UFED). This category applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class.

☐ Other. Please describe:

_____

☐ I prefer not to answer.

7. What **percentage** of your typical caseload is comprised of individuals with any of the eating disorders described above (i.e., Anorexia Nervosa (AN), Bulimia Nervosa (BN),

Binge Eating Disorder (BED), Avoidant Restrictive Food Intake Disorder (ARFID), Other Specified Feeding or Eating Disorder (OSFED), Unspecified Feeding or Eating Disorder (UFED)?
_____ %

8. In the past 12 months, what percentage of your typical caseload has been comprised of individuals with:
   Anorexia Nervosa (AN): _____
   Bulimia Nervosa (BN): _____
   Binge Eating Disorder (BED): _____
   Avoidant Restrictive Food Intake Disorder (ARFID): _____
   Other Specified Feeding or Eating Disorder (OSFED): _____
   Unspecified Feeding or Eating Disorder (UFED): _____
   Total: _____
9. Does your clinical work with this population include counselling or psychotherapy?
   - Yes
   - No
   - I prefer not to answer.
10. What does your clinical work with eating disorders involve
    - Psychotherapy
    - Counselling
    - Assessment
    - Other. Please specify
      _____

11. Have you received any specific training in the treatment of eating disorders?
    - ○ Yes
    - ○ No
    - ○ I prefer not to answer.
12. What types of training (in eating disorders treatment) have you received? Select all that apply.
    - ☐ Part of graduate clinical training
    - ☐ Workshop or seminar attendance
    - ☐ Read books
    - ☐ Viewed tapes
    - ☐ Formal supervision by colleagues (regularly scheduled meetings)
    - ☐ Informal supervision by colleagues (ad hoc meetings)
    - ☐ Intensive training provided by workplace
    - ☐ Other. Please specify:
    - ☐ I prefer not to answer.

For the following questions, please think about your patients and treatments used in the **past 12 months.**

13. What treatment modalities have you used to treat individuals with eating disorders? Select all that apply.
    - ☐ Individual therapy
    - ☐ Group
    - ☐ Family
    - ☐ Marriage/couples
    - ☐ ⊗Other. Please Specify:

      _____
    - ☐ ⊗I prefer not to answer
14. Which is your primary treatment modality?
    - ○ Individual therapy
    - ○ Group
    - ○ Family
    - ○ Marriage/couples

- ○ Other. Please specify:

_____

- ○ I prefer not to answer.

For the following questions, please think about your patients and treatments used in the **past 12 months.**

15. In what treatment settings do you treat individuals with eating disorders? Select all that apply.
    - ☐ Outpatient
    - ☐ Inpatient
    - ☐ Day treatment
    - ☐ ⊗Other. Please specify:

    _____

    - ☐ ⊗I prefer not to answer.
16. Which is the primary setting in which you treat individuals with eating disorders?
    - ○ Outpatient
    - ○ Inpatient
    - ○ Day treatment
    - ○ Other. Please specify:

    _____

    - ○ I prefer not to answer

For the following questions, please think about your patients and treatments used in the **past 12 months?**

17. Do you currently work in a team with other professional disciplines to provide treatment for eating disorders?
    - ○ Yes
    - ○ No
    - ○ I prefer not to answer.
18. What **percentage** of the time that you are treating an eating disorder client do you collaborate with a physician in their care? By collaboration, essentially, we mean, having repeated communications with a physician about the client's care and/or health status.

    For Anorexia Nervosa (AN): _____
    For Bulimia Nervosa (BN): _____
    For Binge Eating Disorder (BED): _____
    For Avoidant Restrictive Food Intake Disorder (ARFID): _____
    For Other Specified Feeding or Eating Disorder (OSFED): _____

For Unspecified Feeding or Eating Disorder (UFED): _____
For Eating Disorders (EDs) overall: _____
Total: _____

For the following questions, please think about your patients and treatments used in **the past 12 months.**

19. What **percentage** of the time that you work with an eating disorder client would you estimate that the client receives medication specifically to treat their eating disorder symptoms?
    _____ %
20. How confident are you on your estimate on a scale of 1-5?
    - ○ 1 Not at all confident
    - ○ 2
    - ○ 3 Somewhat confident
    - ○ 4
    - ○ 5 Very confident
21. Which of the following age groups have you ever treated for eating disorders? Select all that apply.
    - ☐ Children (age 12 and under)
    - ☐ Adolescents (age 13 - 17)
    - ☐ Adults (age 18 - 64)
    - ☐ Seniors (age 65 and older)
    - ☐ I prefer not to answer
22. What **percentage** of your typical caseload of eating disorder clients are:
    Children (age 12 and under): _____
    Adolescents (age 13 - 17): _____
    Adults (age 18 - 64): _____
    Seniors (age 65 and older): _____
    Total: _____

Treatment Questions

23. In the past 12 months, please rate how often you use each psychotherapeutic approach or technique when treating eating disorders: Please rate how often you use each psychotherapeutic approach or technique when treating eating disorders:

	Never	Sometimes	Often	Always	I prefer not to answer
Acceptance and commitment therapy (ACT)	○	○	○	○	○
Adolescent focused therapy (AFT)	○	○	○	○	○
Addictions-based/12-step (e.g., Overeaters Anonymous, Eating Disorders Anonymous)	○	○	○	○	○
Behavior therapy	○	○	○	○	○
Cognitive-behavioural therapy (CBT)	○	○	○	○	○
Cognitive remediation therapy (CRT)	○	○	○	○	○
Dialectical behavior therapy (DBT)	○	○	○	○	○
EMDR (eye movement desensitization and reprocessing)	○	○	○	○	○
Family therapy	○	○	○	○	○
Family-based treatment (FBT)	○	○	○	○	○
Feminist therapy	○	○	○	○	○

Guided self-help	○	○	○	○	○
Hypnotherapy	○	○	○	○	○
Integrative therapy	○	○	○	○	○
Internet-based psychotherapy	○	○	○	○	○
Interpersonal psychotherapy (IPT)	○	○	○	○	○
Maudsley Anorexia Nervosa Treatment for Adults (MANTRA)	○	○	○	○	○
Meal support	○	○	○	○	○
Motivational interview	○	○	○	○	○
Narrative therapy	○	○	○	○	○
Play therapy	○	○	○	○	○
Psychodynamic therapy	○	○	○	○	○
Psychoeducation	○	○	○	○	○
Psychoeducation for family/carers	○	○	○	○	○
Radically open dialectical behaviour therapy (R-O DBT)	○	○	○	○	○
Self-disclosure	○	○	○	○	○
Solution-focused therapy	○	○	○	○	○

Specialist supportive clinical management (SSCM)	○	○	○	○	○
Supportive therapy	○	○	○	○	○
Other. Please describe:	○	○	○	○	○

24. Which of these is your primary approach for treating individuals with eating disorders?

- ○ Acceptance and commitment therapy (ACT)
- ○ Adolescent focused therapy (AFT)
- ○ Addictions-based/12-step (e.g., Overeaters Anonymous, Eating Disorders Anonymous)
- ○ Behavior therapy
- ○ Cognitive-behavioural therapy (CBT)
- ○ Cognitive remediation therapy (CRT)
- ○ Dialectical behavior therapy (DBT)
- ○ EMDR (eye movement desensitization and reprocessing)
- ○ Family therapy
- ○ Family-based treatment (FBT)
- ○ Feminist therapy
- ○ Guided self-help
- ○ Hypnotherapy
- ○ Integrative therapy
- ○ Internet-based psychotherapy
- ○ Interpersonal psychotherapy (IPT)
- ○ Maudsley Anorexia Nervosa Treatment for Adults (MANTRA)
- ○ Meal support
- ○ Motivational interview
- ○ Narrative therapy
- ○ Play therapy
- ○ Psychodynamic therapy
- ○ Psychoeducation

- Psychoeducation for family/carers
- Radically open dialectical behaviour therapy (R-O DBT)
- Self-disclosure
- Solution-focused therapy
- Specialist supportive clinical management (SSCM)
- Supportive therapy
- Other. Please describe:

_____

25. What are your main reasons for using this approach? Select all that apply.

- ☐ Supported by research
- ☐ Recommended by supervisors/colleagues
- ☐ Consistent with own theoretical orientation
- ☐ Compatible with own clinical style of conducting therapy
- ☐ Flexible; can be tailored to individual clients' needs
- ☐ Clinical experience indicates effectiveness
- ☐ Received training in this approach
- ☐ Worked for your own eating disorder recovery
- ☐ Other. Please specify:

_____

- ☐ ⊗I prefer not to answer

26. Please indicate the **most** important reason for using this primary treatment approach.

- Supported by research
- Recommended by supervisors/colleagues
- Consistent with own theoretical orientation
- Compatible with own clinical style of conducting therapy
- Flexible; can be tailored to individual clients' needs
- Clinical experience indicates effectiveness
- Received training in this approach
- Worked for your own eating disorder recovery
- Other. Please specify:

_____

- I prefer not to answer

27. Which is your primary treatment approach with the following eating disorder patients:

- ○ Children (age 12 and under)

_____

- ○ Adolescents (age 13 - 17)

_____

- ○ Adults (age 18 - 64)

_____

- ○ Seniors (age 65 and over)

_____

- ○ Other. Please specify

_____

- ○ I prefer not to answer

_____

28. Which is your primary approach for individuals with:

- ○ Anorexia Nervosa (AN)?

_____

- ○ Bulimia Nervosa (BN)?

_____

- ○ Binge Eating Disorder (BED)?

_____

- ○ Avoidant Restrictive Food Intake Disorder (ARFID)?

_____

- ○ Other Specified Feeding or eating disorder (OSFED)?

_____

- ○ Unspecified Feeding or eating disorder (UFED)?

_____

29. To what extent do you use the following techniques when working with this population?

	Never	Sometimes	Often	Always	I prefer not to answer
Self-monitoring	○	○	○	○	○
Written homework assignments	○	○	○	○	○
Cognitive restructuring	○	○	○	○	○

Formal problem solving	○	○	○	○	○
Stimulus control techniques	○	○	○	○	○
Prescribing distracting activities	○	○	○	○	○
Relapse prevention strategies	○	○	○	○	○
Other. Please describe:	○	○	○	○	○

30. Do you use these cognitive-behavioural techniques for patients with. Select all that apply.

- ☐ Anorexia Nervosa (AN)
- ☐ Bulimia Nervosa (BN)
- ☐ Binge Eating Disorder (BED)
- ☐ Avoidant Restrictive Food Intake Disorder (ARFID)
- ☐ Other Specified Feeding or Eating Disorder (OSFED)
- ☐ Unspecified Feeding or Eating Disorder (UFED)
- ☐ Other. Please describe which unspecified feeding or eating disorder (UFED) patients you may use cognitive behavioural techniques with:

  _____

- ☐ ⊗I prefer not to answer

31. Earlier you indicated that you do not use cognitive-behavioural therapy with bulimia nervosa (BN) and binge eating disorder (BED) clients. What is your primary reason for not using this treatment approach?

- ○ Lack of compelling research
- ○ Not confident that existing research generalizes to specific cases
- ○ Clinical decisions not influenced in particular by research findings
- ○ Not supported by supervisors/colleagues
- ○ Inconsistent with own theoretical orientation
- ○ Incompatible with own clinical style of conducting therapy
- ○ Inflexible; not easily tailored to individual clients' needs

- ○ Personal clinical experience indicates lack of effectiveness
- ○ Have not received training in this approach
- ○ Uncertain about how to learn the approach
- ○ Other. Please specify:

_____

- ○ I prefer not to answer

32. Do you **not** use **cognitive-behavioural therapy** with bulimia nervosa (BN) and binge eating disorder (BED) clients for other reasons? Select all that apply.

- ☐ Lack of compelling research
- ☐ Not confident that existing research generalizes to specific cases
- ☐ Clinical decisions not influenced in particular by research findings
- ☐ Not supported by supervisors/colleagues
- ☐ Inconsistent with own theoretical orientation
- ☐ Incompatible with own clinical style of conducting therapy
- ☐ Inflexible; not easily tailored to individual clients' needs
- ☐ Personal clinical experience indicates lack of effectiveness
- ☐ Have not received training in this approach
- ☐ Uncertain about how to learn the approach
- ☐ Other. Please specify:

_____

- ☐ I prefer not to answer
- ☐ There are no other reasons I don't use cognitive behavioural therapy (CBT)

33. To what extent do you use the following family-based treatment techniques when working with eating disorder patients?

	Never	Sometimes	Often	Very Often	I prefer not to answer
Weigh the client at the beginning of every therapy session	○	○	○	○	○
Ensure that all family members attend the first session of treatment	○	○	○	○	○

Charge the parents with the task of refeeding/symptom interruption	○	○	○	○	○
The family meal	○	○	○	○	○
Direct/redirect therapeutic discussions towards food/eating/symptom interruption until normal	○	○	○	○	○
Provide suggestions and/or solutions to help parents achieve the tasks of refeeding/symptom interruption	○	○	○	○	○
Food diaries	○	○	○	○	○
Reflecting team family therapy	○	○	○	○	○
Individual therapy with the client	○	○	○	○	○
Use of mindfulness	○	○	○	○	○

34. Earlier you indicated that you **do not use** family-based treatment with eating disorder clients. What is your primary reason for not using this treatment approach?

- ○ Lack of compelling research
- ○ Not confident that existing research generalizes to specific cases
- ○ Clinical decisions not influenced by research findings
- ○ Not supported by supervisors/colleagues
- ○ Inconsistent with own theoretical orientation
- ○ Incompatible with own clinical style of conducting therapy
- ○ Inflexible; not easily tailored to individual clients' needs
- ○ Personal clinical experience indicates lack of effectiveness
- ○ Have not received training in this approach
- ○ Uncertain about how to learn the approach

- Other. Please specify:
  _____
- I prefer not to answer

35. Previously you indicated that you use a 12-step addictions-based approach to eating disorder treatment. For which eating disorder(s)? Select all that apply.

- ☐ Anorexia Nervosa (AN)
- ☐ Bulimia Nervosa (BN)
- ☐ Binge Eating Disorder (BED)
- ☐ Avoidant Restrictive Food Intake Disorder (ARFID)
- ☐ Other Specified Feeding or Eating Disorder (OSFED)
- ☐ Unspecified Feeding or Eating Disorder (UFED)
- ☐ ⊗I prefer not to answer

36. Please briefly describe what this 12-step/addictions-based approach involves.

_____

_____

_____

_____

_____

37. Do you integrate a 12-step/addictions-based approach with other psychotherapies or refer clients to adjunctive 12-step programs such as Overeaters Anonymous?

- Integrate 12-step and other therapies
- Refer clients to adjunctive 12-step programs such as Overeaters Anonymous
- Both integrate and refer
- Neither. Please describe:
  _____
- I prefer not to answer

38. What are is your primary reason for using an addictions-based/12-step approach with individuals with eating disorders?

- ☐ Client's request
- ☐ Supported by research
- ☐ Recommended by supervisors/colleagues

- ☐ Consistent with own theoretical orientation or clinical style of conducting therapy
- ☐ Personal clinical experience indicates effectiveness
- ☐ Received training in this approach
- ☐ View behavior patterns in eating disorders (EDs) as like those of substance addictions such as alcoholism
- ☐ Provide clients with added support
- ☐ Uncertain about alternative approaches to use
- ☐ Other. Please specify:

_____

- ☐ ⊗I prefer not to answer

39. What other important reasons do you have for using an addictions-based/12-step approach with individuals with eating disorders? Select all that apply.

- ☐ Client's request
- ☐ Supported by research
- ☐ Recommended by supervisors/colleagues
- ☐ Consistent with own theoretical orientation or clinical style of conducting therapy
- ☐ Personal clinical experience indicates effectiveness
- ☐ Received training in this approach
- ☐ View behavior patterns in EDs as like those of substance addictions such as alcoholism
- ☐ Provide clients with added support
- ☐ Uncertain about alternative approaches to use
- ☐ Other. Please specify:

_____

- ☐ ⊗I prefer not to answer

ARFID Questionnaire

40. What modalities of therapy do you typically utilize when treating patients with Avoidant-Restrictive Food Intake Disorder (ARFID)? Select all that apply.

- ☐ Individual
- ☐ Group
- ☐ Family

- ☐ Other. Please specify:

  _____

- ☐ ⊗I prefer not to answer

41. What approaches do you typically utilize in your therapy for patients with Avoidant-Restrictive Food Intake Disorder (ARFID)? Select all that apply.

    - ☐ Cognitive Behavioral Therapy (CBT)
    - ☐ Family-Based Therapy (FBT)
    - ☐ Cognitive Restructuring
    - ☐ Exposure Therapy (without response prevention)
    - ☐ Exposure with Response Prevention (ERP)
    - ☐ Other. Please specify:

      _____

    - ☐ ⊗I prefer not to answer

42. In what treatment settings do you treat individuals with these symptoms? Select all that apply.

    - ☐ Outpatient
    - ☐ Inpatient
    - ☐ Day treatment
    - ☐ ⊗Residential treatment
    - ☐ Other. Please specify:

      _____

    - ☐ ⊗I prefer not to answer

43. In addition, do you utilize any food-specific treatments?

    - ☐ Food chaining
    - ☐ White palate plate
    - ☐ Enteral feeding
    - ☐ Nutritional supplements
    - ☐ ⊗Other. Please specify:

      _____

    - ☐ ⊗I prefer not to answer

44. What would you consider your primary treatment modality for patients with Avoidant-Restrictive Food Intake Disorder (ARFID)?

Acceptance and commitment therapy (ACT)

- Adolescent focused therapy (AFT)
- Addictions-based/12-step (e.g., Overeaters Anonymous, Eating Disorders Anonymous)
- Behavior therapy
- Cognitive-behavioural therapy (CBT)
- Cognitive remediation therapy (CRT)
- Dialectical behavior therapy (DBT)
- EMDR (eye movement desensitization and reprocessing)
- Family therapy
- Family-based treatment (FBT)
- Feminist therapy
- Guided self-help
- Hypnotherapy
- Integrative therapy
- Internet-based psychotherapy
- Interpersonal psychotherapy (IPT)
- Maudsley Anorexia Nervosa Treatment for Adults (MANTRA)
- Meal support
- Motivational interview
- Narrative therapy
- Play therapy
- Psychodynamic therapy
- Psychoeducation
- Psychoeducation for family/carers
- Radically open dialectical behaviour therapy (R-O DBT)
- Self-disclosure
- Solution-focused therapy
- Specialist supportive clinical management (SSCM)
- Supportive therapy
- Other. Please describe: _____
- I prefer not to answer

45. What are your main reasons for using this approach? Select all that apply.

- ☐ Supported by research
- ☐ Recommended by supervisors/colleagues
- ☐ Consistent with own theoretical orientation
- ☐ Flexible; can be tailored to individual clients' needs
- ☐ Clinical experience indicates effectiveness
- ☐ Received training in this approach
- ☐ Other. Please specify:

_____

- ☐ ⊗I prefer not to answer

46. How effective do you believe the method used was for treating your last patient's symptoms of Avoidant-Restrictive Food Intake Disorder (ARFID)?

- ○ Not at all effective
- ○ Not very effective
- ○ Unsure
- ○ Somewhat effective
- ○ Very effective

47. Have you received any specific training in the treatment of Avoidant-Restrictive Food Intake Disorder (ARFID) symptoms?

- ○ Yes
- ○ No
- ○ I prefer not to answer

48. What types of training in Avoidant-Restrictive Food Intake Disorder (ARFID) treatment have you received? Select all that apply.

- ☐ Part of clinical training in a graduate program
- ☐ Workshop or seminar attendance
- ☐ Read books
- ☐ Formal supervision by colleagues that involved regularly scheduled meetings
- ☐ Informal supervision by colleagues that involved ad hoc meetings
- ☐ Intensive training provided by workplace
- ☐ Other. Please specify:

_____

- ⊗I prefer not to answer

Appendix D
Demographic Questionnaire

1. What is the level of your highest educational degree and in what field? Specify the degree and the field.
   - ○ Bachelor's Degree _____
   - ○ Master's Degree _____
   - ○ Doctoral or professional degree (PhD, PsyD, MD, etc.) _____
   - ○ I prefer not to answer
2. In what year did you receive your most advanced degree?
3. Are you registered or chartered in your profession under the BC Health Professions Act?

○ Yes

○ No

○ I prefer not to answer

4. Which college are you registered or chartered with in your profession?
   - ☐ College of Psychologists of British Columbia (CPBC)
   - ☐ British Columbia College of Social Workers
   - ☐ Canadian College of Physicians and Surgeons
   - ☐ Other _____
   - ☐ ⊗I prefer not to answer
5. If you are registered or chartered with the College of Psychologists of British Columbia, please select the most applicable option.

○ Registered

○ Provisionally registered

○ I prefer not to answer

○ Not applicable

6. How many years have you been providing psychotherapy or counselling to eating disorder patients since you have been practicing not including graduate training?
7. What is your ethnic background? Select all that apply.
   - ☐ African/Caribbean
   - ☐ East Asian (e.g., China, Taiwan, Hong Kong, Japan, South Korea, North Korea, etc.)
   - ☐ Filipino
   - ☐ First Nations
   - ☐ Inuit

- ☐ Latin American
- ☐ Métis
- ☐ Middle Eastern/West Asian (e.g., Afghanistan, Israel, Iran, Palestine, Saudi Arabia, Syria, etc.)
- ☐ South Asian (e.g., Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, Sri Lanka, etc.)
- ☐ Southeast Asian (e.g., Cambodia, Thailand, Vietnam, Indonesia, Laos, Malaysia, etc.)
- ☐ White/European
- ☐ I don't have an option that applies to me. I identify as _____
- ☐ ⊗I do not know
- ☐ ⊗I prefer not to answer

8. What is your age?

- ○ Enter age in years _____
- ○ I prefer not to answer

9. What gender(s) do you identify with?

- ☐ Fluid/genderqueer
- ☐ Man
- ☐ Non-binary
- ☐ Two-spirit
- ☐ Woman
- ☐ Transgender
- ☐ ⊗I don't have an option that applies to me. I identify as: _____
- ☐ ⊗I do not know
- ☐ ⊗I prefer not to answer

10. How old was your most recent eating disorder patient?

- ○ Infant (0 - 2 years old)
- ○ 2 - 4 years old
- ○ 5 - 8 years old
- ○ 9 - 12 years old
- ○ 13 - 18 years old

- 19 - 24 years old
- I do not know
- I prefer not to answer

11. Have you treated individuals with eating disorders with any of the following gender identities? Select all that apply.

    - ☐ Fluid/genderqueer
    - ☐ Man
    - ☐ Non-binary
    - ☐ Two-spirit
    - ☐ Woman
    - ☐ Transgender
    - ☐ ⊗I don't have an option that applies to them. Other identities I have treated include: _____
    - ☐ ⊗I do not know
    - ☐ ⊗I prefer not to answer

12. Have you treated individuals with eating disorders with any of the following ethnicities? Select all that apply?

    - ☐ African/Caribbean
    - ☐ East Asian (e.g., China, Taiwan, Hong Kong, Japan, South Korea, North Korea, etc.)
    - ☐ Filipino
    - ☐ First Nations
    - ☐ Inuit
    - ☐ Latin American
    - ☐ Métis
    - ☐ Middle Eastern/West Asian (e.g., Afghanistan, Israel, Iran, Palestine, Saudi Arabia, Syria, etc.)
    - ☐ South Asian (e.g., Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, Sri Lanka, etc.)
    - ☐ Southeast Asian (e.g., Cambodia, Thailand, Vietnam, Indonesia, Laos, Malaysia, etc.)
    - ☐ White/European

- ☐ Other. Please specify:

  _____

- ☐ ⊗I do not know
- ☐ ⊗I prefer not to answer

Appendix E
The Intolerance of Uncertainty Scale-12

Please select the response that best corresponds to how much you agree with each of the following statement.

	Not at all characteristics of me	A little characteristic of me	Somewhat characteristic of me	Very characteristic of me	Entirely characteristic of me	I prefer not to answer
Unforeseen events upset me greatly.	○	○	○	○	○	○
It frustrates me not having all the information I need.	○	○	○	○	○	○
One should always look ahead so as to avoid surprises.	○	○	○	○	○	○
A small, unforeseen event can spoil everything, even with the best of planning.	○	○	○	○	○	○
I always want to know what the future has in store for me.	○	○	○	○	○	○

I can't stand being taken by surprise.	○	○	○	○	○	○
I should be able to organize everything in advance.	○	○	○	○	○	○
Uncertainty keeps me from living a full life.	○	○	○	○	○	○
When it's time to act, uncertainty paralyzes me.	○	○	○	○	○	○
When I am uncertain I can't function very well.	○	○	○	○	○	○
The smallest doubt can stop me from acting.	○	○	○	○	○	○
I must get away from all uncertain situations.	○	○	○	○	○	○

Appendix F
The Positive and Negative Affective Schedule

Indicate the extent you have felt this way over the past week.

	Very slightly or not at all	A little	Moderately	Quite a bit	Extremely	I prefer not to answer
Interested	○	○	○	○	○	○
Distressed	○	○	○	○	○	○
Excited	○	○	○	○	○	○
Upset	○	○	○	○	○	○
Strong	○	○	○	○	○	○
Guilty	○	○	○	○	○	○
Scared	○	○	○	○	○	○
Hostile	○	○	○	○	○	○
Enthusiastic	○	○	○	○	○	○
Proud	○	○	○	○	○	○
Irritable	○	○	○	○	○	○
Alert	○	○	○	○	○	○
Ashamed	○	○	○	○	○	○
Inspired	○	○	○	○	○	○

Nervous	○	○	○	○	○	○
Determined	○	○	○	○	○	○
Attentive	○	○	○	○	○	○
Jittery	○	○	○	○	○	○
Active	○	○	○	○	○	○
Afraid	○	○	○	○	○	○

Appendix G
The Attitudes to Treatment Manuals Questionnaire

1. How many years of graduate school have you completed?
2. How many years have you been in clinical practice after your training?
3. Currently, what is your primary employment setting? Select one.

- College/ University/Academic
- College/University Counselling
- Community Clinic/Agency
- Primary/Secondary School
- Private practice
- Hospital
- Other. Please specify: _____
- I prefer not to answer

4. Currently, what is your predominant professional activity? Select one.

- Direct patient contact
- Teaching
- Research
- Consulting
- Other. Please specify: _____
- I prefer not to answer

5. Have you heard of psychotherapy treatment manuals?

- Yes
- No

6. How clear an idea do you have of what a psychotherapy treatment manual is?

- Totally unclear
- Somewhat unclear
- Reasonably clear
- Very clear
- I prefer not to answer

13. How much thought have you given to the use of treatment manuals in your own clinical practice?

- None at all
- A little bit
- Some
- A fair amount

- A lot
- I prefer not to answer

14. How strong are your attitudes and feelings about the role of treatment manuals in clinical practice?

- Not at all strong
- Somewhat strong
- Strong
- Very strong
- I prefer not to answer

15. How would you describe your first experience with treatment manuals?

- Positive
- Negative
- Neutral
- I have never used a treatment manual
- I prefer not to answer

16. How often do you use treatment manuals in your clinical (non-research) work?

- Never
- Rarely
- Sometimes
- Often
- Almost exclusively
- I prefer not to answer

17. How often do you use treatment manuals in your research?

- I don’t do research
- Never
- Rarely
- Sometimes
- Often
- Almost exclusively
- I prefer not to answer

18. How many different treatment manuals do you use on a semi-regular basis?

- None
- 1-2
- 3-4

- ○ >4
- ○ I prefer not to answer

19. Have you ever helped create a treatment manual?

- ○ Yes
- ○ No
- ○ I prefer not to answer

Please select the response that best corresponds to how much you agree with each of the following statements

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree	I prefer not to answer
Manuals make therapists more like technicians than caring human beings.	○	○	○	○	○	○
Manuals force individual clients into arbitrary categories.	○	○	○	○	○	○
Using a treatment manual makes a therapist think more about sticking to the manual than the needs of the individual client.	○	○	○	○	○	○
Using a treatment manual keeps therapists from using his or her intuition in responding to a client.	○	○	○	○	○	○

Treatment manuals ignore the unique contributions of individual therapists.	○	○	○	○	○	○
Using treatment manuals detracts from the authenticity of the therapeutic interaction.	○	○	○	○	○	○
Using a treatment manual undermines clinical creativity and artistry.	○	○	○	○	○	○
Treatment manuals are appropriate for research clients but not "real-world" clients.	○	○	○	○	○	○
Treatment manuals over-emphasize therapeutic techniques.	○	○	○	○	○	○
Manuals force a therapist to conform to one theoretical orientation.	○	○	○	○	○	○
Treatment manuals help clinicians to	○	○	○	○	○	○

utilize only interventions which have been demonstrated to be effective.						
Following a treatment manual will enhance therapeutic outcomes by ensuring that the treatment being used is supported by research.	○	○	○	○	○	○
Treatment manuals, if used appropriately, will enhance the average outcomes of clients treated in psychotherapy.	○	○	○	○	○	○
Treatment manuals can help keep therapists on track during therapy.	○	○	○	○	○	○
If a treatment has been shown scientifically to be effective, then the therapist is ethically obligated to use that treatment as	○	○	○	○	○	○

opposed to one that has not been studied.						
Using a treatment manual helps a therapist to evaluate and improve his or her clinical skills.	○	○	○	○	○	○
The field of psychotherapy will eventually move towards almost exclusively manual-based practice.	○	○	○	○	○	○

Please rate how characteristic each statement is of treatment manuals.

	Not at all characteristic	Somewhat characteristic	Characteristic	Very characteristic	I prefer not to answer
Descriptions of specific therapeutic techniques	○	○	○	○	○
An emphasis on the importance of the therapeutic relationship	○	○	○	○	○
Presentation of a comprehensive theory of change	○	○	○	○	○
Presentation of a comprehensive theory of psychopathology	○	○	○	○	○
A thorough discussion of the	○	○	○	○	○

relationship between theory and treatment					
A "cookbook" of therapeutic techniques	○	○	○	○	○
An emphasis on individual case conceptualization	○	○	○	○	○
Clinically relevant case examples	○	○	○	○	○
A treatment protocol imposed by a third-party payer	○	○	○	○	○

How appropriate is it to use a treatment manual for the following problems/disorders ranging from 1 (not appropriate at all) to 5 (very appropriate)

	1 (Not appropriate at all)	2	3	4	5 (Very appropriate)	I prefer not to answer
Stress management/behavioral health problems	○	○	○	○	○	○
Anxiety disorder	○	○	○	○	○	○
Major depression	○	○	○	○	○	○
Child behavior problems	○	○	○	○	○	○
Adjustment	○	○	○	○	○	○
Substance abuse	○	○	○	○	○	○
Bipolar	○	○	○	○	○	○
Marital problems	○	○	○	○	○	○
Schizophrenia	○	○	○	○	○	○

Personality	○	○	○	○	○	○
Eating disorders	○	○	○	○	○	○

Appendix H
Clinicians Experience with and Use of Treatment Manuals

Item	*n*	%
Have you heard of psychotherapy treatment manuals? (*n* = 104)		
Yes	89	85.6
No	15	14.4
How clear an idea do you have what a psychotherapy treatment manual is? (*n* = 102)		
Totally unclear	9	8.8
Somewhat unclear	21	20.6
Reasonably clear	34	33.3
Very clear	37	36.3
I prefer not to answer	1	1.0
How much thought have you given to the use of treatment manuals in your own clinical practice? (*n* =103)		
None at all	24	23.3
A little bit	15	14.6
Some	31	30.1
A fair amount	22	21.4
A lot	10	9.7
I prefer not to answer	1	1.0
How strong are your attitudes and feelings about the role of treatment manuals in clinical practice? (*n* = 103)		
Not at all strong	33	32.0
Somewhat strong	42	40.8
Strong	16	15.5
Very strong	4	3.9
I prefer not to answer	8	7.8
How would you describe your first experience with treatment manuals? (*n* = 102)		
I have never used a treatment manual	21	20.6
Positive	28	27.5
Neutral	40	39.2
Negative	7	6.9
How often do you use treatment manuals in your clinical (non-research) work? (*n*= 103)		
Never	30	29.1
Rarely	26	25.2
Sometimes	33	32.0
Often	9	8.7

I prefer not to answer	5	4.9
How often do you use treatment manuals in your research? (*n*= 103)		
I don't do research	67	65.0
Never	7	6.8
Rarely	8	7.8
Sometimes	8	7.8
Often	5	4.9
I prefer not to answer	8	7.8
How many different treatment manuals do you use on a semi-regular basis? (*n*= 103)		
None	40	38.8
1-2	40	38.8
3-4	15	14.6
>4	2	1.9
I prefer not to answer	6	5.8
Have you ever helped create a treatment manual? (*n*= 104)		
Yes	15	14.4
No	84	80.8
I prefer not to answer	5	4.8

Note. Clinicians' experience with manuals was assessed using the Attitudes to Treatment Manuals Questionnaire.

Appendix I
Item Level Responses of Clinicians' Attitudes Toward Treatment Manuals

Clinicians' Attitudes Toward Treatment Manuals (N = 97-98)

How much do you agree with each statement?	*M*	*SD*
Manuals make therapists more like technicians than caring human beings.	2.89	1.08
Manuals force individual clients into arbitrary categories.	3.15	1.07
Using a treatment manual makes a therapist think more about sticking to the manual than the needs of the individual client.	3.24	1.07
Using a treatment manual keeps therapists from using his or her intuition in responding to a client.	3.05	1.06
Treatment manuals ignore the unique contributions of individual therapists.	3.06	1.10
Using treatment manuals detracts from the authenticity of the therapeutic interaction.	3.09	1.00
Using a treatment manual undermines clinical creativity and artistry.	3.18	1.05
Treatment manuals are appropriate for research clients but not "real-world" clients.	2.82	1.04
Treatment manuals over-emphasize therapeutic techniques.	3.04	0.92
Manuals force a therapist to conform to one theoretical orientation.	3.22	1.04
Treatment manuals help clinicians to utilize only interventions which have been demonstrated to be effective.	3.20	0.87
Following a treatment manual will enhance therapeutic outcomes by ensuring that the treatment being used is supported by research.	3.16	0.85
Treatment manuals, if used appropriately, will enhance the average outcomes of clients treated in psychotherapy.	3.35	0.81
Treatment manuals can help keep therapists on track during therapy.	3.60	0.78
If a treatment has been shown scientifically to be effective, then the therapist is ethically obligated to use that treatment as opposed to one that has not been studied.	2.71	0.93
Using a treatment manual helps a therapist to evaluate and improve his or her clinical skills.	3.45	0.90

The field of psychotherapy will eventually move towards almost exclusively manual-based practice.	1.90	0.91

Note. 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree.
Clinicians' attitudes toward manuals were assessed using The Attitudes to Treatment Manuals Questionnaire.