

## TRAINING SCHOOL PSYCHOLOGISTS TO CONDUCT EVIDENCE-BASED TREATMENTS FOR DEPRESSION

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Cognitive behavioral therapy is an effective approach to the treatment of depressive disorders within schools, due to its demonstrated efficacy, as well as its availability in manualized treatment form. When implemented by therapists with inadequate training, the treatment is often stilted, less engaging for participants, and aimlessly guided through rigid adherence to the treatment manual. The transportability of such interventions to schools will be discussed, highlighting challenges that school psychologists may face, along with addressing important aspects for the successful implementation of treatments. The ACTION treatment program, a highly effective cognitive behavioral intervention for depressed youth, is provided as an example of one such program. Primary treatment components of ACTION are described along with subtleties to effectively train school psychologists who intend to treat depressed youth. The importance of improved training for school psychologists to become effective at implementing cognitive behavioral interventions is highlighted. © 2011 Wiley Periodicals, Inc.

Training psychologists to use evidence-based interventions is essential. Despite growing evidence of the efficacy of particular interventions, it is challenging for school psychologists to select and implement new practices (Reinke, Herman, Stormont, Brooks, & Darney, 2009). In fact, research indicates that, even after receiving training in evidence-based treatments, school psychologists often do not use such interventions any more than non-evidence-based interventions. It appears that they are most likely to use an evidence-based intervention if (a) they believed that they had adequate knowledge and skill for implementing it; (b) it fit with their overall approach to practice; and (c) they had adequate technical support following training (Forman, Fagley, Dreitlein Steiner, & Schneider, 2009).

### EMPIRICAL EVALUATION OF PSYCHOSOCIAL INTERVENTIONS FOR DEPRESSED YOUTH

As school psychologists broaden their services to include more therapy, they will likely be referred students who are experiencing depressive disorders, which are some of the most common disorders of childhood and adolescence. Due to the adverse psychosocial and educational impacts of depressive disorders, it is important for school psychologists to provide intervention services. The treatment outcome literature can help school psychologists identify effective treatments for depressed youth. (For a more comprehensive review, see Stark, Streusand, Arora, and Patel, in press). Cognitive-behavioral therapy (CBT) has been labeled as “well-established” for both depressed children and adolescents (David-Ferdon & Kaslow, 2008). Results of large-scale clinical trials (e.g., Brent et al., 2008; March, 2004) with depressed adolescents indicate that the combination of CBT and a selective serotonin reuptake inhibitor (SSRI) is the most effective treatment in terms of the probability of producing a positive response and improving symptoms and general functioning (Kennard et al., 2006; Vitiello et al., 2006). While inclusion of an SSRI also produces improvements at a significantly faster rate than CBT, the addition of CBT appears to help prevent suicidal ideation and behavior that may occur as a result of taking the SSRI (TADS Team, 2007). CBT alone appears to be effective, but these effects appear at a much later point in treatment (TADS Team, 2007). The minimal dose of CBT necessary for producing a therapeutic effect appears to be nine sessions (Brent et al., 2008).

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Although significantly less outcome research has been conducted with depressed children, results indicate that CBT also is effective with this population. In our own large-scale evaluation of the effectiveness of the ACTION treatment program, CBT was significantly more effective than a minimal contact control condition, and more than 80% of the girls who participated in CBT with or without parent training were no longer depressed following treatment. In contrast, 46% of the girls in the minimal contact condition were no longer depressed following the control period. At posttreatment, there was no difference in scores or rates of depression for girls who received CBT or CBT plus parent training. There was a dosing effect, however, with girls who completed at least 18 meetings reporting a significantly better outcome. Another important finding is that girls whose parents participated in parent training reported significantly better maintenance of treatment effects over 1–4 years. Once again a dosing effect was found with girls whose parents attended six or more meetings reporting significantly greater maintenance of treatment effects (Stark, Stapleton, Sander, & Krumholz, 2010).

Therapists in the large-scale clinical trials received extensive training in CBT and in the manualized treatments themselves, as well as ongoing expert supervision. The therapists in the aforementioned adolescent studies were clinicians from university clinics who had extensive histories of providing evidence-based cognitive behavioral treatments for youth with a variety of disorders. Most clinicians, including school psychologists, do not have this level of training, nor do they have time for or access to ongoing expert supervision. Thus, it begs the question: Are manualized evidence-based treatments as effective when they are delivered by therapists with less specialized training?

#### TRANSPORTABILITY

While effective interventions have been developed for depressed youth, virtually none of the empirically supported treatments have made their way into regular practice (Weisz, 2000). A key aspect to overcoming the research-to-practice gap is the development and evaluation of procedures to transport evidence-based practices into real-world settings (Kazdin, 2008).

Weisz and colleagues (2009) addressed the transportability question by randomizing community clinic therapists to brief training (e.g., one 6-hour training) and supervision (e.g., 30 minutes weekly) in CBT for youth depression or to usual care (UC). Treatment was permitted to continue to natural termination. While CBT and UC treatment groups did not differ on depressive symptoms at posttreatment, with both resulting in subclinical levels of depressive symptoms, participants who received CBT used fewer adjunct services (e.g., pharmacotherapy), and the therapy was shorter in length (i.e., 24 vs. 39 weeks), less costly, and produced higher parent ratings of therapeutic alliance. This study is significant because it provides an example of the successful transportation of an evidenced-based-treatment to a clinical setting, with the inclusion of an acceptable and realistic model of training and supervision.

The amount of training and supervision necessary for successfully transporting a manualized treatment for depression to the school setting may be related to the complexity of the treatment as well as a variety of other variables. The ACTION treatment program is manualized and has been used extensively and effectively in the schools with depressed youth. Although the therapists in our outcome study were students in a doctoral school psychology program, they received specialized training in the intervention that is described in the next section. Because the likelihood of school psychologists using a treatment program and the amount of training necessary is related to the complexity of the treatment, we first describe the ACTION treatment for depression and some of the subtleties to effectively conducting the treatment; then the training procedures are described.

## DESCRIPTION OF THE ACTION TREATMENT PROGRAM

ACTION is a developmentally and gender-sensitive program that consists of a 20-session child treatment component (e.g., Stark, Schnoebelen, et al., 2005), a workbook that facilitates completion of therapeutic homework (Stark, Simpson, et al., 2005), and an eight-session parent training component (Stark, Simpson, Yancy, & Molnar, 2005; Stark, Yancy, Simpson, & Molnar, 2005) that are briefly described later in text. (For a more in-depth description, see Stark et al., in press.) The treatment was designed for a group format and for girls between the ages of 9 and 13. The intervention is appropriate for boys, however, and can be modified for older youth and for an individual delivery format.

The child intervention includes: (a) psycho-education; (b) goal setting; (c) coping skills training; (d) problem solving training; (e) cognitive restructuring; and (f) activities that build a positive self-schema. Because the ACTION program is based on a coping skills model, additional treatment procedures include training in self-monitoring, self-evaluation, and self-reinforcement. Each of these treatment procedures is briefly described in the following sections.

*Psycho-education*

Psycho-education provides participants with an understanding of their experience of a depressive disorder, the potential causes of depression, and the rationale for treatment. It also helps the participants become more aware of the emotions, inaccurate thoughts, and behaviors that stem from and maintain depression. Participants are first taught to become more aware of their experience of pleasant emotions; then they are taught to become aware of and sensitive to changes in mood so that they can use the changes as cues to engage in therapeutic strategies. Participants are taught how to use a mood meter to rate intensity and subjective nature of their mood disturbance.

*Goal Setting*

Goal setting contributes to the development of the therapeutic alliance and it individualizes the intervention. As each of the child's goals is achieved, the therapist emphasizes the child's role in achieving the goal, thus building a sense of personal efficacy.

*Coping Skills Training*

Coping skills training is a building block in the treatment of depressed youth, helping children improve and regulate their mood, as well as manage the emotional impact of uncontrollable stressful events. When coping skills are used to treat other disorders (e.g., anxiety disorders), the child's baseline mood is pleasant and coping skills are engaged to either prevent anxiety or to reduce anxiety so that the child's mood returns to the pleasant norm. In contrast, with depressed youth their dominant mood is dysphoria, irritability, or anhedonia (loss of the pleasure response). As such, one of the primary objectives of coping skills training is to provide the depressed child with skills that he or she can use to improve mood in general. This process is commonly referred to as behavioral activation—getting the child re-engaged in behaviors that lead to pleasant mood, promote mastery experiences, increase positive social interactions, and further the acquisition of other reinforcing events. Another objective of coping skills training with depressed youth is to lift mood when the child experiences a decline in mood. Coping skills training also can be used to prevent experiences of stress or moderate the impact of stress.

Participants are taught five broad categories of coping strategies: (1) Do something fun and distracting; (2) do something that is soothing and relaxing; (3) do something that expends a lot of energy; (4) talk to someone about it; or (5) change your thinking. Children are taught the mood-regulating value of coping skills within the meetings and then are encouraged to use the skills outside

of meetings. They are provided with some didactic education and guided discovery about the five broad categories of coping skills. During the first nine meetings, the girls complete activities that demonstrate the value of use of each of the five skills. After experiencing such mood-elevating benefits, the girls generate lists of examples of activities that they could use outside of the meetings to enhance mood. At the end of each meeting, they are assigned therapeutic homework to use coping skills.

Coping skills also have an indirect impact on the probability that children will use other treatment strategies. A child who is overwhelmed by stress or is extremely dysphoric may not independently try to use problem solving or cognitive restructuring. Coping skills provide an easy way of raising their mood and reaching the energy and affective state necessary to attempt independent use.

### *Problem Solving*

As participants acquire a better understanding of their emotions, accurately identify them, recognize their impact on behavior and thinking, and understand that they can take action to moderate the intensity and impact of them, they are taught that some of the undesirable situations that lead to unpleasant affects can be changed. Problem solving is used as a strategy for changing situations that are within the child's control but that produce stress, unwanted outcomes, or undesirable affects. Research consistently indicates that problem solving is related to adjustment. Participants are taught to break problem solving down into five component steps through education, modeling, coaching, rehearsal, feedback, and participation in a number of within-session activities. To simplify the process and to help the girls remember the steps, the therapist refers to them as the "five Ps".

### *Cognitive Restructuring*

Cognitive restructuring is implemented in a developmentally sensitive fashion. Training in cognitive restructuring is most effective when it is preceded by systematically teaching children about the nature of cognition and identifying negative thoughts. To help participants understand their cognitions, we use activities to establish that (a) thoughts affect feelings and behavior, (b) there are multiple stimuli that can be attended to at any time, (c) thoughts are constructed, (d) the construction process is not veridical so thoughts may not be true, (e) thoughts can be changed, and (f) changing thoughts changes affect and behavior. The notion that thoughts may *not* be true is foreign to children. Prior to completing these activities, they believe "Because I think it, it must be true." This knowledge serves as the rationale for cognitive restructuring and contributes to the credibility of the procedure.

To identify negative thoughts, participants are first taught to listen for times when their therapist and other group members verbalize negative thoughts. As they become proficient listeners, they complete homework assignments and within-group activities that help them identify their own negative thoughts and they are reinforced for doing so.

Cognitive restructuring is not simply replacing negative thoughts with positive thoughts. It involves evaluating the validity of the negative thoughts, and this evaluation is guided by a number of questions: (a) What is the evidence? (b) What is another way to think about it? (c) What would I tell my best friend? and (d) What if the thought is true? We use the first two questions with youngsters 14 or younger and all four questions with older youth. In addition, we use a procedure with younger participants that they have named "Talking Back to the Muck Monster." This procedure involves the therapist verbalizing the target child's typical negative thoughts, playfully, as the Muck Monster. The target child then talks back to the Muck Monster by arguing against the negative thoughts,

with other group members assisting as needed (for a description, see Stark, Krumholz, Ridley, & Hamilton, 2009). This procedure works extremely well with younger children, and they report that it is a memorable experience that they apply outside of sessions.

The ultimate objective of cognitive restructuring is changing the core beliefs that underlie negative thoughts and are associated with sadness: I'm unlovable, I'm helpless, and I'm worthless (Beck, Rush, Shaw, & Emery, 1979). The depressed youngster is likely to hold one or more of these core beliefs.

### *Parent Training*

The parent-training component is a hybrid of parent training and family therapy. The objective of the training is to teach parents the same skills that their daughters are learning, to change the family environment so that it is more positive, and to change parent-child interactions that contribute to the development and maintenance of the depressive style of thinking.

The parent-training component includes positive behavior management, family problem solving, communication skills, conflict resolution, and changing behaviors that support depressive core beliefs. Positive behavior management strategies are taught to parents first to try to change the affective tone in the home so that it supports the effort to improve the child's mood through coping skills training and behavioral activation. Parents are taught family problem solving so that they can model the procedure for their children, help them acquire the skill, and support them as they adopt a general problem-solving attitude. Parents are then taught effective communication skills (e.g., empathic listening), followed by conflict resolution skills because these can contribute to a more positive family environment. To support the desired cognitive change that the children are working toward, it is necessary to decrease conflict in the family and enhance positive interpersonal interactions between family members. Finally, with the children and families functioning more adaptively, the parents can collaboratively assess behaviors that they enact that support their children's negative core beliefs. Subsequently, they work at changing these behaviors to behaviors that communicate positive messages to their children, thus supporting the cognitive restructuring that their children are simultaneously learning and applying.

### TRAINING OF ACTION THERAPISTS

As is evident from the description earlier in text, the ACTION program is a multicomponent treatment that requires a great deal of skill to effectively implement. The doctoral student clinicians who conducted the treatment in the outcome study received extensive training and supervision that is described in this section. Would the same level of training be required of a practicing school psychologist, or would less training be necessary?

### *Training and Supervision Procedures*

The doctoral student therapists had completed 3 years of coursework, including a year of coursework in CBT that included a semester of practicum experience with three or four child clients experiencing a variety of emotional difficulties. Following these experiences, they studied the ACTION manuals and workbooks and received session-by-session didactic training in the implementation of the manual. After they completed the didactic training, therapists-in-training observed a senior therapist implementing the treatment. Then, the therapist-in-training co-led a group with a senior therapist. If it was apparent during supervision and from listening to audiotapes of meetings that she could implement the treatment with fidelity, the therapist-in-training would then lead a group while receiving supervision by the first author. It also is important to note that all therapists participated in weekly group and individual supervision throughout their training and

implementation of the treatment. From listening to the audiotapes of the meetings, by the time that the therapists were independently leading their third treatment group, they were implementing the treatment in a relatively expert and “artistic” fashion.

The ACTION therapists had training in the CBT model of depressive disorders and they were taught to develop a cognitive conceptualization of depression (e.g., Beck, 1995) for each child in their group. This conceptualization, which included the child’s core beliefs, was used as the road map that guided the application of the intervention for each group member. A combination of direct training and ongoing supervision is necessary for school psychologists to learn the higher-order thinking necessary for developing case conceptualizations and for using them to guide treatment.

Supervision of the therapists consisted of weekly group and individual meetings to discuss the therapists’ case conceptualizations, experiences implementing the intervention, concerns about individual group members, and group process issues. Supervision included listening to and evaluating audiotapes of meetings. While listening to the audiotapes, the supervisor would identify opportunities to teach the therapists how to better implement the treatment procedures and how to individualize the intervention strategies for each group member.

### *Difficulties Implementing the ACTION Treatment*

Learning how to be flexible while implementing the treatment with fidelity is an important issue when training school psychologists to deliver evidence-based interventions including ACTION. The therapist must flexibly, but with fidelity, adapt the content of the manual to individualize it to meet each child’s needs. Flexibility refers to the therapist’s ability to bring the treatment manual to life for each child, changing the content of the meeting to that of a different meeting, or using a different treatment strategy (e.g., social skills) than the one in the manual when indicated by the participant’s therapeutic needs or the situation. The therapists, moreover, must make treatment interesting and “real” for each child. With regard to the former, the therapist must be able to make the content of the sessions appealing and engaging for the participants. For this, the therapist has to become creative in terms of designing activities that enable participants to experience the therapeutic concepts so that they make sense and are real, and so that they experience benefits of therapeutic procedures within the meetings. With regard to making it “real,” therapists should communicate that treatment procedures are designed to work with, and be appropriate for, concerns that each child brings to the session. Rather than teach participants skills in a didactic fashion devoid of therapeutic content, the therapist brings it to life and executes it in a way that helps participants to learn and apply it to their real-life problems. To achieve this more sophisticated level of implementing the treatment, ongoing supervision by an expert therapist is necessary, and the therapist has to understand the big picture of where the treatment manual is heading and how to use the procedures to get there.

One of the quintessential characteristics of CBT is that sessions are structured, and this is true of ACTION. Structuring treatment sessions is something that has proven difficult for therapists who are not used to doing it. After they have had some supervision and practice with structuring sessions they become comfortable with the progression and learn how to do it flexibly to fit both the agenda for the meeting and the participants’ specific needs and current concerns. The structuring of sessions seems to be taught most effectively through feedback based on listening to audiotapes of meetings.

Coping skills training is relatively straightforward, and it is possible to quickly teach school psychologists how to train depressed youth to use coping skills. Similarly, it is easy for new therapists to learn how to help participants use problem solving. The most difficult skill to teach is cognitive restructuring. The first step to teaching someone to use cognitive restructuring is helping the individual to recognize and elicit thoughts that are negatively distorted in a maladaptive way. Not only must the therapist-in-training learn to recognize and elicit distorted thoughts, he or she has

to learn which thoughts are of higher priority to change. When conducting the ACTION program in a group format, the therapist is often presented with an overwhelming number of negative thoughts verbalized by participants. The therapist has to know which ones are most important to target for change in each child. This decision is based on the child's case conceptualization. Once a negatively distorted thought has been identified as a target for change, the therapist must choose and use the most effective cognitive restructuring strategy. Then, he or she must effectively implement the strategy. In addition, the therapist must be aware of how a negatively distorted thought may stem from a core belief and then use the cognitive restructuring to change the child's core belief. A number of additional important lessons that we learned about how to most effectively conduct the treatment are presented in Appendix 1.

#### TRAINING PSYCHOLOGISTS TO USE EVIDENCE-BASED INTERVENTIONS

The procedures that were used to train the ACTION therapists drew upon the literature and previous experiences conducting treatment outcome research with depressed children (e.g., Stark, 1990; Stark, Reynolds, & Kaslow, 1987). To develop recommendations for training school psychologists to implement the ACTION program (and likely other evidence-based treatments for depression), it is important to review research that evaluates the effectiveness of training procedures for school psychologists who have completed workshops on evidence-based interventions. Characteristics of the training process influence treatment outcome and contribute to weaker effects when a treatment is transported to new settings (Schoenwald & Hoagwood, 2001). The most common method for school psychologists to obtain continuing education is to complete a 1- or 2-day workshop. While this practice is economical and efficient, it does not appear to be effective at producing fidelity in the implementation of the treatment or the same quality of treatment outcome. Training through workshops alone, in the absence of other techniques and supports, were not effective in establishing clinician competence (Sholomskas et al., 2005). When workshops were followed by ongoing supervision, expert consultation, and the provision of feedback on cases, fidelity of implementation was improved. Results of meta-analytic studies of child treatment outcome literature suggest that using treatment manuals and reviewing session tapes were directly linked to greater effectiveness of the interventions (Weisz, Donenberg, Han, & Weiss, 1995).

Clearly, a treatment manual cannot be picked up and immediately implemented in a maximally effective fashion, nor can it be implemented with fidelity after completing a 1- or 2-day workshop. Therapists do not learn many of the subtle aspects of implementing the treatment, nor do they learn the clinical judgment and decision making that is necessary to successfully implement the intervention in such a fashion (Collins, Leffingwell, & Belar, 2007). Additional ongoing supervision and support are necessary to successfully learn and implement an evidence-based treatment. One form of higher-order thinking that has not been discussed to date in the training literature is the process of developing case conceptualizations. The development of case conceptualizations is important as it is this case conceptualization that guides the implementation of the evidence-based treatment manual. The case conceptualization process involves a great deal of higher-level thinking, integrating of information, and decision making that is acquired through supervision and extended training following the workshop.

#### RECOMMENDATIONS FOR TRAINING

As noted earlier, school psychologists maintain a hectic schedule that does not leave adequate time for learning new treatment procedures. Unfortunately, this reliance on workshops for training because of the lack of time for training during the school year is not an effective strategy. In addition, this practice does not teach school psychologists the higher-order thinking and decision making that are necessary for effectively implementing the intervention, nor does it help them adapt the

treatment for cases that present in a somewhat different fashion or with any of a number of comorbid disorders. Furthermore, some of the treatment strategies are not simplistic or intuitive enough for most therapists. Consequently, it is recommended that an alternative training model be adopted that accepts the fact that providing effective therapy is a complex skill that takes a significant amount of training to master.

Adequate training of school psychologists as effective therapists for depressed youth, or for youth with any psychological disorder for that matter, must begin during graduate training. School psychologists must be exposed to and helped to learn appropriate and necessary attitudes, higher-level thinking, and basic therapy skills throughout their professional training courses and practicum experiences. In addition, it is important for graduate students to be exposed to evidence-based interventions through a minimum of a year of didactic coursework that is either accompanied by or followed by a minimum of a year of practicum experience in which students receive supervision from school psychologists who are experts in the delivery of evidence-based interventions. From experience teaching the sequence of courses in CBT at the University of Texas, it is apparent that students have a good basic exposure to CBT after a year of coursework and an additional year of practicum experience. They have the prerequisite and basic knowledge, skills, attitudes, abilities, and experience necessary to benefit from additional training in specific evidence-based interventions during their internship year and subsequently while they are working in a school or school-linked setting.

If school psychologists are provided with adequate coursework and practicum experience in CBT during graduate school, then they are in a good position to benefit from additional training in specific evidence-based interventions, such as the ACTION program, following matriculation. Such training should include a minimum of a 2-day workshop designed to provide an understanding and basic knowledge of how to implement each of the treatment components. This initial workshop should be followed by another 1-day workshop 6 months later to discuss difficulties experienced implementing the intervention and to teach more advanced skills. Additional critical and necessary training components include ongoing supervision and consultation for a year following the workshop while the school psychologist is attempting to apply the ACTION treatment. In addition to the multitude of reasons noted for the ongoing supervision and consultation, it is important to note that depressed youth (and children in general) differ greatly in their experiences of depression and in the causes of their depression. They are likely to vary in terms of severity, age of onset, culture, existence of comorbid conditions, complicating family variables and life circumstances, learning difficulties, and a multitude of other characteristics. Expert consultation and supervision help the therapist to adjust the program intensity and content to meet the needs of children who differ along these characteristics. As noted earlier, inclusion of supervision and consultation increases fidelity and thus efficacy of the intervention. Successfully treating depressed youth will solidify use of new treatment skills, whereas experiences of failure are likely to lead to a regression to the use of old, comfortable approaches to treatment, which are likely to lack an empirical underpinning and produce minimal improvement.

Ongoing supervision including listening to audiotapes allows the supervisor to monitor and evaluate the therapist's ability to structure sessions, implement treatment with appropriate flexibility, and appropriately implement other treatment strategies. More advanced higher-order thinking, such as completing ongoing modifications to the case conceptualization, identifying optimal opportunities to use certain treatment strategies, and identifying core beliefs, can also be instructed. Listening to tapes also can help therapists identify and develop plans for modifying maladaptive behaviors that are occurring during group sessions. As a multitude of activities are occurring in the context of the session, it is easy for the therapist to miss maladaptive interactions. Similarly, parent meetings, especially those that include both children and parents, are so complex that it is useful to have another listen to tapes to provide feedback and observations regarding parent-child interactions.

As mentioned earlier, the most difficult treatment component to learn and effectively implement is cognitive restructuring. A year of ongoing supervision including listening to audiotapes of sessions is necessary for teaching cognitive restructuring. Listening to audiotapes enables the supervisor to help the therapist identify depressive thoughts and core beliefs. Tapes also are used to evaluate the therapist's ability to make decisions about which thoughts to restructure and which strategy to use for restructuring. As the therapist becomes proficient at basic aspects of cognitive restructuring, more advanced cognitive restructuring skills can be taught and monitored as they are used.

Given the time commitment of this model, it may be necessary to participate in the 2-day workshop during the summer when students are not in school. Supervision could occur either right after the students leave for the day or during the late afternoon on Fridays, when students are too distracted to meet for testing or therapy. In addition, this level of training is likely to be significantly more expensive than the traditional workshop model, which does not include ongoing supervision. To obtain this level of commitment for time spent in training, the school psychologist would have to secure permission from relevant administrators. An argument could be made that, if the school district is going to commit to their school psychologists conducting therapy, then they should commit to it being the best possible and most effective therapy. Conducting therapy that has little chance of working is a waste of everybody's time and effort.

#### DISCUSSION

Due to their role in the delivery of mental health services and extraordinary access to youth, school psychologists are in a unique position to deliver evidence-based treatments. It has been noted that such an expansion in roles is contingent on the effectiveness of treatment, which in turn is related to the training and supervision that they receive. CBT has been deemed as "well-established" for the treatment of child and adolescent depression. The ACTION treatment program—a manualized, school-based intervention for the treatment of depressed girls—is prototypical of effective treatments for depressed youth. The ACTION treatment is a multicomponent treatment that is relatively complex and takes extensive training to implement with fidelity. Workshops alone have not demonstrated the ability to produce the necessary treatment fidelity that enables school psychologists to effectively implement similar evidence-based treatments. Supervised clinical training, monitoring of treatment implementation, and ongoing supervision are necessary parts of training.

#### APPENDIX 1

##### *Other Subtle but Important Lessons Learned About How To Effectively Implement ACTION*

1. Children must experience therapeutic concepts rather than simply gain an academic understanding of them.
2. Child treatments should be fun, engaging, and memorable.
3. Children appear to benefit more from meeting twice versus once a week for therapy.
4. It is important to establish no more than three goals at any one time. Otherwise, a depressed child sees him- or herself as too "messed up" and thinks that his or her problems are too vast to be able to be overcome.
5. Many depressed children do not know how to create their own entertainment and do not know how to actively engage in recreational activities, especially activities that include friends.
6. Problem identification and definition may be the most difficult step for depressed children to learn as they often view a problem as representative of a personal weakness.
7. Depressed youth need help choosing constructive goals and avoiding destructive or self-defeating goals for problem solving.
8. It is important for the therapist to process the outcome of problem solving as depressed youngsters are likely to minimize their successes and magnify the significance of their failures.

9. It is important for depressed youth to learn whether a problem is within or outside of their control.
10. The most difficult part of problem-solving training is getting the participants to *use* problem solving outside of the meetings.
11. It is useful to write down more adaptive thoughts on a 3 × 5 index card. Then, when the child experiences a negative thought, he or she can pull out the index card, read, and remember the more valid way of thinking.
12. An activity that can be used to help participants remember positive restructures is to have them write down positive thoughts and place them in a “treasure chest” (shoe box). When they are feeling down or experiencing self-doubt, the children access these reminders and use them as additional evidence with which to evaluate their negative thoughts.
13. Parent training will be effective only if parents attend the meetings. The more personal contact the therapist has with the primary caregiver, the more likely he or she is to participate in the meetings.
14. Failure of at least one parent to attend parent-training meetings has an adverse impact on the depressed child as it is interpreted as evidence that she is unlovable, worthless, and that nothing is going to change this situation.

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