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Does the Delivery of CBT for Youth Anxiety Differ Across Research and Practice Settings?

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Does delivery of the same manual-based individual cognitive-behavioral treatment (ICBT) program for youth anxiety differ across research and practice settings? We examined this question in a sample of 89 youths (*M* age = 10.56, *SD* = 1.99; 63.70% Caucasian; 52.80% male) diagnosed with a primary anxiety disorder. The youths received (a) ICBT in a research setting, (b) ICBT in practice settings, or (c) non-manual-based usual care (UC) in practice settings. Treatment delivery was assessed using four theory-based subscales (Cognitive-behavioral, Psychodynamic, Client-Centered, Family) from the Therapy Process Observational Coding System for Child Psychotherapy–Revised Strategies scale (TPOCS-RS). Reliable independent coders, using the TPOCS-RS, rated 954 treatment sessions from two randomized controlled trials (1 efficacy and 1 effectiveness trial). In both settings, therapists trained and supervised in ICBT delivered comparable levels of cognitive-behavioral interventions at the beginning of treatment. However, therapists trained in ICBT in the research setting increased their use of cognitive-behavioral interventions as treatment progressed whereas their practice setting counterparts waned over time. Relative to the two ICBT groups, the UC therapists delivered a significantly higher dose of psychodynamic and family interventions and a significantly lower dose of cognitive-behavioral interventions. Overall, results indicate that there were more similarities than differences in manual-based ICBT delivery across research and practice settings. Future research should explore why the delivery of cognitive-behavioral interventions in the ICBT program changed over time and across settings, and whether the answers to these questions could inform implementation of ICBT programs.

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GIVEN THE DOCUMENTED DIFFERENCES between the clients, therapists, and contexts in research and practice settings (e.g., Southam-Gerow, Rodriguez,

Chorpita, & Daleiden, 2012), it is possible that the delivery of evidence-based treatments (EBTs) may vary across settings (Weisz et al., 2013). Practice and research settings differ across several important dimensions (e.g., youth, therapist, and setting characteristics; Southam-Gerow, Weisz, & Kendall, 2003) that may influence treatment delivery (i.e., those aspects of treatment under the influence of the therapist). It is possible that one, or more, youth, therapist, or setting factors could influence treatment delivery in practice settings, the place where most youth receive mental health care services (Schoenwald & Hoagwood, 2001; Schoenwald et al., 2011). Since treatment delivery is linked with clinical outcomes (Hogue et al., 2008), it is important to understand if differences in treatment delivery across settings do exist. For this reason, treatment delivery is considered an important outcome domain in implementation research, a field focused on the process and outcome of transporting EBTs from research to practice settings (Proctor et al., 2011).

Treatment integrity represents an important measurement domain that can be used to characterize variations in treatment delivery across settings. Treatment integrity is composed of several components, including *treatment adherence*, *treatment differentiation*, and *therapist competence* (Bellg et al., 2004; McLeod, Southam-Gerow, Tully, Rodriguez, & Smith, 2013; Perepletchikova & Kazdin, 2005; Waltz, Addis, Koerner, & Jacobson, 1993). Two of these components, treatment adherence and differentiation, focus on the type and quantity (i.e., dosage) of the interventions being delivered, with adherence reflecting the extent to which interventions prescribed by the treatment model were delivered and differentiation capturing the extent to which a wider range of interventions were delivered. Though most efforts to characterize delivery in the treatment literature have thus far focused on adherence measurement (Perepletchikova, Treat & Kazdin, 2007), some have questioned whether this is sufficient when trying to discern how setting or context may influence treatment delivery (Garland et al., 2010; Southam-Gerow & McLeod, 2013).

Treatment differentiation may be an important component to assess when trying to assess differences in delivery across settings (McLeod et al., 2013). First, most differentiation instruments assess interventions prescribed by a treatment and thus provide an index of treatment adherence, though less precise than an instrument designed solely for adherence. Second, differentiation permits a rich description of the delivery of other observed interventions, including interventions that are proscribed by the treatment model (e.g., in the case of cognitive-behavioral treatment [CBT] for youth anxiety, psychodynamic interventions) and those that are permitted but not explicitly prescribed by the treatment model (e.g., in the case of CBT for youth anxiety, client-centered interventions).

When EBTs are transported to practice settings, several factors increase the likelihood that interventions (proscribed or otherwise) not found in the treatment model may be delivered (Garland et al., 2010; McLeod et al., 2013). Therapists in practice settings have varied training backgrounds and experience (Santa Ana et al., 2009), and some have hypothesized that these factors may increase the likelihood these therapists deliver a range of interventions, including some that are proscribed by the treatment model, when delivering an EBT (e.g., Southam-Gerow et al., 2010; Weisz et al., 2009). In contrast, therapists in research settings tend to have more specialized training backgrounds (Bearman et al., 2013; Herschell, Kolko, Baumann, & Davis, 2010), which may help decrease the likelihood that they will deliver proscribed interventions. Regarding youth factors, the youth seen in practice settings are more demographically and clinically heterogeneous (Southam-Gerow et al., 2003; Southam-Gerow, Marder, & Austin, 2008); it is thus possible that therapists make adaptations to EBTs based on those differences with the hope of making them effective in practice settings (Weisz, Jensen, & McLeod, 2005). Adherence measurement would exclude information about these other interventions (McLeod et al., 2013). Thus, when attempting to characterize treatment delivery in practice settings, it may be important to use a differentiation instrument that captures treatment content beyond adherence to one specific protocol.

Though it is reasonable to assume that EBT delivery may vary across settings, to our knowledge this assumption has not been tested. Research that directly evaluates this assumption could be used to ensure that EBTs delivered in practice settings are implemented along lines consistent with the treatment model (Bond, Becker, & Drake, 2011; Schoenwald, 2011). For example, researchers could use data on differentiation to characterize the variability (or lack thereof) of delivery of an EBT by therapists in practice settings compared to the EBT when delivered in research settings (McLeod et al., 2013).

In this study, we evaluated whether the delivery of an efficacious individual CBT (ICBT; i.e., *Coping Cat*; Kendall & Hedtke, 2006) program for youth diagnosed with anxiety disorders varies across research and practice settings. The *Coping Cat* program is well suited for testing this assumption as it was developed and evaluated in a research setting (Kendall, Hudson, Gosch, Flannery-Schroeder, &