

Feasibility and Acceptability of Implementing the SKILLS Program,
A Group Behavioral Activation Treatment for Schools

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Abstract

Anxiety and depression have been found to be highly comorbid and among the most commonly diagnosed disorders in youth. Research indicates that these disorders are generally left untreated, which increases risk for greater impairment and a longer course of psychological dysfunction. Cognitive behavioral therapy has been shown to be effective in treating youth internalizing problems, but most treatment manuals have focused on a single disorder. Transdiagnostic treatments, which focus on commonalities among disorders, may be more relevant to treating internalizing problems than standard treatment manuals. In particular, Behavioral Activation, which has been found to be a key ingredient in the treatment of depression, shows promise as a transdiagnostic treatment because of its parallel goals with exposure-based therapies for anxiety. Implementing these treatments in a school-based setting may serve to reduce the barriers to treatment and increase the number of youth receiving services for internalizing disorders. Before a treatment can be implemented in a school, a variety of acceptability and feasibility issues must first be assessed. The focus of the current study was to obtain feedback from a range of potential providers on the feasibility and acceptability of implementing a group behavioral activation treatment (GBAT), known as the SKILLS Program, in middle schools with children who have elevated levels of anxiety and/or depression. Eighteen professionals participated in the current study. Overall ratings indicated highly positive impressions of the therapist manual and workbook, and all subscales related to acceptability received close to maximum ratings. Feasibility ratings were routinely lower, indicating that respondents found that the time allotted for tasks may have been less than desirable and that some of the assigned tasks may have been challenging to accomplish in school settings. However, ratings were still above the midpoint rating, suggesting that respondents found the

program overall feasible. Despite potential challenges, individual professionals felt positive about the implementation potential of GBAT. Discussion focuses on implications of study findings, potential ways to increase feasibility, further examination of open-ended feedback, as well as limitations of the study and suggestions for future research.

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Feasibility and Acceptability of Implementing the Skills Program, a Group Behavioral
Activation Treatment for Schools

Anxiety and depressive disorders are among the most frequently diagnosed psychological problems affecting children and adolescents. It is estimated that anxiety disorders affect between 12-20% of youth, while the prevalence of depression in children is estimated to be 2%, increasing with age to 4-6% among adolescents (Angold & Costello, 1993; Cheung, Emslie, & Mayes, 2005; Kovacs & Devlin, 1998; Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993; Mineka, Watson, & Clark, 1998). Furthermore, anxiety and depressive disorders have been found to be highly comorbid, with 16-50% of youth meeting diagnostic criteria for more than one anxiety and/or depressive disorder in community samples, and up to 70% in clinical samples (Angold, Costello, & Erkanli, 1999; Kendall, Kortlander, Chansky, & Brady, 1992; Seligman & Ollendick, 1998). Research findings indicate that anxiety and depressive disorders can negatively impact functioning, interfering with family, peers, school, and extracurricular activities (Birmaher et al., 1996; Rapee, 2003).

As children grow older, these disorders are more likely to be accompanied by significant functional impairment if left untreated (Kovacs & Devlin, 1998; Rapee, Schniering, & Hudson, 2009). Additionally, comorbid disorders are associated with greater impairment and a longer course of psychological dysfunction (Kendall et al., 1992; Weissman, Antinoro, & Chu, 2008). While internalizing disorders are among the most prevalent psychological disorders diagnosed during childhood and adolescence, research shows that anxiety and depression are generally left untreated in community samples (Kovacs & Devlin, 1998). Considering the prevalence rates of these anxiety and depressive disorders during childhood and adolescence and the functional

impairment across various life domains consistent with them, this discrepancy between prevalence and access to treatment is a major health concern.

Traditional vs. Transdiagnostic Treatments

In general, cognitive-behavioral therapy (CBT) has been shown to be effective in treating youth anxiety and depression (Rapee et al., 2009; Seligman & Ollendick, 2011). CBT for child anxiety and depression typically includes some combination of skills including psychoeducation, relaxation training, cognitive restructuring, and behavioral activation or gradual exposures (Chu & Harrison, 2007; Connolly, Suarez, & Sylvester, 2011). Randomized controlled trials of skills-based CBT protocols for youth anxiety and depression have consistently demonstrated superior gains when compared to treatment as usual or wait list (Compton, Burns, Helen, & Robertson, 2002; Silverman, Pina, & Viswesvaran, 2008). These studies have typically demonstrated that approximately 55-60% of anxious youth who receive CBT show significant improvements, compared to about 30% of those on the waitlist (Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; Rapee et al., 2009). In a review of treatment for youth depression, CBT was found to consistently outperform waitlist and control conditions, producing medium to large effect sizes (Brent, Gaynor, & Weersing, 2002; Weersing, Iyengar, Kolko, Birmaher, & Brent, 2006).

One drawback to traditional empirically supported treatments is that most consist of manual-based treatments targeting a single disorder or narrow class of disorders (Chu, Merson, Zandberg, & Areizaga, 2011). Although flexibility is encouraged when approaching a disorder from a single-target treatment manual (Kendall, Chu, Gifford, Hayes, & Nauta, 1998), clear guidelines are not available to ensure fidelity in implementing the treatment manual for use with youth who have comorbid anxiety and/or depressive disorders. The abundance of treatment

manuals available for different internalizing disorders, coupled with the lack of resources available to adequately train treatment providers, may impede efforts to efficiently disseminate treatment to children and adolescents in need (Allen, Ehrenreich, & Barlow, 2005). Treatments focused on targeting psychological mechanisms common across anxiety and depressive disorders may serve to maximize and facilitate dissemination to reach a larger number of youth, making them more clinically relevant than single-target treatments. Transdiagnostic approaches to treatment are based on the clinical observation that certain psychological disorders tend to be maintained by similar pathological processes (Fairburn, Cooper, & Shafran, 2003).

Transdiagnostic treatments acknowledge that many overlapping dimensions exist among disorders, as appears to be the case for anxiety and depressive disorders. Recent research regarding nosology, phenomenology, and underlying components of internalizing disorders supports a need for a unified approach to treatment that would emphasize commonalities among disorders with considerable overlap (Barlow, Allen, & Choate, 2004). For example, one underlying factor that appears to be central to the presentation of anxious and depressive disorders among youth is avoidance of feared, challenging, or difficult situations or activities (Harvey, Watkins, Mansell, & Shafran, 2004; Jacobson, Martell, & Dimidjian, 2001). Avoidant responses are used to cope with negative feelings associated with distress. In the short-term, avoidance is successful at relieving distress but in the long-run, avoidant responses increase through negative reinforcement, often leading to secondary detrimental effects. Transdiagnostic treatments suggest thinking about internalizing disorders from a behavioral perspective, targeting the avoidant responses that typically arise when anxious or depressed youth are faced with stressors. Thus, transdiagnostic treatments are distinctive in that they suggest focusing on the common etiology and maintaining factors underlying disorders.

While CBT has been shown to be an effective treatment, concentrated behavioral therapies appear to be efficacious in the treatment of adult anxiety and depression (Barlow et al., 2004; Dimidjian et al., 2006; Jacobson et al., 1996). Behavioral therapies used to treat depression include Behavioral Activation (BA), and exposure-based treatments are considered first-line treatment for anxiety disorders (Silverman et al., 2008). A good case can be made for BA as a transdiagnostic therapy across internalizing disorders, because current empirically supported treatments for anxiety and depression emphasize similar goals. BA and exposure therapy both aim to reduce avoidance, reduce passivity, and foster new learning to increase the likelihood that an individual will approach challenging and stressful situations, experience reinforcing events, and re-engage naturally reinforcing behaviors. Through a functional analysis, BA helps individuals become more aware of contextual triggers that serve as stressors and the individual's typical response to such triggers.

Research shows that avoidance patterns tend to increasingly narrow the repertoire of behaviors in which an individual engages, resulting from a cycle of avoidance, negative reinforcement (reduction of distress), and continued avoidance. In the short term, this response style is successful at reducing distress, but it can lead to secondary problems (Jacobson et al., 2001). For example, a child with social phobia may skip school on a day that an oral report needs to be completed, leading to initial feelings of relief. However, continuously missing school to avoid participating can lead to missed class time and time away from friends or peers, which over time can negatively impact school grades and/or peer relationships. BA targets the escape and avoidance behaviors and the secondary problems that contribute to and maintain internalizing disorders by having the individual first identify where avoidance is interfering, and

second, to adopt a more approach style to engage activities that increase positive reinforcement and work to break the avoidance cycle.

Transdiagnostic Approaches in Youth

To date, a few transdiagnostic treatments targeting youth anxiety and depression have been piloted and are in various stages of development, including Integrated Brief Behavior Therapy (Weersing, Gonzalez, Campo, & Lucas, 2008), Emotion Detectives (Ehrenreich-May & Bilek, 2011), and the focus of this current study, Group Behavior Activation Therapy: The SKILLS Program (Chu, Colognori, Weissman, & Bannon, 2009). Integrated Brief Behavior Therapy is aimed at treating individuals, while the SKILLS Program and Emotion Detectives are intended to be carried out in group format.

Integrated Brief Behavior Therapy (Weersing et al., 2008) is an 8 session treatment that includes the core therapeutic elements found in disorder-specific treatment protocols for anxiety and depression. The first four sessions focus on skill building, including psychoeducation and treatment rationale, problem-solving and relaxation training, and reducing avoidance and goal-setting. The next three sessions focus on increasing engagement and activation, while the final session is focused on relapse-prevention. An initial pilot study was conducted and included 45 participants ranging in age from 7 to 17 diagnosed with an anxiety disorder, depression, or comorbid anxiety and depression. The outcomes for two participants, both with comorbid anxiety and depression, provide preliminary support for this treatment protocol, with both participants showing significant improvement in symptoms.

Emotion Detectives (Ehrenreich-May & Bilek, 2011) is a 15 session group treatment that is based on the Unified Protocol for adults (Barlow et al., 2010) and intended to be implemented in outpatient settings. The treatment focuses on emotion regulation skills and preventing

emotional avoidance through emotion exposure exercises. Parents are present at the beginning of each session, while group leaders provide psychoeducation and homework is reviewed. The parents then leave to participate in their own simultaneous group focused on parenting skills. An initial pilot study was conducted and outcomes were reported for two children who participated in the treatment. One participant met diagnostic criteria for comorbid anxiety disorders, while the other was diagnosed with one anxiety disorder and endorsed subclinical depression. Upon completing the treatment protocol, a reduction in symptoms was noted for both participants, providing initial support for this Emotion Detectives program.

Group Behavior Activation Treatment (GBAT): The SKILLS Program (Chu et al., 2009) is a 10 session program meant to be implemented in middle schools. The treatment was designed to be completed in hour-long sessions but can flexibly accommodate different schedules (i.e., shorter meetings, more sessions). The treatment focuses the core BA principles of psychoeducation, functional analysis, problem solving, and behavioral activation/graded exposures. Additionally, students have two individual meetings with a group leader at the start of the program. The first focuses on building rapport, restating the goals of the program, and assessing motivation, while the second individual meeting helps students identify personalized and meaningful goals to work towards. The initial pilot study included five students who met diagnostic criteria for comorbid anxiety and/or depression. Four of the students completed the program. Results of the study revealed support for the GBAT program, with 75% completers no longer meeting diagnostic criteria for their primary diagnosis and 75% no longer meeting diagnostic criteria for their secondary diagnosis.

Transporting Psychosocial Interventions to Schools

A transdiagnostic treatment approach targeting avoidance behaviors common to both anxiety and depression may serve to reduce some of the discrepancy between prevalence rates among youth and availability of services by allowing for more efficient dissemination. However, previous research indicates that despite the availability of effective treatments, the majority of children with internalizing disorders do not receive treatment and fewer receive evidence-based treatment (Elkins, McHugh, Santucci, & Barlow, 2011; Masia-Warner et al., 2005; Miller, DuPaul, & Lutz, 2002; Storch & Crisp, 2004). Considering that children spend a significant amount of time in school and that the school setting can reduce many barriers to treatment, school-based treatments may be ideal. Schools have access to a wide range of children from different demographic backgrounds, some of whom would otherwise not receive the treatment they need (Weissman et al., 2008). Availability of evidence-based treatment at schools would eliminate the cost and transportation needs of families who have limited resources. Given that schools are generally located within the child's community and they represent a familiar setting where there is already an established relationship, parents may be more comfortable having their children participate in school-based treatment programs. Thus, these factors may reduce perceived stigma associated with receiving mental health services (Angelosante, Colognori, Goldstein, & Masia-Warner, 2011). Schools may be one of the settings where noticeable impairment is occurring for some children, and with trained professionals on staff who have expertise in child development, this allows for more frequent observation and communication between school personnel and treatment providers. Furthermore, the school setting allows for practicing behavioral strategies in a more naturalistic setting, which will likely expedite the generalization of the skills (Evans, 1999; Storch & Crisp, 2004).

Any treatment program intended to be delivered in schools should be evaluated for a variety of feasibility and acceptability issues related to the school. Feasibility and acceptability issues may in fact be more important to assess in schools because of the unique school aspects that need to be taken into account (e.g., non-mental health setting, non-treatment seeking population). School counselors or school psychologist would be likely candidates to carry out treatment protocols for children and adolescent with internalizing disorders, making it important to evaluate the acceptability of different psychosocial interventions to such school staff. School counselors may question the appropriateness of a coping skills/mental health program in schools where the primary objective is education (Miller et al., 2002). Potential providers may doubt their own ability to deliver this type of program. They may not feel it is appropriate to take on the additional responsibilities of participating in training and implementing the treatment, and may request an increase in pay or less responsibilities in other areas of their job (Angelosante et al., 2011).

Administrative and resource issues are also a concern. Schools will have questions about which personnel or faculty would lead a behavioral program in school. For example, schools will be concerned about whether the school can afford to find release time for that provider. Schools might also be concerned about whether their personnel have the training or skills required to lead behavioral treatment groups, and if not, how these skills would be obtained, who would do the training, and how would the expenses be covered (Angelosante et al., 2011; Weissman et al., 2008). Providers, themselves, may not feel they have the administrative support (e.g., release time, support for training) or resources (rooms, teaching materials, ongoing supervision). They may even worry that they will not have the support of their fellow faculty. For example, they

may be concerned that other school counselors/school psychologists will object to their participation or resent providing coverage for the staff leading the groups.

The Current Study

The purpose of this study was to obtain feedback from both experts in the field and a range of potential providers (end-users) on the feasibility and acceptability of implementing a group behavioral activation treatment (GBAT), known as the SKILLS Program, in middle schools with children who have elevated levels of anxiety and/or depression. The feasibility and acceptability was evaluated by obtaining feedback from experts selected to represent a broad range of relevant professionals who might have opinions about psychological treatments delivered in schools or professionals who might be expected to deliver the treatment (i.e., clinical psychologists, school psychologists, graduate students in psychology masters/doctoral program). Surveys obtained the perception of the overall quality of the treatment manual and workbook, assessed the treatment's success in achieving its objectives, and examined perceived feasibility and acceptability of this program for school settings.

Treatment acceptability refers to the degree to which an individual (layperson, patient, professional, or other) perceives a treatment protocol as appropriate, fair, and reasonable for a given population or problem (Tarrier, Liversidge, & Gregg, 2006). Research regarding treatment acceptability is particularly important, given that treatments deemed as unacceptable are less likely to be utilized regardless of their effectiveness (Miller et al., 2002). Furthermore, research suggests that aside from increasing the probability of utilization, acceptability also impacts the degree of integrity to which the treatment protocol is carried out (Tarrier et al., 2006). Given that most of the research on acceptability of school-based treatment for children and adolescents has focused on treatment protocols for externalizing disorders (Miller et al., 2002), the research

examining acceptability of treatment for youth internalizing disorders is lacking. If schools are to play an integral role in reducing the discrepancy between the high prevalence rates of internalizing disorders among youth and access to care, issues related to treatment acceptability need to be further researched.

Hypotheses

Acceptability. In therapist ratings of acceptability, it was hypothesized that there would be no differences in how discipline groups (clinical vs. school) and professional level groups (practicing professional vs. student) rated clarity of content, amount of information, appropriateness of use with target population and acceptability/efficacy. It was hypothesized that clinical psychologists and clinical psychology doctoral students would differ from school psychologists and school psychology doctoral students in how they rate consistency with theory and utility of session. It was thought that school professionals and students may have less prior knowledge or exposure to behavioral therapy than clinical professional and students, contributing to differences. It was also hypothesized that school psychologists and school students would differ from clinical psychologists and clinical students in how they rate organizational support because they may have more insight or specific opinions about how administrative personnel would respond and they may be more aware of barriers present within schools. We were also interested in exploring how implementation beliefs (availability of resources, administration support) differed depending on professional level (practicing professional vs. student). The literature in this area is limited, so these analyses should be considered exploratory.

Feasibility. It was hypothesized that there would be significant differences in how school psychologists and school graduate students rate the feasibility of carrying out the goals/interventions of the treatment in a school setting compared to clinical psychologists and

clinical graduate students. School psychologists and school graduate students may be more aware of potential barriers and time constraints, which could influence their ratings.

Methods

Participants

Eleven professionals with a doctoral degree in either clinical or school psychology (Mean years since graduation = 12.2; range: 3-27) and seven graduate students enrolled in either a clinical or school psychology doctoral program (Mean year in program = 3.1; range: 2-5) served as participants. Sixty-one percent of participants were female. The majority of participants (56%) identified their theoretical orientation as Cognitive or Cognitive-Behavioral, 11% as Psychodynamic, 11% as eclectic, 11% as Behavioral, 6% as Systems, and 6% as Interpersonal. Twenty-eight percent reported not using a treatment manual with any of their current cases, 44% of participants indicated using a treatment manual for up to 25% of their caseload, 6% reported using a treatment manual for 25-50% of their caseload, and 22% reported using a treatment manual for 75-100% of their caseload.

Inclusion criteria were licensed clinical or school psychologists, graduate students enrolled in either a clinical or school psychology doctoral program, or school counselors. Participants had to be willing to review the treatment materials and complete a 15-item questionnaire about ten weekly group sessions and an additional questionnaire based on the overall treatment manual. Exclusion criteria consisted of first-year doctoral students as it was thought they might not have sufficient experience to formulate opinions on the acceptability and feasibility of the treatment program. The sample was recruited to represent a broad range of individuals who have experience working with children, implementing evidence-based treatments, and might have opinions about delivering psychological treatments in schools.

Measures

Two measures were used to assess the acceptability and feasibility of implementing the SKILLS program in schools. One measure was completed for each of seven distinct treatment sessions, and the other measure was completed to evaluate the overall treatment program.

GBAT Manual Rating Form. The GBAT Manual Rating Form (MRF) is a 13-item measure that was developed for this study and completed by all study participants, providing feedback on the acceptability of each session of The Skills Program using a 1 to 7 point scale with varying anchors. For items #2 and #9, (“How much information did the manual include?” and “How much did the manual allow for flexibility in this session?”), the most acceptable rating equated to 4 “The right amount” in a range of 1 “Not at all enough/too rigid” to 7 “Too much information/not enough guidance.” All other items ranged from 1 “Not at all easy” or “Not at all” to 7 “Very easily understood” or “Very much.” The focus of the questionnaire included questions on clarity of content (1 item), amount of information (1 item), consistency with theory (1 item), appropriateness of use with target population (2 items), utility/helpfulness of session strategies (1 item), feasibility (2 items), flexibility of manual (1 item), and overall contribution of the session techniques to the goals of the treatment (1 item). Mean scores were calculated for all 8 items that had consistent anchors and subscale scores were calculated mean scores of subscale items. Participants also answered three open-ended items to provide feedback about the manual and its contents: unnecessary elements of the session, if important elements missing in the session, and to offer any other comments about the session.

Implementation Potential Scale. The Implementation Potential Scale (IPS; Forman, Fagley, Chu, & Walkup, 2012) is a 30-item measure adapted from existing treatment acceptability scales (e.g., Miller, DuPaul, & Lutz, 2002) and constructs drawn from the treatment

implementation literature (Rogers, 2003). A short-form of the IPS was used here where the 14 items with the highest factor loadings to their respective subscales were kept (Forman et al., 2012). The four subscales characterize the potential of a treatment to be implemented by service providers including, treatment acceptability/efficacy (4 items), availability of organizational support (3 items), availability of administrative support (3 items), and an individual's (respondent's) reported intention to use the treatment (4 items). Items are rated on a 6-point Likert scale, ranging from 1 ("Strongly Disagree") to 6 ("Strongly Agree"). The coefficient alpha for the current sample is 0.66.

Treatment Manual

The SKILLS Program is a manual-based, group behavioral activation therapy (GBAT) aimed at treating youth with elevated anxiety and depression in a school setting. The 10-session program uses behavioral activation (BA) strategies to target anxiety, sad mood, and anger. Through the program, youth learn coping strategies and work towards achieving goals to improve functioning in numerous domains (Chu et al., 2009). The program targets individualized goals based on a functional assessment of numerous life domains including family and peer interactions, school, extracurricular activities, and health and self-care. The overall structure of the program is based on the SKILLS acronym, which serves as a model for problem solving and approaching difficult situations that typically keep students from engaging in activities.

The SKILLS acronym is structured after the four core principles of behavior activation which consist of psychoeducation, functional analysis, problem solving and exposures and/or behavioral activation (Chu et al., 2009). The first step, "See where I'm stuck," encourages students to assess their current functioning, which helps them to determine where they need to make improvements. They are instructed to think about where improvements can be made in

terms of areas where they are underperforming or feeling overwhelmed. Step 2, focuses on helping students to “Keep active and keep approaching.” Here the idea is to help foster an understanding of how avoidance maintains anxious and/or sad feelings, while actively approaching challenging experience will ultimately help them get more out of life. Next, the program helps students to more specifically “Identify goals [I] want to achieve” and barriers that keep them from obtaining their goals. In this way, the program can be individualized to the needs of each individual student. This step really targets creating an awareness of typical avoidant behavioral patterns that the students get stuck in. Here the TRAP acronym (Trigger, Response, Avoidance Pattern) is introduced and the group leaders stress the importance of practicing to achieve both competence and confidence. “Look for ways to accomplish my goals” focuses on specific problem solving techniques that are encapsulated in the acronym TRAC (Trigger, Response, Active Coping). This step guides students in breaking down goals into smaller, attainable steps. “Lasting change” sets out to help students accomplish their goals through guided practice, such as in vivo exposures and/or behavioral activation. Students are encouraged to pick a goal and take steps towards achieving that goal. By practicing in session first, potential barriers can be identified and problem-solved with the help of other group members and the group leader. The final step is to “See what’s worked.” At this point, the students are asked to re-evaluate their functioning in each of the domains, noting where they see improvements and where there is still work to be done. The focus of this last step is to ensure that students take appropriate steps to maintain the gains they’ve made and keep working in areas where improvement is still needed. While the skills program emphasizes skill building, particularly around functional assessments and problem-solving, a major component of the treatment is exposures and behavioral activation.

Procedures

Participants were recruited through university-based, graduate and alumni listservs, as well as through contacts at local elementary and middle schools. Thirty individuals responded to a recruitment email, expressing interest in participating in the study. These thirty individuals were mailed study materials including a cover letter with instructions, the SKILLS workbook, therapist manual, seven copies of the Manual Rating Forms for each distinct treatment session, one copy of the Implementation Potential Scale, and a self-addressed, stamped envelope. Participants were asked to return the completed questionnaires in the self-addressed, stamped enclosed envelope within six weeks of receipt. For their participation, study participants were told they would be entered in a raffle for a \$50 gift card. All procedures were approved by the university Institutional Review Board.

Eighteen participants, representing clinical and school psychologists as well as clinical and school doctoral students, reviewed the materials and returned all eight questionnaires, fully completed. Twelve initially interested individuals did not return the materials and did not respond to multiple efforts to retrieve study materials. These individuals included licensed clinical psychologists ($n = 4$), licensed school psychologist ($n = 2$), clinical and school doctoral students ($n = 3$) and school counselors ($n = 3$). Thus, although an effort to recruit school counselors was made, none completed study participation.

Analyses

Means, standard deviations (SD), and ranges were computed for each IPS and MRF subscale and total score. To test the hypotheses that there would be no difference in how groups rated clarity of content, amount of information, appropriateness of use with target population, and acceptability/efficacy, separate ANOVA were conducted with each acceptability subscale

entered as the dependent variable and the professional level (doctoral vs. student) entered as the independent variable. A second set of ANOVA was conducted using these same acceptability subscales as the dependent variable and the discipline group (clinical vs. school) entered as the independent variable. To test the hypotheses that there would be differences in how discipline groups rate consistency with theory, utility of session, feasibility, and organizational support, separate ANOVA were conducted with each acceptability, feasibility, or implementation subscale entered as the dependent variable and the discipline group (clinical vs. school) entered as the independent variable. Additional ANOVA were conducted using the implementation subscales as the dependent variable and professional group (professional vs. student) as the independent variable on an exploratory basis.

A qualitative analysis of the three Manual Rating Form (MRF) open-ended items was conducted by looking for themes among the answers provided by participants. The content of the information provided in the open-ended questions was assessed for similarities and categorized accordingly. To benchmark the acceptability of GBAT, the Implementation Potential Scale (IPS) subscale and total scores were compared to prior IPS scores administered to psychologists assessing acceptability of a traditional cognitive-behavioral treatment for pre-teen depression (Forman et al., 2012).

Results

Similarity between therapist caseload and context of GBAT

Participants were asked to provide information about their caseload, as well as their experience with manualized treatment. Twenty-eight percent of participants reported up to 25% of their current caseload had a primary diagnosis of anxiety, 39% indicated that 25-50% of their caseload, 28% said between 50-75%, and 6% said 75-100%. Six percent of participants indicated

that none of their cases have a primary diagnosis of depression, 22% of participants reported up to 25% of their caseload has a primary diagnosis of depression, 44% of participants indicated that 25-50% of their caseload, and 28% of participants said between 50-75%. The majority of participants (78%) indicated that they have previously provided a treatment similar to the SKILLS program. Fifty-six percent indicated that they had previous training in a similar treatment.

Participant rating of appropriateness for and consideration of use with caseload

In addition to providing information about caseload and experience with manualized treatment, participants were also asked to consider the appropriateness of using the entire SKILLS program or its specific strategies with their current cases. Eleven percent of participants indicated that the entire manual would be appropriate for up to 25% of their caseload, 11% participants endorsed 25-50%, 22% participants said 50-75%, and the majority of participants (56%) said it would be appropriate for 75-100% of their caseload. When asked to consider the appropriateness of using selective parts of SKILLS for their caseload, 6% indicated it would be appropriate for up to 25%, 11% participants said 50-75%, and 83% participants said 75-100%. Table 1 shows participant report of the percentage of anxious/depressed youth for which participants believe specific components of the SKILLS program component would be appropriate.

Participants were also asked to rate the percent of their caseload for which they would actually consider using the entire SKILLS program or specific aspects. Eleven percent of participants indicated that they would not consider using the entire manual for any of their cases. Eleven percent indicated they would consider using the manual for 25-50% of their caseload, 22% participants said 50-75%, and the majority of participants (56%) said 75-100%. When

asked to consider the percentage of their caseload for which they would actually consider using specific aspects of the program, 6% of participants said they would use selective aspects of the program with up to 25% of their clients, 11% participants said 50-75%, and 83% participants said 75-100%. Table 1 shows participant report of the percentage of anxious/depressed youth for which they would actually consider using specific aspects.

Acceptability and Feasibility

Table 2 summarizes participants' perception of GBAT workbook and therapist manual, including six subscales of the Manual Rating Form (MRF) for each of seven key sessions, as well as participants' overall perception of each subscale. For six of eight subscales, each item was rated on a 0-7 scale with the maximum score of a seven indicating a very favorable response. For the amount of information and flexibility subscales, a score of four indicated the most favorable response, indicating that certain aspects of the manual were perceived as "just right," a score of one indicated that there was "too little information," and a score of seven indicated "too much information."

For all sessions, the majority of subscales had ratings above six with narrow ranges, indicating participants viewed GBAT favorably on nearly all dimensions across all sessions. The amount of information and flexibility subscales were consistently close to the most favorable rating of 4 across sessions (overall $M = 4.51$, $SD = 0.25$ and $M = 3.99$, $SD = 0.08$, respectively). Range of means across sessions for these subscales was: amount of information (4.17-4.89) and flexibility (3.89-4.11). Of the eight subscales, six assessed participants' acceptability of the GBAT workbook and therapist manual. Overall, participants rated the acceptability favorably across sessions on clarity ($M = 6.54$, $SD = 0.15$), amount of Information ($M = 4.51$, $SD = 0.25$), consistency with theory ($M = 6.54$, $SD = 0.05$), appropriateness of use with target population (M

= 6.2, $SD = 0.17$), utility of session ($M = 6.41$, $SD = 0.16$), flexibility ($M = 3.99$, $SD = 0.08$) and overall contribution of session techniques to the goals of the treatment ($M = 6.39$, $SD = 0.12$).

Range of means across sessions for each subscale was: clarity of content (6.39-6.78), amount of information (4.17-4.89), consistency with theory (6.44-6.61), appropriateness of use with target population (5.92-6.39), utility of session (6.11-6.56), flexibility (3.89-4.11) and overall contribution of session techniques to the goals of treatment (6.22-6.56). The feasibility subscale of the MRF achieved the lowest ratings in overall and session scores. Overall mean was 5.65 with a SD of 0.41. Across sessions, a large range was found (5.17-6.28). For sessions 1, 3, and 4, the Feasibility subscale had the lowest ratings with scores that ranged from 3.5-7 ($M = 5.17$, $SD = 1.03$), 1-7 ($M = 5.25$, $SD = 1.60$) and 4.5-7 ($M = 5.31$, $SD = 1.06$). Although scores were still above the midpoint rating of “4” (somewhat feasible), these items were routinely scored lower than others assessing acceptability. The two items associated with the Feasibility scale that were consistently rated lower were Item #7 on the MRF ($M = 5.62$, $SD = 0.47$) and Item #8 on the MRF ($M = 5.67$, $SD = 0.42$). Item #7 assessed “the likelihood that [the therapist] would be able to accomplish the goals of the session in the time allotted.” Item #8 assessed “the likelihood that [the therapist] could accomplish the session tasks in a school setting.” See Table 2 for means for each session and subscale.

ANOVA were conducted to examine hypotheses related to the MRF acceptability and feasibility subscales. No significant differences were found between discipline groups or professional level on subscales related to acceptability scales (clarity of content, amount of information, appropriateness of use with target population; all $p > .05$). Additionally, no significant differences were found in all ANOVA comparing discipline groups (clinical vs. school) on measures of feasibility ($p > .05$).

Implementation Potential

Table 3 summarizes participant perception of GBAT's implementation potential (IPS). In general, individual professionals and students felt positive about the implementation potential of GBAT. Overall, high mean IPS ratings were found for acceptability/efficacy ($M = 5.46$), organizational support ($M = 4.96$), administrator support ($M = 4.98$), and commitment to implementing the protocol ($M = 5.08$). Range of means across professional and discipline groups was: acceptability/efficacy (5.17-5.63), organizational support (4.22-5.27), administrator support (4.50-5.27), and commitment to implementing the protocol (4.83-5.38). ANOVA indicated a significant difference between psychologists and students in Organizational support, $F(1, 16) = 10.64$, $p = .05$, where practicing psychologists ($M = 5.24$, $SD = .45$) perceived greater organizational support for the implementing GBAT in schools than clinical and school students ($M = 4.52$, $SD = .47$). No significant differences were found in ANOVA comparing professional vs. student ($F(1, 16) = 0.03$, $p = .873$) and comparing school vs. clinical groups ($F(1, 16) = 0.46$, $p = .510$) on the acceptability/feasibility subscale of the IPS. Additional ANOVA conducted on an exploratory basis found no other significant differences between the professional level groups on the IPS. See Table 3 for means across participant groups for each subscale.

Benchmarking acceptability of GBAT

Although there is no benchmark to compare MRF scores to, the IPS has been administered to a national sample of school psychologists assessing acceptability of a traditional cognitive-behavioral treatment for pre-teen youth with depression (Foreman, Fagley, Chu, & Walkup, 2011). IPS subscale and total scores were compared to these prior scores to benchmark acceptability of GBAT. Mean ratings on all subscales of the IPS were higher for GBAT than for

the generic CBT program described in the original study: acceptability/efficacy subscale (GBAT: $M = 5.46$ and original study: $M = 4.64$), organizational support (GBAT: $M = 4.96$ and original study: $M = 3.96$), administrative support (GBAT: $M = 4.98$ and original study: $M = 4.20$), and implementation commitment subscale (GBAT: $M = 5.08$ and original study: $M = 4.26$).

Qualitative analysis of acceptability and feasibility

Participants were provided with an opportunity on the GBAT Manual Rating Form (MRF) to give open-ended feedback about the manual and its contents in three additional questions asking if there were any unnecessary elements of the session, if important elements missing in the session, and to offer any other comments about the session. Overall, there were 116 comments across the seven key sessions of the treatment manual, with session 1 containing more comments ($n = 30$) than the other sessions ($r = 9-19$). These comments were categorized into one of eight themes, including: too much content, needs more cultural sensitivity, positive evaluation of session/specific aspect, questions/concerns about content/specific aspect, negative feedback on content/specific aspect, suggestion for minor change to session, content not developmentally appropriate, or other.

Of the total comments, the category that had the highest rate of comments was positive evaluations of the session/specific aspects of the session being assessed (35%). One respondent indicated that the “material is very usable and very accessibly having not been familiar with behavioral activation before.” Another respondent said, “Great materials. I think the kids will respond well to them.” The theme that had the next highest amount of comments was too much content (23%). The sessions that seemed to produce the most feasibility comments stating that there was too much material were 1 (30% of comments), 3 (32% of comments), and 4 (31% of

comments). This was consistent with the feasibility subscale on the MRF, which had the lowest ratings on sessions 1, 3, and 4. Comments in these sessions included, “too many objectives,” “it would be hard to do everything in the session and allow time for discussion,” and “amount in this session is biggest concern.” Across all sessions, there were some suggestions for minor changes to the session content, which accounted for 16% of the overall comments. For example, one participant suggested that the authors “add discussion of long and short term goals and how they can conflict with each other” and others suggested that the workbook “include more visuals and pictures”. See Table 4 for more details.

There were several other themes that contained fewer comments across sessions. Responses related to the need for more cultural sensitivity, which came up most in session 1 (10%) and session 2 (22%), and accounted for 5% of all comments. For example, respondents noted that the workbook should “explore culturally salient terms for feelings” and “should provide opportunity to assess stigma or cultural ways of understanding behavior.” Related to the functional assessment and setting goals, one respondent suggested that the authors “be careful of reinforcing values that are asyntonic to the family values.” Negative evaluations of wording or specific aspects of a session accounted for 10% of the comments related to session 1, 11% of the comments related to session 2, 5% of the comments related to session 3, and 6% of the comments related to session 4. For example, one participant commented that a technique suggested for reducing anger was “not realistic.” Another participant indicated that “the language seems like it might be condescending to kids, such as the phrase ‘get ‘er done.’”

Questions/concerns about the content/specific aspects of session came up infrequently and included comments like, “wondering how different target emotions fit together.” These comments accounted for 6% of total comments. Comments related to the developmental

appropriateness of the language used or exercises in session accounted for 5% of total comments. For example, one participant had concerns about the use of an activity/mood chart with younger children or lower functioning teens. See Table 4 for complete breakdown of comments across categories for each session.

Discussion

The aim of this study was to assess the acceptability and perceived feasibility of implementing GBAT in a school setting. Eighteen adults, representing a range of professionals who might implement GBAT in their work setting were asked to complete a 13-item Manual Rating Form to assess the feasibility and acceptability of interventions prescribed in each session. Participants also completed a 14-item brief Implementation Potential Scale (IPS; Forman et al., 2012) to assess the overall potential for the intervention to be implemented in the respondent's current practice (clinic, school, or hospital). Consistent with hypotheses, GBAT was acceptable overall.

Questionnaires also asked participants about their current or recent caseload, prior experience being trained in a treatment similar to GBAT, experience implementing a treatment similar to GBAT, the appropriateness of using either the entire GBAT manual or components of it with their caseload, and the likelihood that they would actually consider using the entire program or components of it with their caseload. The majority of participants indicated that at least 25% of their caseload had a primary diagnosis of anxiety, and at least 25% had a primary diagnosis of depression. The majority of participants (78%) had previously provided a similar treatment and/or previously had training in a similar treatment (56%). Participants of this study appeared to have adequate experience with the target populations for this treatment and reasonable experience with manualized treatment to provide feedback on the content. After

reviewing the materials, the majority of participants (56%) indicated that the entire program would be appropriate for 75-100% of their caseload, and 83% said components would be appropriate for 75-100% of their caseload. The same ratings were given when asked about the likelihood that they would actually consider using the whole program (56%) or components of it (83%). These responses were consistent with the overall acceptability of the GBAT program in this study.

Treatment acceptability refers to the degree to which an individual perceives a treatment protocol as appropriate, fair, and reasonable for a given population or problem (Tarrier, Liversidge, & Gregg, 2006). Participant ratings on acceptability scales of the MRF indicated highly positive impressions of the therapist manual and workbook. All items (clarity of content, consistency with theory, appropriateness for use with target population, utility/helpfulness of session strategies, and the overall contribution of the session techniques to the goals of the treatment) received average ratings of 6.0 or greater for almost all sessions, indicating close to maximum ratings on acceptability. The two subscales, amount of information and flexibility, with “4” as the most desirable score both routinely received ratings close to “4” indicating that those aspects were considered “Just right.”

These findings are important considering the potential implications that acceptability has on the application of GBAT, as well as the potential barriers that come with transporting psychosocial treatments to school settings. Though an initial pilot study found GBAT to be effective in reducing symptoms of anxiety and depression (Chu et al., 2009), prior research has found that treatments considered to be unacceptable are less likely to be utilized, regardless of research demonstrating their effectiveness (Miller et al., 2002). Given that GBAT is a novel

treatment, assessing acceptability was a necessary step towards implementation on a larger scale and within school settings, and the results of this study show promise.

Though still rated favorably, feasibility ratings were routinely lower, with mean scores ranging from 5.17 to 6.28 across sessions. These scores were still above the midpoint rating of "4" (Somewhat feasible); however, this indicated that respondents found that the time allotted for tasks may have been less than desirable. For example, qualitative comments suggested participants thought there may have been too many objectives in some sessions, and that some of the assigned tasks may have been challenging to accomplish in school settings. Concerns related to feasibility are of significance given that research shows that treatment programs rated low on feasibility are less likely to be implemented (McHugh, Murray & Barlow, 2009).

Treatment sessions 1, 3 and 4 received the lowest feasibility ratings, though still above the midpoint rating of "4" and ranging from 5.17 to 5.31. Data from these three sessions in particular show the importance of assessing feasibility amongst potential providers, as well as the benefit of involving school personnel in the development of GBAT to ensure its structure and content are feasible and appropriate for schools. It should be noted that the GBAT developers included a section in the group leader manual that identified key objectives to prioritize if time was tight. Nevertheless, these findings suggest that perhaps more guidance was needed in structuring the sessions so that key objectives were covered more feasibly or more creatively. This could be done through more explicit instruction in the group leader manual, though group leaders with less experience facilitating groups and/or with less background knowledge of the program's core principles may still experience difficulty with managing time and objectives. Alternatively, it may be necessary for the developers to review the content of these three sessions and determine if there is a way to divide them into more sessions with fewer goals. The latter

solution would reduce concerns about time but would have implications for the overall length of the program. Increasing the number of sessions may be of concern to school personnel and could bring about a different set of feasibility issues (e.g., ability of group leader to commit to longer duration, student missing more weeks of a particular class, etc.).

In comparing sessions with the lowest ratings (1, 3, and 4) to the remaining key sessions (2, 5, 6 and 10) that received feasibility ratings between 5.81 and 6.28, those sessions rated higher on feasibility appeared to have fewer objectives. The three sessions with lower feasibility ratings each had 6-8 objectives while the remaining key sessions each had 4 objectives. Additionally, the objectives were potentially more manageable in terms of the time needed to describe them, which could potentially leave more flexibility and time for group discussion. Session 1 of the manual had the following therapist objectives: review confidentiality, discuss basic ground rules, introductions and ice breakers, description of the group and goals of the program, help students identify situations that cause them to feel “stuck,” introduce the concept of “getting active” to improve mood (involved three activities to target each of three emotions: anxiety, sadness, and anger), review main lessons of session and assign take-home practice. The objectives of this session were necessary to help group members have a general understanding of the overarching principles of the group (e.g., feeling stuck and getting active), as well as to increase familiarity with the group members and leaders. The challenge to splitting up this session is that group members could potentially leave the session lacking a clear understanding of the purpose, which could possibly impact their buy in and commitment. Alternatively, the goal to introduce the concept of “getting active” to improve mood could possibly be merged with another session, as long as it does not lead to similar feasibility issues with other sessions. In fact, this particular

goal was not one identified as a component to prioritize if the group leader deemed length of time to be an issue.

Session 3 had the following objectives: review activity/mood chart homework, discuss activities for “getting active,” introduce distress loop for each of three emotions (anxiety, sadness and anger), introduce downward distress spiral, review main lessons of session and assign take-home practice. These objectives were thought to fit together nicely and build off one another. In hindsight, dividing this session into two sessions, one focused on getting active and the other focused on distress loops and the distress spiral, could reduce perceived feasibility issues related to meeting all the goals of this one session. Additionally, the activity from session 1 (introduce the concept of “getting active” to improve mood (involved three activities to target each of three emotions: anxiety, sadness, and anger) could easily be merged with the activation activities in session 3 to make a new session. Again, careful consideration would need to be made about increasing the number of sessions with the GBAT program.

The objectives for Session 4 included: review personalized distress spiral homework, define avoidance and anger, introduce TRAP acronym and explain how distress loops are maintained by avoidance, introduce Goals ladder, review main lessons of session and assign take-home practice. The priority for this session included all objectives except the introduction of the Goals ladder. This determination was made because following session 4, group leaders meet with each member in individual sessions during which the goal is to create an individualized goal ladder. Perhaps this goal could be left out of session 4 altogether or it could be made more clear to potential providers that this is not a mandatory objective of the session.

The above issues related to feasibility, though not alarming when considering the favorable ratings, have important implications for the GBAT program related to dissemination

and sustainability. Though there have been studies evaluating the transportability of evidence-based treatments (EBTs) into school settings (Masia-Warner et al., 2005; Mufson, Dorta, Olfson, Weissman, & Hoagwood, 2004), there is a general dearth of research examining adaptations needed to make EBTs more feasible and transportable (Hoagwood, Burns, & Weisz, 2002). Researchers who had at least preliminary success in transporting EBTs to schools have recommended that treatments be flexible while maintaining fidelity to the intervention, involve communication and dialogue with potential providers, and involve training opportunities for potential providers. These researchers also suggest that treatment manuals be easy to use, provide practical information on implementing treatments across a range of settings and systems, and clearly define components of the manual essential to maintain effectiveness and aspects that can be modified (Masia-Warner et al., 2004 & Mufson et al., 2004). Although the GBAT developers attempted to provide guidance within the group leader manual to support flexibility and promote feasibility, the current study provides valuable feedback that can further development to reduce potential barriers to transportability to and sustainability in schools.

In addition to the data collected through the acceptability and feasibility subscales, important information was also learned from open-ended participant feedback. Overall, the feedback from participants contained many positive evaluations of the session or specific aspects of each key session being assessed. Comments related to the session containing “too much material” were consistent with feasibility ratings on the MRF and most notable for sessions 1, 3 and 4. The next highest category of comments included suggestions for minor changes to session content. Additional comments were made, though to a lesser degree, expressing negative evaluations of the language or specific techniques/aspects of a session, questions/concerns about

the content/specific aspects, and developmental appropriateness of either the language or exercises used in sessions.

Interestingly, and perhaps less anticipated, were responses related to the need for more cultural sensitivity. All comments related to cultural sensitivity were provided in the first two treatment sessions. Related to session 1, comments recommended “a stronger consideration of culture,” including “exploration of culturally salient terms for feelings,” an “opportunity to assess stigma” and discussion of “cultural ways to understand behavior.” Comments in session 2 were related to an activity during which group members were encouraged to assess different life domains (e.g., school, extracurricular activities, friends and family) by rating them as “maxed out” (overloaded with responsibilities, pressures or expectations), “just right” (sufficiently challenged and engaged) or “under-performing” (not living up to potential). Specifically, one participant expressed concern about “reinforcing values that are asyntonic to the child and/or family cultural values.” The participant further indicated that “what might be considered ‘just right’ or ‘overloaded’ might be different depending on the family’s culture or ethnic values.”

Though these comments were few and only accounted for a small percentage of the total number of comments, it is important to explore how more openness could be accomplished. This is especially relevant given the potential for the GBAT program to be implemented into school settings with diverse populations. Perhaps the group leader manual can encourage more of a discussion around cultural/familial background and stigma related to discussing feelings like anxiety, sadness, and anger. When assessing different life domains, discussion can include how values and expectations may be different depending on cultural differences. Perhaps examples could be provided to demonstrate some of these differences and group leaders can include these examples at their own discretion depending on the population they are working with. Further

exploration on ways to establish openness are needed to insure that GBAT can be implemented in a cultural sensitive way that will reduce any feelings of isolation that group members might experience.

In addition to the data collected through the MRF on the acceptability and feasibility scales, as well as through open-ended comments, participants rated the implementation potential of GBAT on the IPS. Ratings on this measure, which was adapted from existing treatment acceptability scales, were favorable across all four subscales: treatment acceptability/efficacy, availability of organizational support, availability of administrative support and an individual's (respondent's) reported intention to use the treatment. Furthermore, participant ratings of GBAT were found to be higher than ratings for a generic CBT program as rated by a national sample of school psychologists. Though our sample size was much smaller than that of the original study, the favorable ratings show promise for the potential of GBAT to be utilized in schools.

Several hypotheses were explored based on potential differences between groups (professional vs. student; clinical vs. school) on various subscales. No significant differences were found in how participant groups rated the acceptability/efficacy scale of the IPS, suggesting that all participants found the program equally acceptable and efficacious. See Table 3 for means across participant groups for each subscale. In the exploratory analyses, there were no significant differences between how professional level groups rated Acceptability/Efficacy, Administrative Support, or Implementation Commitment; however, there was a significant difference in ratings on the Organization Support scale. Psychologists rated more organizational support for the implementation of GBAT program in schools than doctoral students. This was contrary to the original hypothesis, which stated that school psychologist and school doctoral students may rate Organization Support lower since they may have more insight or specific opinions about how

administrative personnel would respond and they may be more aware of barriers present within schools. On the contrary, given that clinical and school psychologists are likely to have had more experience working in school settings, they may be more familiar with resources that would be available for implementing programs like GBAT than doctoral students, and perhaps have had positive experiences with new initiatives within schools themselves. Experienced professionals may also have greater experience or confidence in working around low resourced settings when they are committed to implementing a program. Doctoral students may have less knowledge of possible resources or support and may have been making negative assumptions about how much organization support would be available.

Additional hypotheses did not find significant differences as originally expected. It was hypothesized that there would be significant differences between discipline groups related to how they would rate consistency with theory, utility of session, and feasibility. It was thought that school psychologists and school doctoral students would have less prior knowledge of behavioral therapy, which would impact their ability to determine if the principles in each session were consistent with the theory and/or if the session itself was a useful component of the overall treatment. It is possible that significant differences were not found because the majority of participants (78%) had previously utilized a treatment similar to GBAT, and many participants (56%) had prior training in a similar treatment. Thus, participants may have had more familiarity with behavioral therapy and principles than previously anticipated.

Finally, it was hypothesized that there would be differences in how discipline groups would rate feasibility given that school psychologists and school graduate students would be more aware of potential barriers to implementing a program like GBAT in schools. This hypothesis was not supported. Information was not collected on prior experiences or years of

experience working in a school setting, though it would be interesting to know how similar discipline groups might have been in their experience.

Overall, despite minor potential challenges related to feasibility and a few concerns about cultural sensitivity, individual professionals felt positive about the implementation potential of GBAT.

Limitations to Current Study

Though this study provides valuable information for the development of the GBAT program, there are several important limitations to the current study. One of the most salient is the sample size. There were eighteen participants across four different participant groups, with the smallest group containing only three participants (school doctoral students) and the largest group containing six participants (school psychologists). Given this small number, it is hard to know if the findings of this study would generalize to other potential providers, and providers who may have less experience or training with manualized treatment and/or less familiarity with behavioral interventions.

Other limitations are related to the survey methodology. In particular, the recruitment pool was limited in that the main method of recruitment was through a single graduate school's listservs for current students and alumni. This presents limitations because it is possible that since all participants came from a single doctoral program, there may have been more similarities than differences in their training and experiences compared to having professionals participate from a range of doctoral programs.

Additionally, the email used for recruitment specifically stated that this study was to obtain feedback on a group treatment program using behavioral activation. Those who agreed to participate might have been drawn to the study because of the emphasis on manualized treatment

and/or behavioral intervention. In fact, 78% of participants reported having prior experience with manualized treatment similar to GBAT. Given the recruitment procedures, level of training and experience with manualized treatment, and potential prior interest in behavioral activation, results of this study may not generalize particularly well to other individuals, particularly those who may have less of an interest in behavioral activation or less experience with manualized treatment protocols.

Additionally, the lack of school counselor participation is of concern considering they are less likely to have experience with manualized treatment protocols, less likely to have background knowledge of overarching behavioral principles, and they are among the most likely to implement the GBAT protocol in schools. Finally, information was not collected about participants' current work setting or years of experience working in a school setting so it is impossible to know how similar or different participant groups in this realm and how that might have contributed to findings of this study.

Future Directions

There are several potential areas for further investigation that could lead to improvement and continued development of the GBAT program. Of significance is the need to examine the acceptability of GBAT among other potential treatment providers including those from different doctoral programs, other school professionals (e.g., counselors), and professionals with experience working diverse populations (e.g., different cultural backgrounds, middle and high school levels, etc.). Such a study could lead to more generalizable results and could provide additional information or suggestions for ways to improve GBAT. Research that replicates and extends the present study with participants who actually implement the interventions could be important given that there may be differences between what participants report about an

intervention and their actual use of it. If such a study is conducted, it could also be interesting to compare providers/participants acceptability of GBAT before and after implementing the protocol. Follow-up studies could be conducted examining the relationship between treatment acceptability and actual usage to determine if acceptability ratings translate into practice.

Further research related to feasibility could be beneficial given the minor challenges presented in this study. Perhaps, the proposed changes to session 1, 3, and 4 could be made and further evaluation of feasibility could be assessed as a follow-up study with the same participant group or a combination of those who participated in this study and additional participants.

Related to feasibility, research related to the actual implementation of the program in school settings would be important to assess whether perceived challenges with feasibility translate to difficulties in actual practice.

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Table 1

Mean Percentage for Appropriateness of and Intent to Use Specific Strategies with Current Caseload

	Psychoed	Activity tracking & selecting	TRAP	TRAC	Goal ladder	In vivo exposures	Homework
Percent of caseload strategy is appropriate for:	86.7 (21.9)	73.9 (27.9)	77.5 (22.4)	78.1 (24.4)	76.7 (25.8)	76.9 (29.8)	76.67 (29.5)
Overall Range	15-100	10-100	10-100	10-100	15-100	10-100	10-100
Percent of caseload with whom therapist would actually consider using strategy:	89.7 (21.6)	78.9 (25.6)	79.4 (22.0)	77.2 (22.9)	80 (25.4)	80 (29.9)	81.4 (24.4)
Overall Range	15-100	10-100	10-100	10-100	15-100	10-100	10-100

Table 2

Mean (SD) of Manual Rating Form Subscales by Session

	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Session 10	Overall Mean (SD)	Overall Range
Clarity	6.78 (0.55)	6.56 (0.78)	6.44 (0.70)	6.44 (0.70)	6.44 (0.78)	6.39 (0.78)	6.72 (0.46)	6.54 (0.15)	4-7
Amount of Information*	4.89 (0.90)	4.61 (0.70)	4.56 (0.78)	4.50 (0.99)	4.17 (0.71)	4.61 (1.09)	4.22 (0.65)	4.51 (0.25)	3-7
Consistency with Theory	6.61 (0.61)	6.50 (0.51)	6.44 (0.62)	6.56 (0.70)	6.56 (0.70)	6.56 (0.62)	6.56 (0.62)	6.54 (0.05)	5-7
Appropriateness	6.11 (0.80)	5.92 (1.26)	6.11 (0.81)	6.28 (0.83)	6.25 (1.17)	6.36 (0.87)	6.39 (0.76)	6.20 (0.17)	3-7
Utility of Session	6.11 (0.90)	6.28 (0.90)	6.50 (0.62)	6.44 (0.70)	6.50 (0.62)	6.50 (0.71)	6.56 (0.62)	6.41 (0.16)	4-7
Feasibility	5.17 (1.03)	5.81 (1.05)	5.25 (1.60)	5.31 (1.06)	5.78 (1.10)	5.94 (1.19)	6.28 (0.75)	5.65 (0.41)	1-7
Flexibility*	3.89 (0.47)	4.06 (0.87)	4.00 (0.77)	3.94 (0.87)	4.11 (0.58)	3.94 (0.80)	4.00 (0.49)	3.99 (0.08)	3-6
Overall Contribution of Session	6.33 (0.84)	6.44 (0.62)	6.22 (0.65)	6.28 (0.83)	6.39 (0.70)	6.50 (0.86)	6.56 (0.62)	6.39 (0.12)	4-7
Overall Rating	6.185 (0.57)	6.25 (0.32)	6.16 (0.47)	6.22 (0.46)	6.47 (0.11)	6.38 (0.23)	6.51 (0.15)	6.29 (0.34)	1-7
Range	3-7	3-7	1-7	3-7	3-7	3-7	3-7		

* These subscales had "4" as the most acceptable rating.

Session 1 – Introduction to SKILLS program/psychoeducation

Session 2 – Functional domain assessment/Introduction to activity/mood monitoring

Session 3 – Distress loop/downward distress spiral

Session 4 – TRAP acronym/psychoeducation about avoidance

Session 5 – TRAC acronym/encouraging approach behaviors

Session 6 – Introduction to exposures

Session 7 – In-session exposure practice

Session 8 – In-session exposure practice

Session 9 – In-session exposure practice

Session 10 – Reassess functional domains/Relapse prevention & planning for the future

Table 3

Mean (SD) of Implementation Potential Scale Subscales by professional grouping

	Clinical PsyD	School PsyD	Clinical students	School Students	All doctoral level	All students	All clinical	All school	Overall
Acceptability/Efficacy	5.50 (0.47)	5.46 (0.70)	5.63 (0.32)	5.17 (1.04)	5.48 (0.58)	5.43 (0.69)	5.56 (0.39)	5.36 (0.77)	5.46 (0.60)
Organizational Support	5.27 (0.43)	5.22 (0.50)	4.75 (0.32)	4.22 (0.51)	5.24 (0.45)*	4.52 (0.47)*	5.04 (0.45)	4.89 (0.69)	4.96 (0.57)
Administrative Support	5.27 (0.60)	5.22 (0.40)	4.50 (1.45)	4.67 (0.67)	5.24 (0.47)	4.57 (1.10)	4.93 (1.06)	5.04 (0.54)	4.98 (0.82)
Implementation Commitment	5.00 (0.66)	5.08 (0.97)	5.38 (0.43)	4.83 (1.60)	5.05 (0.80)	5.14 (1.02)	5.17 (0.57)	5.00 (1.12)	5.08 (0.87)

Note: * post-degree professionals and graduate students were statistically significantly different on perceived organizational support at $p < .05$.

Table 4

Themes of Qualitative Data & Number of Comments Across Sessions

	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Session 10	Total Comments	Percent
Too much content	9	4	6	5	1	2	0	27	23%
Needs more cultural sensitivity	3	3	0	0	0	0	0	6	5%
Positive evaluation of content/aspect	8	6	7	4	3	8	5	41	35%
Questions/concern about content/aspect	1	0	1	2	1	2	0	7	6%
Negative feedback on content/aspect	3	2	1	1	0	0	0	7	6%
Suggestion for minor change to session	3	2	3	2	3	1	4	18	16%
Content not developmentally appropriate	2	1	1	0	1	1	0	6	5%
Other	1	0	0	2	1	0	0	4	3%
Overall comments	30	18	19	16	10	14	9	116	
Percent of comments	26%	16%	16%	14%	9%	12%	8%		

Manual Rating Form – Please complete after reading each session/group.

Rater’s Initials: _____ Session #: _____ Date: _____

1. How easy was it to **understand** the content of this session (description of goals and techniques/activities)?

1 Not at all easy	2	3	4 Somewhat	5	6	7 Very easily understood
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2. How much **information** did the manual include for this session?

1 Not at all enough	2	3	4 The right amount	5	6	7 Too Much information
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3. How much were the content and goals consistent with Behavioral Activation principles and theory?

1 Not at all	2	3	4 Somewhat	5	6	7 Very much
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4. How applicable do you think the strategies/activities in this session are to working with a **depressed** youth?

1 Not at all	2	3	4 Somewhat	5	6	7 Very much
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5. How applicable do you think the strategies/activities in this session are to working with an **anxious** youth?

1 Not at all	2	3	4 Somewhat	5	6	7 Very much
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6. How **helpful** overall do you think the strategies/activities would be in treating anxiety/depression?

1 Not at all	2	3	4 Somewhat	5	6	7 Very much
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7. How likely would you be able to accomplish the goals for this session in the time allotted?

1 Not at all	2	3	4 Somewhat	5	6	7 Very much
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8. How likely could you accomplish these tasks in a school setting?

1 Not at all	2	3	4 Somewhat	5	6	7 Very much
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9. How much does the manual allow for flexibility in this session? Flexibility should allow for treatment to be personalized and tailored to the needs of the group, while maintaining the overall goals of the treatment.

1	2	3	4	5	6	7
Not enough – too rigid			The right amount			Too much – not enough guidance

10. How much did the content/strategies represented in this session contribute to the overall goal of the manual?

1	2	3	4	5	6	7
Not at all important			Somewhat important			Very Critical to manual

11. Were there unnecessary elements included in this session?

If so please describe _____

12. Were there important elements missing from this session?

If so please describe _____

13. Please include any other comments about this session below:

Would you consider using this program?

Please complete this after you have reviewed the entire SKILLS manual and workbook.

Please answer some questions about your **OVERALL** impression of the SKILLS program. Think about how it would fit into your current practice (e.g., clinic, school, hospital). Think about the intended clients of the intervention. Would it meet the needs of these clients in your practice? PLEASE ANSWER ALL QUESTIONS. If you are unsure, please circle your best answer based on your opinions about the program.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1. This would be an acceptable intervention for youth anxiety or mood problems.	1	2	3	4	5	6
2. Given my workload, the time and effort needed to implement this intervention is reasonable (in the context of my work setting)	1	2	3	4	5	6
3. My local administrator (e.g., clinic director, school principal) would view this intervention in a positive way.	1	2	3	4	5	6
4. It would be worth my personal time and energy to implement this intervention.	1	2	3	4	5	6
5. I like the procedures used in this intervention.	1	2	3	4	5	6
6. I believe any resources (supplies, equipment, space) needed to implement this intervention would be available to me at my work setting.	1	2	3	4	5	6
7. My regional administrators (e.g., school board, regional managers/administrators) would view this intervention in a positive way.	1	2	3	4	5	6
8. I would advocate for this intervention at my practice (e.g., clinic, school, hospital).	1	2	3	4	5	6
9. The intervention would NOT result in negative side effects for clients.	1	2	3	4	5	6
10. I believe that if I needed assistance and advice to help with implementation, I would be able to obtain it.	1	2	3	4	5	6
11. In general, I am encouraged to implement new programs at my practice (e.g., clinic, school, hospital).	1	2	3	4	5	6
12. I would be willing to spend time outside of work to help implement this intervention (pursue further training, organize resources).	1	2	3	4	5	6
13. This intervention is supported by research.	1	2	3	4	5	6
14. Implementing this intervention at my practice would make me a better therapist.	1	2	3	4	5	6

Now I am going to ask you to think about child or adolescent cases (about ages 11 – 16 years old) you are currently (or recently) seeing in your practice or work setting. Please consider the following about the *SKILLS* program.

1. Please think about your **current or recent** caseload of youth (about 11 – 16 years old). Think of any youth with whom you are currently treating for **anxiety or mood** disorders or elevated anxiety or mood problems.

- a. For what percentage of your current or recent anxious/depressed cases do you find the **whole SKILLS program appropriate**? _____ (0 -100%)
- b. For what percentage of your current or recent anxious/depressed cases do you find **selective parts** of the *SKILLS* program **appropriate**? _____ (0 -100%)

Now, please rate what **percentage (0 – 100%)** of anxious/depressed youth, you think *each SKILLS* program component would be appropriate for. For example, “I believe [activities tracking and selection] would be appropriate for _____% of my current caseload of anxious and depressed youth.”

- c. _____ (0 -100%): **Psychoeducation** (distress loop, impact of anxiety/depression, self-assessment of functional life domains, definitions of activation and avoidance).
- d. _____ (0 -100%): **Activity Tracking and Selection** (Activity-mood tracking, identification of patterns, planning rewarding activities).
- e. _____ (0 -100%): **TRAP** (individual functional assessment of mood traps).
- f. _____ (0 -100%): **TRAC** (individualized activation planning and problem solving STEPS).
- g. _____ (0 -100%): **Goal ladder** (individualized goals and activation plans).
- h. _____ (0 -100%): **In vivo exposures** (individual or group role plays or in vivo exposures).
- i. _____ (0 -100%): **Homework** (assigning or reviewing homework).

2. Please think again about your **current or recent** caseload of anxious/depressed youth (11 – 16 years old).

- a. For what percentage of these cases would you actually consider using the **whole SKILLS** program? _____ (0 -100%)
- b. For what percentage of these cases would you actually consider using **selective parts** of the *SKILLS* program? _____ (0 -100%)

Now, please rate for what **percentage (0 – 100%)** of anxious/depressed youth in your caseload, you would **actually consider using** *each SKILLS* program component. For example, “I would consider using [activities tracking and selection] for _____% of my current caseload of anxious and depressed youth.”

- c. _____ (0 -100%): **Psychoeducation** (distress loop, impact of anxiety/depression, self-assessment of functional life domains, definitions of activation and avoidance).
- d. _____ (0 -100%): **Activity Tracking and Selection** (Activity-mood tracking, identification of patterns, planning rewarding activities).
- e. _____ (0 -100%): **TRAP** (individual functional assessment of mood traps).
- f. _____ (0 -100%): **TRAC** (individualized activation planning and problem solving STEPS).

- g. _____ (0 -100%): **Goal ladder** (individualized goals and activation plans).
- h. _____ (0 -100%): **In vivo exposures** (individual or group role plays or in vivo exposures).
- i. _____ (0 -100%): **Homework** (assigning or reviewing homework).

Finally, Please provide some information about yourself

1. Gender:	Male	Female
2. City and State of Practice:		
3. Highest degree obtained:		
4. Years since completing highest degree:		
5. Current Occupation		
6. Age range of clients whom you serve:	Youngest: _____	Oldest: _____
7. % of your caseload who are primarily <u>anxious</u> :	%	
8. % of your caseload who are primarily <u>depressed</u> :	%	
9. % of your caseload in which you use a <u>treatment manual</u> :	%	
10. Have you ever <u>provided</u> a similar treatment as the SKILLS program?	Yes	No
11. Have you received <u>previous training</u> in the treatment procedure described in the SKILLS Program?	Yes	No

Theoretical orientation: DEPRESSION

Theoretical Orientation: ANXIETY

12. How would you characterize your primary approach to treating **depression** in youth?

- | | |
|---------------------------------------|----------------------|
| ___ Psychodynamic | ___ Behavioral |
| ___ Cognitive or Cognitive-Behavioral | ___ Object Relations |
| ___ Systems | ___ Interpersonal |
| ___ Medication | |
| ___ Other (please specify) _____ | |

13. How would you characterize your primary approach to treating **anxiety disorders** in youth?

- | | |
|---------------------------------------|----------------------|
| ___ Psychodynamic | ___ Behavioral |
| ___ Cognitive or Cognitive-Behavioral | ___ Object Relations |
| ___ Systems | ___ Interpersonal |
| ___ Medication | |
| ___ Other (please specify) _____ | |