

AN EVALUATION OF A STANDARDIZED TRAINING PROTOCOL FOR GUIDED SELF-
HELP BEHAVIORAL ACTIVATION

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Abstract

Despite the remarkable progress in the development of evidence-based psychotherapies, access to these treatments remains severely limited for the general population. The development of effective and efficient training practices may help to improve the availability of evidence-based treatments. Following a review of the central themes of implementation science as it relates to evidence-based psychotherapies, the current study examined the use of a standardized protocol for training novice mental health clinicians in a brief behavioral treatment for depression utilizing a multiple-baseline across participants design. Clinicians first received didactic instruction and written materials describing the background and model of the treatment and outlining how to apply it. Then, they received a video model of the treatment skills. Finally, the clinicians received corrective feedback based on their performance. Results indicate that the clinicians acquired the skills and were able to demonstrate them with a high degree of accuracy in simulated treatment sessions. The results of this study have implications for the use of behavioral skills training in mental health service delivery and the dissemination and implementation of evidence-based mental health treatments.

Keywords: Skills training, psychotherapy, dissemination, implementation science, guided self-help

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LIST OF TABLES

Table		Page #
1.	Participant Outcomes by Phase.....	47

LIST OF FIGURES

Figures	Page #
1. Percentage of Correct Use of BAgsh Adherence Skills.....	46

TABLE OF CONTENTS

ABSTRACT	ii
ACKNOWLEDGEMENTS	iii
LIST OF TABLES.....	iv
LIST OF FIGURES	v
INTRODUCTION.....	1
The Global Burden of Mental Illness.....	1
The Current State of Treatment	3
Disrupting the Status Quo of Treatment and Training.....	6
METHOD.....	12
Participants	12
Setting and Materials.....	12
Design and Measurement	13
Procedure.....	14
RESULTS	15
DISCUSSION	16
Findings	16
Limitations.....	18
Comments on Treatment Adherence and Treatment Integrity.....	19
APPENDICES.....	23
REFERENCES.....	37

Introduction

Research indicates that psychological and behavioral problems are dramatically impacting the lives and livelihoods of people throughout the world. Even in wealthy western nations, such as the United States, mental health disorders are highly prevalent, have a devastating personal and economic impact, and frequently go either untreated or ineffectively treated. Current epidemiological research suggests that 18 - 25% of the US population meet the diagnostic criteria for at least one mental health disorder within a given 12-month span, and as many as 50% of the people in the United States experience symptoms of mental illness severe enough to meet diagnostic thresholds over the course of their lives (Kessler & Wang, 2008). These statistics fail to express that even subthreshold symptoms may cause an individual distress and result in some measure of dysfunction. As a result, prevalence statistics may in fact underestimate the burden that mental illness places on both individuals and societies (Kazdin & Blase, 2011).

The Global Burden of Mental Illness

Global estimates of the prevalence of mental illness paint a somewhat more complex picture. Data from the World Health Organization (WHO) suggest that the highest lifetime prevalence rates of mental illness among the 17 countries studied ranged from approximately 12% to greater than 47%, with the US topping the list (World Health Organization, 2014). These data also indicate that the 12-month prevalence of the countries included in the study range from approximately 6% to 27%, with the US again claiming the greatest prevalence (Kessler et al., 2009). While these findings clearly suggest that the burden of mental illness is not borne equally

around the world, it is essential to recognize that healthcare and mental healthcare resources are also not evenly distributed throughout the world, with even greater contrast.

Unsurprisingly, WHO statistics (WHO, 2014) indicate that resource rich countries, such as the UK, the US, and France, have a high ratio of mental healthcare providers relative to their populations, but these ratios do not necessarily correspond to the prevalence of mental illness within the population. For example, the UK reports 12-month prevalence rates of mental illness comparable to those of the United States, or approximately 25%. However, the ratio of mental health providers per 100,000 residents is a staggering 318.9, compared with the 125.2 providers per 100,000 people in the United States. Perhaps unsurprisingly, data regarding the availability of mental health services diminishes rapidly as one leaves the modern industrialized western nations, and those data that are available paint a bleak picture. In the emerging economy of Brazil, the ratio of mental health workers falls to approximately 30 per 100,000, whereas the ratio in fellow South American nation Peru is only 12.4 (WHO, 2014). Clearly, these statistics reflect a number of factors, such as economic wealth, broad access to quality healthcare, and educational infrastructure, as well as somewhat less tangible concepts, such as cultural understanding and conceptualization of mental illness and issues of stigma surrounding mental health treatment.

It is also crucial to assess the societal impact of mental illness. The WHO reports that mental illness is the greatest source of disability-adjusted life years (DALYs; a metric of healthy years of life lost to any source of disability or illness) worldwide (WHO, 2011a). Research reported by the Agency for Healthcare Research and Quality estimates that the economic burden of mental illness in the United States is nearly equivalent to that of cancer – approximately \$57.5 billion per year (Soni, 2009). However, this estimate may significantly underrepresent the true

burden of mental illness, which may include enormous personal and societal costs related to both direct factors (i.e., treatment), as well as indirect factors, such as loss of productivity due to absence from work, reduced effectiveness and productivity while at work, unemployment or under-employment, increased healthcare utilization, and many others. Nevertheless, the WHO estimates that the global burden of mental illness equates to approximately \$2.5 trillion (USD) per year and is expected to continue to rise over the coming decades (WHO, 2011a). For reference, \$2.5 trillion is comparable to the entire gross domestic product of nations with relatively strong economies, such as France and Brazil.

The Current State of Treatment

Thankfully, an abundance of research indicates that at least some existing interventions, (namely behavioral and cognitive behavioral therapies, as well as a few other empirically supported treatments), are well-suited to treat common mental health conditions effectively. Just as importantly, there is a growing body of evidence suggesting that these interventions have the potential to be cost neutral or even result in net healthcare cost savings. As noted above, the indirect costs of mental illness may be quite widespread, impacting economic costs and productivity within a number of sectors. As a result, while effective treatment may necessitate an increase in direct costs, the overall value returned to the economy may be greater still.

For example, a review article of international cost-effectiveness studies on the use of CBT interventions for mood, anxiety, psychotic and somatoform disorders (conducted to inform healthcare policy decisions in Canada) observed that compared with usual care, investment in CBT often cost less and produced a greater societal benefit. However, the authors specifically cautioned against simply increasing total access to all mental health treatments, recommending

that “[p]ublic funding should prioritize competent delivery of specific, evidence-based interventions for specific indications” in order to maximize health and economic outcomes (Myhr & Payne, 2006, p. 668).

As a result of the factors listed above, there is a clear benefit in improving access to mental health services worldwide, both in terms of human and economic costs. Mental illness is a major source of disability and reduces the economic productivity and quality of life for billions of people each year worldwide. Nevertheless, troubling disparities exist regarding access to mental health resources which may be irreconcilable through existing treatment, training, dissemination and implementation paradigms. Once the need for an expansion of global mental health services is recognized, the next step is determining how best to meet this objective.

Current research has focused largely on identifying and developing treatments that result in the greatest outcomes, which are typically measured in terms of symptom reduction, amelioration of a specific disorder or problem behavior, or quality of life improvements (or a combination of these). Unfortunately, merely establishing the efficacy of these treatments and making them available to providers has thus far done little to substantially reduce the prevalence of mental illness worldwide, probably for a host of reasons. These may include institutional barriers, such as a lack of support from leadership, insufficient access to funds for training, supervision or materials, or duration of treatment that is shorter than indicated for the execution of a treatment protocol, or provider-level barriers, such as insufficient training, misguided beliefs regarding evidence-based treatments and their use, or orientation preferences, among many others. However, another primary reason that the availability of evidence-based treatments has not yet meaningfully impacted the global prevalence of mental illness may be due to the current format in which interventions themselves are developed and delivered. In other words, while the

psychotherapy research community has been diligently building better tools for clinicians to use, it has neglected to properly package them in ways that users will find appealing, applicable, transportable, convenient, and user-friendly on a large enough scale to make a difference.

For example, preliminary outcome research supports the efficacy of the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders, a cognitive behavior therapy protocol designed to treat a range of anxiety disorders and unipolar depression (Farchione et al., 2012). In and of itself, this work represents a significant advancement for the field, in that it utilizes an understanding of common mechanisms that maintain psychopathology to consolidate existing components of a number of extant protocols into a single transdiagnostic treatment. Indeed, a recent investigation comparing the Unified Protocol with four well-supported diagnosis-specific interventions for common anxiety disorders (panic disorder with or without agoraphobia, social anxiety disorder, obsessive-compulsive disorder, and generalized anxiety disorder) found that patients achieved nearly identical levels of improvement, suggesting that the transdiagnostic treatment is potentially quite capable of replacing an array of existing manuals, as its developers intended (Barlow et al., 2017). This protocol includes a number of features which are considered to be best practices, including components addressing patient motivation and goal setting, cognitive reappraisal skills, and interoceptive and in-vivo exposures in a single flexible package, establishing it as a cutting-edge technology. While there are substantial benefits associated with the development of this approach, it adheres to a treatment format which assumes a single therapist (with advanced education and training) working with a single client per 50-minute session once per week for a period of 12-18 weeks.

By historical standards, this may rightfully be considered a brief treatment, especially in relation to its aims. Still, this format may soon become impractical for a number of reasons. First,

the assumption that a highly educated therapist is necessary to administer an effective treatment is impractical for the purposes of addressing mental health needs in impoverished regions of the world, where these types of clinicians simply do not exist. As discussed above, the ratio of mental health specialists in the United States is 125.2 per 100,000 people. By contrast, India, which has a population approximately four times greater than that of the US, has a ratio of mental health specialists that is only 0.6 per 100,000 (WHO, 2014). Improving this ratio through conventional training practices (i.e., a university education, followed by a graduate-level training program) would be an extremely slow and costly proposition.

Disrupting the Status Quo of Treatment and Training

Moreover, there is evidence to suggest that highly educated clinicians are not required for the effective delivery of mental health services. In their 1994 discussion of the topic, Christiansen and Jacobson reviewed research examining the relationship between years of education or professional experience and client outcomes. The literature they presented consistently found that client outcomes were no worse with nonprofessional or paraprofessional therapists, and in some instances, were superior to those outcomes produced by professional clinicians. These findings were, and continue to be, shocking to the community of mental health professionals. While some therapists may view these conclusions as an indictment of their trade, in light of the topic at hand, it may be more useful to understand them as an indictment of the state of clinical training, and a powerful rebuke to the assumption that an advanced degree is required to be an effective clinician. A recent study by Patel and colleagues (2017) provides further evidence for this position through its use of nonprofessional community counselors, many of whom had the equivalent of a high school education, to administer a behavioral

treatment (deemed the “Healthy Activity Program” or HAP) for depression. Indeed, the results of the study on the use of the HAP concluded that a relatively simple treatment, delivered in primary healthcare settings by “lay counselors” can produce robust improvements in terms of symptom severity (an adjusted mean difference of -7.57, $p < 0.0001$ on the BDI-II), rates of remission (64% in the treatment group, compared with 39% in enhanced usual care group), and a host of meaningful secondary outcomes, including disability score, days unable to work, and reported intimate partner violence. (Patel et al., 2017).

Adjustment of additional parameters of the standard treatment format may similarly improve treatment availability. By reducing the number of sessions in a protocol, and/or decreasing the duration of a session, it stands to reason that the time demands on a given therapist per patient are reduced, thereby permitting each therapist to treat a greater number of patients. Modifications of this type may also provide greater opportunity for clinical services to be provided in atypical treatment settings, such as schools, primary care provider offices, community centers, or even big-box-store type retail settings, some of which already provide health-related amenities such as vision and pharmacy services. Indeed, with appropriate treatments, treatment formats, and clinicians it may be plausible to bring basic mental healthcare to anywhere that flu shots are available today.

It is all the more encouraging, then, that treatments suitable for delivery in these kinds of settings already exist and carry some empirical support. In the same review article described above, Christiansen and Jacobson (1994) also discussed the use of materially assisted self-directed therapy, which is referred to as *bibliotherapy* or *guided self-help* (*gsh*, when conducted with the assistance or support of a paraprofessional). For example, in a guided self-help treatment for Binge Eating Disorder (BED), a patient might be oriented to the treatment by a

trained clinician and provided with basic psychoeducation on the nature of their disorder, before being provided with a self-help manual (such as *Overcoming Binge Eating*, Fairburn, 1995), along with some supplemental materials to inform use of the book and increase participation. The patient would then go on to run the protocol as directed by the book, with brief weekly sessions with a clinician to help navigate difficult concepts, troubleshoot, and manage motivation for change.

A number of studies published after the Christiansen and Jacobson review have provided support for the use of *gsh* protocols to effectively treat eating disorders (Grilo & Masheb, 2005; Zandberg & Wilson, 2013), major depression (Vernmark et al., 2010), and phobic and panic disorders (Schneider, Mataix-Cols, Marks & Bachofen, 2005). In fact, meta-analyses of treatment outcome studies suggest that treatments for anxiety and depressive disorders that are delivered in a *gsh* format produce outcomes that are at least comparable as those delivered in a traditional format (Cuijpers et al., 2010). As discussed above, from a dissemination and implementation perspective, *gsh* treatments typically demand less therapist time overall, and may be implemented by paraprofessional therapists who require only a relatively short course of training, resulting in a lower-cost treatment that may more easily be brought to populations in need.

The essential purpose of identifying the limitations of the conventional therapy format is not merely to be disruptive to the traditions of the profession, but rather to highlight the importance of considering factors such as cost, feasibility, and scalability in the development of mental health interventions. For this reason, Kazdin and Blase (2011) advocate “rebooting” psychotherapy, by which they mean reimagining treatment delivery in a fundamental way, in order to better address the global burden of mental illness. This suggests that efforts to further

improve treatments themselves (“build a better mouse-trap”) may yield diminishing returns in terms of total impact on worldwide prevalence of mental illness. By contrast, advancements in training technologies will be an essential component of this effort, while also providing the field with an opportunity to improve treatment integrity.

The issue of therapist training is also central to the recognition of an emerging phenomenon within the psychotherapy outcome literature. As the body of treatment outcome research has accumulated, it has become possible to begin to outline best practices for the amelioration of a range of behavioral and psychological problems. However, findings have suggested that the promising outcomes observed within the research settings where the protocols are developed are greatly diminished when the treatments are implemented by community clinicians and more naturalistic settings. This loss in treatment effectiveness is known as the dissemination cliff (or dissemination gap) and reflects a significant challenge to the psychotherapy research community (Shafran et al., 2009; Weisz, Ng & Bearman, 2014).

Although a comprehensive review of the dissemination and implementation literature is beyond the scope of the current discussion, it is important to recognize this phenomenon, and begin to conceptualize the role that the current state of training may play in maintaining this problem. For example, while much remains unknown about the causes of the dissemination cliff, there is research to suggest that the perspectives of community practitioners and clinical researchers may differ significantly with regard to incentives to contact research, viable avenues for engaging with treatment outcome research, and beliefs about the applicability and utility of new treatments (see Weisz, Ng & Bearman, 2014 for further discussion). These differences undoubtedly are the result of many factors, but the possibility remains that many community clinicians may not be oriented – *trained* – during their graduate education to value these

advancements in treatment technology, and even if these developments are valued, community providers may not have sufficient opportunities to learn and use them effectively. Therefore, an emphasis on improving the technology of training, both systemically in terms of the initial graduate education pipeline, and as an ongoing process to facilitate continued competence and the maintenance of clinical skills in the population of community clinicians, may be an essential step towards addressing this problem.

One possible way to address the need for better clinical training may lie in the use of behavioral skills training (BST). Within Applied Behavior Analysis, BST represents an evidence-based approach to changing staff behavior through packages that include elements such as instructions, modeling, rehearsal, and feedback which are designed to demonstrably change professional performance, rather than knowledge (Miles & Wilder, 2009; Parsons, Rollyson & Reid, 2012). BST packages have been effectively used to teach a range of professional skills to direct care staff in schools, day programs, and other treatment settings. These skills have included a range of behavioral assessment and treatment tasks, including the implementation of paired-stimulus preference assessments (Lavie & Sturmey, 2002), discrete trial-instruction (Sarokoff & Sturmey, 2004) and functional analysis procedures (Iwata et al., 2000; Moore et al., 2002) among others. To date, very little research has been conducted investigating whether similar interventions may be used to train clinicians in the use of evidence-based psychotherapy skills, perhaps due to the relative complexity of these skills. However, treatments presented in a *gsh* format, and designed to be implemented by paraprofessional staff may be appropriate targets for a BST package. In recognition of these issues, the purpose of the current study is to investigate the utility of a standardized BST protocol on the implementation of a Behavioral Activation guided self-help (BAGsh) treatment for depression.

Behavioral Activation is a brief psychotherapeutic treatment for depression, developed in its current form by Jacobson and colleagues (Jacobson, Martell & Dimidjian 2001). The BA model is based upon the theory that depressogenic behaviors are broadly maintained through negative reinforcement processes wherein the avoidance of aversive experiences (both in terms of life stressors and distressing private events) has generalized across contexts, resulting in a pattern of ineffective short-term coping responses, and diminished access to valued (positively reinforcing) activities. Numerous studies support the efficacy of BA-based treatments for depressive disorders, frequently reporting medium to large effect sizes (Cuijpers, van Straten & Warmerdam, 2007; Dimidjian et al., 2006; Richards et al., 2016). Studies investigating the effectiveness of BA in community settings have also been favorable (e.g. Daughters et al., 2008; Kanter et al., 2014; Moradveisi et al., 2013; Porter, Spates & Smitham, 2004). As noted above, the Healthy Activity Program implemented in India is based firmly upon BA (with minor modifications) and delivered in primary care settings by nonprofessional/paraprofessional therapists (Chowdhary et al., 2015; Patel et al., 2017), providing evidence for BA's suitability to the type of application outlined in the current study.

The first phase of the treatment includes a functional assessment of the patient's current behavioral patterns through the use of mood/event monitoring. The second phase of the treatment employs a variety of behavioral self-management strategies to help the patient to notice and reduce avoidance responses and increase valued activities, including the use of scheduling and routine regulation, graded task assignments, problem-solving skills, the development of avoidance-competing and avoidance-incompatible behaviors, and the use of brief grounding/mindfulness skills to compete with covert verbal avoidance behaviors (i.e., rumination or worrying). The treatment concludes with relapse prevention training, wherein the patient is

helped to identify events and patterns historically associated with the onset of depression and guided through the creation of a task list to perform in response to those and similar events. The relative simplicity of the treatment, as well as the availability of a published self-help manual (*Overcoming Depression One Step at a Time*, Addis & Martell, 2004) suggest that BA is suitable for adaptation to a guided self-help format, and a standardized behavioral skills training program for clinicians.

Method

Participants

Two female and one male 1st year graduate students in clinical psychology doctoral programs served as trainees for this study. Participants attested that they had minimal prior experience with behavioral activation, guided self-help interventions, or administering manualized psychological treatments before their participation in the present study.

Setting and Materials

Training sessions took place in therapy rooms within a university-based outpatient mental health clinic at the university where the trainees are enrolled. All training sessions occurred during the 1st year of the participants' matriculation in the program. This schedule was used to ensure that the training occurred before the participants had received extensive direct clinical contact with patients and had only limited exposure to coursework related to clinical intervention. The protocol that the participants were trained on was based upon the *Overcoming Depression One Step at a Time* self-help manual written by Addis and Martell (2004). Supplemental materials outlining the use of the manual for guided self-help sessions were

identical to those used in a previous study (Schwartz, 2017). Additionally, video files featuring role-players demonstrating BA_gsh sessions and techniques were created for use in this study.

Design and Measurement

A multiple baseline across participants design was used to assess training phases and outcomes (Kazdin, 2011). For the purpose of this investigation, the term *session* will refer to the particular point in the BA_gsh protocol that a participant is executing, while *trial* will refer to a discrete unit of observation of a participant. Similarly, for the sake of clarity, *participant* refers to the clinicians in each trial, where *client* will refer to the study confederates (role-players). Each phase consisted of a minimum of three trials. All trials were videotaped, and participants were scored according to their performance on the BA_gsh adherence skills (see below for a comprehensive description of skills) following each trial. The percentage of correct BA_gsh adherence skills were calculated by dividing the total number of BA_gsh behaviors performed correctly by the total number of skills listed on the BA_gsh session adherence checklist and multiplying the ratio by 100. BA_gsh sessions consisted of a limited range of different skills according to where they occur on the treatment sequence. As a result, the total number of skills listed on the BA_gsh session adherence checklist varied according to the session number being assessed. Participants were always informed about which session they were expected to perform prior to the start of the session. All trials were conducted with confederates who were advanced graduate students or early-career professionals in mental health service-delivery fields, who had been instructed to develop character backstories and symptom profiles consistent with mild to moderate depression, in collaboration with the principal investigator.

Inter-observer agreement (IOA) data were collected for 33% of trials, and agreement was calculated by dividing the number of agreements on the presence or absence of the BAgsh adherence skills by the total number of agreements and disagreements and multiplying by 100. IOA data were collected by 3rd year graduate students familiar with Applied Behavior Analysis, the intervention protocol, and trained in data collection procedures. The average agreement across trials and participants was 87% (range, 73% to 100%).

Procedure

Baseline. As a group, participants were provided with copies of *Overcoming Depression One Step at a Time* (Addis & Martell, 2004), which served as a primary treatment manual for both the client and clinician on this protocol, approximately one week before the initiation of baseline trials. Prior to each baseline trial, participants were provided with a brief written description of a client's presenting problem and history, as well as the current session number. The participants were then instructed to conduct the corresponding BAgsh session to the best of their ability.

Training Phase 1 (Didactic Instruction). Individually, participants were exposed to approximately 90 minutes of in-person didactic instruction regarding the implementation of BAgsh. This instruction consisted of an overview of the BA model of depression, a brief discussion of the evidence base supporting the use of the treatment and the *gsh* format (especially as it contrasts with conventional treatment formats), as well as explanations on the proper use of activities and homework assignments within the treatment, use of the session checklist to structure the sessions, and troubleshooting. Each of the BAgsh adherence skills (see appendices) were explicitly described during phase 1, and all therapist materials, including the

therapist manual, user's guide, homework forms, and session checklists were made available to the participants. Participants were then instructed to conduct BAGsh sessions to the best of their ability, in a manner similar to the prompt provided for the baseline condition.

Training Phase 2 (Video Model). This phase consisted of exposure to a series of video recordings, depicting a clinician trained in BAGsh and a research assistant role-playing as a depressed client. The recordings demonstrated BAGsh adherence skills within the context of a simulated BAGsh session. Participants were granted access to the video to watch and refer to throughout the remainder of the study. Following exposure to the video models, participants were instructed to conduct BAGsh sessions to the best of their ability, per previous conditions.

Training Phase 3 (Feedback). In this phase, participants were provided with approximately 60 minutes of direct verbal feedback regarding their performance on the BAGsh adherence skills they have demonstrated in previous trials. Feedback was provided by the Principal Investigator and included both corrective comments and praise regarding specific examples of BAGsh adherence skills. Examples of skills drawn from the participant's own performance recordings were viewed and referenced during Phase 3 meetings. If applicable, BAGsh adherence skills were briefly demonstrated and/or roleplayed during feedback meetings in this phase. After the conclusion of the feedback meeting, participants were again instructed to conduct BAGsh sessions to the best of their ability.

Results

Figure 1 displays the percentage of correct responses by the participants during the simulated treatment trials. Performance during baseline was low (mean percentage of correct responses $\leq 10\%$) across all participants. Performance increased dramatically during phase 1

after the participants were provided with supplemental written materials and didactic instruction which included a conceptual overview of the guided self-help format, the theoretical basis for Behavioral Activation, and a review of the treatment protocol and materials. For participants 1 and 2, the data for phase 1 were characterized by a decreasing trend, suggesting that the training resulted in skill acquisition, but that this learning was not well maintained. Following exposure to the video model in phase 2, the performance trends for participants 1 and 2 reversed. However, for participant 3, the data in phase 2 represented a slightly decreasing trend. Regarding phase 3, the data for participants 1 and 2 continued to trend upward, while the data for participant 3 showed an increased overall level, and a trend which was essentially flat. Importantly, all three participants demonstrated their greatest performance averages during phase 3, and that for two of the three participants, those final performance averages represented an accuracy greater than 90% (see Table 1).

Discussion

Findings

The need to expand access to mental health treatments through effective and inexpensive training practices is increasingly well understood. This study examined the use of a relatively simple, standardized protocol for training clinicians in the use of a guided self-help treatment for depression. The training protocol detailed above included four basic elements (didactic instruction, written training materials, video modelling, and corrective feedback), presented over three phases. The total amount of time spent in training for each participant was less than three hours, excluding time that the participants spent watching the training video, suggesting that this system of training may be conducted expediently and inexpensively. At the conclusion of the

study period, two of the three participants demonstrated an average rate of correct responding greater than 90%, while the other participant demonstrated an average rate of correct responding of nearly 80%. The data presented above provide evidence that mental health treatments presented in a *gsh* format may be trained with a high degree of accuracy in novice clinicians in a brief and cost-effective manner. Moreover, in light of the fact that the data for all three participants reflected a flat or increasing trend through phase 3 suggests that BA_{gsh} skills were well maintained over the course of the study.

Some aspects of this study are currently uncommon in the training of mental health clinicians. Specifically, while the video modelling of professional skills for practitioners has been evaluated in a number of studies within the behavior analytic literature, its role and impact in the training of skills for mental health clinicians is less well understood. Furthermore, while the use of simulated patients has been commonplace in the training of medical professionals for decades (Lane, Slavin & Ziv, 2001), it appears rarely used (or at least, rarely investigated) within the mental health field (Beidas, Cross & Dorsey, 2014). It is the author's view that the use of standardized role-playing in the development of professional skills in therapists is important to improving standards of care for patients throughout the mental healthcare field as a whole. While the regular and effective use of standardized role-players may appear costly, it may be possible for an organization to use existing staff for this purpose, or for pairs or cohorts of trainees to serve as standardized role-players for each other throughout the training process.

While the focus of the training protocol developed for this study was centered on a treatment for depression, the elements of the protocol were intended to be broadly applicable to therapies delivered in a *gsh* format. As noted above, evidence supports the efficacy of guided self-help interventions for a range of common mental health concerns, including depression,

anxiety disorders, and eating disorders. Further investigation is required in order to evaluate the efficacy of protocols such as the one used here in training clinicians on other *gsh* treatments. However, approaches to training such as this one may represent a development in evidence-based training practices.

Limitations

This study had a number of limitations. First, this study did not include an opportunity for participants to demonstrate their performance of BAGsh skills with actual depressed patients. As a result, it is unclear how participant's behavior may change between training and service provision settings. Due to time constraints, this study also did not include generalization or maintenance probes. Furthermore, while all three of the confederates were guided on the development of their characters, and assisted on their conduct throughout the study, they were not formally trained as actors, and their performance was not systematically rated or evaluated. As noted above, the confederates created the characters that they portrayed in collaboration with the Principal Investigator. This was done in order to reduce burden on the confederates, and with the intention of increasing their comfort and ability to adhere consistently to their characters. However, this introduced some variability into the different experiences of the participants. It would be prudent for future investigations of this type to regulate the specific clinical presentations and behaviors of the role-players more systematically.

Accordingly, a thorough and formal analysis of the integrity and consistency of the training intervention itself was not conducted. From a pragmatic perspective, the use of video models in this study contributes to the fidelity of the training protocol as it was applied to the three different participants. However, use of pre-recorded didactics, or a didactic script (delivered by a

live facilitator, either in-person or remotely, thereby providing the trainees with opportunities to ask questions) would undoubtedly further enhance the integrity of the training procedures. Such materials would also have the added benefit of further improving the feasibility and scalability of the training protocol.

Comments on Treatment Adherence and Treatment Integrity

Because participants in this investigation did not have the opportunity to demonstrate their skills with actual patients, it is not possible to infer the relationships between treatment adherence and patient outcomes. It is important to recognize that the design of this study allows for the measurement of treatment *adherence* (defined as the degree to which the clinicians utilized the procedures specified by the protocol) but does not permit a full analysis of treatment *integrity*. Existing literature has conceptualized treatment integrity as the degree to which a given intervention was implemented as its developers intended, and it has been proposed that treatment integrity is composed of three components: adherence (“Are the specified treatment elements present?”), competence (“How well have the elements been executed?”) and differentiation (“Have unique elements of other treatments been excluded?”) (Fairburn & Cooper, 2011; Sechrest & Redner, 1979; Sechrest et al., 1979; Waltz, Addis, Koerner & Jacobson, 1993).

While there is some evidence within the behavior analytic literature to suggest that “good enough” (but imperfect) treatment integrity may not adversely impact the outcomes of some interventions (e.g. Northup et al., 1997), the relationship between integrity and patient outcome is less well understood within psychotherapy research as a whole (Perepletchikova, Treat & Kazdin, 2007; Webb, DeRubeis & Barber, 2010). As discussed above, the “dissemination cliff” observed in psychotherapy outcome research describes the marked decrease in effectiveness

observed when treatments are delivered in community settings, compared with administration by the treatment's developers. It stands to reason that, when the effectiveness of a treatment at a high level of integrity is known, subsequent implementation at a lower level of integrity may produce worse outcomes. By contrast, in the case that the intervention has shortcomings or low established efficacy, low integrity may actually produce better outcomes, depending on the particular ways that clinicians stray from the prescribed treatment components (Perepletchikova, 2011).

Nevertheless, knowing how closely the administration of a treatment matches what was intended, as well as the factors impacting integrity, are crucial both for the scientific evaluation of psychotherapies and for the practical matter of training clinicians. The current study provides a model of clinical training which is broadly consistent with many of the recommendations provided by this literature. These include operational definition of the intervention through the manual, indirect training procedures (i.e., didactic instruction and written materials, including session checklists), direct training procedures (i.e., repeated role-playing of treatment elements, access to video model, opportunities for interactive performance feedback, video recording of treatment sessions, direct assessment of a high percentage of sessions (in this case, 100% of sessions), inter-observer agreement ratings conducted by trained raters, and specific definitions of treatment adherence (session checklists) and informative analysis of adherence data (e.g., percentage of correct responding) both at the session level and by phase (Perepletchikova, 2011). Future assessment of this training protocol would benefit from the inclusion of structured assessments of therapist competence and treatment differentiation.

It would be reasonable to question the impact that the repeated performance trials had on skill acquisition through practice effects. The fact that baseline responding was low across all

three participants, and moreover, the fact that no participant's baseline data reflected an increasing trend suggests that mere practice is insufficient to improve performance outcomes. Furthermore, as noted above, the data for two of the three participants was characterized by a decreasing trend following training phase 1. If each trial in-and-of-itself contributed to skill acquisition, decreasing trends following training would appear unlikely. The implications of this are broadly consistent with the findings discussed in Christiansen and Jacobson (1994) – namely, that repeated opportunities to conduct treatment (for example, number of year spent as a provider, or “clinical experience”) itself may not contribute to the acquisition of effective clinical skills.

Based upon the research suggesting that didactic instruction by itself results in an increase in declarative knowledge, but little sustained changes to therapists' behaviors in the provision of psychological treatments (Walters, Matson, Baer & Ziedonis, 2005), the marked improvements in performance observed across all three participants between baseline and phase 1 were somewhat unexpected. A number of possible explanations may account for these findings. A reasonable possibility is that the availability of the written training materials, which included session-by-session checklists, provided an in-session prompt to perform many of the required behaviors. Similarly, a key element of *gsh* treatments may be learning what to *exclude* from more conventional psychotherapy sessions, in order reduce the total client-therapist contact time to the expected 20-25 minute session timeframe. In turn, this may also contribute positively to intervention integrity, by minimizing protocol-inconsistent elements and therapist drift. Didactic instruction may be more effective at inhibiting therapists' incorrect or superfluous responding, rather than developing and increasing accurate responding. Further research is

required to better understand the role of didactic instruction, in-session checklists, and other discrete training components in the acquisition of therapy skills.

Finally, as noted above, it is important to recognize that this study assessed the presence or absence of BAGsh skills but did not employ any assessment of how well those skills were executed. Anecdotally, the participants reported improvements in their comfort and confidence in the use of BAGsh, but an analysis of therapist competence was not formally conducted within this investigation. Similarly, it is unknown to what extent the quality of the treatment skills was influenced by the different phases of the training, or even from other sources entirely. While this is unfortunate from a scientific perspective, it would seem to mirror the way in which the quality of therapeutic behaviors are shaped in standard professional training settings currently; namely through modeling and feedback, both formal (i.e., supervision) and informal (i.e., patient reactions). As novice clinicians enrolled in graduate training programs, the development of the participant's "non-specific" skills through introductory coursework and introductory clinical experiences was not controlled for.

In conclusion, much work remains to be done to address the global burden of mental illness. To date, a large amount of research has been conducted concerning the development of psychotherapeutic treatments, while comparatively little has been done to meaningfully and effectively promote the use of these treatments by clinicians and improve the availability of evidence-based mental health services for people in need. Both innovative treatments and novel approaches to training, dissemination and implementation will be required in order to reduce both the personal suffering and economic impact of common mental health conditions. Investigations such as this are one small step towards the development of feasible, scalable, economical and effective training methodologies for mental health service providers worldwide.

APPENDIX A

Overview of BAGsh Adherence Skills

Greet the patient (<1 minute): The clinician will welcome the patient to the session (e.g. “Hello, [patient name], thank you for meeting with me today.”). The clinician will then indicate the current session number, and the number of sessions remaining in treatment (e.g. “This is our first session together, which means that we have 9 more after this one.”)

Outcome Monitoring (5 mins): The clinician will provide the patient with a blank copy of an appropriate outcome monitoring measure (e.g. the BDI-II, PHQ-9, etc.) and a writing implement. The clinician will then provide the patient with brief instructions to complete the measure (e.g. “Please take a moment to fill this out. Let me know if you have any questions.”). The clinician will then answer any questions that the patient asks, and then collect the completed form. The therapist will then score the measure, and verbally summarize the results with the patient, and ask about severity and changes in symptoms (e.g. “Your score on the PHQ-9 is an 11 this week, which indicates a moderate level of severity. What have you noticed about your symptoms this week?”) This step must be completed prior to all subsequent steps.

Orient Patient to Guided Self-Help (10 mins – Session 1 Only): The clinician will verbally provide the patient with a definition of guided self-help [“Guided self-help means that, in a very real way, you will be learning to be your own therapist. You will have access to written materials, and brief, regular meetings with me to help bring you through the process. This format has a number of advantages over traditional treatment formats, in that it provides you an

opportunity to progress at your own pace, gives you access to a book that you can refer to at home, and it may help you to be better prepared if you even experience depression again in the future.”] The therapist will also address the following: session length, treatment duration, roles and responsibilities of patient (including use of the Patient’s Guide and Checklist), roles and responsibilities of therapist, the relationship between out-of-session work at outcomes, and “driver’s ed” metaphor. The therapist will then ask the client if they have any questions, and provide relevant answers.

Provide Treatment Orientation and Overview (15-20 mins – **Session 1 Only**): The clinician will introduce behavioral activation, present the BA model of depression (bottom half of model) point-by-point, and prompt the client to consider ways in which their own experiences relate to/are reflected by the model (e.g. “Can you think of any of your own depression-related behaviors that are reflected in this part of the model?”). The therapist will then review the treatment model (upper half of model), and prompt the patient to identify any ways in which their own relate to/are reflected in this part of the model (e.g. “Can you think of any activities that are important to you, that you’ve tried even when you were feeling down, that ended up helping you feel better?”). The therapist will then ask the client if they have any questions, and provide relevant answers (or redirect the client to written material).

Review Patient’s Guide Checklist Items (5-10 mins – **Sessions 2-9 Only**): The clinician will ask the patient about their progress on the Patient’s Guide Checklist items over the past week (e.g. “Were you able to check all the items off of the Checklist this week?”). If the patient answers affirmatively, the clinician will ask brief follow-up questions about adherence (e.g. “What was

the most difficult part of the program for you this week?”, “What was the easiest part?”, “How well have you been understanding the reading?” etc.). If the patient indicates that they did not complete all of the checklist items, the clinician will briefly assess barriers (e.g. “What got in the way of you being able to complete the Checklist items this week?”) and responding to barriers by redirecting to the book or in a manner consistent with the BA model (e.g. “Was that addressed in the reading this week? Let’s look together.”, “Let’s look back at the model. How do you think this might be able to help us understand that concern?”). The clinician will then discuss with the patient whether or not they are prepared to move on to the next step in treatment, based upon the extent to which checklist items were completed.

Preview Next Step and Provide Relevant Materials (5-10 mins): The clinician will either review the current step (if the patient did not move on), or briefly describe the next step (if the patient did move on). For example, the client might say the following at the end of Step 1, when the client is moving on to the next step: “Now that we’ve decided to move on, let’s take a look at the page addressing Step 2 in the Patient’s Guide. Make sure to read the pages indicated for this section as early as you can in the week, so that you can get as much as possible out of the material for the rest of the week. A few important concepts to look out for this week include the “depression loop”, which refers back to the bottom half of the BA model we discussed last week, and Activity Scheduling. Based on the self-monitoring you did this week, where do you think depression loops might be occurring? Activity scheduling is one way that shift away from the depression loop. Based on your self-monitoring, start to think about ways that you can schedule and commit to do more of those activities associated with improvements in your mood. Here is a

form to help you, and a sample form to help get you started.” The clinician will provide the patient with all relevant forms and modules associated with the step.

APPENDIX B

Session One (40-45 minutes)**Necessary Materials:**

- Self-Help Book
- User's Guide
- Activity Record
- BA Model of Depression

Agenda**Check In (5 minutes)**

_____ Welcome. This is session 1. We have 9 sessions left after this one.

Review outcome monitoring

_____ Review and discuss any symptoms changes

_____ Assess any suicidality endorsed

Orientation to GSH (10 minutes)

_____ Strong evidence base

_____ "It has helped many people with problems just like you"

_____ Explain "guided self-help"

_____ Goal of GSH is to help you become your "own therapist"

_____ Introduce "Driver's Ed" metaphor

_____ The more effort you put into following the program, the more likely you are to benefit from it. The homework assignments are crucial in this program

_____ Describe number of sessions and session length

_____ Emphasize attending all sessions and making sessions on time

Introduce Treatment (10-15 minutes)

_____ Introduce and give patients *Overcoming Depression One Step at a Time*

_____ Explain and emphasize exercises throughout book

_____ Mark relevant sections in the book that you want to discuss

_____ Introduce and give patients "User's Guide"

_____ Explain how to use it and emphasize its importance

_____ Explain Review Checklists

_____ Success in this program depends on how well you complete each step and not how many you complete or how quickly you complete them

Preview Step 1 (10-15 minutes)

_____ Introduce model of depression

_____ Illustrate model on white board

_____ Discuss and emphasize self-monitoring

_____ Introduce Activity Record

_____ Handout example Activity Record

Session Two (20-25 minutes)

Reading Completed: Y/N or N/A	Exercises Completed: ___ of ___ or N/A
Monitoring Completed: Y/N	
Used Checklists: Y/N	Checklist Adherence: ___ of ___
Moved on: Y/N or N/A	

Necessary Materials:

- Activity Record
- Example Activity Scheduling

Agenda**Check In (5-7 minutes)**

___ Welcome. This is session 2. We have 8 sessions left after this one.

Review outcome monitoring

___ Review and discuss any symptoms changes
 ___ Assess any suicidality endorsed.

Review Patient's Use of Program

___ How well were you able to follow the assignments and do the reading?
 ___ Praise patient's effort and completion of exercises/assignments

Review Monitoring Forms (8-10 minutes)

___ Review collaboratively patient's Activity Record
 ___ Positive comment on all signs of progress or attempts to change

*20 minutes into session → Must review checklists + Preview Next Step/Review Current Step

Review Step Checklist (3 minutes)

___ Did you refer to the review checklist throughout the week?
 ___ Go through any unanswered questions
 ___ How well do you think you did on this step?
 ___ Discuss and decide whether or not to move on

Preview Next Step (3 minutes)

___ Read Step 2
 ___ Discuss and illustrate Depression Loop
 ___ Introduce Activity Scheduling
 ___ Handout example Activity Scheduling

or Review Current Step (3-5 minutes)

___ Reread current step
 ___ Troubleshoot difficulties
 ___ Review current forms
 ___ Encourage patient despite pace

Session Three (20-25 minutes)

Reading Completed: Y/N or N/A	Exercises Completed: ___ of ___ or N/A
Monitoring Completed: Y/N	HW Completed: Y/N
Used Checklists: Y/N	Checklist Adherence: ___ of ___
Moved on: Y/N or N/A	

Necessary Materials:

- Activity Record
- Values Module

Check In (5-7 minutes)

___ Welcome. This is session 3. We have 7 sessions left after this one.

Review outcome monitoring

- ___ Review and discuss any symptoms changes
 ___ Assess any suicidality endorsed

Review Patient's Use of Program

- ___ How well were you able to follow the assignments and do the reading?
 ___ Praise patient's effort and completion of exercises/assignments

Review Monitoring Forms + Additional HW Assignments (8-10 minutes)

- ___ Review collaboratively patient's monitoring records and HW assignments
 ___ Review collaboratively key assignments and address any difficulties
 ___ Positive comment on all signs of progress or attempts to change

*20 minutes into session → Must review checklists + Preview Next Step/Review Current Step

Review Step Checklist (3 minutes)

- ___ Did you refer to the review checklist throughout the week?
 ___ Go through any unanswered questions
 ___ How well do you think you did on this step?
 ___ Discuss and decide whether or not to move on

Preview Next Step (3 minutes)

- ___ Handout and introduce Values Module
 ___ Discuss values and their relevance
 ___ Introduce Coping Card
 ___ Encourage patient despite pace

or Review Current Step (3-5 minutes)

- ___ Reread current step
 ___ Troubleshoot difficulties
 ___ Review current forms

Session Four (20-25 minutes)

Reading Completed: Y/N or N/A	Exercises Completed: ___ of ___ or N/A
Monitoring Completed: Y/N	HW Completed: Y/N
Used Checklists: Y/N	Checklist Adherence: ___ of ___
Moved on: Y/N or N/A	

Necessary Materials:

- Activity Record
- TRAP/TRAC x5

Agenda**Check In (5-7 minutes)**

___ Welcome. This is session 4. We have 6 sessions left after this one.

Review outcome monitoring

- ___ Review and discuss any symptoms changes
 ___ Assess any suicidality endorsed

Review Patient's Use of Program

- ___ How well were you able to follow the assignments and do the reading?
 ___ Praise patient's effort and completion of exercises/assignments

Review Monitoring Forms + Additional HW Assignments (8-10 minutes)

- ___ Review collaboratively patient's Activity Record
 ___ Review collaboratively key assignments and address any difficulties
 ___ Positive comment on all signs of progress or attempts to change

*20 minutes into session → Must review checklists + Preview Next Step/Review Current Step

Review Step Checklist (3 minutes)

- ___ Did you refer to the review checklist throughout the week?
 ___ Go through any unanswered questions
 ___ How well do you think you did on this step?
 ___ Discuss and decide whether or not to move on

Preview Next Step (3 minutes)

- ___ Read Step 4 before Session 5
 ___ Remind patients that Step 4 lasts 2 sessions
 ___ Discuss avoidance loop
 ___ Discuss TRAP/TRAC
 ___ Introduce TRAP/TRAC Worksheets

or Review Current Step (3-5 minutes)

- ___ Reread current step
 ___ Troubleshoot difficulties
 ___ Review current forms
 ___ Encourage patient despite pace

Session Five (20-25 minutes)

Reading Completed: Y/N or N/A	Exercises Completed: ___ of ___ or N/A
Monitoring Completed: Y/N	HW Completed: Y/N
Used Checklists: Y/N	Checklist Adherence: ___ of ___
Moved on: Y/N or N/A	

Necessary Materials:

- Activity Record
- TRAP/TRAC x5

Agenda**Check In (5-7 minutes)**

___ Welcome. This is session 5. We have 5 sessions left after this one.

Review outcome monitoring

- ___ Review and discuss any symptoms changes
 ___ Assess any suicidality endorsed

Review Patient's Use of Program

- ___ How well were you able to follow the assignments and do the reading?
 ___ Praise patient's effort and completion of exercises/assignments

Review Monitoring Forms + Additional HW Assignments (8-10 minutes)

- ___ Review collaboratively patient's Activity Record
 ___ Review collaboratively key assignments and address any difficulties
 ___ Positive comment on all signs of progress or attempts to change

*20 minutes into session → Must review checklists + Preview Next Step/Review Current Step

Review Step Checklist (3 minutes)

- ___ Did you refer to the review checklist throughout the week?
 ___ Go through any unanswered questions
 ___ How well do you think you did on this step?
 ___ Discuss and decide whether or not to move on

Preview Next Step (3 minutes)

- ___ Reread Step 4
 ___ Review avoidance (i.e. TRAP & TRAC)
 ___ Troubleshoot problems with avoidance

or Review Current Step (3-5 minutes)

- ___ Reread current step
 ___ Troubleshoot difficulties
 ___ Review current forms
 ___ Encourage patients despite pace

Session Six (20-25 minutes)

Reading Completed: Y/N or N/A	Exercises Completed: ___ of ___ or N/A
Monitoring Completed: Y/N	HW Completed: Y/N
Used Checklists: Y/N	Checklist Adherence: ___ of ___
Moved on: Y/N or N/A	

Necessary Materials:

- Activity Record
- Example Monitoring Rumination
- Example Rumination Cues Action

Agenda**Check In + Checkpoint (5-7 minutes)**

___ Welcome. This is session 6. We have 4 sessions left after this one.

Review outcome monitoring

- ___ Review and discuss any symptoms changes
 ___ Assess any suicidality endorsed
 ___ Review overall progress (present graph of outcome data)

Review Patient's Homework Assignments

- ___ How well were you able to follow the assignments and do the reading?
 ___ Praise patient's effort and completion of exercises/assignments

Review Monitoring Forms + Additional HW Assignments (8-10 minutes)

- ___ Review collaboratively patient's Activity Record
 ___ Review collaboratively key assignments and address any difficulties
 ___ Positive comment on all signs of progress or attempts to change

Review Step Checklist (3 minutes)

- ___ Did you refer to the review checklist throughout the week?
 ___ Go through any unanswered questions
 ___ How well do you think you did on this step?
 ___ Discuss and decide whether or not to move on

*20 minutes into session → Must review checklists + Preview Next Step/Review Current Step

Preview Next Step (3 minutes)

- ___ Read Step 5
 ___ Discuss rumination
 ___ Introduce Rumination Record
 ___ Introduce Rumination Cues Action

or Review Current Step (3-5 minutes)

- ___ Reread current step
 ___ Troubleshoot difficulties
 ___ Review current forms
 ___ Encourage patient despite pace

Session Seven (20-25 minutes)

Reading Completed: Y/N or N/A	Exercises Completed: ___ of ___ or N/A
Monitoring Completed: Y/N	HW Completed: Y/N
Used Checklists: Y/N	Checklist Adherence: ___ of ___
Moved on: Y/N or N/A	

Necessary Materials:

- Activity Record
- Monitoring Rumination Worksheet
- Rumination Cues Action Worksheet
- Rumination Handout

Agenda**Check In (5-7 minutes)**

___ Welcome. This is session 7. We have 3 sessions left after this one.

Review outcome monitoring

- ___ Review and discuss any symptoms changes
 ___ Assess any suicidality endorsed

Review Patient's Homework Assignments

- ___ How well were you able to follow the assignments and do the reading?
 ___ Praise patient's effort and completion of exercises/assignments

Review Monitoring Forms + Additional HW Assignments (8-10 minutes)

- ___ Review collaboratively patient's Activity Record
 ___ Review collaboratively key assignments and address any difficulties
 ___ Positive comment on all signs of progress or attempts to change

*20 minutes into session → Must review checklists + Preview Next Step/Review Current Step

Review Step Checklist (3 minutes)

- ___ Did you refer to the review checklist throughout the week?
 ___ Go through any unanswered questions
 ___ How well do you think you did on this step?
 ___ Discuss and decide whether or not to move on

Preview Next Step (3 minutes)

- ___ Reread Step 5
 ___ Review rumination
 ___ Provide Rumination Handout
 ___ Troubleshoot problems with rumination

or Review Current Step (3-5 minutes)

- ___ Reread current step
 ___ Troubleshoot difficulties
 ___ Review current forms
 ___ Encourage patient despite pace

Session Eight (20-25 minutes)

Reading Completed: Y/N or N/A	Exercises Completed: ___ of ___ or N/A
Monitoring Completed: Y/N	HW Completed: Y/N
Used Checklists: Y/N	Checklist Adherence: ___ of ___
Moved on: Y/N or N/A	

Necessary Materials:

- Activity Record
- Short-Term Goal Plan x3

Agenda**Check In (5-7 minutes)**

___ Welcome. This is session 8. We have 2 sessions left after this one.

Review outcome monitoring

___ Review and discuss any symptoms changes
 ___ Assess any suicidality endorsed

Review Patient's Homework Assignments

___ How well were you able to follow the assignments and do the reading?
 ___ Praise patient's effort and completion of exercises/assignments

Review Monitoring Forms + Additional HW Assignments (8-10 minutes)

___ Review collaboratively patient's Activity Record
 ___ Review collaboratively key assignments and address any difficulties
 ___ Positive comment on all signs of progress or attempts to change

*20 minutes into session → Must review checklists + Preview Next Step/Review Current Step

Review Step Checklist (3 minutes)

___ Did you refer to the review checklist throughout the week?
 ___ Go through any unanswered questions
 ___ How well do you think you did on this step?
 ___ Discuss and decide whether or not to move on

Preview Next Step (3 minutes)

___ Read Step 6
 ___ Discuss goal vs. mood dependence
 ___ Discuss values vs. goals
 ___ Introduce Short-Term Goal Plan

or Review Current Step (3-5 minutes)

___ Reread current step
 ___ Troubleshoot difficulties
 ___ Review current forms
 ___ Encourage patient despite pace

Session Nine (20-25 minutes)

Reading Completed: Y/N or N/A	Exercises Completed: ___ of ___ or N/A
Monitoring Completed: Y/N	HW Completed: Y/N
Used Checklists: Y/N	Checklist Adherence: ___ of ___
Moved on: Y/N or N/A	

Necessary Materials:

- Activity Record
- Relapse Prevention Module
- Post-Therapy Plan

Agenda**Check In (5-7 minutes)**

___ Welcome. This is session 9. We have 1 sessions left after this one.

Review outcome monitoring

___ Review and discuss any symptoms changes
 ___ Assess any suicidality endorsed

Review Patient's Homework Assignments

___ How well were you able to follow the assignments and do the reading?
 ___ Praise patient's effort and completion of exercises/assignments

Review Monitoring Forms + Additional HW Assignments (8-10 minutes)

___ Review collaboratively patient's Activity Record
 ___ Review collaboratively key assignments and address any difficulties
 ___ Positive comment on all signs of progress or attempts to change

*20 minutes into session → Must review checklists + Preview Next Step/Review Current Step

Review Step Checklist (3 minutes)

___ Did you refer to the review checklist throughout the week?
 ___ Go through any unanswered questions
 ___ How well do you think you did on this step?
 ___ Help patient set the pace if he/she is unsure

Preview Next Step (3 minutes)

___ Read Step 7 – Handout Module
 ___ Discuss Relapse Prevention
 ___ Introduce Post-Therapy Plan
 ___ If behind pace, assign next step + Step 7

or Review Current Step (3-5 minutes)

___ Reread current step
 ___ Troubleshoot difficulties
 ___ Review current forms
 ___ Encourage patient despite pace

Session Ten (40-45 minutes)

Reading Completed: Y/N or N/A	Exercises Completed: ___ of ___ or N/A
Monitoring Completed: Y/N	HW Completed: Y/N
Used Checklists: Y/N	Checklist Adherence: ___ of ___

Necessary Materials:

- All Patient Forms

Agenda**Check In (5-7 minutes)**

___ Welcome. This is session 10, our final session together.

Review outcome monitoring

- ___ Review and discuss any symptoms changes
 ___ Assess any suicidality endorsed

Review Patient's Homework Assignments

- ___ How well were you able to follow the assignments and do the reading?
 ___ Praise patient's effort and completion of exercises/assignments

Review Monitoring Forms + Additional HW Assignments (8-10 minutes)

- ___ Review collaboratively patient's Activity Record
 ___ Review collaboratively key assignments and address any difficulties
 ___ Positive comment on all signs of progress or attempts to change

*20 minutes into session → Must review checklists + Review Step 8 + Treatment Wrap-up

Review Step Checklist (3-5 minutes)

- ___ Did you refer to the review checklist throughout the week?
 ___ Go through any unanswered questions

Review Step 7 (10 minutes)

- ___ Troubleshoot any difficulties and assist patient with Post-Therapy Plan
 ___ Discuss questions or concerns beyond treatment
 ___ If patient behind pace, encourage them to continue with program on their own

Treatment Wrap-up (15 minutes)

- ___ Review Follow-up Measures (5 minutes)
 ___ Review overall progress on outcome monitoring for patient (present graph)
 ___ Discuss any necessary referrals
 ___ Discuss brief follow-up assessment in a month
 ___ Praise patient on all their efforts throughout the program

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Figure 1

Percentage of Correct Use of BAGsh Adherence Skills

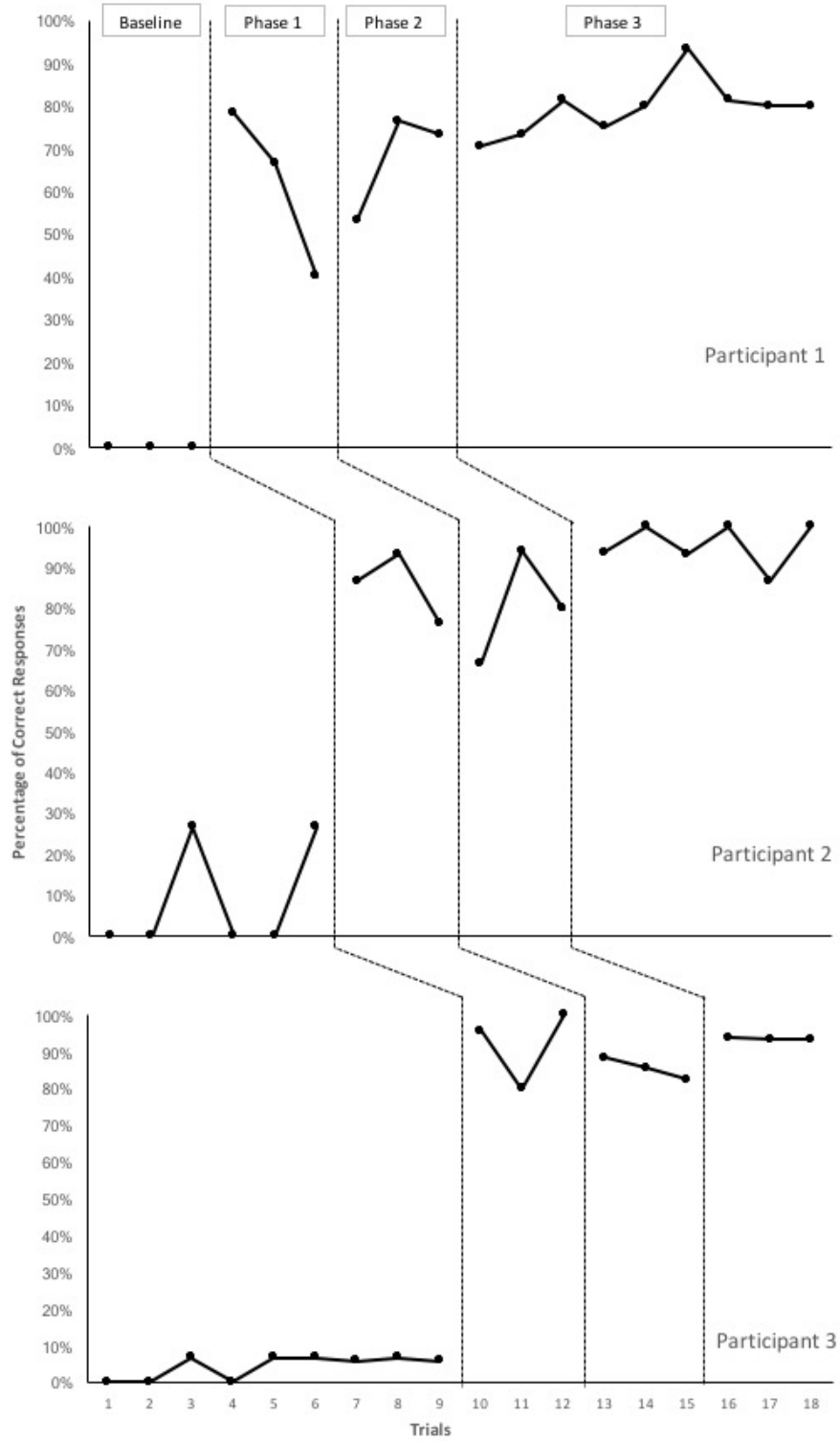


Table 1
Participant Outcomes by Phase

<u>Participant</u>	<u>Baseline</u>	<u>Phase 1</u>	<u>Phase 2</u>	<u>Phase 3</u>
P1	0.0	61.6	67.7	79.4
P2	8.9	85.5	80.3	95.6
P3	4.3	91.9	85.4	93.5

Percentage of correct responses