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Therapist Responses to Observable In-Session Engagement Challenges:
Contributing Factors and Implications
for Delivering Evidence-Based Practices with Youth

A dissertation submitted in partial satisfaction of the
requirements for the degree Doctor of Philosophy
in Psychology

by

Joanna Jandee Kim

2019

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ABSTRACT OF THE DISSERTATION

Therapist Responses to Observable In-Session Engagement Challenges:
Contributing Factors and Implications
for Delivering Evidence-Based Practices with Youth

by

Joanna Jandee Kim

Doctor of Philosophy in Psychology

University of California, Los Angeles, 2019

Professor Anna Shan-Lai Chung, Chair

This dissertation investigates community mental health therapists' responses to youth engagement challenges when delivering evidence-based practices. The study provides a typography of observable responses that naturally occur in treatment sessions, identifies therapist, client, and session level correlates of responses, and in turn, how these responses are related to the intensity of evidence-based practice implementation within sessions.

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DEDICATION

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Introduction

An estimated 13-20% of youth will suffer from a mental illness in their lifetime (Merikangas et al., 2010). Although there is a plethora of evidence-based practices (EBPs) that have been shown to reduce children's mental health problems, levels of youth engagement and participation in effective treatments set the upper limit of the impact of EBPs in community settings. Indeed, the past 30 years have witnessed a surge of interest in understanding how to improve treatment outcomes by way of increasing treatment engagement. Research has examined characteristics of community settings and consumers associated with obstacles to engagement, such as logistic, financial, attitudinal, and cultural barriers. Furthermore, research has identified therapist behaviors and elements of psychotherapy that may promote engagement in youth treatment (e.g., Becker, Buckingham, Rith-Najarian, & Kline, 2015; Buckingham, Brandt., Becker, Gordon, & Cammack, 2016; Haine-Schlagel, Martinez, & Bustos, 2014; Lindsey et al., 2014; Snell-Johns, Mendez, & Smith, 2004). However, it is not yet clear the extent to which these strategies are invoked by community therapists delivering EBPs. Furthermore, we do not yet understand how therapist use of engagement strategies may be related to therapist and client characteristics, and the extent to which strategy use is associated with improved delivery or impact of EBPs. This dissertation aims to: (1) characterize community therapists' responses to in-session youth engagement challenges, (2) identify correlates of these therapist responses, and (3) examine the extent to which these responses are associated with EBP implementation outcomes within community mental health settings. This study is among the first systematic examinations of therapist responses to client engagement challenges within community implementation of EBPs. It is hoped that findings will support the translation of clinical science to improve clinical care within our communities.

Why Study Barriers to Implementing EBPs with Youth?

Psychotherapy has made immense advances since the 1950s and 1960s when research appeared to suggest that psychotherapy did not seem to have an effect above that of time (e.g., Eysenck, 1952; Levitt, 1957; Eysenck, 1966). Since then, the field has galvanized to generate data demonstrating the efficacy of hundreds of treatments for youth, to critically evaluate the impact of EBPs in improving care outcomes in community settings, and to begin to understand how to translate these clinical efficacy outcomes into real-world improvements in public health.

Numerous meta-analyses have shown EBPs to be superior to no treatment or treatment as usual for a wide range of child mental health problems (Weisz et al., 2013; Hoffman, Asnaani, Vonk, Sawyer, & Fang, 2012; Weisz, Jensen-Doss, & Hawley, 2006; Weisz, McCarty, & Valeri, 2006; Hoagwood et al., 2001; Durlak & Wells, 1997). Of note, these effect sizes from clinical trials rival those of EBPs for adults, and in many cases widely accepted medical treatments (APA Presidential Task Force on Evidence-Based Practice, 2006). In addition, EBPs have been found to be superior in the durability of their effects (Weisz et al., 1995; Weisz et al., 1987). There is also reason to believe that youth EBPs not only ameliorate the specific symptoms and presenting problems that are the focus of treatment, but they also have more global, non-specific benefits for youth (Weisz, Sandler, Durlak, & Anton, 2005; Weisz et al., 1995). Indeed, the case for EBPs, as studied within research settings, is compelling.

However, the evidence garnered within randomized controlled trials (RCTs) has not translated directly into gains when EBPs are transported to real-world practice settings. When implemented within usual care settings (rather than university clinics) by community therapists (rather than university affiliated clinicians) serving clients referred through traditional channels

(rather than participants recruited for research trials), EBPs have sometimes failed to yield statistically significant gains over that of usual care (Southam-Gerow et al., 2010; Weisz et al., 2009). Meta-analyses that included samples representative of community conditions (e.g., referred versus recruited youth, usual care practice settings, community therapists) show that the overall effects of EBPs drop markedly compared with the treatment benefits shown in RCTs. In one recent meta-analysis, the authors found that a child client selected at random from an EBP condition had a probability of .58 of showing a better treatment outcome compared to a youth client randomly selected from usual care (Weisz et al., 2015). Recalling that the probability of mere chance is .50, this is a jarring indicator of the need for improved client outcomes when delivering EBPs in the real world.

One explanation for why EBPs do not appear to reap expected gains in usual care settings is that there are often barriers to EBP delivery and implementation in community practice settings. When EBPs are no longer being employed with subjects screened and recruited for randomized trials, environmental, cultural, familial, and systemic factors may conspire to compromise therapist implementation, client response, or both. Within everyday practice contexts, therapists are confronted with complexities such as comorbid disorders, language and access obstacles, cultural diversity, emergent life events, and family stressors related to poverty and socioeconomic disadvantage (Weisz et al., 2015; Guan et al., 2016).

Certainly, the clients of community mental health centers do differ from participants in randomized controlled trials. Youth in community samples tend to be more ethnically diverse, poorer, sicker, and present with a range of difficulties that may interfere with treatment engagement. Comparisons confirm that youth enrolled in community clinics faced significantly higher economic and structural disadvantage than youth treated in research contexts. In one such

examination, almost all community services youth reported annual household annual incomes below \$50,000, the majority identified as an ethnic minority, were observed to have increased externalizing symptoms, total symptoms, and diagnoses (Southam-Gerow, Weisz, & Kendall, 2003). Others also report relatively low parental education compared with research samples (Garland et al., 2010), higher rates of single-parent households, lower social support, and history of domestic violence (Baker-Ericzén, Hurlburt, Brookman-Frazee, Jenkins, & Hough, 2010). In addition to significant differences in client demographics, youth served in community clinics tend to have more comorbid psychopathology. For example, youth treated for anxiety and depression in community clinics are more likely to have co-occurring attention problems, and delinquent and aggressive behavior (Ehrenreich-May et al., 2011), which may complicate symptom presentation, client-therapist alliance and youth engagement. In totality, these differences in demographic and clinical characteristics likely contribute to more complex child and family treatment needs within community settings.

Considering the ethnic diversity observed in community samples, the potential impact of cultural barriers to care deserves attention as EBPs are transported to community practice settings. For example, Latino parents' beliefs about discipline, expectations for improvement of child behavior problems, and perceived access barriers predict dropout from community treatment (McCabe, 2002). In research on Parent-Child Interaction Therapy (PCIT), Latino families have been found to take longer to complete treatment perhaps due to an extended period needed to establish rapport before proceeding with skills training (Antshel, 2002; Ayón & Aisenberg, 2010; McCabe et al., 2005; Matos et al., 2006). Trials of parent training with African American and Asian American families also suggest that teaching culturally unfamiliar parenting techniques may necessitate additional supports and practice in more treatment sessions

(Fernandez & Eyberg 2004; Lau, Fung, Ho, Liu, & Gudino, 2011). Lau et al (2011) highlighted issues related to both acceptability and understanding of parent training concepts among Chinese immigrant parents. Collectively these findings suggest that therapists may encounter barriers to the delivery of EBPs with culturally diverse families that necessitate a greater dose of treatment in community settings.

The findings above on potential cultural barriers to EBP have focused on caregiver-directed treatment for youth. This focus on adult caregivers is appropriate particularly when studying barriers to entry into children's mental health service because the onus is often on adults (e.g., caregivers, teachers) who act as gatekeepers to identify emotional and behavioral needs of youth and seek treatment. Yet, less attention has focused on barriers to engaging youth in EBPs once they have commenced treatment, this may be particularly salient when treatment is sought out by adult caregivers. Barriers to youth engagement may occur in the context of parent-youth disagreement about the nature of the child's difficulties, or even the need for treatment (Hawley & Weisz, 2003). Youth engagement in community settings may be even more difficult in the context of referrals to care that are experienced by families as coercive, such as referrals stemming from juvenile justice, child welfare, or school disciplinary actions. These are all sectors where ethnic minority youth are overrepresented and often subject to disparate treatment (Burns et al., 2004; Rawal, Romansky, Jenuwine, & Lyons, 2004).

In addition to client factors that may be related to engagement in EBP delivery, there exist several potential therapist factors that may explain less robust EBP implementation in community settings. For one, community therapists often have less exposure to EBPs and less systemic support to learn and deliver EBPs. Therapists may therefore be reticent, underprepared, or ill-supported to deliver them. Although treatment manuals have galvanized the dissemination

and evaluation of EBPs, therapist receptivity to manualized therapies has been mixed (Herschell, McNeil, & McNeil, 2004). An early survey of 891 therapists by Addis and Krasnow (2000) found that although 77% of respondents had heard of EBPs, 47% of respondents reported never using a treatment manual. Graduate training of therapists has likewise been slow to include training in EBP approaches. A nationally representative survey of accredited programs in psychology, psychiatry, and social work revealed limited training in EBPs and low trainee interest, particularly in more practice-oriented training programs (i.e., professional schools of psychology and social work programs; Weissman et al., 2006). Once entering the workforce, graduate training experiences may shape attitudes toward obtaining training in EBPs. Perceptions of cost and burden of training, psychodynamic theoretical orientation, and graduate training that did not emphasize EBPs have all predicted low willingness to attend EBP workshops (Stewart, Chambless, & Baron, 2012).

Therapists' attitudes toward and perceptions of EBPs may further influence their subsequent experiences with EBP delivery, which may in turn be associated with important treatment elements such as client attendance (Garland, Haine-Schlagel, Accurso, Baker-Ericzen, & Brookman-Frazee, 2010). Providers' attitudes toward EBPs influence how and the extent to which they implement EBPs as intended (Beidas et al., 2012; Southam-Gerow, Rodriguez, Chorpita, & Daleiden, 2012), which in turn may impact clients buy-in to treatments (Aarons & Palinkas, 2007). Therapists' preference for their own intuitive clinical style and perceived dissonance between clients' needs and EBP content are associated with negative attitudes toward and less willingness to use EBPs even when required to do so (Gaudiano, Brown, & Miller, 2011) or higher likelihood of skipping EBP elements (Lau et al., 2017).

On the other end of perceptions, therapists who had positive attitudes toward EBPs were less likely to perceive client barriers to implementation of CBT for depression (Lewis & Simons, 2011). The implementation of the Positive Parenting Program (Triple P) illustrates the potential for therapist perceptions of EBPs to impact treatment delivery outcomes (Shapiro, Prinz, & Sanders, 2011). Therapist-reported confidence in delivering Triple P and perceptions of their knowledge of behavioral intervention skills was significantly related to increased Triple P use. But most importantly, Triple P was perceived by therapists as producing positive change in families, which subsequently served to facilitate implementation fidelity. Thus, positive therapist attitudes may promote both increased EBP delivery and proficiency among therapists as well as overall EBP implementation.

Therapists' Responses to Engagement Challenges

Client engagement barriers occurring during the delivery of EBPs may be one likely contributing factor to the “implementation cliff” or drop in intervention effectiveness when practices are translated out of the laboratory and into the community (Weisz, Ng, & Bearman, 2014). As such, it is crucial that we identify effective strategies that therapists can employ when attempting to address clients who present with engagement challenges during EBP delivery. There is a broader literature on intervention strategies that can promote engagement outcomes more generally that can inform this objective. The literature on engagement strategies encompasses multiple categories: theoretical models about the mechanisms of engagement (e.g., Staudt, 2007), descriptions of stand-alone client engagement interventions (e.g., Haine-Schlagel, Martinez, Roesch, Bustos, & Janicki, 2016; Nock & Kazdin, 2005), reviews of evidence-based interventions that include engagement strategies (e.g., Becker et al., 2015a; Becker et al., 2015b, Becker, Boustani, Gellatly, & Chorpita, 2018; Lindsey et al., 2014), qualitative studies of

therapist and client perspectives on engagement promoting strategies (e.g., Buckingham et al., 2016; Pagoto et al., 2007), and finally observational studies of therapist in-session responses to client engagement barriers (e.g., Patterson & Chamberlain, 1994).

At the broadest level, one theoretical model makes a potentially useful distinction between behavioral and attitudinal engagement (Staudt, 2007). The behavioral component of engagement addresses the need for the client to enact new behaviors that are necessary in the treatment model and includes homework completion, engaging in role-plays, and responding to therapist questions and requests. The attitudinal component, in contrast, refers to the client's motivation, emotional investment, and commitment to treatment. Attending to both components can guide therapist responses to types of engagement challenges that arise in session. Some engagement challenges may be best addressed by strategies that promote behavioral engagement (e.g., supporting practice and the mastery of skills) versus attitudinal engagement (e.g., promoting "buy-in" or confidence in the intervention). Although both attitudinal engagement and behavioral engagement are presumed crucial to client outcomes, Staudt argues that attitudinal component as the vital channel through which therapist behaviors can lead to positive client outcomes. The premise is that therapist behaviors cannot directly generate behavioral engagement; rather, therapists must first evoke attitudinal engagement, which spurs client action. Staudt calls attitudinal engagement the "heart" of engagement. Consistent with this theoretical assertion, a qualitative study of therapist perceptions of barriers and facilitators to implementing EBPs in usual care revealed that most therapists believed that barriers were most often related to low client motivation for engagement (Pagoto, Spring, Coups, Mulvaney, Coutu, & Ozakinci, 2007). However, the supposition that strategies targeting attitudinal engagement are a necessary precondition to strategies addressing behavioral engagement is untested. Nonetheless, it may be

useful to codify engagement strategies into those that target processes underlying attitudinal versus behavioral engagement when therapists are met with an in-session engagement challenge.

Recent exhaustive reviews of the controlled trial literature have generated a much more differentiated taxonomy of engagement strategies that appear within interventions with demonstrated effectiveness or efficacy in children's mental health. Becker, Chorpita and colleagues have employed the Distillation and Matching Model (DMM; Chorpita, Daleiden, & Weisz, 2005) to identify engagement strategies that address distinctive domains of client engagement (e.g., Becker et al., 2015; Becker, Boustani, Gellatly, & Chorpita, 2018). Within the DMM framework, effective interventions are first selected from the evidence base, and elements of interventions are identified to produce a summary of potent ingredients that drive treatment effects. After interventions have been "distilled" to the key engagement elements, they are "matched" on to a differentiated set of engagement domain outcomes. In this manner, Becker and colleagues (2018) identified engagement strategies associated with five domains of engagement denoted by the REACH acronym: Relationship (therapeutic alliance), Expectancy (expectations and beliefs about treatment), Attendance (treatment attendance), Clarity (understanding of treatment structure, goals, rationale, and client/therapist roles), and Homework (in-session participation and homework completion). Assessment, psychoeducation, accessibility promotion, goal setting, and addressing barriers to treatment emerged as indicated engagement strategies for most youth and families involved in mental health services. The REACH model provides a much more differentiated constellation of engagement domains than described by Staudt (2007), however, it is plausible that Relationship, Expectancy, Clarity targets are more proximally related to attitudinal/motivational/cognitive engagement, whereas Attendance and Homework are indicators of behavioral engagement.

Stand-alone protocols and intervention augmentations have been developed and tested for their potential to improve engagement outcomes in children's mental health. Although treatment attendance (e.g., total number of sessions, punctuality) are most often examined as markers of treatment engagement (Becker et al., 2015, Santisteban et al., 1996), engagement interventions have sought to also elicit higher levels of active participation within sessions. For example, Haine-Schlagel and colleagues (2016) set out to increase parent participation by training therapists in the Parent and Caregiver Active Participation Toolkit which included strategies to increase therapist-parent alliance (e.g., active listening, conveying parent-therapy partnership), collaboration (e.g., seeking parent input on treatment activities), and parental empowerment (e.g., acknowledging parents' strengths and efforts). Compared with the control group, the experimental condition resulted in increased parent participation in child therapy sessions and more session attendance. In addition, the engagement strategies were found to be acceptable, feasible, and linked with improved job attitudes among therapists. Whereas Haine-Schlagel and colleagues infused treatment sessions with therapists' strategies to elicit greater participation and engagement, similar outcomes have been found with brief, adjunctive engagement interventions that have focused on addressing logistic and attitudinal barriers to engagement (e.g., Nock & Kazdin, 2005). Analysis of elements of these engagement interventions can also contribute to a typology of potential therapist responses to in-session client engagement challenges in the community delivery of EBPs to youth.

The research reviewed above provides insights into best practices for engaging caregivers and clients in evidence-based interventions and/or community mental health services. These strategies and interventions do not necessarily emerge in response to observed problems with client engagement, rather many strategies reviewed are used proactively to prevent engagement

problems later, for example, by providing an orientation to treatment or setting clear expectations for client and caregiver roles. However, there is less information on naturalistic therapist responses to engagement challenges arising in the course of therapy. The proposed investigation characterizing spontaneous community therapist responses to in-session engagement challenges can provide important information on how these responses align with best practices and can provide ‘practice-based evidence’ on unstudied responses or strategies. To date, few studies have systematically examined therapist-driven strategies following an engagement challenge and assessed their impact on implementation outcomes (Snell-Johns et al., 2004).

Although not in response to an engagement challenge, one an early investigation attempted to measure community therapist in-session behaviors and their associations with rates of subsequent client retention versus attrition (Shields, Sprenkle, & Constantine, 1991). The researchers observationally coded portions of initial family therapy sessions and examined the association between therapist behaviors and premature termination. They found that therapist “structuring” behaviors (e.g., refocusing clients on topic, checking or seeking agreement with family members, changing the subject or introducing topics or problems, telling clients to speak directly to one another) were associated with treatment continuation.

Another early example of observational research shed light on reactive therapist behaviors in response to engagement challenges. Patterson and Chamberlain (1994) utilized microanalytic observational coding and sequential analyses to identify how therapists responded to parental ‘resistance’ during the implementation of evidence-based parent training with low-income, disadvantaged families (e.g., support, confront, reframe, express like/dislike). They examined two categories of parent engagement characterized by (1) hopelessness or defense of actions (i.e., “I can’t” behaviors) and (2) disagreement with or challenge to the therapist’s

instruction (i.e., “I won’t” behaviors). Results revealed that caregiver factors of psychopathology, stress, social disadvantage, and antisocial traits were associated with initial levels of observed resistance. After parent resistance was observed, therapist response behaviors included confrontation and expressing dislike for the client, running counter to best practices for engagement. Therapists were also observed to intervene in parental resistance using reframing with mothers, but not fathers, a technique that was found to increase client non-compliance and resistance in a previous experiment (Patterson & Forgatch, 1985). Among mothers, overall resistance behaviors during treatment were associated with fewer parent training sessions delivered, however, fathers’ display of “I can’t” behaviors ultimately resulted in a higher dose of parent training delivered (Patterson & Chamberlain, 1994). In other words, engagement challenges by mothers were met earlier termination, whereas father engagement challenges may have resulted in more opportunities for active learning in parent training. In sum, caregiver engagement appeared to alter the behavior of therapists and also had implications for overall treatment intensity and dose although in diverse ways.

Thus, it is important to consider the types of client barriers to engagement in order to understand their potential for shaping specific therapist responses, and to examine the associations of these responses with EBP implementation outcomes (e.g., sustainment of services and interventions, EBP-favorable climate). It is possible that some types of engagement challenges are more likely to prompt ineffective therapist responses that give way to poorer EBP implementation outcomes, whereas other types of engagement challenges may actually lead therapists to augment their EBP delivery. These findings point out the potentially complex interplay between client barriers to engagement, therapist responses to these barriers, and their resultant implications for EBP implementation. Although previous observational studies of

community therapists' spontaneous use of engagement strategies appear to support the use of directive behavioral strategies to promote engagement in family therapy and parent training, continued investigation is needed within community implementation of EBPs broadly. In addition, previous studies have focused primarily on engagement of adult caregivers and less is known about community therapists' approaches to responding to youth clients who exhibit engagement challenges.

The literature reviewed on practices in evidence-based interventions known to improve engagement (Becker et al., 2018), components of specific engagement protocols (Haine-Schlagel et al., 2016), and findings from observational studies of therapist in-session behaviors (Patterson & Chamberlain, 1994) can inform a potential typology of therapist responses to client engagement challenges in the community delivery of EBPs (see Table 1). The more comprehensive list of possible engagement strategies and dimensions may be narrowed by focusing on reactive strategies that may be observed in response to an in-session engagement challenge. Therefore, we propose a synthesis that identifies three primary categories of in-session, reactive therapist responses to engagement challenges: (1) responses intended to elicit relational engagement, (2) responses intended to elicit cognitive behavioral engagement, and (3) responses likely counter to client engagement (i.e., desistance responses).

Regarding relational engagement strategies, theoretical models (attitudinal engagement from Staudt, 2007), reviews (Relationship domain from REACH; Becker et al., 2018), and observational studies (therapist like/dislike in Patterson & Chamberlain, 1994) converge on the potential importance of behaviors that aim to promote therapeutic bond or alliance in the face of in-session engagement challenges from clients. Thus, discrete, in-session therapist responses to build rapport, strengthen the relationship may include behaviors such as supportive listening,

communicate partnership and conveying warmth and positive affect (as codified in the PACT toolkit, Haine-Schlagel, Martinez, & Bustos, 2014).

The literature clearly emphasizes the importance of prompting cognitive and behavioral participation or the client's "performance of tasks that are necessary to implement treatment and to ultimately achieve outcomes" (Staudt, 2007, p. 185). From the REACH model, Expectation and Clarity tap into cognitive or attitudinal engagement and the Adherence and Homework engagement domains align with the goal of eliciting greater cognitive and behavioral participation, both which are necessary for client engagement and participation in session (Becker et al. 2018). Potential therapist responses in this cluster include strategies such as psychoeducation, assessment of barriers, reinforcement of client participation, and motivational interviewing tactics. Likewise, the "Empowerment" and Collaboration" behaviors contained in the Haine-Schlagel et al. (2016) protocol similarly activate caregiver cognitive and behavioral engagement in skills training. However, it is unclear the extent to which these engagement practices are demonstrated by community therapists during the delivery of EBPs when they encounter client disengagement and/or lack of participation.

Finally, although relational and cognitive behavioral strategies have been shown to elicit greater treatment engagement and participation, previous studies suggest that therapists do not always act in ways consistent with best practices in therapeutic engagement. Recall that therapists also respond to such challenges with behaviors that may actually denote therapist disengagement. It is likely that therapists may go off protocol and desist from the EBP in response to client engagement challenges. As therapists have been observed to confront clients with negative affect, and to relent to client complaints, off task-behavior, or withdrawal by delivering a lower dose of the EBP (Patterson & Chamberlain, 1994; Patterson & Forgatch,

1985). As such, it is important to include these potential reactions in a typology of community therapist responses to client engagement challenges and to examine their relation to EBP implementation outcomes.

In summary, the literature points to promising engagement strategies employed in evidence-based interventions that have been linked to a range of engagement outcomes, a subset of which may characterize therapists' *responses* to observed engagement challenges during community implementation of EBPs. Many engagement strategies identified in the literature are also general components of EBPs more generally that proactively encourage behavioral engagement rather than address barriers that arise (e.g., homework assignment and review; modeling target skills). Finally, the engagement literature has enumerated strategies demonstrated to positively impact engagement and may not capture the full range of community therapist responses to challenges that naturalistically occur within sessions. Thus, it is the aim of this dissertation to identify categories of therapist responses that address within-session engagement challenges that are in direct response to client engagement challenges, which may have either positive or negative implications for EBP implementation outcomes.

Client Engagement Challenges and Implications for EBP Delivery

The foregoing discussion supports the concern that therapists in community settings may encounter notable challenges to the engagement of youth in the context of EBP delivery. Indeed, studies of usual care suggest that community therapists generally deliver EBP strategies with low intensity in the treatment of children (Garland et al, 2010; Brookman-Frazee, Taylor, & Garland, 2010). When challenges to engagement do arise, there is little research that bears upon therapist responses that are associated with high quality EBP implementation.

It may be precisely when therapists are met with challenges to engagement that robust EBP delivery is called for. However, an early examination of client resistance within parent training revealed that therapist responses to engagement challenges often led to a decrease in time spent teaching parent training skills. Thus, engagement challenges may not only portend the risk of premature termination, but may also result in derailed therapist delivery of EBPs. This may help to explain the low intensity delivery of EBP strategies in usual care settings (Brookman-Fraze et al., 2008; Garland et al, 2010).

Although it is reasonable to anticipate that engagement challenges can act to sidetrack therapist delivery of EBP strategies, it may also be possible that some client engagement challenges prompt robust implementation of EBP strategies. Recall the mixed impact of observed parental “resistance” on parent training implementation (Patterson & Chamberlain, 1994). Among low-income socially disadvantaged families in treatment, “I won’t” resistance behaviors (i.e., clients expressing they are unwilling to enact prescribed skills) may be more likely to curtail EBP delivery, whereas client behaviors that represent “I can’t” concerns (i.e. clients expressing that they are unable or unprepared to enact prescribed skills) may prompt greater therapist support of client active learning within the EBP.

A recent observational investigation of a caregiver-mediated intervention for children with autism spectrum disorder found that observed client expressed concerns about the intervention (e.g., expressing concerns about treatment strategies, expressing difficulty using skills) were positively correlated with parent participation behaviors (e.g., asking questions, participating in treatment activities, showing commitment to therapy) (Guan et al., under review) In additional, both observed client engagement challenges and parent participation behaviors were associated with clinician adherence to the EBP. This suggests that within collaborative

treatment models, client behaviors traditionally conceptualized as barriers may actually be indicators of engagement and opportunities to discuss treatment and clarify interventions. In particular, the client behaviors of expressing concerns about interventions and describing difficulties learning skills, may elicit supplemental support from therapists.

Overall, available information on the impact of in-session client engagement challenges is limited and somewhat mixed. We know little about how community therapists typically respond to engagement challenges, particularly in interventions directed to youth. Additionally, the implications of different therapist responses for EBP implementation outcomes has not often been investigated. It is crucial to distill therapist responses to engagement challenges that are associated with greater EBP implementation intensity versus responses that may detract from implementation. Additionally, much previous research has been conducted within parent training interventions. To date, we know much less about how such engagement challenges emerge within psychotherapy sessions with youth and children.

Study Context: Multiple EBP Implementation in Los Angeles County

The Los Angeles County Department of Mental Health (LACDMH) launched the Prevention and Early Intervention transformation in 2010. Driven by system-level stakeholders, the PEI initiative provided implementation support for EBPs, promising practices, and community-defined evidence practices meant to address the wide range of behavioral and emotional problems prevalent among those LACDMH serves. PEI provided training and implementation support for an initial set of six practices: Cognitive Behavioral Interventions for Trauma in Schools (CBITS), Child-Parent Psychotherapy (CPP), Managing and Adapting Practices (MAP)¹, Seeking Safety (SS), Trauma-Focused Cognitive Behavior Therapy (TF-

¹ MAP is not an EBP protocol. Rather, MAP is a model for identifying the most suitable evidence-based treatments for clients based on their presenting problems and background characteristics and making research-informed

CBT), and Triple P Positive Parenting Program (Triple P). By the 2010–2011 fiscal year, over 32,000 children and transition age youth were served in PEI programs (LA County Department of Mental Health, 2011).

The Knowledge Exchange on Evidence-based Practice Sustainment (4KEEPS; Lau & Brookman-Fraze, 2016) is an observational study with the primary aims of characterizing sustainment outcomes and identifying agency- and therapist-level factors associated with the sustained use of multiple EBPs over time within the PEI initiative. Unlike experimental studies, 4KEEPS capitalizes on the already changing landscape of community mental health following large-scale, fiscally driven implementation of EBPs. The naturalistic design allows for examination of how EBP implementation fares in the real world of community mental health, replete with all the characteristics that make community mental health particularly inimitable (e.g., high therapist turnover, younger and less experienced therapists within the workforce, complex presenting problems, clients facing structural inequities that impact treatment access). Another distinct strength of 4KEEPS is its examination of the sustainment of multiple EBPs. Unlike traditional effectiveness trials that roll out single interventions from the laboratory, real-world large-scale implementation efforts aimed at addressing diverse client needs across a system will likely disseminate multiple EBPs simultaneously. Thus, 4KEEPS is capitalizing on the opportunity to identify determinants of sustainment across multiple EBPs in the largest county-operated mental health department in the U.S. serving one of the most diverse populations in real time.

The 4KEEPS study team collected online therapist surveys assessing training background, workload, perceptions of organizational climate, perceptions of EBPs, and reports

decisions around treatment design and implementation. However, within the scope of the PEI transformation, MAP is often referred to and included under the umbrella term of EBPs.

of EBP delivery and barriers to implementation from 777 therapists from 98 community mental health agencies within Los Angeles County who were trained to deliver at least one of the six aforementioned EBPs. A subset of therapists was invited to take part in the In-Depth Study in which therapists participated in semi-structured interviews and completed surveys describing their delivery of EBPs in up to three sessions with up to three clients (for up to nine sessions per therapist). For each session, therapists reported on the extent to which they covered therapy content and techniques consistent with EBP protocols and reported their overall perception about whether they were able to deliver their intervention as planned.

Therapists also supplied audio recordings of all therapy sessions they reported on. Each session recording was coded in its entirety by the 4KEEPS research team to identify: (1) the intensity of EBP strategy delivery for the child's target problem, and (2) the extent to which observable client engagement challenges were noted. For the dissertation, session recordings in which an engagement challenge was observed were also coded for therapist responses following the initial observed engagement challenge. Initial engagement challenges were observed within the first 10 minutes of a session among 60.68% of sessions, and within the first 20 minutes among 82.48% of sessions. On average, the initial engagement challenge occurred 11 minutes 18.55 seconds into the treatment session (SD = 12 minutes 32.79 seconds).

The Current Study

In sum, although there is ample evidence of the efficacy of EBPs for a wide range of disorders, there is less support for their sustained effects when transported into community settings serving low-income, ethnic minority and immigrant youth and families. This drop in EBP effectiveness is accounted for, in part, due to differences between laboratory settings and the reality of community mental health featuring both clients with more complex presentations

and facing structural barriers to treatment and therapists with less experience with EBPs and less organizational support for EBP use. Youth client engagement challenges naturally arise in the treatment session. Engagement challenges may impact the delivery and uptake of EBP content and strategies, conditional on how therapists respond to such engagement challenges. Yet, there is a dearth of standardized, observations of therapists' responses to difficulties encountered in engaging *youth* clients specifically rather than their caregivers and their families. Thus, the current study was intended to provide a naturalistic examination of how community therapists respond to youth engagement challenges treatment sessions and to identify therapist responses to engagement challenges that are associated with high overall intensity delivery of EBPs in the real world.

As such, this dissertation answers three research questions. First, how do therapists respond to in-session engagement challenges in treatment sessions with youth? Given the current state of limited systematic and observed-coded review of therapist responses to barriers, I have developed a standardized, observational coding system to identify these behaviors at the session level. The therapist response codes were derived from reviews of studies identifying common engagement strategies found in evidence-based treatment protocols (e.g., Becker et al., 2015a; Becker et al., 2015b, Becker, Boustani, Gellatly, & Chorpita, 2018; Lindsey et al., 2014), stand-alone engagement interventions (e.g., Haine-Schlagel et al., 2016; Nock & Kazdin, 2005), qualitative examinations of client-preferred engagement strategies (e.g., Buckingham et al., 2016), and observational studies of therapist responses to engagement challenges (e.g., Patterson & Chamberlain, 1994).

Second, the dissertation study identifies session, client, and therapist characteristics that predict types of therapist responses to in-session engagement challenges encountered in the

delivery of EBPs with youth clients. In particular, the dissertation examines whether application of various therapists' responses differs by client age, race/ethnicity, gender, presenting problem, therapists' own characteristics (including demographics, experience, and perceptions of EBPs), and/or types of engagement challenges observed.

Finally, this study examines how therapists' responses to client engagement challenges predict the intensity with which EBP strategies are delivered in the same session. Conventional wisdom and some research suggest that in-session client engagement challenges may derail therapists' delivery of EBPs and coverage of relevant content (Gellatly et al., 2019). Yet, emerging evidence points toward the potential for in-session engagement challenges to provide opportunities for therapists to augment their EBP delivery (Lau et al., 2018). As such, the dissertation explores whether engagement challenges indeed derail EBP implementation or whether they signal therapists to respond in ways compatible with robust EBP delivery. Furthermore, I examine how distinct types of therapist responses following client-expressed barriers may relate to EBP implementation outcomes.

Method

Participants

Participants for this dissertation are drawn from the larger 4KEEPS study in which 98 agencies operated by or contracted by the Los Angeles County Department of Mental Health were contacted for study participation (Lau & Brookman-Frazee, 2016). Each of the 98 agencies were included in the initial contact for participation based on their implementation of at least one of the six EBPs of interest for the parent study. Of these 98 agencies, 69 agencies (70.4% participated the initial online survey. A subset of agencies was recruited for inclusion in the In-Depth Study portion of 4KEEPS, which included in-person interviews with program leaders and

therapists, and the collection of audio-recordings and therapist reports of implementation in treatment sessions in which one of the six EBPs of interest was being delivered. Of the 69 agencies that participated in the larger study, 24 program sites across urban, suburban, and semi-rural areas of Los Angeles County participated in the In-Depth Study.

For the dissertation study, community therapists from the In-Depth Study who submitted at least one session recording of a youth-only treatment session in which an engagement challenge was observed were included in the dissertation study sample. This provided us with a sample of 85 community therapists for the dissertation study. Demographic and background data such as age, licensure status, years of practice, race, overall caseload, and theoretical orientation of therapists included in the dissertation study are summarized in Table 2. Among the current sample of community therapists, 86.25% self-identified as staff (versus trainee), 85% were female, 78.75% were not licensed, and 90% reported a Master's Level degree. The majority of therapists report their primary theoretical orientation as behavioral or cognitive behavioral (71.25%), followed by family systems (10%) and eclectic/other (8.75%). On average, therapists reported that they were 34.83 years old ($SD = 9.06$, Range = 25-62), had a caseload of 17.34 clients at the time of the survey ($SD = 7.21$, Range = 1-44), and had been delivering psychotherapy for a total of 4.81 years ($SD = 4.72$, Range 0-35).

Procedures

Therapists participants completed a survey tapping into perceptions of EBPs, EBP training background and caseload, and perceived organizational climate. Through the survey, we have also gathered therapist demographic characteristics and background characteristics such as age, education level, licensure status, and years practicing therapy and years at their agency.

In addition to the initial survey, these therapists were asked to provide three treatment session audio recordings each for three different youth clients and to complete additional measures describing their EBP implementation for each session recording provided. Therapists were asked to submit session recordings for clients who they believed would remain in treatment for the next two or more months. Aside from this guidance, therapists were allowed to select clients and sessions of their choosing. Therapists were not required to submit consecutive sessions. Therapists received \$20 for completing the background survey and an additional \$10 for each session for which they provided an audio recording and session questionnaire (up to 9 sessions total). All study procedures were approved by the UCLA Institutional Review Board.

Session Sampling

All youth-only sessions were coded for observed engagement challenges and the extensiveness of delivery of EBP strategies (see below). Sessions in which an engagement challenge was observed were then coded for therapist responses following an initial engagement challenge. Sessions recordings in which there was no observed barrier were not included in the dissertation study. In order to prevent coding contamination, coding of engagement challenges, therapists' response behaviors, and EBP strategy delivery were completed by three independent coding teams.

For the In-Depth Study, therapists submitted a total of 686 sessions within the treatment of 299 child clients. Of the 686 sessions, 399 were youth-only sessions. Of the 399 youth-only sessions submitted, 236 (59.15%) were found to have at least one observed client engagement challenge and thereby were included in this dissertation study. Within the 236 sessions included in the dissertation study, 149 child clients were represented.

Client and session descriptives for the dissertation sample are presented in Table 3. The average child client age was 11.04 years, 59.06% were female, and the vast majority identified as a member of an ethnic minority group (95.97%), primarily Hispanic/Latinx (69.80%). Within this sample of sessions, therapists reported using MAP for 57.20% of sessions, TF-CBT for 35.17% of sessions, and Seeking Safety for 17.63% of sessions. Almost all sessions were conducted in English (97.88%; 5 sessions included some spoken Spanish).

Measures

Therapist characteristics. Demographic and background data were collected in the initial survey and are presented in Table 2.

Client and session characteristics. For each of the 149 clients represented in the session audio recordings, therapists provided information on clients' age, sex, and race/ethnicity. Therapists also provided information about the specific practice, language, and location of the session. Client and session characteristics represented in the sample are presented in Table 3.

EBP Problem Target. For each session recording submitted, therapists reported on the presenting problem or behavior that was the focus of the session. Therapist responses were recategorized into one of four EBP problem targets: conduct or disruptive behaviors, anxiety, depression, and trauma.

Observable client engagement challenges. Therapist participants in were asked to supply three audio-recordings of therapy sessions from three different clients, for a maximum of nine sessions per therapist. For the purpose of this dissertation, I will focus solely on responses to engagement challenges observable in audio recordings of psychotherapy sessions with youth. Each recording underwent both (1) *micro-analytic coding* to assess the occurrence of

engagement challenges and global ratings of (2) *extensiveness coding* of each challenge as outlined in the Barriers to Implementation Coding Manual – 4KEEPS Version.

For this micro-analytic coding, each coder listened to the complete session audio recording, made detailed notes on client behaviors, and assessed each 5-minute interval for the presence or absence of a barriers to implementation, which include (1) client-expressed concerns about the helpfulness/relevance/acceptability/feasibility of an intervention strategy, (2) demonstrations of unengaged/passive behavior, (3) reluctance/refusal to participate in therapy activity, (4) expressing difficulty mastering skills or understanding concepts covered in therapy, (5) failure to complete assignments or out of session skill application/practice, (6) negative affect directed at the therapist or the therapy activities, or (7) in session disruptive behaviors. The timestamp of each observed engagement challenge was also recorded. Table 4 outlines each of the engagement challenge codes with brief definitions.

Following the listening and detailed note-taking process, each session recording was assigned a global extensiveness rating on a 5-point Likert-type scale reporting the extent to which each engagement challenge was observed (0 = *Not observed* to 4 = *Observed to a great extent*). Coders considered the detail, depth, duration and intensity, with which the client expressed an engagement challenge when assigning extensiveness ratings.

Prior to independent coding, each undergraduate and post-baccalaureate research assistant coder attended group didactic sessions in which they were trained on the engagement challenges codes and coding procedures. Each coder independently coded a minimum of six gold standard practice sessions and met with a coding trainer to assess reliability and discuss how to minimize discrepancies. Once coders reached 80% agreement within 1-point on global codes, coders were allowed to code independently. To assess reliability, 20% of sessions were randomly

selected to be coded by a second coder. Examination of double-coded sessions showed good inter-rater reliability as evidenced by ICCs of .40 and greater for six of the seven youth engagement challenge codes ($M_{ICC} = .64$, $Range_{ICC} = .41-.81$). The ICC for the code “expressed difficulty mastering skills or understanding concepts” was below .40 and was therefore omitted from subsequent analyses. A three-level (i.e., sessions within clients within therapists) confirmatory factor analysis (CFA) of the six remaining engagement challenge codes was conducted to establish two youth client engagement challenge factors: (1) active/disruptive engagement challenges (encompassing expressions of concern about the helpfulness/relevance/acceptability/feasibility of an intervention strategy, negative affect toward therapy/therapist, and in-session disruptive behaviors) and (2) passive/unengaged engagement challenges (encompassing demonstrations of unengaged/passive behavior, reluctance/refusal to participate in therapy, failure to complete assignments or out of session skill application/practice). Due to the complex nested nature of the data (e.g., three levels, uneven distribution of sessions and clients per therapist), the CFA was estimated using occurrence variables (e.g., 0 = engagement challenge no observed, 1 = observed). Fit indices are currently unavailable for three-level CFAs, as such factor loadings at the session level were observed to evaluate model fit. At the session level, all standardized factor loadings were above .40 for both factors ($M_{Expressed} = .67$, $Range_{Expressed} = .53 - .94$; $M_{Disengaged} = .63$, $Range_{Disengaged} = .47 - .90$). Therefore, the two-factor solution was deemed to have sufficient model fit (Tabachnick and Fidell, 2001).

Therapist responses following observed engagement challenges. *Coding*

Development. The Coding Manual for Therapist Responses to Observed In-Session Challenges to Treatment was developed for the present study (Appendix A). The structure of the manual was adapted from the AIM HI Coding Manual (Brookman-Fraze & Chlebowshi, 2013) and the

Barriers to Implementation Coding Manual – 4KEEPS Version. Table 5 summarizes final therapist response codes included in the study and provides brief definitions. During code development, an initial list of therapist behaviors was conceptualized from the literature on therapist behaviors associated with engagement, coding manuals for therapist engagement behaviors, and literature on therapist responses following client behaviors (e.g., see Table 1).

Figure 1 lists and organizes therapist responses to engagement challenges included in the present study according to hypothesized factors of relational responses, cognitive behavioral responses, and desistance behaviors. Relational engagement responses included strategies designed to promote trust in, reliance on, and partnership with the therapist (Haine-Schlagel et al., 2016). These include relationship and rapport building techniques via *therapist positive affect*, *communicating alliance or partnership* with the client, and *normalizing/validating/reflecting the client's experiences* (Becker et al., 2015a, Becker et al., 2015b, Buckingham et al., 2016).

Within the cluster of cognitive behavioral engagement responses are therapist responses meant to draw forth greater client participation in-session and out-of-session activities. These included in-session *assessment of barriers* and *developing a plan* to address respective engagement challenges, often cited as “winning” engagement strategies (Becker et al., 2015) and specifically related to Expectancy and Attendance engagement outcomes (Becker et al., 2018). Efforts to empower the client to collaborate within treatment by *seeking client input* may also prove crucial to increasing client engagement. In addition to soliciting the client's comments and suggestions and providing opportunities for the client to ask questions communicates to the client that his or her participation is crucial to the movement of treatment, *incorporating the*

client's input is crucial to ensuring the treatment is accessible and the client remains engaged in treatment.

Feedback from therapists that reinforces or discourages specific in-session behaviors are also likely response patterns to affect client participation. This includes therapists' *comments on client efforts and engagement* signaling approval and appreciation for client's in-session participation (Karver, Handelsman, Fields, & Bickman, 2006), *labeling client (lack of) engagement* such that clients are alerted to their lack of engagement and prompted to attend to the treatment session activities, and providing *troubleshooting and corrective instruction* during skills building as a way to intervene when the client may be feeling stuck in order to enable the client to overcome the specific challenges to participation and rehearsal. In fact, therapists' efforts to promote rehearsal and provide reinforcement were frequently seen in the Expectancy and Homework engagement profiles (Becker et al., 2018).

Responses that enhance "buy-in" to the treatment activities are also commonly cited in the engagement literature and likely to boost cognitive behavioral engagement. These include motivational techniques such as *eliciting change talk* (associated with the Expectancy engagement domain; Becker et al., 2018), which includes the use of Socratic questioning which can serve to reveal how the client's goals may be met by engaging in treatment. *Psychoeducation* has been identified as an essential engagement strategy that can provide a clear rationale for treatment activities and their relation to desired outcomes and has been consistently seen in Expectancy, Attendance, and Clarity domains of engagement (Becker et al., 2018). However, it is also a principal EBP strategy generally (which contributes to the extensiveness of EBP strategy scores in later analyses). Therefore, we included psychoeducation as an indicator of cognitive behavioral engagement responses in models predicting therapist responses to

engagement challenges, but did not include psychoeducation in the cognitive behavioral engagement responses in models predicting extensiveness of EBP strategy delivery.

Therapist desistance behaviors for the coding manual were drawn largely from the codes observed from Patterson and Chamberlain's examination of within session therapist responses to client resistance. Although Patterson and Chamberlain observed and coded therapist expressions of dislike, preliminary coding showed very low base rates of therapists expressing dislike within sessions in the current study. As such, the code was broadened to capture *therapist negative affect*. In addition, therapists *relenting or ending a therapy activity or session* in response to an engagement challenge was included in order to tap into the response of drifting from the planned or intended activity within a session. This was intended to represent the within-session process that might related to an overall decrease in treatment dose observed by Patterson and Chamberlain (1995) in response to engagement challenges by mothers in parent training.

Some common engagement strategies listed in Table 1 were not included in the observation coding due to the strategy being potentially less relevant as responses to within session engagement challenges. For instance, accessibility promotion and incentives for attendance were not observed within the context of ongoing treatment sessions in the current context. Other engagement strategies were not included because of the overlap with common EBP strategies included as key indicators of extensiveness of EBP strategy delivery (e.g., modeling, homework assignment). Retained codes were adapted and trimmed as necessary during the piloting and reliability analysis phases of the dissertation study.

Coder Training. Coders included five psychology undergraduate students, one post-baccalaureate research assistant and one graduate student who were trained in the Coding Manual for Therapist Responses to Client Engagement Challenges. Coders met weekly to review

and discuss the coding manual and then to apply the coding system to practice sessions. Coders discussed item content, code definitions, as well as exemplars of codes. The coding manual was revised to incorporate feedback and reflect these discussions. After coders reached agreement within 1-point on a minimum of 80% of the global ratings for six gold standard sessions, the coders were assigned to independently code two audio sessions weekly. Coders met regularly to prevent coder drift.

Coding Procedures. Sessions in which an engagement challenge was observed were assigned to be subsequently coded for therapist response behaviors. The timestamp of the first observed engagement challenge was used as the starting point for the therapist response behavior coding. Coders begin to listen to sessions and take detailed notes on therapist actions following the first observed engagement challenge.

Following the observed initial engagement challenge till the end of the session recording, coders rate the *occurrence* of each therapist response behavior (0 = *Absence* or 1 = *Presence*) within each 5-minute interval. Coders also rated the *extensiveness* of each therapist behavior observed. The extensiveness rating was designed to reflect both the intensity and the frequency with which each behavior was observed in order to capture not only the level of detail and comprehensiveness each behavior was employed but also how often each code was utilized. Global extensiveness for each code was rated on a 7-point Likert-type scale (0 = *Not present/observed* to 6 = *High extensiveness/intensity*).

EBP intensity scores. EBP intensity was measured through the EBP Concordant Care Assessment (ECCA), which measures the intensity of EBP strategy delivery by examining the degree to which the treatment delivered resembled and included strategies one would expect for a given problem focus (e.g., strategies deemed necessary for treatment of depression within

evidence-backed protocols). The 4KEEPS project team developed the ECCA Observational Coding System to provide a common metric for which to assess the extent to which a therapist delivers practices considered “essential” for EBPs for six major child mental health domains: anxiety, depression, conduct problems, attachment problems, substance use, and trauma both through therapist report and through standardized observational coding (Brookman-Fraze et al., under review).

ECCA Development. The project team examined existing practice inventories (MTPS; Child and Adolescent Mental Health Division, 2012; Orimoto, Higa-McMillan, Mueller, & Daleiden, 2012; McLeod & Weisz, 2010; Garland et al., 2010; PRAC TPOCS-S; Garland, Brookman-Fraze, & McLeod, 2008) to extract EBP elements for inclusion. Practice experts in each of the six practices being studied (e.g., intervention developers, researchers conducting efficacy/effectiveness trials, LACDMH practice leads) rated each item on a 7-point Likert-type scale indicating the extent to which each strategy included in the list was “essential” or “interfering.” Practice experts were also invited to write in additional strategies believed to be essential to the specific practice their expertise is in. Distribution of item ratings and inter-rater agreement was examined within each practice. Strategies without inter-rater agreement were dropped from the full scale and write-in strategies suggested by at least two practice experts (including an intervention developer) were retained. A total list of 34 items was retained with each strategy included being identified as “essential” for at least one of the six EBPs and are listed in Table 7. These strategies were then grouped based on the EBP Problem Target the strategies addressed to create ECCA Composites: 1) Trauma Composite (14 items; addressed in CPP, CBITS, TF-CBT, SS, MAP), 2) Conduct Composite (26 items; addressed in Triple-P, MAP), 3) Anxiety Composite (14 items; addressed in MAP), and 4) Depression Composite (15

items; addressed in MAP). Although there is shared item content across the EBP Target Composites, each represents a unique set of content and strategies for its respective target domain.

Observational Coding. Session recordings underwent observational coding in accordance to the ECCA Observational Coding System Manual: In Session Therapist Strategies (4KEEPS, 2017). In order to prevent coding contamination, an independent group of coders (i.e., no coders who had coded engagement challenges or therapist response behaviors) coded sessions for EBP strategy delivery. Similar to the coding procedures outlined for assessing engagement challenges and therapist responses, coders listened to the session recording, took detailed notes, and assessed for the absence or presence of each ECCA item for every 5-minute interval. Coders were instructed and trained to code explicit behaviors and not intended behaviors. Once standardized coders listened to the entirety of all session recordings provided by therapists, coders made global extensiveness ratings assessing the thoroughness and frequency of the therapists' use of strategy or coverage of a topic throughout the session. Coders rated observed extensiveness of each item on a 7-point Likert-type scale (0 = *Not at all* to 6 = *To a great extent*). Examination of double-coded sessions showed strong inter-rater reliability (ICC > .40) for 31 of the 34 ECCA items with a mean ICC of .74 (Range = .44-.92). The three items with poor reliability (ICC < .40) were omitted from analyses.

ECCA composite extensiveness scores were calculated by taking the average of each of the ECCA items within the specific target of the session. For instance, for a session in which Anxiety was the specific target, the mean extensiveness score across all the Anxiety ECCA items was used as the ECCA composite score. Therefore, each session's ECCA score represents the ECCA composite that corresponded to the specific child mental health target of the EBP for that

session. When therapists delivered MAP (which can be used to treat multiple problem targets), they indicated the problem target for the youth client and this dictated the ECCA composite used for that session. In order to address differences in ECCA scores that are a result of different specific EBP targets and not necessarily differing degrees of EBP intensity (i.e., ECCA composite), the youth problem target was included as a covariate when modeling the ECCA composite as the outcome.

EBP attitudes. Therapists' attitudes toward EBPs was assessed through the Perceived Characteristics of Intervention Scale (PCIS). The 8-item *PCIS* (Cook et al., 2014) taps into perceived characteristics of practice innovation that theoretically are likely to influence therapists' own attitudes toward and delivery of each of the six EBPs examined in the present study. Therapists rated their agreement with each of the eight items assessing therapists' sense of *Relative Advantage* (e.g., "[The practice] is more effective than other therapies I have used."), *Compatibility* (e.g., "[The practice] is aligned with my clinical judgment."), *Complexity* (e.g., "[The practice] is easy to use."), and *Potential for Reinvention* (e.g., "[The practice] can be adapted to meet the needs of my patients.") on a 5-point Likert-type scale (1 = *Not at all* to 5 = *A very great extent*). The therapists' responses to the eight items were averaged for each EBP they reported using. Some therapists reported using more than one EBP and therefore reported separate PCIS scores for each EBP they utilized in treatment. In these cases, the mean of the different PCIS scores were calculated as therapist-level variables. From the therapist responses currently available, the measure showed good reliability for each EBP ($\alpha_{CBITS} = .99$, $\alpha_{CPP} = .92$, $\alpha_{MAP} = .89$, $\alpha_{SS} = .92$, $\alpha_{TF-CBT} = .95$, $\alpha_{Triple-P} = .97$) and a mean reliability of $\alpha_{mean} = .94$.

Results

Research Question 1. How do therapists respond to in-session youth engagement challenges?

Coding Reliability

Of the total number of sessions identified for therapist behavior coding, 25% were coded by a secondary coder in order to assess inter-rater reliability. Table 6 presents the therapist response codes and their corresponding intraclass coefficients (ICCs). Of the 14 total therapist response codes, 10 out of 14 demonstrated acceptable reliability as evidenced by ICCs greater than .40 (mean ICC = .66, range: .48-.74). The four therapist response codes with ICCs below .40 were omitted during data analysis (i.e., seeking client input, incorporating client input, troubleshooting client-identified difficulties and provide corrective instruction, developing a plan to address barriers). These codes were observed at a relatively low base rate by the initial coder (e.g., troubleshoot or provide corrective instruction was observed in 17 out of the 236 sessions coded).

Modeling of Response Factors

A three-level confirmatory factor analysis (CFA) was conducted to examine the fit of a model specifying three therapist response factors indicated by the set of therapist response codes described above. The CFA was conducted using Mplus 8.0 (Muthén & Muthén, 2017) with the codes nested within the session level: relational strategies, cognitive behavioral strategies, and desistance behaviors. At the client and therapist levels, all response items were modeled as one factor. In order to accommodate the complexity of a three-level CFA with multiple factors, indicators were binary variables indicating presence or absence of a given response. Because fit indices are currently not available for three-level CFAs, factor loadings were examined for

appropriateness of the factor structure; Factor loadings above .40 were judged to represent appropriate fit (Floyd & Widaman, 1995). As depicted in Figure 5a, each of the indicators for relational responses (standardized loadings Range = .49-.69), cognitive behavioral responses (standardized loadings range = .48-.87), and desistance behaviors (standardized loadings = .62) were above the acceptable cutoff of .40 (Floyd & Widaman, 1995).

A second three-level CFA was conducted with psychoeducation omitted as one of the indicators on the cognitive behavioral strategies factor for forthcoming analyses examining the association between therapists' response strategies and the ECCA (which also includes psychoeducation as an indicator). As depicted in Figure 5b, each of the indicators for relational strategies (standardized loadings range = .63-.87), cognitive behavioral strategies (standardized loadings range = .44-.95), and desistance behaviors (standardized loadings = .60) were above the acceptable cutoff of .40 in the trimmed model (Floyd & Widaman, 1995).

Response Code Descriptives

Stata 14.2 (StataCorp) was used to characterize the frequency with which therapist responses occurred in treatment sessions within the sample. Frequency of occurrence and mean extensiveness ratings of the individual therapist response codes were calculated. Extensiveness ratings were calculated only among sessions in which a coder observed a given therapist response in order to distinguish between the extensiveness of a response across all sessions versus the extensiveness of a sessions only when it is applied. This helped elucidate if some therapist responses were infrequently observed, but when noted, were seen at high levels of intensity.

Figure 2 presents the frequency and extensiveness with which each of the therapist response codes was observed during the treatment session. Figure 3 presents the frequency and

extensiveness with which therapist response codes were observed during the treatment session. Therapists were observed to display positive affect (92.37%) and comment on client's efforts and strengths (86.02%) in almost every session in response to an engagement challenge. Therapists were observed to normalize, validate, and reflect on client experiences (69.92%) and provide psychoeducation (58.47%) more than half the time an engagement challenge occurred. Less frequently observed were therapists communicating partnership (42.80%), relenting or ending session early (35.17%), assessing for barriers (33.47%), labeling client engagement (24.15%), eliciting change talk (21.61%), and expressing negative affect (12.29%). Despite the wide range of frequency observed, in sessions where the respective response was observed, responses were consistently coded as low-to-moderate in extensiveness on average (range = 1.62-3.29).

Frequency and extensiveness were also examined within the response composites substantiated in the aforementioned CFAs (see Figure 4). Based off the results of the CFA, composite variables for each of the response factors are calculated by taking the mean of each of the therapist response codes within a given factor. For instance, the relational response composite was calculated by taking the mean of the extensiveness scores for the following response codes: normalize/validate/reflect, communicate partnership, express positive affect. Two versions of the cognitive behavioral response composites were created with and without the psychoeducation code. Table 8 presents correlations between response codes, including within the relational, cognitive behavioral, and desistance items.

Relational (97.46%) and cognitive behavioral responses (94.07% with psychoeducation, 91.95% without psychoeducation) were examined in nearly every treatment session coded. Desistance behaviors were observed in less than half (41.53%) of sessions. In sessions where the

respective response was observed, codes were rated as low-moderate in extensiveness (range = 2.08-2.74) regardless of response factor.

Research Question 2. What session, client, and therapist characteristics predict therapists' responses to in-session youth engagement challenges?

Data Clustering

Linear mixed models were conducted using Stata 14.2 (StataCorp LP, College Station, TX). For the present study, sessions were nested within clients within therapists within agencies. In order to determine which levels of clustering are necessary to account for in the statistical modeling, a series of null models with the therapist response composites as the outcome. As indicated by the intraclass correlation coefficient (ICC), clustering was less than 5% at the agency level for the null models predicting relational responses ($ICC_{Agency} < .001$), cognitive behavioral responses ($ICC_{Agency} = .04$), and desistance responses ($ICC_{Agency} = .03$). As such, accounting for agency-level clustering was deemed unnecessary for subsequent analyses (Hayes, 2006). ICCs were markedly higher for the therapist-level ($ICC_{Relational} = .22$, $ICC_{Cognitive Behavioral} = .29$, $ICC_{Desistance} = .14$) and client level ($ICC_{Relational} = .25$, $ICC_{Cognitive Behavioral} = .35$, $ICC_{Desistance} = .20$). Thus, subsequent modeling was done using three-level models accounting for the session, client, and therapist levels.

Predictive Modeling

Based off the confirmatory factory analysis performed in Research Question 1, a series of models each predicting extensiveness of one of the three therapist response factors as the outcome variable were conducted. Client demographic information such as client age, client gender was included as Level 2 predictors of therapist response (Level 1). Therapist attitudes and background characteristics were included in Level 3 as potential predictors of therapist

response to engagement challenges. At Level 1 (Session level) characteristics of interest included (1) the specific EBP utilized in session, (2) EBP problem target, (3) observer-coded engagement challenges to treatment, and (4) observer-coded therapist response. Below is one such example of a random coefficient model tested in the present analyses:

$$\text{Level 1: Response}_{ijk} = \pi_{0jk} + \pi_{1jk}(\text{Presenting problem}_{ijk}) + \pi_{2jk}(\text{Practice}_{ijk}) + \pi_{3jk}(\text{Session length}_{ijk}) + e_{ijk}$$

$$\text{Level 2: } \pi_{0jk} = b_{00k} + b_{01k}(\text{Client age}_{jk}) + b_{02k}(\text{Client ethnicity}_{jk}) + b_{03k}(\text{Client gender}_{jk}) + r_{0jk}$$

$$\pi_{1jk} = b_{10k} + r_{1jk}$$

$$\pi_{2jk} = b_{20k} + r_{2jk}$$

$$\pi_{3jk} = b_{30k} + r_{3jk}$$

$$\text{Level 3: } b_{00k} = \gamma_{000} + \gamma_{001}(\text{Therapist age}_k) + \gamma_{002}(\text{Licensure}_k) + \gamma_{003}(\text{EBP attitudes}_k) + u_{00k}$$

$$b_{01k} = \gamma_{010} + u_{01k}$$

$$b_{02k} = \gamma_{020} + u_{02k}$$

$$b_{03k} = \gamma_{030} + u_{03k}$$

$$b_{10k} = \gamma_{100}$$

$$b_{20k} = \gamma_{200}$$

$$b_{30k} = \gamma_{300}$$

In the above equation, Response_{ijk} refers to the extensiveness of the therapist response (e.g., relational, cognitive behavioral, desistance) within session i for client j of therapist k . Response scores range from 0, indicating absence of the therapist response behavior, to 6, indicating great extensiveness of the response.

Continuous predictors (e.g., client age, therapist age, and therapist EBP attitudes) were grand mean centered prior to conducting analyses. As such, the intercept (π_{0jk}) represents the average extensiveness rating for a given response code when the client gender is female and the therapist is not licensed. The magnitude of coefficients represents the degree of association with therapist response code extensiveness and a given predictor variable's deviation from the grand mean.

Associations Between Engagement Challenges and Relational Responses

Table 9 presents results to the three models examining how background variables and client expressed concerns versus disengaged behaviors may be differentially associated with relational, cognitive behavioral, and desistance responses.

Disengaged engagement challenges were marginally associated with relational responses ($B = .23, p = .06$). Expressed engagement challenges were not significantly associated with relational responses ($B = .12, p = .33$). As in previous analyses, therapist PCIS scores were significantly negatively associated with relational responses ($B = -.21, p < .05$). Client male gender was negatively associated with relational responses ($B = -.28, p < .05$), such that when the client was male, therapists were observed to use relational responses less extensively.

Associations Between Engagement Challenges and Cognitive Behavioral Responses

Disengaged engagement challenges were significantly positively associated with cognitive behavioral responses ($B = .29, p < .001$). In other words, the more disengaged the client was observed to be, the more the therapist was observed to use cognitive behavioral responses. Expressed engagement challenges were not significantly associated with cognitive behavioral responses ($B = .06, p = .42$). Client age was negatively associated with cognitive behavioral responses ($B = -.03, p < .05$).

Associations Between Engagement Challenges and Desistance Responses

Both expressed ($B = .30, p < .01$) and disengaged engagement challenges ($B = .29, p < .01$) were associated with desistance responses. In other words, the more engagement challenges were observed, the more therapists were observed to act with desistance responses. Therapist multi-lingual ability was associated with more extensive desistance responses ($B = .37, p < .01$).

Research Question 3. How do therapists' responses to client engagement challenges predict extensiveness of therapist delivery of EBP strategies?

Data Clustering

Similar to procedures in Research Question 2, empty mixed linear models within a four-level structure of sessions nested within clients nested within therapists within agencies were conducted. ICCs were examined to determine the appropriate number of levels to account for in the subsequent modeling.

Data clustering was also examined using a null model with the ECCA composite as the outcome. ICCs were negligible at the agency-level ($ICC_{Agency} = .02$). ICCs indicated that over 20% of the variance in the ECCA composite was attributable to therapist and client level variability ($ICC_{Therapist} = .26$, $ICC_{Client} = .42$). As such, subsequent modeling was done using three-level models accounting for the session, client, and therapist levels.

Predicting EBP Intensity

To answer Research Question 3, I examined the associations between observed therapist response behaviors with observational coding of therapist implementation of EBP strategies within each session using the mean ECCA extensiveness score for the target mental health problem.

The extensiveness of each therapist response factor was included in Level 1 as a predictor of interest. Background and demographic variables such as EBP problem target, practice, client age, client gender, therapist age, and therapist licensure status were included in each model as covariates in order to identify the impact of therapist behaviors above and beyond that of client and therapist demographics. Below is one example of a linear mixed model for this research question:

$$\text{Level 1: } ECCA_{ijk} = \pi_{0jk} + \pi_{1jk}(\text{Presenting problem}_{ijk}) + \pi_{2jk}(\text{Practice}_{ijk}) + \pi_{3jk}(\text{Response}_{ijk}) + e_{ijk}$$

$$\begin{aligned} \text{Level 2: } \pi_{0jk} &= b_{00k} + b_{01}(\text{Client age}_{jk}) + b_{02k}(\text{Client ethnicity}_{jk}) + b_{03k}(\text{Client gender}_{jk}) + r_{0jk} \\ \pi_{1jk} &= b_{10k} + r_{1jk} \\ \pi_{2jk} &= b_{20k} + r_{2jk} \\ \pi_{3jk} &= b_{30k} + r_{3jk} \end{aligned}$$

$$\begin{aligned} \text{Level 3: } b_{00k} &= \gamma_{000} + \gamma_{001}(\text{Therapist age}_k) + \gamma_{002}(\text{Licensure}_k) + u_{00k} \\ b_{01k} &= \gamma_{010} + u_{01k} \\ b_{02k} &= \gamma_{020} + u_{02k} \\ b_{03k} &= \gamma_{030} + u_{03k} \\ b_{10k} &= \gamma_{100} \\ b_{20k} &= \gamma_{200} \\ b_{30k} &= \gamma_{300} \end{aligned}$$

The intercept (π_{0jk}) represents the average ECCA score for a given practice and presenting problem, when the Response extensiveness, client age, and therapist age are all at the level of the overall sample mean. The coefficient π_{3jk} represents the association between the extensiveness of a given therapist response and EBP strategy delivery as assessed via the ECCA.

In the three-level model with ECCA composite as the outcome, the cognitive behavioral engagement strategies variable was computed without psychoeducation included in the composite so as not to conflate associations between the cognitive behavioral response variable and the ECCA composite variable that also includes psychoeducation. Therapist, client, and session level characteristics in the previous analyses were retained as covariates in the final model. As the ECCA composite score differed as a function of the EBP problem target, EBP problem target was included as a covariate in the model. Results are meant to represent that associations between response behaviors and ECCA composite regardless of EBP problem target.

As presented in Table 10, observed cognitive behavioral responses were significantly positively associated with the session ECCA composite ($B = .26, p < .01$) and observed desistance behaviors were significantly negatively associated with the ECCA composite ($B = -.11, p < .05$). Therapists' relational responses were not significantly associated with the ECCA composite ($B = -.01, p = .83$). Therapist male gender ($B = -.26, p = .06$) and PCIS ($B = .12, p$

= .06) were marginally associated with the ECCA composite. Neither expressed engagement challenges ($B = -.03, p = .67$) or disengaged engagement challenges ($B = -.07, p = .40$) were associated with EBP delivery.

Discussion

The present dissertation sought to answer three primary questions: (1) How do therapists respond to in-session youth engagement challenges?, (2) What session, client, and therapist characteristics predict therapists' responses to in-session engagement challenges encountered in the delivery of EBPs with youth clients?, (3) What is the association between therapists' responses to client engagement challenges and the intensity with which EBPs are delivered in the same session?

First, through observationally coding therapists' behaviors following an initially observed youth client engagement challenge, therapists were found to frequently employ at least one of several engagement strategies. In almost every session where an engagement challenge was observed, therapists were also observed to employ a relational strategy (97.46% of sessions) *and* a behavioral strategy (94.07%), suggesting that within the context of delivering an EBP, therapists are actively infusing strategies to encourage engagement and participation among their youth clients through diverse means. Though relational and cognitive behavioral strategies differ in their content, community therapists within our sample use them in tandem and to similar levels of low-moderate extensiveness. This combined relational and cognitive behavioral approach to treatment engagement is in line with previous conceptual frameworks and empirical data underlining the need to attend to both attitudinal and behavioral engagement (Becker et al., 2013; Dorsey et al., 2014; Ingoldsby, 2010; Jungbluth and Shirk, 2009; Lindsey et al., 2013).

Interestingly, therapists were also observed to demonstrate desistance behaviors following an initial engagement challenge. Though these responses were observed considerably less often than relational and cognitive behavioral engagement strategies, they were still present in 41.53% of sessions following an engagement challenge, although when present they were observed at lower levels of extensiveness relative to the other responses. Within the desistance behaviors, *relenting or ending session early* was most often observed. That is to say that in approximately one-third of sessions in which an engagement challenge was detected, therapists derailed from their session activity or ended sessions prematurely, perhaps setting the stage for lower intensity and dose of EBP delivery across an episode of care (Patterson & Chamberlain, 1994). It is possible that desisting responses to engagement challenges encountered by community therapists during the delivery of EBPs may in part explain the drop off in EBP effectiveness in routine care settings.

It is worth noting that we had difficulties reliably coding certain types of therapist responses to youth engagement challenges. There are multiple potential explanations for this, including insufficient coder training or overly subjective description of behavioral codes. However, another potential contribution was that these codes corresponded to low base-rate therapist behaviors. For example, the code for therapist troubleshooting and scaffolding youth clients learning did not meet reliability criteria and was identified in only 17 instances by any coder. Use of behavioral rehearsal strategies are also among the behaviors that are challenging for therapists to reliably report (Ward et al., 2013). The relatively low frequency with which responses that involved directly addressing engagement barriers through active teaching and rehearsal strategies align with the overall low intensity of the very strategies that include in vivo

practice within community treatment settings that tend to drive client outcomes (Bearman et al., 2013; Beidas, Cross, & Dorsey, 2014; Garland et al., 2010, 2013; Waller & Turner, 2016).

In addition to characterizing the typography of therapists' responses to engagement challenges, we found some patterns associated with child client characteristics. Girls tended to receive more extensive relational responses in response to engagement challenges than boys, and therapists tended to respond to engagement challenges with younger clients with more cognitive behavioral responses. Therapists' tendency to respond to girls with more warmth and positive affect and active supportive listening strategies, cannot be readily explained by therapist-client gender-match driving the increase in relational responses or presenting problem type (Wintersteen, Mensinger, & Diamond, 2005), as these variables were covaried in the model. Likewise, EBP problem target (e.g., trauma) was also controlled for, thus the increase in relational responses for is unlikely due to target problem presentation. Problem target aside, youth's affective presentation in the room may partially explain the differential therapist response by client gender (Southam-Gerow & Kendall, 2002). Generally, boys often present more negative emotion and externalizing emotions such as anger, whereas girls tend to exhibit more internalizing emotions such as sadness and anxiety (Chaplin & Aldao, 2015; Cole Zahn-Waxler, & Smith, 1994; Hankin et al., 1998). It is plausible that girls in the current sample presented with more internalizing emotions, which in turn elicited more empathic relational responses from therapists encountering an engagement challenge. This is consistent with past findings that psychiatric care providers tend to exert more structure and attempt to control externalizing emotions and behaviors, whereas internalizing problems tend to elicit more warmth and support (Van Dam et al., 2011). There were no child gender differences in the extensiveness

of therapists' behavioral nor desistance responses, suggesting a specific type of gendered response occurring in the therapy room.

Therapists' mean extensiveness of behavioral engagement responses were higher for younger clients than older ones. However, client age was not associated with differential extensiveness of relational or desistance responses among therapists despite the correlations between relational, behavioral, and desistance response clusters. This association was largely driven by differences in therapists commenting on the client's strengths and efforts in session by client age. Therapists were observed to provide verbal positive reinforcement through this code much more extensively with their younger clients than older clients. We did not find significant differences in any other cognitive behavioral response codes by client age, suggesting that therapists were not limiting their use of behavioral responses with young clients to commenting on strengths and efforts alone. As we found a positive association between behavioral engagement responses and EBP delivery, increasing acknowledgment of efforts to participate in the session and strengths and subsequent signaling of preferred behaviors with older clients may be indicated.

Otherwise, we found that few therapist, session, and client characteristics were significantly associated with different response factors. Therapists with different levels of background experience, race, and gender were not observed to differentially rely on relational, behavioral engagement and were not systematically more likely to desist from the EBP in the face of engagement challenges. This is one of the first studies to examine associations between engagement responses and therapist background among a diverse sample of community therapists. Therapist background and experiences are not often examined for their potential role in engagement strategies in engagement intervention RCTs given the homogeneity of therapists

often included in RCTs (e.g., Nock & Kazdin, 2005). But, even when the sample includes a diverse, community sample of therapists, researchers often look to client and organizational characteristics' relation to engagement strategies and not the therapist own training and experiences (e.g., Haine-Schlagel et al., 2016). Looking to the EBP practices literature (and not strictly client engagement), we also see that there are no differences in EBP delivery by therapist background and experience level within community settings (e.g., Brookman-Frazee et al., 2010). The lack of significant associations by other client factors suggests that for the most part, therapists are using relational, behavioral, and desistance behaviors at similar rates and intensity for different clients and presenting problems. It did not appear that specific presenting problem targets were associated with differences in engagement responses. In the current study, racial/ethnic disparities in engagement responses were not apparent.

Instead, we do see that the extensiveness and types of engagement challenges were associated with the extensiveness of different types of therapist responses observed. For one, both youth expressed concerns and disengaged behaviors were associated with desistance behaviors. In other words, the more intensely youth and children complained about the helpfulness or feasibility of intervention or showed reluctance *or* refusal to participate in activities, the more likely therapists were to respond with negative affect and end the therapeutic activity at hand. These findings echo previous findings of desistance occurring in response to parent resistance (Patterson & Forgatch, 1985; Patterson & Chamberlain, 1994). Disengaged engagement challenges were also significantly associated with cognitive behavioral responses and desistance behaviors and marginally associated with relational behaviors, suggesting that within sessions in which a client was disengaged, therapists tend to respond with a variety of strategies across clusters. It appears that when youth appear disengaged, therapists make attempts

to elicit cognitive and behavioral engagement in their clients. Therapists may perceive such passive disengagement as reluctance, apprehension, or perhaps even fatigue and see promise in cognitive and behavioral engagement intervention in eliciting more client activity in session, unlike expressed challenges which therapists may construe as client resistance (Patterson & Forgatch, 1985). Especially in the context of mandated EBP delivery and increased EBP training, therapists in the current study may elect to utilize additional EBP-related strategies in order to evoke client engagement and participation. We also found that disengaged engagement challenges were only marginally associated with relational responses. Therapists may find it more difficult or less appropriate to try to connect with disengaged youth, and instead may be more likely to take an active or directive approach.

Conversely, expressed engagement challenges specifically were not associated with relational or cognitive behavioral responses; Only desistance responses were linked with expressed engagement challenges, the extent to which youth actively communicated concerns regarding the feasibility/acceptability of the intervention or were disruptive. Though this may certainly present a challenge to client engagement, raising concerns about the intervention may also signal active participation in session activities (Guan et al., under review). For instance, a client may bring up expected difficulties in implementing a skill, leering about the relevance of session activities to his/her situation, or skepticism of the treatment approach, each of which are likely to occur in the face of clients actively considering therapists' suggestions or following session activities. It is disappointing to see that in the current sample there was no significant link between expressed engagement challenges and relational or cognitive behavioral responses, given the potential opportunity these specific challenges may present for collaborative activity. Instead, the current data suggests that expressed engagement challenges may be construed as

resistance and met with greater therapist desistance rather than support or treatment facilitation (Patterson & Chamberlain, 1994).

Subsequently, we found that desistance behaviors were associated with decreased EBP intensity as measured by the extensiveness of EBP essential component delivery. Previous studies have found that expressed engagement challenges were related to therapists' self-reported difficulty carrying out intended activities in the same session (e.g., Gellatly et al., under review) and as potential obstacles to robust EBP delivery overall (e.g., Becker et al., 2018), but have rarely sought to identify the mechanism by which EBPs are derailed or their delivery diminished (Patterson & Chamberlain, 1994 being one exception). The current study provides preliminary evidence that therapist desistance behaviors may mediate the link between youth engagement challenges and the voltage drop in EBP delivery, a pattern similar to that earlier seen in parent-mediated interventions (Patterson & Chamberlain, 1994; Patterson & Forgatch, 1985). Regardless, it is important to note that the current sample of therapists was relatively inexperienced, being primarily unlicensed and on average had been practicing for less than five years. It is plausible that further experience may mitigate the association between engagement challenges and desistance behaviors. As such, findings point to an important area of training for therapists. Education that supplements therapist self-awareness around his/her own responses to engagement challenges and their subsequent links to EBP delivery may help offset the troubling link between engagement challenges, desistance, and EBP interference we found in the current study.

With this being said, there may be some instances in which desistance behaviors might be reasonable or unavoidable. For instance, should safety concerns arise in session, regularly scheduled activities must be tabled, and the client's safety attended to. Similarly, in the case of

severe emergent life events (ELEs) or clients' unexpected, acute events, therapists may need to put the EBP protocol aside or otherwise risk being dismissive or invalidating of the client's experience of a serious emergent event (Guan et al., in press). Though planned activities may be deflected, ELEs may provide opportunities for in-session rehearsal and generalization of relevant therapeutic skills (Guan, Boustani, & Chorpita, 2018). Thus, desistance in the form of relenting to the client's preferred topic or activity when there is a safety concern or ELE may be beneficial to attend to client safety, preserve the therapist-client relationship, and promote EBP delivery in future sessions.

An unanticipated finding was that therapists' positive perceptions of the EBP being delivered were negatively associated with the extensiveness of their relational responses to youth engagement challenges. It is possible that the higher the therapists' regard for an EBP's utility, appeal, and adaptability, the more committed they were to adhere to the EBP protocol at hand and thus they may have not spent as much time empathizing or validating youth concerns about the intervention. However, if this were the case, we might have expected therapist EBP perceptions to be significantly negatively associated with desistance responses and or positively associated with overall observed extensiveness of EBP strategy delivery. Instead we found that therapist PCIS scores were only marginally positively associated with ECCA composite scores and not associated with desistance responses. As such, therapists who endorse the appeal and fit of the EBP may express positive affect, normalizing and validate the youth's concerns, but at lower levels than therapists who have less favorable impressions of the EBP. Consistent with this interpretation, base rates of relational responses were very high, with overall extensiveness of these responses being slightly higher compared to behavioral and desistance responses. In general, future research is needed to understand the transaction between relational responses and

cognitive behavioral responses to engagement challenges, the degree to which there may be opportunity costs associated with high levels of one versus the other, and their potential interplay in predicting implementation outcomes.

Overall, community therapists are confronted with environmental, cultural, familial, and systemic factors that may compromise therapist implementation of EBPs and/or clients' response to interventions (Weisz et al., 2015). These include complex presenting problems and histories married with comorbid disorders, trauma backgrounds, access issues, language barriers, cultural differences, and stressors related to poverty and socioeconomic disadvantage. Yet, we were heartened to find that despite this, therapists primarily responded to challenges to youth engagement in treatment session with active strategies to elicit participation. Disengaged engagement challenges were associated with desistance behaviors, but disengaged engagement challenges were also met with significantly more therapists' cognitive behavioral responses and marginally more relational responses. Assessing barriers to engagement, eliciting change, and labeling client engagement and so forth were in turn associated with greater EBP delivery as measured by the ECCA. Thus, the current study provides evidence that community therapists are able to deliver EBP elements in the face of session-level engagement challenges. Further research is needed to understand the implications of therapist responses patterns for client level outcomes including therapist-client alliance, therapists' treatment persistence across a treatment episode, and client symptom/functioning outcomes, particularly within community settings.

Findings also point to avenues for intervening with therapist training that may help increase EBP implementation outcomes for our most vulnerable youth in the community. In addition to previously discussed findings showing the negative relationship between desistance behaviors and EBP delivery, we found that cognitive behavioral responses, but not relational

responses were significantly positively associated with EBP delivery. That is, assessing barriers, eliciting motivation to change, and providing feedback on client engagement, efforts, and strengths appeared to enable therapists to provide EBP elements to a greater degree. These strategies were already associated strong EBP delivery, attendance, and treatment outcomes in previous studies and reviews (e.g., Becker et al., 2015; Becker et al., 2018; Nock & Kazdin, 2005; Staudt, 2003). Relational strategies, on the other hand, which were also demonstrated with be associated with greater engagement and treatment outcomes (Becker et al., 2018; Haine-Schlagel et al., 2016; Lindsey et al., 2014) were not associated with intensity of EBP delivery above and beyond the effects of behavioral strategies in the same model. This may suggest that if therapists must prioritize one type of response to elicit engagement and participation when in the midst of a session, a behavioral strategy may be most advisable. However, this must be considered with the caveat that responses falling within the behavioral engagement umbrella often most resemble EBP elements. Although efforts were taken to not mistakenly conflate therapist responses with EBP delivery (i.e., ECCA items), some overlap may continue to persist. Nonetheless, extensive training in behavioral strategies look to not only help boost engagement strategies but also broadly bolster EBP strategies and skills.

When employed, the average extensiveness of relational strategies and behavioral strategies was at low-moderate extensiveness. Even when looking at the individual response items, average extensiveness ranged from low to moderate (1.62-3.29 out of 6). Indeed, there is room for therapists to increase the intensity and frequency of these behaviors to match the engagement challenge in the room. Trainings often focus on learning the tenets of a manualized treatment and delivering EBP components with high fidelity. However, less attention is paid to addressing engagement challenges that inevitably arise during sessions. Future trainings for

therapists that (1) teach cognitive behavioral engagement strategies in response to youth engagement challenges, (2) emphasize the relation between cognitive behavioral response strategies and overall EBP delivery, (3) model the full range of potential response available to therapists, and (4) encourage sustained use of cognitive behavioral responses in treatment sessions following an engagement challenge may help boost the real-world effectiveness of EBPs (Becker et al., 2015; Becker, Boustani, Gellatly, & Chorpita, 2018).

Limitations

Certainly, study findings need to be considered in light of limitations. One study limitation lies in the lack of inter-rater reliability for codes previously conceptualized to be pertinent to in-session treatment engagement. We were not able to establish inter-rater reliability for four of the fourteen conceptualized therapist response codes within the current study. Although disappointing, potential reasons for low reliability for codes may be illuminating. Low base rates of codes, differences in youth-only treatment, and use of treatment-naïve coders were likely obstacles to establishing reliability. For *troubleshooting client-identified difficulties*, the lack of reliability is likely in part due to the very low base rate of observations. This code points to in-vivo practice and discussion to address client-identified challenges and was noted in only 7% of sessions, the low denominator likely making it difficult for coders to reach reliability. The low base rate at which troubleshooting was observed points to an interesting pattern in therapist response behavior. Given that assessing barriers was observed in approximately one third of sessions, it appears that even when assessment was done, troubleshooting to address an identified barrier was not commonly seen.

Though *developing a plan* was observed in almost a third of sessions, coders were not able to reliably rate the extensiveness to which therapists attempted to design ways to overcome

challenges to treatment engagement within the session. This may be due to the fact that most coders were psychotherapy-naïve undergraduate research assistants who may not have been able to differentiate between different levels of extensiveness to address a barrier given the wide variety of engagement challenges that come up in community mental health settings, spanning issues with transportation, issues related to income and poverty, and crises of the week. Indeed, the difficulty in establishing reliability with these codes is echoed in the difficulty for previous studies to establish reliability with a similar code “address barriers to participation” (Haine-Schlagel, Martinez, Roesch, Bustos, & Janicki, 2016).

It was simultaneously surprising and disappointing that we were not able to establish reliability via an ICC above .40 for *seeking client input* and *incorporating client input*, given that both codes were reliable in a previous study coding the in-session behaviors of community therapist participants (Haine-Schlagel, Martinez, Roesch, Bustos, & Janicki, 2016). However, two major distinctions exist the current and past studies. First, the current study includes youth-only sessions whereas that of Haine-Schlagel and colleagues includes parent-mediated sessions exclusively. Identifying when and to what extent therapists seek and incorporate client input may be less demanding when the repartee is between two adults than when it is between a therapist and child client. Second, Haine-Schlagel and colleagues examined sessions in which half intentionally tasked therapists with activity increasing parent and caregiver participation within treatment. Within the context of a study specifically teaching therapists to elicit parent and caregiver participation, it is likely easier to reliability detect and classify therapist behaviors. Additionally, seeking input was initially observed in 93.6% of sessions. This code may have been overly inclusive and difficult to assign an appropriate extensiveness score given how frequently (albeit at low intensity) it was observed by coders.

There were also limitations based on our research design. For one, the sampling of the session recordings was not conducted at random and therefore may not be representative of therapists' response patterns to engagement challenges across community settings. During the recruitment process and procedures, therapists were allowed to select which three clients they would like to supply three audio recordings of for study participation. Although the study team reminded therapists that they were not going to be judged or evaluated on their therapeutic skill and the study team encouraged therapists to provide examples that cover a range of different types of clients and session, the choice of which treatment sessions to submit for coding was ultimately up to therapists. Therefore, we cannot draw conclusions about the prevalence of specific therapist response behaviors within community mental health settings at large.

We were also limited in our ability to identify and codify in-session behaviors to what was explicitly observable within an audio recording. Indeed, there are many engagement challenges and therapist responses that may not be captured within an audio recording. The current study was not able to identify and codify clients' and therapists' facial expressions, body language, and gestures that very well may signal engagement and responsiveness to engagement/disengagement within the session.

Additionally, the dissertation utilized the temporal precedence of observable engagement challenges as a way to characterize subsequent therapist behaviors as a response to an engagement challenge. Observable therapist behaviors following an initial engagement challenge may not necessarily be in direct response to the engagement challenge. It is possible that therapists engage in these behaviors regardless of the presence or absence of an engagement behavior.

Finally, the current study focused on the relations between engagement challenges, therapist responses, and EBP delivery all *within* a treatment session and therefore all conclusions are limited to in-session behavior only. Future studies linking in-session behaviors to client outcomes, fidelity or adherence to a specific EBP, or engagement across sessions in community samples could help inform efforts to addressing the voltage drop in EBP delivery and efficacy in real world settings.

Conclusions

Collectively, study findings illuminate the myriad of ways that therapists currently respond to youth client engagement challenges within the context of EBP delivery. County and state public mental health systems are increasingly moving toward multiple EBP-promotion and even mandates for EBP delivery, and the current study sheds light on engagement strategies that are not intervention specific and lend themselves to high quality and high intensity EBP delivery. Limitations notwithstanding, the present dissertation addresses a clear gap in the literature by detailing the typography of community therapists' response behaviors following observed youth treatment engagement challenges when delivering EBPs. Whereas extant literature almost exclusively focuses on therapists' responses within the context of caregiver- and family-mediated interventions, the current study is solely focused on observable behaviors in youth-only treatment sessions. The study naturalistically examines how real-world community therapists are currently responding to in-session engagement challenges. The dissertation provides new practice-based evidence on therapist behaviors to support youth engagement in sessions and marks a first step toward guiding an evidence-based approach for in-session therapist responses to youth engagement challenges.

Tables and Figures

Table 1. Therapist behaviors associated with treatment engagement within a sample of studies and reviews

	<i>Engagement interventions</i>		<i>Review of engagement strategies in evidence-based interventions</i>					<i>Client focus groups</i>	<i>Session-level observational study</i>	<i>Potential in-session responses to engagement challenges</i>
	Haine-Schlagel et al., 2016	Nock & Kazdin, 2005	Becker et al., 2015b	Ingoldsby, 2010	Snell-Johns et al., 2004	Lindsey et al., 2014	Becker et al., 2018	Buckingham et al., 2016	Patterson & Chamberlain, 1994	
Attendance incentive; Accessibility promotion			X	X	X	X	X	X		
Assessment; Assessment of barriers	X	X	X	X		X	X			X
Behavioral contracting and response cost						X				
Case management, crisis management			X			X		X		
Communicating partnership; relationship/rapport building	X		X			X		X		X
Eliciting change talk, motivational enhancement strategies		X		X	X	X				X
Seeking and incorporating client input	X							X		X
Enhancing caregiver support, coping, and strengths				X	X	X				*
Goal and expectation setting						X	X	X		
Homework assignment			X			X				*
Recognizing client efforts/strengths; Praise; Reinforcement	X					X	X			X
Modeling						X				*
Monitoring/labeling client engagement							X		X	X
Problem solving, rehearsal						X	X			X
Psychoeducation	X	X	X			X	X	X		X*
Relenting or ending activity/session									X	X
Support networking, peer pairing			X			X				

Supportive listening, validating and reflecting client concerns/culture, expressing genuine care/hope for client	X		X		X	X	X	X	X	X
Therapist affect									X	X

Note. Psychoeducation is included in both the Therapist Response observational coding system and the ECCA coding system. So as not to conflate associations between therapist responses and the ECCA, psychoeducation was omitted from the therapist response factors in analyses for Research Question 3. *Captured in the ECCA.

Table 2. Therapist background and demographic characteristics (N = 85; N_{missing demographics} = 5)

	<i>M</i>	<i>SD</i>	Range
Age (in years)	34.56	8.66	25-62
Caseload (in number of clients)	17.34	7.32	1-44
Years practicing therapy	4.80	4.80	0-35
Years at current agency	2.57	2.61	0-14
Client race as percent of caseload			
Non-Hispanic White	8.04	9.68	0-40
Hispanic	75.53	27.79	0-100
Black, African American	15.75	22.33	0-90
Asian American, Pacific Islander	0.33	1.52	0-10
American Indian or Alaska Native	0.10	0.89	0-8
Other	0.22	1.26	0-10
	N	%	
Therapist gender			
Female	68	85.00	
Male	12	15.00	
Therapist race			
Non-Hispanic White	19	23.75	
Hispanic	45	56.25	
Black, African American	7	8.75	
Asian American, Pacific Islander	9	11.25	
Staff type			
Staff	69	86.25	
Trainee	11	13.75	
Primary theoretical orientation			
Cognitive behavioral/Behavioral	57	71.25	
Humanistic	4	5.00	
Family systems	8	10.00	
Psychodynamic	4	5.00	
Eclectic/Other	7	8.75	
Licensure status			
Licensed	17	21.25	
Not licensed	63	78.75	
Highest level of education			
Bachelor's degree	1	1.25	
Master's degree	72	90.00	
Doctoral degree	7	8.75	

Table 3a. Client demographic characteristics (N = 149)

	<i>M</i>	<i>SD</i>	Range
Age (in years; N _{missing} = 9)	11.04	3.17	6-18
	N	%	
Client gender (N _{missing} = 9)			
Female	88	59.06	
Male	52	34.90	
Client race (N _{missing} = 9)			
Non-Hispanic White	6	4.03	
Hispanic	104	69.80	
Black, African American	21	14.09	
Asian American, Pacific Islander	3	2.01	
Other	6	6.04	

Table 3b. Session characteristics (N = 236)

	N	%
Practice		
Managing and Adapting Practice	135	57.20
Seeking Safety	18	17.63
Trauma Focused CBT	83	35.17
EBP Problem Target		
Conduct	52	22.03
Anxiety	44	18.64
Depression	36	15.25
Trauma	104	44.07
Session Location (N _{missing} = 95)		
Office	64	27.12
Home	39	16.53
Classroom, school setting	36	15.25
Other (e.g., church, restaurant)	2	0.85
Session Language		
English	231	97.88
At least some Spanish	5	2.12

Table 4. Observed client engagement challenges definitions

Engagement challenges code	Definition
1. Concerns about the helpfulness/ relevance/acceptability/feasibility	Client/caregiver expressed concerns that an intervention strategy may not be helpful/ relevant/ acceptable/ feasible for the youth/caregiver.
2. Unengaged/passive behavior	Client/caregiver demonstrated unengaged/ passive behavior as evidenced (e.g., responding to therapist questions with silence for a prolonged period, providing one-word responses, saying “I don’t know” or “I don’t care” repeatedly).
3. Reluctance/refusal to participate	Client/caregiver verbally expressed refusal/reluctance to participate.
4. Difficulty mastering skills or understanding concepts	Client/caregiver commented on slow progress or difficulty mastering a therapy skill either outside session or during session, or stated that concepts were unfamiliar (i.e., “I don’t get it”; “I’m having a hard time with this”).
	<p><i>Exemplars:</i></p> <ul style="list-style-type: none"> • <i>Therapist is engaging the child and encouraging them to share about his/her feelings. Youth: How? I don’t get it.</i> • <i>Therapist: You understand that statement? Youth: (long pause) I kind of understand it.</i> • <i>While filling out a cognitive restructuring worksheet Youth: I don’t know what a negative would be for being bit by spiders</i> • <i>While completing cognitive triangle worksheet Youth: Hitting is an action, right? Oh wait, you can’t tell me... This is hard!!</i> • <i>During role play Youth: I can’t do this! I don’t know what to say!</i>
5. Failure to complete assignments or out of session skill application/practice*	Client/caregiver stated that they did not complete assignments or out of session skill application/practice.
6. Negative affect	Client/caregiver expressed tone of voice expressed hostility, irritability, impatience, sarcasm, or other negative affect.
7. Disruptive behaviors	Client/caregiver displayed disruptive, destructive, aggressive, hyperactive or impulsive behaviors (including language).

Note. *Coded for absence/presence only. No global rating of extensiveness assigned for this code.

Table 5. Observed therapist response coding definitions

Therapist response code	Definition
1. Communicating partnership	Conveying client-therapist partnership (e.g., working toward common goal).
2. Normalizing, validating, and reflecting feelings and experiences	Normalizing client's concerns and challenges; validating client's statements or experiences; and/or reflecting back the client's underlying feelings.
3. Seeking client input	Asking client to provide input about causes and solutions to problems, goals/progress in therapy, or client involvement in therapy; asking client to provide input about comments/ suggestions offered by the therapist or child (or others); and/or providing opportunities for client to ask questions.
4. Incorporating client input	Describing how client input is helpful or will be used; explicitly using client input to inform session topics; adjusting therapeutic tasks based on client input; and/or collaborating with the client on preferences.
5. Eliciting change talk	Probing disadvantages of the status quo, advantages of change, optimism, and intention to change with the goal of increasing youth/family participation in treatment often by implementing strategies such as cost-benefit analysis, persuasion, or Socratic questioning or a variety of other approaches.
6. Assessment of barriers	Learning about barriers to participation during the session and therapist attempts to identify barriers.
7. Relenting or ending activity/session	Moving on to a different topic or activity instead of exploring further when engagement/treatment barrier is noted by observer rating; and/or premature session end wherein therapist explicitly ends session earlier than planned.
8. Commenting on client efforts and strengths	Commenting on client's effort to participate in session and/or praise for the client working hard, persisting or making attempts to practice skills.
9. Labeling client engagement	Commenting specific to the client's lack of effort or engagement, therapist's frustration with the client's behaviors or therapy engagement, or other related behaviors.
10. Providing psychoeducation	Providing psychoeducation about the nature of child problems in general, the nature of client specific symptomology, factors that may contribute to identified problem, the process of treatment, participants and their roles in treatment, and/or rationale for treatment model, skills, or strategies.
11. Therapist positive affect	Expressing positive affect as noted by tone of voice, diction, and overall affect.
12. Therapist negative affect	Expressing negative affect as noted by tone of voice, diction, and overall affect.
13. Developing a plan to address barriers	Developing a plan to address or overcome barriers that include soliciting support, giving advice/solutions, generating advice/solutions to address barriers, and prompting in-session practice/rehearsal/modeling/psychoeducation review/other practice content and techniques. Exclusively applies to planning and not the techniques themselves.
14. Troubleshooting client-identified difficulties and provide corrective instruction	Providing corrective instructional suggestions, corrective feedback, or scaffolding to client by making suggestions of new actions, making corrective feedback and adjustments to client's use of skills within session and outside of session, and/or coaching the client on how to make adjustments to a skill. Exclusively applies to addressing an identified difficulty/barrier in the client understanding/using content/technique (Engagement challenge #4).

Table 6. Inter-rater reliability analyses for therapist response codes in order of reliability

	ICC
1. Normalizing, validating, and reflecting	0.74
2. Providing psychoeducation	0.74
3. Commenting on efforts and strengths	0.73
4. Labeling client engagement	0.68
5. Therapist positive affect	0.67
6. Therapist negative affect	0.66
7. Eliciting change talk	0.65
8. Relenting or ending session/activity	0.63
9. Communicating partnership	0.52
10. Assessment of barriers	0.48
11. Seeking client input	0.12
12. Incorporating client input	0.12
13. Troubleshooting client-identified difficulties and provide corrective instruction	-0.10
14. Developing a plan to address barriers	-0.20

Table 7. ECCA Items

Item	Trauma Composite	Anxiety Composite	Depression Composite	Conduct Composite
<i>Techniques related to organizing/structuring treatment</i>				
Establishing/Reviewing Agenda/Treatment Goals	X	X	X	X
Psychoeducation	X	X	X	X
Tracking/Reviewing Client's Progress	X	X	X	X
<i>Techniques related to skill building</i>				
Modeling		X		X
Role Playing & Practice	X	X	X	X
Assigning/Reviewing Homework	X	X	X	X
Delivering Positive Reinforcement & Rewards				X
<i>Techniques related to engaging client/family</i>				
Family Engagement				X
End of Session Positive		X	X	X
<i>Content related to behavioral parent training</i>				
Stimulus/Antecedent Control				X
Praise	X	X		X
Tangible Rewards				X
Ignoring/Differential Reinforcement of Other Behaviors				X
Attending				X
Natural & Logical Consequences				X
Time Out				X
Commands				X
Behavioral Contracting				X
Self-Reward/Praise		X		
Monitoring	X	X	X	X
Problem Solving Training			X	X
Exposure	X	X		
Cognitive Restructuring	X	X	X	X
Activity Scheduling			X	
Talent or Skill Building			X	
Education Support/Academics				X
Maintenance/Relapse Prevention	X	X	X	X
<i>Content related to relating to others</i>				
Communication and Social Skills			X	X
Assertiveness Training			X	
Relaxation	X	X	X	X
Caregiver Coping				X
Common Reactions to Trauma	X			
Trauma Narrative	X			
Safety Skills	X			

Table 8. Pairwise correlations among therapist response codes

	1	2	3	4	5	6	7	8	9	10
1. Communicating partnership	--									
2. Normalizing, validating, and reflecting	.17**	--								
3. Therapist positive affect	-.01	.01	--							
4. Eliciting change talk	.08	.08	-.05	--						
5. Assessment of barriers	.24**	.21**	-.01	.07	--					
6. Commenting on efforts and strengths	.08	.11 [†]	.58***	.02	-.01	--				
7. Labeling client engagement	.06	-.11 [†]	.06	.10	.25***	.05	--			
8. Providing psychoeducation	.09	.27***	.02	.10	-.05	.18**	-.03	--		
9. Relenting or ending session/activity	-.03	.20**	.19**	.02	.10	.12	.08	.12 [†]	--	
10. Therapist negative affect	.27***	-.02	.02	.06	.21**	.07	.38***	-.15*	.10	--

Note. Correlations among relational response codes shaded in blue, among behavioral response codes shaded in green, and among desistance response codes shaded in orange. [†] $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .001$.

Table 9. Three-level model of engagement challenges and background variables predicting therapist response composites

	Relational Responses^a	Cognitive Behavioral Responses^a	Desistance Responses^a
	<i>B (SE)</i>	<i>B (SE)</i>	<i>B (SE)</i>
Intercept	2.29 (.51)***	.74 (.33)**	-.03 (.41)
<i>Therapist level</i>			
Therapist gender (Female)			
Male	.02 (.22)	-.07 (.15)	-.05 (.17)
Therapist race (Non-Hispanic White)			
Hispanic	.12 (.20)	.10 (.14)	-.10 (.15)
Other	-.11 (.22)	.03 (.15)	.10 (.17)
Language status (Monolingual)			
Able to provide treatment in non-English language	.07 (.17)	.16 (.12)	.37 (.13)**
Years of practice	.01 (.01)	-.01 (.01)	-.01 (.01)
<i>Client level</i>			
Client gender (Female)			
Male	-.28 (.14)*	-.01 (.09)	.17 (.12)
Client age	-.004 (.02)	-.03 (.01)*	-.01 (.02)
<i>Session level</i>			
Expressed engagement challenges ^b	.12 (.13)	.06 (.08)	.30 (.11)**
Disengaged engagement challenges ^b	.23 (.12) [†]	.29 (.08)***	.29 (.11)**
Session length (≤ 30 minutes)			
31-60 minutes	.14 (.27)	.01 (.17)	.06 (.23)
61-90 minutes	-.11 (.36)	-.17 (.23)	-.09 (.31)
EBP Problem Target (Conduct)			
Anxiety	-.06 (.21)	.16 (.13)	.16 (.17)
Depression	-.12 (.22)	.12 (.14)	.01 (.18)
Trauma	.08 (.19)	.16 (.12)	-.19 (.15)
PCIS	-.21 (.09)*	.05 (.06)	.04 (.07)

Note. ^aExtensiveness scores (range 0-6). ^bExtensiveness scores (range 0-4). For categorical variables, reference group in parentheses. [†] $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .001$.

Table 10. Three-level model of therapist responses predicting extensiveness of essential content and techniques

	ECCA ^a <i>B (SE)</i>
Intercept	.30 (.34)
<i>Therapist level</i>	
Therapist gender (Female)	
Male	-.26 (.14) [†]
Therapist race (Non-Hispanic White)	
Hispanic	-.001 (.13)
Other	.11 (.14)
Language status (Monolingual)	
Able to provide treatment in non-English language	.13 (.11)
Years of practice	-.01 (.01)
<i>Client level</i>	
Client gender (Female)	
Male	.05 (.09)
Client age	.001 (.01)
<i>Session level</i>	
Relational engagement responses ^a	-.01 (.05)
Cognitive behavioral engagement responses ^{ac}	.26 (.07)**
Desistance responses ^a	-.11 (.05)*
Expressed engagement challenges ^b	-.03 (.08)
Disengaged engagement challenges ^b	-.07 (.08)
Session length (≤ 30 minutes)	
31-60 minutes	.16 (.17)
61-90 minutes	.11 (.23)
EBP Problem Target (Conduct)	
Anxiety	.47 (.13)***
Depression	.30 (.14)*
Trauma	.34 (.12)**
PCIS	.12 (.06) [†]

Note. ^aExtensiveness scores (range 0-6). ^bExtensiveness scores (range 0-4). ^cPsychoeducation excluded in this composite. For categorical variables, reference group in parentheses. [†] $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .001$.



Figure 1. Hypothesized clustering of therapist response codes.

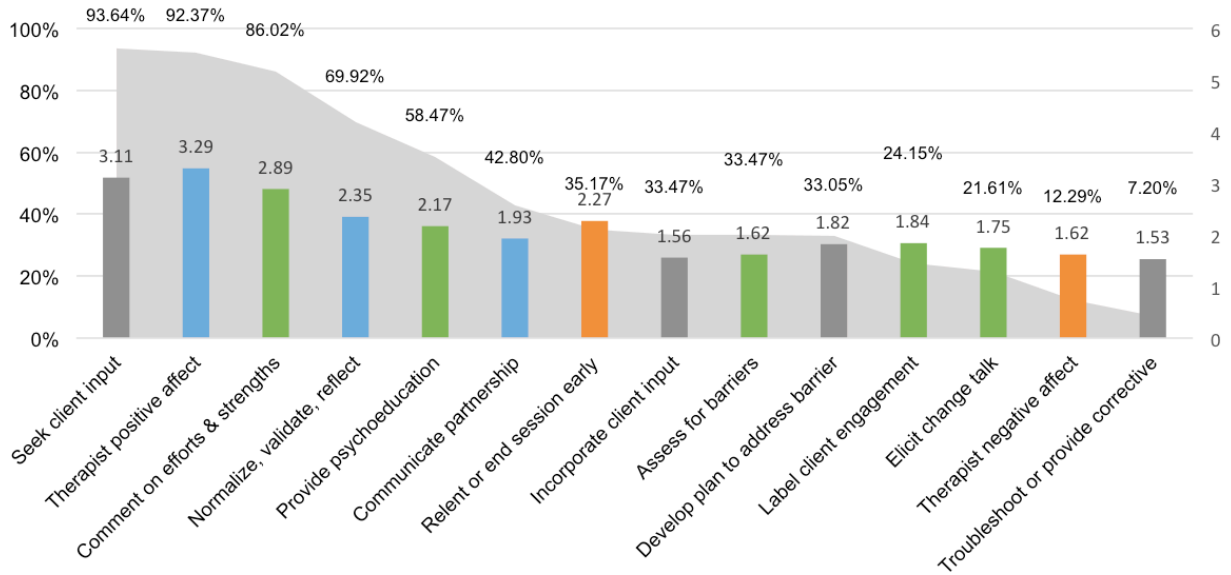


Figure 2. Frequency of therapist responses and mean extensiveness of all response codes among sessions in which the respective therapist response was observed.

Note. Bars represent the mean extensiveness of each code among sessions in which the code was observed. Mean extensiveness is reported immediately above each bar. Grey background represents the frequency with which each respective code was observed in coded sessions. Percent of sessions in which the code was observed is displayed above the frequency graph horizon. Relational response codes depicted in blue, cognitive behavioral response codes depicted in green, and desistance response codes depicted in orange. Response codes with ICCs < .40 are depicted in grey.

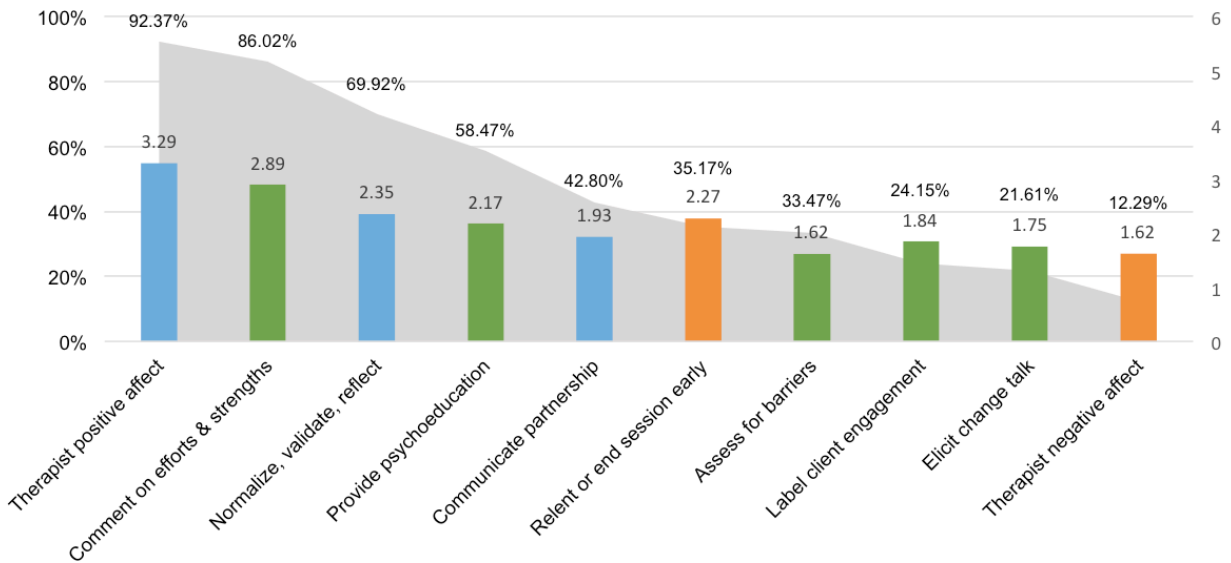


Figure 3. Frequency of therapist responses and mean extensiveness of response codes among sessions in which the respective therapist response was observed for codes with ICCs > .40.

Note. Bars represent the mean extensiveness of each code among sessions in which the code was observed. Mean extensiveness is reported immediately above each bar. Grey background represents the frequency with which each respective code was observed in coded sessions. Percent of sessions in which the code was observed is displayed above the frequency graph horizon. Relational response codes depicted in blue, cognitive behavioral response codes depicted in green, and desistance response codes depicted in orange.

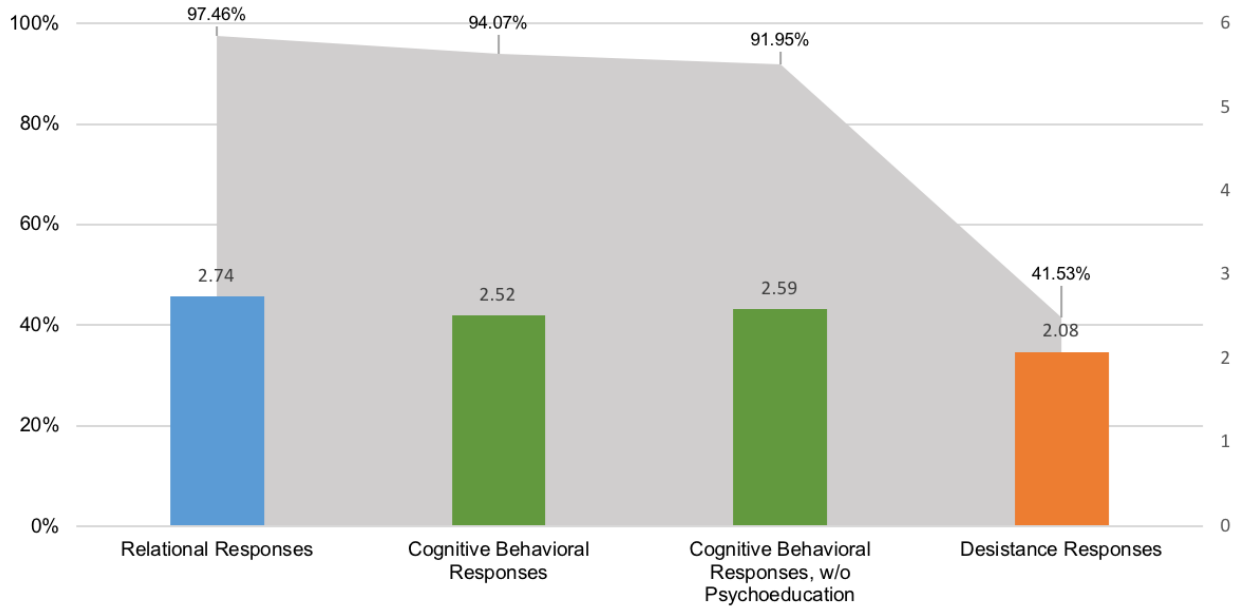


Figure 4. Frequency of therapist response composites and mean extensiveness of response composites among sessions in which the respective response was observed.

Note. Bars represent the mean extensiveness of each composite among sessions in which at least one code in the composite was observed. Mean extensiveness is reported immediately above each bar. Grey background represents the frequency with which each respective composite was observed in coded sessions. Percent of sessions in which the composite was observed is displayed above the frequency graph horizon.

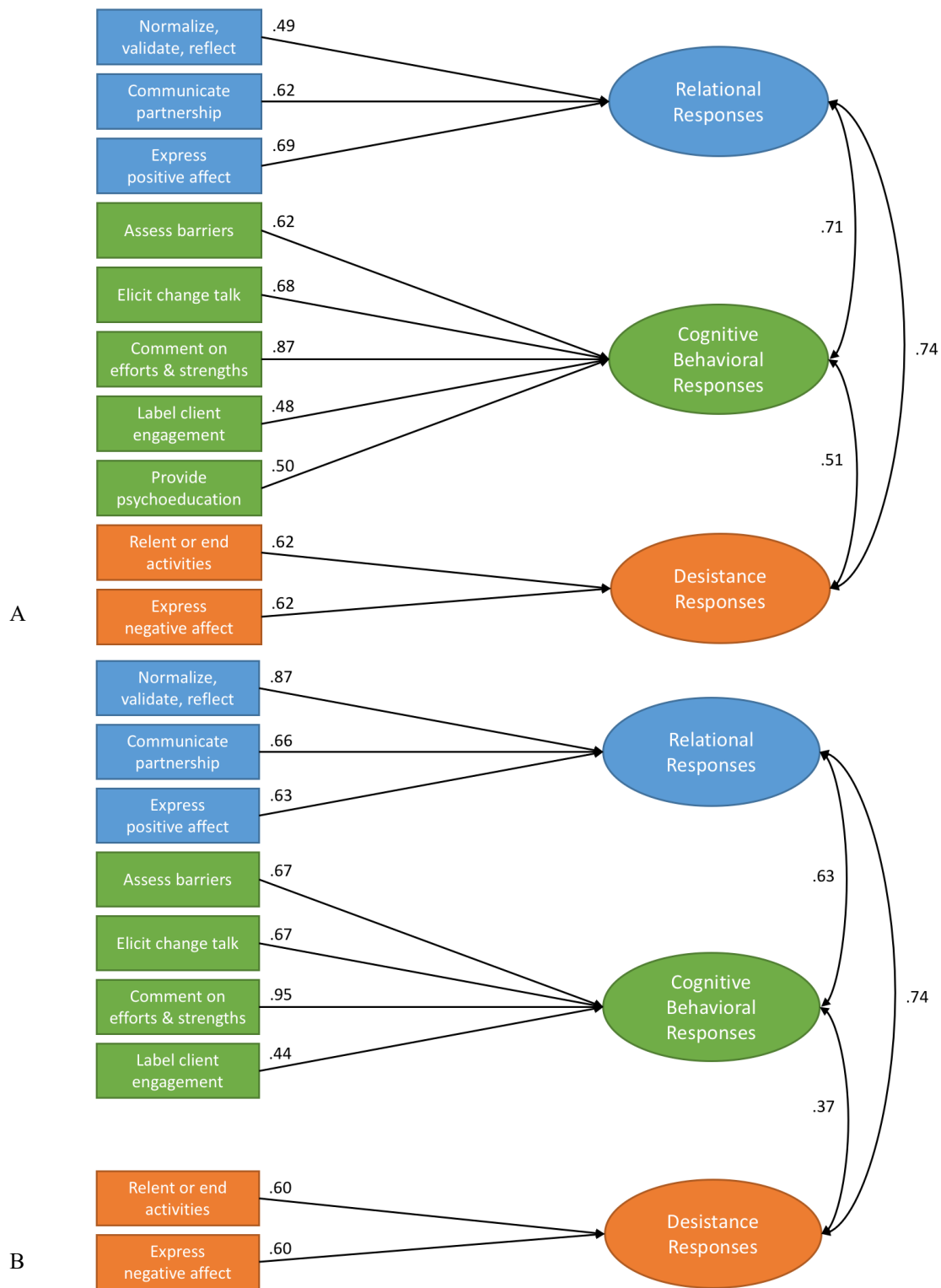


Figure 5. Confirmatory factor analyses of therapist response codes with psychoeducation (A) and without psychoeducation (B) included as an indicator in the cognitive behavioral responses factor.

Appendix A

**Coding Manual for
Therapists' Responses to In-Session Challenges to Client Engagement and Participation**

Coding Manual Developed By:
Joanna Kim, M.A.

With Support From:
Miya Barnett, Ph.D., Lauren Brookman-Frazee, Ph.D., Anna Lau, Ph.D., & Jennifer Regan,
Ph.D.

4/10/2017 Version – Revised from feedback following Preliminary Orals

Structure of the coding manual is adapted from the following:
AIM HI Coding Manual (Brookman-Frazee & Chlebowski, 2013)
Barriers to Implementation Coding Manual – 4KEEPS Version

I. PURPOSE OF CODING

Importance of reliability

The goal of the coding process is to obtain valid and reliable descriptive data about how therapists respond to barriers to client engagement and participation in therapy sessions. The potential validity of the codes is based, in part, on the extent to which the codes are used reliably by multiple coders. Reliability refers to the degree to which independent observers provide the same (or similar) ratings of the events that they observe. If two different coders were to use very different codes to describe the same therapy session, the coding system would be unreliable and have little meaning. It is critical to maximize the degree to which independent raters code sessions similarly. To achieve that objective, a number of different elements have been put in place to maintain the reliability of the codes including: (a) clear definitions of codes, (b) a structured coding process, (c) training and ongoing practice, and (d) continuous reliability review. Reliability is absolutely critical to the scientific process and most of the instructions in this manual are designed to help you code as efficiently and reliably as possible. If tapes are not coded reliably, the scientific objectives of the study will be seriously compromised.

II. CODER TRAINING PROCESS

The training process includes the following steps:

- 1. Independent Review of Manual**
- 2. Group Didactic Trainings**
 - a. Introduction to Coding Process
 - i. Review project background and research questions
 - ii. Overview of coding procedures
 - iii. Discussion of confidentiality, reporting of concerns, and potential reactions to session content
 - b. Review audio of session as a group to orient to recordings and coding process
 - c. Introduction to Therapist Response Codes
 - i. Review each code individually (including discussion of how the rating is determined for each code)
 - ii. Group practice coding (Note-taking and Ratings)
- 3. Individual Practice Sessions**
- 4. Booster sessions**

Independent coding will commence once a coder is considered reliable. Each coder will be assigned 3-4 tapes weekly. If more than 2 weeks of coding are missing, coders are required to re-read the manual and attend a booster session to prevent coding drift. Coders should keep track of coding questions throughout this period and email them to Joanna Kim and coding team as they come up.

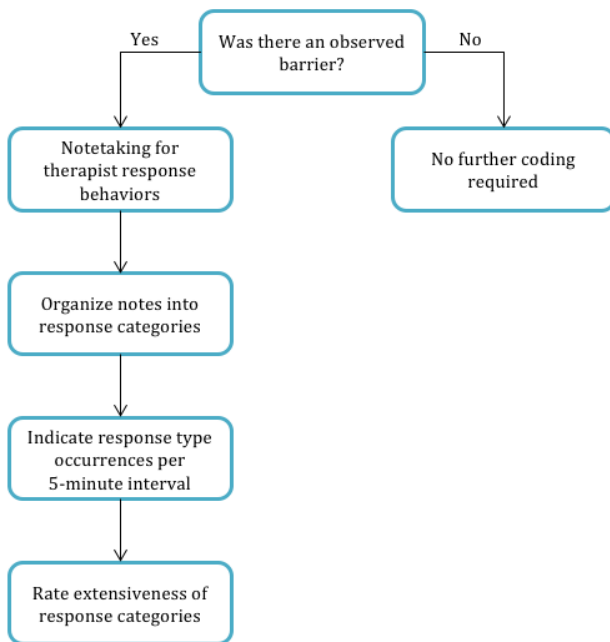
III. GENERAL CODE DESCRIPTIONS

Coding for this project will encompass coding of microanalytic items and global items to characterize therapist responses to observed, in-session barriers.

1. **Microanalytic items** are assess for presence or absence of therapist behaviors. Two categories of microanalytic items include:

- a. **Therapist response behaviors**
 - b. **Therapist affect**
2. **Global items** take into account the extensiveness of each code *over the entire session*; thus, they should only be rated after watching an entire session. Global extensiveness ratings are designed to measure the extent to which the therapist responded to the client's barriers to engagement/participation.
- As with extensiveness ratings for barriers, extensiveness for therapist response reflects two dimensions: the *presence/frequency* of the therapist's response and the *intensity* of the response:
- a. **Presence/frequency** is whether client participation behavior occurred at all and the amount of times a client participation behavior is observed. It relates to the number of times a client participation behavior occurs during a session.
 - b. **Intensity** of client participation engagement. Intensity is determined by the following:
 - i. The detail/quality of the therapist's response; and
 - ii. The extent to which the therapist pursues and attempts to engage the client within his/her chosen response.

IV. CODING PROCESS AND GUIDELINES



1. Session audio recordings will be initially coded for barriers to client engagement and participation (done by barriers coding team).
2. A timestamp will be recorded for each time a barrier occurred (done by barriers coding team).
3. Coders for the present study will receive the time of *first* observed barrier and will be prompted to listen and make notes on therapists' responses for all therapist responses following the first observed barrier.

4. Use iShare coding form to populate notes with timestamps and information on how therapists' responded to the client in session. Notes should have enough information to be able to describe the behavior and for coders to be able to distinguish how the behavior is evidence for specific codes.
5. Organize therapist response notes into the specific categories of therapist responses.
6. For each 5 minute interval following the initial barrier, coders are to indicate which categories of responses were observed.
7. Finally, coders will assign global ratings for each category of responses observed.

Code behaviors not intentions

For barriers to implementation, coders should only score what the therapist actually does in session, not what might have been done. Try not to speculate too much on what the therapist may have been intending to do - focus on what she/he did or said. Only observed therapist behaviors should be considered when scoring responses. Here is a brief summary of important guidelines for coding therapist responses:

- Code only therapist behavior.
- Rate only what a therapist does and not what you believe the therapist might have intended to do.

Never assume or interpret what a therapist might be doing. If there is no behavioral evidence of a specific barrier in the form of something the therapist says or does, then do not endorse the corresponding item.

Jumping the gun

Since global ratings refer to the entire session, they should not be scored until the entire session has been viewed. What happens later in the session may influence a coder's perspective on what happened earlier. Re-estimation is important because it can result in a coder increasing or decreasing an extensiveness score or a rating on a characteristic of a response.

Avoiding potential biases

Coders should be careful to avoid instances of response bias, such as "halo" effects. Halo effects refer to situations where the scoring for one item is biased or influenced by the scoring of another item, or by a global judgment about the whole session. Potential biases come in many forms; here are some relevant examples:

- A coder decides she/he likes the therapist. As a result, the coder tends to observe many more actions to code on the part of the therapist OR codes unwarranted high extensiveness ratings.
- A coder believes a specific therapeutic intervention is not helpful or well-executed by the therapist. As a result, the coder does not code the therapist response OR codes unwarranted low extensiveness ratings.
- A coder observes early on that the client appears very engaged in session. Having formed this opinion, the coder decides not to follow the coding of therapist response to the agreed upon barriers.

To avoid halo effects, coders have to follow the consistent criteria provided by this manual.

V. CONFIDENTIALITY

To protect the privacy of the participants (therapists and clients) in the 4KEEPS study, all tapes, notes, and coding forms are to remain in a secure location. Audio files of the therapy tapes must be coded in the 4KEEPS coding room with the door closed and headphones on at all times.

Audio files should never be downloaded from the UCLA Cloud. When you finish coding, make sure you are signed out of the UCLA Cloud and iShare, and the door to the room is closed and locked.

Confidentiality also means that as a coder in this study, you agree not to discuss the contents of the tapes with anyone other than the coding trainers in private meetings.

At times, you may have negative reactions to session content. If your reaction is continuing to cause you distress, please let a coding trainer know and they will be happy to discuss it with you. As discussed above, commenting about session content to anyone other than the coding trainers in a private meeting is a violation of confidentiality.

VI. REFERENCES

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Lindsey, M. A., Brandt, N. E., Becker, K. D., Lee, B. R., Barth, R. P., Daleiden, E. L., & Chorpita, B. F. (2014). Identifying the common elements of treatment engagement interventions in children's mental health services. *Clinical Child and Family Psychology Review*, 17(3), 283-298.

MICROANALYTIC CODING GUIDELINES

Of note, it is possible for therapists to utilize more than one of the categories of responses in response to one specific barrier. In such cases, code all responses that there is evidence for and include the timestamp of each response so that we can see the sequence of responses.

Table 1. Therapist Response Codes

1. Communicating partnership
2. Normalizing, validating, and reflecting feelings and experiences
3. Seeking client input
4. Incorporating client input
5. Eliciting change talk
6. Assessment of barriers
7. Relenting, ending activity/session
8. Commenting on client efforts and strengths
9. Commenting on client engagement
10. Provide psychoeducation
11. Therapist positive affect
12. Therapist negative affect
13. Developing a plan to address barriers
14. Troubleshooting client-identified difficulties and provide corrective instruction

CODING DEFINITIONS

1. Communicating partnership (Adapted from ACEs Coding Manual, Version 8)

- Partnership language usually includes use of “we/us” statements (see exemplars below). However, this code is about conveying client-therapist partnership, and some statements may not include a “we/us” statements (e.g., *“This is a joint process”*, *“You and I are partners in this.”*)
- Remember to code partnership language directed to client. Do not code partnership language directed to child, even if therapist is referring to client and therapist as “we” (e.g., *“We want you [child] to feel better”*).
- INCLUDES Suggesting (not necessarily telling) therapeutic tasks to client, communicating a team effort, and working together toward a goal.
- Note: Just because “we/us” language is used, it not sufficient enough to code this unless client-therapist partnership is being demonstrated. For example, you would not count statements such as *“How are we doing on time”*, *“Let’s get started”*, as these statements are not necessarily demonstrating therapist-client partnership.
- *Examples:*
 - *“We can work together to figure out how to use consequences to target his negative behavior.”*
 - *“I’m just trying to help you figure out a better plan because if we’re going to make a change to make things better, we have to make at least one change about what we’re going that’s leading us back to the same conclusion. I’m wondering if we can brainstorm an alternative path.”*
 - *“How about we discuss some options together?”*
 - *“I’ll help you, I’ll support you.”*

Not a good example:

- *“I’d like for us to check in about this past week.”*
- *“What else did we do?”*
- *“We always need a reason.”*
- *“We talked about that, right?”*
- *“How does our body feel?”*

2. Normalizing, validating, and reflecting feelings and experiences (Adapted from ACEs Coding Manual, Version 8)

- Therapist:
 - Normalized client’s concerns and challenges, OR
 - Validated client’s statements or experiences, OR
 - Reflected back the client’s underlying feelings
- Normalizing usually requires the therapist to state that the client experience is not odd/unique/extraordinary/etc. and that it is in fact more common than the client may have originally perceived.
- Usually, normalizing is used in a way in which the therapist communicates to the client that their feelings are often normal given the client’s circumstances.
- Validating client will likely include a statement of agreement with client (e.g., *“I agree”*, *“You’re right”*, etc.), but verbal agreement it is not needed to count this code, as therapist tone may indicate agreement.
- Validating the client is also applicable toward both negative and positive experiences.
- Reflecting is often about summarizing back to the client what he/she had communicated.
- Do not code brief verbal continuers that may demonstrate care and concern (e.g., *“uh-huh, right, yeah”*, etc.)
- *Examples:*
 - *Normalizing client’s concerns and challenges*
 - *“That’s really common.”*
 - *“It’s OK if you don’t know the answer, because this is a hard one.”*
 - *“Most people feel this way. It’s actually quite normal.”*
 - *“That sounds familiar.”*
 - *“Most people find themselves in the same situation for quite a while before they adjust.”*
 - *“That’s often the case with a lot of teenagers when major life changes occur!”*
 - *“I think that’s a normal response.”*
 - *Validating client’s statements or experiences*
 - *“I agree, developing a rewards program can be complicated with many steps to fine-tune.”*
 - *“You’re right, it can be challenging to pay attention to and give praise for positive behaviors when you feel that your child is mostly doing negative things.”*
 - *“It makes a lot of sense that you are exhausted – look at everything you are balancing right now in your life.”*
 - *“Yeah, because you care a lot about your mom, right?”*
 - *“Based on your family environment and hearing your outlook, it would make sense why you would feel angry right now.”*

- *“I know it gets frustrating and sometimes it seems like you’re getting punishment too, but you can’t give in and say, I don’t care! Go watch TV. Bye bye!”*
- *“Yeah I think I’d be angry and sad, too.”*
- *Reflecting feelings and experiences*
 - *“Are you uncomfortable? You are fidgeting all over the place! And normally you’re calm, cool, and collected.”*

3. Seeking client input (Adapted from ACEs Coding Manual, Version 8)

- Therapist **sought out client input** by
 - Asking client to provide input about causes and solutions to problems, goals/progress in therapy, or client involvement in therapy, OR
 - Asking client to provide input about comments/ suggestions offered by the therapist or child (or others), OR
 - Providing opportunities for client to ask questions.
- The objective of seeking client input is to incorporate the opinion of the client into the treatment model or activity, NOT to attain factual information. (How do you feel vs. What are you doing)
 - Examples of therapeutic tasks or activities include role-play, exposure therapy, relaxation exercises, mindfulness practices, problem solving, behavior chains (outlining thought and emotional process that precluded an event).
- Questions toward coming up with a goal for therapy would be included here.
- Be careful to not include all questions that the therapist asks of the client simply because a question is being asked. For instance, asking “What did you do over the weekend?”, is simply asking the client a question and to be differentiated from seeking input for therapeutic purposes.
- Instances where the therapist asks the client for examples to then use those examples within the session would be an instance of seeking client input.
- *Examples:*
 - *Following client silence, “Are you feeling nervous talking about your brother right now? Let’s stop, let’s take a deep breath because I can tell you’re getting really nervous and anxious and teary eyed so let’s take a break.” Then proceeds to work in relaxation skills.*
 - *“I’m just trying to help you figure out a better plan because if we’re going to make a change to make things better, we have to make at least one change about what we’re going that’s leading us back to the same conclusion. I’m wondering if we can brainstorm an alternative path.”*
 - This example would be coded as **Seeking client input** as the therapist is clearly communicating to the client the intent to incorporate the client’s thoughts and ideas, particularly in the sentence “I’m wondering if we can brainstorm an alternate path.”
 - This example would also be coded as **Eliciting change talk**, particularly when looking at the first half of the example. Here, the therapist reminds the client that previous actions have not helped and attempts to spur the client into making a change in his/her behaviors.

- This example would also be coded as **Partnership language** as the therapist is clearly communicating to the client that they intend to work on the issue together.
- *“I want to make sure that what we’re doing is working for you. What are your thoughts about the process? Are we moving at a comfortable pace that works for you?”*
- *“Is there anything you need to know from me that will make this conversation a bit easier?”*
- *“So what do you think using self control means?”*
- *“Have we talked about the cognitive triangle before?”*

4. Incorporating client input (Adapted from ACEs Coding Manual, Version 8)

- Therapist incorporated client’s input into therapeutic tasks by
 - Describing how client input is helpful or will be used, OR
 - Explicitly using client input to inform session topics, OR
 - Adjusting therapeutic tasks based on client input OR
 - Collaboration with the client on preferences.
- This should be explicitly about therapist adjusting the therapeutic activity or discussion based off of the client’s statements and/or preferences.
- Instances where the therapist asks the client for examples and then uses those examples within the session would be an instance of incorporating client input.
- Do not include if the therapist is only adjusting his/her language to adjust to the client’s developmental capacity or age.
- *Examples:*
 - Therapist asks client if he would like to do a particular activity, he declines, and Therapist follows suit.
 - Therapist follows client’s request for activity selection.

5. Eliciting change talk (Adapted from Lindsey et al., 2014)

- Probing disadvantages of the status quo, advantages of change, optimism, and intention to change with the goal of increasing youth/family participation in treatment
- Exercises designed to increase readiness to participate in services (e.g., cost–benefit analysis, persuasion, or Socratic questioning or a variety of other approaches). The objective is to *elicit* change in the patient NOT by directly telling them how to change, but guiding the client to come to the conclusion themselves.
 - Recall that this is often because research suggests that people are generally better persuaded to “change” when they have come to a reasoning/understanding themselves, and so the therapist will be helping them get to this place.
- In such cases, the therapist may ask evocative, open-ended questions or for elaboration
- Include attempts to motivate the client to change the problem
- *Examples:*
 - *“What’s worked before?”*
 - *“I’m just trying to help you figure out a better plan because if we’re going to make a change to make things better, we have to make at least one change about what we’re going that’s leading us back to the same conclusion. I’m wondering if we can brainstorm an alternative path.”*

- This example would also be coded as **Partnership language** as the therapist is clearly communicating to the client that they intend to work on the issue together.
- *“Why would you want to make this change?”*
- *“How would you do it if you decide to make this change”*
- *“So far, we have been trying to work on your anger issues. Can you list at least three good reasons as to why you should control your anger?”*
- *“How important is this to you?”*
- *“What are some steps you think you should do now?”*
- *“It sounds like you’re really considering a change. Help me understand your thought process.”*

6. Assessment of barriers (Developed by 4KEEPS team)

- Therapist assessed barriers by:
 - Attempting to identify barriers, OR
 - Learning about barriers to participation during the session.
- *Examples:*
 - *“How do you think things would be different if you did this? Instead of Situation A, how do you think communication would look different?”*
 - *“Are you sure you want to end session early? You don’t want to talk about anything? Okay... It’s been five minutes but I’m going to give you a little extra time to think. Sometimes it comes to us when we sit down and we think.”*
 - *“Why are you afraid [to practice role play]?”*
 - *[client is being disruptive and not answering therapist questions] “Are you tired today?”*
 - *“You’re quiet. How come?”*

7. Relenting, ending activity/session

- Therapist moves on to a different topic or activity instead of exploring further when engagement/treatment barrier is noted by observer rating
- Includes premature session end wherein therapist ends session earlier than planned instead of trying to elicit engagement through other above means.
- Includes dismissing out-of-session skill application/practice non-compliance
- Includes if therapist does not pursue more information about how and why out-of-session practices were completed or therapist responds that skill application/practice was not important
- Does not need to explicitly be initiated by the therapist. For instance, if the client changes topic and the therapist no longer asks on-topic questions.
- *Examples:*
 - *“You don’t know? That’s okay, that wasn’t that important anyway.”*
 - *“Let’s take a little bit of a break because you’re about to fall apart on me. Why don’t we play a game for a little bit and relax ourselves?”*
 - *“You want to play ‘Would you rather?’”*
 - *“You didn’t do it [homework]? Okay.”*
 - *“Well, I guess since you don’t want to play any games, we will end a little early. We only have 10 minutes left anyway. We still start where we left off next week.”*

- To code premature session end, it needs to be explicit that the therapist is ending the session early. Do **NOT** rely on the length of session as it is plausible that the client arrived late to the session or did not record from the start of the session.
- Client changes topic from talking about feelings to their recent trip to Disneyland. *“Wow, what did you do at Disneyland? Did you have fun?”* and therapist drops previous activity to engage in off-topic conversation.
- *“Okay I’m going to end session early, but you need to ask your mom.”*

8. Commenting on client efforts and strengths

- Therapist comments specific to the client’s efforts and behaviors should be included here.
- Therapist praise for the client working hard, persisting, or making attempts should be included in this code.
- DO NOT code for validating statements alone. For example, when a therapist says, “I know this is really hard stuff.” They are providing validation but not noting that the client is making a particular effort or that a skill is their strength.
- *Examples:*
 - *“This is so hard, but I can tell you’re trying really hard to stick with it.”*
 - *The key here for this code, is when the therapist states “I can tell you’re trying really hard to stick with it” which is a **comment on effort**. The first part “This is so hard” should be coded as the therapist being **validating** of the client’s experience.*
 - *“I can see that you put in so much hard work. That’s great!”*
 - *“You’re doing so well, keep up the good work!”*
 - *“That’s a fine thing to say!”*
 - *“So far you’re doing pretty good, I’m very proud.”*
 - *“That sounds like a pretty honest answer, I appreciate you.”*
 - *“I’m going to give you an extra sticker because you did such a great job in drawing the faces.”*
 - *“You know what I really like? I like how much you’re using your words today. That makes me feel so happy.”*
 - *“Good job! Un-freeze. Super cool! That was really good!”*

9. Commenting on client engagement

- Commenting specific to the client’s
 - Client’s lack of effort, OR
 - Client’s lack of engagement, OR
 - Therapist’s frustration with the client’s in-session behaviors or other related behaviors.
- *Example:*
 - *“No, your main job is to go to school and to get an education. But you’re not doing that. And then when I say something about you not bringing your responsibility chart home, then you say it doesn’t matter.... Yes it does matter.”*
 - *“I think he just makes stuff up sometimes.”*

- *“You disagree with everything she says. Why? Yeah it is [true]. It’s true.”*
- *“You know, that was a bad decision.”*
- *“That was not a good idea. You could have seriously hurt somebody.”*
- *Oh man you’re really not following directions. You keep choosing not to do the task. Okay it looks like you keep choosing not to follow directions, so I don’t think we’re going to be coming back to this room.*
- *What do you want to do? You don’t know? How will I know how to help you if you don’t tell me what you want to do?*
- *Look, I know this isn’t easy, and we haven’t been in therapy for long, and we can stop the recording any time if you think it’s challenging. But I have noticed that it’s really difficult to talk about these things. And it’s not my job to make suggestions or assumptions about why you feel this way, but we both agree there’s a problem right? And there are things you had to deal with, and we’re talking about discovery and this is a good topic because I feel like this is a huge challenge for you because I think that in your head you have all these ideas but you’re not allowing yourself to openly discuss them.*
- *“Are you trying to be difficult with me today?”*

10. Provide psychoeducation (Adapted from ACEs Coding Manual, Version 8)

- Therapist’s specific efforts to provide psychoeducation about child problems AND/OR treatment should be included here.
- Therapist provided psychoeducation about problems to client by:
 - describing the nature of problem areas in children in general (e.g., symptoms of child behavior problems, diagnoses of child behavior problems, impairment from behavior problems), OR
 - describing the nature of problems specific to their child (e.g., symptoms, diagnoses, impairment), OR
 - describing general or specific factors that may contribute to the identified problem in children (e.g., genetics, parenting behaviors, environment, stressors, experiences, temperament), OR
 - describing what will occur over the course of treatment, such as session tasks or out of session actions, frequency or duration of treatment, or changes that may be expected, OR
 - describing participants and their roles in treatment (introducing therapy structure and expectations), OR
 - providing rationale for treatment model or strategies/skills.
- Note: psychoeducation about child problems occurs when the therapist teaches and imparts information to the client about child problems to educate the client.
 - This information can come from outside sources (e.g., a therapist relaying information from child’s teacher about child’s behavior problems in the classroom).
- If a therapist is reviewing information that is listed on a worksheet, do not code as psychoeducation unless the therapist is imparting new information.

- For providing rationale, pay attention to therapist statements that say, “*The reason why we’re doing this is...*” or “*Doing this is useful/helpful because...*”
- Teaching vocabulary does not count as psychoeducation.
- *Examples:*
 - “*It sounds like you had a hard time managing your feelings and maintaining self control. So today I actually want to teach you about using self control. And using self control is actually a social skill that will help you when you’re angry.*”
- *Not a good example:*
 - “*Bravery/Worry means...*” This example would NOT be counted as psychoeducation. If the therapist elaborated and explained how worry can be connected to headaches or stomach aches, then that would be psychoeducation.

11. Therapist positive affect

- Therapist positive affect as noted by tone of voice, diction, and overall affect should be noted here.
- Include both specific timestamps and global notes (throughout the tape).
- *Examples:*
 - *Ohh yeah! Yes! Oh that sounds like a great! Oh yeah that sounds cool!*
 - *Good job! Unfreeze. Super cool! That was really good!*
 - *How did you know?! Bam! A prize!*

12. Therapist negative affect

- Therapist negative affect as noted by tone of voice, diction, and overall affect should be noted here.
- Include both specific timestamps and global notes (throughout the tape).
- Short interjections and questions can be expressions of negative affect.
- *Examples:*
 - “*‘No, no,’ what?!’*”

13. Developing a plan to address barriers

- After a barrier has been identified (e.g., Barrier #4) Therapist attempts in developing a plan to address/overcome barriers by
 - soliciting support, OR
 - giving advice/solutions, OR
 - generating advice/solutions to address barriers, OR
 - include prompting to do in-session practice/rehearsal/modeling/psychoeducation review/other ECCA content areas and techniques.
- This code is only to apply for therapist’s planning behaviors and not techniques
- This code applies to after identification of a barrier.
- *Examples:*
 - *E.g., “We didn’t practice this enough, let’s go over it more”*
 - *“Can I help you ask? Will that be better? I’m going to say, D’s mom. D wants to ask you something right now. [clt says he doesn’t want to do role play and he’s*

nervous to ask]. I don't understand. Does your mom get mad when you ask? What happens when you ask?"

14. Troubleshooting client-identified difficulties and provide corrective instruction

- Therapist's attempts to troubleshoot/address barriers within behavioral rehearsal and practice of skills.
 - Making corrective feedback and adjustments to client's use of skills within session and outside of session, OR
 - Coaching the client on how to make adjustments to a skill, OR
 - Providing supports in order to guide the client's understanding and/or ability to exercise a skill (i.e., scaffolding).
- **MUST be in response to expressed difficulty/barrier in using a skill**
 - *E.g., Therapist is engaging the child and encouraging them to share about his/her feelings. Youth: How? I don't get it.*
 - *E.g., Therapist: You understand that statement? Youth: (long pause) I kind of understand it.*
 - *E.g., While filling out a cognitive restructuring worksheet Youth: I don't know what a negative would be for being bit by spiders*
 - *E.g., While completing cognitive triangle worksheet Youth: Hitting is an action, right? Oh wait, you can't tell me... This is hard!!*
 - *E.g., During role play Youth: I can't do this! I don't know what to say!*
- **Specific to addressing the barrier (not troubleshooting generally) to address an identified barrier**
- **Not teaching a skill, only troubleshooting following an expressed barrier**
- Most often this code will be applied to practicing skills in the room but can also be used for when the therapist is helping the client to modify behaviors outside of treatment that can ensure proper use and practice of the skill being built.
- *Examples:*

GLOBAL CODING GUIDELINES

Extensiveness ratings are designed to measure the extent to which the therapist responded to the client’s barriers to engagement/participation.

As with extensiveness ratings for barriers, extensiveness for therapist response reflects two dimensions: the *presence/frequency* of the therapist’s response and the *intensity* of the response:

- **Presence/frequency** is whether client participation behavior occurred at all and the amount of times a client participation behavior is observed. It relates to the number of times a client participation behavior occurs during a session.
- **Intensity** of client participation engagement. Intensity is determined by the following:
 - The detail/quality of the therapist’s response
 - The extent to which the therapist pursues and attempts to engage the client within their chosen response
 - E.g., In a rehearsal response, therapist may walk client through cognitive triangle with more than one situation. Such would reflect higher intensity than if the therapist guided the client through only one situation in which the client could rehearse the cognitive triangle
- Additional global coding is required on **therapist affect**.
 - At the end of notetaking till the end of each session recording, coders are to rate therapists’ positive affect regardless of their demonstration of negative affect. In other words, therapists can have a high negative affect score AND a high positive affect score if the therapist is generally very high in affect and in expressed emotion throughout the session.
 - Similarly, at the end of the session, coders are to rate therapists’ negative affect, regardless of their demonstration of positive affect.
- Note: Some codes do not reflect both frequency and intensity, but rather intensity alone.

1. To what extent did the therapist communicate partnership?			
0	1-2	3-4	5-6
Therapist did not communicate partnership in the session or use any communal, partnership language.	Therapist used partnership language a few times during the session. AND/OR Therapist minimally expressed partnership through the use of words such as “we” or “us” but did not elaborate on shared goals.	Therapist used partnership language several times . AND/OR Therapist moderately expressed partnership through the use of words such as “we” or “us” but did not elaborate on shared goals.	Therapist used partnership language consistent and/or recurrently throughout the session . AND/OR Therapist extensively expressed partnerships through discussing mutual, shared goals, and/or vested interest.
Guidelines:			
<ul style="list-style-type: none"> ● Simply using the word “we” or “us” does not count as partnership language. 			

- E.g., “Let’s get started” would not be coded here.
- Exemplar:
 - “I’ll support you”

2. To what extent did the therapist normalize, validate, and reflect feelings and experiences?			
0	1-2	3-4	5-6
Therapist did not normalize, validate, or reflect client feelings and/or experiences.	Therapist made a few comments to normalize, validate, or reflect client feelings and/or experiences.	Therapist made several comments to normalize, validate, or reflect client feelings and/or experiences. AND/OR Therapist made comments to normalize, validate, or reflect client feelings and/or experiences that were slightly more involved and elaborated upon.	Therapist consistently and recurrently made comments to normalize, validate, or reflect client feelings and/or experiences throughout the session. AND/OR Therapist made comments to normalize, validate, or reflect client feelings and/or experiences that were more involved and elaborated upon.
<p>Guidelines:</p> <ul style="list-style-type: none"> ● Therapist does not need to do all three (normalizing, validating, or reflecting) to be coded here. ● Should a therapist engage only in one of the behaviors (normalizing, validating, or reflecting) they must exhibit high frequency and elaboration within these instances to be rated a 5. ● Reserve the 6 global rating for instances in which the therapist uses more than one just one behavior and does them consistently and recurrently throughout the session. <p>Exemplars:</p> <ul style="list-style-type: none"> ● <i>“Yeah, I think I’d be angry and sad, too.”</i> ● <i>“I think that’s a normal response.”</i> ● <i>“So they were rude. You said ‘What’s that?’ and they said, ‘Shoes you can’t afford.’ That’s a rude thing to say.”</i> ● <i>“From started school to Dec. now you’ve made a big change... you’ve had a rough time starting school, poor grades, kept focus all OK because of what you went through, but I see that you’re pulling yourself out – does that feel good to have such a good support around you?”</i> 			

3. To what extent did the therapist seek client input?			
0	1-2	3-4	5-6
Therapist did not seek client input throughout the session.	Therapist sought client input a few times during the session. AND/OR Therapist verbally followed-up with client a few times during the session. AND/OR Therapist verbally checked-in with client's understanding and/or participation a few times during the session.	Therapist sought client input several times during the session. AND/OR Therapist verbally followed-up with client several times during the session. AND/OR Therapist verbally checked-in with client's understanding and/or participation several times during the session.	Therapist sought client input consistently and recurrently throughout the session. AND/OR Therapist extensively followed-up with client throughout the session. AND/OR Therapist extensively checked-in with client's understanding and/or participation during the session.
<p>Guidelines:</p> <ul style="list-style-type: none"> • Include instances of the therapist checking in with the client as low intensity seeking of input. <ul style="list-style-type: none"> ○ E.g., "How does that sound?" ○ E.g., "Does that make sense?" • Questions toward coming up with a goal for therapy would be included here. • Be careful to not include all questions that the therapist asks of the client simply for the action of asking a question. For instance, asking "What did you do over the weekend?", is simply asking the client a question and to be differentiated from seeking input for therapeutic purposes. • Instances where the therapist asks the client for examples to then use those examples within the session would be an instance of seeking client input. <p>Exemplars:</p> <ul style="list-style-type: none"> • <i>"What does that mean?"</i> • <i>"Do you know what I'm talking about?"</i> • <i>"Have we talked about the cognitive triangle before?"</i> 			

4. To what extent did the therapist incorporate client input?			
0	1-2	3-4	5-6

Therapist did not incorporate client input throughout the session.	Therapist incorporated client input a few times during the session.	Therapist incorporated client input several times during the session.	Therapist incorporated client input consistently and recurrently throughout the session. AND/OR Therapist extensively incorporated client's input and/or participation during the session.
<p>Guidelines:</p> <ul style="list-style-type: none"> • This should be explicitly about therapist adjusting the therapeutic activity or discussion based off of the client's statements and/or preferences. • Instances where the therapist asks the client for examples and then uses those examples within the session would be an instance of incorporating client input. 			

5. To what extent did the therapist elicit change talk?			
0	1-2	3-4	5-6
Therapist did not elicit change talk throughout the session.	Therapist made a few attempts to elicit change talk during the session. AND/OR Therapist minimally attempted to elicit change talk during the session.	Therapist made several attempts to elicit change talk during the session. AND/OR Therapist moderately attempted to elicit change talk during the session.	Therapist consistently and recurrently attempted to elicit change talk throughout the session. AND/OR Therapist extensively attempted to elicit change talk during the session.
<p>Guidelines:</p> <ul style="list-style-type: none"> • Code attempts regardless of if the client participates. • Often times, these may come in the form of rhetorical questions. <p>Exemplars:</p> <ul style="list-style-type: none"> • <i>“You’re gonna do your work? When? You said that before.”</i> • <i>“You don’t think it’s a big deal if you don’t do your school work? Is it going to be a big deal when you’re 16 and still in 7th grade? 6th grade? Aren’t you going to feel silly when you’re sitting in 6th grade year after year?”</i> 			

6. To what extent did the therapist assess barriers?			
0	1-2	3-4	5-6
Therapist did not attempt to assess barriers throughout the session.	Therapist made a few attempts to assess barriers during the session.	Therapist made several attempts to assess barriers during the session.	Therapist consistently and recurrently attempted to assess barriers throughout the session.
<p>Guidelines:</p> <ul style="list-style-type: none"> Includes that therapist trying to learn about a barrier and gathering more information about a barrier. <p>Exemplars:</p> <ul style="list-style-type: none"> <i>“Are you sure you want to end session early? You don’t want to talk about anything? Okay... It’s been five minutes but I’m going to give you a little extra time to think. Sometimes it comes to us when we sit down and we think.”</i> <i>“Why are you afraid [to practice role play]?”</i> <i>[client is being disruptive and not answering therapist questions] “Are you tired today?”</i> 			

7. To what extent did the therapist relent/end activity/session?			
0	1-2	3-4	5-6
Therapist did not relent/end activity/session throughout the session.	Therapist relented a few times during the session. AND/OR Therapist ended an activity a few times during the session.	Therapist relented several times during the session. AND/OR Therapist ended an activity several times during the session.	Therapist consistently and recurrently relented or ended an activity throughout the session. AND/OR Therapist explicitly ended the treatment session early (Code as a 6).
<p>Guidelines:</p> <ul style="list-style-type: none"> If the therapist explicitly ends the session prematurely, that would be coded a 6. <p>Exemplars:</p> <ul style="list-style-type: none"> <i>Therapist brings up new topic</i> <i>“Okay, let’s move on to something else.”</i> <i>Therapist and client are discussing something else, and then therapist asks, “Did you talk to him about what we discussed last week?”</i> 			

8. To what extent did the therapist comment on the client's efforts and strengths?			
0	1-2	3-4	5-6
Therapist did not comment on the client's efforts and strengths throughout the session.	Therapist made a few comments on the client's efforts and strengths during the session.	Therapist made several comments on the client's efforts and strengths during the session.	Therapist consistently and recurrently commented on the client's efforts and strengths throughout the session.
<p>Guidelines:</p> <ul style="list-style-type: none"> • Do note code tone and affect here. This code should only be used for when coding the explicit language used by the therapist that is a comment on the client's efforts and/or strengths. <p>Exemplars:</p> <ul style="list-style-type: none"> • <i>"You're really good at that!"</i> • <i>"That's a fine thing to say!"</i> • <i>"I'm going to give you an extra sticker because you did such a great job in drawing the faces."</i> 			

9. To what extent did the therapist comment on the client's engagement?			
0	1-2	3-4	5-6
Therapist did not comment on the client's efforts, engagement, and behaviors throughout the session.	Therapist made a few comments on the client's efforts, engagement, and behaviors during the session.	Therapist made several comments on the client's efforts, engagement, and behaviors during the session.	Therapist consistently and recurrently commented on the client's efforts, engagement, and behaviors throughout the session.
<p>Guidelines:</p> <ul style="list-style-type: none"> • Includes comments on lack of effort/engagement and client's behaviors that are inconsistent with that is desired. <p>Exemplars:</p> <ul style="list-style-type: none"> • <i>"You know, that was a bad decision."</i> • <i>"That was not a good idea. You could have seriously hurt somebody."</i> • <i>Oh man you're really not following directions. You keep choosing not to do the task. Okay it looks like you keep choosing not to follow directions, so I don't think we're going to be coming back to this room.</i> • <i>What do you want to do? You don't know? How will I know how to help you if you don't tell me what you want to do?</i> 			

- *“Look, I know this isn't easy, and we haven't been in therapy for long, and we can stop the recording any time if you think it's challenging. But I have noticed that it's really difficult to talk about these things. And it's not my job to make suggestions or assumptions about why you feel this way, but we both agree there's a problem right? And there are things you had to deal with, and we're talking about discovery and this is a good topic because I feel like this is a huge challenge for you because I think that in your head you have all these ideas but you're not allowing yourself to openly discuss them.”*
- *“Are you trying to be difficult with me today?”*

10. To what extent did the therapist provide psychoeducation?			
0	1-2	3-4	5-6
Therapist did not provide psychoeducation throughout the session.	Therapist provided psychoeducation a few times during the session. AND/OR Therapist's psychoeducation was short and shallow in nature .	Therapist provided psychoeducation several times during the session. AND/OR Therapist provided slightly more extensive psychoeducation explanations.	Therapist provided psychoeducation consistently and recurrently throughout the session . AND/OR Therapist provided extensive psychoeducation during the session.
<p>Guidelines:</p> <ul style="list-style-type: none"> • Do note code instances when the therapist is explaining vocabulary. • Pay particular attention to the extensiveness of the psychoeducation and how much the therapist elaborates and provides examples in the psychoeducation given. • Instances where the therapist will ask the client questions during the psychoeducation discussion MUST be also coded as seeking client input (and incorporating input accordingly). <p>Exemplars:</p> <ul style="list-style-type: none"> • <i>“That's why we come here! Why we come to therapy.”</i> 			

11. To what extent did the therapist demonstrate positive affect?			
0	1-2	3-4	5-6
Therapist did not demonstrate positive affect through tone or diction throughout the session.	Therapist made a few demonstrations of positive affect through tone or word choice.	Therapist made several demonstrations of positive affect through tone or word choice.	Therapist consistently and recurrently demonstrated positive affect through tone or word choice

			throughout the session.
<p>Guidelines:</p> <ul style="list-style-type: none"> • Laughter, inflections in tone of voice, and overall affect can be considered here. • In many cases there will be some double coding between this code and with (Code 8) Commenting on client’s efforts and strengths. However, it’s important to remember that sometimes therapists may have positive comments without positive affect. As such, not all instances of commenting on effort and strengths would also be included here. • Be particularly mindful of the consistency of therapist’s affect when making global ratings. 			

12. To what extent did the therapist demonstrate negative affect?			
0	1-2	3-4	5-6
Therapist did not demonstrate negative affect through tone or diction throughout the session.	Therapist made a few demonstrations of negative affect through tone or word choice.	Therapist made several demonstrations of negative affect through tone or word choice.	Therapist consistently and recurrently demonstrated negative affect through tone or word choice throughout the session.
<p>Guidelines:</p> <ul style="list-style-type: none"> • Inflections in tone of voice, and overall affect can be considered here. • Be mindful of words that have particularly negative connotations here. <p><i>Exemplars:</i></p> <ul style="list-style-type: none"> • “No, no, what?!” 			

13. To what extent did the therapist troubleshoot client-identified difficulties and provide corrective instruction?			
0	1-2	3-4	5-6
Therapist did not troubleshoot client-identified difficulties and provide corrective instruction throughout the session.	Therapist troubleshooted client-identified difficulties a few times during the session. AND/OR Therapist provided corrective instruction a few times during the session.	Therapist troubleshooted client-identified difficulties a several times during the session. AND/OR Therapist provided corrective instruction a several times during the session.	Therapist consistently and recurrently troubleshooted client-identified difficulties throughout the session. AND/OR Therapist consistently and recurrently provided corrective instruction

			throughout the session.
<p>Guidelines:</p> <ul style="list-style-type: none"> • Therapist’s attempts to troubleshoot/address barriers within behavioral rehearsal and practice of skills. • <u>MUST be in response to expressed difficulty/barrier in using a skill</u> <ul style="list-style-type: none"> ○ <i>E.g., Therapist is engaging the child and encouraging them to share about his/her feelings. Youth: How? I don’t get it.</i> ○ <i>E.g., Therapist: You understand that statement? Youth: (long pause) I kind of understand it.</i> ○ <i>E.g., While filling out a cognitive restructuring worksheet Youth: I don’t know what a negative would be for being bit by spiders</i> ○ <i>E.g., While completing cognitive triangle worksheet Youth: Hitting is an action, right? Oh wait, you can’t tell me... This is hard!!</i> ○ <i>E.g., During role play Youth: I can’t do this! I don’t know what to say!</i> • <i>Exemplars:</i> <ul style="list-style-type: none"> ○ <i>“[Client says, I forget what the last one is] REST it starts with a t.”</i> 			

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