

Running head: BUILDING EVIDENCE-BASED TREATMENTS

BUILDING EVIDENCE-BASED TREATMENTS FROM THE GROUND UP:  
TREATMENT DEVELOPMENT THROUGH RESEARCH-CLINICIAN  
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# BUILDING EVIDENCE-BASED TREATMENTS

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## ABSTRACT

It is well established that youth anxiety and depression are highly comorbid, and that co-morbidity is linked to worse outcomes and greater impairment. Though numerous evidence based treatments (EBTs) exist for these disorders, treatment developers have historically neglected to fully consider the realities of community-based practice, thereby hindering widespread implementation of EBTs. This project seeks to bridge the gap between research and practice by incorporating community clinicians early in the development process. Community clinicians were recruited to use a novel, behaviorally-based, transdiagnostic protocol with a youth client. Four participants implemented Individual Behavioral Activation Treatment (IBAT) protocol, which incorporates Behavioral Activation and in vivo exposure to treat anxiety, depression, and anger in youth. Prior to treatment, clinicians completed questionnaires regarding therapist variables, biases in case conceptualization, and attitudes towards different treatment strategies. During treatment, clinicians provided qualitative and quantitative feedback on the acceptability and feasibility of the protocol after every four sessions. Following treatment completion, participants gave input regarding specific treatment strategies, overall attitude towards the protocol, and suggestions for future iterations. Given the low usage rates of exposure exercises in community practice, questionnaires included items specifically designed to assess attitudes towards, barriers to, and facilitators of the use exposure. Results demonstrated that clinicians found the protocol to be acceptable, feasible to implement, and appropriate in addressing clients' needs. The protocol's detailed structure, organizational guidelines, and worksheets facilitated treatment. Despite overall acceptance, clinicians indicated that IBAT as a whole would only be appropriate for a portion (58.5%) of the cases they see focusing on anxiety and

depression, possibly due to traditional understandings of treatment tools such that exposures are used exclusively for anxiety and that behavioral activation is used exclusively for behavioral activation. Recommendations included spacing activities over more sessions and adding additional tips or modules to address factors related to the treatment of anxiety and depression, such as building motivation or sleep and eating hygiene. Feedback has been used to generate a list of specific recommendations for future iterations of IBAT.

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## TABLE OF CONTENTS

	PAGE
ABSTRACT .....	ii
ACKNOWLEDGEMENTS .....	iv
TABLE OF CONTENTS .....	vi
LIST OF TABLES .....	ix
LIST OF FIGURES .....	x
CHAPTERS	
I. INTRODUCTION .....	1
Background .....	1
Psychopathology within a Youth Population.....	2
Evidence for Behavioral Activation.....	5
Dissemination and Implementation .....	9
Stakeholder Involvement and Mixed Methods Approaches in Treatment Development.....	11
Development of Group Behavioral Activation Therapy and Individual Behavioral Activation Treatment .....	13
The Current Study .....	16
Aims .....	17
II. METHODS .....	17
Participants.....	17
Measures .....	18
Therapist Background Questionnaire .....	18

Manual Rating Form .....	19
Manual Summary Survey .....	20
Treatment Manual .....	21
Procedures .....	22
III. RESULTS .....	24
Clinician Variables .....	24
Acceptability and Feasibility of Manual Organization and Presentation .....	25
Acceptability and Feasibility of Manual Interventions and Strategies .....	26
Anticipated Barriers to Exposure Use .....	26
Barriers and Facilitators to Exposure in Sessions 1-12 .....	27
Facilitators of Exposure: Sessions 1-12 .....	28
Perceived Effectiveness and Difficulty of Implementing IBAT Strategies .....	29
Perceived Applicability and Generalizability of IBAT Strategies and Manual .....	30
Qualitative Feedback and Recommendations: Sessions 1-12 .....	31
Overall Qualitative Feedback and Recommendations .....	33
IV. DISCUSSION .....	35
Recommendations .....	44
Limitations .....	46
Conclusions and Future Directions .....	47



REFERENCES .....	48
TABLES .....	63
FIGURES .....	68
APPENDIX.....	69
Therapist Background Questionnaire .....	69
Manual Rating Form Sessions 1-4.....	76
Manual Rating Form Sessions 5-8.....	82
Manual Rating Form Sessions 9-12.....	87
Manual Rating Summary Survey.....	93

## LIST OF TABLES

Table 1. Mean (SD) of Manual Rating Form Subscales by Treatment Phase.....	63
Table 2. Mean (SD) Barriers to Exposure Use Subscales by Treatment Phase .....	64
Table 3. Mean (SD) Facilitators of Exposure Use Subscales by Treatment Phase .....	65
Table 4. Mean (SD) Clinician Attitudes Toward IBAT components/intervention....	66
Tables 5. Themes of Qualitative Feedback from Session 1-12, Valence of Responses, and Suggestions .....	67

LIST OF FIGURES

Figure 1. Schematic presentation of participant enrollment, retention, and  
assessment completion.....68

## Introduction

### Background

Anxiety and depressive disorders are consistently among the most prevalent of disorders in youth, (Angold, Erkanli, Silberg, Eaves, & Costello, 2002; Canino et al., 2004; Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Costello, Egger, Angold, 2004; Costello, Egger, & Angold, 2005; Green, McGinnity, Meltzer, Ford, & Goodman, 2004; Kessler, Peukhova, Sampson, Zaslavsky, & Wittchen, 2012; Meltzer, Gatward, Goodman, & Ford, 2000; Roberts, Roberts, & Xing, 2007), and it has been well established that there is a high level of comorbidity found between these disorders (Costello et al., 2004; Sorensen, Nissen, Mors, & Thomsen, 2005; Weersing, Gonzalez, Campo, & Lucas, 2008, Angold, Costello, & Erkanli, 1999). Behavioral Activation (BA), which is a psychological intervention that addresses avoidant behavioral patterns to address mood and anxiety problems, has received substantial empirical support for its efficacy in treating adults and youth with depression (Dimidjian et al, 2006; Jacob, Keeley, Ritschel, & Craighead, 2013; Jacobson et al., 1996; Martell, Addis, & Jacobson, 2001; McCauley et al., 2015). Recent evidence has also provided support for BA as an efficacious treatment for anxiety (Chu et al., 2016; Hopko, Lejuez, & Hopko, 2004). suggesting that BA may function to address diverse sets of problems. Still, only a minority of youth in need of services ever receive evidence-based treatments, such as BA, because few community-based clinicians seek training and implement novel treatments with research support (Palinkas et al., 2011).

One criticism of evidence-based treatment protocols is that they are typically developed in highly controlled research settings (e.g., universities, medical centers) and do not fully account for the needs and resource limitations of typical clinical practice (Landsverk, 2013). By the time novel treatments (even those with empirical support) are presented to practicing clinicians for

potential adoption, potential end-users may view the intervention as academic and limited in its ability to address the concerns of their complex caseload or fit within the demands of their organizations (Schoenwald & Hoagwood, 2001). As a result, many empirically supported treatments are never adopted as part of usual care practice, and a huge majority of youth welfare services do not employ evidence-based practices (Palinkas et al., 2011). To help bridge the gap between experimental treatment development and local community practice, Beidas, Koerner, Weingardt, and Kendall (2011) recommend involving potential end-users (e.g., therapists, administrators) early in the development process, thereby allowing researchers to address potential barriers while it is still feasible to do so. The current project aims to implement this model in developing a novel behavioral activation treatment by integrating researcher and community clinician feedback in an iterative fashion. The resulting treatment promises to incorporate the best of scientific evidence into a structured protocol intentionally designed to accommodate the demands of local practice.

### **Psychopathology within a Youth Population**

A vast number of child and adolescents under the age of 18 suffer from some form of psychopathology. Estimates vary, with studies reporting that 7% to 20% of youth will meet criteria for some form of psychological disorder within a 12-month period (Costello et al., 2003; Canino et al., 2004; Ford, Goodman, & Meltzer, 2003; Green et al., 2005; Roberts et al., 2007). Results from the National Comorbidity Study- Replication Adolescent Supplement suggest even higher rates of mental disorders among youth ages 13 to 18, with a 12-month prevalence rate between 41.1% and 45.2% and a lifetime prevalence rate between 52.4% and 54.3% (Kessler et al., 2012). Anxiety disorders consistently rank among the most prevalent of disorders among youth, with life-time prevalence rates up to 29% and 12-month prevalence rates ranging from 3%

to 24% among youth; depressive disorders are believed to have a 12-month prevalence rate ranging from 1% to 8% for individuals under 18 (Angold et al., 2002; Canino et al., 2004; Costello et al., 2003; Costello et al., 2004; Costello et al., 2005; Green et al., 2004; Kessler et al., 2012; Meltzer et al., 2000; Roberts et al., 2007). Research also demonstrates that a greater number of individuals meet criteria for a psychological disorder at a younger age than in past cohorts, with approximately half of all mental illness diagnosed before the age of 15 (Kessler et al., 2003; Kessler & Üstün, 2008).

These disorders have been linked to a range of negative consequences involving family, social, and academic impairment (Gotlib, Lewinsohn, & Seeley, 1998; Kovacs & Devlin, 1998; Rapee, Schniering, & Hudson, 2009; Reinherz, Giaconia, Hauf, Wasserman, & Silverman, 1999). When looking at causes of disability-adjusted life- years (DALYs), a unit that measures the expected number of years of life lost to death or lived with disability, nine of the top ten causes are either a psychiatric disorder or a problem highly associated with psychopathology, with depression ranked as number one (Murray and Lopez, 1996). It has also been well established that there is a high level of comorbidity found between anxiety and depressive disorders, with some clinical samples demonstrating comorbidity rates as high as 75% (Angold et al., 1999; Costello et al., 2004; Sorensen et al., 2005; Weersing et al., 2008). Research has demonstrated that individuals with co-morbid disorders appear to have worse outcomes, with increased functional impairment across domains, higher rates of psychopathology later in life, and increased suicidal behavior (Birmaher et al., 1996; Ezpeleta, Domenech, & Angold, 2006; Lewinsohn, Clarke, Seeley, & Rohde, 1994, Lewinsohn, Rohde, & Seeley, 1995, Reich et al., 1993).

Comorbidity poses unique problems to treatment delivery. Although single-disorder protocols offer targeted techniques, the effects may not generalize across disorders unless adaptations are made. In these instances, flexibility can allow for greater applicability to different problems, but clinicians are left without concrete instruction or recommendations on how to appropriately deviate from protocols to ensure best results (Kendall & Beidas, 2007; McHugh & Barlow, 2010;). Another option is to use modular treatments which allow providers to select which portions of manual to use a client's presenting problem. This enables more individualized treatment, but still necessitates relying on clinical judgment to determine what modules are most relevant, and may result in clinicians feeling overwhelmed with options or the need to incorporate additional modules (Chu, Merson, Zandberg, & Areizaga, 2012). An increasingly promising option is to use a transdiagnostic model to target a common mechanism across disorders. Transdiagnostic modules offer a standardized order of treatment components, while also allowing for variability in the number of sessions spent on particular interventions. A clear departure from the single-disorder protocols that have long been the standard treatment of psychopathology, transdiagnostic protocols are specifically designed to address the high levels of comorbidity found among individuals suffering from mental disorders.

As reviewed by Chu, Skriner, & Staples (2013), significant evidence suggests that avoidance plays a key role as a common mechanism across a range of different disorders, including anxiety, depression, and externalizing disorders. Accordingly, researchers have designed protocols to specifically target this mechanism, including Group Behavioral Activation Therapy (GBAT), developed by Chu, Colognori, Weissman, & Bannon (2009), and Brief Behavioral Therapy (BBT), developed by Weersing, Gonzales, Campo, and Lucas (2008). These

protocols rely on behavioral techniques and strategies, with a particular emphasis on Behavioral Activation, in order to effectively and efficiently target avoidance.

### **Evidence for Behavioral Activation**

Early behavioral models suggested that one could decrease depression by increasing the number of pleasant activities in one's life and subsequently provide greater opportunity for reinforcement and rewards in day-to-day life (Lewinsohn & Graf, 1973; Lewinsohn & Libet, 1972). Decades later, Jacobson, Martell, and Dimidjian. (2001) presented a re-conceptualized version of Behavioral Activation which posited that individuals turn to avoidance to quickly escape distress triggered by stressors in day-to-day life. Avoidance is negatively reinforced by the relief from distressing emotions, but further perpetuates a cycle of depression by failing to resolve the initial stressor, causing additional problems, and decreasing opportunities for positive reinforcement. BA seeks to halt this cycle by targeting avoidance behaviors and increasing activation.

Trials comparing BA to full Cognitive Therapy and antidepressant medication have demonstrated that BA has outcomes equivalent to both treatment options (Dimidjian et al, 2006; Jacobson et al., 1996; Martell et al., 2001; Richards et al., 2016). Findings from a number of individual studies and reviews looking at different BA treatment components and unique BA protocols (Hopko, Lejuez, Ruggiero, & Eifert, 2003; Kanter et al., 2010), in addition to meta-analyses of studies comparing BA to other treatment options (Cuijpers, Van Straten, & Warmerdam, 2007; Ekers, Richards, & Gilbody, 2008; Ekers et al., 2014; Mazzucchelli, Kane, & Rees, 2010) have consistently demonstrated that BA is an effective treatment for adult depression, with significant potential as a cost-effective, efficient treatment. Follow-up studies have also provided evidence that BA may be better than medication at preventing recurring



episodes of depression following treatment (Dobson et al., 2008). More recent reviews have cited ongoing research on the efficacy of BA to treat depression within different settings, such as hospital inpatient units (Hopko, Lejuez, LePage, McNeil, & Hopko, 2003) and for different populations, including those at varying stages of life, with comorbid diagnoses, and of different cultural backgrounds (Dimidjian, Barrera, Martell, Munoz, & Lewinsohn, 2011; Hopko et al., 2004; Hopko, Robertson, & Colman, 2008; Hopko, Sanchez, Hopko, Dvir, & Lejuez, 2003; Polenick & Flora, 2013).

The re-conceptualized BA model for depression closely parallels anxiety treatment models; as anxiety increases, an individual seeks to escape the distress through avoidant behaviors, which are subsequently negatively reinforced by the removal of anxiety (Mineka & Zinbarg, 2006). Despite short-term relief, it causes additional problems over time and fails to reduce the global level of anxiety over time. Exposure exercises have become a key component of anxiety disorder treatment and are explicitly designed such that individuals can practice approaching feared stimuli rather than avoiding them (Kendall et al., 2016). These similarities suggest that BA may be well suited to treat anxiety, and a small number of studies have examined this as a possibility.

Researchers implemented a 12-week behavioral activation treatment of anxiety (BATA) protocol among three individuals with anxiety disorders and found significant decreases in self-reported anxiety post-treatment and at three-month follow-up (Turner & Leach, 2010). Another study used BA and pharmacotherapy to treat an individual with chronic comorbid OCD and MDD over 21 months and found that self-reported anxiety and stress were no longer within elevated ranges. Additionally, compulsive behaviors had significantly decreased and were no longer impairing following treatment (Arco, 2015). Other case studies have demonstrated

promising support for the use of BA to treat PTSD (Mulick & Naugle, 2004), co-morbid anxiety and depression (Hopko et al., 2004), and anxiety and depression among cancer patients (Hopko et al., 2011).

Although the majority of BA research has been conducted with adults, there is also a growing literature on the use of BA for youth. In a six-participant pilot study assessing a BA manual that had been developed with client input, Ritschel, Ramirez, Jones, & Craighead (2011) found that all participants' depression scores had decreased at post-treatment, and four of the six individuals had scores in the normative range. Following a similar model, McCauley, Schloedt, Gudmundsen, Martell, and Dimidjian (2011) incorporated feedback from a pilot study testing a BA protocol for adolescents into a second iteration of the manual titled the Adolescent Behavioral Activation Program (A-BAP). Changes included increased flexibility regarding presentation of material and order of treatment priorities, in addition to the inclusion of a problem solving module. When A-BAP was compared to uncontrolled evidence-based practice (consisting primarily of CBT and IPT informed practice) in an RCT with 60 adolescent participants, both treatment conditions resulted in significant improvement in symptoms and had similar retention rates (McCauley et al., 2015). In a separate study, Jacob et al (2013) conducted a pilot study examining the use of BA for low-income, African American adolescents. Results demonstrated that both clients and caregivers were satisfied with the treatment, and that two of the three participants no longer met criteria for MDD and post-treatment.

These findings regarding BA for adolescent depression, in conjunction with initial evidence suggesting that BA may be efficacious in treating anxiety for adults, have resulted in increasing focus on the use of BA to treat anxiety and depression concurrently through transdiagnostic interventions, with avoidance targeted as the core mechanism across disorders.

Still in its infancy, transdiagnostic research examining the use of BA for anxiety and depression has demonstrated early success. Weersing et al. (2008) developed two behaviorally based protocols for children and adolescents between the ages of 7-17 presenting with an internalizing disorder in a primary care setting, including Brief Behavioral Therapy (BBT) for Pediatric Anxiety and Depression (previously referred to as IBBT) and Brief Behavioral Therapy (BBT) for Anxiety and Pediatric Abdominal Pain (Weersing, Rozenman, Maher-Bridge, and Campo, 2012). Results from a 54 participant pilot study using the original IBBT, and findings from subsequent case studies that used the updated protocols showed promise, with treatment leading to a reduction in symptoms across disorders. In a follow-up randomized clinical trial, 185 youth between the ages of 8-16 with anxiety or depressive disorders received either BBT for anxiety or depression within a pediatric care setting or were provided with assisted referral to care (ARC). Results demonstrated that youth receiving BBT showed significantly higher rates of clinical improvement and better functioning as compared to youth in the ARC condition (Weersing et al., 2017).

An initial pilot study of Group Behavioral Activation Therapy, a transdiagnostic manual targeting avoidance in anxiety and depression, has demonstrated promising results regarding acceptability and utility. Specifically, findings showed that 75% of invited individuals agreed to enter treatment, and 75% of treatment completers experienced clinically significant change in their principal diagnoses (Chu et al., 2009). In a follow-up study, Chu et al. (2016) conducted an RCT with 35 youth, ages 12 to 14, all with primary diagnoses of anxiety (82.9%) or depression (17.1%) who were assigned to the GBAT condition or a 15-week waitlist (WL). At post-treatment, youth in GBAT demonstrated significantly reduced overall impairment related to anxiety and depression and significantly greater remission in secondary diagnoses compared to

WL. Scores on the Anxiety Disorder Scheduled Interview (ADIS) Clinical Severity Rating (CSR) were significantly lower for secondary diagnoses, but not for primary diagnosis, among youth in GBAT vs. WL. Further, as compared to WL, GBAT was associated with a reduction in the number of diagnoses and comorbid disorders, which is an important outcome for a protocol specifically aiming to address problems transdiagnostically. Also important is that youth continued to demonstrate gains at 4-month follow-up, showing significant improvement in principle and secondary diagnosis CSR, number of diagnoses and comorbid diagnoses, and global impairment.

### **Dissemination and Implementation**

Though the early evidence for the use of BA in transdiagnostic protocols is promising, a major movement in the field of psychology is to expand the focus of research from efficacy to effectiveness (National Institute of Mental Health Advisory Council Workgroup Report, 2001). Kazdin (2000) defined treatment acceptability as the extent to which consumers view the treatment as pleasant, fair, reasonable, and justified. Concerns regarding acceptability and feasibility have been present within psychology for some time (Addis et al., 1999), yet the primary focus of research has typically been on treatment fidelity and the need to ensure strict adherence to protocols in order to optimize internal validity (Landsverk, 2013). Although this approach has aided in the development of efficacious treatments, it has perhaps minimized, or underestimated, how interventions would adapt to “real-world” settings (i.e., the treatment’s effectiveness), and the focus on these top-down approaches in research has stymied implementation and dissemination efforts (Sexton, Chamberlin, Landsverk, Oritz, & Schoenwald, 2010).

One major criticism is that most treatments are developed within academic environments that do not reflect typical care settings. For example, most outpatient clinics are not able to provide in-depth training, ongoing supervision, or fidelity monitoring, and as a result, protocols developed within the confines of research may not translate particularly well into these community care settings (Schoenwald & Hoagwood, 2001). Due to this wide gap between research and practice, a huge majority of youth welfare services do not employ any of the evidence-based practices that exist (Palinkas et al., 2011). A prime example of this is the use of exposures. Despite the known efficacy of exposure based treatments, a huge portion of clinicians in the field do not use them (Becker, Zayfert, & Anderson, 2004; Freiheit, Vye, Swan, & Cady, 2004; Powers & Deacon, 2013), even after intensive training and an extensive period of consultation (Chu, Crocco, Arnold, Brown, Southam-Gerow, & Weisz, 2015). This is of particular concern in behavioral protocols in which the primary intervention includes behavioral activation and exposures.

In examining potential explanations for this, a number of studies have noted that therapists' beliefs and attitudes play key roles in both the use of EBPs and overall treatment outcomes. For example, Becker et al. (2004) found that practitioners frequently endorsed concerns regarding potential contraindications (i.e., suicidality, homicidality, psychotic disorders, dissociation, or any comorbid disorder) and potential complications related to the use of imaginal exposure (IE) to treat Post-Traumatic Stress Disorder (PTSD). These findings suggested that therapist belief that IE would not appropriate for individuals with any contraindications, or could augment impairing symptoms or patient desire to drop-out, could pose a significant barrier to the use of this intervention. Other studies have found some evidence suggesting that therapists believe that EBPs detract from therapeutic alliance, are excessively

focused on technique and structure, and lack flexibility (Harvey & Gumpert, 2015). Research has shown that clinicians are less likely to implement interventions that are not rated high on acceptability (Miller, DuPaul, & Lutz, 2002) and demonstrate less stringent adherence to these protocols than to interventions rated as more acceptable (Tarrier, Liversidge, & Gregg, 2006). To this end, there has been a growing call to consider factors of external validity within the early stages of treatment development in order to better address provider concerns and increase feasibility and acceptability (Landsverk, 2013).

### **Stakeholder Involvement and Mixed-Methods Approaches in Treatment Development**

In a review of current research trends, Beidas et al. (2011) outline the typical stepped approach to treatment development: studies advance from basic research to pilot studies, to efficacy-focused RCTs, and finally to effectiveness trials. This raises a number of potential problems, including the previously stated unrealistic expectation for community providers to implement treatment manuals that have not been developed with the considerations of community settings in mind. In addition to relegating critical matters of implementation to the final step in development, at which point there is little flexibility for developers to adjust protocols and increase effectiveness (Glasgow, Vogt, & Boles, 1999), development efforts are limited by assuming that advances must exclusively stem from research before transitioning to practice. In order to make advances in the dissemination and implementation (D&I) of effective treatments, a new model is needed in which treatment setting variables are considered from the outset of protocol development (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001).

Beidas et al. (2011) recommend involving potential consumers, in this case treatment providers, significantly earlier in the development process in order to allow researchers to incorporate feedback and address potential barriers while it is still feasible to do so. Researchers

are encouraged to borrow from other fields and use product development models that are specifically designed to gather information on consumer needs, identify opportunities for growth, elicit consumer feedback, and establish a collaborative relationship between researchers and consumers from the onset of a project (Crawford & Di Benedetto, 2010; Forman, Olin, Hoagwood, Crowe, & Saka, 2009). Recommendations from trauma research, an area at the forefront of D&I research due to the highly publicized need for effective interventions, also suggest using collaborative planning with agency leaders in order to help optimize acceptability and feasibility (Kolko, Hoagwood, & Springgate, 2010). For example, Chung, Jones, Dixon, Miranda, and Wells (2010) used community-partnered participatory research (CPPR) to compare the effectiveness of multi-agency collaborative care versus individual agency care in the treatment of depression for low-income communities where incidence of trauma is more widespread. In this large-scale study, researchers recruited representatives of community administrators and providers. These individuals completed surveys at baseline, 12-months, and 24-month follow-up regarding study planning, training, and implementation. Throughout planning, all parties were reportedly given equal weight in establishing compromises to help address concerns raised in the surveys, and substantial changes were implemented to make the study more acceptable and feasible to the community. While it is not a practical to partner with every potential outpatient treatment provider, this model parallels the previously discussed suggestions to involve potential stakeholders as early as possible, and it is likely that input from a subset of providers may help address concerns found in other similar settings. After initial input, it is then important to utilize targeted exercises (e.g., group discussion of pros and cons of an intervention, or structured questionnaire assessing intentions, pros and cons, and potential facilitating factors to assess attitudes, norms, and perceived control regarding the product (i.e.,

the treatment protocol) to aid in the evaluation and evolution of the product as it proceeds through its various stages (Casper, 2007; Francis et al., 2004).

These steps call for the use of both quantitative and qualitative research, and there is increasing support for the use of mixed-methods approaches in D&I research. A review of mixed-methods studies demonstrated that while qualitative measures are often secondary to quantitative measures within research, the inclusion of qualitative data can serve a range of important functions (Palinkas et al., 2011). Qualitative measures can expand upon the process behind quantitative findings and improve understanding of the data, capture the complex contexts relevant in effectiveness research, and gather and employ consumer feedback in the development of new models, measures, and treatments. Additionally, qualitative measures can be incorporated at various time points during a study, either as a secondary source of information gathered within the context of larger efficacy trials, or as the primary focus during the nascent stages of development to inform subsequent pilot studies.

### **Development of Group Behavioral Activation Therapy and Individual Behavioral Activation Treatment**

In creating Group Behavioral Activation Treatment, the developers combined evidence based interventions with end-user involvement and feedback (Chu et al., 2009). Seeking to harness the potential benefits of school based interventions and reach a large number of youth at a convenient location, GBAT was designed to be run in schools during school hours. Accordingly, steps were taken to determine if the manual could be implemented within this setting, beginning with an initial pilot study conducted through a local middle school. At this early stage, five participants met for 13 weeks during a typical class period within the school counseling office. Results demonstrated that three participants experienced remissions in their



primary diagnoses, reduced anxiety and depressive symptoms, and decreased avoidance of target situations at post-treatment (Chu, Hoffman, Johns, Reyes-Portillo, & Hansford, 2014).

Importantly, this pilot trial also sought feedback from the treated youth regarding the acceptability and feasibility of the program. Attendance and satisfaction ratings suggested that GBAT was acceptable to youth.

In examining feasibility, a key piece of GBAT development was ensuring that it was practical to implement within schools. Accordingly, developers utilized feedback to adapt the manual to better fit within the school setting and to address their needs. For example, GBAT was expanded from addressing exclusively anxiety and depression to also targeting anger, as this was a commonly expressed emotion among youth during the trial. Following the initial pilot trial and subsequent modifications, an RCT was conducted with 35 youth (Chu et al., 2016). School counselors were included as co-therapists, which provided further opportunity to assess the feasibility of the treatment when implemented by non-specialists who were naturally employed in the school setting. No differences in adherence were found between mental health specialists or school counselors, and all participants with primary diagnoses of anxiety (82.9%) or depression (17.1%) demonstrated reduced impairment from pre-treatment to post-treatment in comparison with a WL control group. Overall, the findings indicated that GBAT could effectively be implemented within a school setting.

Given the promising results of GBAT, Individual Behavioral Activation Treatment (IBAT) was developed as an individually based transdiagnostic treatment targeting avoidance across internalizing disorders (Chu et al., 2012). Unlike GBAT, which was designed for use in school to target groups of adolescents, IBAT was geared towards individual children and adolescents seeking treatment in outpatient community settings. The program consists of 10-12

weekly 60 minute sessions. Like GBAT, IBAT helps youth identify where they are stuck through self-assessment and monitoring. Youth are coached on how to set meaningful goals, formulate active problem solving strategies, and approach distressing scenarios and increase activity level through in-session and at-home exposures and behavioral activation.

IBAT differs from other individually based BA and transdiagnostic treatments in a number of ways. Though all BA protocols aim to target avoidance, session content may differ. IBAT is unique in its emphasis on in-session behavioral activation and exposure tasks. While other manuals may provide instruction or guidance on how to use these interventions, they typically rely on out-of-session practice. This is also true of the transdiagnostic BBT protocol, which was specifically developed for use in primary care settings and subsequently has a shorter treatment duration (i.e., six sessions for BBT for Anxiety and Pediatric Abdominal Pain) that necessitates out of session exposures (Weersing et al., 2012). In comparison to these protocols, IBAT's use of session time to implement behavioral activation and exposure tasks allows for valuable assessment of the client's functioning in challenging situations, and affords the client real-time coaching and feedback. This system betters the understanding of client's behavioral patterns and increases the clinician's ability to reinforce their efforts and shape behavior.

IBAT is also significantly different from UP-Youth (UP-Y; Ehrenreich, Goldstein, Wright, & Barlow, 2009), a downward extension of the adult *Unified Protocol for the Treatment of Emotional Disorders* (Barlow, Allen, & Choate, 2004). The most significant difference is that UP-Y focuses on the underlying mechanism of emotion regulation, rather than avoidance. Session time is spent on behavioral tasks, though there is also explicit work done on altering antecedent cognitive appraisals, and the overall goal is to decrease youth emotion dysregulation, rather than avoidance. UP-Y treatment ranges from eight to 21 individual sessions with five

mandatory modules and three optional modules. In its current form, IBAT is administered as one complete treatment and does not include multiple modules to choose from. Though this may reduce flexibility, it also allows for a simple, streamlined manual that reduces the necessity of relying on clinical judgement to dictate treatment choices. Additionally, while UP-Y incorporates multiple components in its treatment, IBAT exclusively focuses on decreasing avoidance, thereby reducing the number of exercises and skills that clinicians and youth need to master.

### **The Current Study**

As has been demonstrated, there are considerable challenges in transporting behavioral interventions from research settings into practice. Developing interventions within the settings for which they are intended and systematically incorporating end-user feedback during the developmental process may prove more successful than imposing a completed protocol on a professional community after the fact (Chorpita, 2002). Such a process enhances the chances that the final product will have more of the features that the intended end-user requires for faithful use. The current study partnered with community clinicians, whose primary responsibilities entail direct clinical service, to gather their feedback early in the development process and utilize this information in the production of an ecologically valid manual and client workbook. Participants consisted of practitioners who were likely to have opinions about psychological treatments for youth seeking individual treatment for anxiety and depression, and came from a range of backgrounds experience and current practice. Eliciting input from such individuals provided valuable information at this early stage in treatment development.

A key goal of this feedback process is to gain insight into clinician attitudes and behaviors regarding the use of behavioral activation and exposures within the manual. As

discussed, despite the known efficacy of exposure based treatments, a substantial portion of clinicians in the field do not use them (Becker et al., 2004; Powers & Deacon, 2013). Even within the GBAT RCT, clinicians did not implement exposures in 40% of sessions in which the manual intended (Chu et al., 2016). As such, in addition to providing feedback about the manual as a whole, clinicians were asked for input about perceived and actual barriers to the use of exposures, the utility of elements within the manual designed to facilitate exposure exercises, and suggested modifications to improve the ease and acceptability of implementing exposures.

### **Aims**

Within this study, we sought to 1) identify strengths and weaknesses of IBAT, 2) gather understanding of clinician attitudes towards exposure use, and 3) use outcomes and feedback to inform a list of recommendations for futures iterations of the manual. Regarding Aim 1, in evaluating different components of the manual particular emphasis was given to manual presentation and content, applicability to client difficulties, implementation, and use of interventions. To fulfill Aim 2, qualitative and quantitative feedback was reviewed to illuminate barriers and facilitating factors of exposure exercises in session. For Aim 3, qualitative responses were coded for content themes that highlighted key areas of feedback. These content areas, as well as specific suggestions and quantitative outcomes, gave direction to a list of IBAT revisions.

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### **Methods**

#### **Participants:**

Participants included seven psychologists who were willing to use IBAT for 12 sessions with a client age 11-17 with a primary diagnosis of anxiety or depression. All participants were

female, ranging in age from 30-44 ( $SD = 4.9$ ). Among the participants, four identified as Caucasian, one as African American, one as Cuban and Irish, and one as Hispanic. Regarding qualifications, three had earned Ph.D.s, three had earned Psy.D.s, and one was a licensed school psychologist with a Psy.M.. Participants primarily worked in private practice, with one clinician based in an outpatient hospital clinic and one at a high school mental health program. Over the course of the study, feedback was obtained from four the seven participants due to dropout (see Figure 1).

Inclusion criteria included working as a mental health professional with a Masters or doctoral degree, an ability to read and speak in English, and access to the internet to complete questionnaires. Doctoral students were excluded as they were likely to require supervision time far in excess of what clinicians in the community would receive in consultation with other practitioners or in formal supervision. Other exclusion criteria included individuals who were not able to speak or read English, as the entirety of the study materials were written in English. The sample was recruited to represent individuals with experience working with adolescents and implementing evidence-based treatments, and who were likely to have opinions about delivering psychological treatments within the community.

**Measures:**

The following measures were administered to assess therapist background and perceived feasibility, acceptability, and utility of the IBAT protocol.

**Therapist Background Questionnaire.** The Therapist Background Questionnaire (TBQ) is a 31-item measure completed once by all study participants during the pre-treatment phase prior to participants beginning use of the IBAT manual with a client. It assesses therapist variables (18 items), including credentials (i.e., degrees earned, years of professional training)

and orientation, in addition to use of therapeutic interventions (4 items), and use of treatment manuals (4 items). Questions assessing attitudes towards manuals were taken from a survey developed by Addis and Krasnow (2000) and include the two survey items most highly correlated with negative process (i.e., a manual's negative effect on the therapeutic relationship) and the two items most highly correlated with positive outcome (i.e., a manual's ability to enhance therapeutic outcomes). The final portion of the questionnaire includes questions regarding perceived barriers towards the use of exposure exercises (3 items).

Several questions were adapted from the Becker et al. (2004) survey assessing clinician attitudes towards exposures. This includes questions regarding perceived contraindications to the use of exposures, potential negative outcomes of exposure use, perceived barriers to exposure use. Modifications included altering question content to more identify contraindications and negative outcomes associated with youth anxiety and depression (as compared to adult Post-Traumatic Stress Disorder, as was the focus of the original survey). The list of barriers was expanded from the original study to capture a broader range of potentially interfering factors.

**IBAT Manual Rating Form.** Adapted from the GBAT Manual Rating form (Chu et al., 2016), the IBAT Manual Rating Form (MRF) is a 24-item questionnaire completed by all study participants at sessions four, eight, and 12 during the Treatment phase of the study. The form elicits feedback using a 1 to 7-point scale with varying anchors. Items assess acceptability and feasibility regarding several topics, including structure and content of the manual (3 items), applicability to the client (3), adherence (2 items), interventions (3 items), implementation (2 items), and exposure exercises (2 items). These final two items ask clinicians to identify the extent to which numerous barriers interfere with use of exposures in session, and the extent to which numerous factors facilitate the use of exposures in session. These items mirror the TBQ

question regarding perceived barriers to exposure use. There are also 5 open-ended items asking for specific suggestions regarding elements within the manual that should be removed, added, or changed, and ways to increase the feasibility and acceptability of behavioral activation and exposure exercises. The MRF for sessions 1 through 4 contains one additional question asking clinicians to indicate the diagnoses met by the selected client.

**Manual Summary Survey.** The Manual Summary Survey (MSS), adapted from Chu et al. (2016), is a 26 item questionnaire completed once by all study participants following the final IBAT session. The first portion of the questionnaire asks clinicians to provide information on case status and attitudes towards the IBAT manual using a 5 point likert-type scale from 1 = *Completely Disagree* to 5 = *Completely Agree*. This section includes modified versions of the Addis and Krasnow (2000) questions used in the TBQ to determine how clinicians perceive the IBAT manual.

The second portion of the survey uses modified versions of items from a survey used by Chu et al. (2016) to gather clinician feedback on youth treatment manuals. It employs a 10 point likert-type scale from 0 = *Not at all*, to 5 = *Moderately*, to 9 = *Extremely* to assess clinician attitudes towards particular elements of the treatment manual. This allows for a more nuanced understanding of how different strategies and interventions are received. An important component of this section are the short-answer items, which asks participants to provide open-ended responses regarding strengths and weaknesses of IBAT within real-world practice, suggested changes to IBAT, and components of IBAT that should remain the same.

In section three of the questionnaire, four of eight potential follow-up questions are asked based on clinician responses to items in section two regarding overall effectiveness, overall feasibility, and feasibility of implementing exposure exercises and behavioral activation

exercises. Positive responses prompt questions asking for specific feedback on what made the manual or strategy effective or easy to implement, in addition to suggestions to further improve the manual or strategy. Negative responses prompt questions asking for feedback on what made the manual or strategy ineffective or challenging to implement, in addition to suggestions to further improve the manual or strategy.

### **Treatment Manual**

Individual Behavioral Activation Treatment (IBAT) is a manual-based, individual behavioral activation therapy aimed at treating youth with anxiety, depression, and anger. The 12-session treatment uses behavioral activation (BA) strategies to target avoidance by helping youth identify stuck points in their lives through functional assessment of numerous life domains, including family and peer interactions, school, extracurricular activities, and health and self-care. Across sessions, youth learn and practice skills as they work towards achieving goals and improving functioning in these numerous domains (Chu et al., 2009).

The overall structure of the program employs four core principles of behavioral activation: psychoeducation, functional analysis, problem solving and exposures and/or behavioral activation (Chu et al., 2009). After identifying areas in need of improvement and establishing concrete, meaningful goals, youth are taught skills via the TRAP acronym (Trigger, Response, Avoidance Pattern) and TRAC acronym (Trigger, Response, Active Coping; Addis & Martell, 2004), which helps youth to recognize avoidance patterns and replace them with approach-oriented solutions. Throughout each session, youth are able to practice these skills through behavioral experiments, which help to solidify the information, provide experiential learning, model active choices, and offer real-time coaching from the therapist. Additionally, by



practicing in session, potential barriers can be identified and problem-solved with the help of the clinician.

The latter half of the manual incorporates extended Behavioral Activation and In Vivo Exposure exercises to optimize experiential learning. Given consistent findings that exposures are typically not implemented by clinicians, the IBAT manual includes a number of elements specifically aimed at increasing use of these techniques, such as clear, simplified explanations, lists of potential exposures for clinicians to use, and vignettes to serve as models for clinicians. Additionally, the protocol has been modified to optimize activity and engagement in each session through individualized and active sessions exercises

**Procedure:**

Participants were recruited through university-based, alumni, and professional organization listservs, as well as through contacts at local middle schools, and local private and group practices. Treatment developers contacted interested individuals by phone to orient them to the study, provide details regarding clinician involvement, and assess if clinicians met inclusion criteria. The study staff who conducted the phone call addressed any concerns and answered any questions the individuals had. Individuals who expressed interest in the study via phone were sent an electronic consent form, which was reviewed with study staff for limits of confidentiality (e.g., breaking confidentiality in event of suspected child abuse) and details of the study. Signed consent forms were collected from each participant.

From this point, the study included three stages: pre-treatment, treatment, and post-treatment. During pre-treatment, participants who provided consent were invited to attend an optional workshop reviewing the IBAT manual and its implementation within community practice. Two participants attended the workshop in person, and two were given access to a video-taped version of

the workshop, in addition to copies of any informational handouts or slides that are used during the workshop. Participating clinicians received the client workbook, therapist manual, a timeline regarding each phase of project and a checklist corresponding to each element of clinician involvement. Clinicians completed the Therapist Background Questionnaire prior to beginning treatment with a client using the IBAT manual

The treatment phase for each participating clinician began when she conducted her first IBAT session with an existing or new client in her local practice. Investigators for the current study had no contact with the youth clients, and youth clients did not complete any research procedures for this study. Participating clinicians were entirely responsible for scheduling and conducting sessions as per their usual practice. During this phase, providers were permitted up to three one-hour phone calls with treatment developers to consult regarding the use of IBAT, though no participants did so.

During the treatment phase, clinicians completed the Manual Rating Form every four weeks, after sessions four, eight, and 12. Over the course of the treatment phase, two of the four clinicians had clients who withdrew from treatment, and they therefore only completed feedback on sessions 1-4. In these instances where treatment terminated prior to session 12, clinicians completed the Manual Rating Form following their final session. In the event that treatment extended beyond 12 weeks, clinicians completed the Manual Rating Form following their final session or at session 16, whichever occurred first. At no point were clients asked to complete any assessments for this study.

The post-treatment phase began after the clinician's final IBAT session with the client, at which point clinicians completed the Manual Summary Survey. Once all surveys were completed, treatment developers sent participants payment and thanked them for their time and input. Participants were invited to ask questions or raise concerns. Throughout the study, all

feedback was provided via Qualtrics questionnaires. This method allowed for a combination of quantitative and qualitative information. Open-ended responses served a similar function as would feedback from a focus group. Though questionnaires do not allow for the collaborative thought process invoked by focus groups, the questions were designed to illicit feedback on both broad and specific topics and spur genuine input from participants. Given the demands of community clinicians, it was determined that questionnaires would prove more feasible and acceptable to participants, and treatment developers sent e-mail links for the surveys to each participating clinician. Participants received reminders to complete these questionnaires if they were not completed within one week. Participating clinicians were compensated \$50 for completing forms. All procedures were approved by the university Institutional Review Board.

## **Results**

### **Clinician Variables**

Therapist background and training experiences revealed the sample was highly educated, received specialized training in behavioral techniques, and had open-minded attitudes toward treatment manuals. Prior to pre-treatment, all clinicians had received training in exposure therapy in graduate school or as a post-graduate (i.e., as a postdoctoral fellow, in postdoctoral supervision, or through continuing education workshops), and 75% had received training in BA as a graduate or post-graduate. One clinician had never received training for BA. On a scale of 1 (not at all comfortable) to 4 (very comfortable), clinicians reported a mean comfort level of 3.8 ( $SD = 0.5$ ) with exposure and a mean comfort level of 3.0 ( $SD = 1.4$ ) with BA. Regarding use of theoretical orientation, one clinician primarily conceptualized cases from a systems perspective, two clinicians from primarily behavioral and cognitive behavioral perspectives, and one primarily from a dialectical behavioral perspective. On a scale of 1 (completely disagree) to 5

(completely agree), clinicians had mean ratings of 1.3 ( $SD = 0.5$ ) and 1.8 ( $SD = 1.0$ ), respectively, regarding statements that manuals “make therapists more like technicians than caring human beings” and “force individuals into arbitrary categories.” They agreed with statements that manuals “help clinicians to utilize only interventions which have been demonstrated to be effective” and “enhance therapeutic outcomes by ensuring that treatment being used is supported by research,” with mean ratings of 4.3 ( $SD = 0.5$ ) for both items.

### **Acceptability and Feasibility of Manual Organization and Presentation**

Attitudes towards IBAT were positive overall, with results suggesting that clinicians found the protocol to be generally acceptable and using clear explanations and appropriate detail. It was noted that it was difficult to complete all session activities within the session time, and that the early portions of the manual were not as flexible as clinicians would have preferred. Clinicians provided feedback on scales of 1 (negatively valenced responses) to 7 (positively valenced responses) regarding the presentation and organization of materials within IBAT (Table 1). Ratings were analyzed for mean scores across all 12 sessions, and examined for trends in sessions 1-4 (which focused on psychoeducation and skill building) compared to session 5-12 (which involved practical application of skills via exposure and behavioral activation tasks). Across all 12 sessions, clinicians reported a mean overall acceptability rating of 6.6 ( $SD = 0.5$ ). Clinician ratings of the clarity of explanations of IBAT theory and strategy ranged from “moderately clear” to “extremely clear” ( $M = 6.6$ ,  $SD = 0.5$ ). When asked to report on the extent of information and detail in IBAT on a scale of 1 (significantly lacking information) to 7 (significantly excessive information), respondents reported that IBAT included an “optimal amount of information” ( $M = 4.0$ ,  $SD = 0.0$ ). Ratings of flexibility, scored on a scale of 1 (significantly too inflexible) to 7 (significantly too flexible), ranged from 2 to 4 ( $M = 3.3$ ,  $SD =$

1.0) for Session 1-4, indicating an average perception of the manual as “slightly too inflexible” where scores of 4 equate to, “optimal level of flexibility.” Sessions 5-12 were perceived to provide that ideal level of flexibility ( $M = 4.0$ ,  $SD = 0.0$ ). Clinicians reported that they were always able to complete between 65%-80% of IBAT activities ( $M = 74.4\%$ ,  $SD = 7.8\%$ ) within session time.

### **Acceptability and Feasibility of Manual Interventions and Strategies**

Feedback suggested that clinicians perceived IBAT to be helpful in addressing their client’s needs and that specific strategies were, for the most part, easy to implement and useful within the course of treatment. As seen in Table 1, responses to questions about IBAT interventions ranged from 1 (negatively valenced responses) to 7 (positively valenced responses). Clinicians reported that it was easier to apply the avoidance model described in IBAT to their client’s individual difficulties in the first four sessions of treatment as compared to sessions 5-12, but that overall it was “moderately easy” to apply ( $M = 6.4$ ,  $SD = 1.1$ ). Regarding feasibility, clinicians thought that, IBAT interventions were “moderately easy to implement” with individual clients ( $M = 6.3$ ,  $SD = 1.2$ ), and found that TRAP/TRAC exercises were “moderately helpful” within session in regard to conceptualization ( $M = 6.4$ ,  $SD = 1.1$ ). The TRAP/TRAC tools appeared to become more helpful as treatment progressed. All clinicians reported that IBAT interventions were either “moderately effective” or “extremely effective” at addressing client needs across all sessions ( $M = 6.6$ ,  $SD = 0.5$ ).

### **Anticipated Barriers to Exposure Use**

At pre-treatment, when asked about anticipated barriers to using exposures, clinicians denied that any barriers would moderately or significantly interfere with the intervention, and reported that most client and clinician variables, such as concern about increased discomfort or

potential harm to the alliance, would cause minimal deterrence. More notable was that limited resources related to lack of training and time were anticipated to cause the greatest interference. Clinicians estimated the extent to which these factors would interfere with exposure use on a scale of 1 (not at all a barrier) to 4 (significant barrier). As demonstrated in Table 2, all clinicians unanimously reported that exposure use would only be “slightly limited” or “not limited at all” by factors such as client distress or resistance ( $M = 2.0$ ,  $SD = 0.0$ ), concern about harming alliance ( $M = 1.3$ ,  $SD = 0.5$ ), exposure not fitting with case conceptualization ( $M = 1.3$ ,  $SD = 0.5$ ), concern about exacerbating symptoms or causing unmanageable side effects ( $M = 1.0$ ,  $SD = 0.0$ ), or potential for clinician distress ( $M = 1.0$ ;  $SD = 0.0$ ). There was greater variability in responses regarding the impact of lack of training or experience conducting exposures ( $M = 1.8$ ,  $SD = 1.5$ ), potential to disrupt others ( $M = 1.8$ ,  $SD = 1.5$ ), lack of adequate resources ( $M = 2.5$ ,  $SD = 1.7$ ), lack of adequate time ( $M = 2.3$ ,  $SD = 1.3$ ), difficulty think of or preparing for exposures ( $M = 2.3$ ,  $SD = 1.3$ ), and parent or guardian distress ( $M = 2.3$ ;  $SD = 1.3$ ).

### **Barriers and Facilitators to Exposure in Sessions 1-12**

One notable finding of the study was that clinicians rated all potential barriers to exposures as less interfering during treatment than they had anticipated at pre-treatment, suggesting that clinician worries about exposures may not be born out during implementation. Importantly, the factors that did slightly deter exposure use were largely situational, including a lack of training, preparation time, and resources, all of which were more problematic as treatment progressed and exposures took a larger role in sessions. Table 2 details the extent to which various factors interfered with use of exposures on a scale of 1 (not at all a barrier) to 4 (significant barrier) during the implementation phase of IBAT. Across all time points, there were no factors that resulted “moderate” or “significant” interference to use of exposures, and there

were several factors that clinicians unanimously reported as having no inhibitory impact on the use of exposures ( $M = 1.0$ ,  $SD = 0.0$ ). These factors included parent/guardian distress, concern that exposure would exacerbate symptoms or lead to unmanageable side effects, risk of patient drop-out or harm to alliance, clinician-experienced distress, exposure not fitting with conceptualization of case, or potential to disrupt others within the practice or institution. There was greater variation in responses regarding several other factors, including client distress ( $M = 1.4$ ,  $SD = 0.5$ ), lack of training/experience conducting exposures ( $M = 1.4$ ,  $SD = 0.5$ ), difficulty thinking of exposures ( $M = 1.4$ ,  $SD = 0.5$ ), lack of adequate resources ( $M = 1.8$ ,  $SD = 0.7$ ), and lack of adequate time ( $M = 1.2$ ,  $SD = 0.4$ ). Average ratings for these items were similar between sessions 1-4 and session 5-12.

### **Facilitators of Exposure: Sessions 1-12**

Clinicians reported that a range of IBAT features and situational factors were influential in aiding the use of exposures at different points during the treatment. Situational factors (i.e., having sufficient training, preparation time, and resources) were consistently seen as facilitators, suggesting that well thought-out logistics are an important foundation for exposures. However, treatment specific elements, such as clear rationale, examples, and early success in treatment may be seen as more important to facilitating treatment in the second half of treatment than the first half as exposures are employed more intensively. Participants were asked to report on the extent to which a variety of factors increased the feasibility and acceptability of exposures during the implementation phase of IBAT on a scale of 1 (did not at all increase) to 4 (significantly increased). Responses are detailed in Table 3, and almost all factors were noted as helpful to implementing exposures during sessions 5-12 as compared to sessions 1-4. Across all 12 sessions, pre-planning for exposures was found to be the most important facilitator for exposure

use ( $M = 3.3$ ,  $SD = 1.2$ ). The rationale for exposures and guided outline of exposures within IBAT was also a helpful factor overall ( $M = 3.0$ ,  $SD = 1.3$ ), and was particularly relevant during the latter portion of treatment ( $M = 3.5$ ,  $SD = 0.6$ ). Early success implementing IBAT exercises was similarly impactful in the latter portions of treatment ( $M = 3.5$ ,  $SD = 0.6$ ), though had only a slight impact during sessions 1-4 ( $M = 2.0$ ,  $SD = 1.2$ ). In contrast, previous training conducting exposures was more helpful in the first portion of treatment ( $M = 3.0$ ,  $SD = 1.5$ ) than in the second ( $M = 2.5$ ,  $SD = 1.7$ ). One factor that served to moderately increase acceptability and feasibility of exposures was access to appropriate resources ( $M = 3.0$ ,  $SD = 1.2$ ), which was consistently relevant across treatment. Factors that did not at all or only slightly increased exposure feasibility and acceptability included the list of exposure ideas within the IBAT manual ( $M = 2.0$ ,  $SD = 1.3$ ), case vignettes of sample exposures within IBAT ( $M = 1.9$ ,  $SD = 1.1$ ), and institutional support for exposure exercises ( $M = 2.6$ ,  $SD = 1.4$ ).

### **Perceived Effectiveness and Difficulty of Implementing IBAT Strategies**

Post-treatment feedback on IBAT interventions illustrate a complicated picture, with clinicians finding behavioral interventions to be among the most effective and most difficult interventions to implement, raising both potential benefits and concerns about consumer adoption of the protocol. After completing use of IBAT, clinicians reported positive perceptions of the manual in terms of how it helped them use interventions backed by evidence without eliminating compassion or forcing clients into arbitrary categories. Table 4 summarizes therapist attitudes towards IBAT and its strategies. Regarding ratings of effectiveness of IBAT components on a scale of 0 (not at all effective) to 9 (extremely effective), average perceived effectiveness scores across techniques ranged from 6.3 to 8.3, indicating components were, on average, rated more than “moderately” effective (based on anchors given to respondents).



Among the components perceived to be the most effective were exposure ( $M = 8.3$ ,  $SD = 0.5$ ) and behavioral experiments ( $M = 8.0$ ,  $SD = 0.8$ ). Behavioral activation, though perceived to be the least effective ( $M = 6.3$ ,  $SD = 1.7$ ) component, was still rated as more than moderately effective. The average rating of overall IBAT effectiveness was a mean of 6.0 ( $SD = 1.8$ ), indicating that IBAT was perceived to be more than moderately effective by clinicians.

Regarding overall difficulty of implementing specific IBAT components, average results ranged from 1.0 to 3.8 on a scale of 1 (not at all challenging) to 9 (extremely challenging), indicating that all components were relatively easy to implement. The easiest component to implement was the goal ladder ( $M = 1.0$ ,  $SD = 1.4$ ), and the most difficult to implement was exposure ( $M = 3.8$ ,  $SD = 2.9$ ) where a score of 4 equated to, “Moderately difficult to implement.” The mean response with regard to overall ease of IBAT implementation was 2.8 ( $SD = 2.4$ ).

### **Perceived Applicability and Generalizability of IBAT Strategies and Manual**

Feedback was mixed regarding the potential applicability of IBAT to cases outside of the study, with clinicians indicating that portions of IBAT would be widely applicable to the majority of clients with anxiety, depression, relationship difficulties, and attentional and disruptive disorders, but that IBAT in its entirety would only be indicated for approximately half of their current cases with anxiety and depression. When asked to indicate the percent of current or recent clients with anxiety and depression for whom IBAT components may be applicable, clinicians reported that all components would be appropriate for the majority of cases (Table 4). The components with the most perceived applicability included the goal ladder ( $M = 100\%$ ,  $SD = 0.0\%$ ), distress loops ( $M = 97.5\%$ ,  $SD = 5.0\%$ ), and functional domain assessment ( $M = 95\%$ ,  $SD = 10.0\%$ ). The least applicable components included exposure ( $M = 67.5\%$ ,  $SD = 42.7\%$ ),

behavioral activation ( $M = 67.5\%$ ,  $SD = 22.2\%$ ), and activity tracking ( $M = 67.5\%$ ,  $SD = 15.0\%$ ). Overall, clinicians reported that IBAT in its entirety would be appropriate for 58.5% of cases ( $SD = 19.1\%$ ), and that components of IBAT would be appropriate for an average of 95% of anxiety or depression cases ( $SD = 10.0\%$ ).

Clinicians were also asked to provide feedback on the potential utility of IBAT across a range of primary disorders and problems. Outside of anxiety and depression, IBAT (in all or part) was considered most appropriate for youth presenting with family relationship problems ( $M = 84.0\%$ ,  $SD = 12.5\%$ ). IBAT was also perceived to be appropriate for the majority of youth presenting with Attention Deficit/Hyperactivity Disorder ( $M = 65.5\%$ ,  $SD = 17.3\%$ ) and defiance or oppositional behaviors ( $M = 75.25\%$ ,  $SD = 4.2\%$ ).

### **Qualitative Feedback and Recommendations: Sessions 1-12**

After every four sessions, clinicians were asked to provide short answer feedback to open-ended prompts to elicit clinician input on IBAT strengths and weaknesses, as well as to gather specific recommendations to help IBAT better fit clinician needs. Using a grounded theory approach (Corbin & Strauss, 2008; Glaser & Strauss, 1967), short answer responses were reviewed and coded for themes that arose in participant feedback. The themes that emerged included applicability and utility of interventions (21.0% of comments), presentation and organization of material (21.0% of comments), time (11.6% of comments), use of worksheets (23.2% of comments), and suggested additions (23.2% of worksheets; Table 5). Among all comments, 53% were positively valanced, 33% were neutral, and 14% were negative.

In general, clinicians reported that IBAT interventions were both applicable and useful in addressing their clients' needs, and could be improved through additional guidance on streamlining interventions for narrow presenting problems. Clients specifically commented on

activity and mood tracking, emotions practice, getting active experiments, the goal ladder, and TRAP/TRAC as beneficial components that helped clients identify and practice core concepts. Specific feedback included, “It was nice to have concrete ways/activities described in the manual to use. I also like the ‘getting active experiment,’ again, because it was active and really helped the client to understand the concept.” Clinicians did report that some exercises were not applicable to every client (though it was noted that exercises were easy to skip over), and that older teenagers may feel like some of the activities were developmentally young. One suggestion was for treatment developers to create a flow chart to help clinicians decide what activities to use based on a client’s presenting problems.

Among the most frequent pieces of feedback were statements about the well laid out organization, structure, and presentation of materials within IBAT, though clinicians commonly noted that each IBAT session had more activities than could be realistically completed each week. Clinicians reported that IBAT material was laid out in a way that made “exercises very feasible and acceptable,” and that the detailed explanations of how to implement interventions and specific exercises was helpful. Feedback also indicated that the individual session checklists and the list of what exercises to prioritize if time was tight minimized prep time, helped sessions remain on track, and was useful in guiding decisions in session. While IBAT was helpful in this manner, there were several comments focused on the tight timing of sessions, and clinicians indicated that it was not always possible to complete all session activities, review with parents, or plan for the next session with the client. Further, there was little buffer room if a client required more time to fully understand a concept.

Another frequent topic addressed in feedback was IBAT worksheets, such that clinicians found the worksheets to be very useful in identifying stuck points and ways to get back on track,

as well as to set up exposure exercises and behavioral experiments. One comment noted, “[the worksheets] help set a consistent structure for the session while making sure we consistently talk about the BA model, including how to set and evaluate specific goals, and [as] a reminder to conclude with a discussion of the “take-home message.” Though the majority of comments were positive, one clinician noted that the worksheets in their entirety became less helpful towards the end of treatment when clients were very familiar with exercises, and one clinician treating a client with a specific phobia noted that the worksheets became “very repetitive” since the target behaviors remained consistent throughout treatment.

When asked if anything was unnecessary or anything missing within individual sessions, clinicians consistently reported “no.” However, there were a number of suggestions that arose from prompts asking for specific recommendations. These included adding a bigger list of BA activities (i.e., ways to augment activity level such as a list of potential hobbies, short session-based games, or tasks that promote mastery) that could be used in session or at home, being more specific about the reward system implemented in IBAT, and supplementing the exposure list with additional specific phobia ideas, particularly for phobias that could be difficult to practice in session (i.e., thunderstorms).

### **Overall Qualitative Feedback and Recommendations**

After completing use of IBAT, clinicians provided short-answer feedback to several prompts regarding treatment as a whole. When asked to comment on factors that made it easier or more challenging to implement IBAT, comments focused on client motivation, conceptualization, and practical barriers. Numerous clinicians indicated that exposures and BA exercises were easy because the client was, “Ready to jump in,” willing to participate, or, “Quite engaged in treatment from the start.” Conversely, for one clinician whose client dropped out of

treatment early, low motivation on the part of the client made IBAT difficult to implement. Though not explicitly stated, clinician conceptualization of underlying factors also appeared to play a role in ease and effectiveness of IBAT. For example, one clinician reported that the client's presenting problems, "Were ripe for exposures," while another noted that her client exhibited more, "Biologically based physical symptoms that required using distress tolerance skills" accomplished by going off protocol. It is likely that the latter clinician was referring to biological vulnerability to emotional dysregulation that she felt called for crisis survival skills found in Dialectical Behavior Therapy. Notably, these would not be inconsistent with the BA principle of learning to ride the wave of emotion rather than engaging in avoidance behaviors that unintentionally escalate the dysregulated behavior. Practical barriers were also important, such as the ease of doing social anxiety exposures in a busy office building, versus the difficulty of doing specific phobia exposures for fireworks in an office during winter.

In responding on the strengths of IBAT, clinicians' responses focused on the organization and detailed content, emphasis on practice, and adaptability. One clinician reported, "The manual and workbook were very comprehensive and gave great suggestions, while being easy to follow." Another noted, "The client got to practice (aka: follow through) in session, and follow through is often the hardest part about therapy!" In commenting on aspects of the manual that should remain intact for future iterations of the manual, clinicians advocated for continued use of interventions backed by research, the focus on behavioral experiments and exposures, goal setting, monitoring, and TRAP/TRAC, "Which can easily fit most, if not all, patient presentations."

In thinking about weaknesses, clinicians commented on the practical difficulties of conducting sessions within a 45-minutes time slot and or gaining adequate buy-in within a 12-

session protocol. It was also noted that the transdiagnostic nature of the protocol sacrificed the nuanced information and recommendations found in single-disorder protocols. Expanding on these comments, clinicians made a number of recommendations, including spacing material out over more sessions, and including optional modules on motivation enhancement, disorder specific psychoeducation, or distress tolerance.

### **Discussion**

The current study gathered and reviewed clinician feedback on a novel transdiagnostic behavioral intervention with specific aims of identifying strengths and weaknesses of the IBAT protocol, developing a list of recommendations to enhance feasibility and acceptability of the manual among community based clinicians, and improving understanding of clinician attitudes towards use of exposures. Four community based clinicians implemented the 12-week IBAT protocol in their work settings with youth clients presenting with primary anxiety or depressive disorders. Clinicians completed the Manual Rating Form after every four sessions, and then completed the Manual Summary Survey once following termination.

Overall, clinicians found IBAT to be acceptable and feasible to implement. Positive ratings were received in regard to both the presentation of IBAT material (i.e., extent and clarity of information and flexibility of sessions) and IBAT interventions (i.e., utility of TRAP/TRAC, applicability of the model, ease of implementation, and perceived effectiveness). Qualitative feedback demonstrated that clinicians appreciated a number of IBAT features, such as the session checklists and the list of activities to prioritize, both of which were found to help with decision making and staying on track in session. Clinicians also responded well to the emphasis placed on conducting active sessions. In reviewing use of IBAT outside of the study, clinicians reported that specific IBAT strategies (e.g., goal setting, TRAP/TRAC, etc.) would be highly

applicable to their anxiety and mood cases, and that parts of IBAT would be applicable to the vast majority of clients struggling with anxiety, depression, or relationship difficulties.

Though clinicians generally viewed IBAT as a helpful, effective treatment, there were several areas in which they saw potential for improvement. Sessions were reported to be tightly packed, which limited the extent to which clinicians could review with parents or plan for next suggestions. Notably, IBAT sessions were designed to be 55 minutes, whereas most participants conducted 45-minute sessions. It is possible that future iterations of the manual need to plan for shortened session length or be reconfigured to better space activities over time. Clinicians also felt that the manual was lacking in suggestions, tips, or interventions for difficulties related to depression and anxiety, such as sleep or eating hygiene and general motivation for treatment. Similarly, clinicians reported that for youth with very narrow presenting problems (i.e., specific phobia), or very complex cases with multiple maintaining factors (i.e., a youth with high avoidance and emotion dysregulation), IBAT may either be too broad, or too narrow, respectively.

Clinicians also noted that the first portion of treatment (i.e., sessions 1-4 focused on psychoeducation and introduction to skills) was “slightly too inflexible.” The treatment developers attempted to optimize flexibility by encouraging clinicians to individualize treatment by tailoring activities to a client’s problem areas. For example, in each of the first four sessions, the manual includes different examples of how to conduct exercises for a youth presenting with sadness and/or anxiety and/or anger. Clinicians are specifically provided with guidance on how to do this for activities such as reviewing emotions and identifying stuck points, getting active, introducing the distress loop, and explaining TRAP/TRAC. The hope was to allow clinicians to

present the information in a way that specifically addressed the emotion(s) that the individual client struggled most with, and skip the information that was less relevant.

Notably, however, the first four sessions were tightly packed and left little time for clinicians to add or review activities that they thought might be helpful. Further, there were a set of proscribed activities that the manual outlined within the first four sessions, and not every activity included multiple versions for clinicians to pick and choose from. Developers also did not encourage clinicians to substitute or skip exercises. It is possible that clinicians felt that not all exercises were as helpful for their particular client, and would have preferred to omit certain tasks or include their own activity (though no specific feedback was provided about this).

Past research has established a number of ways in which flexibility can be increased while maintaining fidelity. One is to use a modular based approach, as it allows clinicians greater control over when to use different interventions over the course of treatment (Chu et al., 2012). Though used in other protocols, modules would not fit within IBAT as the protocol exclusively focuses on behavioral interventions rather than incorporating multiple practice elements. Further, IBAT intentionally prioritizes the use of behavioral interventions so that other treatment strategies do not unintentionally detract from the use of this evidence-based tool. Chu et al. (2012) also discuss the shift towards transdiagnostic manuals to help improve therapist ability to address concerns across disorders. While IBAT is specifically designed to do this, it may benefit from additional encouragement and explanation in the introduction as to how exposure and behavioral activation can be used to flexibly address anxiety and depressive symptoms as they arise.

Other suggestions to improve flexibility focus on the delivery of content in the manual and the implementation of exercises in session. For example, protocols can specifically note



where there is flexibility for clinicians to add sessions, explain concepts, complete an activity in their own way, or collaborate with the client to determine how best to practice a strategy (Hamilton, Kendall, Gosch, Furr, & Sood, 2008; Kendall & Beidas, 2007). Though IBAT has already incorporated a number of these suggestions, future editions can more notably “call-out” places in which clinicians should feel free to substitute worksheets for their own version of the information or principles can be discussed using unique activities (e.g., explaining an avoidance cycle by drawing it on a whiteboard or demonstrating it through a story, rather than looking at a page in the worksheet). It is also likely that by spacing activities over more sessions and leaving more time to get through material, clinicians will have more freedom to supplement sessions with materials that they find appropriate for a client.

In addition to the looking for specific feedback and recommendations on IBAT, the current study also sought to gain a better understanding of clinician attitudes towards exposure exercises and the extent to which IBAT interventions were viewed as generally applicable outside of the study. One promising piece of feedback was that there were several factors that facilitated the use of exposure, including pre-planning for exposure prior to session, previous training, IBAT’s rationale and exposure guide, and institutional support for exposures. Each of these components enhance the clinician’s ability to arrive at session with a clearly laid out plan, meaning that sessions can be entirely focused on executing the task rather than waylaid by addressing practical concerns or making decisions about what intervention to use or when to do so. For example, IBAT advises clinicians and clients to spend the last five minutes of each session preparing for the upcoming exposure. This gives clinicians and families a full week to procure any necessary resources (e.g., contacting confederates for a social exposure) and helps clinicians maximize efficient use of the next session because they are not spending the first ten

minutes deciding what to do or scrambling for materials. Additionally, if a clinician-client dyad has preemptively established a goal and set part of the agenda, it minimizes the possibility of session time being lost to general “catch-up” or taken over by a crisis-of-the-week. Further, factors like previous training and the clearly explained IBAT rationale/guidelines for exposure likely enhance a clinician’s comfort and ability to make informed decisions on how to flexibly individualize an exposure while maintaining fidelity to the intervention. It is possible that these components, as well as institutional support, also serve to enhance motivation to use exposure because clinicians have an appreciation of its effectiveness and are encouraged through their workplace to use it.

Unfortunately, these facilitating factors are not easy to guarantee. It is often difficult for clinicians to find the time to prepare ahead of session or thoroughly read through a manual. Additionally, if a clinician did not initially receive training in exposure therapy during graduate school, it is often difficult to procure intensive training once in practice. Given this, teams that are developing treatments or actively disseminating protocols could consider a number of ways to enhance these elements. As is suggested by the findings of this study, treatments are likely enhanced by imbedding facilitating factors within the program. Rather than assuming that clinicians will prepare ahead of each session, build preparation into the timeline of treatment. Given that clinicians within the current study were not always able to follow guidelines for weekly preparation, this strategy may be further enhanced by having clinicians and clients brainstorm a list of exposures early in treatment as they discuss goals so that clinicians have a list of specific tasks to refer back to on a weekly basis. IBAT did appear to benefit from the inclusion of exposure guidelines and rationale. Even if clinicians do not thoroughly read through

a full manual, it appears as if treatments are aided by outlines that clinicians can quickly refer to for reminders or to help maintain focus.

Suggested practices related to active training and system level support provide insight into how facilitating factors related to previous training and institutional support can be enhanced. A number of studies recommend using active learning techniques, such as modeling and practice opportunities, within training (Beidas & Kendall, 2011; Cross, Matthieu, Cerel, & Knox, 2007). Though not provided in written feedback, IBAT developers were provided with verbal feedback that the sample exercises modeled in the pre-treatment workshop were helpful demonstrations for the study. It may be that a higher reliance on these methods would help clinicians overcome a prior lack of experience or training. This may be particularly important for exposure, which is consistently found to be difficult to implement.

There is also the factor of institutional support. Findings demonstrate that ongoing supervision is likely necessary for long term adoption of interventions (Beidas & Kendall, 2011), such as exposure, meaning that treatment developers need to help build supervisory capacity within institutions that they hope will adopt new protocols. It has also been suggested that adoption of interventions can be enhanced by the social exchange of knowledge. Beidas et al. (2011) discuss this on a large scale, such as through online communities that bring experts and novices together. However, in looking at community based adoption of protocols, it is possible that within-system knowledge transfer is equally as important. In discussing exposure use specifically, it is possible that encouraging clinicians within a site to leave doors open to help with exposures, discuss use of the intervention in case conference or grand rounds, and to have resources (i.e., guides, videos samples, materials) available may help to increase knowledge and

competence as clinicians grow together, and also promote the message that the institution as a whole is a proponent of exposure use

Looking at anticipated barriers prior to treatment, clinicians expected that numerous factors would “slightly” interfere with exposure use in session, but that no factors would significantly interfere. After implementing IBAT, clinicians reported that these factors did not pose as much of a hindrance as they had anticipated. In fact, only client distress and lack of adequate resources posed slight barriers to exposure use, and not to the extent anticipated by clinicians. Given the discrepancy between anticipated and actual barriers to treatment, it may be the case that the experience of implementing exposures, more so than problem-solving specific barriers ahead of time, is a key factor in increasing acceptability of this strategy. Essentially, nothing succeeds like success. Like previous research, the current study demonstrates that clinicians continue to hold a number of assumptions about barriers to exposures. However, it is promising to see that the types of anticipated barriers differ from those noted among clinicians asked about using imaginal exposure (IE) for PTSD (Becker et al., 2004). In that study, clinicians’ concerns focused on conceptualization (i.e., IE would be contraindicated by a broad range of problems that may be co-occurring with PTSD) and alliance (i.e., patient dropout may increase). In this study, clinicians generally had more practical concerns related to a lack of resources. Notably, the clinicians in the current study had higher than average experience with exposure use, potentially demonstrating the point that as clinicians use exposure more and more, worries about the theoretical applicability of exposure and potential negative outcomes decrease. As IBAT espouses, experiential learning can be a powerful tool in quelling existing concerns and demonstrating the utility of practice. Indeed, while results demonstrated that exposure and BA

were among the most difficult IBAT strategies to implement, they were also found to be among the most effective.

While this is promising, successful experience of exposure use alone does not appear to be adequate to promote long term implementation of exposure. For example, in a follow-up study of community clinicians who had received intensive CBT training and supervision as part of a randomized effectiveness study (Chu et al., 2015), results showed that exposure was used in only 34.5% of anxiety cases seen after study participation was complete. It is possible that these numbers may vary based on the average experience and training of participants in a particular sample. Results from the current study provide some support for this. Specifically, participating clinicians (who entered the study with a relatively high rate of training and experience in exposure and BA strategies) reported that exposure and BA would be applicable for approximately two-thirds of their current anxiety/depression cases, which is close to double the rates of actual exposure use reported in the YADS Follow-up. Though promising in some regard, exposure and BA still had the lowest applicability rates of any of the IBAT strategies used. Further, clinicians reported that IBAT as a whole would only be appropriate for approximately 50% of their anxiety or depression cases.

This was a surprising result given the high levels of acceptability reported throughout treatment, and there are a number of potential explanations. First, terminology may be impacting attitudes towards interventions. Though IBAT conceptualizes BA and exposure similarly (i.e., practice pushing through distressing situations), these terms may hold very specific meanings to individual clinicians. If a clinician views exposure exclusively as a technique used to decrease anxiety through habituation to increasingly distressing stimuli, he or she would not likely conceptualize it as applicable for a client with depression. Similarly, if BA is thought of

exclusively as a way to build engagement with positive experiences, it may appear irrelevant for a client who is fearful, but does not have low mood. As IBAT intertwines exposure and BA throughout the protocol, a clinician with traditional conceptualizations of these strategies may not perceive IBAT in its entirety be appropriate for a client with only anxiety or depression. Additional support for this explanation may lie in the fact that behavioral experiments were viewed as more applicable than either exposure or BA. Though treatment developers conceptualized behavioral experiments as similar to both strategies, it is not a technique that is exclusively associated with anxiety or depression. The term, which was used in IBAT to describe active practice in which a client enacted numerous solutions to a problem, could be perceived as having greater applicability to mood and anxiety cases in general as it is not associated with one or the other a priori.

Qualitative feedback provides insight into another potential explanation for the low applicability rates regarding IBAT as a whole. Specifically, comments suggested that IBAT was perceived to be too broad in respect to clients with singular presenting problems (e.g., specific phobia) and too narrow for clients conceptualized as having poor emotion regulation. It is possible that more thorough explanations of the flexibility of IBAT could help assuage these concerns. For simple, clear cut cases, clinicians would be easily able to skip exercises or worksheets without losing the essence of active practice. Similarly, for more complex cases, additional strategies could be incorporated without sacrificing time spent on exposure. For example, use of exposure does not preclude the use of distress tolerance strategies for a client who struggles with emotion regulation. Rather, the use of exposure may increase the likelihood of a client using distress tolerance skills in daily life because he or she would be given an opportunity to practice them In Vivo with the help of a therapist. While a clinician could use

both strategies without following a manual, research suggests that this does not occur. IBAT provides a structure that prioritizes the active strategies routinely observed to be most effective for youth with anxiety and depression, thereby increasing the likelihood that these elements are not lost. It is possible that additional case examples highlighting the applicability of IBAT for both narrowly focused and complex cases may help demonstrate the utility of the protocol interventions across the scope of emotional difficulties.

To address the concerns raised in the qualitative and quantitative feedback, we have constructed a list of specific modifications to include in future iterations of the manual:

1. Reconfigure activities in sessions 1-4 to decrease time constraints. By spacing activities in the early portions of treatment across a greater number of sessions, clinicians will be more likely to complete all activities. Clinicians can add sessions to the latter portion of treatment as necessary based on the degree to which a specific client could benefit from additional exposures.
2. Include additional tip sheets. Future iterations of IBAT would benefit from a list of BA tasks that could be completed in session or at home. The existing sample exposure list will be expanded to include additional ideas for specific phobia exposures.
3. Add a Motivational Interviewing module. IBAT developers will incorporate an optional Motivational Interviewing module to the appendix of the treatment in order to help guide clinicians to improve commitment from clients who may be ambivalent about change.
4. Create a list of supplemental resources. A number of clinicians discussed the potential benefits of incorporating interventions to address problems that often co-occur with

- anxiety and depression, such as sleep difficulties. Though it would not be feasible to create modules for each potential problem area, IBAT developers will create a list of resources that clinicians can reference if looking for additional information on topics outside of primary anxiety and depression.
5. Create a decision tree to guide use of interventions. IBAT is specifically designed so that clinicians can apply interventions across numerous problem areas. However, a number of specific disorders or presentations may benefit from a more stream-lined protocol. To help clinicians tailor treatment, IBAT will include a decision tree for specific presenting problems to indicate which activities or worksheets that can be skipped.
  6. Enhance opportunities for flexibility. IBAT is designed to help guide clinicians through a series of behavioral interventions that can be flexibly adapted to a client's presenting problem. This can be improved by highlighting areas in which clinicians should feel comfortable substituting specific worksheets or wording for their own activities and explanations that convey the same message. It is likely that this goal will be aided by a number of the above recommendations, including the use of a decision tree to provide clinicians with more freedom to skip unnecessary elements, as well as more time within the first four sessions to allow for relevant supplements to be added.
  7. Add additional case study examples that highlight the reach of behavioral experiments and exposures. For example, clinicians felt the IBAT model of exposures did not apply to cases where emotional dysregulation was primary. Case studies could



- show how exposure models conceptualize distress tolerance and employ behavioral techniques to regulate emotions.
8. A supplemental training guide could be developed to address implementation issues related to organizational, practical, and resource concerns. This could include a “to do” list of resources and structure that clinicians and clinic directors need to consider as they implement IBAT. It could also include training tips, such as rehearsal exercises and video-recorded illustrations to provide engaging models. These may enhance perceptions of flexibility as well as increase fidelity to the model.

### **Limitations**

The current study had a number of limitations, most notably the small sample size. With only four clinicians providing feedback, and only two that were able to complete the full protocol, it is not possible to generalize the findings beyond the current sample. Further, participants were, on average, well trained and experienced in exposure and BA. Though such clinicians were intentionally recruited to maximize feedback from individuals who were likely to have useful recommendations regarding the treatment of youth anxiety and depression, it is likely that ratings of acceptability and feasibility were more favorable than might be seen among community clinicians in general. Similarly, a number of the clinicians had connections to the graduate program through which the study was conducted, which may have resulted in biased responses. Though these limitations do not negate the utility of the feedback and suggestions as they pertain to IBAT, the opinions expressed by participants cannot be assumed to accurately represent those of community clinicians in general and it is therefore unclear how acceptable IBAT would be on a larger scale. Another limitation of the study is the sole reliance on clinician

feedback. Future studies would benefit from gathering feedback from clients, for whom acceptability rating may also prove important in dissemination.

### **Conclusions and Future Directions**

While there is room for growth, the current study suggests that IBAT has potential as a transdiagnostic protocol focused on helping clinicians flexibly implement some of clinical psychology's most potent strategies- in vivo exposure and BA, particularly amongst clinicians with at least some background in exposure-based interventions. Presentation and organization of materials were found to be clear and useful, and interventions were perceived to be feasible and effective. Still, there appears to remain a disconnect between perceived utility of exposure and perceived applicability to cases in general. While results suggest that use of exposure may help challenge concerns about anticipated barriers to treatment, treatment developers need to consider ways to clarify misconceptions resulting from semantic discrepancies and demonstrate the utility of these strategies to a broad range of presenting problems.

The discrepancies noted between general acceptability and perceived applicability highlight the importance of conducting pilot studies in the early stages of protocol development. The feedback provided has clarified what elements of IBAT are working well, and what elements are not. Specifically, by enhancing understanding clinicians' preferences and concerns at this point, treatment developers can make thoughtful, informed choices about potential practical and conceptual changes before it is too late to do so. Moving forward, IBAT should be revised based on the above recommendations, and tested on a larger scale to determine its efficacy and acceptability in comparison to other evidence-based treatments.

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Table 1  
*Mean (SD) of Manual  
 Rating Form Subscales  
 by Treatment Phase*

	Sessions 1-4	Session 5-12	Overall <i>M</i> ( <i>SD</i> )	Overall Range
Clarity	6.5 (0.5)	6.75 (0.5)	6.6 (0.5)	6-7
Amount of Information*	4.0 (0.0)	4.0 (0.0)	4.0 (0.0)	4
Flexibility*	3.3 (1.0)	4.0 (0.0)	3.6 (0.7)	2-4
Percentage of activities completed	72.5% (7.5)	76.3% (7.5)	74.4% (7.8)	65-80%
Ease of applying model	6.8 (0.5)	6.0 (1.4)	6.4 (1.1)	4-7
Ease of Implementation	6.3 (1.5)	6.3 (1.0)	6.3 (1.2)	4-7
Utility of TRAP/TRAC	6.0 (1.4)	6.8 (0.5)	6.4 (1.1)	4-7
Effectiveness	6.8 (0.5)	6.5 (0.6)	6.6 (0.5)	6-7
Overall Acceptability	6.5 (0.5)	6.8 (0.5)	6.6 (0.5)	6-7
Range	2-7	4-7		

Note: Responses rated on a scale of 1 (negatively valenced) to 7 (positively valenced)

\*Subscales for which 4 represents the most positive outcome (e.g., “the right amount of flexibility”).

Session 1 – Introduction to IBAT program/psychoeducation

Session 2 –Goals ladder/ mood monitoring

Session 3 – Finding active options/getting active experiment/distress loop

Session 4 – Behavioral experiment/TRAP acronym/psychoeducation about avoidance

Session 5 – Behavioral experiment/TRAC acronym/encouraging approach behaviors

Session 6 – Introduction to exposures/exposure practice

Session 7-11– In-session exposure practice

Session 12 – Reassess functional domains/Relapse prevention & planning for the future

Table 2

*Mean (SD) Barriers to Exposure Use by Treatment Phase*

	Anticipated Barriers	Perceived Barriers During Treatment			
	Pre-treatment	Sessions 1-4	Sessions 5-12	Overall <i>M (SD)</i> Sessions 1-12	Overall Range
Client distress or resistance	2.0 (0.0)	1.5 (0.6)	1.3 (0.5)	1.4 (0.5)	1-2
Parent/guardian distress or resistance	2.3 (1.3)	1.0 (0.0)	1.0 (0.0)	1.0 (0.0)	1
Concern that exposure would exacerbate clients' symptoms or result in unmanageable side effects	1.0 (0.0)	1.0 (0.0)	1.0 (0.0)	1.0 (0.0)	1
Risk of exposure increasing likelihood of patient drop-out or harming therapeutic alliance	1.3 (0.5)	1.0 (0.0)	1.0 (0.0)	1.0 (0.0)	1
Conducting exposures would cause/caused me distress	1.0 (0.0)	1.0 (0.0)	1.0 (0.0)	1.0 (0.0)	14
Exposure not fitting with my conceptualization/ belief that other interventions would be effective	1.3 (0.5)	1.0 (0.0)	1.0 (0.0)	1.0 (0.0)	1
Lack of prior training/experience conducting an exposure	1.8 (1.5)	1.3 (0.5)	1.5 (0.6)	1.4 (0.5)	1-2
Difficulty thinking of/preparing for exposures	2.3 (1.3)	1.3 (0.5)	1.5 (0.6)	1.4 (0.5)	1-2
Lack of adequate resources (i.e., space, materials, confederates to help)	2.5 (1.7)	1.5 (1.0)	2.0 (0.0)	1.8 (0.7)	1-2
Lack of adequate time to conduct an exposure in session	2.3 (1.3)	1.3 (0.5)	1.0 (0.0)	1.2 (0.4)	1-3
Potential to disrupt others at my practice or institution	1.8 (1.5)	1.0 (0.0)	1.0 (0.0)	1.0 (0.0)	1-2
Overall Range	1-3	1-3	1-2		

Note: Responses rated on a scale of 1 (not at all a barrier) to 4 (significant barrier)

Table 3

*Mean (SD) Facilitators of Exposure Use by Treatment Phase*

	Sessions 1-4	Sessions 5- 12	Overall <i>M</i> ( <i>SD</i> ) Sessions 1-12	Overall Range
Previous training/experience conducting exposures	3.0 (1.5)	2.5 (1.7)	2.9(1.6)	1-4
Early success implementing IBAT exercises	2.0 (1.2)	3.5 (0.6)	2.8(1.2)	1-3
IBAT manual's rationale for exposures/guided outline of exposure activities	2.5 (1.7)	3.5 (0.6)	3.0(1.3)	1-4
Pre-planning for exposure exercises prior to session	3.5 (1.0)	3.0 (1.4)	3.3 (1.2)	1-4
List of exposure ideas within the IBAT manual	1.3 (0.5)	2.8 (1.5)	2.0(1.3)	1-4
Case vignette of sample exposures within the IBAT manual	1.3 (0.5)	2.5 (1.3)	1.9 (1.1)	1-4
Access to appropriate resources (i.e., space, materials, confederates to help)	3.0(1.2)	3.0 (1.4)	3.0 (1.2)	1-4
Institutional support for exposure exercises	2.5(1.7)	2.8 (1.3)	2.6 (1.4)	1-4
Overall range	1-4	1-4		

Note: Responses rated on a scale of 1 (did not increase exposure use at all) to 4 (significantly increased exposure use)

Table 4

*Mean (SD) Clinician Attitudes Toward IBAT components/intervention*

	Funct. domain assess.	Activity tracking	Goal ladder	Behavioral experiments	Distress loop	TRAP	TRAC/ Problem solving	In Vivo Exp.	BA	HW	Whole IBAT	Parts of IBAT
Ease of implementing IBAT within my regular practice*											4.6 (0.5)	
Attitudes towards IBAT cases												
Effective (0-9)		7.0 (1.8)		8.0 (0.8)		7.5 (1.3)	7.3 (1.7)	8.3 (0.5)	6.3 (1.7)	7.8 (1.0)	6.0 (1.8)	
Difficult to implement (0-9)	2.0 (1.8)	1.5 (1.7)	1.0 (1.4)	1.5 (1.9)	1.3 (1.9)	1.8 (1.7)	2.3 (1.7)	3.8 (2.9)	2.0 (2.2)	2.8 (1.0)	2.8 (2.4)	
% of Anxiety/ Depression cases component is “appropriate” for	95% (10.0)	67.5% (15.0)	100% (0.0)	77.5% (17.1)	97.5% (5.0)	77.5% (20.6)	77.5% (20.6)	67.5% (42.7)	67.5% (22.17)	87.5% (25.0)	58.5% (20.2)	95% (10.0)

Note: Responses rated on a scale of 1 (negatively valenced) to 7 (positively valenced)

\*Subscales for which 5 represents the most positive outcome

Table 5

*Themes of Qualitative Feedback from Session 1-12, Valence of Responses, and Suggestions*

	Total number of comments	Percent of total comments	Positive valence	Neutral valence	Negative valence	Example Recommendations
Applicability/utility of interventions	9	21.0%	8	1	0	Provide guidance on materials to skip based on presenting problem
Presentation/organization of material	9	21.0%	9	0	0	
Time	5	11.6%	0	2	3	Redistribute activities over more sessions
Worksheets	10	23.2%	6	2	2	Streamline/shorten worksheets as treatment progresses
Suggested additions	10	23.2%	0	9	1	Add list of BA activities (e.g., hobbies, in-session tasks); Provide further details on reward system; Provide resources of sleep/eating hygiene; Incorporate module on enhancing motivation; Augment sample exposure list for specific phobia
Total number of comments	43		23	14	6	

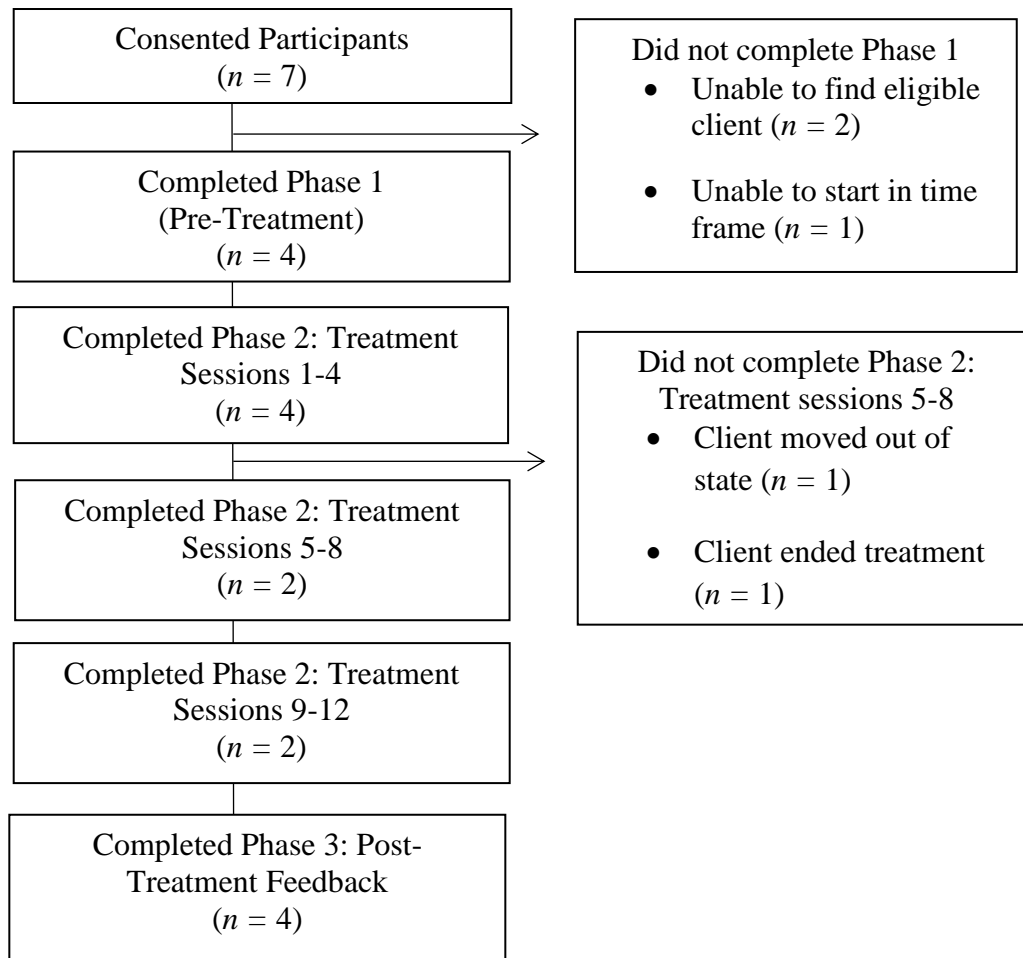


Figure 1. Schematic presentation of participant enrollment, retention, and assessment completion

## APPENDIX

**Stage 1: Therapist Background Questionnaire**

Please complete this questionnaire prior to beginning the IBAT treatment manual with your selected client. Read the instructions and anchors for each question carefully before responding.

1. ID#: \_\_\_\_\_
2. Today's Date: \_\_\_\_\_
3. Age: \_\_\_\_\_
4. Gender:
  - a. Male
  - b. Female
5. Ethnicity: \_\_\_\_\_
6. Professional Specialty: \_\_\_\_\_
7. State Licensed:
  - a. Yes
  - b. No
8. Date of most advanced degree: \_\_\_\_\_
9. Current work setting/referral sources: \_\_\_\_\_
10. Degree and credentials earned (Check all that apply):
  - a. \_\_\_\_\_ BA/BS
  - b. \_\_\_\_\_ MA
  - c. \_\_\_\_\_ MSW
  - d. \_\_\_\_\_ PhD
  - e. \_\_\_\_\_ PsyD
  - f. \_\_\_\_\_ MD
  - g. \_\_\_\_\_ EdD
  - h. \_\_\_\_\_ LCSW
  - i. \_\_\_\_\_ MFCC/MFT
  - j. \_\_\_\_\_ Other (please explain) \_\_\_\_\_



11. Please indicate yes or no:

	Yes	No
I attended the optional workshop		
I watched the video-taped version of the online workshop		
I reviewed the written materials that were provided at the online workshop		

12. How many years of professional/clinical **training** (beyond your earliest undergraduate degree) have you had? \_\_\_\_\_

13. How many years of full-time professional/clinical **experience** have you had since your formal clinical training ended (i.e., since your earliest degree that made your license-eligible)? \_\_\_\_\_

14. About what percentage of your **current caseload** is with:

	[Slider bar: 0%-100%]
Children aged 5 or younger	
Children aged 6-12	
Adolescents aged 13-17	
Adults aged 18 or older	

15. How many **active cases** do you typically carry at one time? \_\_\_\_\_

16. Approximately how long is the length of your typical session length? \_\_\_\_\_

17. About how many hours do you allot each week for **training or supervision** for your cases? \_\_\_\_\_

18. In what percentage of your work with children and adolescents have you used the following theoretical orientations in **conceptualizing cases and thinking about therapeutic goals**?

	[Slider bar: 0%-100%]
Psychodynamic	
Behavioral	
Cognitive or Cognitive Behavioral	
Object Relations	
Systems	
Other	

a. If other, please specify \_\_\_\_\_

Tyler is a 15-year-old boy who has been diagnosed with MDD and social phobia. His appetite and sleep have decreased, and he often feels hopeless and irritable, particularly in social situations that trigger anxiety. Tyler frequently has thoughts such as “I can’t do anything right,” “Everybody is going to laugh at me,” and “I’m never going to fit in.” As a result, he has become increasingly withdrawn from his friends and hobbies. For example, Tyler has quit soccer, frequently ignores invitations from his friends to hang out, and refuses to attend neighborhood get-togethers or school activity nights. When his parents or teachers attempt to persuade him to participate, he quickly becomes angry. He notes that he becomes very tense and that his heart races, and he subsequently lashes out with inappropriate language, yelling, and occasionally throwing items.

19. When you think about what would be most helpful in treating Tyler, which of the following would you prioritize as the primary target?

- |   |   |
|---|---|
| a. Avoidance (behavioral or cognitive)                                      | c. Interpersonal effectiveness            |
| b. Emotion dysregulation (quickly escalating behavior, impulsive reactions) | d. Unrealistic negative thinking patterns |
|   | e. Other: _____                           |

Sophia is an 11-year-old girl who has been diagnosed with separation anxiety disorder, panic disorder, and agoraphobia. She experiences high levels of somatic complaints (i.e., racing heart, shallow breathing, headaches, etc.) throughout the day. She constantly expresses fear that something bad will happen to her when she is away from her parents and believes that she is always at risk of dying. She has begun to avoid situations she deems unsafe, such as areas with large crowds or places where there could be lots of germs, and has demonstrated increasing school refusal behavior. Sophia engages in constant reassurance seeking, such as calling and texting her parents when they are not together, asking about any new bump or mark she notices on her body, or checking about the “safety” of a situation. When her parents are late or do not answer the phone, she thinks “They must have gotten into an accident,” or “What if they don’t come back and I’m stuck here all alone forever?”

20. When you think about what would be most helpful in treating Sophia, which of the following would you prioritize as the primary target?

- |   |   |
|---|---|
| a. Avoidance (behavioral or cognitive)                                      | d. Unrealistic negative thinking patterns |
| b. Emotion dysregulation (quickly escalating behavior, impulsive reactions) | e. Other: _____                           |
| c. Interpersonal effectiveness  |   |

21. Which of the following interventions do you tend to rely on the most in treating youth **depression**? (select up to three)

- |                            |                                  |                       |
|----------------------------|----------------------------------|-----------------------|
| a. Assertiveness Skills    | f. Dynamic Interpretations       | m. Monitoring         |
| b. Behavioral Activation   | g. Emotion Regulation            | n. Play Therapy       |
| c. Cognitive Restructuring | h. Emotional Awareness exercises | o. Problem Solving    |
| d. Communication Analysis  | i. Exposure                      | p. Psychoeducation    |
| e. Distress Tolerance      | j. Family-Based interventions    | q. Relaxation         |
|                            | k. Interpersonal Effectiveness   | r. Supportive Therapy |
|                            | l. Mindfulness                   | s. Other              |

22. Which of the following interventions do you tend to rely on the most in treating youth **anxiety**?  
(select up to three)

- |                            |                                  |                       |
|----------------------------|----------------------------------|-----------------------|
| a. Assertiveness Skills    | f. Dynamic Interpretations       | m. Monitoring         |
| b. Behavioral Activation   | g. Emotion Regulation            | n. Play Therapy       |
| c. Cognitive Restructuring | h. Emotional Awareness exercises | o. Problem Solving    |
| d. Communication Analysis  | i. Exposure                      | p. Psychoeducation    |
| e. Distress Tolerance      | j. Family-Based interventions    | q. Relaxation         |
|                            | k. Interpersonal Effectiveness   | r. Supportive Therapy |
|                            | l. Mindfulness                   | s. Other              |

23. How comfortable are you with using each of the following interventions in treatment?

	Not at all comfortable	Slightly comfortable (heard of, but don't know much about it)	Somewhat comfortable (use in treatment, but not extensively)	Very Comfortable (use regularly)
Behavioral Activation				
Cognitive Restructuring				
Exposure				
Relaxation				

24. Please check all of the time points you received training in the following interventions.

	Never	Graduate School	Internship	Postdoctoral Fellowship	Other Postdoctoral Supervision	Post Graduate CE Workshops	Other
Behavioral Activation							
Cognitive Restructuring							
Exposure							
Relaxation							

Please rate to what extent you agree with the following:

		Completely Disagree 1	Somewhat Disagree 2	Neutral 3	Somewhat Agree 4	Completely Agree 5
25.	Manuals make therapists more like technicians than caring human beings.					
26.	Manuals force individual clients into arbitrary categories.					
27.	Treatment manuals help clinicians to utilize only interventions which have been demonstrated to be effective.					
28.	Following a treatment manual will enhance therapeutic outcomes by insuring that the treatment being used is supported by research.					

29. Please rate the likelihood that the following client characteristics would contraindicate the use of **exposure therapy** as a treatment for anxiety or depression? By exposure therapy, we include imaginal or In-Vivo enactments of challenging situations during session.

		Very Likely Contraindicate	Somewhat Likely	Somewhat Unlikely	Very Unlikely
a.	Any Comorbidity				
b.	Suicidality				
c.	Self-injury				
d.	Physical Aggression				
e.	Low levels of Social or Interpersonal Support				
f.	Past treatment non-response				
g.	Past adherence problems in psychotherapy				
h.	Other				

i. If other, please specify: \_\_\_\_\_

30. Please rate the likelihood that the following client problems might be worsened/exacerbated during or immediately after a course of **exposure** therapy. By exposure therapy, we include imaginal or In-Vivo enactments of challenging situations during session.

		Very Likely Worsened	Somewhat Likely	Somewhat Unlikely	Very Unlikely
a.	Any Comorbidity				
b.	Suicidality				
c.	Self-injury				
d.	Physical Aggression				
e.	Overwhelming Anxiety				
f.	Difficulties in Alliance with Therapist				
g.	Difficulties in Personal Relationships				
h.	Desire to Drop Out of Therapy				
i.	Other				

i. If other, please specify: \_\_\_\_\_

31. To what extent do you believe each of the following may interfere with or limit your use of exposure exercises in sessions?

	Significantly interfere with/ limit	Moderately interfere with/ limit	Slightly interfere with/ limit	Would not interfere with/ limit at all
Client distress or resistance				
Parent/Guardian distress or resistance				
Concern that exposure would exacerbate clients' symptoms or result in unmanageable side effects				
Risk of exposure increasing the likelihood of patient drop-out or harming therapeutic alliance.				
Conducting exposures caused me distress				
Exposure did not fit with my conceptualization of anxiety or depression, or I believed other interventions were more effective				
Lack of training or experience conducting an exposure				
Difficulty thinking of, or preparing for exposures				

Lack of adequate resources (i.e., space, materials, confederates to help)				
Lack of adequate time to conduct an exposure in session				
Potential to disrupt others at my practice or institution				
Other				

**Stage 2: Manual Rating Form: Sessions 1 through 4**

If possible, please complete this form after conducting IBAT sessions 1, 2, 3, and 4 with your client. Read the instructions and anchors for each question carefully before responding.

1. Please enter your study ID#: \_\_\_\_\_
2. Please enter today's date: \_\_\_\_\_
3. Which sessions have you completed since the completing the previous questionnaire?

a. 1	e. 5	i. 9
b. 2	f. 6	j. 10
c. 3	g. 7	k. 11
d. 4	h. 8	l. 12
4. Please enter the date of the most recent IBAT session: \_\_\_\_\_
5. Please list the diagnoses your client meets criteria for:
  - a. Anxiety Disorder
    - i. Separation Anxiety Disorder
    - ii. Selective Mutism
    - iii. Specific Phobia
    - iv. Social Phobia
    - v. Panic Disorder
    - vi. Agoraphobia
    - vii. Generalized Anxiety Disorder
    - viii. Other Specified/Unspecified Anxiety Disorder
    - ix. Other: \_\_\_\_\_
  - b. Depressive Disorder
    - i. Major Depressive Disorder
    - ii. Persistent Depressive Disorder
    - iii. Disruptive Mood Dysregulation
    - iv. Other Specified/Unspecified Depressive Disorder
    - v. Other: \_\_\_\_\_
  - c. Disruptive, Impulse-Control, and Conduct Disorder
    - i. Oppositional Defiant Disorder
    - ii. Intermittent Explosive Disorder
    - iii. Conduct Disorder
    - iv. Other Specified/Unspecified Disruptive, Impulse-Control, And Conduct Disorder
    - v. Other: \_\_\_\_\_
  - d. Neurodevelopmental Disorder
    - i. Autism Spectrum Disorder
    - ii. Attention-Deficit/Hyperactivity Disorder
    - iii. Tic Disorders
    - iv. Other Specified/Unspecified Neurodevelopmental Disorder
    - v. Other: \_\_\_\_\_

6. To what extent did you feel the manual provided clear explanations of theory and strategies?

1 Extremely unclear	2 Moderately unclear	3 Slightly unclear	4 Neutral	5 Slightly clear	6 Moderately clear	7 Extremely clear
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7. To what extent did you feel the manual provided enough information and detail?

1 Significantly lacking information	2 Moderately lacking	3 Slightly lacking	4 Optimal amount of information	5 Slightly excessive	6 Moderately excessive	7 Significantly excessive
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8. Were there unnecessary elements included within the last four sessions? If so, please describe:

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9. Were there important elements missing within the last four sessions? If so, please describe:

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10. How easy was it for you to apply the avoidance model used in the manual to your client's individual difficulties?

1 Extremely challenging to apply	2 Moderately challenging to apply	3 Slightly challenging to apply	4 Neither easy nor challenging	5 Slightly easy to apply	6 Moderately easy to apply	7 Extremely easy to apply
-------------------------------------	--------------------------------------	------------------------------------	-----------------------------------	-----------------------------	-------------------------------	------------------------------

11. To what extent were you able to complete all outlined activities in the manual within the allotted session time?

1 No activities completed	2 Few activities completed (~20%)	3 Some activities completed (~35%)	4 50% of activities completed	5 More than half of activities completed (~65%)	6 Almost all activities completed (~80%)	7 All activities completed
------------------------------	--------------------------------------	---------------------------------------	----------------------------------	--	---	-------------------------------

12. To what extent did you feel the interventions within the manual were easy to implement with your client?

1 Extremely challenging	2 Moderately challenging	3 Slightly challenging	4 Neither easy nor challenging	5 Slightly easy	6 Moderately easy	7 Extremely easy
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13. How helpful did you find the TRAP/TRAC exercises within session in regards to conceptualization, as a tool for your client, or as part of behavioral exercises?

1 Extremely unhelpful	2 Moderately unhelpful	3 Slightly unhelpful	4 Neither helpful nor unhelpful	5 Slightly helpful	6 Moderately helpful	7 Extremely helpful
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14. To what extent did you use behavioral activation exercises within your sessions?

1 Not used at all	2 Briefly mentioned, but not used	3 Minimally used	4 Somewhat used	5 Used as a significant part of the session	6 Used as a primary intervention within session	7 Used as the sole intervention within session
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15. To what extent did you use exposures exercises within your sessions?

1 Not used at all	2 Briefly mentioned, but not used	3 Minimally used	4 Somewhat used	5 Used as a significant part of the session	6 Used as a primary intervention within session	7 Used as the sole intervention within session
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16. What do you think could be added or altered in order to increase the feasibility or acceptability of behavioral activation and exposure exercise?

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17. To what extent do you think the manual allowed for flexibility within the session? Flexibility should allow for the personalization of interventions for clients while adhering to recommended interventions.

1 Significantly too inflexible- too rigid	2 Moderately too inflexible	3 Slightly too inflexible	4 Optimal level of flexibility	5 Slightly too flexible	6 Moderately too flexible	7 Significantly too flexible- not enough guidance
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18. To what extent did you find yourself straying from the manual's content and implementing interventions not included in the manual (e.g., cognitive restructuring, mindfulness, supportive therapy)?

1 Did not stray at all	2 Slightly strayed	3 Somewhat strayed	4 Moderately Strayed	5 Significantly strayed	6 Excessively strayed	6 Completely strayed
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19. How much did you like or enjoy using this manual? In other words, how acceptable did you find this manual?

1	2	3	4	5	6	7
Extremely Unacceptable	Moderately Unacceptable	Slightly Unacceptable	Neutral	Slightly Acceptable	Moderately Acceptable	Extremely Acceptable

20. Which aspects of this manual did you like the most? Please describe:

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21. What elements would you like to see changed in the manual, and how? Please explain:

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22. To what extent did you feel the interventions within the manual were effective in addressing your client's needs?

1	2	3	4	5	6	7
Extremely ineffective	Moderately ineffective	Slightly effective	Neutral- neither effective nor ineffective	Slightly effective	Moderately effective	Extremely effective

23. To what extent did your client engage in active interventions in session (i.e., behavioral activation or exposure exercises)?

1	2	3	4	5	6	7
Extremely disengaged	Moderately disengaged	Slightly disengaged	Neither engaged nor disengaged	Slightly engaged	Moderately engaged	Extremely engaged

24. To what extent did each of the following considerations limit the acceptability or feasibility of exposure use in the most recent four sessions:

	Significantly interfere with/ limit	Moderately interfere with/ limit	Slightly interfere with/ limit	Would not interfere with/ limit at all
Client distress or resistance				
Parent/Guardian distress or resistance				
Concern that exposure would exacerbate clients' symptoms or result in unmanageable side effects				
Risk of exposure increasing the likelihood of patient drop-out or harming therapeutic alliance.				
Conducting exposures caused me distress				
Exposure did not fit with my conceptualization of anxiety or depression, or I believed other interventions were more effective				
Lack of training or experience conducting an exposure				
Difficulty thinking of, or preparing for exposures				
Lack of adequate resources (i.e., space, materials, confederates to help)				
Lack of adequate time to conduct an exposure in session				
Potential to disrupt others at my practice or institution				
Other				

25. To what extent did each of the following increase the feasibility or acceptability of exposure use in the previous four sessions:

	Significantly increase	Moderately increase	Slightly interfere increase	Would not increase
Previous training or experience conducting exposures outside of this project				
Having early success implementing IBAT exercises				
The IBAT manual's rationale for exposures and/ or guided outline of exposure activities				
Pre-planning for exposure exercises prior to session				
List of exposure ideas within the IBAT manual				
Case vignettes of sample exposures within the IBAT manual				
Access to appropriate resources (i.e., space, materials, confederates to help)				
Institutional support for exposure exercises				
Other				

i. If other, please specify

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**Stage 2: Manual Rating Form: Sessions 5 through 8**

If possible, please complete this form after conducting IBAT sessions 5, 6, 7, and 8 with your client. Read the instructions and anchors for each question carefully before responding.

1. Please enter your study ID#: \_\_\_\_\_

2. Please enter today's date: \_\_\_\_\_

3. Which sessions have you completed since the completing the previous questionnaire?

- |      |      |       |
|------|------|-------|
| a. 1 | e. 5 | i. 9  |
| b. 2 | f. 6 | j. 10 |
| c. 3 | g. 7 | k. 11 |
| d. 4 | h. 8 | l. 12 |

4. Please enter the date of the most recent IBAT session: \_\_\_\_\_

5. To what extent did you feel the manual provided clear explanations of theory and strategies?

1	2	3	4	5	6	7
Extremely unclear	Moderately unclear	Slightly unclear	Neutral	Slightly clear	Moderately clear	Extremely clear

6. To what extent did you feel the manual provided enough information and detail?

1	2	3	4	5	6	7
Significantly lacking information	Moderately lacking	Slightly lacking	Optimal amount of information	Slightly excessive	Moderately excessive	Significantly excessive

7. Were there unnecessary elements included within the last four sessions? If so, please describe:

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8. Were there important elements missing within the last four sessions? If so, please describe:

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9. How easy was it for you to apply the avoidance model used in the manual to your client's individual difficulties?

1	2	3	4	5	6	7
Extremely challenging to apply	Moderately challenging to apply	Slightly challenging to apply	Neither easy nor challenging	Slightly easy to apply	Moderately easy to apply	Extremely easy to apply

10. To what extent were you able to complete all outlined activities in the manual within the allotted session time?

1	2	3	4	5	6	7
No activities completed	Few activities completed (~20%)	Some activities completed (~35%)	50% of activities completed	More than half of activities completed (~65%)	Almost all activities completed (~80%)	All activities completed

11. To what extent did you feel the interventions within the manual were easy to implement with your client?

1	2	3	4	5	6	7
Extremely challenging	Moderately challenging	Slightly challenging	Neither easy nor challenging	Slightly easy	Moderately easy	Extremely easy

12. How helpful did you find the TRAP/TRAC exercises within session in regards to conceptualization, as a tool for your client, or as part of behavioral exercises?

1	2	3	4	5	6	7
Extremely unhelpful	Moderately unhelpful	Slightly unhelpful	Neither helpful nor unhelpful	Slightly helpful	Moderately helpful	Extremely helpful

13. To what extent did you use behavioral activation exercises within your sessions?

1	2	3	4	5	6	7
Not used at all	Briefly mentioned, but not used	Minimally used	Somewhat used	Used as a significant part of the session	Used as a primary intervention within session	Used as the sole intervention within session

14. To what extent did you use exposures exercises within your sessions?

1	2	3	4	5	6	7
Not used at all	Briefly mentioned, but not used	Minimally used	Somewhat used	Used as a significant part of the session	Used as a primary intervention within session	Used as the sole intervention within session

15. What do you think could be added or altered in order to increase the feasibility or acceptability of behavioral activation and exposure exercise?

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16. To what extent do you think the manual allowed for flexibility within the session? Flexibility should allow for the personalization of interventions for clients while adhering to recommended interventions.

1	2	3	4	5	6	7
Significantly too inflexible-too rigid	Moderately too inflexible	Slightly too inflexible	Optimal level of flexibility	Slightly too flexible	Moderately too flexible	Significantly too flexible-not enough guidance

17. To what extent did you find yourself straying from the manual's content and implementing interventions not included in the manual (e.g., cognitive restructuring, mindfulness, supportive therapy)?

1	2	3	4	5	6	6
Did not stray at all	Slightly strayed	Somewhat strayed	Moderately Strayed	Significantly strayed	Excessively strayed	Completely strayed

18. How much did you like or enjoy using this manual? In other words, how acceptable did you find this manual?

1	2	3	4	5	6	7
Extremely Unacceptable	Moderately Unacceptable	Slightly Unacceptable	Neutral	Slightly Acceptable	Moderately Acceptable	Extremely Acceptable

19. Which aspects of this manual did you like the most? Please describe:

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20. What elements would you like to see changed in the manual, and how? Please explain:

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21. To what extent did you feel the interventions within the manual were effective in addressing your client's needs?

1	2	3	4	5	6	7
Extremely ineffective	Moderately ineffective	Slightly effective	Neutral- neither effective nor ineffective	Slightly effective	Moderately effective	Extremely effective

22. To what extent did your client engage in active interventions in session (i.e., behavioral activation or exposure exercises)?

1	2	3	4	5	6	7
Extremely disengaged	Moderately disengaged	Slightly disengaged	Neither engaged nor disengaged	Slightly engaged	Moderately engaged	Extremely engaged

23. To what extent did each of the following considerations limit the acceptability or feasibility of exposure use in the most recent four sessions:

	Significantl y interfere with/ limit	Moderately interfere with/ limit	Slightly interfere with/ limit	Would not interfere with/ limit at all
Client distress or resistance				
Parent/Guardian distress or resistance				
Concern that exposure would exacerbate clients' symptoms or result in unmanageable side effects				
Risk of exposure increasing the likelihood of patient drop-out or harming therapeutic alliance.				
Conducting exposures caused me distress				
Exposure did not fit with my conceptualization of anxiety or depression, or I believed other interventions were more effective				
Lack of training or experience conducting an exposure				
Difficulty thinking of, or preparing for exposures				
Lack of adequate resources (i.e., space, materials, confederates to help)				
Lack of adequate time to conduct an exposure in session				
Potential to disrupt others at my practice or institution				
Other				



24. To what extent did each of the following increase the feasibility or acceptability of exposure use in the previous four sessions:

	Significantly increase	Moderately increase	Slightly interfere increase	Would not increase
Previous training or experience conducting exposures outside of this project				
Having early success implementing IBAT exercises				
The IBAT manual's rationale for exposures and/ or guided outline of exposure activities				
Pre-planning for exposure exercises prior to session				
List of exposure ideas within the IBAT manual				
Case vignettes of sample exposures within the IBAT manual				
Access to appropriate resources (i.e., space, materials, confederates to help)				
Institutional support for exposure exercises				
Other				

If other, please specify \_\_\_\_\_

**Stage 2: Manual Rating Form: Sessions 9 through 12**

Please complete this form after conducting IBAT sessions 9, 10, 11, and 12 with your client. Read the instructions and anchors for each question carefully before responding.

1. Please enter your study ID#: \_\_\_\_\_
2. Please enter today's date: \_\_\_\_\_
3. Which sessions have you completed since the completing the previous questionnaire? [drop down : 1-12]
4. Please enter the date of the most recent IBAT session: \_\_\_\_\_
5. To what extent did you feel the manual provided clear explanations of theory and strategies?

1	2	3	4	5	6	7
Extremely unclear	Moderately unclear	Slightly unclear	Neutral	Slightly clear	Moderately clear	Extremely clear

6. To what extent did you feel the manual provided enough information and detail?

1	2	3	4	5	6	7
Significantly lacking information	Moderately lacking	Slightly lacking	Optimal amount of information	Slightly excessive	Moderately excessive	Significantly excessive

7. Were there unnecessary elements included within the last four sessions? If so, please describe:

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8. Were there important elements missing within the last four sessions? If so, please describe:

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9. How easy was it for you to apply the avoidance model used in the manual to your client's individual difficulties?

1	2	3	4	5	6	7
Extremely challenging to apply	Moderately challenging to apply	Slightly challenging to apply	Neither easy nor challenging	Slightly easy to apply	Moderately easy to apply	Extremely easy to apply

10. To what extent were you able to complete all outlined activities in the manual within the allotted session time?

1	2	3	4	5	6	7
No activities completed	Few activities completed (~20%)	Some activities completed (~35%)	50% of activities completed	More than half of activities completed (~65%)	Almost all activities completed (~80%)	All activities completed

11. To what extent did you feel the interventions within the manual were easy to implement with your client?

1	2	3	4	5	6	7
Extremely challenging	Moderately challenging	Slightly challenging	Neither easy nor challenging	Slightly easy	Moderately easy	Extremely easy

12. How helpful did you find the TRAP/TRAC exercises within session in regards to conceptualization, as a tool for your client, or as part of behavioral exercises?

1	2	3	4	5	6	7
Extremely unhelpful	Moderately unhelpful	Slightly unhelpful	Neither helpful nor unhelpful	Slightly helpful	Moderately helpful	Extremely helpful

13. To what extent did you use behavioral activation exercises within your sessions?

1	2	3	4	5	6	7
Not used at all	Briefly mentioned, but not used	Minimally used	Somewhat used	Used as a significant part of the session	Used as a primary intervention within session	Used as the sole intervention within session

14. To what extent did you use exposures exercises within your sessions?

1 Not used at all	2 Briefly mentioned, but not used	3 Minimally used	4 Somewhat used	5 Used as a significant part of the session	6 Used as a primary intervention within session	7 Used as the sole intervention within session
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15. What do you think could be added or altered in order to increase the feasibility or acceptability of behavioral activation and exposure exercise?

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16. To what extent do you think the manual allowed for flexibility within the session? Flexibility should allow for the personalization of interventions for clients while adhering to recommended interventions.

1 Significantl y too inflexible- too rigid	2 Moderatel y too inflexible	3 Slightly too inflexibl e	4 Optimal level of flexibilit y	5 Slightl y too flexible	6 Moderatel y too flexible	7 Significantl y too flexible- not enough guidance
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17. To what extent did you find yourself straying from the manual's content and implementing interventions not included in the manual (e.g., cognitive restructuring, mindfulness, supportive therapy)?

1 Did not stray at all	2 Slightly strayed	3 Somewhat strayed	4 Moderately Strayed	5 Significantly strayed	6 Excessively strayed	6 Completely strayed
------------------------------------	--------------------------	--------------------------	----------------------------	-------------------------------	-----------------------------	----------------------------

18. How much did you like or enjoy using this manual? In other words, how acceptable did you find this manual?

1 Extremely Unacceptable	2 Moderately Unacceptable	3 Slightly Unacceptable	4 Neutral	5 Slightly Acceptable	6 Moderately Acceptable	7 Extremely Acceptable
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19. Which aspects of this manual did you like the most? Please describe:

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20. What elements would you like to see changed in the manual, and how? Please explain:

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21. To what extent did you feel the interventions within the manual were effective in addressing your client's needs?

1	2	3	4	5	6	7
Extremely ineffective	Moderately ineffective	Slightly effective	Neutral- neither effective nor ineffective	Slightly effective	Moderately effective	Extremely effective

22. To what extent did your client engage in active interventions in session (i.e., behavioral activation or exposure exercises)?

1	2	3	4	5	6	7
Extremely disengaged	Moderately disengaged	Slightly disengaged	Neither engaged nor disengaged	Slightly engaged	Moderately engaged	Extremely engaged

23. To what extent did each of the following considerations limit the acceptability or feasibility of exposure use in the most recent four sessions:

	Significantly interfere with/ limit	Moderately interfere with/ limit	Slightly interfere with/ limit	Would not interfere with/ limit at all
Client distress or resistance				
Parent/Guardian distress or resistance				
Concern that exposure would exacerbate clients' symptoms or result in unmanageable side effects				
Risk of exposure increasing the likelihood of patient drop-out or harming therapeutic alliance.				
Conducting exposures caused me distress				
Exposure did not fit with my conceptualization of anxiety or depression, or I believed other interventions were more effective				
Lack of training or experience conducting an exposure				
Difficulty thinking of, or preparing for exposures				
Lack of adequate resources (i.e., space, materials, confederates to help)				
Lack of adequate time to conduct an exposure in session				
Potential to disrupt others at my practice or institution				
Other				

24. To what extent did each of the following increase the feasibility or acceptability of exposure use in the previous four sessions:

	Significantly increased	Moderately increased	Slightly increased	Did not increase
Previous training or experience conducting exposures outside of this project				
Having early success implementing IBAT exercises				
The IBAT manual's rationale for exposures and/ or guided outline of exposure activities				
Pre-planning for exposure exercises prior to session				
List of exposure ideas within the IBAT manual				
Case vignettes of sample exposures within the IBAT manual				
Access to appropriate resources (i.e., space, materials, confederates to help)				
Institutional support for exposure exercises				
Other				

i. If other, please specify

\_\_\_\_\_

\_\_\_\_\_

**Stage 3: IBAT Manual Summary Survey**

Please complete this questionnaire after your last IBAT treatment session with your selected client. Read the instructions and anchors for each question carefully before responding.

1. Please enter your study ID#: \_\_\_\_\_
2. Please enter today's date: \_\_\_\_\_
3. IBAT recommends 12 sessions. What would be the ideal number of sessions to use IBAT in treating your client's symptoms?
4. What would you recommend as the optimal amount of time needed to complete a standard IBAT session? \_\_\_\_\_
5. Did you continue to see the client or recommend additional treatment that was different from IBAT?
  - i. Yes
  - ii. No

b. If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_
6. During the treatment phase, how many of the optional consultation phone calls did you utilize?
  - a. 0
  - b. 1
  - c. 2
  - d. 3



Please rate to what extend you agree with the following:

		1 Completely Disagree	2 Somewhat Disagree	3 Neutral	4 Somewhat Agree	5 Completely Agree
7.	The IBAT manual made me feel more like a technician than caring human beings.					
8.	The IBAT manual forced me to conceptualize my client within an arbitrary category.					
9.	The IBAT manual helped me utilize only interventions which have been demonstrated to be effective.					
10.	The IBAT manual enhanced therapeutic outcomes by insuring that the treatment I used was supported by research.					
11.	The IBAT manual would be easy to effectively implement within my institution's regular practice.					

Now you will be asked some questions about the IBAT manual as a whole, as well as what you think about the different components of the program. We are interested in your impressions of both positive and negative aspects of the manual.

For the next several questions, we will be using a 0-9 scale, where 0 means “Not at all” and 9 means “Extremely.” A 5 would mean “Moderately.” Do you understand the scale?

-----0-----1-----2-----3-----4-----5-----6-----7-----8-----9

Not at all

Moderately

Extremely

12. In using the manual, how *effective* were the IBAT components for your case? How effective was \_\_\_\_\_?

	0	1	2	3	4	5	6	7	8	9
<b>Activity Tracking:</b> (weekly monitoring of events and moods)										
<b>Behavioral experiments</b> (in-session “Getting Active” tasks, testing effectiveness of different options)										
<b>TRAP</b> (individual functional assessment. helping youth identify triggers, responses, avoidance patterns)										
<b>TRAC /Problem-Solving</b> (individual functional assessment. helping youth identify triggers, responses, and active or alternative coping, identifying problems, generating solutions, picking and executing solutions).										
<b>In Vivo Exposure for fear or anxiety based challenged</b> (real-life challenges)										
<b>Behavioral Activation Exercises for mood/ depression based challenges</b> (real-life behavioral tasks, pleasant activities)										
<b>Homework</b> (practice task)										

13. Now thinking of the IBAT treatment overall. How *effective* do you think the IBAT treatment overall was for the case you saw for the IBAT study?

-----0-----1-----2-----3-----4-----5-----6-----7-----8-----9

Not at all

Moderately

Extremely

-----0-----1-----2-----3-----4-----5-----6-----7-----8-----9  
Not at all Moderately Extremely

15. Now thinking of the IBAT treatment overall. How *challenging* or *difficult* do you think it was to implement the IBAT treatment for the cases you saw during the study?

-----0-----1-----2-----3-----4-----5-----6-----7-----8-----9  
Not at all Moderately Extremely

Now I am going to ask you to think about child or adolescent cases you are seeing currently or have seen recently for which anxiety and/ or depression was a clinical focus. We are going to stop using the 0-9 scale and I will ask you to respond using a percentage, from 0-100. As an example, “What percentage of your clients wear hats to session?”

16. I am now going to read a list of specific components of the IBAT program. Thinking about your current or recent work with anxious or depressed youth, for what % of clients would \_\_\_\_\_ be *appropriate* for? (0 - 100%)

	[Slider bar]
<b>Functional Doman Assessment</b> (assessing impairment across important domains)	
<b>Activity Tracking:</b> (weekly monitoring of events and moods)	
<b>Getting Active Preparation</b> (developing list of 10 active activities to use when stuck, “basic training” for emotions)	
<b>Goals Ladder</b> (identifying specific goals to work on in treatment)	
<b>Behavioral experiments</b> (in-session “Getting Active” tasks, testing effectiveness of different options)	
<b>Distress Loop</b> (linking anxious, sad, or angry reactions to increased distress)	
<b>TRAP</b> (individual functional assessment. helping youth identify triggers, responses, avoidance patterns)	
<b>TRAC /Problem-Solving</b> (individual functional assessment. helping youth identify triggers, responses, and active or alternative coping, identifying problems, generating solutions, picking and executing solutions).	
<b>In Vivo Exposure for fear or anxiety based challenged</b> (real-life challenges)	
<b>Behavioral Activation Exercises for mood/ depression based challenges</b> (real-life behavioral tasks, pleasant activities)	
<b>Homework</b> (practice task)	

17. Now think about your current or recent caseload of anxious or depressed youth and the times when you have *considered* using or *have used* IBAT techniques or strategies:

	[Slider bar]
For what percentage of your current or recent anxiety or depression cases do you find the <b>whole</b> IBAT program <b>appropriate</b> ?	
For what percentage of your current or recent anxiety or depression cases do you find <b>selective parts</b> of IBAT <b>appropriate</b> ?	

18. You may have used or considered using all or parts of IBAT for youth presenting with problems other than anxiety or depression. For what percentage (0 – 100%) of cases with \_\_\_\_\_ would you find all or part of IBAT appropriate for:

	[Slider bar]
Youth presenting primarily with <b>ADHD</b> ?	
Youth presenting primarily with <b>Defiance/behavior problems</b> ?	
Youth presenting primarily with <b>Family relationship problems</b> ?	
Youth presenting with <b>Other primary problem (please describe)</b> ?	

- a. If other, please specify:

\_\_\_\_\_

Now I am going to ask you to tell me about aspects of the IBAT program that you saw a strengths and aspects that you saw as weaknesses.

19. Please describe the strengths of the IBAT program, as you see them, in terms of being able to use the approach in real world practice.

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20. Please describe the weaknesses of the IBAT program as you see them, in terms of being able to use the approach in real world practice.

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21. What would be three changes you would make to IBAT to make it “fit” better in real-world practice?

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22. What parts of IBAT would NOT need to change?

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**Logic Questions:**

23. Question 14: Effectiveness Follow-up- Pos
  - a. If 6 or higher: What do you think makes IBAT effective for your clients?
24. Question 14: Effectiveness Follow-up- Neg
  - a. If 4 or lower: What do you think makes IBAT ineffective for your clients?
25. Question 16: Feasibility Follow-up- Pos
  - a. If 6 or higher: What made IBAT easier to implement?
26. Question 16: Feasibility Follow-up- Neg
  - a. If 4 or lower: What made IBAT challenging to implement?
  - b. If 4 or lower: What could have been altered to increase ease of implementation?
27. Question 15- Exposure- Pos
  - a. If 6 or higher: What made Exposure easy to implement?
  - b. If 6 or higher: What suggestions do you have to further improve use of exposure?
28. Question 15- Exposure- Neg
  - a. If 6 or higher: What made Exposure challenging to implement?
  - b. If 6 or higher: What could have been altered to increase ease of implementation?
29. Question 15- BA- Pos
  - a. If 6 or higher: What made BA easy to implement?
  - b. If 6 or higher: What suggestions do you have to further improve use of exposure?
30. Question 15- BA- Neg
  - a. If 4 or lower: What made IBAT challenging to implement?
  - b. If 4 or lower: What could have been altered to increase ease of implementation?