Evidence-Based CBT for Anxiety and Depression in Children and Adolescents

A Competencies Based Approach

Edited by
Elizabeth S. Sburlati,
Heidi J. Lyneham,
Carolyn A. Schniering,
and Ronald M. Rapee

WILEY Blackwell

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To Melba: your strength, resilience, commitment, warmth and playfulness continue to inspire
Liz

To my Mum, who inspires people to strive for competence every day
Heidi

To Mark, Nicola, and Henry
Carolyn

To Wendy, Alice, and Lucy
Ron

Contents

Notes on Editors

Elizabeth S. Sburlati, PhD MClinPsych, is involved in research at Macquarie University's Centre for Emotional Health. Elizabeth is also a clinical psychologist. Her research interests are in the dissemination and implementation of evidence-based practice in "real-world" settings, as well as in the treatment of child and adolescent anxiety and depression. She has published journal articles in peer-reviewed journals, has presented research at conferences, has peer-reviewed articles for numerous journals, and has peer-reviewed presentation proposals for the 1st and 2nd biennial Global Implementation Conferences.

Heidi J. Lyneham, PhD MClinPsych, is the Clinic Director at the Emotional Health Clinic, Centre for Emotional Health, Macquarie University, Australia. Heidi's research interests include improving assessment and treatment methods for emotional problems experienced by children and adolescents. With a specific focus on improving access to services, Heidi has published a number of papers that investigate the use of supported bibliotherapy in treating anxiety, particularly for those from rural areas. She is an author of the well-known Cool Kids Anxiety Treatment Program.

Carolyn A. Schniering, PhD MClinPsych, is a senior lecturer and child psychologist at the Centre for Emotional Health, Department of Psychology, Macquarie University, Australia. Carolyn has first-hand experience in the treatment of adolescents with emotional difficulties and recently developed and evaluated a new transdiagnostic treatment that targets both anxiety and depression in youth. She also developed the Children's Automatic Thoughts Scale (CATS), which has been used on a national and international scale to identify thinking styles associated with emotional syndromes in children and adolescents.

Ronald M. Rapee, AM PhD MSc (Psych), is currently Distinguished Professor in the Department of Psychology, Macquarie University, Sydney and Director of the Centre for Emotional Health. He has published extensively on the understanding and management of emotional difficulties across the lifespan and has written and edited books for professionals and for the general public. Ron has received several awards for his scientific contributions, and in 2012 he was made a Member of the Order of Australia for his contributions to clinical psychology in Australia.

Notes on Contributors

Rinad S. Beidas, PhD, conducts research centered on the dissemination and implementation of evidence-based practices (EBPs) for youth in community settings. Previous work includes an NIMH-funded F31 MH 083333 randomized controlled trial investigating the efficacy of three training methods and ongoing support of therapist fidelity. Current work involves an NIMH funded K23 MH099179 project that prospectively investigates the impact of a policy on implementation of EBPs in outpatient mental health services for youth.

James Bennett-Levy is an associate professor at the University of Sydney's University Centre for Rural Health (North Coast). He has been one of the leading writers and researchers on CBT therapist training over the past decade. He has also co-authored the *Oxford Guide to Imagery in Cognitive Therapy* (2011) and co-edited the *Oxford Guide to Behavioural Experiments in Cognitive Therapy* (2004) and the *Oxford Guide to Low Intensity CBT Interventions* (2010).

Gemma Bowers works as a clinical psychologist with children and young people in Norfolk, UK. She has a particular interest in working with families who have a child with a chronic health problem, such as diabetes. She has also worked with children in mental health services and has an interest in the treatment of anxiety disorders in children.

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Philip C. Kendall, PhD, ABPP, is Laura H. Carnell Distinguished University Professor at Temple University. He has been a fellow at the Center for Advanced Study in the Behavioral Sciences, won the Outstanding Contribution for Educational/Training Activities from ABCT, the Distinguished Career Research Award (Division 53) and the Distinguished Scientific Contribution Award (Division 12) from the APA, the Research Recognition Award from the Anxiety Disorders Association of America, and was identified as a "top therapist" by Philadelphia Magazine. Philip's contributions include the treatment of anxiety disorders in youth, research methodology, and cognitive behavioral theory, assessment, and treatment.

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1

An Introduction to the Competencies-Based Approach

Elizabeth S. Sburlati, Heidi J. Lyneham, and Carolyn A. Schniering

The Genesis of This Book

Empirically supported treatment, evidence-based practice, and the real world

There are a number of cognitive behavioral empirically supported treatments (ESTs) available for treating child and adolescent anxiety and depressive disorders that therapists practicing in routine clinical practice (RCP) can use when delivering evidence-based practice (EBP). However, interventions for children and adolescents may not be as effective when implemented in real world RCP settings as they are when implemented in research settings (Weisz, Ugueto, Cheron, and Herren 2013). Research is now indicating that poor real-world implementation of ESTs could be partly due to inadequate training of the therapists who work in RCP (Beidas, Barmish, and Kendall 2009; Herschell, Kolko, Baumann, and Davis 2010). As a result, there has been a call to examine and improve the quality of therapist EST training (Rakovshik and McManus 2010). However, until recently, the specific competencies that are required for the effective implementation of ESTs that target anxious and depressed children and adolescents were unknown, which made the development of more effective EST training difficult.

The competencies-based approach

The field of psychology is moving away from the traditional training approach, which focused on the trainee's satisfying training activities (e.g., courses, client contact hours, supervision hours) to a competencies-based approach to training that aims to

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conceptualize, systematically train, and effectively assess the competence of trainees in performing as independent professionals (e.g., Hunsley and Barker 2011; Kaslow 2004; Kaslow et al. 2004; Knight 2011; Laidlaw and Gillanders 2011; Pachana, Sofronoff, Scott, and Helmes 2011; Roberts, Borden, Christiansen, and Lopez 2005). Competence is defined within the competencies-based approach as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (Epstein and Hundert 2002, p. 227). The competencies-based approach suggests that competence is comprised of competencies, which are the important component parts of competence (Kaslow 2004; Kaslow et al. 2004). According to the competencies-based approach, these competencies include a therapist's knowledge, attitudes, and skills that are related to his or her area of practice (Kaslow 2004; Kaslow et al. 2004).

A model of therapist competencies for the evidence-based treatment of child and adolescent anxiety and depressive disorders

As a part of a large-scale initiative in the United Kingdom, the dissemination project Improving Access to Psychological Therapies (IAPT), Roth and Pilling (2008) developed a model of therapist competencies for the evidence-based cognitive behavioral treatment of adult anxiety and depression. This model was designed to be used so as to develop a training curriculum aimed at teaching therapists in RCP to implement evidence-based practice in real-world settings. Drawing on the work of Roth and Pilling (2008) and acknowledging the vast array of different competencies required when treating children and adolescents (as opposed to adults), Sburlati, Schniering, Lyneham, and Rapee (2011) developed a therapist competence model targeting the empirically supported cognitive behavioral treatment of child and adolescent anxiety and depressive disorders. This model drew on all empirically supported treatment manuals that had been published prior to January 2010 and utilized the knowledge and feedback of experts from all around the world (for a complete description of the manuals, experts, and methods used in the model development, see Sburlati et al. 2011). The outcome was a model that provides a comprehensive listing of the individual competencies needed to conduct evidence-based practice with youth experiencing internalizing disorders in real-world clinical practice. The individual competencies in the model are grouped together by similarity, into competency categories, and these competency categories are placed under the three domains of competence (Sburlati et al. 2011). These three domains of competence are described below, in the part devoted to the subject. In the model, competencies were shaded gray if they were specific to the treatment of children and adolescents (but not adults) or require considerable adaptation when working with children and adolescents. (To view the model in its original format, see Sburlati et al. 2011, p. 94).

Sburlati et al. (2011) domains of competence

Generic therapeutic competencies

Generic therapeutic competencies, first identified by Roth and Pilling (2008), are those competencies that a therapist needs in order to interact with people within a therapeutic context, irrespective of therapeutic orientation. These competencies are

not seen in cognitive behavioral therapy (CBT) only, but rather are used across all therapeutic models (Roth and Pilling 2008). The generic therapeutic competencies were reviewed, adapted, and expanded by Sburlati and colleagues (2011) to account for the needs of children and adolescents. The competency categories and individual competencies included in the generic therapeutic competencies domain can be seen in Table 1.1. These competencies are discussed across Chapters 3 to 7 of this book.

Table 1.1 Generic therapeutic competencies.

Category	*Individual competencies*
1. Practicing professionally:	(a) knowledge of and ability to operate within professional, ethical, and legal codes of conduct relevant to working with children and adolescents, and their families (e.g., providing a duty of care);
	(b) ability to actively participate in supervision;
	(c) possession of an open attitude toward psychotherapy research, and the ability to access, critically evaluate and utilize this research to inform practice;
	(d) ability to self assess current level of competence, and to seek relevant professional development.
2. Understanding relevant child and adolescent characteristics:	(a) knowledge of developmental issues including cognitive, social, and emotional maturation from childhood to adolescence and how these can impact on therapy;
	(b) knowledge of child or adolescent relevant individual differences (e.g., learning disorders, familial culture) and how these can impact on therapy;
	(c) knowledge of other environmental factors (e.g., socioeconomic status, family structure, education) and life events (e.g., bullying, trauma, health issues, life transitions) and how these can impact on therapy;
	(d) knowledge of child and adolescent psychopathology and comorbid presentations and how these can impact on therapy.
3. Building a positive relationship:	(a) ability to engage the child or adolescent through age appropriate methods (e.g., games, activities, humour, technology, language), and appropriate session pacing;
	(b) ability to foster and maintain a good therapeutic alliance with the child or adolescent;
	(c) ability to foster and maintain a good therapeutic alliance with the parent;
	(d) ability to instil hope, and optimism for change.

(*Continued*)

Table 1.1 (*cont'd*)

Category	*Individual competencies*
4. Conducting a thorough assessment:	(a) ability to undertake an evidence-based, multi method (e.g., self-report, observational), multi informant (e.g., child, parent, teacher, allied health professional) psychological assessment of the disorder presentation; (b) ability to integrate assessment reports from both the child or adolescent, parent and other parties; (c) ability to determine clinical diagnoses with consideration of differential diagnosis; (d) ability to undertake a generic assessment of the child or adolescent's current functioning, family functioning, peer relationships, developmental history and stage, and their suitability for the intervention; (e) ability to assess and manage risk of self-harm and suicide.

Source: Sburlati, Schniering, Lyneham, and Rapee (2011, p. 94).

CBT competencies

CBT competencies are those competencies required to plan, administer, and flexibly tailor specific CBT techniques to the individual needs of the child or adolescent and his or her family (Sburlati et al. 2011). The CBT competencies domain in Sburlati and colleagues (2011) is not to be found in the Roth and Pilling (2008) model; it was derived from combining two separate Roth and Pilling (2008) competence domains – basic CBT competencies and metacompetencies. The competency categories and the individual competencies included in the CBT competencies domain can be seen in Table 1.2. These competencies are discussed across Chapters 8 to 11 of this book.

Specific CBT techniques

Specific CBT techniques are techniques that target the theoretical factors that maintain anxiety and depression and that are included within empirically supported cognitive behavioral treatments for child and adolescent anxiety and depressive disorders (Roth and Pilling 2008; Sburlati et al. 2011). The competency categories and the individual techniques included in the specific CBT techniques domain can be seen in Table 1.3. These competencies are discussed across Chapters 12 to 19 of this book.

About This Book

Aims

The present book calls on the expertise of many leaders in the field to explore in detail each of the competencies in Sburlati and colleagues' (2011) model. This book is aimed at two main audiences. First, it is aimed at clinical supervisors who are

Table 1.2 CBT competencies.

Category	*Individual competencies*
5. Understanding relevant CBT theory and research:	(a) knowledge of theoretical underpinnings of CBT, and the ability to implement CBT in line with these; (b) knowledge of cognitions relevant to the maintenance of anxiety disorders and depression; (c) knowledge of behaviors relevant to the maintenance of anxiety disorders and depression; (d) knowledge of family and other environment factors relevant to the maintenance of anxiety disorders and depression in children and adolescents.
6. Devising, implementing, and revising a CBT case formulation and treatment plan:	(a) ability to devise and revise a CBT case formulation that appropriately accounts for child or adolescent disorder presentation, developmental level, individual differences, family factors, and the presence of comorbidity; (b) ability to devise, implement, and flexibly revise an evidence-based CBT treatment plan by selecting, sequencing, and applying the most appropriate specific CBT techniques, at the appropriate dosage, for the case formulation; (c) ability to communicate appropriate psychoeducation about the nature of the disorder, the case formulation, and the treatment plan to both the parent and the child or adolescent; (d) ability to collaboratively negotiate and agree on treatment goals; (e) ability to use measures and self-monitoring to guide therapy and to monitor outcome; (f) ability to manage obstacles to CBT; (g) ability to plan for the end of therapy and for long-term maintenance of gains after treatment.
7. Collaboratively conducting CBT sessions:	(a) ability to collaboratively set and adhere to session goals/agenda; (b) ability to communicate rationale for each specific CBT technique; (c) ability to elicit and respond to feedback; (d) ability to implement specific CBT techniques flexibly for the client disorder presentation, needs or preferences, cultural background, and current mood; (e) ability to make use of experiential strategies to implement specific CBT techniques (e.g., role play, modeling, corrective feedback and reinforcement); (f) ability to conduct sessions with developmental sensitivity (e.g., using age-appropriate worksheets, instruction, play-based activities, token economies); (g) ability to facilitate an appropriate level of *in session* collaboration between child or adolescent, parent and therapist; (h) ability to facilitate parents to take an appropriate role *between sessions* (e.g., as coach); (i) ability to collaboratively set, plan and review personally meaningful homework; (j) ability to end sessions in a planned manner.

Source: Sburlati, Schniering, Lyneham, and Rapee (2011, p. 94).

Table 1.3 Specific CBT techniques.

Category	*Individual techniques*
8. Managing negative thoughts:	(a) cognitive restructuring; (b) behavioral experiments; (c) thought substitution/self-talk; (d) positive imagery; (e) thought stopping/interruption; (f) thought acceptance.
9. Changing maladaptive behaviors:	(a) interoceptive exposure; (b) *in vivo* exposure; (c) imaginal/narrative exposure; (d) response prevention; (e) behavioral activation; (f) pleasant events scheduling; (g) self-evaluation and self-rewards.
10. Managing maladaptive mood and arousal:	(a) emotion identification, expression, and regulation; (b) progressive muscle relaxation; (c) applied tension; (d) breathing retraining.
11. General skills training:	(a) problem-solving skills; (b) interpersonal engagement skills; (c) friendship skills; (d) communication and negotiation skills; (e) assertiveness skills; (f) dealing with bullying skills.
12. Modifying the family environment:	(a) family communication and conflict resolution; (b) parental expectations management; (c) parent intrusiveness and overprotection management; (d) parent contingency management; (e) parent emotion management; (f) parent modeling of adaptive behavior.

Source: Sburlati, Schniering, Lyneham, and Rapee (2011, p. 94).

mentoring therapists who will be (or are) treating children and adolescents with anxiety and depression, and at trainers who are developing and/or delivering training programs in university or college settings and continuing professional development programs. The book will assist this audience with the development of comprehensive and effective training curricula, will guide trainers and supervisors on relevant competencies that should be assessed throughout training, and can be used as a resource to support training or supervision programs leading to trainee therapists gaining a wide range of empirically based competencies. Second, given the current push for therapists to assess their own level of competence and to govern their own professional development (e.g., Bellande, Winicur, and Cox 2010), this book is

aimed at therapists who wish to gain an understanding of the competencies they need to acquire in order to effectively work with the targeted population and to come to know what competent practice looks like for each individual competency; and the competency descriptions will provide a benchmark against which they can assess themselves. Third and finally, the aim of this book is to improve the quality of the treatment provided to children and adolescents as a result of the enhancement of individual therapists' abilities.

Book structure

This book is divided into three parts that reflect the three-domain structure of the competencies model described earlier. Further, chapters within these three parts broadly map onto the competency categories of each domain. For example, Part I covers the generic therapeutic competencies domain of the model and includes five chapters that focus on the four competency categories within this domain, namely "Practicing Professionally," (which is covered over two chapters) "Understanding Relevant Child and Adolescent Characteristics," "Building a Positive Relationship," and "Conducting a Thorough Assessment."

Chapter structure

In order to ensure comprehensive coverage of each of the Sburlati and colleagues (2011) competencies as well as consistency throughout the volume, most chapters in this book contain a number of recurrent sections. The headings below give a general description of these sections; the exact wording may have been adapted within each chapter. Chapters 5, 8, and 9 do not follow this structure, as their content does not fit with this manner of organizing (e.g., the chapter is knowledge-based).

Key features of competencies
The first section of each chapter describes each competency in detail, highlighting the behavioral markers of each of the individual competencies. Illustrations or examples of the competent use of therapeutic techniques and processes are also included, so as to increase the clinical utility of the book.

Competence in treating the anxiety disorders and depression
Considerable differences exist among the different anxiety disorders (e.g., between panic disorder and social phobia) and also between anxiety disorders in general and depression. Therefore all chapters include a section focused on how the competencies covered in the chapter might be uniquely tailored when treating these different disorders.

Competence in treating both children and adolescents
Since this book spans competent practice across a large age range (from early childhood to late adolescence), the third section in each chapter highlights important developmental differences in treating children from different age groups. Specifically, unique competencies required for adapting evidence-based CBT for cognitive, emotional, and social maturation are considered.

Common obstacles to competent practice and methods to overcome them
Given that there are inevitably obstacles to the competent implementation of evidence-based CBT, the final section of each chapter covers typical obstacles to competent practice and provides strategies for overcoming them. These strategies come from the literature and clinical expertise.

Conclusion

It is the editors' hope that this book will become the cornerstone of the development of a generation of therapists competent in treating children and adolescents with anxiety and depressive disorders. We believe that, by raising the standard of practice, the quality of the treatment provided to youth seeking a way out of these common and debilitating conditions in real-world RCP settings can be enhanced.

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2

Effective Training Methods

Emily Jones and Katharina Manassis

Introduction

Outcomes for cognitive behavioral therapy (CBT) and other evidence-based psychotherapies have been evaluated extensively, but the research literature on methods of training in these therapies and on disseminating them is relatively sparse. Recent changes in the mandates of governments, mental health agencies, and research associations have, however, sharpened the focus on knowledge translation and evidence-based practices. Therefore research has started to examine what constitutes effective training for CBT and how to best help trainees implement CBT in real-world conditions of practice when working with clients of various ages who suffer from internalizing disorders. This chapter examines training methods generally, then more specifically in relation to the treatment of anxiety disorders, depression, children and adolescents. It concludes with a review of obstacles to effective training.

Key Features of Training: Presenting Training Material Using Effective Strategies

Effective strategies for presenting training material have been derived from learning models. Three different but complementary models are reviewed and then linked to specific training methods. Beidas and Kendall (2010) seek to understand how training models affect the translation of evidence-based practices (EBP) through a systems-contextual perspective. Theirs is considered a broad, holistic approach that emphasizes that an individual works within a system and thus quality of training, organizational supports, therapist variables, and client variables interact to effectively

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