

DSHS Mental Health Resiliency and Disease Management Fidelity Toolkit – September 2006

III. C. Children’s Mental Health Programs – Cognitive-Behavioral Therapy for Children and Adolescents With Anxiety and Depression Fidelity Manual

This manual is intended to be a guide for administering the Fidelity Scale for Cognitive-Behavioral Therapy for Children and Adolescents with Anxiety and Depression. This manual includes the following:

- I. **Introduction:** This section provides a program description of Cognitive-Behavioral Therapy for children and adolescents with anxiety and depression and an overview of the Fidelity Scale for Cognitive-Behavioral Therapy for children and adolescents.
- II. **Protocol:** This section provides descriptions and scoring guidance for each of the fidelity scale items, including:
 - A definition and rationale for each item.
 - A list of sources of data that are most appropriate for assessing the items (e.g., training records, progress notes, consumer interview, etc.)
 - Decision rules to help you correctly score the item.
- III. **Scoring Sheets:** The **Fidelity Review Individual Scoring Sheet (FRISS)** is provided to score the fidelity item ratings for each consumer sampled. The FRISS contains the individual item scores for each record reviewed. The **Program Summary Fidelity Review Sheet (PSFRS)** reflects the fidelity ratings averaged across all consumers within the sample and represents the overall fidelity rating for the program.
- IV. **Additional Resources:** The four selected Cognitive-Behavioral Therapy models and additional references are included in this section.

INTRODUCTION

Program Description

Cognitive-Behavioral Therapy (CBT) is based on the theory that thoughts, emotions, and behaviors are interrelated. That is, the way we perceive or evaluate events influences our emotional and behavioral responses. CBT is a collaborative approach that involves teaching children and adolescents about the relationship between thoughts, emotions, and behavior and teaching them skills to change one or more of these components in order to reduce symptomatology. CBT sessions are structured and focus on the triggers for anxiety and depression.

With anxiety and depressive disorders in children and adolescents, the common elements in the treatment protocols that have proven effective include psychoeducation, cognitive interventions (e.g., cognitive restructuring, thought stopping), behavioral interventions (e.g., self-monitoring, rewards, relaxation). For **anxiety disorders**, the use of graduated exposure to anxiety-provoking stimuli is utilized to desensitize children and adolescents to the fear-inducing stimuli.

Four separate models of cognitive-behavioral therapy have been selected for implementation. *Taking Action, Coping Cat, The C.A.T. Project, Adolescent Coping with Depression Course*. Two of the models are for depression and two are for anxiety, with models separately targeting children or adolescents.

An Overview of the Fidelity Scale for Cognitive-Behavioral Therapy

The Fidelity Scale for CBT for Children and Adolescents with Anxiety and Depression identifies the key elements deemed necessary for adequate implementation of the models. The scale items are based on elements common across the evidence-based models of CBT for children, as well as unique elements to address specific disorders. The scale is divided into three sections: one assessing system supports necessary for implementation, one assessing therapeutic strategies that are important to CBT, and the final measuring the specific intervention and skill development components of CBT.

Each fidelity item is scored for **each child record** randomly selected for the review. Fidelity ratings are based on one or more source of information recommended for the item. After all individual records are scored; item scores are averaged across the records for a final summary score.

Item Scoring: (How items are rated)

The cognitive behavioral therapy fidelity review instrument consists of 15 items which are to be rated individually on a five-point scale with "1" denoting the program element is not implemented, "3" being midpoint and denoting minimally adequate implementation, and "5" reflecting exceptional implementation. Some items are rated with "1" or a "5" based upon a "Yes/No," format.

Each fidelity item is averaged across all consumers within the review sample. A final score for the program can then be presented for each item.

Fidelity Review Process

Although all children are eligible for CBT, fidelity reviews should be based on samples of children who are eight years or older. During a fidelity review, child records that have been selected randomly are reviewed using the scoring sheet included below. Whenever possible, selected child records should be for children and families who have completed treatment. If there are insufficient child records for children and families who have completed treatment, child records for children and families who have not completed treatment will be used. In such cases, the individual record will be scored based on the number of completed sessions, and the calculation of the fidelity score will be the same as outlined above based on the number of completed sessions. Uncompleted treatment sessions will be coded N/A.

PROTOCOL

The Fidelity Scale for CBT is completed for each individual child record reviewed during the Fidelity Review. Scores must be determined for the individual records before an overall site score (average) can be determined to indicate overall fidelity.

General Definitions:

Adolescent - an individual who is at least 13 years of age, but younger than 18 years of age.

Child - an individual who is at least 3 years of age, but younger than 13 years of age.

LPHA (Licensed Practitioner of the Healing Arts: refers to a staff member who is a physician, licensed professional counselor, licensed clinical social worker (as determined by Texas State Board of Social Work Examiners in accordance with Texas Occupation Codes, Chapter 505), a psychologist, an advanced practice nurse (recognized by the Board of Nurse Examiners for the State of Texas as a clinical nurse specialist in psych/mental health or nurse practitioner in psych/mental health), or licensed marriage and family therapist.

System Support for Cognitive Behavioral Therapy (CBT)

General Rationale: Experience with CBT implementation efforts and the knowledge base on organizational change suggest that certain program supports are necessary for successful implementation of this type of intervention.

Item 1: Credentials

Definition: Therapists providing CBT are LPHAs or have a master's degree in a human services field, are actively working toward licensure and practice under the supervision of an LPHA. Human Services Field refers to a master's degree that can lead to licensure and inclusion as an LPHA. Medicaid does not reimburse for counseling sessions with an unlicensed therapist, even if the individual is supervised by an LPHA, and sessions may not be billed to the supervisor's Medicaid number.

Rationale: Effective implementation of CBT for children and adolescents with *anxiety* and *depression* requires that providers have appropriate qualifications and training. Only *qualified professionals* with the required education and training should provide CBT.

Source: Human Resource records

Item Scoring: This item may be answered "yes" (5) or "no" (1) only. The reviewer answers "yes" if human resources records indicate that the provider is an LPHA, or that the provider has a master's degree in a human services field and is actively working toward licensure. If the therapist does not meet these credentials, the reviewer will score a "no"..

Item 2: Training

Definition: All providers and supervisors of CBT are trained in the department-approved evidence-based models. Training in the evidence-based models must be completed before providers can provide CBT to children and adolescents and before a supervisor can provide clinical supervision.

Rationale: In order to ensure consistency in training levels and a minimum knowledge base, all providers should receive training in any of the four cognitive behavioral models that they will implement.

Source: Training Records

Item Scoring: This item is answered “yes” (5) or “no” (1). The reviewer may answer “yes” if:

- Training records indicate the provider and his/her supervisor have been trained in the selected CBT models prior to the provision of CBT or supervision. Training records must indicate that the provider and supervisor participated in the full training on the selected CBT models, the name of the trainer, the dates of the training.
- Otherwise, the answer is “no”.

Item 3: Supervision

Definition: After completion of the training course in cognitive behavioral therapy, therapists are supervised either individually or in a group by a supervisor skilled in CBT until competency is reached. Sites should have a documented process to assess therapist competency in the provision of cognitive behavioral therapy. Supervision of CBT needs to be provided by a licensed therapist who has been trained in and who has provided CBT according to the department-approved models.

Rationale: Training in CBT requires continued skill development during actual therapy sessions with consumers. Competency is unlikely to be reached by most therapists through didactic and experiential coursework alone. The development of new therapy skills will be enhanced by monitoring and feedback by a skilled clinical supervisor.

Source: Human Resource records and supervision records

Item Scoring: To score this item, reviewers should look for two criteria. First, the reviewer will look for whether the agency has defined procedures for assessing the competency of therapists to provide CBT to children and adolescents and determine if these procedures are clear and objective. Second, the reviewer will look to see the frequency at which the supervision is provided to therapists. Therapists who are not receiving supervision should have documentation that they were assessed and judged competent to provide the service without supervision according to the agency's policies. The supervision frequency criteria may be scored as met if therapists generally receive supervision at the specified frequency, even if the criteria is not met during every time period (week, month, etc.). Agencies must meet both criteria (policies on competency and supervision frequency) within an anchor to receive that score. If only one criteria is met, the lower score should be evaluated to determine if it is met.

Cognitive Behavioral Strategies

General Rationale: In addition to the vital interpersonal skills required for any effective therapeutic relationship (warmth, empathy, unconditional positive regard), provision of CBT involves specific therapeutic behaviors aimed at effectively using time in a brief therapy approach, creating an active, collaborative therapy process, and increasing generalization of the use of skills outside of therapy.

Item 4: Structured and Goal Oriented Sessions

Definition: Structured and goal oriented sessions refer to the therapist having concrete objectives for each session and using the available time effectively to ensure session goals are met. Each of the four cognitive-behavioral models provides the therapist with the specific goals of each individual session, as well as suggested activities and techniques to achieve session goals.

Rationale: One of the key elements that distinguish cognitive behavioral models from supportive therapies is their reliance on structured sessions. As the chosen CBT models are all brief treatments, therapists must use time effectively to ensure children and adolescents learn the skills necessary to overcome presenting symptoms and prevent relapses. In the selected cognitive-behavioral models, the intent of each session is stated at the beginning of the session, and each session includes the teaching of new skills *and* the opportunity to practice these skills.

Source: Child record (progress notes), supervision notes, observation, audio/ videotapes.

Item Scoring: The therapist uses a basic framework at each session, generally mirroring the session goals documented in the manuals. The therapist effectively uses the time in therapy to address skills development, practice, and opportunities for generalization. Each session is judged independently on whether it demonstrates adequate structure and the item is scored based on the percentage of sessions meeting this goal. If clinicians modify the scheduled curriculum significantly, appropriate clinical rationale must be documented and the modifications must maintain the essential elements of the CBT approach.

Item 5: In-Session Practice

Definition: The therapist uses modeling, role playing and other strategies to provide opportunities to practice new skills during sessions. Each session should include the practice of new skills taught during the current or previous sessions. Each of the cognitive-behavioral models includes instructions on in-session practice of new skills. The therapist may choose exercises suggested in the manuals or choose other age-appropriate strategies to encourage practice of new skills.

Rationale: In-session practice provides an opportunity to try new skills, to receive feedback on the practice and to practice until skills are mastered in this environment. However, it should be noted that in-session practice is not sufficient for children and adolescents to generalize the skills to natural settings.

Source: Child record (progress notes), supervision notes, observation, audio/ videotapes.

Item Scoring: Each session must include at least one exercise in which the child/adolescent can practice skills in the session. A variety of exercises or activities are appropriate, but they should include active participation by the youth in demonstrating the skill verbally, in writing, or behaviorally. Each session is judged independently on whether it meets this goal. If the child/adolescent refuses to participate, the therapist should adequately document strategies to enhance engagement in the in-session practice. The item is scored based on the percentage of sessions meeting this goal.

Item 6: Homework

Definition: The therapist consistently (a) suggests activities or exercises for the client to do at home which build on the work being done in therapy, and which furthers the client's skills or self-understanding, and (b) reviews previous home assignments to ensure success and learning. Each of the cognitive-behavioral models includes suggested homework assignments and the therapist may utilize these or other clinically appropriate tasks.

Rationale: Homework assignments allow clients to continue practice outside of their sessions. This enhances skill development, assists with generalization to other settings, and encourages the client to take an active role in their treatment. Homework assignments and adherence to homework assignments have consistently been found to be important predictors of a positive response to CBT (Kazantzis, Deane, & Ronan, 2000).

Source: Child record (progress notes), child/family interviews, supervision notes, observation, audio/ videotapes.

Item Scoring: Each session must include both the description of the homework assigned and evidence that progress on previous homework was reviewed. Each session is judged independently on whether it meets this goal. If the child/adolescent repeatedly fails to complete homework, the therapist should adequately document strategies to enhance engagement in the out-of-session practice. The item is scored based on the percentage of sessions meeting this goal.

References

Kazantzis, N. Deane, F.P., & Ronan, K.R. (2000). Homework assignments in cognitive and behavioral therapy: A meta-analysis. *Clinical Psychology: Science and Practice*, 7, 189-202.

Item 7: Parent/Caregiver Involvement

Definition: Parent or caregiver involvement refers to the purposeful inclusion of an adult caregiver in the child or adolescent's treatment. Goals of parent/caregiver involvement include:

- 1) participation in psychoeducation,
- 2) provision of positive support for the child or adolescent,
- 3) participation in a reward system to reinforce gains by the child or adolescent,
- 4) to learn problem solving and negotiation skills to use with the child or adolescent,
- 5) to enhance communication skills with the child or adolescent, and
- 6) to identify any treatment needs for others within the family and make appropriate referrals.

It is expected that parents/caregivers will be involved in multiple sessions, with the therapist retaining significant flexibility in the format in which this occurs (e.g. brief time with parent at end of session, parent only sessions, family sessions). It is the responsibility of the therapist to convey that parent/caregiver involvement occurred and the goals of the encounter.

Rationale: Parents or other adult caregivers play an important role in the lives of young people and, in many families, play a significant role in changing or maintaining children's behaviors. Although research is still mixed about the additional impact of parental involvement in CBT for anxiety and depression, it remains important to engage families in the treatment program and encourage their supportive involvement whenever possible.

Source: Child record (progress notes), child/family interviews, supervision notes, observation, audio/ videotapes.

Item Scoring: Parent involvement should be documented in more than one treatment session. Documentation must describe the goal(s) of the parent contact and the caregiver's response to the contact. If one or more of the six goals described is not appropriate for the caregiver, this should be documented within the record. The reviewer may judge this documentation as sufficient in addressing this specific parent involvement goal. For example, the therapist may document that parent-child communication is a significant strength for the dyad and no needs are identified in this dimension. The rater would then judge that goal to have been adequately addressed.

Content of Cognitive-Behavioral Therapy

General Rationale: The aim of CBT is to reduce the symptoms of depression by providing youth with strategies to change maladaptive thoughts, emotions, and behavior. A variety of strategies should be taught, so that children and adolescents have a repertoire of effective coping strategies to increase their resilience, manage stressors effectively, and prevent relapse in the future.

Item 8: Self-Monitoring

Definition: Children and adolescents are taught skills to recognize and record specific experiences that affect anxiety and depression. Children and adolescents are taught to self-monitor in some or all of the following critical areas:

- Physical sensations that occur when anxiety and depression are present
- Thoughts that precipitate anxiety and depression
- Emotions experienced
- Events that precipitate anxiety and depression
- Actions that may follow the feelings of anxiety and depression

Rationale: Self-monitoring is an intervention that assists children and adolescents to become self-aware of factors that contribute to anxiety and depression and to become self-aware of the impact of their new skills on their symptoms of anxiety and depression. Self-monitoring provides the "data" upon which interventions are based. Progress can be measured over time and the children and adolescents can become aware of the strengths and skills gained to manage anxiety and depression.

Source: Child record (progress notes), child interviews, supervision notes, observation, audio or videotapes

Item Scoring: This item is scored "yes" if sources demonstrate that the youth was (a) instructed in how to self-monitor their experiences of anxiety and/or depression and associated elements *and* (b) practiced this skill either in one or more therapy sessions or as a "homework" assignment.

Item 9: Changing Irrational and Negative Thought Patterns

Definition: Cognitive interventions are strategies that help youth recognize irrational or maladaptive thoughts and replace them with more appropriate or helpful thoughts. Cognitive interventions provide children and adolescents with different strategies to interrupt, examine, or test common problematic thoughts. The goal for the child or adolescent is to replace distorted thoughts with realistic thoughts that reduce the intensity of anxiety and depression. Cognitive interventions include (but are not limited to):

- Thought Stopping
- Testing the Validity of a Thought
- Challenging Assumptions/Expectations
- Positive Reframe
- Coping Self-Talk

Rationale: A key tenet of cognitive behavioral therapy is that individuals with anxiety and/or depression tend to view themselves, the world, and the future in a way that inhibits healthy coping and leads to increased depression or anxiety. Cognitive interventions are intended to modify these maladaptive cognitive processes. It is a key principle of the cognitive behavioral model that replacing dysfunctional thoughts will result in more adaptive feelings and behaviors.

Source: Child record (progress notes), child interviews, supervision notes, observation, audio or videotapes

Item Scoring: This item is scored "yes" if sources demonstrate that the youth was (a) taught strategies to examine and replace maladaptive thoughts or cognitions *and* (b) practiced this skill either in one or more therapy sessions or as a "homework" assignment.

Item 10: Relaxation Strategies

Definition: Relaxation training is the teaching of interventions that induce physiological calming and counteract arousal. Relaxation strategies that are generally helpful include:

- Progressive Muscle Relaxation

- Deep Breathing Exercises
- Guided Imagery (selected by the therapist)
- Pleasant Visualizations (selected by the child or adolescent)
- Other strategies outlined in the department-approved models

Relaxation strategies are to be used with all four of the cognitive-behavioral models, even if not explicitly detailed in the curriculum.

Rationale: Relaxation strategies have been found to be very effective in the management of anxiety and depression. Some research studies have demonstrated that the use of relaxation strategies *alone* has successfully reduced the severity of the depression. Relaxation strategies can be easy to implement, have a relatively rapid effect on reducing the frequency and intensity of anxiety and depression, and provide the youth with a successful treatment experience.

Source: Child record (progress notes), child interviews, supervision notes, observation, audio or videotapes

Item Scoring: This item is scored “yes” if sources demonstrate that the youth was (a) taught one or more relaxation strategies to reduce physiological arousal *and* (b) practiced this skill either in one or more therapy sessions or as a “homework” assignment.

Item 11: Increasing Pleasant and Successful Activities

Definition: Increasing pleasant and successful activities refers to a behavioral strategy to increase the number of events in which the youth experiences pleasure and/or mastery during the day. Pleasant and successful activities should be negotiated with the child or adolescent and based on his or her strengths and interests.

Rationale: Research demonstrates that individuals with depression tend to withdraw from activities and social interactions, which reduces their opportunities for positive experiences. They may avoid challenging tasks, which reinforces feelings of low self-esteem. Individuals with anxiety avoid experiences that may lead to anxious feelings, thereby reinforcing their avoidance. This avoidance then reduces the individual’s opportunities for positive experiences and leads to increased depression and anxiety. Behavioral activation strategies are important to gradually reverse this pattern and have been shown to be an effective component of cognitive behavioral therapies.

Source: Child record (progress notes), child interviews, supervision notes, observation, audio or videotapes

Item Scoring: This item is scored “yes” if sources demonstrate that the youth was (a) taught one or more strategies to increase pleasant or successful events *and* (b) practiced this skill as a “homework” assignment.

Item 12: Problem Solving Skills (Depression Only):

Definition: Children and adolescents with depression are taught specific steps to take to solve problems that are significant to them. The steps for problem solving generally include:

1. Identification of the problem
2. Brainstorming of possible solutions
3. Consideration of the advantages and disadvantages of each possible solution
4. Selecting a solution
5. Implementation of the solution
6. Analysis of the results/effectiveness of the solution
7. If the problem remains, a different solution may be tried or the reason the chosen solution failed may be examined.

The number and complexity of the problem solving steps should be appropriate for the developmental level of the child.

Rationale: Problem solving is an essential ingredient to resiliency in childhood. Youth face different developmental challenges, and their ability to recognize problems, generate solutions, and competently choose a solution will greatly impact their psychological health. Children experiencing depression and/or anxiety may have many barriers to effective coping. They may lack problem solving skills, have cognitions that prevent effective coping (e.g., “Nothing will help.”), or have difficulty identifying or enacting solutions due to symptomatology (e.g., poor concentration, lethargy). Skills training in problem solving strategies provides youth with concrete steps to take to identify and solve problems that are causing distress.

Source: Child record (progress notes), child interviews, supervision notes, observation, audio or videotapes

Item Scoring: This item is scored “yes” if sources demonstrate that the youth was (a) taught all basic components to the problem solving model (steps may be merged) *and* (b) practiced this skill either in one or more therapy sessions or as a “homework” assignment.

Item 13: Social and Communication Skills (Depression Only):

Definition: Social and communication skills refer to the ability of the child or adolescent to effectively manage a variety of social experiences, including initiating and maintaining friendships, managing conflict with peers or adults, and recognizing and following social rules (e.g., taking turns). Examples of social and communication skills that may need to be taught and practiced by youth with depression include (1) taking turns, sharing, or cooperating; (2) starting conversations; (3) resolving conflict; (4) following the rules; (5) listening to others; (6) helping others; (7) making eye contact; and (8) complimenting others and accepting compliments.

Rationale: Meaningful social relationships, both with adults and peers, are essential to healthy psychological development. Having social support through family and friends has been shown to be a protective factor for many negative outcomes, including depression, delinquency, and substance abuse (McFarlane, A.H., Bellissimo, A., Norman, G.R., & Lange, P., 1994). Generally, children and adolescents with depression are more likely to be “self-isolating, timid, immature, and are often classified as rejected or neglected by peers” (Ladd, 1999, p. 351). Social and communication skills training aims at minimizing any skills deficits or delays in social development and to increase social competence of youth with depression.

Source: Child record (progress notes), child interviews, supervision notes, observation, audio or videotapes

Item Scoring: This item is scored “yes” if sources demonstrate that the youth was (a) taught at least four social skill components *and* (b) practiced these skills either in one or more therapy sessions or as a “homework” assignment. If a child or adolescent is documented as having no deficits in one or more social skills, this can be scored as meeting the criteria of training for that social skill component.

References:

Ladd, G.W. (1999). Peer relationships and social competence during early and middle childhood. *Annual Review of Psychology, 50*, 333-359.

McFarlane, A.H., Bellissimo, A., Norman, G.R., & Lange, P. (1994). Adolescent depression in a school-based community sample: Preliminary findings on contributing social factors. *Journal of Youth and Adolescence, 23*, 601 – 620.

Item 14: Graduated Exposure (Anxiety Only)

Definition: Graduated exposure involves the creation of a hierarchy of anxiety-provoking stimuli and the gradual exposure of the youth to these stimuli, starting with low anxiety-provoking situations. Exposure to each stimuli generally begins with imaginable exposure and proceeds to in vivo exposure. Youth are encouraged to use previously-learned coping skills during exposure in order to master the experience and exposure continues until the child’s level of anxiety is reduced.

Rationale: The goal of graduated exposure is not the elimination of anxiety but the practice of skills in coping with anxious arousal and the gradual desensitization of the youth to the anxiety-provoking stimuli. Children and adolescents with anxiety are gradually exposed to anxiety-provoking stimuli to desensitize them to the stimuli and to provide practice of coping strategies for generalization of new skills.

Source: Child record (progress notes), child interviews, supervision notes, observation, audio or videotapes

Item Scoring: This item is scored “yes” if sources demonstrate that the youth was (a) engaged in exposure to at least four anxiety-provoking situations, (b) exposure occurred both imaginably and in vivo; *and* (c) exposure occurred gradually, with low anxiety-provoking stimuli first.

Item 15: Reward System

Definition: Tangible or social rewards are used to reinforce the child or adolescent’s strengths, participation in skills development, and practice of new skills outside of therapy. Children and adolescents should be taught to reward themselves based on the age and abilities of the child. Family, teachers, friends, etc., involved in the child’s social ecology may be involved in reinforcing the youth’s efforts at practicing or using new skills, as well. Tangible and social rewards should be based on the age, developmental level, strengths and interests of the children and adolescents.

Rationale: A reward system is essential to maintaining the engagement of many children and adolescents in the treatment program. Rewards serve to reinforce positive coping efforts and provide a strategy for building self-esteem. Natural reinforcers of the new skills, such as reduced distress, may not be immediate enough to encourage continued efforts for most children.

Source: Child record (progress notes), child/family interviews, supervision notes, observation, audio or videotapes

Item Scoring: Evidence should exist that the therapist has worked with the child/adolescent and family to develop an effective reward system and instructed them on its use. The therapist should document following up on the reward system to determine its effectiveness. If a reward system is ineffective, the therapist should review the system and its implementation to help the child/adolescent or parents modify the program. The item is scored “yes” if (a) there is documentation that use of rewards was taught to the youth and/or parent and that (b) the effectiveness of the reward system was reviewed and modifications were made, if indicated, when youth non-adherence was noted.

Fidelity Review Individual Scoring Sheet (FRISS)

Cognitive-Behavioral Therapy for Children and Adolescents with Anxiety and Depression

Consumer ID: _____

Therapist ID: _____

Element	Source	1	2	3	4	5	Notes
A. System Support for Cognitive-Behavioral Therapy (CBT) Effective implementation of cognitive-behavioral therapy for children and adolescents with anxiety and depression requires system support to ensure providers have required qualifications, training and supervision. All three areas are essential to achieve fidelity.							
1. Credentials The service provider is an LPHA or has a master's degree in a human services field, is actively working toward licensure, and practices under the supervision of an LPHA.	Human Resources records	No	N/A	N/A	N/A	Yes	
2. Training The provider and his/her supervisor has completed training in the department-approved CBT models prior to the provision or supervision of CBT.	Training records	No	N/A	N/A	N/A	Yes	
3. Supervision The therapist is supervised either individually or in a group by a supervisor skilled in CBT until competency is reached. If the provider is deemed competent, sites must have a documented process to assess therapist competency in the provision of cognitive behavioral therapy.	Training records; supervision records; interview of clinical supervisor	The therapist does not receive supervision following training.	The therapist receives supervision only occasionally or upon request.	The therapist receives at least 1 hour per month of supervision.	The therapist receives at least 2 hours per month of supervision.	The therapist receives at least 1 hour per week of supervision or are deemed competent with a clearly documented process for assessing competency.	Note: This item may not be able to be fully accomplished until adequate expertise in CBT is developed within the system.
B. Cognitive-Behavioral Strategies The cognitive-behavioral therapist conducts structured and goal-directed sessions to teach new skills to children and adolescents and to facilitate practice of the new skills to manage anxiety and depression. These sessions are interactive and practice-oriented and are designed to reduce anxiety and depression across an episode of care. Established educational and therapeutic strategies are used to teach and reinforce new skills. Homework assignments are given to continue practice outside of sessions for generalization to natural settings.							
4. Structured and Goal-Oriented Sessions The therapist focuses on concrete objectives for each session and uses the available time effectively to ensure session goals are met.	Child record (progress notes), supervision notes, observation, audio/video tapes, supervision notes	Less than 50% of sessions are structured and goal-oriented.	50% - 69% of sessions are structured and goal-oriented.	70% - 79% of sessions are structured and goal-oriented.	80% - 89% of sessions are structured and goal-oriented.	90% - 100% of sessions are structured and goal-oriented.	
5. In-Session Practice The therapist uses modeling, role playing and other strategies to provide opportunities to practice new skills during sessions.	Child record (progress notes), supervision notes, observation, audio/video tapes	Less than 50% of sessions provide in-session practice for new skills.	50% - 69% of sessions provide in-session practice for new skills.	70% - 79% of sessions provide in-session practice for new skills.	80% - 89% of sessions provide in-session practice for new skills.	90% - 100% of sessions provide in-session practice for new skills.	

Element	Source	1	2	3	4	5	Notes
<p>6. Homework The therapist consistently (a) suggests activities or exercises for the client to do between sessions which build on the work being done in therapy, and which furthers the client's skills or self-understanding, and (b) reviews previous home assignments to ensure success and learning.</p>	Child record (progress notes), supervision notes, observation, audio/video tapes, child/family interviews	In less than 50% of sessions, appropriate home activities are assigned and previous assignments are reviewed.	In 50% to 69% of sessions, appropriate home activities are assigned and previous assignments are reviewed.	In 70% to 79% of sessions, appropriate home activities are assigned and previous assignments are reviewed.	In 80% to 89% of sessions, appropriate home activities are assigned and previous assignments are reviewed.	In 90% to 100% of sessions, appropriate home activities are assigned and previous assignments are reviewed.	
<p>7. Parent/Caregiver Involvement Parents/caregivers are involved in treatment for more than one session. The goals of parent involvement include:</p> <ol style="list-style-type: none"> 1) participation in psychoeducation, 2) provision of positive support for the child or adolescent, 3) participation in a reward system to reinforce gains by the child or adolescent, 4) to learn problem solving and negotiation skills to use with the child or adolescent, 5) to enhance communication skills with the child or adolescent, and 6) to identify any treatment needs for others within the family and make appropriate referrals. 	Child record (progress notes), supervision notes, observation, audio/video tapes, family interviews	Therapists involve parents or caregivers in sessions to achieve none or 1 of the 6 listed goals.	Therapists involve parents or caregivers in sessions to achieve 2 of the 6 listed goals.	Therapists involve parents or caregivers in sessions to achieve 3 of the 6 listed goals.	Therapists involve parents or caregivers in sessions to achieve 4 of the 6 listed goals.	Therapists involve parents or caregivers in sessions to achieve 5 or more of the 6 listed goals.	
<p>C. Content of Cognitive-Behavioral Therapy Cognitive-behavioral therapy for depression follows the <i>Taking Action</i> model for children developed by Dr. Kevin Stark and the <i>Adolescent Coping with Depression Course</i> for adolescents developed by Dr. Greg Clarke. Cognitive-behavioral therapy for anxiety follows the <i>Coping Cat</i> model for children and the <i>C.A.T. Project</i> for adolescents developed by Dr. Phillip Kendall. Each model includes content in specific skill areas shown to be effective in reducing symptomatology. The sessions teach and reinforce critical skills needed to reduce anxiety and depression.</p>							
<p>8. Self-Monitoring The youth was (a) instructed in how to self-monitor their experiences of anxiety and/or depression and associated elements and (b) practiced this skill either in one or more therapy sessions or as a "homework" assignment. Potential areas of monitoring include:</p> <ul style="list-style-type: none"> • Physical sensations that occur when anxiety and depression are present • Thoughts that precipitate anxiety and depression • Emotions experienced • Events that precipitate anxiety and depression • Actions that may follow the feelings of 	Child record (progress notes), supervision notes, observation, audio/video tapes, child Interviews	No	N/A	N/A	N/A	Yes	

Element	Source	1	2	3	4	5	Notes
anxiety and depression							
9. Changing Irrational and Negative Thought Patterns The therapist teaches the youth strategies to examine and replace maladaptive thoughts or cognitions <i>and</i> (b) practiced this skill either in one or more therapy sessions or as a “homework” assignment. Cognitive interventions include: 1) Thought Stopping 2) Testing the Validity of a Thought 3) Challenging Assumptions/ Expectations 4) Positive Reframe and 5) Coping Self-Talk.	Child record (progress notes), supervision notes, observation, audio/video tapes, child interviews	No	N/A	N/A	N/A	Yes	
10. Relaxation Strategies The therapist teaches the youth (a) one or more relaxation strategies to reduce physiological arousal <i>and</i> (b) practiced this skill either in one or more therapy sessions or as a “homework” assignment. Relaxation strategies include: <ul style="list-style-type: none"> • Progressive Muscle Relaxation • Deep Breathing Exercises • Guided Imagery (selected by the therapist) • Pleasant Visualizations (selected by the child or adolescent) • Other strategies outlined in the department-approved models. 	Child record (progress notes), supervision notes, observation, audio/video tapes, child interviews	No	N/A	N/A	N/A	Yes	
11. Increasing Pleasant and Successful Activities The therapist teaches the youth (a) one or more strategies to increase pleasant or successful events <i>and</i> (b) practiced this skill as a “homework” assignment.	Child record (progress notes), supervision notes, observation, audio/video tapes, child interviews	No	N/A	N/A	N/A	Yes	
12. Problem-Solving Skills (Depression Only) The therapist teaches the youth (a) all basic components to the problem solving model (steps may be merged) <i>and</i> (b) practiced this skill either in one or more therapy sessions or as a “homework” assignment. The general steps are as follows: 1. Identification of the problem 2. Brainstorming of possible solutions 3. Consideration of the advantages and disadvantages of each possible	Child record (progress notes), supervision notes, observation, audio/video tapes, child Interviews	No	N/A	N/A	N/A	Yes	

Element	Source	1	2	3	4	5	Notes
<p>solution</p> <p>4. Selecting a solution</p> <p>5. Implementation of the solution</p> <p>6. Analysis of the results/effectiveness of the solution</p> <p>7. If the problem remains, a different solution may be tried or the reason the chosen solution failed may be examined.</p>							
<p>13. Social and Communication Skills (Depression Only)</p> <p>The therapist teaches the youth (a) at least four social skill components <i>and</i> (b) practiced these skills either in one or more therapy sessions or as a “homework” assignment. Social skills include the following components:</p> <p>1. Taking turns, sharing, or cooperating</p> <p>2. Starting conversations</p> <p>3. Resolving conflict</p> <p>4. Following the rules</p> <p>5. Listening to others</p> <p>6. Helping others</p> <p>7. Making eye contact</p> <p>8. Complimenting others and accepting compliments</p>	Child record (progress notes), supervision notes, observation, audio/video tapes, child interviews	No	N/A	N/A	N/A	Yes	
<p>14. Graduated Exposure (Anxiety Only)</p> <p>The therapist (a) engaged the youth in exposure to at least four anxiety-provoking situations, (b) exposure occurred both imaginably and in vivo; <i>and</i> (c) exposure occurred gradually, with low anxiety-provoking stimuli first.</p>	Child record (progress notes), supervision notes, observation, audio/video tapes, child interviews	No	N/A	N/A	N/A	Yes	
<p>15. Reward System</p> <p>A reward system is used to reinforce participation in skills development and practice of new skills outside of therapy. The therapist (a) teaches the youth/parent to use the reward system and (b) reviews its effectiveness any time non-adherence is noted.</p>	Child record (progress notes), supervision notes, observation, audio/video tapes, child/family interviews	No	N/A	N/A	N/A	Yes	

Program Summary Fidelity Review Scoring Sheet (PSFSS)
Cognitive-Behavioral Therapy for Children and Adolescents with Anxiety and Depression

Element	1	2	3	4	5	Notes
A. System Support for Cognitive-Behavioral Therapy (CBT)						
1. Credentials	Less than 100% of sample scored 5.	N/A	N/A	N/A	100% of sample scored 5.	
2. Training	Less than 100% of sample scored 5.	N/A	N/A	N/A	100% of sample scored 5.	
3. Supervision	Average score of 1.00 to 1.49.	Average score of 1.50 to 2.49.	Average score of 2.50 to 3.49.	Average score of 3.5 to 4.49.	Average score of 4.50 or above.	
B. Cognitive-Behavioral Strategies						
4. Structured and Goal-Oriented Sessions	Average score of 1.00 to 1.49.	Average score of 1.50 to 2.49.	Average score of 2.50 to 3.49.	Average score of 3.5 to 4.49.	Average score of 4.50 or above.	
5. In-Session Practice	Average score of 1.00 to 1.49.	Average score of 1.50 to 2.49.	Average score of 2.50 to 3.49.	Average score of 3.5 to 4.49.	Average score of 4.50 or above.	
6. Homework	Average score of 1.00 to 1.49.	Average score of 1.50 to 2.49.	Average score of 2.50 to 3.49.	Average score of 3.5 to 4.49.	Average score of 4.50 or above.	
7. Parent/Caregiver Involvement	Average score of 1.00 to 1.49.	Average score of 1.50 to 2.49.	Average score of 2.50 to 3.49.	Average score of 3.5 to 4.49.	Average score of 4.50 or above.	
C. Content of Cognitive-Behavioral Therapy						
8. Self-Monitoring	Therapists teach self-monitoring to less than 50% of youth.	Therapists teach self-monitoring to 50% to 69% of youth.	Therapists teach self-monitoring to 70% to 79% of youth.	Therapists teach self-monitoring to 80% to 89% of youth.	Therapists teach self-monitoring to 90% to 100% of youth.	
9. Changing Irrational and Negative Thought Patterns	Therapists teach strategies for changing cognitions to less than 50% of youth.	Therapists teach strategies for changing cognitions to 50% to 69% of youth.	Therapists teach strategies for changing cognitions to 70% to 79% of youth.	Therapists teach strategies for changing cognitions to 80% to 89% of youth.	Therapists teach strategies for changing cognitions to 90% to 100% of youth.	
10. Relaxation Strategies	Therapists teach relaxation strategies to less than 50% of youth.	Therapists teach relaxation strategies to 50% to 69% of youth.	Therapists teach relaxation strategies to 70% to 79% of youth.	Therapists teach relaxation strategies to 80% to 89% of youth.	Therapists teach relaxation strategies to 90% to 100% of youth.	
11. Increasing Pleasant and Successful Activities	Therapists intervene with youth to increase pleasant or successful events with less than 50% of youth.	Therapists intervene with youth to increase pleasant or successful events with 50% to 69% of youth.	Therapists intervene with youth to increase pleasant or successful events with 70% to 79% of youth.	Therapists intervene with youth to increase pleasant or successful events with 80% to 89% of youth.	Therapists intervene with youth to increase pleasant or successful events with 90% to 100% of youth.	

Element	1	2	3	4	5	Notes
12. Problem-Solving Skills (Depression Only)	Therapists teach problem solving skills to less than 50% of youth.	Therapists teach problem solving skills to 50% to 69% of youth.	Therapists teach problem solving skills to 70% to 79% of youth.	Therapists teach problem solving skills to 80% to 89% of youth.	Therapists teach problem solving skills to 90% to 100% of youth.	
13. Social and Communication Skills (Depression Only)	Therapists teach at least 4 components of social skills to less than 50% of youth.	Therapists teach at least 4 components of social skills to 50% to 69% of youth.	Therapists teach at least 4 components of social skills to 70% to 79% of youth.	Therapists teach at least 4 components of social skills to 80% to 89% of youth.	Therapists teach at least 4 components of social skills to 90% to 100% of youth.	
14. Graduated Exposure (Anxiety Only)	Therapists use graduated exposure with less than 50% of youth.	Therapists use graduated exposure with 50% to 69% of youth.	Therapists use graduated exposure with 70% to 79% of youth.	Therapists use graduated exposure with 80% to 89% of youth.	Therapists use graduated exposure with 90% to 100% of youth.	
15. Reward System	Therapists teach use of rewards with less than 50% of youth.	Therapists teach use of rewards with 50% to 69% of youth.	Therapists teach use of rewards with 70% to 79% of youth.	Therapists teach use of rewards with 80% to 89% of youth.	Therapists teach use of rewards with 90% to 100% of youth.	

Additional Resources

Selected Models:

- **Taking Action** for children (8 – 12) with depression by Dr. Kevin Stark (may be used individually and in a group – 18 sessions – brief parent elements)
- **Adolescent Coping with Depression Course** for adolescents (13 - 17) with depression by Dr. Greg Clark (**group model** may be used individually and in group – 16 sessions – brief parent elements)
- **Coping Cat** for children (8 – 12) with anxiety by Dr. Phillip Kendall (16 sessions – brief parent elements)
- **The C.A.T. Project** for adolescents (13 – 17) with anxiety by Dr. Phillip Kendall (16 sessions – brief parent elements)

The two models selected for the treatment of anxiety are for the treatment of the following Anxiety Disorders:

- **Generalized Anxiety**
- **Specific Phobia**
- **Separation Anxiety**
- **Social Phobia.**

Additional References: These references are provided for additional information for the treatment of Anxiety Disorders not included above, for the treatment of co-morbid disorders and for treatment in specific cultural settings.

- **Internalizing Disorders**
 - Compton, Scott N., Burns, Barbara J., Egger, Helen L. and Robertson, Elizabeth. “Review of the Evidence Base for Treatment of Childhood Psychopathology: Internalizing Disorders”, *Journal of Consulting and Clinical Psychology*, 2002, Volume 70, Number 6, pages 1240 – 1266.
 - Fairbank, John A., Booth, Sharon R. and Curry, John F. “Integrated Cognitive-Behavioral Therapy for [Post] Traumatic Stress Symptoms and Substance Abuse”, Community Treatment for Youth, Oxford University Press, Inc., 2002.
 - Pina, Armando A., Silverman, Wendy K., Fuentes, Rebecca M., Kurtines, William M. and Weems, Carl F. “Exposure-Based Cognitive-Behavioral Treatment for Phobic and Anxiety Disorders: Treatment Effects and Maintenance for Hispanic/Latino Relative to European-American Youths,” *Journal of the American Academy of Child and Adolescent Psychiatry*, October 2003.

The following references on **Agoraphobia and Panic Disorder**, **Obsessive-Compulsive Disorder** and **Posttraumatic Stress Disorder** are from an article by Gail A. Wasserman, Susan J. Ko and Peter S. Jensen. The article is entitled “Columbia [University] Guidelines for Child and Adolescent Mental Health Referral.” It is included in *Report on Emotional and Behavioral Disorders in Youth*, Winter 2001, Volume 2, Number 1, pages 9 – 14 and page 23.

- **Agoraphobia and Panic Disorder**
 - Barlow, David, “Cognitive-Behavioral Therapy for Panic Disorder”, *Journal of Clinical Psychiatry*, 1997, Volume 58 (Suppl 2), pages 32 – 37.
- **Obsessive-Compulsive Disorder**
 - March, John S. et al., Cognitive Behavioral Therapy, 1994, Duke University Medical Center, Box 3527, Durham, North Carolina 27710, E-mail: jsmarch@acpub.duke.edu. (Obsessive-Compulsive Disorder)

- **Post-traumatic Stress Disorder**

- Deblinger, E., McLeer, S.V. and Henry, D., “Cognitive Behavioral Treatment for Sexually Abused Children Suffering Post-Traumatic Stress”, *Journal of the American Academy of Child and Adolescent Psychiatry*, 1990, Volume 29, pages 747 – 752. E-mail: deblines@umdnj.edu.
- Cohen, Judith and Mannarino, Anthony P., “Cognitive-Behavioral Therapy for Child and Adolescent [Post] Traumatic Stress”, Center for Traumatic Stress in Children and Adolescents, Pittsburgh, Pennsylvania 15212. E-mail: JCohen1@wpahs.org and amannari@wpahs.org.
- Web-based training for Trauma-Focused CBT (Cohen & Mannarino): www.musc.edu/tfcbt
- Foa, E.B., “Psychosocial Treatment of Post-Traumatic Stress Disorder,” *Journal of Clinical Psychiatry*, 2000, Volume 61 (suppl 5), pages 43 – 48.

- **Bipolar Disorders**

- Pavuluri, Mani N., “Cognitive-Behavioral Therapy Useful for Bipolar Disorder in Children,” the American Academy of Child and Adolescent Psychiatry, 50th Annual Meeting: Abstract C6, October 2003.