

Chapter Three

Method

Participants

Participants in this study were 237 Ph.D.-level mental health professionals with knowledge of behavioral and/or cognitive-behavioral theory and practice. Table 3 summarizes the training disciplines and levels of education of participants. The theoretical orientation of participants was predominantly cognitive-behavioral ($n = 174$; 73%). Table 4 summarizes the theoretical orientations of respondents. Seventy-two (30%) participants indicated a specialization in child psychology, 129 (54%) indicated a specialization in adult psychology, and ten (4%) indicated a specialization in both areas. One hundred-fourteen (48%) participants indicated that they had a specialized interest in internalizing disorders (e.g., anxiety, depression), 42 (18%) indicated a specialized interest in externalizing disorders (e.g., Attention Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder), and 47 (20%) indicated a specialized interest in both areas. The percentage of professional time participants devoted to clinical work ranged from 0% to 100%; the average percent of time spent in clinical duties was 38% ($n = 235$). Years of post-doctoral experience ranged from 0 (interns) to 45 years; on average, participants had 11 years of post-doctoral experience. The final sample included 113 (48%) men and 124 (52%) women. Participants' ages ranged from 26 to 69 years, with the average age being 41 years.

Treatments

Twelve fictional vignettes were developed to serve as the experimental conditions for this study. Vignettes were developed in the following manner: first, a vignette was developed which provided basic presenting problem, depressive symptomatology, and assessment information on a 6-year-old child presenting for treatment at an outpatient clinic. This vignette was then modified slightly to represent a child of 10 and a child of 14 years of age. Each of these three basic vignettes was then elaborated upon in order to provide a developmental history and a case formulation of the child's depressive symptomatology consistent with each of the three major cognitive-behavioral pathogenic processes (cognitive distortion, skills deficit, and environmental deficit). This resulted in a total of 12 vignettes: a Control vignette for ages 6, 10, and 14; a Cognitive Distortion

vignette for ages 6, 10, and 14; a Social Skills Deficit vignette for ages 6, 10, and 14, and an Environmental Deficit vignette for ages 6, 10, and 14. (See Appendix A).

Measures

Demographic Questionnaire. Each participant completed a brief demographic questionnaire requesting basic information such as the participant's age, sex, education level, theoretical orientation, and specialization area (e.g., child or adult psychology; internalizing, externalizing, or other focus) (See Appendix B).

Treatment Selection Checklist (TSC). The TSC consists of 9 cognitive-behavioral strategies which are commonly used in the treatment of childhood depression: 3 identified as being primarily appropriate for the treatment of environmental deficits, 3 identified as being primarily appropriate for addressing social skills deficits, and 3 identified as being primarily appropriate for the treatment of cognitive distortions. The selection of treatments for each category was conducted with the advice of an expert in the field of cognitive-behavioral therapy and childhood internalizing disorders, and it was validated by two independent Ph.D.-level graduate students with specialized training in cognitive-behavioral treatment of internalizing disorders in children. Participants were asked to rate each of the treatments on a Likert Scale from 1 to 5, with 1 = "Not at all appropriate - Would not use this strategy with this child"; 2 = "Possibly appropriate - Might try this strategy with this child"; 3 = "Probably appropriate - Would definitely use this strategy, but only if others failed"; 4 = "Clearly appropriate - would try this strategy as a secondary alternative"; and 5 = "Definitely appropriate - Would try this treatment strategy first". Two forms of the TSC were used: Form 1, which listed the treatments in randomized order, and Form 2, which presented this randomized list in reverse order (See Appendix C).

Procedure

Participants were recruited via electronic mail (e-mail). The majority of participants ($n = 230$, 97%) were recruited from the Association for the Advancement of Behavior Therapy Directory. Each e-mail address in the directory was randomly assigned (within sex) to 1 of 12 groups corresponding to 1 of the 12 vignettes described above. Within each of these groups, participants were randomly assigned to receive either Form 1 or Form 2 of the TSC. Each of these 12 groups of candidates were further

divided into small groups of 20 to 30 candidates per group, and invitations to participate (in the form of e-mail messages) were delivered to candidates in these small groups. In order to protect candidates' privacy, messages were sent as "blind carbon copies" to each candidate, so that no identifying information was visible on the messages. Candidates were provided with the Demographic Questionnaire, one of the 12 vignettes described in the previous section, and either Form 1 or Form 2 of the TSC. Candidates were asked to indicate the likelihood that they would select each of the 9 treatments included in the TSC, based on the information available to them about the child in the vignette. Candidates were given the option of responding via e-mail or regular mail. As an incentive to participate, each candidate who provided a complete and readable response within a month of the invitation to participate was offered the opportunity to be entered into a drawing for a cash prize of \$500. As an additional incentive, participants who returned their responses within a week were entered into the drawing twice (See Appendix D for a sample e-mail message). Consent to participate in the study was implied by response to the survey.

Three weeks after the original invitation to participate, all candidates were sent a follow-up e-mail message reminding them of the opportunity to participate and of the deadline for the drawing, and offering to re-send the survey if necessary. When a candidate requested that the investigator send a new survey, the drawing deadlines were adjusted to give the candidate adequate time to complete the survey.

A total of 2,431 invitation e-mail messages were sent. Of these, 662 were undelivered for various reasons (unknown recipient, invalid address, etc.), resulting in 1,769 candidates actually being contacted and invited to participate in the study. Of those contacted, 329 (18.6%) elected to participate. All participants who returned their responses via e-mail were sent messages thanking them for their participation and confirming their entry into the drawing.

Inclusion Criteria. Respondents to the survey were included in the study if they: (1) were identified in the AABT directory as being members of AABT **or** were not listed in the AABT mailing list but identified their primary theoretical orientation as behavioral, cognitive, or cognitive-behavioral; and (2) were Ph.D. level mental health professionals or interns, **or** had completed all requirements for a Ph.D. in a field of mental health

except the dissertation. Surveys completed by respondents who did not meet these criteria were excluded from the final data set; 92 responses were excluded in all. All respondents who returned their surveys by the deadlines were included in the drawing.