

Does Clinical Evidence Reach Psychological Treatments?

Psychotherapy Status in Argentina

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Conflict of Interest Statement

All authors declare no conflict of interest.

Data Availability Statement

All data and code supporting the findings of this study are freely available on GitHub at https://github.com/Nicobruno92/Psy_ResearchAttitudes |

Abstract

This study examined the role of research in shaping the theoretical orientations and clinical decision-making of Argentine psychotherapists. A total of 283 clinical psychotherapists completed an online survey that assessed demographic information, factors influencing their choice of theoretical orientation, reliance on various sources of information (e.g., research, supervision, personal experience), and attitudes toward empirical research. After exclusions, 262 participants were analysed using multivariate and cluster analyses. Results indicated that therapists across all orientations relied more on personal experience, supervision, and books than on empirically supported publications. However, CBT practitioners relied more on scientific articles, clinical guidelines, and evidence-based practices than psychoanalysts, who emphasised personal therapy and were less likely to adopt new research-based interventions. Cluster analyses identified four distinct groups, which differed significantly in terms of mean age and clinical workload. Younger therapists (predominantly CBT) were more open to empirical research, whereas older therapists (mainly psychoanalytic) were more conservative about integrating research findings. These findings highlight a persistent gap between research and practice in Argentine psychotherapy. Future research should explore how training programs and institutional policies can foster a stronger integration of empirical evidence across all theoretical orientations in Argentina.

Key Practitioner Practice

- Sources such as books, supervision, and peer discussion were more commonly used than empirical research across all orientations; however, CBT practitioners used outcome measures and clinical guidelines significantly more often than psychoanalysts.
- Cluster analysis revealed four therapist profiles that differed by age and workload. Younger (mainly CBT) therapists were more open to research, while older (mainly psychoanalytic) therapists were more conservative.

- A research-practice gap persists in Argentine psychotherapy.

Keywords: Psychotherapy, Psychoanalysis, Cognitive-behavioural therapy, Evidence-based practice.

Introduction

Undergraduate psychology education in Argentinian universities is significantly outdated, with a predominant focus on psychoanalytically oriented authors, mostly faculty-written books, and a notable lack of internationalisation (Fierro, Di Doménico, & Klappenbach, 2019; 2021; Moya, 2010). This factor is further exacerbated by the significant scarcity of material resources allocated to psychological research in the country (Fernández Álvarez, 2017). This scenario is alarming, especially considering that Argentina has the world's largest ratio of psychologists per capita, with 193 psychologists per 100.000 inhabitants (Alonso et al., 2016). Moreover, the vast majority of working psychologists in Argentina are clinical psychologists, with 85% dedicated to this field, and their primary theoretical orientation is psychoanalysis (Alonso et al., 2018; Mueller, 2008).

To understand Argentina's strong relationship with psychoanalysis, we must look back at the development of the discipline in the country. Experimental psychology dominated Argentina until the 1930s, when psychoanalysis gained prominence and philosophical thought began to challenge its role (Dagfal, 2018). The country's clinical bias can be traced to early 20th-century pioneers like Piñero and Ingenieros, who, influenced by French medical figures, shaped psychological training while largely disregarding Wundt's contributions (Klappenbach, 2006). By the 1960s, psychoanalysis had become the dominant framework, coinciding with and shaping the institutionalisation of undergraduate psychology programs (Dagfal, 2018). It is important to consider the impact of the curricula used in undergraduate psychology programs at Argentine universities on the training of future therapists, given that, based on the only available report to date, most psychology graduates in Argentina do not pursue further education (Klappenbach, 2004). Fierro et al. (2019) and Fierro (2021) analysed the literature used in undergraduate psychology programs across Argentina, highlighting a strong preference for traditional psychoanalytic texts and authors (e.g., Freud, Lacan), with

limited representation of other theoretical orientations. Across the twelve main psychology faculties, books account for 50.2% of the cited material, while published research papers rank eighth with 3.7% (Fierro, 2021). Research projects are rarely included in the curriculum (2.7%) and often lack peer review, with the majority of sources being Argentine and few international sources included (Fierro et al., 2019; Fierro, 2021).

This scenario stands in stark contrast to the principles of evidence-based practice (EBP), which is defined as “*the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients, integrating individual clinical expertise with the best available external clinical evidence from systematic research*” (Sackett et al., 1996). In the context of psychotherapy, EBP involves clinicians integrating research findings along with their clinical expertise while considering each patient’s individual needs. Within this framework, empirically supported treatments (ESTS) refer to interventions that have been rigorously tested as independent variables in research and have demonstrated efficacy (Chambless & Hollon, 1998). Cognitive-behavioural therapy (CBT) is the theoretical orientation with the strongest empirical support for treating psychological disorders across all age groups (Roth & Fonagy, 2004), and although there is still room for improvement (Cuijpers et al., 2020; Wojnarowski et al., 2019), it stands as the most extensively researched form of psychotherapy (David et al., 2018).

However, it is important to note that evidence-based treatments do not guarantee proper implementation. A significant gap between psychotherapists' implementation of evidence-based therapies and clinical research has been documented and analysed in various studies (Slife et al., 2018; Stewart et al., 2018; Gálvez-Lara et al., 2019; Fernández-Álvarez et al., 2020; Gower, 2023). Furthermore, therapists are susceptible to "therapist drift," a phenomenon in which cognitive biases and errors lead them to deviate from established treatment protocols (Brosan, 2008; Waller, 2009; Waller & Turner, 2016). Additionally, many

clinicians do not stay up to date with the latest research developments (Brosan, 2006), a fundamental requirement of evidence-based practice. A local study conducted in Mar del Plata, Argentina, has also highlighted this gap, showing that while psychotherapists may even recognise the importance of psychotherapy research, it has limited influence on shaping clinical practice (Auriti & Guirín, 2019).

Regardless of their theoretical orientation, therapists often rely solely on clinical intuition and judgment for their clinical decisions, which tend to lack reliability and validity (Roth & Fonagy, 2004). This has been reported to be true even in theoretical orientations with generally positive attitudes toward research, such as CBT (Huisman & Kangas, 2018). Gyani et al. (2014) examined therapists' choice of theoretical orientation and their sources of information in a British population. They found that research ranked among the least utilised sources of information for British therapists and was not a decisive factor in their choice of theoretical orientation. Therapists practising CBT were more likely than those from other orientations to have positive views toward research, while psychoanalysts tended to have negative views, preferring personal experience and intuition.

In Argentina, few studies have been conducted on therapists' interventions, background, and effectiveness (Vera & Mustaca, 2006; Etchebarne et al., 2016; Fierro et al., 2018; Auriti & Guirín, 2019). Some reasons include the expense and difficulty of mounting trials for long-term treatments, as well as a lack of appropriate measures to encompass these treatments (Roth & Fonagy, 2004). To the best of the authors' knowledge, no scientific studies have been carried out in Argentina to investigate the role of research in therapists' clinical decisions or their choice of theoretical orientation.

The present study aims to examine the role of research in shaping the theoretical orientation and clinical decision-making of Argentine therapists. In line with Gyani et al. (2014), we

hypothesise that clinical experience will play a more significant role than research in therapists' decision-making regarding their theoretical orientation, with the importance of research varying according to the chosen orientation. Additionally, we anticipate that research will be the least utilised source of information in clinical decision-making across all theoretical orientations. We further hypothesise that CBT therapists will be more likely than therapists from other orientations to rely on research as a source of information. Moreover, we expect CBT therapists to hold more positive attitudes toward research than therapists from different orientations. Finally, due to Argentina's strong traditional psychoanalytic tradition, we expect psychoanalysis to be the dominant theoretical orientation across the public and private professional sectors.

Methods

Participants

All participants were psychotherapists based in Argentina. They were recruited through social media platforms (Instagram, LinkedIn, X, and Facebook) and email campaigns from various associations, such as the *Neurotransmitiendo association newsletter*. A total of 284 psychotherapists completed the survey. Of these, 79% were female, 20% were male, and 1% preferred not to disclose their gender or were non-binary. The mean age of the participants was 35.14 (S.D. = 9.52). The average years of clinical experience was 6.98 (S.D = 8.87), and the average time spent attending to clients per week was 24.88 hours (S.D = 13.64). Regarding educational attainment, 52.7% of subjects held a graduate degree (the minimum requirement for practice in Argentina), 30.7% had a postgraduate degree, 6.4% held a master's degree, 2.1% had a doctoral degree, and 1.4% had a postdoctoral degree.

Additionally, 6.7% of participants reported other forms of graduate education, including postgraduate diplomas, training programs, education courses, and professional certifications.

Regarding theoretical orientation, 47.7% identified as cognitive-behavioural therapists (CBT, $n = 135$), 28.27% identified as psychoanalysts ($n = 80$), 11.31% identified as eclectics (those who follow more than one theoretical orientation, $n = 32$), and 4.95% identified as systemic therapists ($n = 15$). The remaining 7.77% ($n = 22$) were excluded from the analysis because they were not representative ($n < 5$). Thus, our final sample consisted of 262 psychotherapists.

In the survey, therapists could select the specific therapies they practised within their primary theoretical orientation and apply as many options as they chose. Among those who selected psychoanalysis as their orientation, 58.75% reported practising Lacanian psychoanalysis, 57.5% Freudian psychoanalysis, 13.75% post-Freudian approaches, and 5.0% psychodynamic therapy. Other approaches included Klein's psychoanalysis (2.5%) and analytical psychology (2.5%).

For those who identified with CBT, 33.6% reported practising cognitive therapy, 25% behavioural therapy, 20.5% reported practising acceptance and commitment therapy, 8.2% applied behaviour analysis, 5.3% dialectical behaviour therapy, 4.5% mindfulness-based therapy, 0.8% functional analytic therapy, and 2.0% rational emotive behaviour therapy.

Finally, 31.82% of eclectic psychotherapists reported using CBT, 22.73% psychoanalysis, 13.64% systemic therapy, 10.61% humanistic therapy, and 10.61% psychodynamic therapy.

Materials

We designed a questionnaire in Google Forms specifically for this study, drawing partially on the work of Gyani et al. (2014), which consisted of 39 questions in four sections. Section I

accounted for demographic variables. Section II investigated the influence of different factors by asking, "*How much did these factors influence your theoretical orientation?*". Participants responded by rating sources (e.g, scientific evidence, clinical training, client preferences, intuition, personal therapy). Here, we predicted that clinical experience would be more influential than research in this decision-making process.

Section III evaluated the sources therapists consult in their clinical practice by asking, "*Which sources do you currently use to enhance your clinical abilities and efficacy?*" Participants responded by rating sources (e.g., empirical research with controlled trials, supervision, discussions with colleagues, popular books, and clinical manuals or guides). We hypothesised that research would be among the least cited sources of information. Additionally, we expected cognitive-behavioural therapists to cite research significantly more often than therapists from other theoretical orientations.

Finally, section IV examined therapists' attitudes towards research. Here, we used an adapted version of the Attitudes Towards Research Index used by Gyani et al. (2014). The index includes 22 statements such as "*Therapeutic alliance is more important than learning evidence-based treatments,*" "*Clinical experience is more important than research evidence as a treatment guide,*" and "*Evidence-based treatments are effective.*" Here, we predicted that cognitive-behavioural therapists would have a more positive attitude toward incorporating controlled research results into their practice than therapists from other theoretical orientations.

All questions were presented as single-item questions, with responses measured on a Likert scale from 0 (I do not know/Prefer not to respond) to 1 (Never) to 7 (Always), based on personal experience. This questionnaire is available in the Supplementary Material.

PROCEDURE

The present study utilised a cross-sectional design to investigate multiple factors of interest simultaneously at a single time point. This approach facilitated an analysis of the relationships between therapists' theoretical orientations and their clinical practices, as well as the various sources of information they rely on in their professional work. The survey was disseminated via social media through networks, online groups, newsletters, and forums. Participants were required to be clinical psychotherapists currently working in Argentina. Subjects accessed the online survey through a provided link.

Upon opening the questionnaire's URL, participants were informed about the nature of the study and their informed consent was requested. If participants refused to give informed consent, the questionnaire would automatically end. Participants were instructed to ensure they were in a quiet environment while completing the questionnaire.

Data Analysis

To investigate our hypothesis, we performed three analyses. First, we used a multivariate analysis of covariance (MANCOVA) for each section to account for potential demographic covariables (age, years of experience, working hours), corrected using Tukey's HSD. Here, we used theoretical orientations as our dependent variables and all the single-item responses as our independent variables. Second, we performed a principal component analysis (PCA) and a cluster analysis. The PCA allowed us to reduce the dimensionality of our data, select the variables that most influenced the cluster variation, and enhance the interpretability of the cluster structure. Third, we used multinomial logistic regression to study whether the covariables predicted cluster membership. For this, the dependent variable was the clusters, and the independent variables were age, years of experience, and working hours. All analyses were carried out using Python software. Complete data and scripts can be found at: https://github.com/Nicobruno92/Psy_ResearchAttitudes

Results

Influences On Theoretical Orientation (Section II)

The MANCOVA analysis revealed significant differences across therapeutic orientations for scientific evidence (Wilks' lambda = 0.6787, $F(4, 170) = 20.1224$, $p < 0.0000$) and personal therapy (Wilks' lambda = 0.8933, $F(4, 170) = 5.0774$, $p < 0.0007$) differed significantly across theoretical orientations. We did not find significant differences in personal experience, clinical training, treatment preferences, and intuition.

Post hoc Tukey HSD comparisons revealed significant differences among therapeutic orientations (Figure 1a, Table 1 in Supplementary Material). For instance, in terms of the importance of scientific evidence, we found significant differences between eclectic and CBT (mean difference = 1.7083, $p < 0.00001$), psychoanalysis and systemic therapy (mean difference = 1.2455, $p < 0.0253$), and psychoanalysis and CBT (mean difference = 2.2455, $p < 0.00001$). For personal treatment, we found significant differences between eclectic and psychoanalysis (mean difference = 1.8326, $p < 0.0019$), psychoanalysis and systemic (mean difference = -2.0052, $p < 0.0069$), and psychoanalysis and CBT (mean difference = -2.0735, $p < 0.00001$).

Sources Used in Their Clinical Practice (Section III)

Across all theoretical orientations, books, peer discussions, personal treatment for clients, and supervision were among the most valued sources of information. In contrast, empirical research (e.g., controlled trials) and outcome measures were rated lower (Figure 2).

The MANCOVA analysis revealed significant multivariate effects for clinical case observations (Wilks' $\lambda = 0.9301$, $F(4, 243) = 4.5623$, $p = 0.0014$), outcome measures (Wilks'

$\lambda = 0.9569$, $F(4, 243) = 2.7331$, $p = 0.0297$), clinical guidelines/manuals (Wilks' $\lambda = 0.8837$, $F(4, 243) = 7.9969$, $p < 0.0001$), and age (Wilks' $\lambda = 0.9251$, $F(4, 243) = 4.9185$, $p = 0.0008$).

Post hoc Tukey HSD analyses revealed more significant differences between theoretical orientations (Figure 1B, Table 2 in Supplementary Material). Personal treatment preferences differed between psychoanalysis and CBT (mean difference = -0.5569 , $p = 0.0367$). The use of empirical controlled trials showed differences between psychoanalysis and CBT (mean difference = 1.1606 , $p = 0.0356$) and between psychoanalysis and CBT (mean difference = 1.8356 , $p < 0.001$). Supervision was used significantly less by psychoanalytic practitioners than by eclectic (mean difference = 1.0812 , $p = 0.0112$) and CBT practitioners (mean difference = -0.9231 , $p < 0.0006$). Clinical case observations showed differences between eclectic and psychoanalysis (mean difference = 1.3375 , $p = 0.0034$), psychoanalysis and CBT (mean difference = -1.9074 , $p < 0.001$), and systemic and CBT orientations (mean difference = -1.3646 , $p = 0.0438$). The use of outcome measures differed between eclectic and psychoanalytic practitioners (mean difference = -1.1312 , $p = 0.0485$) and between psychoanalytic and CBT practitioners (mean difference = 2.0352 , $p < 0.001$). Use of clinical guidelines and manuals showed significant differences between eclectic and psychoanalysis (mean difference = -1.7938 , $p < 0.001$), eclectic and CBT (mean difference = 0.8725 , $p = 0.0337$), psychoanalysis and systemic orientations (mean difference = 1.9768 , $p = 0.0002$), and psychoanalytic and CBT practitioners (mean difference = 2.6662 , $p < 0.001$).

Attitudes Towards Research (Section IV)

In the last section of the questionnaire, we evaluated responses from several research attitudes. MANCOVA analysis showed that age significantly influenced responses (Wilks' $\lambda = 0.9285$, $F(4, 229) = 4.4089$, $p = 0.0019$). In contrast, gender and weekly patient hours did not have a significant effect (Wilks' $\lambda > 0.95$, $p > 0.05$). The openness to use

researcher-developed therapies fell to marginal significance (Wilks' lambda = 0.9615, $F(4, 229) = 2.2913$, $p = 0.0605$). For other dependent variables, results were non-significant except for willingness to try new therapies (Wilks' lambda = 0.9530, $F(4, 229) = 2.8216$, $p = 0.0258$) and supervisory requirements for evidence-based treatments (Wilks' lambda = 0.9485, $F(4, 229) = 3.1075$, $p = 0.0162$).

Post-hoc Tukey HSD comparisons revealed significant differences among theoretical orientations (Figure 1c, Table 3 in Supplementary Material). Openness to researcher-developed therapies differed between eclectics and psychoanalysis (mean difference = -1.3187, $p = 0.0007$), psychoanalysis and systemic (mean difference = 1.8411, $p = 0.0007$), and psychoanalysis and CBT (mean difference = 1.2718, $p < 0.001$). For “Therapy cannot be manualised”, differences were identified between psychoanalytic and CBT practitioners (mean difference = -1.5310, $p < 0.001$). Differences in the prioritisation of the therapeutic alliance were found between psychoanalysis and CBT (mean difference = -0.8282, $p < 0.0180$) and systemic and CBT practitioners (mean difference = -1.6693, $p < 0.0161$). Openness to learning a new therapy showed a significant difference between eclectics and systemic practitioners (mean difference = -1.6920, $p < 0.0495$). In focus on individual treatment for each client, we found a significant difference between eclectics and systemic (mean difference = -1.5670, $p < 0.0476$), eclectics and CBT (mean difference = -0.9813, $p < 0.0413$), psychoanalysis and systemic (mean difference = -1.4357, $p < 0.0434$), and a highly significant difference between psychoanalysis and CBT (mean difference = -0.8500, $p < 0.0081$). For “Most therapies are equally effective,” we found a strong difference between eclectics and CBT (mean difference = -1.2157, $p < 0.0026$) and psychoanalysis and CBT (mean difference = -1.5032, $p < 0.0000$) and a modest difference between systemic and CBT (mean difference = -1.2693, $p < 0.0492$). For “Clinical experience is more important as a guide for treatment than scientific evidence,” we found strong significant differences

between eclectics and CBT (mean difference = -1.5907, $p < 0.0000$), psychoanalysis and systemic (mean difference = -1.4089, $p < 0.0166$), and psychoanalysis and CBT (mean difference = -2.1782, $p < 0.0000$). For “My supervisors require/have required me to use evidence-based treatments (i.e., those supported by the scientific method),” we found strong differences between eclectics and psychoanalysis (mean difference = -1.8625, $p < 0.0015$), psychoanalysis and systemic (mean difference = 3.8268, $p < 0.0000$), and psychoanalysis and CBT (mean difference = 2.9866, $p < 0.0000$). For “I can attract new clients by learning an evidence-based treatment,” we found differences in eclectics and psychoanalysis (mean difference = -1.8688, $p < 0.0007$), psychoanalysis and systemic (mean difference = 1.9536, $p < 0.0189$), and psychoanalysis and CBT (mean difference = 2.8583, $p < 0.0000$). For “It is important to incorporate scientific findings into my daily practice,” we found significant differences between eclectics and psychoanalysis (mean difference = -1.5938, $p < 0.0029$), psychoanalysis and systemic (mean difference = 2.5446, $p < 0.0004$), and psychoanalysis and CBT (mean difference = 2.2690, $p < 0.0000$). For “I am interested in learning evidence-based treatments,” we found differences between eclectics and psychoanalysis (mean difference = -1.7062, $p < 0.0019$), psychoanalysis and systemic (mean difference = 2.0679, $p < 0.0088$), and psychoanalysis and CBT (mean difference = 2.5657, $p < 0.0000$). For “The treatments I use with my clients have an empirical basis,” we found significant differences in eclectics and psychoanalysis (mean difference = -1.3188, $p < 0.0230$), eclectics and CBT (mean difference = 1.5660, $p < 0.0020$), psychoanalysis and systemic (mean difference = 3.0196, $p < 0.0000$), and psychoanalysis and CBT (mean difference = 2.8847, $p < 0.0000$). For “My clients are more complex and diverse than those in clinical trials,” we found differences between psychoanalysis and CBT (mean difference = 1.1093, $p < 0.0049$). Finally, for “Training in evidence-based treatments would cost me too much money,” we found differences between eclectics and psychoanalysis (mean difference = -1.5875, $p < 0.0071$),

psychoanalysis and systemic (mean difference = 2.4000, $p < 0.0026$), and psychoanalysis and CBT (mean difference = 2.3074, $p < 0.0000$).

Cluster Analysis

We performed a principal component analysis (PCA) to reduce data dimensionality and identify components that explain 80% of the variance. Nineteen out of thirty-five principal components met this threshold. Using the cumulative variance, we determined the optimal number of clusters using the Elbow method and a Knee Locator. Four clusters were identified. Cluster 0 was highly dominated by CBT ($n = 34$), with minor representation from Eclectic ($n = 4$) and Systemic ($n = 2$) and no representatives from Psychoanalysis. Cluster 1 was also dominated by CBT ($n = 35$), but with a more diverse representation from Psychoanalysis ($n = 8$), Eclectic ($n = 6$), and Systemic ($n = 6$) approaches. Cluster 2 showed a diverse representation for Psychoanalysis ($n = 22$), CBT ($n = 20$), Eclectic ($n = 10$), and Systemic ($n = 5$). Finally, cluster 4 was highly dominated by Psychoanalysis ($n = 25$), with smaller representations from CBT ($n = 3$), Eclectic ($n = 4$), and Systemic ($n = 1$) (see Figure 3a). To confirm that the cluster membership was non-random, we performed a Chi-square test ($\chi^2(9) = 70.30, p < 1.33 \times 10^{-11}$), which indicated a highly significant association. A Cramér's V of 0.36 suggested a moderate effect size. To visualise the mean distribution of variables among clusters, we selected the top five variables from this analysis with the highest variation: scientific evidence, personal experience, supervision, interest in learning evidence-based therapies, and treatments used with an empirical basis. Then we created a radar plot for cluster profiles (Figure 3b).

Multinomial Logistic Regression

Finally, we investigated whether age, gender, and weekly working hours predicted cluster membership. A multinomial logistic regression revealed that, for Cluster 2 (Mixed orientations), age ($\beta = 0.8800$, $p = 0.007$) and working hours ($\beta = 0.5578$, $p = 0.028$) predicted cluster membership (see Figure 4). Thus, older individuals and those with higher workloads were more likely to belong to this cluster. Similarly, for Cluster 3 (Psychoanalysis dominant), both age ($\beta = 1.1631$, $p = 0.001$) and weekly working hours ($\beta = 0.7149$, $p = 0.011$) were significant positive predictors. The analysis did not reveal significance for Clusters 0 and 1 (both CBT dominant). Gender was not a significant predictor for any cluster.

Discussion

Our study aimed to replicate the findings of Gyani et al. (2014) in the Argentinian context, the world's most significant ratio of psychologist per capita (Alonso et al., 2016), with 85% of psychologists dedicated to clinical psychology, with traditional psychoanalysis being their main theoretical orientation (Alonso et al., 2018; Mueller, 2008).

We found that psychoanalytic practitioners relied more on personal experience than science-based research. In contrast, CBT practitioners relied more on science-based research attitudes than on personal experience. These results confirm our hypothesis, suggesting that CBT shows greater evidence-based approaches compared to eclectic and psychoanalytic orientations. In contrast, psychoanalysts rely more on personal therapy than the other theoretical orientations. Similarly, these findings are consistent with the study conducted by Auriti and Guirín (2019). Their results indicated that individuals who select "Cognitivism" as one of their referential frameworks are more likely to justify their choice based on the

purported empirical evidence supporting their theoretical model. This suggests that they assign significant priority and importance to research in psychotherapy.

Furthermore, as expected, we found that psychoanalytic practitioners were more conservative in learning evidence-based therapies in contrast with eclectic or CBT. These results align with Gyani et al. (2014). However, we did not find statistically significant differences in the other variables: personal experience, professional clinic training, use of therapy of preference for patients, and intuition.

Interestingly, despite the differences identified between groups in the MANCOVA analysis, a descriptive analysis revealed that CBT and psychoanalytic psychotherapists rely more on clinical experience and books than empirical research to inform their clinical decisions (see Figure 2). Across all theoretical orientations, books, peer discussions, personal treatment for clients, and supervision were among the most highly valued sources of information. In contrast, empirical research (e.g., controlled trials) and outcome measures were rated as some of the least consulted sources of information. These findings align with those reported by Gyani et al. (2014) and support two of our hypotheses. First, they confirm that clinical experience plays a more significant role than research in therapists' decision-making regarding their theoretical orientation, with the perceived importance of research varying according to the chosen orientation. Second, they corroborate our expectation that research would be the least utilised source of information in clinical decision-making across all theoretical orientations.

By employing PCA to reduce data dimensionality, we identified key factors underlying practitioners' attitudes with scientific evidence, reliance on personal experience, and perceived barriers to evidence-based training. Four clusters emerged from the analysis (cluster 0: CBT-dominant; cluster 1: CBT-dominant but with a minor diversity of

practitioners; cluster 2: mixed theoretical orientations; and cluster 3: psychoanalytical-dominant). This reinforces the heterogeneity in our sample regarding attitudes toward science-based practice.

Interestingly, clusters 0 and 1 were primarily composed of CBT with minor representation from the other theoretical orientations. The main difference relied in personal experience in their daily practices. For instance, cluster 0 (CBT dominant) strongly favoured pure science-based attitudes, whereas cluster 1 was more flexible in adding personal experience to their practices. In contrast, clusters 2 and 3 were more diverse, with Cluster 3 being strongly composed of psychoanalytical practitioners and Cluster 2 being more diverse. Importantly, as CBT and psychoanalysis heavily influenced our data, these clusters were mainly composed of these orientations. This suggests that practitioners' self-reports of belonging to a particular orientation may not share the nature of their behaviours, which are better aligned with eclectic.

The influence of cluster membership was also evident. Age and weekly working hours differed significantly across clusters, with older and more experienced practitioners more likely to belong to clusters 2 (mixed orientations) and 3 (psychoanalysis-dominant). This suggests that more established practitioners are more conservative in their professional practices, particularly when it comes to evidence-based therapies, possibly due to a resistance to integrating newer scientific approaches. Cluster 0, on the other hand, represented younger practitioners who might have received more exposure to evidence-based methodologies during their studies. These may reflect a broader paradigm shift among younger therapists, who have a greater inclination toward evidence-based practices, underscoring the importance of continued research and updates on this topic. These findings align with previous research, which indicates that younger professionals are more likely to adopt evidence-based

treatments than their older counterparts (Aarons & Sawitzky, 2006). Additionally, psychologists trained before the widespread adoption of evidence-based practices may exhibit greater resistance to such interventions (Lilienfeld et al., 2013), consistent with our results showing that psychoanalytic therapists expressed less interest in learning about evidence-based therapies than other groups, as previously expected. Finally, as gender did not play a significant role in cluster differentiation and the multinomial logistic regression, it suggests that theoretical orientation preferences are influenced mainly by training background and professional experience.

Our study has some limitations. First, the sample size is smaller than that reported by Gyani et al. (2014). Although we anticipated that psychoanalysis would be the predominant theoretical orientation in both the public and private sectors, as outlined in the introduction, recruiting a representative number of non-CBT practitioners was challenging. This difficulty may stem from attitudes toward empirical research within psychoanalytic practice, as previously discussed, and from therapists representing diverse orientations, including non-CBT and non-psychoanalytic approaches, in Argentina. Future research should provide a more detailed comparison between eclectic practitioners, CBT, and psychoanalytic therapists. Second, there is a possibility that psychoanalytic practitioners either misunderstood or interpreted some questions differently than other groups. Overall, our findings indicate that, despite persistent differences in research attitudes across theoretical orientations, the integration of empirical evidence into clinical practice remains limited, even among practitioners who prioritise scientific research, such as those in cluster 0 (CBT-dominant) and cluster 1 (CBT with a stronger emphasis on personal experience). This underscores a critical and well-documented challenge in psychotherapy (Slife et al., 2018; Stewart et al., 2018; Gálvez-Lara et al., 2019; Fernández-Álvarez et al., 2020; Gower, 2023): the gap between research and everyday clinical practice. Notably, the generational shift observed in our data

suggests that younger professionals trained in CBT may drive change in the field. However, deeply rooted traditions continue to shape the field of clinical psychology in Argentina. Bridging this gap will require the broader dissemination of research findings and a fundamental shift in how empirical evidence is valued and integrated into professional training, clinical practice, and educational institutions.

Conclusion

Overall, our study found similar results to those reported by Gyani et al. (2014). We found that psychoanalytical practitioners rely more on personal experience than CBT practitioners. As expected, CBT showed a stronger research attitude than the psychoanalytic and eclectic approaches. A cluster analysis confirmed the distribution of psychotherapies into psychoanalytic-dominant, CBT-dominant, CBT-mixed, and a mixed (eclectic) category. Finally, an ANOVA and logistic regression analysis revealed that age and the number of weekly hours spent attending to patients were significant predictors of cluster membership. The psychoanalytic dominant group was significantly older than the CBT group, which was represented by younger and early-career individuals. This suggests a change in the new Argentinian students' paradigms, interests, and attitudes towards clinical Psychology. Future studies should include a considerably larger number of respondents while including the diversity of orientations. Additionally, future studies should examine attitudes among bachelor's and master's students at different stages of their degrees.

If training and studies shape attitudes and decisions, then the future of psychotherapy may be decided long before the first patient's session. However, bridging the gap between research and practice remains one of the greatest challenges across science. A bridge that, despite decades of work and knowledge, still seems far from complete.

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Figures

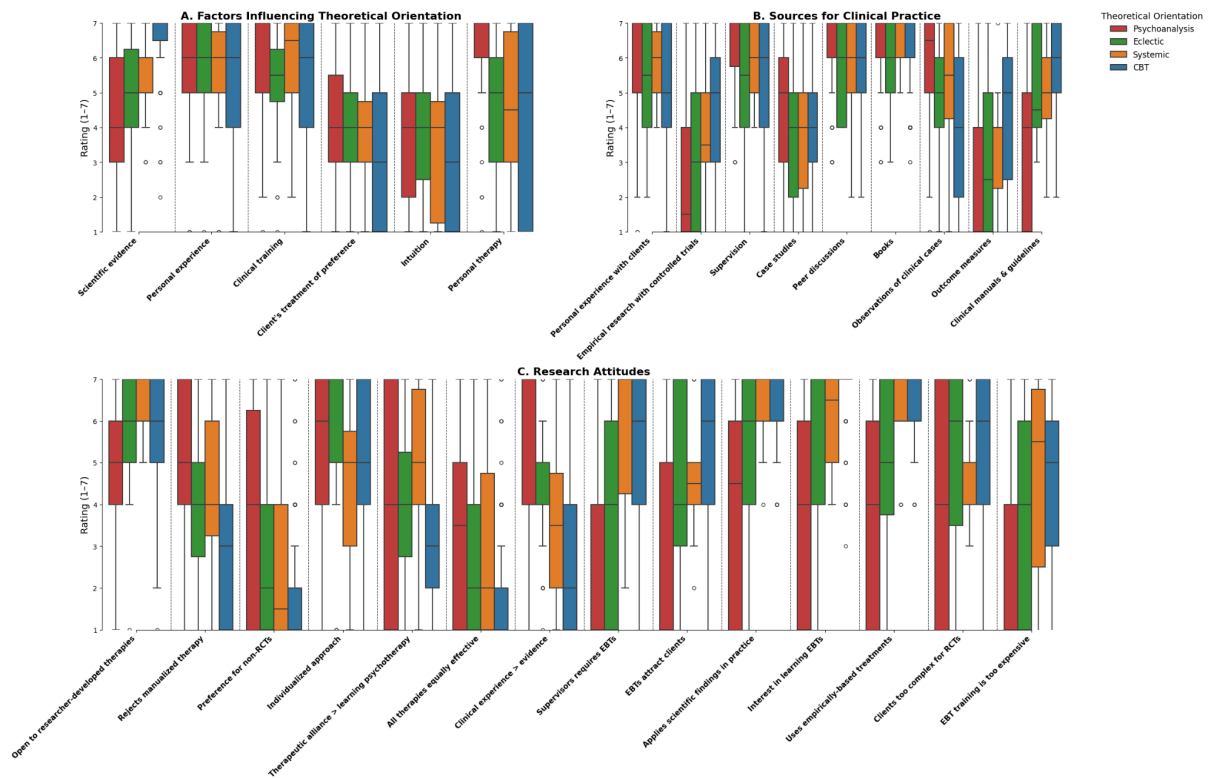


Figure 1. A. Section II. Influence of factors (scientific evidence, personal experience, clinical training, client treatment preferences, intuition, and personal therapy) on choosing a theoretical orientation. MANCOVA and Tukey HSD analysis revealed significant differences in scientific evidence and personal therapy across orientations (see Table 1, Supplementary Material). **B. Section III.** Practitioners' use of sources (books, peer discussions, supervision, personal treatment for clients, clinical case observations, clinical guides and manuals, case studies, empirical research (controlled trials), and outcome measures) to improve their clinical skills. Significant differences were found using clinical case observations, outcome measures, clinical guidelines, and manuals (see Table 2, Supplementary Material). **C. Section IV.** Significant differences in 14 (statistically significant) out of 24 attitudes towards research. The figure displays how these factors and attitudes vary among therapeutic orientations, with post hoc Tukey HSD comparisons identifying specific significant differences (see also Table 3 for all the results in the 24 variables, Supplementary Material).

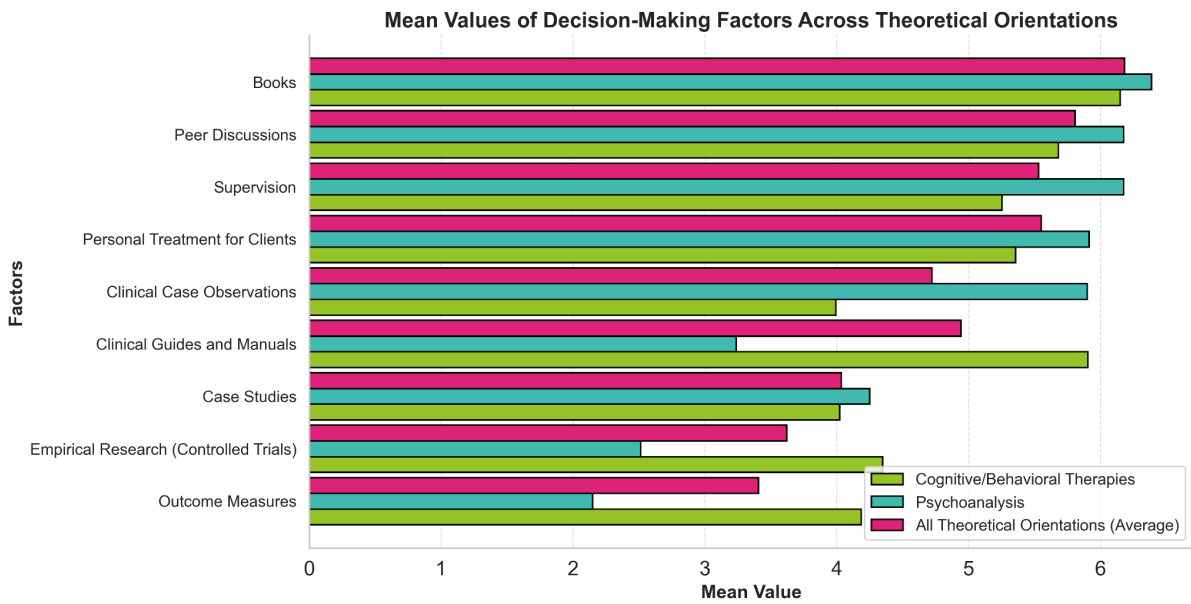


Fig 2. Sources used by practitioners. CBT vs. psychoanalysis vs. the average of responses for all theoretical orientations to improve clinical skills include books, peer discussions, supervision, personal treatment for clients, clinical case observations, clinical guides and manuals, case studies, empirical research (such as controlled trials), and outcome measures. On average, books, peer discussions, and supervision weighed more in psychotherapeutics than empirical research and outcome measures.

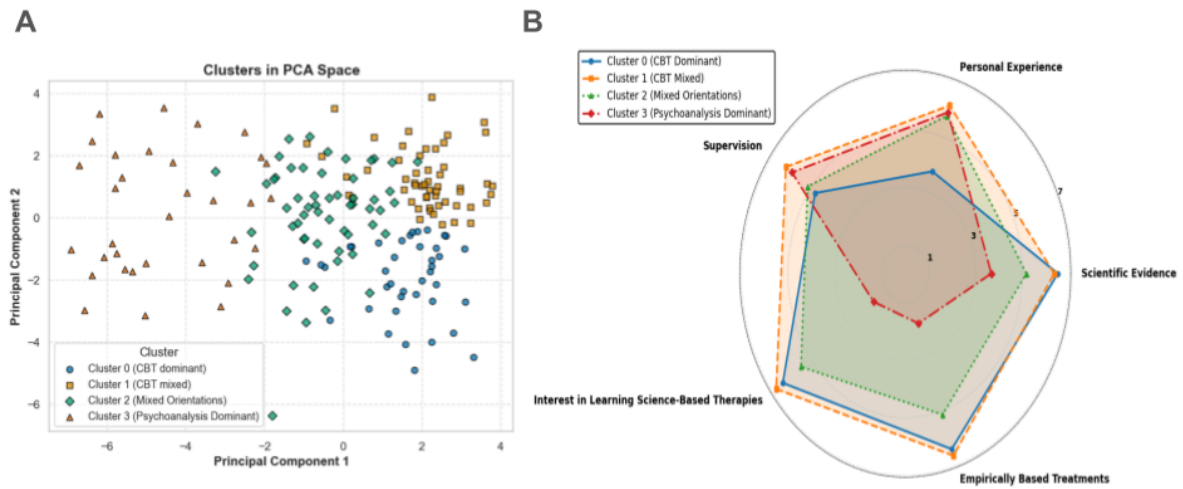


Fig 3. A. Distribution of Clusters Across the PCA Space. Four clusters were detected after running a principal component analysis (PCA). Clusters 0 (CBT-dominant) and 1 (CBT-mixed) show a stronger overlap, which suggests that the same theoretical orientation differs significantly in certain attitudes. Cluster 2 (Mixed Orientations) represents a midpoint, which is expected since it was the most balanced cluster in terms of theoretical orientations. Cluster 3 (Psychoanalysis-dominant) is far from the other clusters, suggesting a unique tendency for some attitudes. **B. Radar Plot.** We selected the top five variables with the highest variance from the PCA to visualise their difference across the clusters. We found that the main difference between Cluster 0 (CBT-dominant) and Cluster 1 (CBT-mixed) was regarding personal experience. Cluster 2 (mixed orientations) was the most balanced across all the variables. In contrast, Cluster 3 (Psychoanalysis-dominant) strongly relied on supervision and personal experience.

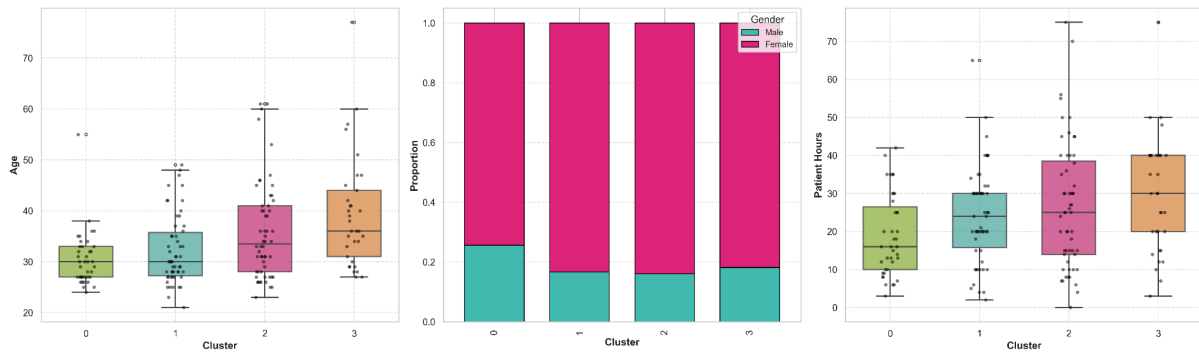


Fig 4. Age, Gender, and Weekly Work Hours Across the Clusters. A) Age significantly differed across Clusters and strongly predicted cluster membership. As age increased, so did the probability of belonging to Cluster 3 (psychoanalysis-dominant). B) Gender did not differ significantly across the clusters, and it was not a predictor of cluster membership. C) Working hours significantly differed across the clusters, particularly in Clusters 2 and 3. Additionally, the number of working hours predicted cluster membership, with more working hours aligning with a higher probability of being in Cluster 3. As Clusters 2 and 3 were significantly older than Clusters 0 and 1, this difference could be explained by the fact that Clusters 2 and 3 contained more experienced professionals.

Table 1. Multiple comparisons Tukey HSD (Eclectic, Psychoanalysis, Systemic, and CBT).. Section II asked respondents about the factors influencing their theoretical orientation. The dependent variables include scientific evidence, personal experience, clinical training, client treatment preferences, intuition, and personal therapy. Significant differences ($p < 0.05$) are marked with an asterisk (*), and highly significant differences ($p < 0.001$) are marked with two asterisks (**). The table also includes 95% confidence intervals (CI) for group mean differences.

Dependent Variable	Group 1	Group 2	Mean Difference	p-value	95% CI (Lower)	95% CI (Upper)
Scientific Evidence	Eclectic	PSA	-0.5371	0.439	-1.4646	0.3903
	Eclectic	Systemic	0.7083	0.476	-0.5666	1.9833
	Eclectic	CBT	1.7083	< .001 **	0.8394	2.5773
	PSA	Systemic	1.2455	0.025 *	0.1106	2.3803
	PSA	CBT	2.2455	< .001 **	1.5993	2.8916
	Systemic	CBT	1	0.084	-0.0876	2.0876
Personal Experience	Eclectic	PSA	0.4508	0.753	-0.7251	1.6267
	Eclectic	Systemic	-0.244	0.98	-1.8605	1.3724
	Eclectic	CBT	-0.2518	0.934	-1.3535	0.8499
	PSA	Systemic	-0.6948	0.595	-2.1337	0.7441
	PSA	CBT	-0.7026	0.121	-1.5218	0.1167
	Systemic	CBT	-0.0078	1	-1.3867	1.3712
Clinical Training	Eclectic	PSA	1.0235	0.052	-0.0063	2.0533
	Eclectic	Systemic	0.756	0.511	-0.6597	2.1716
	Eclectic	CBT	0.3134	0.834	-0.6515	1.2783
	PSA	Systemic	-0.2675	0.946	-1.5277	0.9926
	PSA	CBT	-0.7101	0.054	-1.4276	0.0074
	Systemic	CBT	-0.4425	0.778	-1.6502	0.7651
Client's treatment of preference	Eclectic	PSA	0.5833	0.594	-0.624	1.7907
	Eclectic	Systemic	0.369	0.939	-1.2907	2.0288
	Eclectic	CBT	-0.1123	0.994	-1.2435	1.0189
	PSA	Systemic	-0.2143	0.982	-1.6917	1.2631
	PSA	CBT	-0.6957	0.143	-1.5369	0.1455
	Systemic	CBT	-0.4814	0.814	-1.8972	0.9345
Intuition	Eclectic	PSA	-0.2227	0.969	-1.4996	1.0542
	Eclectic	Systemic	-0.3929	0.938	-2.1482	1.3625
	Eclectic	CBT	-0.7283	0.394	-1.9246	0.4681
	PSA	Systemic	-0.1701	0.992	-1.7326	1.3924
	PSA	CBT	-0.5055	0.456	-1.3952	0.3841
	Systemic	CBT	-0.3354	0.938	-1.8328	1.162

Personal Therapy	Eclectic	PSA	1.8326	0.002 **	0.5346	3.1306
	Eclectic	Systemic	-0.1726	0.994	-1.957	1.6117
	Eclectic	CBT	-0.2409	0.956	-1.4571	0.9752
	PSA	Systemic	-2.0052	0.007 **	-3.5935	-0.4169
	PSA	CBT	-2.0735	< .001 **	-2.9779	-1.1692
	Systemic	CBT	-0.0683	0.999	-1.5904	1.4538

Table 2. Multiple comparisons Tukey HSD (Eclectic, Psychoanalysis, Systemic, and CBT).. Section III asked respondents about sources they use to enhance their clinical skills. The dependent variables include books, peer discussions, supervision, personal treatment for clients, clinical case observations, clinical guides and manuals, case studies, empirical research (controlled trials), and outcome measures. Significant differences ($p < 0.05$) are marked with an asterisk (*), and highly significant differences ($p < 0.001$) are marked with two asterisks (**). The table also includes 95% confidence intervals (CI) for group mean differences.

Dependent Variable	Group 1	Group 2	Mean Difference	p-value	95% CI (Lower)	95% CI (Upper)
Personal Experience With Clients	Eclectic	PSA	0.5687	0.247	-0.2213	1.3588
	Eclectic	Systemic	0.5134	0.692	-0.6969	1.7237
	Eclectic	CBT	0.0118	1	-0.7308	0.7544
	PSA	Systemic	-0.0554	0.999	-1.1496	1.0388
	PSA	CBT	-0.5569	0.037 *	-1.0898	-0.024
	Systemic	CBT	-0.5016	0.613	-1.5621	0.5589
Empirical Research With Controlled Trials	Eclectic	PSA	-0.675	0.449	-1.8517	0.5017
	Eclectic	Systemic	0.7411	0.712	-1.0617	2.5438
	Eclectic	CBT	1.1606	0.036 *	0.0545	2.2668
	PSA	Systemic	1.4161	0.114	-0.2138	3.0459
	PSA	CBT	1.8356	< .001 **	1.0419	2.6294
	Systemic	CBT	0.4196	0.902	-1.16	1.9992
Supervision	Eclectic	PSA	1.0812	0.011 **	0.1815	1.981
	Eclectic	Systemic	0.4777	0.807	-0.9007	1.856
	Eclectic	CBT	0.1581	0.963	-0.6876	1.0038
	PSA	Systemic	-0.6036	0.594	-1.8497	0.6426
	PSA	CBT	-0.9231	0.001 **	-1.5301	-0.3162
	Systemic	CBT	-0.3196	0.903	-1.5274	0.8882
Case Studies	Eclectic	PSA	0.5938	0.517	-0.524	1.7115
	Eclectic	Systemic	0.1295	0.997	-1.5829	1.8418
	Eclectic	CBT	0.366	0.804	-0.6847	1.4166
	PSA	Systemic	-0.4643	0.866	-2.0124	1.0838
	PSA	CBT	-0.2278	0.863	-0.9818	0.5262
	Systemic	CBT	0.2365	0.977	-1.2639	1.7369
Peer Discussion	Eclectic	PSA	0.5187	0.22	-0.1784	1.2159
	Eclectic	Systemic	-0.3705	0.806	-1.4385	0.6975
	Eclectic	CBT	0.0252	1	-0.6301	0.6805
	PSA	Systemic	-0.8893	0.083	-1.8549	0.0763
	PSA	CBT	-0.4935	0.036 *	-0.9638	-0.0233

	Systemic	CBT	0.3958	0.694	-0.54	1.3316
	Eclectic	PSA	0.6375	0.021 *	0.0677	1.2073
	Eclectic	Systemic	0.6071	0.276	-0.2658	1.4801
Books	Eclectic	CBT	0.3981	0.221	-0.1375	0.9338
	PSA	Systemic	-0.0304	1	-0.8196	0.7589
	PSA	CBT	-0.2394	0.375	-0.6237	0.145
	Systemic	CBT	-0.209	0.894	-0.9739	0.5559
	Eclectic	PSA	1.3375	0.003 **	0.3405	2.3345
	Eclectic	Systemic	0.7946	0.535	-0.7328	2.3221
Observations of Clinical Cases	Eclectic	CBT	-0.5699	0.396	-1.5071	0.3673
	PSA	Systemic	-0.5429	0.74	-1.9238	0.8381
	PSA	CBT	-1.9074	< .001 **	-2.58	-1.2348
	Systemic	CBT	-1.3646	0.044 *	-2.703	-0.0261
	Eclectic	PSA	-1.1312	0.049 *	-2.2575	-0.005
	Eclectic	Systemic	0.0759	1	-1.6495	1.8013
Outcome Measures	Eclectic	CBT	0.9039	0.124	-0.1547	1.9626
	PSA	Systemic	1.2071	0.19	-0.3528	2.767
	PSA	CBT	2.0352	< .001 **	1.2755	2.7949
	Systemic	CBT	0.828	0.49	-0.6838	2.3399
	Eclectic	PSA	-1.7938	< .001 **	-2.672	-0.9155
	Eclectic	Systemic	0.183	0.985	-1.1624	1.5285
Clinical Manuals & Guidelines	Eclectic	CBT	0.8725	0.034 *	0.0469	1.698
	PSA	Systemic	1.9768	< .001 **	0.7604	3.1932
	PSA	CBT	2.6662	< .001 **	2.0738	3.2586
	Systemic	CBT	0.6894	0.432	-0.4895	1.8683

Table 3. Multiple comparisons Tukey HSD (Eclectic, Psychoanalysis, Systemic, and CBT). Section IV asked respondents to rate several research attitudes, which were the dependent variables. Significant differences ($p < 0.05$) are indicated with an asterisk (*), while highly significant differences ($p < 0.001$) are marked with two asterisks (**). The table includes mean differences between groups, p-values, and 95% confidence intervals (CI).

Dependent Variable	Group 1	Group 2	Mean Difference	p-values	95% CI (Lower)	95% CI (Upper)
I am open to using different therapies developed by researchers	Eclectic	Psychoanalysis	-1.3187	0.001 **	-2.1959	-0.4416
	Eclectic	Systemic	0.5223	0.747	-0.8214	1.8661
	Eclectic	CBT	-0.047	0.999	-0.8715	0.7775
	Psychoanalysis	Systemic	1.8411	0.001 **	0.6262	3.0559
	Psychoanalysis	CBT	1.2718	< .001 **	0.6801	1.8634
	Systemic	CBT	-0.5693	0.595	-1.7468	0.6081
I would try a new therapy even if it were very different from what I was used to doing (i.e. very different from what I practice)	Eclectic	Psychoanalysis	-0.7313	0.318	-1.834	0.3715
	Eclectic	Systemic	-1.692	0.050 *	-3.3814	-0.0025
	Eclectic	CBT	-0.3951	0.758	-1.4318	0.6415
	Psychoanalysis	Systemic	-0.9607	0.366	-2.4881	0.5667
	Psychoanalysis	CBT	0.3361	0.647	-0.4078	1.08
	Systemic	CBT	1.2968	0.109	-0.1835	2.7772
Therapy cannot be manualised	Eclectic	Psychoanalysis	0.6437	0.464	-0.4976	1.7851
	Eclectic	Systemic	0.2455	0.984	-1.503	1.9941
	Eclectic	CBT	-0.8873	0.144	-1.9602	0.1856
	Psychoanalysis	Systemic	-0.3982	0.915	-1.9791	1.1827
	Psychoanalysis	CBT	-1.531	< .001 **	-2.3009	-0.7611
	Systemic	CBT	-1.1328	0.226	-2.665	0.3994
The diagnoses used in clinical trials are too simple (e.g. randomised controlled trials)	Eclectic	Psychoanalysis	-0.2375	0.95	-1.3788	0.9038
	Eclectic	Systemic	-1.0893	0.374	-2.8378	0.6592
	Eclectic	CBT	-0.2083	0.959	-1.2812	0.8645
	Psychoanalysis	Systemic	-0.8518	0.505	-2.4326	0.729
	Psychoanalysis	CBT	0.0292	1	-0.7407	0.7991
	Systemic	CBT	0.881	0.447	-0.6512	2.4131
The treatments I prefer have not been tested in a randomised controlled trial	Eclectic	Psychoanalysis	0.9562	0.135	-0.1835	2.096
	Eclectic	Systemic	-0.2545	0.982	-2.0005	1.4916
	Eclectic	CBT	-0.9058	0.13	-1.9771	0.1655
	Psychoanalysis	Systemic	-1.2107	0.197	-2.7893	0.3679
	Psychoanalysis	CBT	-1.862	< .001 **	-2.6308	-1.0932
	Systemic	CBT	-0.6513	0.689	-2.1812	0.8786
I have an individual	Eclectic	Psychoanalysis	-0.1312	0.987	-1.1466	0.8841
	Eclectic	Systemic	-1.567	0.048 *	-3.1224	-0.0115

treatment approach for each client.	Eclectic	CBT	-0.9813	0.041 *	-1.9357	-0.0268
	Psychoanalysis	Systemic	-1.4357	0.043 *	-2.842	-0.0294
	Psychoanalysis	CBT	-0.85	0.008 **	-1.5349	-0.1651
	Systemic	CBT	0.5857	0.683	-0.7773	1.9487
The therapeutic alliance is more important than learning how to do a specific form of psychotherapy	Eclectic	Psychoanalysis	0.1813	0.972	-0.8942	1.2567
	Eclectic	Systemic	1.0223	0.378	-0.6252	2.6698
	Eclectic	CBT	-0.647	0.35	-1.6579	0.3639
	Psychoanalysis	Systemic	0.8411	0.463	-0.6484	2.3306
	Psychoanalysis	CBT	-0.8282	0.018 *	-1.5537	-0.1028
	Systemic	CBT	-1.6693	0.016 *	-3.1129	-0.2257
Most therapies are equally effective	Eclectic	Psychoanalysis	0.2875	0.86	-0.6558	1.2308
	Eclectic	Systemic	0.0536	1	-1.3915	1.4987
	Eclectic	CBT	-1.2157	0.003 **	-2.1024	-0.3291
	Psychoanalysis	Systemic	-0.2339	0.967	-1.5404	1.0726
	Psychoanalysis	CBT	-1.5032	< .001 **	-2.1395	-0.8669
	Systemic	CBT	-1.2693	0.049 *	-2.5355	-0.0031
Clinical experience is more important as a guide to treatment than scientific evidence	Eclectic	Psychoanalysis	0.5875	0.315	-0.2953	1.4703
	Eclectic	Systemic	-0.8214	0.397	-2.1739	0.531
	Eclectic	CBT	-1.5907	< .001 **	-2.4206	-0.7609
	Psychoanalysis	Systemic	-1.4089	0.017 *	-2.6317	-0.1862
	Psychoanalysis	CBT	-2.1782	< .001 **	-2.7737	-1.5827
It is my professional duty to stay up to date with new developments in clinical research (understanding research as a process that follows the scientific method)	Systemic	CBT	-0.7693	0.337	-1.9544	0.4158
	Eclectic	Psychoanalysis	-1.3375	0.084	-2.7925	0.1175
	Eclectic	Systemic	-0.4196	0.962	-2.6487	1.8094
	Eclectic	CBT	0.7227	0.522	-0.645	2.0904
	Psychoanalysis	Systemic	0.9179	0.642	-1.0974	2.9331
My clinical training emphasised research (understanding research as a process that follows the scientific method)	Psychoanalysis	CBT	2.0602	< .001 **	1.0787	3.0417
	Systemic	CBT	1.1423	0.432	-0.8109	3.0955
	Eclectic	Psychoanalysis	-1.2562	0.068	-2.5741	0.0616
	Eclectic	Systemic	0.5402	0.9	-1.4787	2.5591
	Eclectic	CBT	0.6873	0.479	-0.5515	1.926
	Psychoanalysis	Systemic	1.7964	0.056	-0.0289	3.6217
My supervisors require/have required that I use evidence-based treatments (i.e.,	Psychoanalysis	CBT	1.9435	< .001 **	1.0546	2.8325
	Systemic	CBT	0.1471	0.997	-1.622	1.9161
	Eclectic	Psychoanalysis	-1.8625	0.002 **	-3.1612	-0.5638
	Eclectic	Systemic	1.9643	0.054	-0.0253	3.9539
	Eclectic	CBT	1.1241	0.083	-0.0967	2.3449

backed by the scientific method).	Psychoanalysis	Systemic	3.8268	< .001 **	2.028	5.6256
	Psychoanalysis	CBT	2.9866	< .001 **	2.1105	3.8626
	Systemic	CBT	-0.8402	0.598	-2.5836	0.9032
I can attract new consultants by learning an evidence-based treatment (as a result of the scientific method)	Eclectic	Psychoanalysis	-1.8688	0.001 **	-3.1114	-0.6261
	Eclectic	Systemic	0.0848	1	-1.8189	1.9886
	Eclectic	CBT	0.9896	0.129	-0.1785	2.1577
	Psychoanalysis	Systemic	1.9536	0.019 *	0.2324	3.6748
	Psychoanalysis	CBT	2.8583	< .001 **	2.0201	3.6966
	Systemic	CBT	0.9048	0.499	-0.7634	2.5729
It is important to incorporate scientific findings into my daily practice.	Eclectic	Psychoanalysis	-1.5938	0.003 **	-2.767	-0.4205
	Eclectic	Systemic	0.9509	0.521	-0.8465	2.7483
	Eclectic	CBT	0.6752	0.39	-0.4276	1.7781
	Psychoanalysis	Systemic	2.5446	0.000 **	0.9196	4.1697
	Psychoanalysis	CBT	2.269	< .001 **	1.4776	3.0604
I am interested in learning evidence-based treatments (as a result of the scientific method)	Systemic	CBT	-0.2757	0.969	-1.8506	1.2993
	Eclectic	Psychoanalysis	-1.7062	0.002 **	-2.9188	-0.4937
	Eclectic	Systemic	0.3616	0.958	-1.496	2.2192
	Eclectic	CBT	0.8595	0.21	-0.2803	1.9993
	Psychoanalysis	Systemic	2.0679	0.009 **	0.3884	3.7473
	Psychoanalysis	CBT	2.5657	< .001 **	1.7478	3.3837
Treatments based on the scientific method are efficient/cost-effective	Systemic	CBT	0.4979	0.859	-1.1298	2.1256
	Eclectic	Psychoanalysis	-1.3188	0.023 *	-2.5076	-0.1299
	Eclectic	Systemic	1.7009	0.077	-0.1204	3.5222
	Eclectic	CBT	1.566	0.002 **	0.4484	2.6835
	Psychoanalysis	Systemic	3.0196	< .001 **	1.373	4.6663
My clients are more complex and diverse than those in clinical trials (from scientific research, e.g. randomised controlled trials).	Psychoanalysis	CBT	2.8847	< .001 **	2.0828	3.6867
	Systemic	CBT	-0.1349	0.996	-1.7308	1.461
	Eclectic	Psychoanalysis	-0.7687	0.396	-2.0325	0.495
	Eclectic	Systemic	-0.0759	1	-2.012	1.8602
	Eclectic	CBT	0.3405	0.88	-0.8474	1.5285
	Psychoanalysis	Systemic	0.6929	0.736	-1.0575	2.4432
My clients prefer treatments other than evidence-based treatments (as a result of the scientific method)	Psychoanalysis	CBT	1.1093	0.005 **	0.2568	1.9617
	Systemic	CBT	0.4164	0.921	-1.28	2.1129
	Eclectic	Psychoanalysis	0.2625	0.94	-0.9244	1.4494
	Eclectic	Systemic	0.1607	0.996	-1.6576	1.979
	Eclectic	CBT	-0.3324	0.868	-1.4481	0.7833
	Psychoanalysis	Systemic	-0.1018	0.999	-1.7457	1.5421
	Psychoanalysis	CBT	-0.5949	0.222	-1.3955	0.2057
	Systemic	CBT	-0.4931	0.854	-2.0864	1.1001

I don't have time to learn evidence-based treatments (as a result of the scientific method)	Eclectic	Psychoanalysis	-0.7437	0.156	-1.6602	0.1727
	Eclectic	Systemic	0.3438	0.921	-1.0602	1.7477
	Eclectic	CBT	-0.2081	0.924	-1.0695	0.6533
	Psychoanalysis	Systemic	1.0875	0.122	-0.1818	2.3568
	Psychoanalysis	CBT	0.5356	0.115	-0.0825	1.1538
	Systemic	CBT	-0.5519	0.653	-1.782	0.6783
Training in evidence-based treatments would cost me too much money (evidence as a result of the scientific method)	Eclectic	Psychoanalysis	-1.5875	0.007 **	-2.8509	-0.3241
	Eclectic	Systemic	0.8125	0.699	-1.123	2.748
	Eclectic	CBT	0.7199	0.399	-0.4677	1.9075
	Psychoanalysis	Systemic	2.4	0.003 **	0.6501	4.1499
	Psychoanalysis	CBT	2.3074	< .001 **	1.4552	3.1596
	Systemic	CBT	-0.0926	0.999	-1.7885	1.6033
My clinical training did not provide sufficient information about evidence-based treatments (as a result of the scientific method)	Eclectic	Psychoanalysis	-0.2688	0.863	-1.1576	0.6201
	Eclectic	Systemic	0.3348	0.92	-1.0269	1.6966
	Eclectic	CBT	-0.6938	0.141	-1.5293	0.1418
	Psychoanalysis	Systemic	0.6036	0.584	-0.6276	1.8347
	Psychoanalysis	CBT	-0.425	0.26	-1.0246	0.1746
	Systemic	CBT	-1.0286	0.118	-2.2218	0.1646
I don't know which treatments are evidence-based (as a result of the scientific method)	Eclectic	Psychoanalysis	-0.725	0.503	-2.0684	0.6184
	Eclectic	Systemic	-0.7679	0.77	-2.8259	1.2902
	Eclectic	CBT	-0.3139	0.918	-1.5767	0.9489
	Psychoanalysis	Systemic	-0.0429	1	-1.9035	1.8178
	Psychoanalysis	CBT	0.4111	0.644	-0.4951	1.3173
	Systemic	CBT	0.454	0.915	-1.3494	2.2573
My employer does not have the funds to pay for me to be trained in evidence-based treatments (as a result of the scientific method)	Eclectic	Psychoanalysis	-0.7312	0.613	-2.2767	0.8142
	Eclectic	Systemic	1.933	0.152	-0.4346	4.3006
	Eclectic	CBT	0.178	0.989	-1.2747	1.6307
	Psychoanalysis	Systemic	2.6643	0.008 **	0.5238	4.8048
	Psychoanalysis	CBT	0.9093	0.111	-0.1332	1.9518
	Systemic	CBT	-1.755	0.129	-3.8296	0.3195
The treatments I use with my clients have an empirical basis (that is, they are supported by the scientific method)	Eclectic	Psychoanalysis	-1.3188	0.023 *	-2.5076	-0.1299
	Eclectic	Systemic	1.7009	0.077	-0.1204	3.5222
	Eclectic	CBT	1.5660	0.002 **	0.4484	2.6835
	Psychoanalysis	Systemic	3.0196	< .001 **	1.3730	4.6663
	Psychoanalysis	CBT	2.8847	< .001 **	2.0828	3.6867
	Systemic	CBT	-0.1349	0.996	-1.7308	1.4610