Principle-Guided Psychotherapy for Children and Adolescents

The **FIRST** Program for Behavioral and Emotional Problems

John R. Weisz
Sarah Kate Bearman

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To the many children, families, and clinicians who have taught us so much, and to our own children: Dawn, Allison, Daniel, and Tamara Weisz, and Willa Bearman-Hamill

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Preface

Efforts to help children and adolescents cope with behavioral and emotional problems, and grow up to be well adjusted, are as old as parenthood. However, helping in the form of psychotherapy by mental health professionals has a relatively short history, extending only to the early 1900s; many see this history as beginning with the work of Sigmund Freud, his daughter Anna Freud, and their intellectual heirs. Truly scientific study of psychotherapy has an even shorter history, spanning a bit more than 50 years, but marked by ballistic acceleration once it began. Research on psychotherapy with children and adolescents (referred to in this book as *youths*) now includes more than 500 randomized controlled trials testing a broad array of treatment approaches. The approaches that have been tested and found efficacious in multiple studies are often referred to as *evidence-based psychotherapies.*

Although evidence-based therapies come in many forms, with a variety of content, a case can be made that those therapies draw from a small reservoir of broad *principles of change.* In this book, we describe five such principles that appear to be central to a broad range of psychotherapy procedures and techniques. Our goal is to provide a way to think about therapy, and to build therapeutic skills, that begins with a focus on these core principles—which can be applied to a diverse array of emotional, behavioral, and mental health problems faced by young people. The principles, forming the acronym **FIRST**, include **Feeling Calm** (self-calming and relaxation, including both progressive muscle relaxation and quick calming procedures for reducing tension and regulating emotion); **Increasing Motivation** (including strategies for making adaptive behavior more rewarding than maladaptive behavior); **Repairing Thoughts** (identifying and restructuring biased or distorted cognitions that lead to maladaptive behavior or painful emotions); **Solving Problems** (learning to use sequential steps of problem solving); and **Trying the Opposite** (identifying and practicing activities that are inconsistent with the behavioral or emotional problem being addressed).

In FIRST, these five principles are applied to youth mental health problems including anxiety, obsessive–compulsive disorder, posttraumatic stress, depression, and misconduct. FIRST is thus a *transdiagnostic* treatment. That is, it is a collection of common treatment principles that can be used in the treatment of diverse youth mental health problems. This approach is different from most evidence-based psychotherapies, which tend to focus on one

type of mental health problem. Many of these therapies also involve a sequence of treatment session content that is prescriptive, delivered in more or less the same order for all youths in therapy. In contrast, FIRST is designed to be highly personalized, with the treatment of each individual youth involving only the principles that appear most relevant, and with treatment session content and sequence tailored to fit that youth.

The FIRST approach is intended to complement the array of traditionally designed evidence-based psychotherapies, many of which make extremely valuable contributions to youth mental health. The distinctive complementary contribution of FIRST includes at least five features intended to make the treatment useful to practicing clinicians and counselors in mental health service settings: (1) brevity and protocol design that facilitate efficient training for busy clinicians; (2) broad problem coverage to span the multiple disorders in a typical clinician's caseload, and the comorbidity that is so common; (3) flexibility in treatment content and sequence, needed to permit shifts in focus and approach when a youth's primary problem or treatment needs shift during episodes of care; (4) principles that can be effectively used alone, thus benefiting youths who do not stay in treatment very long; and (5) treatment design informed by feedback from practitioners and from treatment researchers, thus blending the real-world perspective of those who provide care with the empirical perspective of those who study treatments and measure their impact.

In noting the feedback that has guided our work, we want to express our gratitude to the many wise clinicians and clinical scientists whose valuable contributions have made FIRST possible. Because FIRST is explicitly designed to reflect core principles and procedures of some of the most potent evidence-based treatments, we are completely indebted to the many clinical researchers who have developed and tested those treatments, from which the principles and procedures were derived. Their work, spanning more than five decades, is the entire foundation of evidence-based youth psychotherapy, and of FIRST. In addition, we offer special thanks to five distinguished clinical scientists and treatment developers for providing excellent feedback and wise guidance, based on their reading of an earlier draft of the protocol: David Barlow, Alan Kazdin, Philip Kendall, John Lochman, and Kevin Stark. Very importantly, we sincerely thank our clinical practitioner colleagues who provided such thoughtful input and wise counsel, focusing especially on the appropriateness and likely effectiveness of the FIRST protocol for use with clinically referred children and adolescents who are treated in clinical service programs by practitioners. These practitioner colleagues included Melissa Glynn-Hyman, Craig Burns, Joshua Martin, Beverly Singer, Ana Semering, Sarah Hoxie, and Sue Woodward. We also thank Kitty Moore, Carolyn Graham, Anna Brackett, and Marie Sprayberry, our colleagues at The Guilford Press, who guided production of this book from start to finish, with an excellent blend of publishing expertise and wisdom. Finally, we note with thanks the research support we have received over the years, which set the stage for FIRST. That support has come from the Annie E. Casey Foundation, Casey Family Programs, the Connecticut Health and Development Institute, the Institute of Education Sciences (of the U.S. Department of Education), the John D. and Catherine T. MacArthur Foundation, the National Institute of Mental Health, and the Norlien Foundation.

Contents

List of Reproducibles xi

1 All About FIRST 1

2 Using FIRST and the FIRST Decision Trees to Treat Anxiety/OCD, Posttraumatic Stress, Depression, and Misbehavior 16

3 Beginning Treatment 33

4 Clinician Guides: Facts About the Problems Treated with FIRST 45

5 Help for Caregivers: Handouts on the Problems Treated with FIRST 54

Think FIRST: Planning Treatment, Case by Case 63

Summary Overview of the FIRST Treatment Program 68

6 Using the FIRST Principles: Feeling Calm 72

7 Using the FIRST Principles: Increasing Motivation 88

8 Using the FIRST Principles: Repairing Thoughts 122

9 Using the FIRST Principles: Solving Problems 140

10 Using the FIRST Principles: Trying the Opposite 157

11 Skill Units for Continuing Treatment, Boosting Engagement, and Ending Treatment 182

Appendix I. Published Studies Testing Independent Effects of the Five FIRST Principles **197**

Appendix II. Sample Progressive Muscle Relaxation Script **200**

Appendix III. Using FIRST for Panic Attacks and Tic/Habit Behaviors **202**

Appendix IV. Frequently Asked Questions About Using FIRST in Clinical Practice **207**

References **209**

Index **213**

Purchasers of this book can download and print select materials, including an online-only Spanish supplement, at *www.guilford.com/weisz2-materials* for personal use or use with clients (see copyright page for details).

List of Reproducibles

Figure 2.1. Anxiety and OCD decision tree 17

Figure 2.2. Posttraumatic stress decision tree 22

Figure 2.3. Depression decision tree 25

Figure 2.4. Misbehavior decision tree, caregiver-focused 29

Figure 2.5. Misbehavior decision tree, youth-focused 30

The FIRST Interview—Caregiver 33

The FIRST Interview—Youth 35

Handout 1. Caregiver Problems and Coping Form 41

Handout 2. Youth Problems and Coping Form 43

Handout 3. Help for Caregivers: Understanding Anxiety and Obsessive–Compulsive Disorder 55

Handout 4. Help for Caregivers: Understanding Posttraumatic Stress 57

Handout 5. Help for Caregivers: Understanding Depression 59

Handout 6. Help for Caregivers: Understanding Misbehavior 61

Think FIRST: Planning Treatment, Case by Case 63

Summary Overview of the FIRST Treatment Program 68

Feeling Calm: In-Session Practice 85

Handout 7. Feeling Calm: Home Practice 86

Handout 8. Caregiver Guide to Feeling Calm 87

Handout 9. Increasing Motivation: In-Session Preparation for Home Practice 107

Handout 10. Caregiver Guide to Increasing Motivation **109**

Handout 11. Caregiver Guide to Together Time **110**

Handout 12. Caregiver Guide to Praising Appropriate Behavior **111**

Handout 13. Caregiver Guide to Differential Attention: Active Attending and Active Ignoring **112**

Handout 14. Caregiver Guide to Giving Effective Instructions **114**

Handout 15. Caregiver Guide to Tangible Rewards and Privileges **115**

Handout 16. Caregiver Guide to Time Out from Positive Reinforcement **118**

Handout 17. Caregiver Guide to Developing a Daily School Report **120**

Repairing Thoughts: In-Session Practice **136**

Handout 18. Repairing Thoughts: Home Practice—Catching and Fixing Negative Thoughts **137**

Handout 19. Repairing Thoughts: Home Practice—Catching Positive Thoughts **138**

Handout 20. Caregiver Guide to Repairing Thoughts **139**

Solving Problems with S-O-L-V-E: In-Session Practice **154**

Handout 21. Solving Problems with S-O-L-V-E: Home Practice **155**

Handout 22. Caregiver Guide to Solving Problems **156**

Trying the Opposite: In-Session Practice **179**

Handout 23. Trying the Opposite: Home Practice **180**

Handout 24. Caregiver Guide to Trying the Opposite **181**

1

All About FIRST

FIRST: Origin, Content, and Purpose

> ***Kevin**, age 7, is afraid to separate from his mother. He dissolves in tears and screams in agony when she tries to drop him off at school. Kevin is referred to a counselor who focuses specifically on separation anxiety.*
>
> ***Rachel** is 13. Her parents take her to a mental health clinician because she is sullen, angry, and disrespectful; won't do chores at home; and sometimes refuses to go to school. The clinician soon discovers that Rachel is also depressed and anxious about peer relationships at school, and that her mood—even within a single therapy session—can shift from anger to sadness to anxiety in a matter of minutes.*
>
> *Nine-year-old **Lee** is aggressive with peers and hard for his teacher and parents to manage. His school counselor discovers that Lee has vivid, frightening memories of traumatic experiences he had before his adoption, and that Lee fears others will harm him if he doesn't strike first.*

Unlike Kevin, Rachel and Lee are coping with multiple problems, and their most pressing problem may change frequently during the course of a day—or even in the middle of a session with their clinician. Young people like Rachel and Lee are often seen in treatment and counseling; in fact, they are seen more often than kids like Kevin, who have just one problem or one disorder. FIRST can be used to treat a single problem, like Kevin's, but its flexible design also makes it a good fit to girls and boys with complex difficulties, like Rachel and Lee.

What Does It Mean That FIRST Is "Principle-Guided"?

FIRST can be used with young people as different as Kevin, Rachel, and Lee because it is a **principle-guided** intervention. Instead of prescribing a specific sequence of treatment procedures or techniques for a specific problem or disorder, FIRST uses five core intervention principles that research has shown to be effective with a range of different problems. In FIRST, a clinician uses these principles to design a distinctive individualized intervention

for each young person. FIRST is designed for youths ages 6–15 who have primary problems or diagnoses in the areas of anxiety, obsessive–compulsive disorder (OCD), posttraumatic stress, depression, and/or misbehavior. The 6- through 15-year age range reflects the fact that evidence supporting the use of FIRST principles with all these disorders and problems is found within that range. However, a number of the principles can be extended to youths outside that age range for some of the problem areas. For example, FIRST can be used to treat misbehavior for children as young as 2 years. FIRST can be used to help youngsters with a single problem or disorder, like Kevin, but it can also be applied to youths with complex problems and those whose primary problems and treatment needs shift during treatment, like Rachel and Lee. This is possible because the five FIRST principles can be used in a variety of ways and adapted to fit multiple different problems. A core objective of FIRST is to provide a **user-friendly, flexible approach to evidence-based practice** that can be **personalized to fit each youth.** The broad range of problem coverage is intended to make FIRST relevant to the majority of most clinicians' caseloads.

Where Did the FIRST Principles Come From, and What Are They?

Across more than five decades of clinical research, and more than 500 controlled studies, clinical scientists have identified treatments that are effective with children and adolescents who have mental health and behavioral problems (Asarnow, Rozenman, Wiblin, & Zeltzer, 2015; Schleider & Weisz, 2017; Weisz, Kuppens, et al., 2017). Those treatments with the strongest support—typically from multiple studies—are called *evidence-based* (Weisz & Kazdin, 2017). Five of the core principles of these effective programs appear time and time again, and in treatments for a great variety of youth disorders and problems. These five principles have been used in multiple treatment studies encompassing anxiety/OCD, posttraumatic stress, depression, and misbehavior; the beneficial effects have been evident in a range of settings, including schools, mental health clinics, hospitals, and pediatricians' offices. Studies have also shown beneficial effects of each principle when used alone, as a solo intervention without other treatment procedures (see Appendix I). These five potent, widely used treatment principles have been brought together to form our treatment program. The principles, forming the acronym **FIRST**, include **Feeling Calm** (self-calming and relaxation, including both progressive muscle relaxation and quick calming procedures for reducing tension and regulating emotion); **Increasing Motivation** (including strategies for making adaptive behavior more rewarding than maladaptive behavior); **Repairing Thoughts** (identifying and restructuring biased or distorted cognitions that lead to maladaptive behavior or painful emotions); **Solving Problems** (learning to use sequential steps in problem solving); and **Trying the Opposite** (identifying and practicing activities that are inconsistent with the behavioral or emotional problem being addressed).

There Are Lots of Other Treatments, so Why Use FIRST?

The many studies noted above have led to the development of dozens of manuals, all for the treatment of youth mental health and behavioral problems. Given that all those manuals

already exist, is FIRST really needed? What does it add? There are several answers to this question.

One answer is that FIRST combines evidence-based treatments in a way that supports personalized care for each individual youth (Ng & Weisz, 2016). Most youth mental health treatment manuals are focused on one kind of problem only—depression, for example—and they consist of a set of treatment procedures to be delivered in a relatively fixed order (what to do in Session 1, what to do in Session 2, etc.). That approach can be very good for young people who have only one kind of mental health problem, and these treatments can work well in a variety of specialty clinics. However, many young people who are referred for counseling or psychotherapy have multiple problems, and their problems and needs may change frequently throughout treatment. What these young people need is treatment that has the flexibility to address multiple problems and navigate across changes when there are shifts in their most pressing problems (Bearman, Ugueto, Alleyne, & Weisz, 2010; Bearman & Weisz, 2015; Weisz, Krumholz, Santucci, Thomassin, & Ng, 2015). One approach to doing this is to build a large menu of specific treatment procedures or modules from evidence-based treatments—some for anxiety, some for depression, and so forth (e.g., the program described in Chorpita & Weisz, 2009, contains 33 modules). That approach can be very useful for many purposes, and we have used it often. However, we have found that it can sometimes be a challenge for busy clinicians to master all the components of such a program, and the complexity can be a challenge for some youths and caregivers as well (Weisz et al., in press); the expansive modular approach also requires rather costly and time-consuming training and consultation. An alternative or complementary approach, represented by FIRST, is to use a small number of core principles of therapeutic change, each of which is applicable to treatment of multiple kinds of problems. This latter approach, used in FIRST, resembles what has been called a *shared-mechanisms* approach (Sauer-Zavala, Cassiello-Robbins, Ametaij, Wilner, & Pagan, 2019)—an effort to focus treatment on broad processes that are relevant to multiple disorders and problems. This more *transdiagnostic* approach may facilitate learning, and the efficiency and streamlining can reduce complexity and cost (see Weisz, Bearman, Santucci, & Jensen-Doss, 2017).

An important feature of FIRST is that we have reduced the amount of lengthy content clinicians must learn by consolidating conceptually similar treatment strategies that often appear in slightly different forms in different treatments addressing different disorders and problems. For example, repairing distorted or unhelpful cognitions relies on the same basic practices, whether the thoughts are misinterpreting threats, placing undue blame on the self, or mistakenly attributing hostile intent to another person. In FIRST, a single principle (Repairing Thoughts) addresses each of these problems. As another example, evidence-based therapies use behavioral exposure for anxiety or OCD, exposure to intrusive memories in treatment of posttraumatic stress, behavioral activation for depression, and prosocial behavioral rehearsal for misbehavior; however, these procedures all share the core element of acting in a way that runs counter to one's first impulse, in order to violate one's incorrect expectations and thus to create a corrective experience. Instead of presenting these as separate strategies, FIRST incorporates all of them within one shared principle (Trying the Opposite). Similar reasoning applies to the other FIRST principles: Each principle is a core concept that encompasses multiple treatment procedures for multiple problems.

In this way, FIRST brings together and condenses the content of many separate, well-tested treatment manuals. The goal is to make evidence-based practice accessible to busy clinicians and to fit the complex cases and circumstances clinicians encounter in everyday practice. For versatile application, FIRST integrates five therapeutic principles, each of which has been found to be effective *even when used alone.* Some of the evidence on the independent effects of these five principles is summarized in Appendix I. This appendix is organized into three problem clusters: an anxiety cluster (including OCD, posttraumatic stress, and other disorders and problems involving anxiety), a depression cluster, and a misbehavior cluster. The five principles, which span problems in all these clusters, can be flexibly combined to tailor treatment to the needs of each individual youth. By using previous evidence on which principles work with which clinical conditions and problems, we have created decision trees (presented in Chapter 2) to help guide judgments about which principles to use, and in which order, with each individual youth in treatment. Because clinically referred youths often present with multiple disorders or problems, and their treatment needs may change as treatment progresses, we also provide guidelines for addressing co-occurring problems and flux in treatment needs during episodes of care.

Who Can Be Treated with FIRST?

FIRST was designed to accommodate a large proportion of the youths seen in community practice, schools, clinics, and behavioral health care settings. Specifically, FIRST can be used with youngsters ages 6–15 who have been diagnosed with one or more of the following disorders, *or who have problems associated with or similar to symptoms of these disorders:*

Anxiety, Obsessions, and Compulsions

- Generalized anxiety disorder
- Separation anxiety disorder
- Social phobia (now called social anxiety disorder)
- Agoraphobia
- Selective mutism
- Specific phobia
- OCD (which now has its own diagnostic category, obsessive–compulsive and related disorders, in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* [DSM-5; American Psychiatric Association, 2013])
- Problems involving anxiety, obsessions, or compulsions

Posttraumatic Stress

- Posttraumatic stress disorder
- Acute stress disorder
- Problems involving posttraumatic stress

Depression

- Major depressive disorder
- Persistent depressive disorder (also called dysthymia)
- Problems involving depression

Misbehavior

- Oppositional defiant disorder
- Conduct disorder
- Problems involving misbehavior

Related Problems and the Relevance of FIRST

The FIRST principles may also be applied, with adjustments, to panic attacks/panic disorder and tic/habit behaviors and disorders, as described in Appendix III. In addition, a number of DSM-5 adjustment disorders include core features of the disorders listed above and may be appropriately treated with the principles of FIRST. Importantly, there are many young people who have not been formally diagnosed, but who have problems and challenges closely related to the features of the disorders we have listed. These might include, for example, youths who seem chronically sad or frequently very anxious but don't meet diagnostic cutoffs for a depressive or anxiety disorder, and youths who are often disruptive or disobedient but don't meet criteria for one of the disorders of misbehavior. For such young people, the principles of FIRST may also be relevant and helpful.

What About ADHD?

Although FIRST does not specifically address problems of inattention and hyperactivity, it can be used for the behavioral and conduct problems that are often prominent in attention-deficit/hyperactivity disorder (ADHD). For this reason, many young people who carry a diagnosis of ADHD may be highly appropriate candidates for treatment via FIRST.

What About Medication?

Although pharmacological interventions are not specifically proposed in FIRST, medication can certainly be used adjunctively as needed, when providers and family members agree that it is appropriate.

The Role of Specialty Clinics

In some communities, specialty clinics exist for the treatment of specific mental health conditions—for example, chronic OCD or severe conduct problems. For young people whose problems are focused in one mental health domain, and for whom an evidence-based specialty

clinic with expert clinicians is available, such a clinic may be an excellent fit. In communities where an appropriate specialty clinic is not available, the breadth and flexibility of FIRST may make it a sound option for families, particularly as an initial step of help seeking.

The Five FIRST Treatment Principles

Each of the five treatment principles in FIRST has been tested and shown to be effective as a solo intervention for multiple types of youth mental health problems, in addition to being tested in combination with other principles and skills. A list of illustrative studies testing solo effects of the principles is provided in Appendix I.

F: Feeling Calm

Feeling Calm involves helping young people to use relaxation techniques, including deep breathing, guided imagery, and progressive muscle relaxation; teaching such techniques can be effective as a sole intervention. Depressed youths have shown significant depression reduction when they have learned relaxation skills. Anxious youths and those with posttraumatic stress may find calming techniques helpful as adjuncts to their primary treatment, which typically involves practice doing activities they fear (see "T: Trying the Opposite," below). In addition, calming techniques can contribute to anger management and emotion regulation in boys and girls who have problems involving misbehavior.

I: Increasing Motivation

Increasing Motivation through the use of planned child–caregiver activities, attention and praise for good behavior, active ignoring of not-so-good behavior, and behavioral contingencies/tangible rewards has also proven to be effective as a solo treatment approach. For anxious youths, this technique has been used to increase independent and assertive behaviors, and to boost motivation to confront feared situations (see "T: Trying the Opposite," below). Motivation enhancement has also been used as an active ingredient in well-supported youth depression treatments. For misbehavior, caregiver use of these motivation enhancers has been shown to improve youth conduct and to reduce noncompliance and aggression.

R: Repairing Thoughts

Repairing Thoughts involves helping young people become aware of their unhelpful, unrealistic thoughts, and helping them convert those thoughts into more realistic, helpful, and positive cognitions. Repairing Thoughts has been used as a successful intervention for childhood anxiety and posttraumatic stress (e.g., defusing unrealistically scary thoughts), OCD (as a companion to testing irrational obsessions with behavioral exposure), depression and sad mood (e.g., reappraising depressive distortions), and misbehavior (e.g., altering hostile attributions that lead to aggression). In FIRST, these approaches have been synthesized to

help clinicians use this valuable treatment principle in slightly different ways, depending on which problems are targeted in treatment.

S: Solving Problems

Solving Problems—that is, using a simple, logical sequence of problem-solving steps—is an especially versatile skill that young people can apply to a variety of recurring difficulties at school, at home, and with peers. In fact, problem-solving skill is central to some of the most potent youth treatments. Teaching this skill has proven effective for youths with anxiety-related disorders when used in combination with behavioral exposure, and it has worked as a stand-alone treatment for youths with depression and sad mood. It can also be a powerful intervention for conduct-related problems in young people who need to identify a workable alternative to angry, aggressive, explosive behavior.

T: Trying the Opposite

Trying the Opposite involves confronting the central challenge of a particular problem or disorder by having the young person practice actions that are the *positive opposites* of the problem behaviors. In treating anxiety and OCD, Trying the Opposite takes the form of gradually confronting the feared situation (planned exposure). In treating depression, Trying the Opposite involves having youngsters schedule and practice pleasant activities rather than moping around or being lethargic—activities that can redirect their attention away from unhappy thoughts or feelings, and boost their mood. Approaching avoided activities may also increase access to positive reinforcement (e.g., attending a social event), which can also help to combat depressed mood. For misbehavior, Trying the Opposite involves rehearsing adaptive responses such as self-control and anger management in the face of known triggers for misbehavior. In all instances, Trying the Opposite is a way of giving young people new experiences that challenge their maladaptive expectancies. The goal is to have them learn and practice new skills that will replace problematic behavior.

How to Use FIRST

Overview of FIRST and Its Skill Units

FIRST includes individual **Skill Units** in Chapters 6–10, respectively, for each of the five treatment principles: Feeling Calm (relaxation), Increasing Motivation (rewards and consequences), Repairing Thoughts (cognitive restructuring), Solving Problems (sequential problem solving), and Trying the Opposite (activation, exposure, and adaptive behavior rehearsal). It also includes Skill Units for beginning, continuing, and ending treatment, and for enhancing engagement as needed (see Chapters 3 and 11). Each Skill Unit is essentially a structured plan that a therapist can use in implementing treatment. Each one includes a general introduction for the therapist, including an overview of the material to be conveyed plus general principles for introducing the content in session. Separate in-session Clinician Guides for

all of the problem areas (anxiety, depression, etc.) are provided in Chapter 4, along with examples illustrating how each Skill Unit can be applied to each type of problem. Finally, handouts for the youth and caregiver are included in Chapters 6–10, and Chapter 5 provides caregiver handouts on each of the problem areas covered in FIRST. For some of the skills, the handouts are the same, regardless of the problem area. For other skills, the handouts differ, depending on the problem area.

Identifying the Initial Treatment Focus and Beginning Treatment

Treatment will begin with understanding and clarifying the primary problem(s) that will be the focus of treatment, and this protocol includes an interview to guide this process. It is important to obtain both the parent's and the youth's perspectives on the problems that they consider most important and that they would like therapy to focus on (Weisz et al., 2011). A procedural manual for conducting the Top Problems Assessment (discussed further below) is available free of charge from the website of John Weisz's lab—the Laboratory for Youth Mental Health, Harvard University (*www.guilford.com/weisz-lab*). Ideally, the procedures we suggest will be accompanied by a valid method of diagnostic assessment and/or standardized measures of the youth's problems and adaptive functioning. When the focus of treatment is established, it is important to orient the caregiver and youth to the FIRST treatment approach, and to focus from the outset on enhancing motivation and engagement in therapy. Family engagement is key to ensuring regular attendance and caregiver participation in treatment and preventing dropout (Becker, Boustani, Gellatly, & Chorpita, 2018; Haine-Schlagel & Walsh, 2015). The sections of Chapters 3 and 6–10 on initial, educative sessions provide procedures for engaging and motivating families during these initial meetings. These include guidelines in the following areas.

What to Expect

A mismatch between caregiver expectations and the treatment provided to youths may put families at risk of ending treatment prematurely. Thus therapists should spend time with caregivers to give them an informed preview of the core aspects of this treatment approach. Therapists should help caregivers understand the structure of the treatment, while also beginning to build a working alliance. Therapists will emphasize that the treatment is time-limited and designed to target the specific presenting issues related to anxiety or OCD, post-traumatic stress, depression, and/or misbehavior. Caregivers and youths should understand that the techniques used to meet these goals will include (1) in-session activities, such as role play, to illustrate concepts and skills; (2) homework assignments to practice concepts and skills between meetings; and (3) consistent monitoring of how things are going, week by week. Finally, a therapist will empower a caregiver as a key partner in treatment and set the stage for the caregiver's involvement as a coach to help the youth practice the coping skills that will be learned in therapy. In treatment of misbehavior, caregivers may be much more active participants, learning ways to manage their youths' behavior at home.

Using Assessment to Identify Treatment Needs and Monitor Treatment Response

We encourage therapists, just prior to treatment, to use a broad standardized measure to assess a wide array of possible youth problems and strengths. Such a measure should include forms for both youth self-report and caregiver report (teacher report measures are also valuable whenever their use is feasible). Examples include the Child Behavior Checklist and Youth Self-Report (Achenbach & Rescorla, 2001); the Youth Outcome Questionnaire (Burlingame et al., 2001); and, for those seeking a free measure, the Strengths and Difficulties Questionnaire (Goodman, 2001). We also provide FIRST users with an interview procedure a therapist can use to identify and understand specific problems that are of greatest concern to a youth, and separately to the caregiver. In this **Top Problems Assessment** (Weisz et al., 2011), youths and caregivers (interviewed separately) are asked to identify the three problems they most want to have addressed in therapy (see the procedures for this assessment at *www.guilford.com/weisz-lab*). These problems are used in an engagement exercise (see the next subsection), and ideally are rated for severity each week throughout treatment—youth problems rated by the youth, caregiver problems rated by the caregiver—as a way of monitoring how much treatment is helping with the most important consumer-identified problems.

Engaging Youths and Caregivers, and Addressing Potential Barriers to Treatment

To prevent dropout and to enhance attendance and participation, FIRST includes procedures to identify and address barriers to treatment (e.g., caregiver attitudes toward mental health; negative prior experience in treatment; and practical barriers such as transportation, child care, and scheduling) and to build motivation for active participation. For a therapist's initial meetings with a caregiver and youth (and potentially for later meetings, to revisit plans if difficulties arise), we have included separate **Caregiver** and **Youth Problems and Coping Forms** (see Handouts 1 and 2 on pages 41–44), to be completed in person. These forms represent an engagement strategy inspired in part by Nock and Kazdin's (2005) Participation Enhancement Intervention, a brief intervention that was found to increase attendance and participation in behavioral parent training for youths with significant misbehavior. Using these forms, the therapist will help the youth and the caregiver identify the following:

- For each of the "top problems," why the problem is important to work on, and how life will be different if the problem is solved.
- What the youth and caregiver plan to do to help fix these problems (e.g., participate in meetings with the therapist, learn and practice new skills with the therapist and on their own).
- What obstacles may make it hard to work on the problems (e.g., difficulty in making it to treatment sessions, or trouble finding time to practice the new skills).
- What the youth and caregiver plan to do to cope with each obstacle (e.g., set aside a regular time at home to practice).

Strategies to Support Ongoing Engagement

Because engagement in treatment is an ever-evolving process, we also include strategies that can be used as needed throughout treatment to enhance motivation, clarify expectations, and address issues that arise with attendance, completion of practice assignments, or the client–therapist relationship. These strategies are derived from the impressive evidence (Lundahl & Burke, 2009) on how *motivational interviewing* (Miller & Rollnick, 2013) can help resolve ambivalence and promote behavior change. The strategies include the following:

- Use of Socratic questioning, affirmations, reflections, and summarizing to ensure a collaborative process.
- Promoting change talk on the part of the client or caregiver through the use of evocative questions and assessment of motivation and readiness for change.
- Responding to resistance by focusing on strengths and values, and by using cost–benefit analyses, reflection, and reframing.
- Instilling hope and supporting self-efficacy.
- Encouraging the use of client or caregiver progress monitoring.

Using Decision Trees to Decide Which Principles to Use and When

In using the FIRST protocol, therapists will make a series of judgments in relation to each youth who is seen in treatment. Many of the judgments will apply to decisions about which of the FIRST principles to use and in which order. To help in this process, we provide a decision tree in Chapter 2 for each of the problem areas targeted by FIRST. Each tree depicts a treatment sequence that is suggested by research on the primary problem being targeted in treatment. However, the research is based on group trends, and each individual youth is unique. So, while the sequence in each decision tree is a good starting point, the exact sequence for any individual youth should be personalized. To help with personalizing, each decision tree also includes suggestions for adjusting the sequence to address individual youth characteristics or treatment obstacles. As an example, for a youth who is not very motivated to change, the therapist may need to use the Increasing Motivation skills as a first step in treatment.

Decision Points

As a therapist selects the skills to use in treatment, whether at the start of treatment or as treatment progresses, the decision tree will indicate treatment junctures where the clinician chooses which of the five FIRST principles to use (each juncture is indicated by a diamond-shaped symbol, ). The decision tree will note the nominated principle for the targeted problem area, and will ask whether that principle is appropriate, given the client and situation. We provide assessments to use in deciding whether the nominated principle is appropriate, and if not, which other principle may be a better fit. In each case, the clinician is encouraged to identify the underlying obstacle (e.g., low motivation, unrealistic fears) in order to select the most appropriate principle.

Skill Units and How to Use Them

The **Skill Units**, described above, are structured plans the therapist can use in implementing treatment. Each Skill Unit includes the following parts:

- *Skill Unit Objectives.* These are goals for changes in the youth's knowledge, behavior, thoughts, and feelings, to be met by the end of each unit. A list of Skill Unit Objectives precedes each Skill Unit Outline.

- *Session Components.* These elements are listed in each Skill Unit Outline and should be included in every session, regardless of content. In most sessions, the elements include agenda setting, family information sharing, skill assessment, and "finishing strong" (e.g., by making time for an engaging activity at the end).

- *Skill Unit Components.* These components, also included in each Skill Unit Outline, are the heart of the protocol; they constitute the content to be covered. The components are listed and then described in detail, along with concrete suggestions on how to deliver the material effectively. Each Skill Unit may well require multiple treatment sessions; this section provides therapists with guidance in preparing for those sessions.

- *Additional Suggestions: Developmental Differences, Using [Name of FIRST Principle] in Real Life, Involving the Caregiver, and Taking It to School.* These four sets of suggestions follow the Skill Unit Outlines in Chapters 6–10. ("Developmental Differences" and "Involving the Caregiver" also follow the Skill Unit Outlines in Chapter 11.) One key to success in FIRST is making the treatment procedures work across a broad age and developmental range. Parenting procedures that work well with 8-year-olds may not fit adolescents. Cognitive procedures that work well with teens may confuse 8-year-olds. Our "Developmental Differences" sections include ideas for adapting procedures to fit various levels of maturity and understanding across the 6–15 age range encompassed by FIRST. We also provide tips for making FIRST relevant to young people's real lives outside of treatment sessions (e.g., at home, in school, and with peers), and we provide suggestions for appropriate involvement of caregivers and school personnel.

✦ TRICKS OF THE TRADE: Ideas for Making Treatment Interactive and Developmentally Appropriate

Each Skill Unit in Chapters 6–10 has companion "Tricks of the Trade" sections with suggested methods for building skills in therapy, including modeling, role plays, *in vivo* exercises, strategies for designing valuable homework assignments, and tips on keeping sessions lively and engaging. A key principle of the FIRST model is that youths and caregivers will learn new skills best if they (1) practice them, and (2) experience them as useful both within the session and between sessions. A therapist should look for "hooks" within each session—opportunities to show the relevance of a particular skill in the moment. A youth's bad mood, for example, can be turned into a learning opportunity. If the youth's mood grows darker after he or she tells about an experience followed by a pessimistic thought that followed the

experience, the therapist might note how this shows that thoughts can lead to feelings. The therapist might then suggest some joint "detective work" to see whether that pessimistic thought was actually realistic. Using gentle, Socratic questioning, the therapist might lead the youth to recognize that the pessimistic expectation never actually came true, and thus a more positive thought would be more realistic. The youth might then be asked to describe his or her mood in light of the new, more positive thought—and this could show that making thoughts more realistic can improve mood. The second Skill Unit in Chapter 11 of this book provides more ideas about ways to boost both youth and caregiver engagement in treatment.

Assessing Skill Acquisition

An important aspect of FIRST is continued assessment of the youth's (and/or caregiver's) understanding of, and ability to implement, each of the skills conveyed in therapy. Accordingly, one of the Session Components in each FIRST Skill Unit in Chapters 6–10 is an assessment of skill acquisition, and each of these chapters includes a "Skill Assessment" section to gauge mastery of the skill that has been introduced. These assessments can be used to help the clinician determine when the youth is ready to progress to the next step in treatment.

Addressing Treatment Barriers

Because both pragmatic and philosophical barriers can arise throughout treatment and can threaten progress, we include suggestions for addressing common types of therapeutic obstacles (e.g., difficulties with attendance, participation, and homework completion). Strategies include clarifying goals and values, techniques to identify and resolve ambivalence, problem solving, and contracting. Proactive steps toward anticipating and preventing problems include the use of the Caregiver and Youth Problems and Coping Forms (Handouts 1 and 2 on pages 41–44). Steps that can be taken later in treatment to address engagement problems as they arise can be found in Boosting Engagement, the second Skill Unit in Chapter 11.

Putting It All Together: Continuing Treatment

We have provided a template for how to use previously introduced Skill Units together flexibly, so that sessions can incorporate more than one behavioral principle. This is intended to help a therapist coordinate the use of those FIRST principles that that are most relevant to each youth's needs in a way that is tailored to that specific young person. All this is covered in the first Chapter 11 Skill Unit, Continuing Treatment.

Ending Treatment and Posttreatment Planning

When the relevant skills from FIRST have been learned and can be used effectively without further therapy, the therapist will need to prepare the youth and caregiver for the end of treatment. This preparation should include a review of what skills have been learned and how they can be applied to real-life situations. There should also be a celebration of treatment gains, and some very specific planning for how the youth and/or caregiver will apply

the FIRST skills to possible future stressors. FIRST includes a Skill Unit to help therapists in the process of ending treatment and planning posttreatment. Ending Treatment is the third Skill Unit in Chapter 11.

Examples of Fear Hierarchies and Behavior Charts

As emphasized throughout, we encourage individual tailoring and personalizing of the FIRST principles to fit each young client. However, concrete examples of some of the procedures may provide useful starting points. Figure 10.2 in Chapter 10 gives examples of fear hierarchies that may be used in treating anxiety-related disorders and problems, as well as OCD. Examples of rewards/privileges and responsibilities that can be used to help motivate young people are shown in Handout 15 on pages 115–117.

Sample Script for Progressive Muscle Relaxation

Therapists who use progressive muscle relaxation to help their young clients build their Feeling Calm skills are encouraged to tailor their procedures and exact wording to fit each individual client. However, as a starting point, we have placed one example of a relaxation script in Appendix II.

Ways to Use FIRST with Panic Attacks and Tic/Habit Behaviors

Some rarer behaviors and disorders seen in some young people require adaptations to the FIRST approach. See Appendix III for details on how to use FIRST with panic attacks/panic disorder and tic/habit behaviors and disorders.

Frequently Asked Questions About Using FIRST in Clinical Practice

In Appendix IV, we offer suggestions in response to several questions that are likely to arise for clinicians who use FIRST in their clinical practice—for example, questions about using psychotropic medication, dealing with risk of self-harm, and applying FIRST when youths are placed out of their homes.

Assessment at Intake and Weekly Monitoring

Intake Assessment

Good treatment begins with sound assessment. All youths and their caregivers should first complete their standard clinic intake procedures to ensure that complete family, developmental, and medical histories are obtained. A structured diagnostic interview *may* be used to identify diagnoses for which a youth meets criteria; alternatively (or as a complement to diagnosis), empirically sound standardized assessments can provide information on which of the youth's problem areas are sufficiently severe to fall within the clinical range. It is also important to understand the specific concerns that each youth and caregiver brings to treat-

ment, so that treatment can address those concerns. Again, this can be accomplished via the Top Problems Assessment, mentioned earlier in this chapter.

Weekly Monitoring

In addition to the intake assessment, weekly monitoring of each youth's treatment response is needed throughout treatment to guide the ongoing decision making required in FIRST. The measures used need to be psychometrically sound but also brief, so that youths and caregivers will be willing to complete them repeatedly. We recommend including youth report and caregiver report measures of (1) the severity of the specific problems identified as "most important" by each youth and caregiver in the Top Problems Assessment, and (2) internalizing and externalizing problems assessed via the Behavior and Feelings Survey (Weisz et al., 2019). Like the Top Problems Assessment manual, the youth and caregiver forms of the Behavior and Feelings Survey are available at no cost from *www.guilford.com/weisz-lab*. A Web-based system, **Progress Assessment in Therapy (PATH),** licensed by Harvard University, is available for automated administration of these measures and production of individual youth "dashboards" that display problem severity ratings in graphic form, weekly throughout treatment, for clinician review. The PATH system can also provide a full picture of each youth's treatment trajectory from start to finish, showing the pace of change and how much improvement was evident by the end of treatment.

Dealing with Comorbidity

If multiple clinically impairing disorders or problems are identified before treatment begins, then a decision must be made about what should be the first target of treatment. This decision should be guided by information from the intake assessment, the relative severity of the different problem areas as shown in the standardized measures used, the Top Problems Assessment severity ratings by caregiver and youth, and a judgment about which problems interfere most with the youth's functioning. All these sources of information should be discussed by the clinician, caregiver, and youth (as appropriate) to reach a consensus decision. If there is no consensus, the binding judgment should be that of the caregiver, who has legal responsibility for the youth.

Dealing with Changes in Treatment Focus

At any point in treatment, comorbid disorders may disrupt or interfere. For example, a boy being treated for depression may develop serious conduct problems and refuse to cooperate, or a girl being treated for anxiety may reveal serious symptoms of depression that sap her energy for the anxiety homework. Whenever this happens, the clinician and supervisor should consider whether the initial identification of the primary treatment focus remains appropriate, or whether a different problem should be the main treatment target. A reassessment with caregiver and youth may assist the therapist in deciding either to continue with the originally identified target problem, or to switch the focus to a comorbid problem. At times a shift in focus is needed to deal with a new situation that has arisen, or with a problem that

is time-limited. In these cases, the shift in focus may be temporary—for example, suspending treatment of an anxiety disorder for a few weeks to help the caregiver develop a tangible rewards system (using the Increasing Motivation skills) to avert a school homework crisis. In such cases, the change in treatment focus may be a brief detour, followed by a return to the original focus after the short-term situation has been addressed. In other cases, the problem targeted first (say, separation anxiety with school avoidance) may have been resolved, and an additional problem (say, depression) will need to be addressed before treatment ends.

Coping with Crises by Turning Them into Teaching Moments

Often during treatment episodes, real-life problems or crises arise that demand immediate attention in therapy. Suppose that Evan, age 11, is stunned to learn that his military parent is being deployed overseas, or that 13-year-old Megan is shattered because her best friend has dumped her. Some youngsters experience such events so frequently that they seem like "crises of the week" (COWs). Therapists may be tempted to respond to these COWs by suspending their treatment plans. We recommend, instead, using each COW as an opportunity to apply FIRST skills; a therapist can treat the crisis as a learning opportunity, a teaching moment. The therapist can be very responsive to the young person's concern, focus exclusively on the crisis, *and also* illustrate how the FIRST skills can be used to deal with real-life problems. The Feeling Calm skills may help Evan and Megan settle their surging emotions a bit, to set the stage for clear thinking. The Repairing Thoughts skills may help them distinguish between realistic and distorted ideas about what is happening and what comes next. And the Solving Problems skills may help them think logically about the situation and develop plans for how to respond. At times of crisis, a therapist may have the full attention of a very motivated client, and thus an opportunity to show the real-life relevance of the FIRST principles.

Ending Treatment

Throughout treatment, frequent assessments should guide the clinician's use of the decision trees (see Chapter 2). The assessments can inform judgments about which FIRST principles to use and when, what changes in treatment focus are needed to address comorbidity or treatment obstacles, and when to end treatment. We recommend a combination of methods for determining when treatment should end. These include objective measures of youth symptoms and impairment, a clinician's judgment of a youth's improvement, assessment of the youth's acquisition and mastery of the therapeutic skills (via the skill assessments to be conducted as part of each FIRST Skill Unit in Chapters 6–10), and an indication from the caregiver that he or she is amenable to ending treatment.

2

Using FIRST and the FIRST Decision Trees to Treat Anxiety/OCD, Posttraumatic Stress, Depression, and Misbehavior

The decision trees on the pages that follow (Figures 2.1 through 2.5) are guides to clinician decision making. Please feel free to photocopy them or download and print them from the Guilford website (see the box at the end of the table of contents), post them on a bulletin board, or keep them in view during your sessions.

Treating Anxiety and OCD with FIRST

Which Problems and Disorders?

This treatment focus is appropriate for youths whose primary referral concerns involve anxiety; who have diagnoses of agoraphobia, generalized anxiety disorder, specific phobia, social phobia, panic disorder, separation anxiety disorder, adjustment disorder with anxious mood, or obsessive–compulsive disorder (OCD); or who have problems resembling any of those disorders.

Education

Each treatment focus begins with psychoeducation regarding the nature of the problems or diagnosis, as well as an overview of treatment, expectations for therapy, and rapport-building exercises. The Clinician Guide: Facts About Anxiety and OCD can be found in Chapter 4 (pages 45–47).

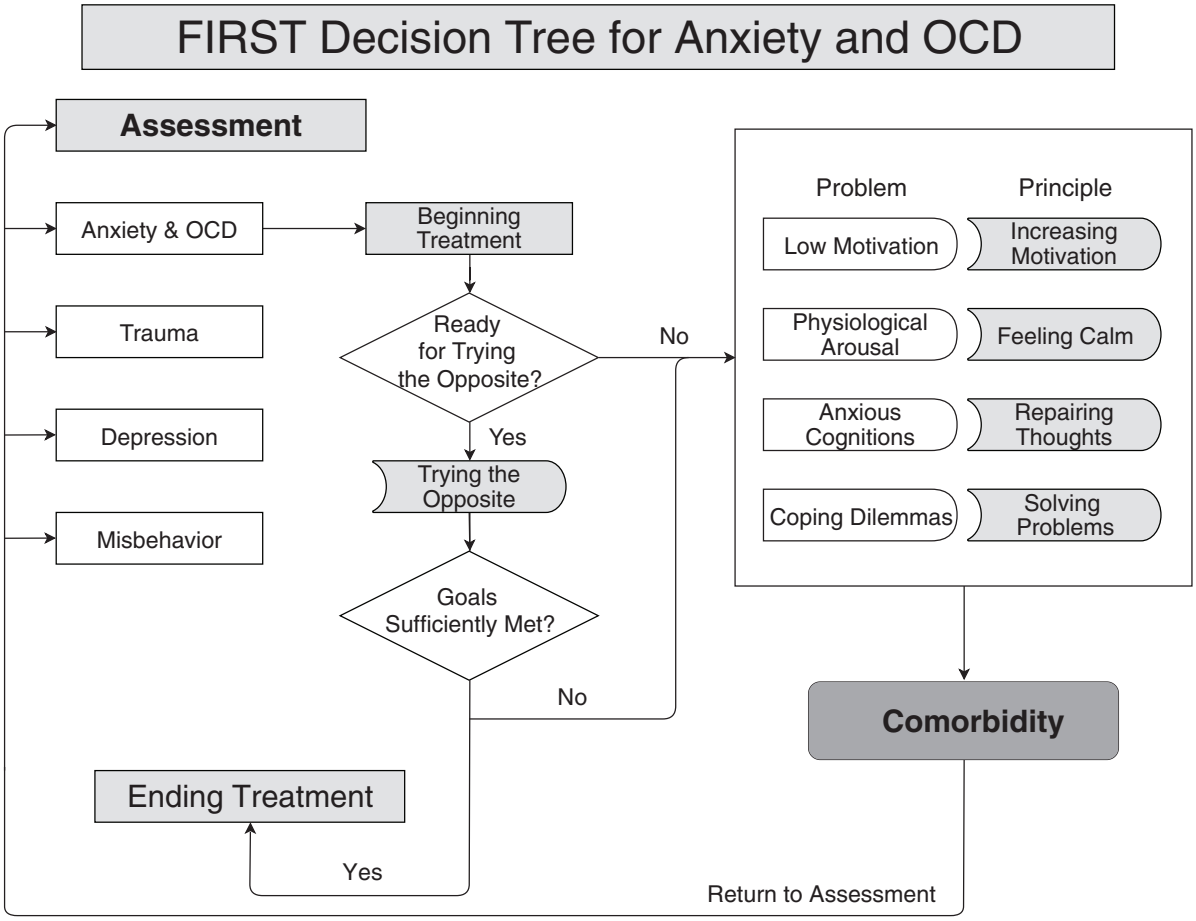


Figure 2.1. Anxiety and OCD decision tree.

Trying the Opposite

For treatment of anxiety, Trying the Opposite takes the form of planned behavioral exposures to the objects or situations that are targets of a youth's unrealistic fears. **Exposure has been shown to be an effective stand-alone treatment for anxiety disorders and is an active component of most empirically supported treatments for anxiety**. First, the therapist works with the youth and caregiver to devise a hierarchy of feared situations, stimuli, and events, ranking them in order from most feared to least feared. Over the following sessions, the therapist introduces the youth to the items on the fear hierarchy in a stepwise fashion, beginning with the least feared items, and using *in vivo* exposures (e.g., real bugs, not just imaginary role-playing bugs) when possible. Between sessions, the youth and caregiver continue to complete exposures as homework, using Socratic questioning to ensure that new learning about expectation violation is optimized. Together, the therapist and youth work their way through the fear hierarchy, progressing from easier items to more challenging items, moving up the hierarchy each time the youth can complete an item with relative ease.

For OCD, some youths and caregivers may not be aware of all the ritualized behaviors that have developed. A first step toward Trying the Opposite can be asking them to spend 24 hours noticing and listing the rituals that occur, and the obsessions or environmental stimuli that have triggered them. The hierarchy for OCD should include avoided situations, people, and objects, and a rating of how difficult it is for the youth to face each of these stimuli with and without the accompanying rituals. Exposure will involve gradually facing the situations that provoke the need for the ritual while preventing the ritual from occurring—a process known as *exposure plus ritual prevention* (sometimes called *exposure plus response prevention*), or ERP. Although it may be too hard to eliminate the ritual completely at first, delaying it or changing it in some way (e.g., waiting 10 minutes before washing hands, or repeating a phrase two times instead of three) can be a good start.

Ready for Trying the Opposite? No

If the youth is unable to begin the exposure, doesn't develop tolerance for the anxious response incited by the exposure, or fails to show treatment gains, the therapist should use the clinical conceptualization developed from the initial assessment (together with input from the caregiver and youth) to determine what might be interfering with progress. Below are factors that may cause interference, and suggestions for how to address them within the FIRST protocol.

Anxious youths have often developed avoidance techniques as a means of reducing their anxiety, and may therefore not view their anxious, avoidant behavior as a problem—although it may cause substantial problems for caregivers and others! Because the FIRST treatment strategies (particularly exposure) will require them to give up some of their avoidant strategies, anxious youths may have low motivation to engage in treatment or may feel ambivalent about giving up the familiar avoidance strategies they have been using and have learned to rely on for relief. To address this challenge, incentives may be used to boost motivation and

engagement, and thus participation. A reward program, in therapy as well as in the home, can be used to reinforce both trying the therapeutic assignments and learning new skills. That is, youths may earn points, privileges, and praise for trying the exposures in session and at home, and for learning to initiate their own exposures when confronting new fears. In other cases, anxious youths may have learned that anxious behaviors are a way to receive desired attention or accommodation from family members. In these situations, the use of praise and attention for "brave" behaviors, paired with active ignoring of anxious behaviors (often called *differential reinforcement*), may increase the youths' motivation to approach anxiety-provoking tasks while extinguishing anxious behaviors.

Anxious youths often feel tense or "uptight," or experience other unpleasant physiological sensations (sometimes including dizziness, nausea, or shortness of breath), when they are asked to confront feared situations or events. For youths who show these reactions, learning relaxation strategies can be a helpful coping skill to use at times when they feel anxious, as long as relaxation isn't paired with exposure. Deep breathing, progressive muscle relaxation, and calming visual imagery are components of many effective treatments for anxiety, and can be used to address the physical manifestations of anxiety.

When confronted with feared events or situations, anxious youths often generate automatic thoughts about the feared stimuli. Such thoughts may include overestimates of how likely it is that the feared situation will arise, overestimates of how dangerous or uncomfortable the situation will be, and underestimates of their own ability to handle the experience. Youths whose anxious beliefs are interfering with progress in treatment can be taught to evaluate the evidence and discover that their anxious thoughts are not realistic. Repairing Thoughts is a way of changing these unrealistic, frightening thoughts to make them more realistic and less frightening. Furthermore, some youths may have difficulty incorporating the new information they have gathered during the exposures—remembering that they faced their fears and nothing bad happened! In these cases, Repairing Thoughts can involve labeling what the exposures showed, and thus challenging the youths' anxious beliefs by documenting and integrating the corrective experiences they have had.

Although it is important to check in consistently with youths who have OCD about the ways in which an obsession was incorrect (i.e., what the youths feared would happen did not actually occur), Repairing Thoughts in the absence of exposure can be tricky for youths with OCD. Often these youths are quite aware that an obsession is irrational, but the distress is so overwhelming that logical challenging of the thought is of little value. Also, youths with OCD are often "experts" on the topics of their obsessions and will happily engage in debate about the validity of their concerns—especially if it limits the time spent on exposures. Repairing Thoughts is therefore best used as a companion to exposure. A therapist can ask a youth, "Did your predictions come true? What is the worst thing that actually happened? What does that tell us about your obsessive thought?"

Coping Dilemmas → Solving Problems

Although planned exposure has been found to be an effective stand-alone treatment, and such exposure should be the primary focus for anxious youths, some youths may also benefit from considering anxiety-provoking situations (in planned exposure or naturally occurring situations) as "problems to be solved" when completing an exposure session seems difficult. Youths with anxiety disorders often have limited repertoires for responding to anxiety-provoking situations; they rely primarily on avoidance and escape as ways to manage their fear. During times of extreme anxiety, they may describe feeling as though their minds "go blank," making it difficult to plan solutions to the problems they face. If a youth is having difficulty enduring exposures or is unwilling to complete therapy homework assignments that involve exposures, problem solving may be used to figure out a solution. Solving Problems can also help youngsters manage residual feelings of anxiety that may emerge even after multiple exposures have helped end avoidance. In problem solving, boys and girls generate a list of solutions to their anxiety when they face a feared situation or object (aka "the problem"); they then evaluate the pros and cons of each solution, and decide which solution to try, thus creating a concrete "action plan" for coping. Possible solutions might include coping strategies such as deep breathing and positive self-talk. Such problem solving may boost success during planned exposures and in naturally occurring anxiety-provoking situations (e.g., being called on in class). More generally, Solving Problems provides a tool for breaking seemingly overwhelming situations down into manageable problems, thus increasing confidence and reducing anxiety.

Comorbidity → Assessment

If a change in symptom presentation, or new information about the youth's disorder or problem, becomes apparent and seems to interfere with treatment progress, a reassessment with caregiver and youth (as appropriate) may be needed. This can inform the decision either to continue with the originally identified target problem, or to switch the focus to a co-occurring problem or comorbid disorder.

Treating Posttraumatic Stress with FIRST

Which Problems and Disorders?

This treatment focus is appropriate for youths whose primary referral concerns involve exposure to traumatic events and subsequent serious changes in affect and behavior; who have diagnoses of posttraumatic stress disorder (PTSD) or acute stress disorder; or who have problems resembling any of those disorders.

Education

Each treatment focus begins with psychoeducation regarding the nature of the problems or diagnosis, as well as an overview of treatment, expectations for therapy, and rapport-building

exercises. The Clinician Guide: Facts About Posttraumatic Stress can be found in Chapter 4 (pages 47–49).

Feeling Calm

Stressful events trigger the body's own built-in alarm system, setting the body up for a fight, flight, or freeze response. Common physical reactions include increased heart rate and rapid breathing, tensed muscles, sweating, increased startle response, and difficulty sleeping. A sensitive alarm system can be advantageous in the short run, but when stress is extreme and severe there may be serious aftereffects—and when stress is chronic, young people may experience a near-habitual stress reaction, even when there is no current danger. An overloaded alarm system can exact a toll on the physical system and on psychological well-being. The physical symptoms of stress may worsen when youths experience traumatic reminders, such as memories of the trauma. Physiological relaxation can help to modulate the bodily reactions, thus smoothing the path to the heart of posttraumatic stress treatment in FIRST: exposure, as embodied in Trying the Opposite.

Trying the Opposite

For treatment of posttraumatic stress, Trying the Opposite takes the form of two types of exposure. The first is **exposure to memories** of the traumatic experience that are causing distress. Typically, these memories are already very much on a youth's mind and are often experienced as intrusive thoughts, flashbacks, or nightmares. In exposure, these memories are deliberately revisited imaginally in a gradual fashion, in an attempt to separate the story of the past event(s) from the acute physiological and emotional responses the events originally caused. With a child, this exposure often takes the form of writing the story of the event and then repeatedly reading that story in the presence of a supportive adult. Quite often, the story is written in stages, in stepwise fashion: The nontraumatic or neutral aspects are written first, followed by the more distressing details of the traumatic event, including the thoughts and feelings related to the experience. Writing the entire descriptive story may take several treatment sessions, followed by sessions in which the story is read and reread from the beginning, with thoughts and feelings incorporated, and with some editing to repair distortions such as inappropriate self-blame. Youths rate their distress during these sessions with a mood-monitoring tool, such as a subjective units of distress scale or a feelings thermometer.

The second type of exposure that is often included in Trying the Opposite for posttraumatic stress is more similar to treatment of anxiety disorders: It consists of ***in vivo* exposure** to safe situations, places, or scenarios that have been avoided since the traumatic event. For example, a girl who was sexually assaulted by a relative may subsequently avoid family members who remind her of the abuser, even though she is no longer in danger. Or an adolescent boy who was in a frightening car accident may subsequently avoid riding in cars. To deal with such avoidance, the therapist, youth, and caregiver first devise a hierarchy of feared situations, stimuli, and events, ranking them in order from most to least feared. Over successive sessions, the therapist introduces the youth to the items on the fear hierarchy, in stepwise fashion: The process begins with the least feared items, and *in vivo* exposures are used when

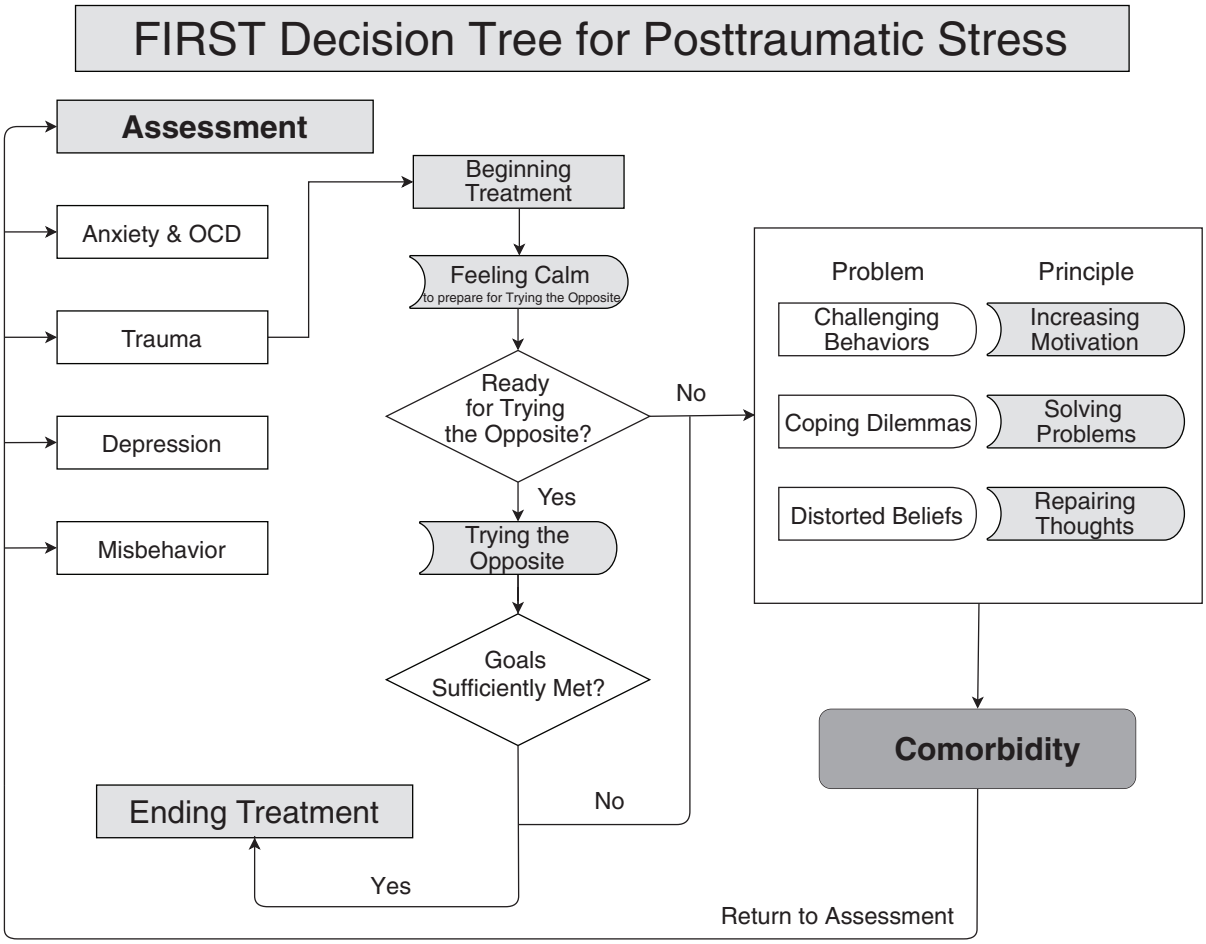


Figure 2.2. Posttraumatic stress decision tree.

possible (e.g., sitting in a car that is not moving, then driving in a parking lot, then driving on a road). Together, the therapist and youth work their way through the fear hierarchy, beginning with easier items and progressing to more challenging items, moving up the hierarchy each time the youth can complete an item with relative ease.

Ready for Trying the Opposite? No

If the youth is unable to begin exposure to traumatic memories or exposure to avoided trauma reminders, doesn't develop tolerance for the anxious response incited by the exposure, or fails to show treatment gains, the therapist should use the clinical conceptualization developed from the initial assessment (together with input from the caregiver and youth) to determine what might be interfering with progress. Below are factors that may cause interference, and suggestions for how to address them within the FIRST protocol.

Challenging Behaviors → Increasing Motivation

Parenting may be especially difficult after a young person has experienced a traumatic event. Youths may respond to their traumatization with increased misbehavior, or may withdraw from family members. Parents may struggle to stand by the routines and limits they enforced prior to the trauma, or may be unsure how to parent effectively after a traumatic event has occurred. In some instances, the traumatic event increases stress for all family members and can lead to conflict or tension. Helping parents use strategies such as those found in Increasing Motivation can have a powerful impact on the parent–child relationship and can help address behavioral problems that occur in response to trauma.

Coping Dilemmas → Solving Problems

Youths who have experienced trauma may have developed maladaptive or ineffective coping responses to stressful situations. They may have limited repertoires for how to handle interpersonal situations (e.g., responding aggressively to uncertain social cues) or may engage in high-risk behaviors as a way of handling extreme emotions (e.g., self-injury or substance use). A different, but very important, coping dilemma might relate to concerns about personal safety. Challenges like these can be addressed through enhancing problem solving via the systematic approach described within Solving Problems. In this approach, a youth specifies what the exact problem is, generates a list of potential solutions, evaluates the pros and cons of each one, and decides which solution to try, thus creating a concrete "action plan" for coping. Note, though, that for problems related to reexperiencing and avoidance, the exposure techniques described in Trying the Opposite should be the first approach used.

Distorted Beliefs → Repairing Thoughts

Following a traumatic event, youths may experience changes in their perspective on themselves, others, and the world around them. These changes may lead to fears about their safety, pessimistic beliefs about their future, doubts about their ability to cope, and blaming and shaming thoughts about events in the past. In FIRST, such posttraumatic cognitions

are typically addressed *after* the fear and avoidance symptoms have been tackled via exposure, as described within Trying the Opposite. This is done because the process of exposure may naturally set the stage for a change in distorted beliefs. However, some youngsters may find that self-defeating thoughts and negative predictions are interfering with their ability to engage in Trying the Opposite, or causing problems with family members/friends and in school. In these instances, Repairing Thoughts can be used to boost positive self-talk and to challenge misinformation or distortions related to personal safety, before the intervention turns to exposure within Trying the Opposite.

If a change in symptom presentation or new information about the youth's disorder becomes apparent and appears to be the primary interfering factor, a brief reassessment with caregiver and youth (as appropriate) will be conducted to inform the decision either to continue with the originally identified target problem, or to switch the focus to a co-occurring problem or comorbid disorder.

Treating Depression with FIRST

Which Problems and Disorders?

This treatment focus is appropriate for youths whose primary referral concerns involve depression; who have diagnoses of major depressive disorder, persistent depressive disorder (dysthymia), or adjustment disorder with depressed mood; or who have problems resembling any of those disorders.

Education

Each treatment focus begins with psychoeducation regarding the nature of the problems or diagnosis, as well as an overview of treatment, expectations for therapy, and rapport-building exercises. The Clinician Guide: Facts About Depression can be found in Chapter 4 (pages 49–51).

Trying the Opposite

For treatment of depressive disorders, Trying the Opposite takes the form of **behavioral activation** to address avoidance and increase engagement in activities likely to elevate mood; this includes **deliberate scheduling of pleasant events,** both within and between sessions. Depressed youths are often lethargic, and they often withdraw from activities and social contact—activities that could potentially boost their mood. Although such behavioral avoidance may provide a bit of short-term relief (e.g., it may feel like a relief to just stay in bed or on the sofa rather than get up, ride a bike, or hang out with friends), the long-term effect can be prolonged depression. To break up this pattern by using FIRST, the therapist's goal is to show the youth that doing something active—something that is enjoyable/engaging, burns

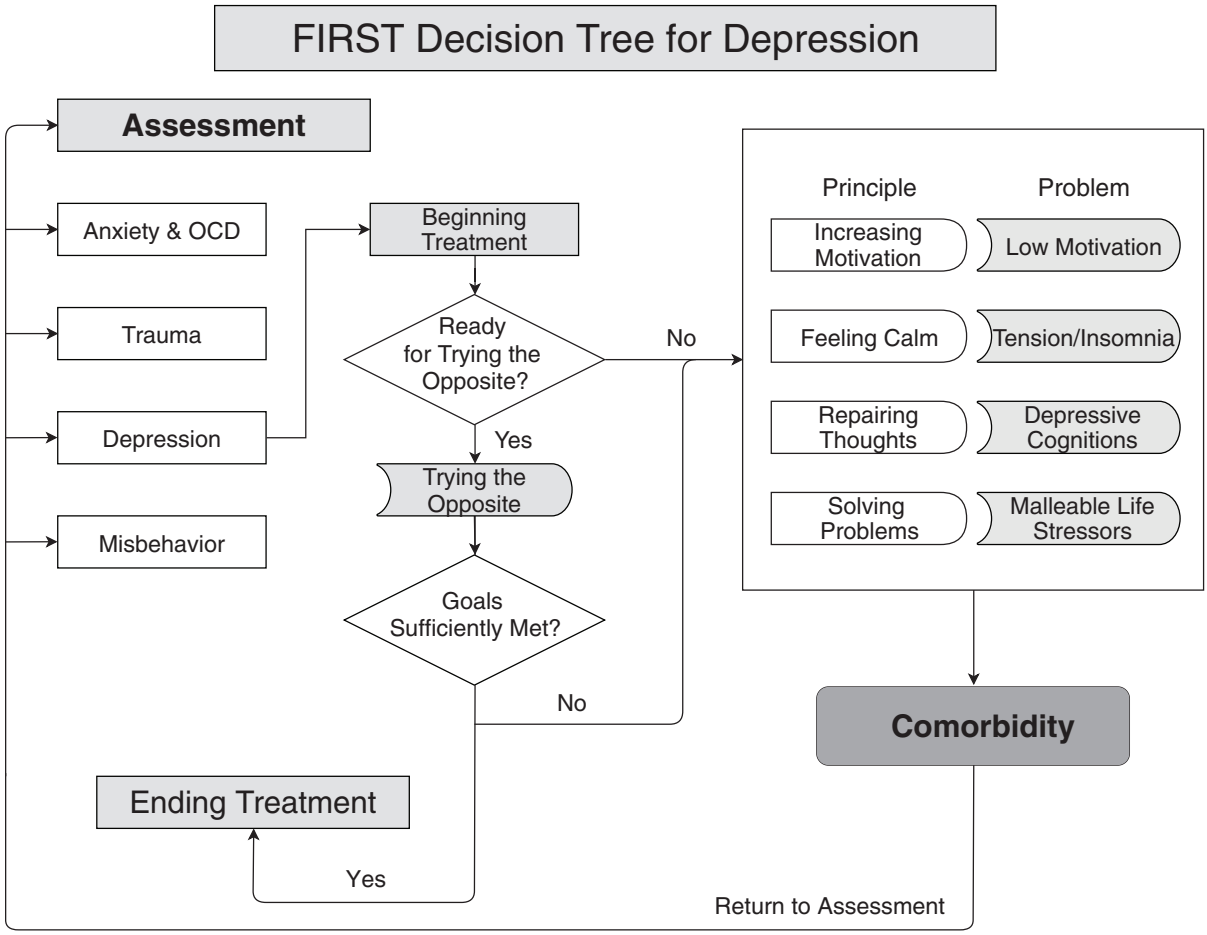


Figure 2.3. Depression decision tree.

energy, involves social interaction, or helps someone else—can improve mood, increase mastery, generate positive thoughts, and even convey a sense of meaning and purpose. A key early step in applying FIRST to depression is identifying activities that are valued by the youth, advance his or her individual goals, lead to feelings of mastery and pleasure, and are incompatible with avoidance (e.g., solo video games don't count!). The therapist, youth, and caregiver (as appropriate) work together to make these activities a regular part of the youth's everyday life. The therapist helps the youth notice how engaging in such activities boosts mood over time, and also helps the youth identify and overcome obstacles that interfere with doing the activities regularly. A metamessage to those young people who succeed in boosting mood by doing these activities is that they are not helpless in the face of sad mood or low energy; that is, they can overcome these problems through their own direct action.

Ready for Trying the Opposite? No

If the youth is unable or unwilling to engage in behavioral activation or pleasant events scheduling, or if the youth remains depressed despite fully engaging in the therapy and homework, the therapist should use the clinical conceptualization developed from the initial assessment (together with input from the caregiver and youth) to determine what might be interfering with progress. Below are some of the factors that may interfere, and some notes on how to address them within FIRST.

Malleable Stressors → Solving Problems

Although a core problem for many depressed youths is withdrawal from pleasant and reinforcing activities, and although deliberately scheduling and practicing such activities can really boost mood, some youths require other strategies for managing depressed mood and the accompanying symptoms. For youths who face modifiable life stressors, learning systematic ways to solve problems can be a useful skill—so useful that it is a component of several depression treatment protocols. As a first step in using Solving Problems, the therapist and youth work together to identify problems that are challenging but potentially controllable by the youth. Taking a systematic approach, the youth and therapist generate possible solutions to the problem, team up to evaluate the pros and cons of each solution, decide which solution to attempt first, and test it to see whether it works and whether the youth's mood is improved as a result. To teach perseverance in the face of challenge, the therapist works with the youth to develop alternative solutions (a Plan B, Plan C, etc.), in case the first solution tried doesn't do the trick. Because depressed youths often feel helpless, learning to solve problems involving relationships, academic stressors, or other real-life challenges can change their perspective in important ways. Over time, the therapist encourages the youth to use the strategies to solve more and more problems, and thus to feel more and more in control.

Repairing Thoughts → Depressive Cognitions

Depressed youths often have virtually automatic negative thoughts about themselves, others, and the world, and these thoughts are closely linked to other depressive symptoms.

For each automatic negative thought, the therapist teaches the youth that "just because you think it, this doesn't mean it's true!" and helps the youth examine the evidence that does and does not support the thought. Once the evidence has been gathered, the therapist and youth can work together to generate a new thought that is more realistic, helpful, and mood-elevating. Repairing Thoughts is especially useful in instances where youths may not be able to change objective circumstances, but can still change the way they *think* about those circumstances, thus altering their impact on the young persons' mood.

Depressed youths may experience physical symptoms (such as difficulty sleeping, psychomotor agitation, and muscle tension) that accompany worry or stress. These physical symptoms can contribute to depressed mood and lead to changes in appetite, decreased social interactions, and feelings of hopelessness. Relaxation techniques have been successfully used alone to treat depressed youths. FIRST includes two approaches—progressive muscle relaxation and deep breathing with guided imagery—to calm the body and counter the physiological symptoms accompanying depression.

Depressed youths may experience low energy and feelings of hopelessness that undermine their motivation to engage in therapy, try new skills (such as practicing pleasant activities), or complete therapy homework. Incentives can be used to address such problems. These can help to boost a youth's engagement, as well as positive caregiver attention to new youth behaviors (which in turn may improve the youth's mood). Positive attention, praise, and even a reward program—in therapy as well as at home—can be used to reinforce the youth for learning new skills, trying them out during therapy sessions, and completing therapy homework.

If a change in symptom presentation or new information about the youth's problems or disorder becomes apparent and appears to be the interfering factor, a brief reassessment with caregiver and youth (as appropriate) can be conducted to inform the decision either to continue with the originally identified target problem, or to switch the focus to a co-occurring problem or comorbid disorder.

Treating Misbehavior with FIRST

Which Problems and Disorders?

This treatment focus is appropriate for youths whose primary referral concerns involve conduct problems; who have diagnoses of oppositional defiant disorder, mild to moderate conduct disorder, or adjustment disorder with disturbance of conduct; or who have problems resembling those disorders.

Education

Each treatment focus begins with psychoeducation regarding the nature of the problems or diagnosis, and an overview of treatment, expectations for therapy, and rapport-building exercises. The Clinician Guide: Facts About Misbehavior can be found in Chapter 4 (pages 51–53).

Caregiver Participation?

For treatment of misbehavior in youths, the strongest body of evidence supports treatments that focus mainly on helping caregivers plan parenting strategies they will implement at home. However, some caregivers may not be able or willing to participate in treatment. **Unless there is some reason that caregiver training is unlikely to be appropriate (e.g., a youth is in transitional foster care; a single caregiver is in an addiction recovery program), the therapist should present information to the caregiver highlighting the effectiveness of working with the caregiver to modify the youth's behavior, and should strongly recommend that treatment involve primarily working with the caregiver(s).** When caregivers agree, it is usually appropriate to begin with the FIRST skill of Increasing Motivation, as discussed in the following paragraph. When caregivers cannot or will not be the primary participants in treatment, a different FIRST skill is recommended as the starting point, as discussed further below.

Caregiver Participation—Yes ➡ Increasing Motivation

Caregivers' use of positive attention, praise, and tangible rewards has been found to be highly effective in managing children's misbehavior and noncompliance. The therapist reviews with the caregiver (or caregivers) the roles of positive attention and of verbal and tangible reinforcers in increasing appropriate behaviors. The therapist models for the caregiver how to carry out these strategies, and then therapist and caregiver use role playing to refine the caregiver's skills. Strategies include using youth-directed play, effective instructions, specific and labeled praise, and behavioral contingencies, as well as developing and refining a reward system to encourage good behavior.

Ready for Increasing Motivation? No

If the caregiver is unable or unwilling to implement the Increasing Motivation skills, or if the youth's misbehavior persists despite effective implementation of the skills, the therapist meets with the caregiver and/or youth (as appropriate) to identify the source of the interference. The therapist should use the clinical conceptualization developed from the initial assessment, (together with input from caregiver and youth) to determine what might be interfering with progress. Below are factors that might interfere, and ideas for addressing each factor within the FIRST protocol.

Anger/Arousal ➡ Feeling Calm

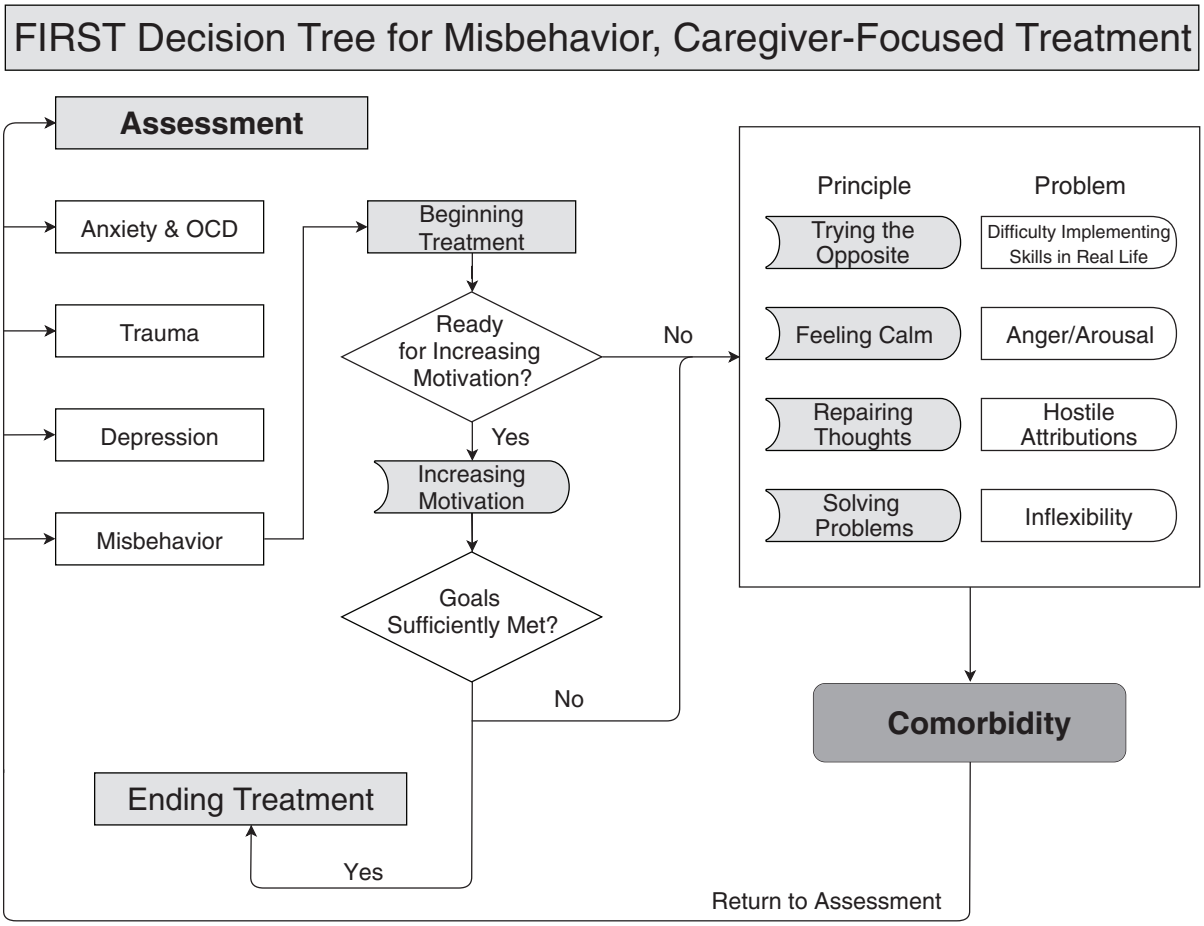


Figure 2.4. Misbehavior decision tree, caregiver-focused.

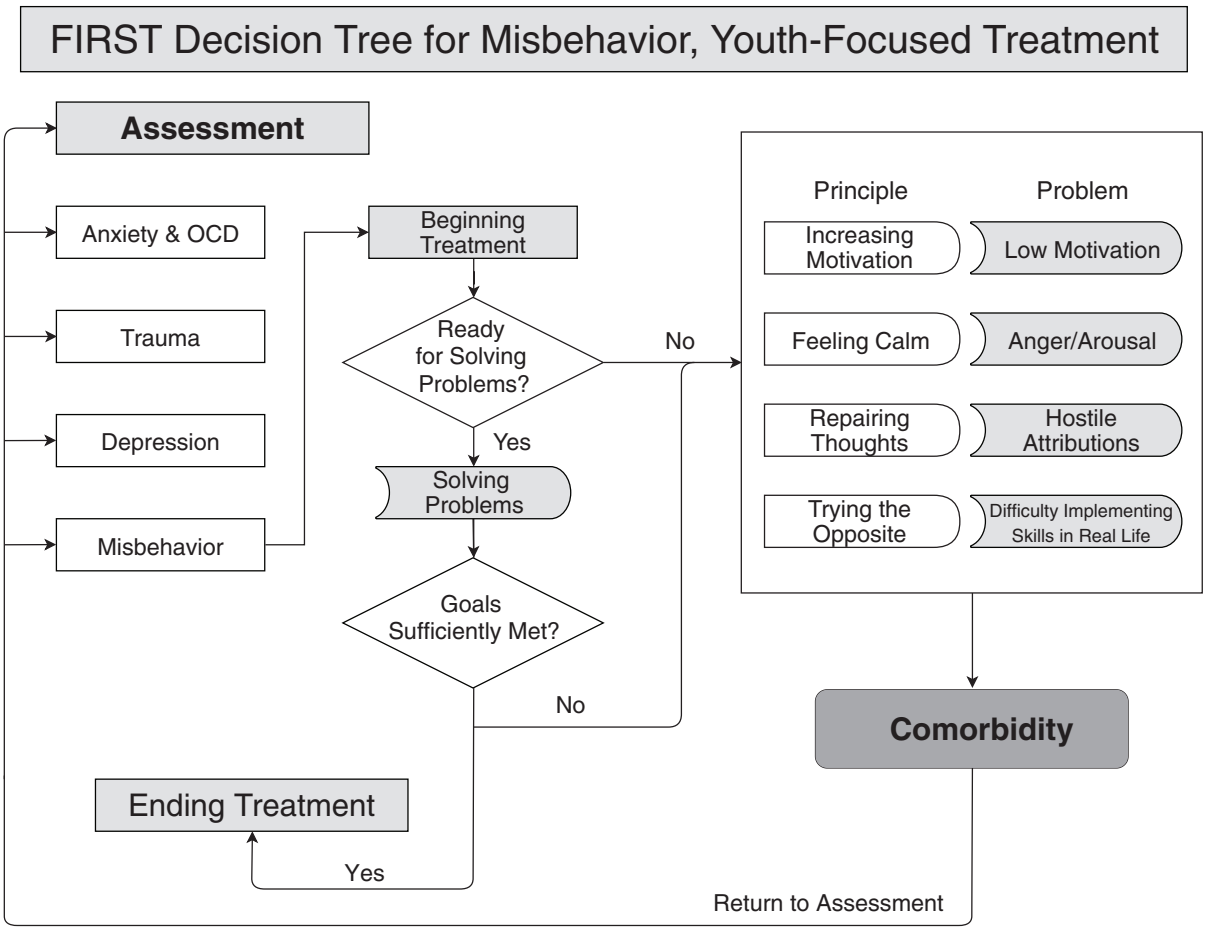


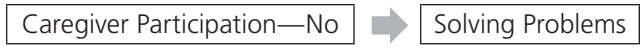
Figure 2.5. Misbehavior decision tree, youth-focused.

Youths treated for misbehavior may have difficulty tolerating frustration and inhibiting impulsive actions. Such youths can benefit from learning to recognize the physiological cues associated with arousal and anger, and learning strategies for self-calming. A therapist works with a youth to identify bodily cues of arousal, frustration, and anger, and the two work together practicing calming strategies such as deep breathing with guided imagery and progressive muscle relaxation. They also practice a skill informally called "quick cooling," which the youth can use for immediate calming in stressful situations that arise quickly, requiring a fast response—situations in which a long session of deep muscle relaxation would be impossible. The youth's homework includes continued practice, particularly in situations likely to provoke frustration and anger.

Youths who have conduct problems including aggression are more likely than others to perceive ambiguous situations and events as threatening, to see hostile intent in other people's behavior, and to react defensively or aggressively even in benign situations. A therapist can help a youth identify these negative interpretations, objectively evaluate the evidence that supports or does not support them, and then develop more realistic and helpful interpretations of events.

Youths with conduct problems may learn useful coping skills, but then have difficulty remembering to use those skills when they are most needed—such as when they are feeling frustrated or angry. Having a good conceptual grasp of the skills discussed in therapy may be a good first step; implementing the skills in real-life situations may be a challenge that requires additional learning, plus practice. In these situations, the therapist sets up lots of practice, presenting the youth with frustrating, anger-provoking scenarios, some in the form of role plays and *in vivo* practices (graduated from least to most provocative), so that the youth can gain experience in feeling the arousal but nonetheless implementing the new, more adaptive skills to overrule the arousal and avoid misbehavior.

Misbehavior can result from a tendency to react to new situations or stressors with a youth's first impulse—sometimes an angry or antisocial impulse. This tendency to act before thinking can lead to a variety of problems, including aggression and other forms of antisocial behavior, harm to victims of such behavior, and of course social and disciplinary consequences for the youth who reacts so impulsively. To address this problem, the therapist teaches the youth a strategy for systematic problem solving. Taking a stepwise approach, the youth and therapist clearly identify what the problem is, generate multiple possible solutions, work together to evaluate the pros and cons of each solution, pick one solution to try, and evaluate the success of the outcome—with others to be tried next if the first option doesn't work well. Over time, the youth is encouraged to "take this show on the road," applying the steps to problems that arise between sessions.



In the event that caregiver participation is not advisable, or not possible despite the therapist's best efforts, treatment of misbehavior should instead begin with individual work with the youth, focused on Solving Problems. This treatment approach has been shown to work, even in the absence of active caregiver involvement in treatment. Each of the FIRST skills described above can be used, according to the decision tree, in the event that Solving Problems fails to address all of the behavior problems that are a source of concern.

If a change in symptom presentation or new information about the youth's disorder becomes apparent and appears to be the interfering factor, a reassessment with caregiver and youth (as appropriate) can be conducted to inform a decision either to continue focusing on the originally identified target problem, or to switch the focus to another problem or a comorbid disorder or co-occurring problem.

3

Beginning Treatment

The FIRST Interview—Caregiver

This is a clinician tool to help determine what the treatment focus should be. The interview can be used as a follow-up or complement to initial intake procedures, including a clinical interview, family and developmental history, and standardized symptom checklists.

1. In your initial intake, you talked about several difficulties [youth's name] has been having. When did you first notice that [name] was having these difficulties?
2. What are the common situations in which [name] displays [anxiety/OCD, posttraumatic stress, signs of depression, or misbehavior]? What are the situations that seem to lead to these problems?
3. Now I want to ask about some specific behaviors boys and girls sometimes experience [gather more information about relevant problem areas below]:

Anxiety and OCD	Depression	Posttraumatic Stress	Misbehavior
Are there any situations or experiences that [youth's name] avoids because they cause [name] to feel very worried or nervous? Or situations that [name] endures with a lot of distress? What about intrusive thoughts, urges, or impulses that come into [name's] mind that cause worry or distress?	Does [name] often (more than other kids of the same age) feel sad, feel irritable, seem uninterested in most things, or seem not to enjoy things very much?	Has [name] experienced a situation in which he or she was exposed to something very scary, or where his or her life or the life of a loved one was in danger [death, threatened death, actual or threatened serious injury, actual or threatened sexual violence, either directly or as a witness]?	Does [name] have a hot temper, get easily annoyed by others, or seem to feel angry more than other kids do?

Anxiety and OCD	Depression	Posttraumatic Stress	Misbehavior
Does [name] ever experience lots of physical signs of anxiety, like feeling that his or her heart is beating too fast, sweating, shortness of breath, lightheadedness, and so on?	When [name] is sad/cranky/bored, do you notice changes in appetite? Sleeping? Energy level?	Since that experience, does [name] reexperience the trauma with unwanted and upsetting memories, nightmares, or flashbacks, or become very upset or stressed any time [name] is exposed to something that reminds him or her of the traumatic experience?	Does [name] often disobey parents/caregivers at home or teachers at school, refuse to follow directions, or argue with adults?
Does [name] ask for a lot of reassurance that he or she did or said the right thing, or that things will work out OK?	When [name] is sad, does he or she have trouble concentrating or making decisions?	Since that experience, does [name] try to avoid thinking about the experience, or try to avoid situations or people that remind him or her of the experience?	Is [name] stubborn? Does [name] argue a lot? Does he or she often want to "get even" with others?
When [name] worries, does he or she experience stomachaches, headaches, muscle tightness, or other types of physical problems?	Does [name] seem to feel guilty a lot of the time, even when things are not his or her fault, or feel down on him- or herself?	Since that experience, does [name] show changes such as difficulty remembering aspects of the experience, feeling very hopeless about the world or his or her future, feeling guilty, being less interested in things, or having trouble feeling happy?	Does [name] often deliberately break known rules, hurt other people, or deliberately destroy property, at home or at school?
Are there certain behaviors [name] feels he or she must repeat, again and again, because these behaviors make [name] feel less worried?	Has [name] ever thought a lot about death or dying, or thought about hurting or killing him- or herself?	Since that experience, does [name] seem more irritable or aggressive, engage in risky or destructive behavior, always seem to be on guard or easily startled, or have trouble concentrating or sleeping?	Is [name] aggressive with other kids, getting into fights, or threatening other kids?

4. Where do these problems cause the most difficulty for [name]—at home, in school, with other kids?

5. When [name] experiences these problems, what are some things you have found that make him or her feel or behave better?

6. Of the different problems we've discussed [review the problems], which is the number one problem that concerns you most—the problem for which you feel your child most needs help? How would you describe that problem in your own words? [Use the same language to get three "top problems."]

7. Now let's make sure I know how to rank these three problems. . . . Which one is the biggest problem? Which one is next biggest? [Continue for all problems.]

8. For each of these problems, please give me a rating to show how big a problem it is. The rating can go from 0 to 4. 0 means it's not a problem at all. 4 means it's a very big problem. What is your rating for each of these problems?

9. *Note to the clinician:* Your goal is to create a little chart like this one:

Caregiver-Reported Top Problems*: Example	Rank	Severity (0–4)
1. He lies.	1	4
2. When things don't go his way, he shuts down.	2	4
3. He seems sad most of the time.	3	3

*A detailed manual of procedures for the Top Problems Assessment is available free of charge on the website of the Laboratory for Youth Mental Health, Harvard University (found at *www.guilford.com/weisz-lab*).

10. *Note to the clinician:* Once you have filled in the chart with the three top problems identified, you should guide the caregiver through completion of the **Caregiver Problems and Coping Form** (Handout 1 on pages 41–42). This handout—designed to strengthen motivation and treatment participation—asks the caregiver to note why each of the problems needs to be worked on, and how life will be different if the problem is solved. It also asks the caregiver what he or she will do to help fix the problems, what obstacles might arise, and how the caregiver will cope with those obstacles. This handout should be saved, and it may be revisited if difficulties arise during treatment—for example, to remind the caregiver of why he or she wanted to work on key problems, or to add new obstacles that are undermining caregiver participation, so that you and the caregiver can discuss ways to cope with those obstacles.

The FIRST Interview—Youth

This is a clinician tool to help determine what the treatment focus should be. The interview can be used as a follow-up or complement to initial intake procedures, including a clinical interview, family and developmental history, and standardized symptom checklists.

1. Now I want to ask about some specific problems kids sometimes experience [gather more information about relevant problem areas below]:

Anxiety and OCD	Depression	Posttraumatic Stress	Misbehavior
Are there any situations or experiences that you avoid because they cause you to feel very worried or nervous? Or situations that you put up with, but they make you worried or nervous? Or do you ever have repeated thoughts, urges, or impulses that come into your mind that cause you to feel worried or distressed?.	Do you often (more than other kids your age) feel sad, feel irritated, just not feel interested in most things, or not enjoy things very much?.	Have you experienced a situation in which you were exposed to something very scary, or where your life or the life of a loved one was in danger [death, threatened death, actual or threatened serious injury, actual or threatened sexual violence, either directly or as a witness]?.	Do you have a hot temper, seem touchy or easily annoyed by others, or get angry more than other kids do?

Anxiety and OCD	Depression	Posttraumatic Stress	Misbehavior
Do you ever have lots of physical signs of anxiety, like feeling that your heart is beating too fast, sweating, shortness of breath, lightheadedness, and so on?.	When you are sad/ cranky/bored, do you notice changes in your appetite? Sleeping? Energy level?.	Since that experience, do you relive that bad experience with upsetting memories, nightmares, or flashbacks, or become very upset or stressed any time you are exposed to something that reminds you of the bad experience?.	Do you often disobey parents or other adults at home, or do you often disobey teachers at school?
Do you worry a lot about whether you did or said the right thing, or whether things in the future will work out OK? And do you often ask adults or friends to tell you that things are OK?.	When you feel sad, is it hard to concentrate or to make decisions?.	Since that bad experience, do you try to avoid thinking about it, or try to avoid situations or people that remind you of the experience?.	Are you stubborn? Do you argue a lot? Do you often feel like you want to "get even" with other people?
When you worry, do you have stomachaches, headaches, tense muscles, or other types of physical problems?.	Do you feel guilty a lot of the time, even when things are not your fault? Or do you feel down on yourself?.	Since that bad experience, have you noticed changes such as difficulty remembering some parts of the experience, feeling very hopeless about the world or your future, feeling guilty, being less interested in things, or having trouble feeling happy?.	Do you often break rules or destroy property on purpose, at home or at school?
Are there certain things you feel you must do, again and again, because doing these things makes you feel less worried?.	Have you ever thought a lot about death or dying, or thought about hurting or killing yourself?.	Since that experience, do you feel more irritable or aggressive, engage in risky behavior, feel like you are always on guard or startle easily, or have trouble concentrating or sleeping?.	Are you aggressive with other kids? Do you get into fights, or threaten other kids?

2. Where do these problems happen most—at home, in school, with peers?
3. Would you like to stop having these problems? Why? How would it help you if you could stop the problems?
4. When you have these problems, what are some things you have found that help to make you feel better or behave better?
5. Of the different things we've discussed [review problems and other significant information], which is the number one problem—the most important one, the one you most want help with? How would you describe that problem in your own words? [Use the same language to get three "top problems."]
6. Now let's make sure I know how to rank these three problems. . . . Which one is the biggest problem? Which one is next biggest? [Continue for all problems.]
7. For each of these problems, please give me a number to show how big a problem it is. The number can go from 0 to 4. 0 means it's not a problem at all. 4 means it's a very big problem. What is your rating for each of these problems?

8. *Note to the clinician:* Your goal is to create a little chart like this one:

Youth-Reported Top Problems*: Example	Rank	Severity (0–4)
1. I worry about my mom when I'm not with her.	1	4
2. I am afraid to talk in class because kids will think I'm dumb.	2	4
3. I feel gloomy most days.	3	3

*Again, a detailed manual of procedures for the Top Problems Assessment is available free of charge online (found at *www.guilford.com/weisz-lab*).

9. *Note to the clinician:* Once you have filled in the chart with the three top problems identified, you should guide the youth through completion of the **Youth Problems and Coping Form** (Handout 2 on pages 43–44). This form—designed to strengthen motivation and treatment participation—asks the youth to note why he or she wants to fix each of the problems, and how life will be different if the problem is fixed. It also asks the youth what he or she will do to help fix the problems, what obstacles might arise, and how the youth will cope with those obstacles. Evidence (e.g., Nock & Kazdin, 2005) suggests that completing a form like this may enhance motivation and treatment participation. The form should be saved, and it may be revisited later if difficulties arise during treatment—for example, to remind the youth of why he or she wanted to fix key problems, or to add new obstacles so that you and the youth can discuss ways to cope with them.

Getting Started in Treatment for Different Problem Areas

For Depression

Because depression can take many forms, it is important for the therapist to learn the specific ways it shows up in the life of the youth being treated, and then to link that information to the plan for treatment. One core element of the treatment is helping the youth learn skills to get "unstuck" from sad, bad, or cranky moods.

For Anxiety and OCD

Anxiety and OCD are largely maintained by behaviors that provide short-term relief from fearful distress. In anxiety disorders, these behaviors involve avoiding feared situations; in OCD, the behaviors are typically neutralizing rituals, called *compulsions*, as well as avoidance. It is important to help these youths and their caregivers understand the central role played by their tendency to overestimate threat and to respond by avoiding feared situations or engaging in rituals. They also need to understand that the treatment will target this pattern by providing corrective experiences with Trying the Opposite (i.e., planned exposures).

For Posttraumatic Stress

Psychoeducation is a critical part of treatment for posttraumatic stress. It helps normalize youths' reactions to past trauma, and it can also help correct myths and misinformation that

both youths and their caregivers may have about the nature of the trauma. In addition to providing information about the symptoms and diagnoses, and about the type of trauma (e.g., domestic violence or natural disasters), initial sessions can be key to instilling hope and reassuring youths and caregivers that many others who have experienced similar trauma have responded well to treatment.

For Misbehavior

Most successful treatments for conduct problems involve working directly with caregivers. So an important goal at the beginning of treatment is to engage caregivers, emphasize the central role they play in their youths' lives, and seek their commitment to a caregiver-focused treatment approach. (If a caregiver declines, FIRST uses an alternative approach that involves working with an individual youth, but a caregiver-focused approach is *much* preferred.)

Skill Unit Objectives

Note: Multiple sessions may be used to cover the full list of objectives.

- Provide educative material regarding the problem area.
- Establish goals for treatment.
- Describe treatment and what it will entail.
- Begin developing rapport.

Skill Unit Outline: Beginning Treatment

Remember this in every session:

SESSION COMPONENTS [Note: These should be included in every session.]

- **Create an agenda** of what will be covered in the session.
- **Share the news** of any new skills or information covered in session with the caregiver and/or the youth at the end of the session (as appropriate). Handouts for parents are included for each problem area (**Learning about Anxiety and OCD,** etc.).
- **Finish strong**: End the session on a strong positive note that affirms the therapist's relationship and positive feelings toward the youth and caregiver—perhaps by doing an engaging activity together, praising the youth and/or caregiver for an important accomplishment in therapy or in real life, or noting how much you value the chance to work with the youth and/or family and are looking forward to the next session.

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Develop rapport.	This may be the first treatment session following more formal assessment meetings; if so, take some time to get to know the youth or caregiver.	With the youth, it can be useful to play some sort of icebreaker or "get to know you" game, or to take turns asking one another questions.
Summarize the problem.	Based on what you have learned about the difficulties that the youth and/or caregiver are experiencing, paraphrase their concerns.	**Example Script** "I want to make sure I understand the concerns that brought you into treatment, and what you most want treatment to address. It sounded like [. . .]. Did I get that right? Is there anything I didn't mention that you'd like me to know?"
Provide psychoeducation.	Inform the youth or caregiver about the nature of the problem area, its course, prevalence, and associated symptoms. Use language that is readily understandable. Check in frequently to see whether the youth or caregiver feels that the description is applicable, and to elicit examples.	Psychoeducative **Clinician Guides** are provided in Chapter 4 for **Anxiety and OCD, Posttraumatic Stress, Depression,** and **Misbehavior,** to assist the therapist in giving information about each disorder, what factors cause it, and how common it is. There are also **Help for Caregivers** handouts for each area to share with caregivers (see Chapter 5).
Describe treatment.	Give an overview of the way treatment will proceed, the sorts of strategies you'll be using in sessions to address the problem areas, and what will happen between sessions (practice).	An overview of the treatment for each primary problem can also be found in the **Clinician Guides.** Although you don't want to get into too much detail at the beginning, let them know the FIRST principles of how treatment will work.
Describe the youth's and caregiver's roles in treatment.	Treatment works best when both the youth and the caregiver are active participants. They are the "true experts," and their perspective is necessary for treatment to be a success.	Depending on the problem area, the role of the caregiver may be central or adjunctive. For all problems, however, the therapist is best seen as a "coach," someone who advises on helpful strategies and helps practice for upcoming performances. The youth and the caregiver are the ones who are actually trying out the strategies and reporting back about what works and what does not.
Establish goals for treatment.	If not already established, develop a concrete understanding of how the youth or caregiver would like for things to be different once treatment is complete.	Consider developing a concrete "Goals" worksheet identifying the overarching goals and smaller steps along the way that will demonstrate progress. The "top problems" nominated by the caregiver and youth during the FIRST Interviews will provide good raw material for goal setting.
Consider barriers to treatment.	What might get in the way of treatment? Consider any practical logistical concerns, such as time, transportation, or child care.	Acknowledge the difficulties in terms of time and resources. Consider the impact of the problem if it is left untreated. As a guide, use the Caregiver or Youth Problems and Coping Form (Handouts 1 and 2, respectively).

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Address ambivalence.	If you have the sense that either the youth or the caregiver with whom you'll be primarily working is unsure or skeptical, it may be helpful to try to address this with a series of open-ended questions, affirmations, reflections, and support for self-efficacy.	Here are some good **open-ended questions** to use in addressing ambivalence: • "What concerns you about this approach?" • "What are the cons of participating in this treatment? What might be some benefits?" Be on the lookout for opportunities to **affirm** the client or caregiver's experience: • "I know it's been a challenge, but you've worked hard to find a solution." • "This seems like a big commitment, and you're not sure it will work." **Reflect** the youth's or caregiver's statements, especially those that represent their desire for change: • "You're not happy with how things are now." • "It's important to you to help your child have more success." • "You really want to feel less anxious/sad." Support **self-efficacy** with empathic statements: • "I can see how hard this has been. I'm so impressed that you were able to come in today." • "It sounds like you've been a great advocate for yourself/your child." • "You have a lot of important knowledge. I am glad we are talking about this."
Answer questions.	Are there any questions about what has been discussed?	It is often very helpful to ask the youth and/or caregiver to summarize what was discussed, as a way of clarifying their understanding.
Instill hope.	The caregiver and/or youth may feel hopeless and worried. Maybe they have tried things before that have failed, or are skeptical for other reasons. Let them know you are confident that the work you do together can make a difference!	Asking the youth and caregiver about their expectations is a good way to begin the conversation. It can also be encouraging for both of them to hear that you have a lot of ideas for things to do in treatment that can help, and that you believe that with everyone working toward the same goal, things can improve!

HANDOUT 1

Caregiver Problems and Coping Form

Name: _____ Date: _____ Therapist: _____

The *Top Problems* I want therapy to work on:

1. _____

2. _____

3. _____

My reasons—why these problems need to be worked on:

Top Problem 1:
Why this problem needs to be worked on:

How life will be different if this problem is solved:

Top Problem 2:
Why this problem needs to be worked on:

How life will be different if this problem is solved:

Top Problem 3:
Why this problem needs to be worked on:

How life will be different if this problem is solved:

What I plan to do to help fix these problems:

(For example, go to meetings with my child's therapist, learn new skills, practice the skills with my child's therapist, practice the skills on my own in real life, help my child learn and practice new skills.)

(continued)

What might make it hard to work on these problems?

A. Will it be hard to go to meetings with my child's therapist? 0 1 2 3 4 5
Not hard Very hard

To cope with this, I will:

B. Will it be hard to practice new skills with my child's therapist? 0 1 2 3 4 5
Not hard Very hard

To cope with this, I will:

C. Will it be hard to practice new skills on my own? 0 1 2 3 4 5
Not hard Very hard

To cope with this, I will:

D. Will it be hard to help my child learn and practice new skills? 0 1 2 3 4 5
Not hard Very hard

To cope with this, I will:

E. Will something else make it hard to work on the problems? If so, what? _____

How big a deal will that be? 0 1 2 3 4 5
Not a big deal Big deal

To cope with this, I will:

HANDOUT 2

Youth Problems and Coping Form

Name: _____ Date: _____ Therapist: _____

The *Top Problems* I want to work on:

1. _____
2. _____
3. _____

My reasons—why these problems need to be worked on:

Top Problem 1:
Why I want to fix this problem:

How my life will be different if I fix the problem:

Top Problem 2:
Why I want to fix this problem:

How my life will be different if I fix the problem:

Top Problem 3:
Why I want to fix this problem:

How my life will be different if I fix the problem:

What I plan to do to work on these problems:

(For example, go to meetings with my therapist, learn some new skills, practice the skills with my therapist, practice the skills on my own in real life.)

(continued)

What might make it hard to work on these problems?

A. Will it be hard to go to meetings with my therapist? 0 1 2 3 4 5
Not hard Very hard

To cope with this, I will:

B. Will it be hard to practice new skills with my therapist? 0 1 2 3 4 5
Not hard Very hard

To cope with this, I will:

C. Will it be hard to practice new skills on my own? 0 1 2 3 4 5
Not hard Very hard

To cope with this, I will:

D. Will something else make it hard to work on the problems? If so, what? _____

How big a deal will that be? 0 1 2 3 4 5
Not a big deal Big deal

To cope with this, I will:

4

Clinician Guides

Facts About the Problems Treated with FIRST

Clinician Guide: Facts About Anxiety and OCD

Anxiety is a normal biological process that helps us stay alert to danger; it keeps us psychologically and physically prepared for action when the stakes are high. In this way, it is like a natural, built-in alarm system. For some people, though, **this alarm system is overly sensitive and perceives danger when there is actually very little to fear.** When this happens, the sympathetic nervous system reacts and triggers the fight, flight, or freeze response—but it's actually a false alarm.

An ***anxiety disorder*** is a pattern of excessive worry or fear about situations or circumstances.

- For some people, this comes in the form of nearly constant worry about things that are very unlikely to happen.
- Others may experience tremendous anxiety in the presence of certain situations, which leads them to avoid some people, places, or things.
- Some people experience physical symptoms of anxiety, such as feeling their hearts beat too hard or too fast, difficulty breathing, tingling in their extremities, sweating, or lightheadedness.
- Anxiety disorders cause individuals to feel distress and may lead them to stop doing things that they would really like to do, such as go to school, make new friends, or participate in activities.
- Anxiety in these forms can be severe and require treatment, even when it doesn't meet all the criteria for a formal anxiety disorder.

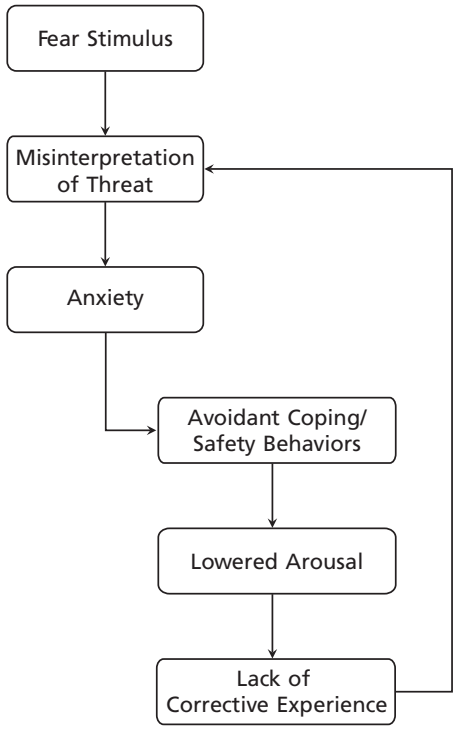
Obsessive–compulsive disorder (OCD) in youths is not unusual; 1 or 2 youngsters out of every 100 will experience the repeated, intrusive thoughts, images, feelings, or sensations that cause distress (called ***obsessions***) and the accompanying behaviors that the youth repeats

again and again to make the distress go away (called ***compulsions*** or ***rituals***). The theoretical model for OCD is very similar to that for anxiety disorders, except that the fear trigger consists of both the obsessive thought *and* (often) an environmental trigger—such as a "dirty" surface or a person with a cold. As with anxiety disorders, a false alarm is involved; in OCD, a youth uses compulsions or rituals to stop the false alarm, but this only ensures that the alarm remains faulty.

- OCD can be described as a "brain hiccup"; the content of the obsessions and compulsions is rarely meaningful. Whatever the nature of the obsessions, youths with OCD find it hard to stop these thoughts, even though they wish they could.
- Common obsessions include thoughts or worries about germs, illness, or contamination; thoughts related to bad things happening to others; "forbidden" thoughts that are sexual or religious in content; or just a feeling that something is "not quite right."
- Common compulsions include washing, checking, aligning, or fixing objects; tapping or touching things; and engaging in other special routines to respond to the obsessions.
- Initially, completing these rituals reduces the distress, but this process reinforces the belief that the obsession is somehow real or dangerous.
- Youths with OCD use avoidance and rituals as a way of lowering distress. Therefore, the target of treatment is helping a youth face feared stimuli (the obsessions and the environmental triggers), while also preventing the use of rituals to lower the distress.

How Is an Anxiety Disorder or OCD Different from Normal Worry?

Both anxiety disorders and OCD are different from the typical worry or nervousness we all may experience before important events (a stage performance or an important test), and are more pervasive and intense than the typical fear we all experience when we confront an *actual* threat. Youths with anxiety disorders or OCD worry more than most people about possible events and often anticipate the worst outcome, even when that outcome is extremely unlikely. They try to avoid situations that make them uncomfortable, or they experience these situations with great distress. They may have stomachaches, headaches, and muscle tension, and may often need adults and others around them to reassure them and tell them they are OK. Some youths worry about very specific things (e.g., certain animals, being away from parents), while others worry about almost everything. The worry and anxiety are very upsetting and take up a lot of time and energy. For youths with OCD, the worry may be briefly



relieved when they engage in compulsions or rituals, but in the long run the intrusive worries return, and the compulsions can take up inordinate amounts of time and effort.

What Is the Guiding Model?

Youths with anxiety disorders or OCD experience both physiological arousal and psychological distress when they encounter certain stimuli (including their own worried thoughts or obsessions). These feelings are unpleasant, so the response is either to avoid the stimuli or to take certain actions, sometimes called ***safety behaviors,*** in response to alleviate the distress (e.g., seeking reassurance, using ritualized compulsions). The avoidance or safety behaviors reduce the distress and arousal, and this reduction increases the likelihood that the youths will continue to avoid or use safety behaviors in response to the stimuli. Unfortunately, because they take measures to avoid facing whatever the fearful experience is, they never have an opportunity to learn that the experience would not be so bad, or that they could actually handle it! Having a corrective experience—such as facing the fear without using the safety behavior—can help a youth reassess the expectation of threat, see the situation in a more realistic way, and incorporate new learning about how to deal with anxious feelings.

What Happens in Treatment?

Treatment for anxiety disorders and for OCD focuses on helping youths more realistically assess situations they find fearful, so that they can learn that these are false alarms. To do this, we identify the situations that are being avoided or managed with safety behaviors or rituals, educate young people about these situations, and help them face and master their fears. While facing the feared situations, youths refrain from using safety behaviors or engaging in rituals, thus learning that they can tolerate the anxious feelings all on their own. Youths are encouraged to "bring on the fear" through planned exposures, and learn that the fears can be tolerated and mastered. It can also help to have the youths examine the beliefs that are making situations so scary, and learn to challenge those beliefs with evidence.

Some Helpful Hints

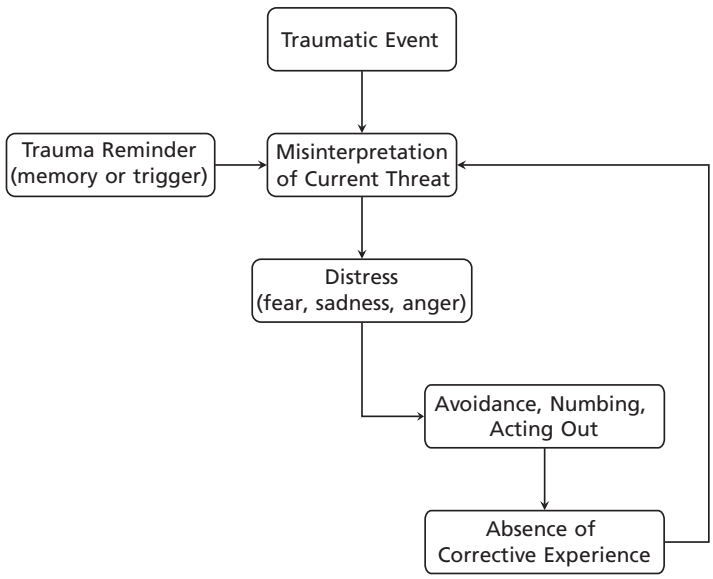
It is important to reassure caregivers that the treatment will begin with what youths can handle and move at the youths' pace. Caregivers may need to consider their own anxiety as their children become braver and more independent; they can support treatment success by conveying the message that they believe their children are safe and capable!

Clinician Guide: Facts About Posttraumatic Stress

Posttraumatic stress refers to behavioral, cognitive, physical, and emotional symptoms that emerge following a traumatic experience. Although most people will experience transient changes in the way they act, think, and feel following a major trauma, children who experi-

ence ***posttraumatic stress disorder*** (PTSD) or ***acute stress disorder*** experience changes that persist *beyond* what would be typical and begin to impair their functioning.

- Children react in different ways to traumatic events; many do not go on to develop the symptoms associated with PTSD or acute stress disorder. In those instances, they may still benefit from therapy, but may not need a treatment to focus specifically on the traumatic event
- Symptoms that occur as a result of posttraumatic stress include the following:
  - *Intrusion symptoms.* These may take the form of unwanted upsetting memories, nightmares, flashbacks, distress or physical reactivity in the face of trauma reminders
  - *Avoidance symptoms.* These are attempts to avoid thinking about or encountering trauma-related reminders.
  - *Changes in thinking and feeling.* There may be changes to cognitions following the traumatic event, including difficulty recalling key aspects of the traumatic event, overly negative beliefs about oneself and the world, and feelings of guilt or self-blame. Changes in emotion are also common—increases in negative affect, decreased interest in activities, feeling isolated, and emotional blunting.
  - *Changes in arousal and reactivity.* Following the traumatic event, youths may experience increases in irritability or aggression, engage in risky behaviors, or seem constantly "on guard." They may startle easily, have trouble concentrating, and find it hard to sleep.
  - For acute stress disorder as defined in DSM-5, symptoms persist for 3 days to 1 month, whereas for PTSD they must persist for more than a month.



What Constitutes a Traumatic Event?

Many children experience stressful and upsetting events—parental divorce, moving, conflicts with friends—and these may be addressed in treatment. However, posttraumatic stress as we refer to it here follows exposure to or a realistic threat of death, serious injury, or sexual violence. These events can be directly experienced, witnessed, or experienced via indirect exposure to detailed descriptions of the trauma. Young people may experience many specific types of traumatic events,

including extreme bullying, community violence, natural disasters, domestic violence, medical trauma, physical abuse, sexual abuse, refugee trauma, terrorism, and violence.

What Is the Guiding Model?

Perhaps as a result of incomplete processing during the traumatic event, a young person with posttraumatic stress continues to experience this past event as a current threat—even when there is no longer any current danger. As in the case of anxiety disorders and OCD, it can be helpful to describe this as an alarm system that has gone awry: The system has become highly sensitive and triggers false alarms that come in the form of feeling scared, sad, or unsafe. Avoidance of these thoughts and situations brings relief in the short term, but prolongs the experiences of hyperarousal and reexperiencing in the long run. In order to distinguish between traumatic memories and actual trauma, and to learn that traumatic memories and related situations are not dangerous, the youth will face the memories of the traumatic event and the feared trauma triggers in therapy. Over time, the ability to face the fear will grow stronger, along with feelings of competence and mastery.

What Happens in Treatment?

The goal of treatment with FIRST is to help restore a sense of bodily safety, overcome avoidance of trauma-related thoughts and feelings as well as of trauma reminders, and increase trust between the youth and a safe, reliable caregiver.

Some Helpful Hints

At the start of treatment, it is important to provide education not only about the symptoms and treatment, but about the type of trauma (e.g., domestic violence, sexual abuse, weather events). It is also important to provide information about the prevalence of such trauma (to show that the young person is not alone and that many others have faced this problem), and, in a case of abuse, to clarify that the perpetrator alone is responsible (to counter self-blame by the victim). Developmentally appropriate language should be used, rather than pseudonyms or vague terms. We recommend the use of reliable resources such as those made available by the National Child Traumatic Stress Network (*www.nctsn.org*). In a case of familial abuse, it is also critical to engage the nonoffending caregiver in treatment, so that this caregiver may be a source of support to the youth as treatment unfolds. Reassure the caregiver that young people can be remarkably resilient, and that this treatment can work to promote the youth's mental health and happiness.

Clinician Guide: Facts About Depression

Depression is more than just feeling sad once in a while; it is a serious clinical condition that grows more and more common as children grow older. One report estimated its prevalence

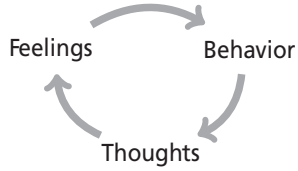
at 3–5% during ages 8–14, increasing to 20% during ages 14–17 (Hankin et al., 2015); another report estimated that almost 14% of adolescents would have a depressive disorder before age 18 (Merikangas et al., 2010).

Major depressive disorder (MDD) is one of the most serious conditions; it is diagnosed when an individual experiences at least five of the following symptoms nearly every day for at least two weeks (at least one of the two **boldfaced** symptoms must be present): **depressed or irritable mood, loss of interest or pleasure in all or most activities,** weight loss or gain, sleeping more or sleeping less, fatigue or loss of energy, feelings of worthlessness or guilt, decrease or increase in appetite, psychomotor agitation or retardation, difficulty concentrating or making decisions, and recurrent thoughts of death or suicidal ideation.

Persistent depressive disorder (PDD) is a chronic, less severe form of depression in which youths have depressed or irritable mood plus at least two additional symptoms every day for a year, without more than 2 symptom-free months. ***Other specified (or unspecified) depressive disorder*** and ***adjustment disorder with depressed mood*** are related, in that they involve symptoms of depression without meeting the criteria for MDD or PDD. Finally, many youths do not meet criteria for any formal diagnosis, but nonetheless experience depression symptoms severe enough or persistent enough to warrant treatment.

How Is Depression Different from Normal Ups and Downs?

Depression is different from experiencing the normal ups and downs of life; when youths are depressed, they become stuck in a pattern of feeling sad, down, irritable, or bored. They don't have good ideas about how to feel better, and they may withdraw from other people and activities, which sometimes provides short-term relief but creates problems over the long run. **In youths, more than in adults, depression may be characterized by irritable mood.** Youth depression is often associated with school interpersonal conflict, and increased risk of future problems such as substance abuse, unemployment, and suicide. Depression sometimes goes away on its own, but it often comes back, so it is important to develop strategies to combat it in the future.



What Is the Guiding Model?

Behaviors, thoughts, and feelings are all connected to one another, with each influencing the others. Youths who experience depression may feel tired, bored, or stressed out; as a result, they may get into the habit of avoiding activities that require energy, even those that once brought them joy. They may also fall into a routine of negative thinking that causes them to behave in a certain way and to feel worse. No one knows for sure how these patterns get started. For some youths, they may reflect a biological predisposition. For others, they may be

due to early life experiences or current stressors. No matter the root cause, changing behavior and/or thoughts can change feelings and interrupt the cycle of depressed mood.

What Happens in Treatment?

Treatment for depression focuses on getting youths "unstuck" from negative feelings through a variety of skill-building strategies. Depressed youths may have relatively few natural resources for handling life stress or negative feelings, so treatment focuses on teaching them new skills. Because depression presents differently for different youths, it can be helpful to have a variety of different skills to choose from—like a toolbox—so that each youth has a choice of strategies. One effective treatment for depression focuses on helping youths decrease behavioral avoidance and increase the number of reinforcing or pleasurable activities they engage in, while also helping them identify and change dysfunctional, "depressogenic" patterns of thinking about themselves and others.

Some Helpful Hints

When people are depressed, it can be hard for them to feel hopeful about the future or believe that anything can help. It's important to emphasize that there is hope and that things can get better, even though it may take some time before changes start to occur.

Clinician Guide: Facts About Misbehavior

The kind of ***misbehavior*** that often leads to treatment involves frequent disobedience, breaking known rules, and failing to follow well-agreed-upon codes of conduct. Such patterns are seen in three main types of disruptive behavior disorders.

Attention-deficit/hyperactivity disorder (ADHD) is a persistent pattern of inattention and/or hyperactive–impulsive behavior that is more frequent and severe than in same age peers. It is estimated to occur in 3–7% of school-age youths. Although the core symptoms of inattention and hyperactivity may be best addressed with medication, co-occurring behavior problems are often managed with psychotherapy. Technically, ADHD is now classified as a neurodevelopmental disorder in DSM-5; however, it is often accompanied by behavioral problems. Youths with ADHD may experience the following:

- Trouble paying attention and concentrating; distractibility.
- Difficulty organizing activities; failure to finish most tasks.
- Interrupting; difficulty waiting for a turn.
- High activity level and impulsivity; acting without thinking.

Oppositional defiant disorder refers to a pattern of noncompliance with rules in the home and at school. It occurs in 2–16% of youths and includes behaviors such as these:

- Frequent defiance of authority and refusal to obey rules.
- Failure to take responsibility for bad behavior or mistakes.

- Resentment and looking for revenge.
- Frequent temper tantrums.

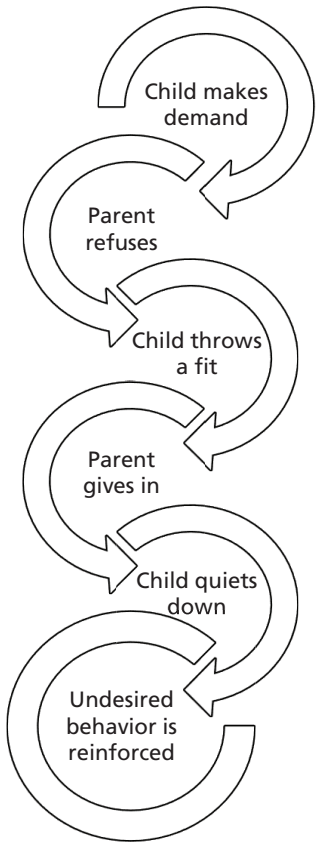
Conduct disorder refers to a persistent failure to follow the rules, regulations, and laws of society. Some 1–4% of youths are diagnosed with conduct disorder. Symptoms include the following:

- Aggressive behaviors that threaten or harm people or animals.
- Behaviors that destroy or damage property, such as setting fires, breaking windows, or creating graffiti.
- Stealing, bullying, or lying to get something.
- Serious rule violations, including school truancy and running away from home.

How Is Serious Misbehavior Different from Normal Noncompliant Behavior?

All young people break some rules. Some oppositional behavior is a normal part of childhood. However, some youths are delayed in the development of skills to handle frustration, postpone gratification, and regulate behavior. In these cases, the rules of everyday life may challenge the resources they have developed. When youths display a pattern of very oppositional behavior; are defiant of authority; and experience *persistent* difficulties at home, school, or with peers, treatment is warranted.

Example of a Coercive Cycle:



What Is the Guiding Model?

Youth conduct problems may stem from inborn temperament and/or social learning patterns and may require different parenting procedures from those used with most children and adolescents. Often, an adult's attempts to reduce or eliminate a young person's problem behaviors may inadvertently reinforce the behaviors; the youth's escalating misbehavior may lead the caregiver to avoid or respond punitively. Over time, parents and their children can be locked into mutually reinforcing cycles of coercion and conflict.

What Happens in Treatment?

The most effective and well-tested treatments for youth disruptive behavior problems involve combinations of medication to address executive functioning deficits (such as those seen in ADHD) and behavioral training of caregivers to

increase rates of appropriate behaviors and decrease rates of inappropriate behaviors. If a caregiver is unable to attend treatment, another option involves working individually with the youth to improve the problem-solving skills needed for appropriate behavior; reduce the physiological arousal that can fuel aggressive, irritable behavior; and strengthen the ability to restructure distorted beliefs about self, others, and the world.

Some Helpful Hints

It may seem strange to ask the caregiver to be the one who meets with the therapist, rather than the youth whose problem behavior has led to therapy. But studies have shown that individual therapy for youths with disruptive behavior problems is not as effective as working with parents and other caregivers. Consider this: Caregivers are the true experts on the young people they care for, spend the most time with them (far more than any therapist ever would), and have the largest influence on their behavior. The strategies described in Chapter 7 on Increasing Motivation can be applied to help address and resolve ambivalence caregivers may feel about participating in treatment—not feeling that they have the time or energy to commit to treatment, yet also wanting things to change and improve with their young people.

5

Help for Caregivers

Handouts on the Problems Treated with FIRST

The handouts that constitute this chapter (Handouts 3–6 on pages 55–62). provide brief psychoeducation for caregivers. For each problem area, the handout provides information on the nature of the problem, the treatment that will be provided, and ways caregivers can help. Please feel free to use these handouts with caregivers of the youths you are treating. You can photocopy the handouts or download and print them from the Guilford website (see the box at the end of the table of contents).

HANDOUT 3

Help for Caregivers: Understanding Anxiety and Obsessive–Compulsive Disorder

ANXIETY AND OBSESSIVE–COMPULSIVE DISORDER IN YOUNG PEOPLE

Anxiety is a normal part of life, and all youths go through phases where they worry more than at other times. The difference between a phase and an ***anxiety disorder*** or ***obsessive–compulsive disorder*** (OCD) is that a phase is temporary and usually harmless. A youngster who sees a scary movie and then has trouble falling asleep may be reassured and comforted. But that is not enough to help a youth with an anxiety disorder or with OCD get past his or her fear and anxiety.

Young people who suffer from an anxiety disorder or OCD experience fear, nervousness, and worry, and they start to avoid specific places, activities, or objects. Sometimes they ask adults over and over again if things are OK, but they never feel convinced for long. Some do things like washing their hands over and over, or checking to make sure things are OK, because they feel so nervous.

Anxiety disorders are common, affecting 1 out of 8 children and adolescents. OCD is a little less common, but still occurs in 2 out of every 100 young people. These disorders often coexist with other problems, such as depression, eating disorders, and attention-deficit/hyperactivity disorder (ADHD).

Research has shown that without the right treatment, youngsters with anxiety disorders and those with OCD are more likely to do poorly in school, miss out on important social experiences, and face difficulties in adulthood. The good news is that with treatment and your support, your child or adolescent can learn how to successfully manage the symptoms of an anxiety disorder or OCD and live a happy and healthy life.

WHY IS MY SON OR DAUGHTER ANXIOUS?

Anxiety disorders and OCD are caused by a combination of biological factors with psychological factors such as thoughts and feelings. Problems are kept in place and made worse when those who are anxious avoid the situations that make them anxious, or engage in other behaviors (such as rituals or seeking reassurance) that "neutralize" the fears.

Biological Factors

Youths who are very sensitive to the physical signs of anxiety (such as a racing heart, upset stomach, or feeling short of breath) are especially likely to have anxiety disorders. Those physical sensations are normal, but some boys and girls have an especially hard time dealing with them.

Psychological Factors

Anxious youths are more likely to have a way of thinking that assumes bad things will happen (even when it is not very likely), and also assumes that they can't handle it if those bad things do happen (even though they probably could). Boys and girls with OCD may also have overly strong feelings of guilt and responsibility.

(continued)

Avoidance

Youngsters who try not to experience feared situations because they don't like the physical signs or the scary thoughts are especially likely to develop anxiety disorders. Sometimes young people can't avoid the situations, but learn ways to make them seem less scary—for example, always carrying a lucky token, or insisting that a trusted adult stay nearby, or engaging in a ritual that may not make much sense to others (like washing, checking, or counting). In the short run, avoidance and related tactics may reduce anxiety, but in the long run the tactics prevent youngsters from learning that the bad thing they imagine usually doesn't happen—or that if it does happen, they can handle it.

Youths with anxiety disorders and OCD experience fear, nervousness, and worry, and they start to avoid places and activities.

> Children with anxiety and OCD often overestimate the likelihood that bad things will happen and underestimate their ability to cope.

WHAT CAN HELP?

The treatment with the most proven success for anxiety disorders and OCD involves ***planned exposure***—helping young people face the things they fear, so they can learn that what happens is not as bad as they imagined. Practicing facing feared situations without avoiding them or seeking reassurance helps them learn to tell the difference between real dangers and "false alarms." They learn to handle anxiety and OCD primarily through practice exercises that allow them to realize that many things that seem dangerous and scary are actually safe. Because anxious youths tend to avoid these things, they limit their opportunities for practice. A therapist and caregiver act as guides who encourage and support a youth in gradually facing these difficult experiences and learning to recognize safe situations. The most important part of this therapy is helping boys and girls learn, through experience, that they can safely do the things they have feared.

HANDOUT 4

Help for Caregivers: Understanding Posttraumatic Stress

POSTTRAUMATIC STRESS IN YOUNG PEOPLE

A ***traumatic event*** is an intense experience that threatens or causes harm to a person's emotional or physical well-being. Some examples of traumatic events include witnessing or experiencing physical violence, physical or sexual abuse, war, natural disasters, upsetting accidents, and painful medical procedures. Sadly, about a fourth of all young people will be exposed to one or more traumatic events before age 16.

Many girls and boys recover from the upsetting experience of a traumatic event and naturally begin to feel and act like they did before the event. However, some have reactions that persist long after the traumatic event has ended. When these reactions interfere with their physical and emotional health and impair daily functioning, this is called ***posttraumatic stress.***

Posttraumatic stress can affect girls and boys in a number of ways—how they feel, how they think, and the way they act. For example, they may feel scared or unsafe even when they are in a safe place, feel sad or guilty about things that were not their fault, or be angry and irritated at other people. There may be changes in how they think about themselves, others, or the world. And there may be changes in behavior, such as difficulty sleeping or eating, withdrawing from others or activities, acting out by breaking rules or arguing, or avoiding people or places.

Some youngsters will develop ***posttraumatic stress disorder*** (PTSD), in which they continue to reexperience the event through nightmares, flashbacks, or other symptoms for more than a month after the original experience. Or they may refuse to think about the event, have trouble remembering part of the event, or feel disconnected from it—and have changes in their moods, sleeping, and social interactions. The good news is that treatment can be very helpful for those with posttraumatic stress or PTSD: It can help them to face the traumatic event directly, begin to heal, and move forward.

WHY DID MY SON OR DAUGHTER DEVELOP POSTTRAUMATIC STRESS?

It is normal to have a strong physical and emotional reaction to a traumatic event when it is happening. During traumatic experiences, the brain and body work together to protect us via a fight, flight, or freeze response. This response is the human body's built-in alarm system; it warns us and prepares us to deal with danger. However, some young people who have experienced trauma continue to experience alarms even when there is no longer a real threat. We don't know all the reasons why some boys and girls are more strongly affected by traumatic events than others, but a number of factors seem to be involved.

Biological Factors

Young people who are very sensitive to the physical signs of anxiety (such as a racing heart, upset stomach, or feeling short of breath) are more likely to develop posttraumatic stress. Those physical sensations are normal, but some youngsters have an especially hard time dealing with them.

(continued)

Prior Experiences

Young people who have experienced prior traumas are more likely to develop symptoms after a recent event.

Type of Trauma

Although all traumatic events can lead to posttraumatic stress, youths who experience interpersonal traumas (such as physical or sexual abuse) may be more likely to develop symptoms.

Regardless of why the symptoms developed, there are several things that can help improve a young person's chance of recovery. A strong social support system is one critical ingredient. Active engagement in an effective therapy is another factor that can help children overcome the impact of trauma.

> Children with traumatic stress often continue to experience alarms even when there isn't any threat.

WHAT CAN HELP?

The treatment with the most proven success for treating posttraumatic stress involves helping youngsters face the memory of the traumatic event gradually, in a safe and therapeutic environment. This helps them process what has happened and learn that even though the memories are painful, there is no longer any real danger. It can also be helpful for them to develop new ways of coping with strong emotions—by learning new and more helpful ways to think, or to act, or both! Caregivers also play a critical role in successful treatment of traumatic stress, by providing a safe environment that is consistent and supportive, and by joining with youths in facing the traumatic event during treatment.

HANDOUT 5

Help for Caregivers: Understanding Depression

DEPRESSION IN YOUNG PEOPLE

Depression is very common in children and adolescents, but it may look different from adult depression. For example, boys and girls who are depressed may seem cranky instead of sad, or they may stop enjoying activities they once liked. Their sleeping or eating habits may change a lot, and they may gain or lose weight. Some depressed youngsters say they feel bad about themselves or others, or they feel as if nothing good will ever happen in the future. Some seem tired, bored, and unmotivated, while others may be irritable and restless. Feeling this way *sometimes* is normal for everyone, but it's not normal or helpful to get "stuck" feeling sad, down, or hopeless. The good news is that there are many helpful ways to deal with these feelings—to help young people feel better and avoid getting "stuck."

WHY IS MY SON OR DAUGHTER DEPRESSED?

Young people get depressed for many different reasons. The causes can include personality and biological factors (bodily changes), psychological factors (thoughts and feelings), and stressful experiences (like problems with school and friends). Most often, depression results from a combination of these causes that pile up over time.

Personality and Biological Factors

Some boys and girls get more easily irritated, upset, or sad than others. They may have very strong feelings in response to bad situations or to distressing information, or they may be "moody." This may put them at risk for depression.

Thoughts and Feelings

Some youngsters believe that the things happening in their lives are pretty much out of their control. This feeling can be made worse when things go badly, when there is a loss of some kind, or when a new situation requires a skill they don't have. Some boys and girls develop a way of thinking about themselves and others that focuses on bad things, rather than seeing things as mixtures of good and bad. This can lead them to feel upset, defeated, and sometimes hopeless. These youngsters may jump to conclusions about the future before they have all the information, leading them to make choices that often fulfill their negative beliefs.

Stressful Experiences

Stressful life experiences can also change how young people feel. For example, youngsters who do badly in school may come to believe that they will never succeed, even if they are actually quite good at other things, like playing sports or making friends. Youngsters who are picked on by a few peers may avoid social events, and thus miss out on experiences that might be fun and help improve their mood. All young people encounter some stress in their lives, but for some this stress takes an especially heavy toll on their thoughts, feelings, and actions.

(continued)

Youths who are depressed may seem cranky rather than sad, or lose interest in doing activities they once enjoyed.

WHAT CAN HELP?

Treatment for youth depression focuses on helping boys and girls learn skills to cope with the specific areas where they are having problems. For example, depressed youths may have developed ways of acting that make them feel worse, such as pulling away from friends and family, doing fewer fun activities, or spending time alone and being inactive. Treatment will address this by helping your son or daughter be more active and find enjoyable things to do—things that are mood-boosting or increase the opportunities for future enjoyment. Depressed youths may also develop unhelpful thought patterns, such as thinking over and over again about all the things that did not go well, worrying about what will happen in the future, or thinking unkind thoughts about themselves. This can be addressed in treatment by helping youngsters learn to think about things differently, and to say encouraging things to themselves. All these skills are introduced in therapy, but a youth will practice and perfect them at home, with the caregiver as the "home coach." The caregiver plays a very important role by encouraging and supporting the young person to try, and to practice, the new skills in order to become comfortable with them. Most of the treatment is about helping the youth practice interacting with and thinking about the world in a new way.

HANDOUT 6

Help for Caregivers: Understanding Misbehavior

MISBEHAVIOR/DISRUPTIVE BEHAVIOR DISORDERS IN YOUNG PEOPLE

Disruptive behavior disorders is a fancy phrase for a group of behaviors that "break the rules." ***Misbehavior*** is the shorter term we use for this group. All youngsters break *some* rules *sometimes*, especially less important rules. A very young child may snatch something from another child, and teenagers may test the rules from time to time. However, young people who *repeatedly* break known rules, disobey adults, or threaten or harm their peers may have misbehavior that needs to be stopped. Such youngsters often appear stubborn, argumentative, and "hot-tempered," and may be very disruptive at home or at school. The good news is that there are skills caregivers can use to help these youngsters follow rules more often; argue less; do what they are told by adults; and have better relationships with family members, with peers, and with teachers.

Why Does My Son or Daughter Misbehave?

There are many possible causes of misbehavior. Some youngsters may have certain "temperamental" (personality) characteristics or styles of thinking that set the stage for misbehavior. Sometimes the interactions between young people and their caregivers increase the likelihood of misbehavior, and this increase in turn can make parenting difficult. Stressful experiences that a youth or family may encounter can also add to the difficulty.

Temperamental and Cognitive Characteristics

Young people who have strong emotional reactions to experiences, who have an extra dose of energy, and who have a hard time paying attention or thinking before they act may be more likely than others to misbehave. Some youngsters tend to interpret other people's actions toward them in negative ways—for example, "That kid is disrespecting me!"—and this can lead to verbal or physical combat.

Caregiver–Youth Interactions

Because it can be difficult to take care of youngsters who argue a lot, don't follow directions, and seem angry a lot of the time, their relationships with their caregivers can sometimes become challenging. A caregiver may find that typical ways of handling behavior problems don't work with a really misbehaving son or daughter. The caregiver and that son or daughter may get caught up in "conflict cycles" that eat up a lot of time, don't solve the problem, and leave everyone frustrated.

Stressful Events

Family stresses, like financial problems, marital/couple conflict, or illness, can make it hard to enforce home rules consistently and maintain structure. This, too, can result in increased misbehavior.

(continued)

The treatment involves working directly with the caregivers—the people who are most important to their sons and daughters and have the most powerful impact on their lives!

WHAT CAN HELP?

The treatment for misbehavior that has shown the best results involves meeting mainly with the caregivers—the people who know the most about, and can have the most impact on, their sons or daughters. Although the parenting practices caregivers use naturally may work well for most of their children, youngsters who chronically misbehave may need a different approach, one that involves new parenting practices. The first step is typically helping a caregiver observe and better understand the youth's problem behaviors and how they affect the family. Next, the caregiver learns to use the most powerful tool—his or her own attention—to increase the youth's good behavior and reduce the frequency of troubling behavior. Other practices (such as targeting good behavior with specific labeled praise, and encouraging good behavior by rewarding it) can also be added to the caregiver's toolbox. Although meeting mostly with a caregiver is the treatment with the greatest success, sometimes treatment also involves having a therapist work directly with a youth to teach self-control skills and strategies for solving problems without misbehaving.

Think FIRST

Planning Treatment, Case by Case

So you've just had a new referral, and you want to start planning your treatment approach for this young person. Let's assume that (1) you've collected some standardized measures of the young person's problems and functioning; (2) you've done detailed intake interviews with the youth (see **The FIRST Interview—Youth,** Chapter 3, pages 35–37) and with one or more of the caregivers (see **The FIRST Interview—Caregiver,** Chapter 3, pages 33–35) to understand the reasons for the referral; and (3) you've also used the **Youth Problems and Coping Form** (Handout 2 at the end of Chapter 3) and the **Caregiver Problems and Coping Form** (Handout 1 at the end of Chapter 3) to assess motivation for treatment, as well as possible obstacles and solutions. Using all that assessment information, you will need to decide . . .

■ **What problem should you focus on first in treatment?** Your treatment might begin with a focus on any of these: **anxiety or OCD, posttraumatic stress, depression,** or **misbehavior.** Of course, many young people present with multiple problems of multiple types. If this is true of your new client, you will want to consider these questions in selecting your initial problem focus:

- **Which problems are most severe and impairing?** Your standardized measures (such as the Child Behavior Checklist or the Strengths and Difficulties Questionnaire) should tell you which of your client's problems are severe enough to fall into the clinical range. Your youth and caregiver interviews should tell you which problems are most impairing (e.g., is anxiety so severe that the youth is missing school days, or are conduct problems at school severe enough to pose a risk of suspension?).

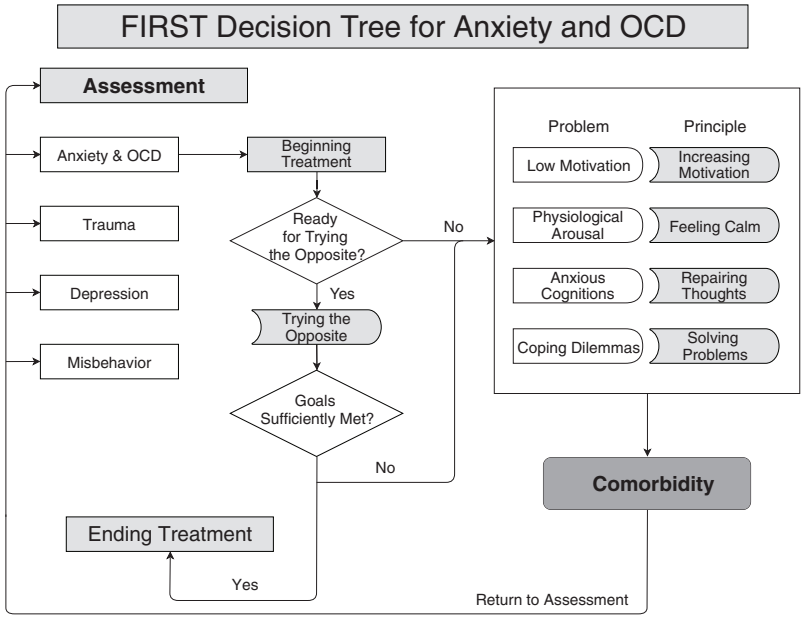
- **Which problems are most distressing?** Your interviews with the youth and caregiver should reveal which problems led to the referral, and which "top problems" are identified as most important by the youth and which ones by the caregiver.
- **Does one type of problem underlie the others?** In some cases, the interviews will point to one type of problem as an underlying cause of the other problems. For example, an irritable, angry social style may reflect underlying depression, or chronic disobedience at home may reflect underlying anxiety (e.g., fear of separating from a parent, fear of sleeping alone). If the evidence is especially strong that an underlying problem has a powerful causal impact, that problem may be a viable candidate as an initial focus of treatment.

For each problem focus you may choose, we've provided a decision tree to assist you as you plan treatment (see Chapter 2, Figures 2.1 through 2.5).

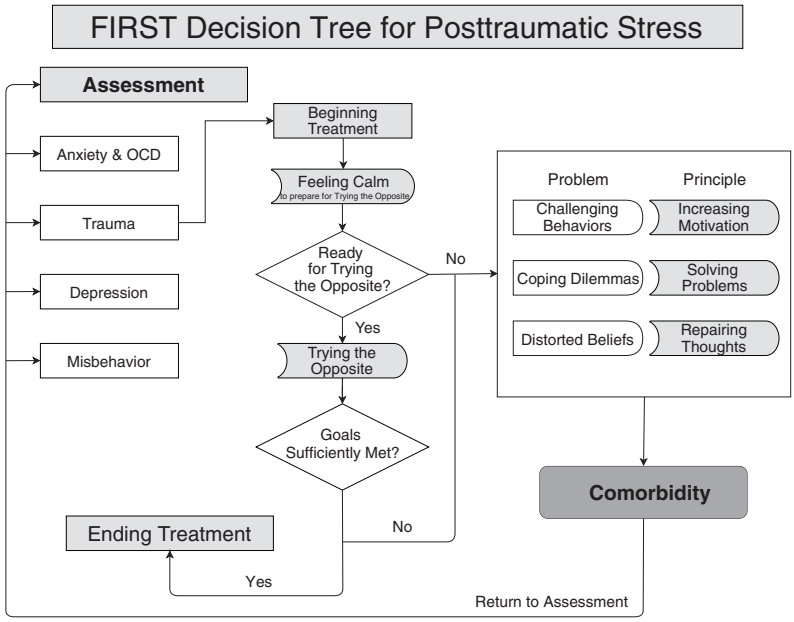
■ **If you begin treatment by focusing on anxiety or OCD,** you will almost always need to use **Trying the Opposite,** in the form of exposure—helping your young client do things that have seemed scary or risky and thus have been avoided. This will help the youth learn that the distress can be tolerated, and also build a realistic picture of what actually *does* happen when the fear is faced. Exposure takes different forms for OCD than for the anxiety disorders, and for generalized anxiety disorder you may need "worry exposures" (one of the different types of exposure is discussed in detail in Chapter 10). Because treating anxiety and OCD can be hampered by certain common obstacles—for example, low motivation, and overly anxious cognitions—you may need to use the treatment principles as shown in the top right portion of the decision tree (facing page, top, and Figure 2.1) to keep treatment on track. If you decide that your treatment also needs to address other disorders or problems, not just anxiety or OCD, you can follow the decision trees for those problems.

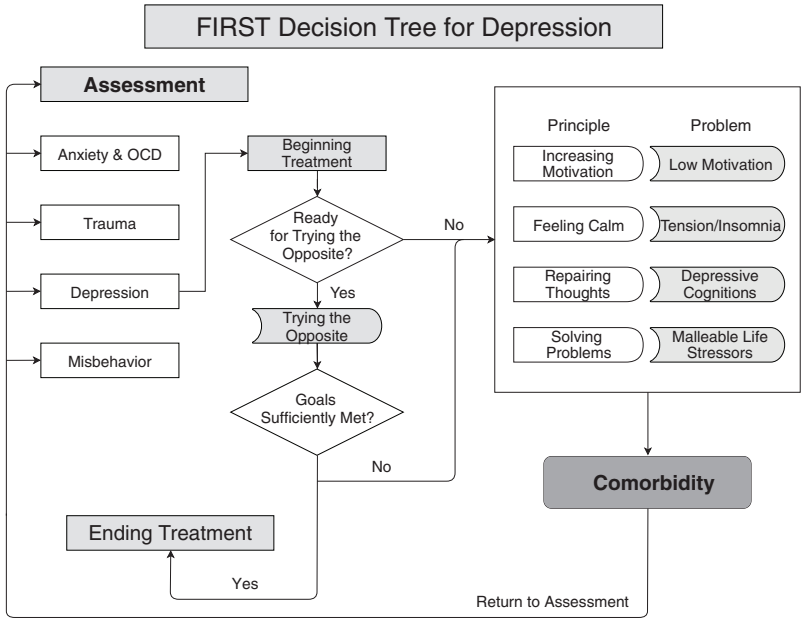
■ If **you begin treatment by focusing on posttraumatic stress,** you will almost always need to use **Trying the Opposite,** in the form of exposure to upsetting memories, and sometimes to memory-triggering places and situations that no longer pose a threat. However, before starting exposure, your young client will likely need to build skills in self-calming; these skills will enable the youth to confront the upsetting memories without being overwhelmed (see the decision tree on the facing page, bottom, and Figure 2.2). Because certain common problems—for example, challenging behaviors or distorted beliefs—can obstruct treatment, you may need to apply the treatment principles shown in the top right portion of the decision tree. If you decide that your treatment also needs to address other mental health disorders or problems, not just posttraumatic stress, decision trees are available for those problems.

■ **If you begin treatment by focusing on depression,** you will often use **Trying the Opposite,** in the form of behavioral activation. That is, you will help the youth engage in activities that boost mood in the short or long term and disrupt the depressive cycle. Because certain common problems can be obstacles to depression treatment—for example, insomnia or troubling life stressors (see top right portion of the depression decision tree on p. 66, top, and Figure 2.3)—we have suggested ways of using the FIRST principles to tackle those problems. If you decide that your treatment also needs to address other disorders or mental health problems, not just depression, you can follow the decision trees for those problems.

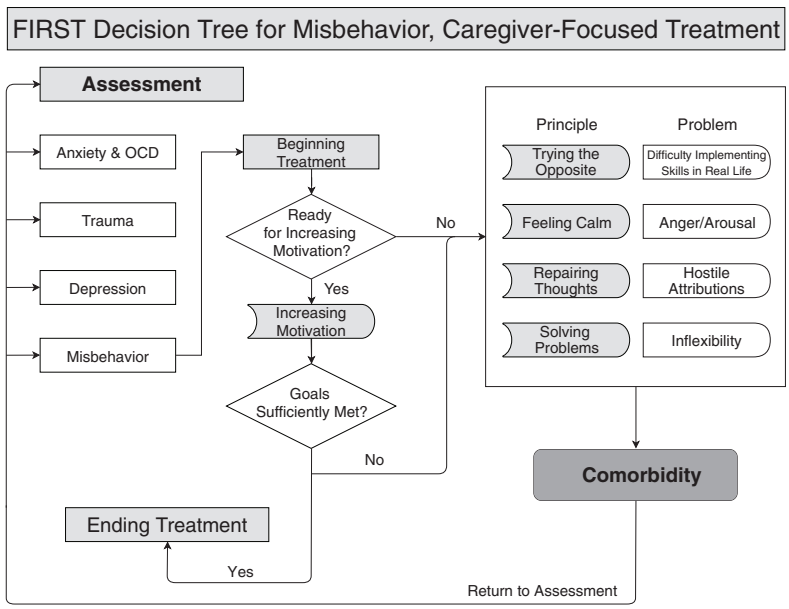


■ If **you begin treatment by focusing on misbehavior,** an important first step is determining whether or not one or more caregivers will be actively involved in treatment, meeting with you more often than the youth does, and focusing on parenting strategies. In most cases this is the preferred approach, so working to engage caregivers is a priority for the effective treatment of misbehavior! Wise implementation of **The FIRST Interview—Caregiver** and the **Caregiver Problems and Coping Form** can give you a clear picture of whether or not your treatment can be mainly caregiver-focused.



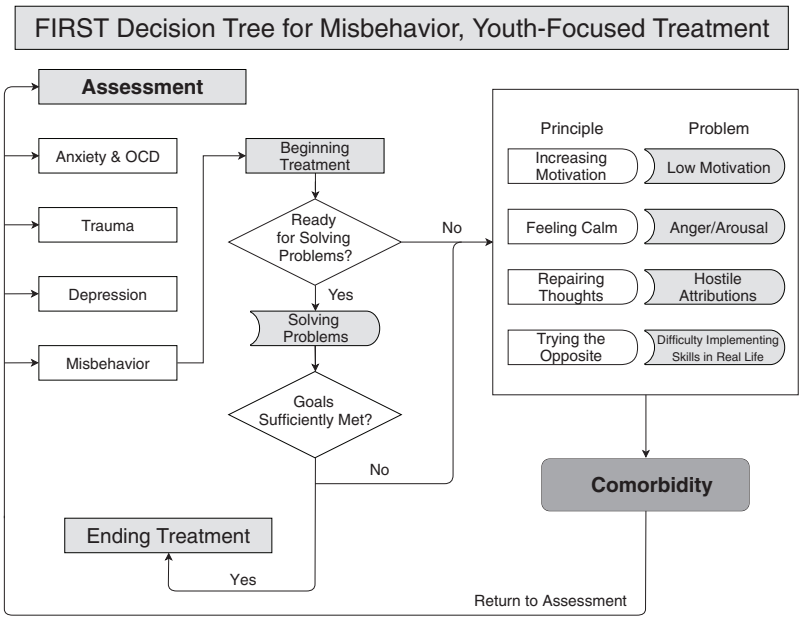


If caregivers will play the primary role in treatment of youth misbehavior, then your work should be guided by the **FIRST Decision Tree for Misbehavior, Caregiver-Focused Treatment** (see below and Figure 2.4). Treatment will involve building parenting skills with a primary focus on boosting the youth's motivation to obey, follow rules, and behave well. Common obstacles to effective parent training are identified in the top right portion of the decision tree; one example is difficulty translating the skills learned in session into caregiver behavior in real life at home. We have discussed ways of addressing each obstacle, using one



or more of the FIRST principles. If you decide that your treatment also needs to address other mental disorders or problems, not just misbehavior, you can rely on the decision trees for those problems.

- **If a caregiver will *not* play the primary role in treatment of misbehavior, and you will instead work mainly with the youth,** then you will focus mainly on helping the youth build and practice problem-solving skills. Your work in this case will be guided by the **FIRST Decision Tree for Misbehavior, Youth-Focused Treatment** (see below and Figure 2.5). You and the youth will apply the sequential problem-solving steps summarized by the S-O-L-V-E acronym (see Chapter 9), to help the youth navigate the situations where misbehavior has been a problem in the past. You will address common reasons for ineffective problem solving (such as hostile attributions, anger, and loss of self-control; see the top right portion of the decision tree) by applying relevant FIRST principles. If you decide that your treatment should address other mental disorders or problems, not just misbehavior, you can use the decision trees that are provided for those problems.



Summary Overview of the FIRST Treatment Program

FIRST is a transdiagnostic treatment for children and adolescents, designed to encompass a broad range of emotional and behavioral problems and disorders. FIRST uses a principle-based approach to support more efficient access by clinicians. It is built on five empirically supported principles of change, each applicable to multiple problems and disorders.

FIRST Component	General Goal	Clinical Problem	Specialized Application(s) Based on the Clinical Problem	Pages
F: Feeling Calm	Help youths apply calming and relaxation strategies in the face of distressing physiological arousal and tension.	**Anxiety and OCD**	Anxious youths may experience physiological hyperarousal in the face of anxiety-provoking stimuli, which can be unpleasant. Relaxation skills may be most beneficial for generalized anxiety disorder, because they may reduce chronic physiological overarousal.	73–79
		Posttraumatic stress	Relaxation can address symptoms of somatic arousal and reactivity following a traumatic event, such as hypervigilance, irritability, exaggerated startle response, and sleep disturbance. It can also promote feelings of body safety before and after exposure when Trying the Opposite is used.	73, 74–77, 79–80
		Depression	Relaxation can address symptoms like muscle tension, headaches, difficulty sleeping, and irritability through relieving physiological sensations associated with depression.	73, 74–77, 80–81
		Misbehavior	Relaxation can help reduce arousal in the face of irritants (i.e., help youths "stay cool" while deciding how to react to stressors). It can stimulate calm reflection that may prevent reacting without thinking.	73, 74–77, 81–82

FIRST Component	General Goal	Clinical Problem	Specialized Application(s) Based on the Clinical Problem	Pages
I: Increasing Motivation	Boost motivation for appropriate and prosocial behavior, thus reducing inappropriate, disobedient, or aggressive behavior.	**Anxiety and OCD**	Avoidance may reduce anxiety in the moment, but it also reinforces detrimental behavior rather than real coping. Increasing Motivation involves using attention, praise, and tangible rewards for brave and effective behavior, to encourage youths to approach feared stimuli and prevent compulsions and other safety behaviors.	89–95
		Posttraumatic stress	Avoidance can prevent youths from building coping skills, and from learning that they can confront traumatic memories while remaining safe. Increasing Motivation procedures can make direct engagement and effective coping more reinforcing than avoidance. They can also help strengthen caregiver–child relationships that are strained by trauma.	89, 90–94, 95–97
		Depression	Using attention, praise, and tangible rewards can help boost depressed youths' motivation to actively engage in therapy, complete practice assignments, and get involved in helpful activities outside of therapy sessions.	89, 90–94, 97–98
		Misbehavior	Developing contingent relationships between obedient, rule-following, and prosocial behavior and reinforcers (attention, praise, tangible rewards) makes good conduct more likely. Introducing effective discipline strategies helps to extinguish inappropriate or rule-breaking behaviors.	90–94, 98–104
R: Repairing Thoughts	Help youths evaluate the ways they think about themselves, others, and the world, and to think in more realistic and helpful ways.	**Anxiety and OCD**	Anxious youths often overestimate the likelihood that something bad will happen and underestimate their own ability to cope if that bad thing did happen. Youths struggling with OCD will fear bad consequences of not performing compulsions. Repairing thoughts in the context of trying the opposite will help reduce these negative thoughts and compulsions.	123–129
		Posttraumatic stress	Youths struggling with the aftermath of a trauma may feel guilty, may be hopeless about the future, or may believe that good things will never happen to them. They may interpret certain harmless situations as dangerous, underestimate their ability to cope, and view the world as unsafe. Repairing these thoughts can help reduce these posttraumatic symptoms.	123, 124–127, 129

FIRST Component	General Goal	Clinical Problem	Specialized Application(s) Based on the Clinical Problem	Pages
R: Repairing Thoughts (*continued*)		**Depression**	Depressive thoughts are often sad and hopeless; these youths may always see the glass as "half-empty." They may assume the worst without thinking about other possibilities. Repairing these thoughts can alleviate depressed mood.	123, 124–127, 130–131
		Misbehavior	Youths who misbehave or disrupt often make negative or hostile guesses about situations that are actually ambiguous, or make negative assumptions about caregivers or other adults who make/enforce rules. Repairing these thoughts can diminish misbehavior.	123, 124–127, 132–133
S: Solving Problems	Help youths systematically identify problems, brainstorm solutions, evaluate the consequences, and make good choices.	**Anxiety and OCD**	Youths struggling with anxiety and OCD need to plan in advance for challenging and anxiety-provoking situations, as well as to brainstorm possible ways of handling those situations. Anxious youths may underestimate their ability to manage outcomes when they face feared situations. Becoming effective at solving problems can build confidence that the feared situations can be managed and mastered.	141–146
		Posttraumatic stress	Youths who have had traumatic experiences often struggle to cope with challenging memories and moods, and often resort to maladaptive behavior. Learning to solve problems can help them navigate these situations, instilling a sense of control and self-efficacy.	141, 142–145, 147–148
		Depression	Depressed youths often feel hopeless in the face of problems and may have a difficult time generating good solutions; they may also give up easily when their first attempt to solve a problem does not succeed. Problem-solving skills, combined with courage and perseverance, can help change these reactions.	141, 142–145, 148–149
		Misbehavior	Misbehaving youths often have an impulsive temperament that makes it difficult to process information, formulate goals, and consider various solutions and their consequences before they act. Teaching systematic problem solving can help them identify the problem, generate multiple solution options, evaluate the pros and cons of those options, and choose a wise course of action.	141, 142–145, 149–151

FIRST Component	General Goal	Clinical Problem	Specialized Application(s) Based on the Clinical Problem	Pages
T: Trying the Opposite	Help youths try new actions that directly challenge their symptoms.	**Anxiety and OCD**	Anxious youths often avoid situations that make them feel tense and scared. Trying the Opposite helps them face the avoided situations in order to learn that they can tolerate anxious feelings, and that avoidance and obsessive–compulsive cycles are not necessary.	158, 159–163, 163–167
		Posttraumatic stress	Youths struggling with the aftermath of trauma may avoid not only emotion-laden situations, but also their own traumatic memories. Trying the Opposite involves helping these youths gradually confront their memories so they can be in control of them, instead of controlled by them.	158, 159–163, 167–171
		Depression	Depression can make youngsters want to self-isolate, sleep, slow down, and stop doing activities. These responses may bring relief in the short term, but over time they wipe out opportunities for reinforcement and social support. Trying the Opposite for depression involves persuading these youths to try out behaviors and monitor how each behavior makes them feel, instead of letting moods dictate behavior.	158, 159–163, 171–174
		Misbehavior	Youths who misbehave need to practice doing the opposite of what is often their first impulse. Practice may involve handling potentially conflictual situations without getting angry, blowing up, or violating a rule.	158, 159–163, 174–176

6

Using the FIRST Principles

Feeling Calm

This principle is used to help youths apply relaxation and calming strategies in the face of physical arousal and tension.

Physiological relaxation is a common therapeutic strategy employed in empirically supported interventions for all of the problem areas represented in FIRST, and for other problem areas as well. Indeed, the use of relaxation is so widespread that some have dubbed it the "aspirin" of behavioral medicine (Russo, Bird, & Masek, 1980), noting that its use even extends to problems like sleep disturbance, migraines, and pain. There are a number of ways to induce physiological relaxation. These include *progressive muscle relaxation,* which involves systematic tensing and relaxing of major muscle groups; *behavioral relaxation training,* in which discrimination training is used to demonstrate relaxed and nonrelaxed body postures (Ferguson & Sgambati, 2009); and *deep breathing* paired with *guided imagery* (Lohaus, Klein-Heßling, Vögele, & Kuhn-Hennighausen, 2001). Regardless of the specific techniques employed, the purpose of relaxation is generally to enhance emotion regulation and effective coping by creating somatic relief. The relief is brought on by activation of the parasympathetic nervous system through direct (as in progressive muscle relaxation) or indirect (as in guided imagery) engagement.

Within FIRST, **Feeling Calm** is used to increase a youth's sense of mastery and control over physical and emotional experience. Calming is particularly recommended for depression that involves somatic symptoms and sleep disturbances (e.g., insomnia), and for posttraumatic stress that involves fears of bodily harm. Although relaxation is often associated with the treatment of anxiety disorders in youths, it is important to note that we do *not* recommend it to manage anxious arousal when clinicians are encouraging young people to approach feared stimuli during exposure; exposure is the primary treatment approach for anxiety and OCD in FIRST (see "For Anxiety and OCD," below). Finally, in cases where misbehavior results from an overdose of frustration, fury, or other raw emotion, calming can be used "to soothe

the fevered brow," giving youngsters the mental space they need for emotion to subside and self-control to win out.

How Feeling Calm Is Used for Different Problem Areas

For Anxiety and OCD

Anxious youths may experience physiological hyperarousal in the face of anxiety-provoking stimuli, and these sensations are often unpleasant and upsetting. It is very important *not* to use relaxation in combination with exposure, however (see Chapter 10 on Trying the Opposite), because exposure involves learning to "bring on the fear" and tolerate the distress and arousal—not to eliminate it through relaxation. We want anxious youths to learn that they can do what they have feared, and that they can tolerate and overcome some initial anxious arousal along the way, to achieve their goals. Outside of the exposure experiences, though, anxious youths may feel the effects of somatic arousal due to constant anticipatory anxiety, as in generalized anxiety disorder. In these cases, teaching relaxation skills can help to reduce chronic physiological overarousal in general, and can address the specific tendency for anxious youths to have rapid, shallow breathing and tense muscles. For youths with OCD, relaxation will not address the core symptoms (obsessions and neutralizing rituals), but it may be useful for dealing with anxious comorbidity, which is common.

For Posttraumatic Stress

One symptom of posttraumatic stress is that changes occur in somatic arousal and reactivity following the traumatic event. These changes can result in hypervigilance, irritability, exaggerated startle response, and sleep disturbance. Relaxation can be used to address these difficulties, and also to promote feelings of body safety *before* and *after* (but not *during!*) the exposures in which the traumatic memories are confronted within Trying the Opposite.

For Depression

Depression is often associated with muscle tension, headaches, and other unpleasant physiological sensations. Youths who feel depressed may also have difficulty sleeping and may feel irritable. Relaxation skills provide a way to relieve the physiological sensations that are often associated with depression, and relaxation can improve sleep, reduce irritability, and improve mood in general.

For Misbehavior

Serious misbehavior in some young people is triggered by their difficulty tolerating frustration, anger, or other intense emotions, or inhibiting impulsive actions; their misbehavior may be an overreaction to stressors, sometimes even mild stressors. Relaxation strategies can help them reduce their arousal in the face of irritants, stay cool, and consider other ways of reacting. At the simplest level, relaxation can stimulate calm reflection, preventing these often disruptive youths from reacting without thinking.

Skill Unit Objectives

Note: Multiple sessions will almost certainly be required to cover the full Skill Unit; therapist and client should continue until the skill of Feeling Calm has been mastered.

- The youth will understand the way physiological cues are felt in the body.
- The youth will learn how calming strategies can defuse the physical sensations.
- The youth will learn several approaches to calming, and identify situations where these approaches can be applied.

Skill Unit Outline: Feeling Calm

Remember this in every session:

SESSION COMPONENTS [Note: These should be included in every session.]

- **Create an agenda** of what will be covered in the session.
- **Review practice,** if any was assigned in the prior session.
- **Share the news** of any new skills or information covered in session with the caregiver or the youth at the end of the session (as appropriate).
- **Assign practice** of calming skills in real-life situations that have led to distressed arousal in the past.
- **Assess skill acquisition:** Is progress being made toward goals in a notable way? Is it time to move to another Skill Unit or consider ending treatment?
- **Finish strong:** End the session on a strong positive note that affirms your relationship and positive feelings toward the youth and/or caregiver—perhaps by doing an engaging activity together, praising the youth and/or caregiver for an important accomplishment in therapy or in real life, or noting how much you value the chance to work with the youth and/or family and are looking forward to the next session.

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Discuss the physical symptoms associated with the problem area.	Ask the youth what body cues are noticeable when he or she starts feeling sad/scared/angry. Consider heart rate, breathing, sweating, muscle tension, etc. Note that this is the body sending a signal; sometimes our bodies know there is a problem before we do!	Depending on the problem area, physiological cues may be present, and may be triggered by different situations. It can be fun to trace the youth's body on a big piece of paper and "map" the feelings he or she has when the feelings associated with the problem area occur. You can also use an experiential activity—something that induces anxiety (like the game Operation), sadness (a sad movie clip), or frustration to discover *in vivo* where the body sensations occur.
Check in on current breathing patterns.	Some youths have learned to breathe rapidly, taking more breaths than they actually need. This type of "overbreathing" can result in a constant state of physical arousal—keeping a youth in a fight, flight, or freeze state much of the time! Before teaching relaxation, it can be useful to check whether the youth is overbreathing. If that is happening, addressing overbreathing is a good first step for intervention!	Time the youth for 1 minute, asking him or her to count the number of full breath cycles (in and out) taken in that time. Or just ask the youth to breathe in her or her usual way, while you count the cycles unobtrusively. Although everyone's breathing varies, about 12 complete in-and-out breath cycles in 1 minute is typical. If the breath cycles in a minute exceed that by a lot, consider making a 1-minute recording for the youth that can be listened to for practice. You can simply say, "Breathe in" and "Breathe out," every 2–3 seconds. The youth can practice this as needed until the breathing pattern slows down.
Practice deep breathing.	Taking deep breaths from the diaphragm and expelling all the air before taking another breath is one of the best ways to turn off the physical sensations associated with distress.	There are lots of ways to practice this. Examples include lying on your back with an object on your stomach and watching the object rise and fall, blowing a pinwheel with a deep belly breath, blowing bubbles, or pretending to inhale the smell of a pizza and then blowing on it to cool it down. Try to identify a method the youth will enjoy.
Use guided imagery.	For some youths, it is helpful to picture a soothing, relaxing, or safe place. For others, it may be helpful to picture an image that opposes what they feel when they are distressed (e.g., imagining ice when feeling hot or frustrated). Some may picture a detailed scene, while others may just focus on a neutral image.	You can help the youth build a mental image of a happy or safe place, asking the youth to provide sensory details (smells, sounds, sights, touches, and tastes). Some youths may already have a mental image identified that they find soothing; others may need to create such an image, with your help.

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Use progressive muscle relaxation.	Many youths find it helpful to set aside time to do progressive muscle relaxation—tensing and then relaxing muscles in one part of the body, then another, etc. This can be combined with mindful awareness of breathing.	Appendix II includes a sample script to guide progressive muscle relaxation. You can use this to guide the youth in session, with the content adjusted based on what the youth finds helpful. Once it's clear what content the youth finds most helpful, you can make a recording for the youth to use at home. Some young people find both the content and their therapist's voice calming.
Use "quick cooling" for stressors that need fast relief.	For stressors that arise quickly and in public, the youth may need a fast, invisible way to calm down. The "quick cooling" procedure described in this chapter can meet that need.	For some youths and some situations—for example, a socially anxious youth just about to enter a party or give an oral report in class—closing eyes, taking a deep breath, picturing a calming place, intentionally relaxing an especially tense muscle group (maybe the neck), and exhaling slowly may do the trick.
Personalize techniques.	There are lots of different ways to calm down and to relax. Some youths find stress balls helpful; others use stretching and counting to 10. Try out different techniques that fit the situations the youth faces, and ask what really *does* help.	Once you know what methods work best for the youth, and in what situations, find ways to help the youth practice those methods both within and between sessions.
Use role plays to practice relaxing.	Either in a role play or in a situation similar to one that causes problems for the youth, try out the new relaxation technique.	The more the role-play situation mirrors one in which the youth could use relaxation in real life, the better! Try to help the youth bring on the physical symptoms of arousal and tension, then practice relaxing. You can use heat-sensitive stickers or thermometers (or even pulse rates) before and after the role play, to show how relaxation calms the body down.
Use aids to support practice and regular use.	Work with the youth to design aids that can prompt, guide, or boost calming in everyday life.	For some youths, an aid may be an object they can touch to recall a calming image (such as a small stone from the beach). For others, it may be a digital recording you have made of the relaxation script, which they can play on their phones when they feel tense.

Additional Suggestions

Developmental Differences

The wording of the progressive muscle relaxation script provided in Appendix II can (and should) be adjusted to fit the developmental level of the individual client. The Appendix II script may be well suited to a mature adolescent. By contrast, an 8-year-old may require more vivid and playful imagery (e.g., "Make your stomach tight enough that a puppy could jump up and down on it"). Options for practicing relaxation between sessions may also vary by developmental level; older youngsters who have their own smartphones or other personal digital devices may be provided with digital recordings of the relaxation script to use on their own—even recordings of the therapist's voice guiding them through the relaxation steps. Younger children may require adult support to use relaxation. For adolescents, involvement in a mindfulness practice such as yoga or meditation can also support these practices.

Using Feeling Calm in Real Life

No matter how good a youngster is at self-calming in the safety of a therapy session, the real measure of success is calming where it really matters—in the crucible of real life, when the therapist isn't there. So it is crucial to help the youth make the transition from practicing self-calming with a therapist nearby to self-initiated calming in real life. As noted earlier, self-calming should not be used to avoid coping with situational anxiety via exposures (see Chapter 10, on Trying the Opposite), but may be helpful in dealing with chronic worry, physiological overarousal, or muscle tension. The goal, as with all five of the FIRST skills, is that the youth will reach the end of therapy with a clear understanding of the situations in which self-calming should be used and with a strong base of experience in using that skill without the therapist's help.

Involving the Caregiver

Teaching the caregiver the Feeling Calm strategies is a good way to support the youth and provide encouragement for using these techniques when they are needed most—in real life. In addition, caregivers who experience similar tension and stress can benefit from using these strategies to remain calm during challenging parenting moments!

Taking It to School

Relaxation may be especially useful in the school context, where stressors often arise and where youths need to be able to sit quietly and focus their minds on academic content. Consider reaching out to teachers to explain how a young client is using relaxation strategies, how they might be able to support its use in school (e.g., having a visual sign to remind the youth to use relaxation strategies or a designated spot in the classroom where relaxation exercises can be implemented), and what clues to look for to suggest that relaxation might be useful. Some teachers may wish to incorporate relaxation exercises for the whole class!

TRICKS OF THE TRADE:

Feeling Calm—Anxiety and OCD

- **Use Feeling Calm selectively for anxiety and OCD.** Although calming is encouraged for some anxious youths to help them sleep, take tests, or interact with others, it should never be used in conjunction with exposure (see Chapter 10 on Trying the Opposite), since it interferes with the process that makes exposure work—experiencing and learning to tolerate fear. Likewise, for OCD it is important to permit the feelings of distress when youngsters are learning to experience obsessions without using compulsions, since this is how the youths learn to "boss back" OCD.

- **Discuss the physical symptoms.** A common companion of both anxiety and OCD is a surge in symptoms related to the sympathetic nervous system—increased heart rate, rapid breathing, muscle tension, and upset stomach. For some youths, these symptoms may come on all at once, seemingly out of the blue, as in a panic attack. For others, headaches and stomachaches may be signs of chronic worry. This happens because the brain is setting off the body's "alarm system," and so the body is preparing to take action—to fight, freeze, or escape. But when this is a false alarm, a youth needs to "deactivate" the system by calming the physiological arousal.

- **Practice deep breathing.** Anxious youths are often "overbreathers," taking rapid, shallow breaths that keep them in a near-constant state of heightened anxiety. To check on this, time them for 60 seconds and count their number of breaths; most nonanxious people breathe 8–12 times in one minute. Overbreathing tells the brain that *something is wrong*. To correct this problem, teach slow, controlled breathing. Ensure that breathing is coming from the diaphragm, not the chest. Lying on the back is a good way to observe and practice proper breathing. The exhaling breath should last as long as the inhaling breath, and both should last for a full count of 4. Some anxious youths will need to practice breathing correctly for 10 minutes each night, using a recording of your (the clinician's) voice to guide their inhales and exhales. This is especially useful for youths experiencing panic attacks—sudden surges in heart rate, difficulty catching breath, or other physiological symptoms. For these youths, the tendency to breathe rapidly keeps them in a state of physical alarm.

- **Use guided imagery.** Have the youth identify, fully describe, and document a safe, peaceful, calming place that provides comfort and peace for the youth. Make sure the description included what the place looks, smells, sounds, and feels like; all these features will help make the image vivid when the youth pictures it later during calming.

- **Consider other relaxing actions.** Progressive muscle relaxation (see the sample script in Appendix II) can be particularly helpful for youths who have generalized anxiety disorder, social anxiety disorder (social phobia), or separation anxiety disorder—all of which involve a lot of anticipatory worry and physical tension. However, youths with panic disorder and OCD usually don't find progressive muscle relaxation very helpful. In these cases, encourage the youths to observe their anxiety without judging it or responding, as if they were outside themselves, looking in—an approach called *mindfulness*. A youth might try to envision the panic symptoms or the obsessions as if they were leaves floating down a stream, or clouds

passing in the sky. They are there, but will come and go, while the youth pursues his or her goals.

■ **"Quick cooling" procedure,** There are times when unexpected events threaten to trigger sudden surges of anxiety. In such situations, there is no time for the progressive relaxation script or some of the other procedures detailed above; instead, young people may need a skill they can deploy for immediate stress reduction. We call one such skill "quick cooling." The steps for a youth to follow for "quick cooling" are these:

1. Take one deep breath and hold it.
2. Call up a calming image (one that is sure to bring on a calmer feeling, and that has been planned in therapy; see "Use guided imagery," above).
3. Consciously relax one muscle group that is known to grow tense when emotion runs high.
4. Exhale very slowly, still focusing on the calming image and relaxing the tense muscle group.

TRICKS OF THE TRADE:

Feeling Calm—Posttraumatic Stress

■ **Use Feeling Calm to reduce symptoms of posttraumatic stress.** Relaxation strategies are a good fit to some of the core symptoms of youths experiencing posttraumatic stress. For example, some young people experience increased heart rate at reminders of a traumatic event, or they may startle more easily. They may feel restless or irritable, have difficulty sleeping, or feel that they must be constantly "on guard." Feeling Calm is a helpful strategy for addressing these uncomfortable sensations and increasing feelings of body safety; calming may be especially important *preceding* the use of exposure to traumatic memories (the kind of exposure described in Chapter 10 on Trying the Opposite).

■ **Establish feelings of safety.** Keep in mind that youths who have experienced traumatic events may be wary of "letting their guard down" and becoming physically vulnerable, as in relaxation. Be flexible with regard to details like body position (lying down or sitting up, closed eyes or open) or lighting (dim or bright), and be sensitive to the fact that your young client will need to develop trust in you and in the work you are doing together.

■ **Describe normal and traumatic stress reactions.** Clarify that it is very natural to feel the impact of stress in our bodies, and for our bodies to react strongly to scary events. Describe the different body reactions people may have (quick shallow breathing, muscle tension, tingling sensations, heart pounding, etc.). These are produced by the human body's "alarm system"; they are there to warn us when we are in danger and to help us prepare for a fight, flight, or freeze response. In most cases, when the danger goes away, the body alarm system also goes back to normal. But sometimes, when we experience very scary events and real danger, this system stays on high alert. It becomes very sensitive and sometimes sounds the alarm (setting off all those body reactions) even when there isn't any actual danger. This

is a false alarm, but it can feel very real and very scary. The good news is that there are things we can do to turn the alarm off, so we can feel calm and safe again.

- **Practice deep breathing.** Learning to take deep, diaphragmatic breaths, in through the nose and out through the nose—a skill practiced in meditation—can provide a sense of calm during vulnerable moments. The youth can close his or her eyes if that is comfortable, or else stare at a spot on the wall or floor. The youth should then should breathe in deeply, so that the diaphragm protrudes during the in-breath and recedes during the out-breath. After you are convinced that the youth is capable of slow, deep breaths, instruct the youth to breathe in slowly (perhaps to a count of 5) and exhale in the same manner. Be aware that young people who have experienced sexual abuse may not feel comfortable lying down or closing their eyes; it is fine to practice this in whatever posture is most comfortable for the youth.

- **Use directed attention.** In order to minimize distracting thoughts that may interfere with relaxation, encourage the youth to focus attention on his or her breathing and on the air that moves in and out of the body. If troubling or distracting thoughts come to mind, encourage the youth to refocus calmly on the breath, perhaps counting to 5 during each inhalation and exhalation. Imagery can also be used to minimize attention to thoughts during the calming exercises; this could include, for example, picturing thoughts or images as birds flying by, or as trains pulling in and out of the station.

- **Consider other relaxing actions.** As with all the FIRST principles, a key in therapy is to find the best fit for each unique youth. Some young people may resist relaxation exercises; it's fine to incorporate their interests in order to help them experience somatic relief. For example, encourage youths to bring in music that they like, and listen to it together as a means of relaxing the body. Some youths may find that aerobic activity increases feelings of relaxation; such exercises too may be incorporated. Developing a "go-to" safe place in the youth's mind by asking for a description of the sounds, smells, sights, tastes, and touches can help create a visual image that is associated with relaxing feelings. For some youths, tactile sensations such as the use of a stress ball or of Play-Doh may also help with relaxation.

TRICKS OF THE TRADE:
Feeling Calm—Depression

- **Discuss the physical symptoms.** Depression in youths is associated with a range of physical sensations. Some youths experience muscle tension, stomach upset, and feeling agitated or "on edge" when depressed. Others have a more sedentary, lethargic presentation and feel tired and weighted down, or feel that their movements are slowed. Sleep is often disrupted. Feeling Calm can be an effective way to reduce these physical problems, help restore sleeping routines, and improve mood.

- **Practice deep breathing.** As described earlier, deep breathing can promote relaxation. To introduce deep breathing and make it very noticeable, find ways to make it vivid and concrete. For example, you can have youngsters lie flat on their backs, place a pillow or other object on their stomachs, and watch it rise and fall as they breathe.

■ **Use guided imagery,** Ask youths to describe an image that makes them feel calm, safe, and peaceful. This can be an actual place or an imagined one—for example, lying on a beach in the warm sun with the sound of waves rolling in and out, the smell of sunscreen, and the tiny prickle of grains of sand blowing across a youth's feet. Again, the most important thing is to make sure that the image is described in great detail (how it looks, sounds, smells, and feels), so that it can be pictured vividly when calming is being practiced. The youth may want to write a short paragraph with all the details of the image, which can then be recorded for repeated listening, or can be reread as needed.

■ **Consider other relaxing actions.** Some youths find it relaxing and calming to exercise, to dance, to pet a favorite dog or cat, or to listen to a special song. It is important to tailor the relaxation to the particular youth, using whatever works as long as it is safe, appropriate, and calming.

■ **Progressive muscle relaxation.** Progressive muscle relaxation (see Appendix II) has been used to good effect in previous studies of youth depression treatment. As noted previously, this method does require practice both in session and at home. The script in Appendix II can be modified to fit the youth's age and preferences, and can be recorded for later use at times convenient for the young person.

■ **"Quick cooling" procedure.** Stressful events at school, with peers, or at home may bring on quick surges of depression symptoms, and calming can reduce the stress and the risk. However, the kind of calming illustrated in the progressive relaxation script can't be used in such real-life situations that arise quickly and may have their impact in a matter of seconds. So, many young people find it helpful to have a strategy in their tool kit for quick stress reduction. "Quick cooling" can be such a strategy, available for use at precisely the moment when a stressful event threatens to bring on an unwanted plunge in mood. The steps for "quick cooling" are described above in the "Tricks of the Trade" for anxiety and OCD.

✦ TRICKS OF THE TRADE:
Feeling Calm—Misbehavior

■ **Use Feeling Calm selectively for misbehavior.** For many disruptive youths (particularly those who misbehave without feeling upset), Feeling Calm may not be helpful or relevant. For a second group (youths whose conduct problems are preceded by anger or other kinds of emotional arousal),calming is one of *two* potentially useful skills: (1) reducing angry arousal, and (2) behaving appropriately *even when angry or upset.* For this group, learning to do self-calming may prevent escalation to anger in some situations, but it is crucial for these youths to learn self-control skills—through the other four FIRST skills—to ensure good self-control *even when the youths feel angry and upset.*

■ **Discuss the physical symptoms.** Often those youths for whom angry arousal triggers disruptive behavior are not even aware of the early signs of arousal that accompany frustration until it is too late and they have already become very angry. Help them identify their own individual early warning signs: Perhaps they can feel their faces get flushed, or their heart rates accelerate, or their muscles tense. Learning to be aware of these early signals

can help boys and girls identify the moments when they most need to implement their self-calming skills.

- **Practice deep breathing.** As described earlier, learning to take deep, diaphragmatic breaths, in through the nose and out through the nose, can provide a sense of calm during vulnerable moments. At these moments, youths susceptible to misbehavior can reduce the risk of acting impulsively in response to anger or other emotions by taking at least three slow, deep breaths, in order to regain a sense of calm. It can be helpful to practice deep breathing in situations that are somewhat volatile, such as in response to an irritating noise or during a role play of an interaction that usually makes a youth angry and upset.

- **Use guided imagery.** Youths who are prone to emotion-generated conduct problems sometimes find that calming is magnified by imagining "cooling" images (such as ice cubes or snow falling) or "chill-out" images (such as lying on a very soft bed or on the beach).

- **Consider other relaxing actions.** As with all the FIRST principles, a key in therapy is to find the best fit for each unique youth. For some, as noted above, angry arousal is not linked to their conduct problems, and calming techniques may thus not be appropriate. For others, anger is an issue, and learning progressive muscle relaxation and "quick cooling" may help prevent anger escalation (see the next two bullet points). For still others, calming music may do the trick.

- **Progressive muscle relaxation.** Like difficulties in the other three problem areas, chronic reactive misbehavior (the kind involving impulsive responses to anger or other strong emotion) can sometimes be reduced by helping young people practice progressive muscle relaxation (once again, see the sample script in Appendix II). This can be practiced during a therapy session, but also at home using a recording that you (the clinician) can provide, adapting the sample script to fit the individual youth's maturity level, preferences, and personality.

- **"Quick cooling" procedure.** Misbehavior in response to a quick surge of anger or other emotion may require a faster remedy than progressive muscle relaxation. The young person may need to cool down in the heat of the moment, just before "trash talk" is hurled or fists fly. In these circumstances, "quick cooling" may ward off impulsive responding. Again, the steps for "quick cooling" are described above in the "Tricks of the Trade" for anxiety and OCD.

Handout 7 (page 86) is a home practice sheet that can be used when youths practice any of the Feeling Calm strategies between sessions. Handout 8 (page 87) is a guide to Feeling Calm for caregivers.

Skill Assessment: Feeling Calm

This assessment is used to determine when a youth has sufficiently grasped the FIRST principle and can use it to manage feelings and behaviors in everyday life. When do you

decide that enough is enough, and that the youth is ready to finish treatment or move on to the next FIRST Skill Unit? Keep in mind that there is always room for more improvement, but that the goal of treatment is to help the youth and the caregiver use these principles on their own to handle the challenges that arise in real life.

Anxiety and OCD

What is the goal?

For anxious youths and those with OCD, Feeling Calm can provide a way to "turn off" the false alarm triggered by the perceived misinterpretation of threat. The goal is for these youths to be able to use calming strategies to lower physiological arousal to address the somatic symptoms accompanied by prolonged anxious arousal in real-life stressful situations.

Has the goal been sufficiently met?

Is an anxious youth able to use deep breathing, guided imagery, progressive muscle relaxation, and/or other techniques to decrease the physical symptoms of anxiety? Is a youth with OCD able to observe the obsessions and desire to engage in a ritual without engaging in the ritual?

What about the caregiver?

Can the caregiver identify situations where a calming technique might be beneficial to the youth, and can the caregiver help the youth to implement this technique?

Posttraumatic Stress

What is the goal?

For youths experiencing symptoms of posttraumatic stress, Feeling Calm can provide a way to "turn off" the false alarm triggered by trauma reminders. The goal is for these youths to be able to use calming strategies to lower physiological arousal, in order to feel safer in their bodies and gain control over their physical reactions to trauma reminders.

Has the goal been sufficiently met?

Is a youth with posttraumatic stress able to use deep breathing, guided imagery, progressive muscle relaxation, and/or other techniques to decrease the physical symptoms related to trauma reminders?

What about the caregiver?

Can the caregiver identify situations where a calming technique might be beneficial to the youth, and can the caregiver help the youth to implement this technique?

Depression

What is the goal?

The goal of Feeling Calm for depressed youths is to teach them ways of exerting control over the tension and insomnia that often accompany depressed mood.

Has the goal been sufficiently met?

When physical symptoms such as restlessness, insomnia, or muscle tension arise, can a youth successfully implement a calming strategy? Goal attainment can be defined as a sustained period of low ratings on the distressing physical symptom.

What about the caregiver?

Can the caregiver identify situations where a Feeling Calm technique might be beneficial to the youth, and can the caregiver help the youth to implement this technique?

Misbehavior

What is the goal?

For youths whose conduct problems are linked to angry arousal, the goal calming is to help the youths better gauge their own physical reactions to frustration and then implement a calming strategy to prevent misbehavior.

Has the goal been sufficiently met?

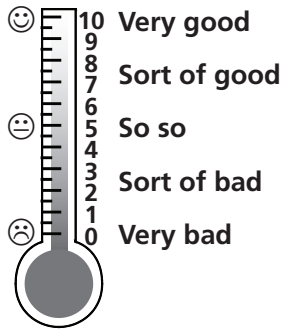
Is a youth able to identify the early indicators of frustration and arousal in the body that predict anger? When frustrated, can he or she use deep breathing, guided imagery, and/or other techniques to remain calm?

What about the caregiver?

Can the caregiver identify situations where a calming technique might be beneficial to the youth, and can the caregiver help the youth to implement this technique?

Feeling Calm: In-Session Practice

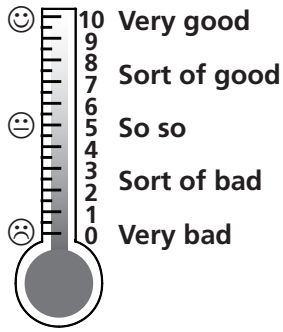
1. First, let's do a stressful activity or have you think about something that makes you feel sort of stressed. This might be like an experience from real life, or just a stressful game or puzzle.
2. (After the activity or thought:) How do you feel now? What rating would you choose on the feelings thermometer?



3. How do you feel when you are stressed in real life? What are the clues from your body, your brain, and your behavior?

   - When you feel a little stressed, you know because . . .
   - When you are medium stressed, you know because . . .
   - When you are VERY stressed, you know because . . .

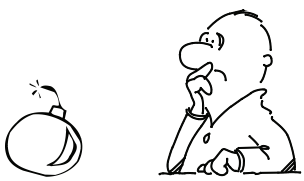
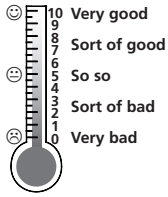
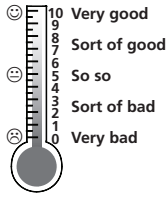
4. Now try your new Feeling Calm strategy.
5. (After the strategy:) How do you feel now? What rating would you choose on the feelings thermometer now?
6. How do you feel when you are calm in real life? What are the clues from your body, your brain, and your behavior?



HANDOUT 7

Feeling Calm: Home Practice

Try **Feeling Calm** ____ times this week. Write down the situation that made you feel _____ in the space below, and complete your rating on the feelings thermometer before and after you do the calming activity.

Situation	Thermometer Rating before Practice (0–10)	Thermometer Rating after Practice (0–10)
		

HANDOUT 8

Caregiver Guide to Feeling Calm

FEELING CALM

When boys and girls get upset, they also become physically agitated in their bodies. One way to help them change the way they feel emotionally is to help them change the way they feel physically. Learning how to keep ourselves calm can improve our own behavior and mood, because we are better able to manage our feelings and make good choices when we feel relaxed. In session, your son or daughter has learned some new ways to stay calm. We've also developed a plan for trying these calming strategies at home, in school, or with peers. **Like all new skills, Feeling Calm takes lots of practice. So please notice and encourage your son or daughter's efforts to stay calm, and praise any successes you see!**

The Feeling Calm strategy my child is practicing this week:
My child has agreed to practice this: When, in what situations, how many times?
Some golden opportunities might be:
Some helpful support might be:
To be completed after practicing: How did it go? Did anything get in the way? If so, what? Did you learn any ways to make the practice work well? If so, what?

7

Using the FIRST Principles

Increasing Motivation

This principle is used to help increase appropriate and helpful behavior by youngsters, and to decrease inappropriate and unhelpful behavior.

One of the best-established ideas in psychology is that consequences influence future behavior. In fact, the only psychological principle ever identified as a "law" is Edward Thorndike's (1898) *law of effect*, which holds that "responses that produce a satisfying effect in a particular situation become more likely to occur again in that situation, and responses that produce a discomforting effect become less likely to occur again in that situation." In other words, *consequences*—things that happen following a given behavior—have a major impact on whether the behavior will recur, increase in frequency, or decrease in frequency. When a positive consequence increases the likelihood of a behavior in the future, that consequence can be considered a *reinforcer.* When a negative consequence decreases the likelihood of a behavior in the future, that consequence can be considered a *punisher.* Consequences can be tangible (e.g., a favorite snack) or intangible (e.g., attention or praise). Often the problem behaviors that need to be addressed in treatment have been inadvertently reinforced over time, and more positive behaviors may have been ignored, or were never learned in the first place—and thus may need to be taught, practiced, and reinforced until they take the place of the problem behaviors.

In FIRST, **Increasing Motivation** is used to reduce misbehavior and to build up more positive behavior by leveraging the law of effect. We use principles of reinforcement to encourage improved behavior and to reduce the frequency of maladaptive behaviors—by removing reinforcement or by adding a brief, safe discipline strategy that will discourage the behavior over time. This is the essence of Increasing Motivation, and it is used mainly to help caregivers address their children's misbehavior. However, Increasing Motivation can also be an adjunctive approach to treatment of anxiety or OCD, posttraumatic stress, or depres-

sion—for example, when youths lack sufficient motivation to engage in new skills that are part of their treatment. In anxiety treatment, for example, Increasing Motivation can be used to boost participation in exposure tasks (see Chapter 10 on Trying the Opposite) and to help parents stop reinforcing their children for fearful behavior.

How Increasing Motivation Is Used for Different Problem Areas

For Anxiety and OCD

Anxious youths use avoidance and reassurance seeking to decrease the uncomfortable feelings associated with facing feared situations or memories. Youths with OCD engage in compulsions in an attempt to "neutralize" or "disarm" their obsessive thoughts. Although these strategies reduce distress in the moment, they also reinforce the anxiety and compulsions, and they limit opportunities for young people to learn about their own capabilities. To encourage youths to refrain from avoidance, reassurance seeking, and compulsions, it is helpful to use praise and tangible rewards, as well as *differential attention*—that is, shifting parental attention away from maladaptive anxious or avoidant behaviors, and toward brave behaviors and effective coping.

For Posttraumatic Stress

As anxious youths do, young people dealing with posttraumatic stress may use avoidance as a way to reduce discomfort, retreating from situations and activities that might stir up painful memories and fears. This may produce short-term relief, but it may also prevent these young people from building strong social relationships and the coping skills needed for success in life. When that is the case, therapists can use the Increasing Motivation procedures to make direct engagement and effective coping more reinforcing than avoidance. Youths may also respond to their traumatization with increased misbehavior—noncompliance and rule breaking. Parents may feel unsure how to enforce rules or limits safely after traumatic events. In some instances, the traumatic event increases family conflict. Helping a parent use the strategies in Increasing Motivation can strengthen the parent–child relationship and help address behavioral problems, and can also be used to reward the child for bravely facing the traumatic memories in treatment.

For Depression

Depressed youths often feel hopeless about their future, and they believe that nothing will work out for them. They also may have feelings of fatigue and lethargy that make it more difficult for them to participate in activities or to try new things. Avoiding activities may result in fewer opportunities to receive the natural reinforcement that comes from parents, peers, and others. Using praise and tangible rewards can help boost their motivation initially and promote engagement in therapeutic activities; over time, the youths may experience natural reinforcers as they resume engaging in pleasant activities.

For Misbehavior

Misbehavior often generates a lot of attention (albeit negative). By contrast, boys and girls may be barely noticed when they are behaving appropriately or prosocially. Increasing attention to obedient, rule-following, and prosocial behaviors, while simultaneously decreasing attention to unwanted behaviors, is a way to reinforce good conduct. Good conduct can also be reinforced by the use of tangible rewards and clear, predictable consequences, as well as by brief, safe discipline procedures to reduce the amount of unacceptable behavior.

Skill Unit Objectives

Note: Multiple sessions will almost certainly be required to cover this full Skill Unit; therapist and client should continue until the skill of Increasing Motivation has been mastered.

- The youth and/or caregiver will identify target behaviors that are causing difficulties.
- The youth and/or caregiver will identify the *positive opposites* of the problematic behaviors.
- The youth and/or caregiver will understand how reinforcement increases the probability of a behavior, and how the removal of reinforcement decreases the probability of a behavior.
- The youth and/or caregiver will develop, implement, and adapt a plan to increase motivation for the positive behaviors.
- As needed, contingencies for the unacceptable behaviors will be developed, implemented, and adapted.

Skill Unit Outline: Increasing Motivation

Remember this in every session:

SESSION COMPONENTS [Note: These should be included in every session.]

- **Create an agenda** of what will be covered in the session.
- **Review practice,** if any was assigned in the prior session.
- **Share the news** of any new skills or information covered in session with the caregiver or the youth at the end of the session (as appropriate).
- **Assign practice** of positive actions in real life for which motivation enhancement is now in place.
- **Assess skill acquisition:** Is progress being made toward goals in a notable way? Is it time to move to another Skill Unit or consider ending treatment?
- **Finish strong:** End the session on a strong positive note that affirms your relationship and positive feelings toward the youth and/or caregiver—perhaps by doing an engaging activity together, praising the youth and/or caregiver for an important accomplishment in therapy or in real life, or noting how much you value the chance to work with the youth and/or family and are looking forward to the next session.

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Identify behaviors.	Work with the caregiver and/or the youth to label the behaviors that are causing difficulty. For misbehaving youths, the problem behaviors may include noncompliance, defiance, aggression, and the like. For anxiety or OCD, these behaviors may include avoidance, reassurance seeking, or ritualized behaviors. For posttraumatic stress, the behaviors may include avoidance or risk taking. For depression, the behaviors may include a negative self-presentation, withdrawal from activities, or rumination about negative events.	It can be useful first to identify goals that the youth and/or caregiver would like to pursue in treatment, and then to identify the challenges that currently stand in the way. For example, if the goal is for the youth to follow directions, identify what behavior currently occurs when an instruction is given (perhaps refusal). If the goal is for the youth to feel less frightened of social situations, what does the youth currently do when such situations arise? If the goal is for the youth not to feel depressed, what behaviors are currently contributing to feeling sad or down?
Explain consequences.	All behavior is affected by consequences—the events that follow a behavior. Most people will do whatever works best for them (e.g., whatever gets them a reward or helps them end an unpleasant situation). What happens currently after this youth shows his or her problematic behavior?	For caregivers, it can be helpful to consider this in a context that is more meaningful for them, such as the context of work. If they stopped receiving a paycheck, what would happen to their productivity at work? What if they received attention only for mistakes and never for the things done well? Youths often receive the most attention for negative behaviors (which increases their frequency) and less attention for positive behaviors (which reduces their frequency). **Example Script** "We are all influenced by the attention we get from others. On our jobs, we may work harder if our work is being noticed and if we are praised for it. Can you remember having a boss or supervisor who was really unrewarding to work with? What was that person like, and what were some of his or her interactions with you? How about a boss or a supervisor you really enjoyed working with—what was that person like, and what were your interactions like? Did you have different feelings about those two people, and was your work for one of them different from your work for the other one? Well, an employment situation is a bit like a family situation. A parent's behavior toward his or her child can affect the child's feelings and motivation to cooperate and do what the parent asks."

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Identify the positive opposite.	What is the *positive opposite* of each problematic behavior? That is, what is the behavior that the intervention should increase?	Make a list of the positive opposites—that is, the behaviors you would like to have the youth increase. The list should be very specific about the behaviors' duration and frequency.
Increase monitoring.	Some youths or caregivers may know exactly which behaviors are problematic; for others, you may need to ask them to spend a bit of time closely monitoring the behaviors, in order to reach a better understanding of the patterns they need to change.	Ask the youth and/or the caregiver to deliberately increase monitoring of the behaviors, both in order to develop a detailed understanding of the problematic behaviors, and also to attend to times when the positive opposites occur. For conduct problems, this may involve getting a better idea of the settings or events that precede misbehavior (and the absence of misbehavior), as well as what happens immediately afterward. For anxiety and posttraumatic stress, it might be noticing which specific situations are being avoided and whether there are any behaviors that seem to be followed by compensatory behaviors (rituals that make the youth feel less anxious). For depression, have the youth monitor his or her mood over the course of a week or so, noting what activities are accompanied by improved or worsening mood.
Introduce strategies to increase appropriate behaviors.	A reinforcer is something that happens *after* a behavior that makes it more likely to recur. Each of these reinforcement strategies is an intervention in and of itself, requiring practice and careful implementation.	Depending on the type of problematic behavior and the age of the youth, various reinforcement strategies may be used: • To improve caregiver–youth interaction: Together Time (youth-led interaction with a caregiver). • To increase naturally occurring positive behaviors and decrease behaviors that are annoying, but not rule-breaking: Differential attention. • To introduce new behaviors/increase the frequency of rare behaviors: Tangible rewards.
Introduce strategies to decrease problematic behaviors.	Once an environment has been established in which the positive opposites are consistently reinforced, the targeted removal of reinforcement following undesirable behaviors can be used.	Note: These interventions will only be used *after* a reinforcement procedure is in place and working well. • To set clear limits and ensure safety: Effective instructions and house rules. • To discipline rule-breaking behaviors: Time out from reinforcement, or point or privilege loss.

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Practice reinforcement.	To make sure the caregiver or youth understands how to use the reinforcement plan, practice it in session.	Role-play the use of each strategy for Increasing Motivation in the session, demonstrating the response to the problematic behavior as well as to the positive opposite.
Troubleshoot and refine until the reinforcement works.	To work out the "bugs," have the caregiver and/or youth practice the reinforcement plan outside the session, review any problems in session, and then revise until the plan works well.	Tell the caregiver and/or youth that the plan will have to be tried out, and probably revised, to get it working well. The best way is to try it between sessions, take notes on what did and didn't work, and then revise the plan in each session until it works well in real life.

Additional Suggestions

Developmental Differences

In general, consequences—both positive and negative—will need to be more concrete and more immediate for young children than for older children and adolescents. Procedures that assume unilateral parental authority and consequences such as time out are also likely to work better for children, whereas procedures that involve more discussion and collaboration between parent and youth, such as removal of points or privileges, are better suited to adolescents.

Using Increasing Motivation in Real Life

The Increasing Motivation strategies can be used to boost participation in treatment and cooperation with therapy goals. However, the most important application of this principle lies in identifying and fine-tuning use of the incentives that will motivate adaptive behavior in everyday life, outside of therapy. *In vivo* exercises and practice assignments need to be fashioned with this objective in mind; otherwise, the skills learned in therapy may not be sustained after termination.

Involving the Caregiver

For some problems (e.g., misbehavior), most of the treatment strategies will be mediated through the caregiver, who will interact directly with the youth. Even when the therapist is working directly with the youth, however, it is important to engage the caregiver in developing and implementing reinforcement plans in the home and other settings where the youth spends the majority of time. Using privileges that the youth cares about, and building motivation during the times when the therapist is not with the youth, are the best ways to ensure that behavior change is sustained. Likewise, involving the caregiver in monitoring and providing reinforcement for the child's new behaviors will encourage the caregiver's engagement

in treatment. Lastly, helping the caregiver identify ways in which his or her natural patterns of attention may inadvertently reinforce unwanted behaviors can help establish new, more effective ways of interacting.

Taking It to School

Many of the same behaviors that pose challenges for girls and boys at home can also cause difficulty at school. Youths who exhibit disruptive behaviors at home may have trouble following school rules or may cause disruptions in class. Each of the strategies that are included within Increasing Motivation can be adapted to fit into the school context, either by linking school behavior to reinforcement systems in the home or by helping teachers use the strategies within the classroom.

TRICKS OF THE TRADE:
Increasing Motivation—Anxiety and OCD

- **Identify behaviors**. Anxious youths and those with OCD experience distress in the face of anxiety-provoking situations, feared stimuli, or worried thoughts or obsessions. To manage this distress, they often avoid experiencing these situations or engage in behaviors that reduce their distress in the short term (such as reassurance seeking or ritualized behaviors), but that ultimately reinforce their fears. One part of working with these youths is to develop a rank-ordered picture of their specific fears related to the domain in which their fears are centered—separation from caregivers, for example—and creating a *fear hierarchy* for each youth. This is discussed in more detail in Chapter 10 on Trying the Opposite.

- **Explain consequences.** Although avoiding feared situations or engaging in safety behaviors can reduce anxiety initially, it robs the youths of a chance to learn that the thing they fear will not happen or will not be so bad, and (even more importantly) that they can tolerate the feelings of distress. If youngsters leave a fearful situation every time they experience distress, the resulting decrease in distress strengthens the likelihood that they will leave again in the future. If they feel better because a caring adult provides reassurance, the reassurance will be sought again and again. If washing hands after touching a sticky surface helps alleviate the fear of contamination, hands will be washed over and over again. Changing what happens after the feared stimuli are encountered, and replacing avoidance, reassurance, and rituals with new behaviors, may require some external motivation. A rewards program can help young people find the motivation to begin facing their fears, experience some distress, and learn that they are capable of tolerating the feelings that are uncomfortable but not dangerous.

- **Introduce strategies to increase appropriate behaviors.** For some youths, introducing a formal *tangible rewards* program for repeatedly facing feared situations, memories, or stimuli can be very helpful. A sample rewards chart is shown in Figure 7.1. It is also important to encourage caregivers to use *differential attention* to recognize and begin attending to—and praising—nonavoidant, brave, or independent behaviors, while decreasing attention

Behavior	Points
Practice sleeping in own bed.	5
Not calling Mom when at friend's house.	10
Filling out Repairing Thoughts sheet instead of asking Mom.	10

Figure 7.1. Sample rewards chart for confronting anxiety.

to clingy, worried, or nervous behaviors. It is helpful to use *labeled praise* ("I like that you did that all by yourself") or *active ignoring* (brief removal of all attention to reassurance-seeking behavior, with attention restored immediately in response to brave, appropriate behavior).

For a youth who has separation anxiety, a move toward brave, independent behaviors may feel like a threat to the close relationship with the caregiver, as the caregiver is discouraged from reinforcing clingy, dependent behavior. To ensure that the same rate of attention is sustained, it can be useful to introduce *Together Time*—that is, youth-led interaction periods of 5–15 minutes per day, with the caregiver and youth spending "quality time" together and the caregiver providing lots of attention and praise. That way, as reduced separation anxiety leads to reduced youth and caregiver time together, the quality and appropriateness of time together will be improved. Together Time is discussed in more detail later.

TRICKS OF THE TRADE:

Increasing Motivation—Posttraumatic Stress

- **Identify behaviors.** Youths who suffer from posttraumatic stress may be working very hard to avoid thinking about the memories of the traumatic event, as well as situations, places, and people that remind them of the event. This may take the form of withdrawal, emotional numbing, or (in some instances; see below) increases in risk taking. In the short run, these behaviors may help them to feel less distress; however, they reinforce continued avoidance and also keeps them from learning that although the memories are painful, they are not dangerous.

Sometimes there can be increases in noncompliance, rule breaking, and disruptive behaviors after a traumatic event. Parents may feel unsure about how to enforce rules or set limits after a traumatic event, or may be frequently drawn into conflict with their children. In these instances, work with the caregivers to identify the specific examples of misbehavior they would like to see reduced at home. Make sure you have a good understanding of exactly what each behavior looks like, what precedes the behavior, and what follows the behavior (i.e., what consequences a youth experiences after the behavior).

■ **Explain consequences.** To address avoidance of memories or trauma reminders, explain that during a traumatic event, the brain and body work hard to keep people safe by activating the "alarm system" of fight, flight, or freeze. As a result, some of the story of the event is not completely processed—and so instead of being put in its rightful place in the past, the trauma may feel as if it's happening again, and the youth doesn't feel safe. Avoiding the memories and triggers, withdrawing, and engaging in risky behaviors can reduce the trauma-based anxiety initially, but also takes away the opportunity to learn that the situation is safe now, and (even more importantly) that the youth can tolerate the feelings of distress and feel in control. The more youths face their memories and trauma reminders, the more they will learn about their own strength, and the sooner they can fully process the story and put it in the past where it belongs. A rewards program can help young people find the motivation to begin facing their painful memories, experience some distress, and learn that they don't need to be controlled by their memories; they can put those memories under their own control.

Sometimes misbehavior in the home can be inadvertently reinforced by caregivers whose children have experienced trauma—often because the caregivers feel guilty, or feel sympathy for the children. A youth who whines when asked to clean his or her room may be reprimanded, but if the caregiver gives in before the task is completed, the tantrum is actually being rewarded. Often youths receive attention (albeit in the form of criticism or scolding) for negative behaviors, while the absence of these behaviors goes unnoticed and thus unreinforced. These are important consequences for the caregiver to consider if misbehavior has increased following traumatic events.

■ **Introduce strategies to increase appropriate behaviors.** For some youths, introducing a formal tangible rewards program for repeatedly facing feared memories or stimuli in session or practicing other coping skills can be very helpful. Especially if there is caregiver–child conflict or misbehavior, some of the strategies for increasing appropriate behaviors described in detail below under the "Tricks of the Trade" for misbehavior may be useful. These strategies are mentioned briefly here; they should be introduced one at a time with opportunities to practice.

- *Together Time: Youth-led interaction.* As noted earlier, this involves setting aside a brief (5- to 15-minute) but consistent period each day when the caregiver joins the youth in doing something the youth enjoys, and focuses on describing and praising the youth's behavior.
- *Labeled praise.* Asking the caregiver to actively look for and "catch" the youth engaging in positive opposite behaviors is an important next step, and it should include clearly identifying the specific behavior that is being praised.
- *Active attending.* Paying close attention is a good way to reinforce the behavior caregivers *want* to see more of.
- *Active ignoring.* Reducing or eliminating the attention paid to non-rule-breaking, annoying behaviors such as whining, nagging, sulking, or displaying an "attitude" will decrease their frequency. Remind caregivers that attention is a kind of "spotlight" that

should be shined on the behaviors they like and immediately removed when unwanted behavior appears.

- *Differential attention.* Coordinated use of attending and ignoring takes the form of differential attention. An important tool in every caregiver's toolbox is *selective* use of attention—that is, selectively ignoring unwanted (but not dangerous or rule-breaking) behavior, combined with actively attending to desired behavior.

- *Tangible rewards.* A rewards program can be used for behaviors a caregiver wants to promote, such as repeatedly facing feared memories or stimuli in sessions, or practicing other coping skills. To ensure that this program is sustainable over time, it is best to use privileges that are not overly expensive, that the caregiver can provide frequently, and that can be changed as the youth's tastes and interests change.

■ **Introduce strategies to decrease problematic behaviors.** In cases where there is caregiver–child conflict or misbehavior, some of the strategies for decreasing inappropriate behaviors described in detail below under the "Tricks of the Trade" for misbehavior may be helpful. Again, these strategies are mentioned briefly here, and they should be introduced one at a time with opportunities to practice.

- *Effective instructions.* The instructions must be simple statements (one command at a time, not phrased as a question or request!) that are communicated to the youth with eye contact, and in a calm tone. The caregiver should practice using this style of instructions and using praise following compliance.

- *House rules.* House rules should be limited to a few (up to five) non-negotiable policies that are clearly defined, written down, discussed and posted.

When a youth fails to comply with an effective instruction or breaks an established house rule, a discipline procedure should be immediately implemented. In FIRST, we recommend *time out from positive reinforcement* for youths age 10 or younger, and *response cost or privilege loss* for older youths or those who are physically aggressive.

TRICKS OF THE TRADE:

Increasing Motivation—Depression

■ **Identify behaviors.** Depressed youths often withdraw from social interactions as well as from energetic activities that were once enjoyable—activities that, if tried, could boost mood and provide distraction from rumination. Depressed youngsters may also fail to practice the skills they are learning in therapy, even though doing such practice in between sessions could be very helpful to them.

■ **Explain consequences.** Avoiding activity and interpersonal interactions over time, or failing to practice useful skills, can result in increased lethargy and sadness as well as decreased opportunities to feel better. However, increasing these behaviors may be difficult at first when a youth feels tired, run down, and apathetic. Using reinforcement initially

can be an important step towards encouraging more active behaviors; and eventually these behaviors should produce natural reinforcement by generating increased energy and pleasure.

■ **Introduce strategies to increase appropriate behaviors.** For some youths, introducing a formal tangible rewards program to reinforce behaviors such as increased social interaction, exercise, pleasant events scheduling, or even challenging negative beliefs can be useful. Working with a caregiver and/or youth, identify privileges or tangible rewards the youth would like to earn. These may be immediate for younger children, or may take the form of points toward a larger, delayed reward for older youths. It is also helpful to teach caregivers to recognize the behaviors that are being encouraged, so that they can provide differential attention. Specifically, a caregiver should increase positive attention and labeled praise for behaviors that a youth is being asked to increase, such as engaging in a specific new energetic activity. At the same time, attention to sullen, lethargic, and anhedonic behavior should be reduced via active ignoring (brief removal of all attention that is paired with immediate attention once more appropriate behavior resumes). Youths can also be encouraged to use self-reward—either by contracting with themselves for easily accessible reinforcers (as shown in Figure 7.2), or by giving themselves praise statements when they practice "positive opposite" behaviors.

TRICKS OF THE TRADE:

Increasing Motivation—Misbehavior

■ **Identify behaviors.** Work with the caregiver to identify the specific examples of misbehavior the caregiver would like to see decreased in the home. Make sure you have a good understanding of exactly what the problem behavior looks like, what precedes the behavior, and what follows the behavior. That is, what are the consequences the youth experiences after misbehaving? You should also find out what happens when the youth does *not* show the problem behavior—for example, those instances in which the youth is able to use an "inside voice" or keeps hands to self. What precedes and follows these positive opposite behaviors?

Things I will do: I will play basketball with my little brother twice this week and will take my dog for a walk with my mom after dinner every night.

Every time I do this, I will reward myself with: Listening to my favorite song.

Figure 7.2. Sample behavioral contract for an easily accessible reinforcer.

■ **Explain consequences.** Sometimes youths are inadvertently reinforced for behaviors that are noncompliant, unpleasant, or inappropriate. For example, a youth who is disruptive at the dinner table is sent to his or her room. If the misbehavior at the dinner table occurred because the youth was bored, then being sent to his or her room, where toys or other entertainment await, could actually be rewarding the unwanted behavior. A youth who has a tantrum when told to do an unpleasant chore may be spoken to sternly or punished, but if the caregiver completes the chore for him or her, the tantrum is actually being rewarded. Often youths receive attention (even though it takes the form of criticism or scolding) for negative behaviors, while the absence of these behaviors goes unnoticed and thus unreinforced.

■ **Introduce strategies to increase appropriate behaviors.** It is wise to use a stepwise approach with the following strategies and the ones for decreasing problematic behaviors—introducing each of the skills in session, one at a time, with practice assigned in the week(s) following each session. There is some logic to the order (increasing positive reinforcement to encourage appropriate behaviors may be thought of as a "down payment" on improved compliance, with remaining misbehavior managed by discipline procedures later in treatment), so we recommend this order with rare exceptions.

- *Together Time: Youth-led interaction.* As mentioned earlier, this involves setting aside a brief but consistent period of time (5–15 minutes) each day when the caregiver joins the youth in doing something that he or she enjoys. The caregiver observes the youth, comments on the behavior via descriptive statements ("You're using lots of colors in your drawing!" or "Ah—you found the right place for that puzzle piece!"), and provides praise ("I like drawing with you," "You're doing a great job on this complicated puzzle"), but *does not* instruct, command, question, or critique. The caregiver will need to rehearse this first in role plays with you (the therapist) before trying it at home with the youth, and may benefit from having you provide live coaching while the caregiver and youth play. For a younger child, we recommend 5 minutes per day and encourage the use of expressive play (blocks, drawing, or other unstructured activities). For an older youth, the play may be more interactive (e.g., a board game or physical activity), but the focus of the caregiver should remain on describing and praising.

- *Labeled praise.* Asking the caregiver to actively look for and "catch" the youth engaging in positive behaviors is an important step. Although the absence of a negative behavior (e.g., sitting quietly rather than fidgeting) may not seem praiseworthy, remarking on the behaviors that are appropriate but not exceptional will make them more likely to recur. If the problem is taking things without permission, caregivers can praise youths each time they ask permission. In order to find these "golden moments" on which to comment, caregivers will need to increase the extent to which they observe and monitor youths' behavior, checking in frequently in order to provide reinforcement.

- *Active attending.* Paying close attention is a good way to reinforce the behavior caregivers *want* to see more of. If a youth and caregiver have a positive connection (and regularly scheduled youth-led interaction can help with that), the caregiver's attention can serve as a real reward. The key is to catch the youth engaging in appropriate behavior—particularly in ways targeted in treatment—and shower that behavior with

lots of attention (and praise). Help the caregiver identify several specific behaviors to be noticed, and have him or her practice—in session and at home—attending to those behaviors.

- *Active ignoring.* Decreasing or eliminating attention to non-rule-breaking, annoying behaviors such as whining, nagging, sulking, or displaying an "attitude" can decrease their frequency. Unsafe behaviors should never be ignored; however, groaning, whining, or eye rolling should not be given attention. When active ignoring is first introduced, caregivers should expect an initial increase, called an *extinction burst*—an increase in behavior before it is eliminated. Caregivers need that to know this burst is likely, so that they will interpret it correctly, know that it won't last, and respond appropriately (with ignoring if the behavior is harmless, or with a consequence such as loss of a privilege if the behavior can't safely be ignored). When caregivers use active ignoring, it is very important that they also use praise for desirable behavior—so that the youths can easily distinguish between disapproved behaviors (which are ignored) and approved behaviors (which the caregiver notices and praises). Remind caregivers that attention should be used as a kind of "spotlight" to shine on the behaviors they like and to be immediately removed when unwanted behavior appears.

- *Differential attention.* Coordinated use of attending and ignoring takes the form of differential attention. An important tool in every caregiver's toolbox is *selective* use of attention—that is, selectively ignoring unwanted (but not dangerous or rule-breaking) behavior, combined with actively attending to desired behavior. For example, when a boy whines while clearing the table, the whining can be ignored, but clearing the table can be lavished with attention ("Wow, you got every dish!").

- *Tangible rewards and privileges.* A rewards program can be used to reinforce the behaviors caregivers want to promote. To ensure that a program is sustainable over time, it is best to use privileges that are not expensive, that the caregiver can provide frequently, and that can be changed as the youth's tastes and interests change. To set the stage for success, we recommend that the list of responsibilities or chores to be rewarded should include one-third behaviors that the youth can already do regularly with little conflict, one-third behaviors that the youth sometimes does successfully (but that the caregiver would like him or her to do more often), and one-third behaviors the youth rarely demonstrates. Likewise, the rewards menu should be a mix of privileges or rewards, some of which can be received often, some less often, and some rarely (and all of which are "priced" accordingly). Using a rewards menu in which there is always something the youth can access even when behavior hasn't been perfect ensures that appropriate behavior is shaped and there is always some motivation. A simple example of a responsibilities and privileges system is shown in Figure 7.3. Caregivers and youth can review the reward options every month or two to ensure that they are still enticing to the youth; tangible rewards are only as good as their value to the youth!

■ **Introduce strategies to decrease problematic behaviors.** If the environment is one in which approved behaviors are being reinforced via attention and/or tangible rewards, and the environment is determined to be generally warm and praising, it is sometimes useful to

Remember that the success of a rewards system relies on the reinforcement value of the rewards, so each reward or privilege should be tailored to fit the specific youth. Note that the responsibilities range from tasks that Eli can do with relative ease to more challenging behaviors, and that the rewards and privileges likewise vary in value.

Eli's Responsibility Chart	
Responsibility	Points Earned
Feeding fish one time per day	1 token
Brushing teeth A.M./P.M.	1 token
Getting dressed before 7 A.M. on school days	3 tokens
Doing homework before dinner	5 tokens
Putting dirty clothing in hamper	3 tokens
Following directions the first time they are given (each time)	2 tokens
Keeping hands to self in the car	5 tokens

Eli's Privilege Chart	
Privilege	Points Cost
Staying up 30 minutes past bedtime	30 tokens
15 minutes of screen time (up to 1 hour)	2 tokens
Choosing dinner	10 tokens
Family game night	30 tokens
Buying a new toy or book	60 tokens
Going out for a special dinner	100 tokens
Pottery painting day	150 tokens

Figure 7.3. Sample responsibilities and privileges chart for 9-year-old Eli, whose parents are concerned about his misbehavior.

introduce removal of reinforcers as a consequence for inappropriate behavior. These should be used sparingly (for one or two behaviors!), as they are not as powerful as reinforcement and can easily be overused. Remember, removal of reinforcers works well to decrease problematic behaviors, but removal can *never* teach new behaviors; this is done by using the strategies to increase appropriate behaviors, just discussed.

- *Effective instructions.* For caregivers to be effective in getting youths to comply, it is crucial that they first be able to give effective instructions. The instructions must be

simple statements (one command at a time, not phrased as a question or request!) that are communicated to a youth with eye contact, in a calm tone. The caregiver should practice using this style of instructions and using praise following compliance. We encourage you to practice this in session with a caregiver and then have the caregiver spend time perfecting it with the youth at home, using periods of simple instructions (e.g., "Please hand me the salt. . . . Thank you").

- *House rules.* House rules also need to be established before a discipline procedure is implemented for breaking rules. House rules should be limited to a few (up to five) non-negotiable policies that are clearly defined, written down, discussed and posted. One example: "No hitting." For some house rules, you may need to help a caregiver to define the behaviors that are described by the house rule(s), as well as those that break the rules. The caregiver should spend some time labeling the appropriate behavior when the youth demonstrates it: "Thank you for not hitting even when you were feeling mad." All house rules should be carefully reviewed and posted (with pictures if a child is too young to read).

When a youth fails to comply with an *effective* instruction or breaks an established house rule, a discipline procedure should be immediately implemented. In FIRST, we recommend *time out from positive reinforcement* for youths age 10 or younger, and *response cost or privilege loss* for older youths or those who are physically aggressive.

- *Time out from positive reinforcement.* This strategy will only work when it is used in a positive environment; a warm, praising environment where the youth can access reinforcement is sometimes called *time in* (Christopherson, 1990). The greater the contrast between time in and time out, the more effective time out will be. Time out is a condition, not a location, but it should involve the brief removal of the youth from all reinforcement—typically to a chair in an uninteresting location (e.g., not facing a window or the television, and not in a place where toys or other entertainment can be accessed). Proper use of time out from positive reinforcement involves the caregiver's using the following sequence:

  1. Provide effective instruction: "Please pick up your shoes." **If the youth complies . . . praise!**
  2. If no compliance, wait 5 seconds (to give the youth time to obey), and then issue one warning: "If you do not pick up your shoes, you will have a time out." **If the youth complies . . . praise!**
  3. Provide effective instruction: "You did not pick up your shoes when I asked, so now you will have a time out." The youth goes to time out for 1–2 minutes per year of age, and for *no more* than 10 minutes total. When time out is completed, the original effective instruction is repeated, and if the youth doesn't comply, the cycle begins again with another time out.
  4. Look for the next opportunity to praise, signaling the return to time in.

When no instruction is given, but a known house rule is broken (e.g., a no-hitting rule), the caregiver follows this sequence:

1. Time out is automatic with no warning. On the way to time out, state, "You _____, which is against our house rules, so now you will take a time out."
2. The youth goes to time out for 1–2 minutes per year of age, and for *no more* than 10 minutes. When time out is completed, issue one calm reminder of the house rule (e.g., "Our house rule is no hitting").
3. Look for the next opportunity to praise, signaling the return to time in.

• *Point or privilege loss.* The loss of points or privileges (taking away points on the rewards chart, or a brief, discrete privilege such as an hour of computer time or a night of TV) can be used for youths who are too old for time out (older than 10, in most cases). However, point loss must be used sparingly so as not to create a point deficit. Remember, a youth who has nothing has nothing to lose! The assignment of not-urgent but helpful work chores can be paired with privilege loss as a requirement for the reinstatement of the privilege (e.g., "You hit your brother, which is against the house rules. You have lost all screen time until you complete this chore for me: vacuuming my car").

■ **Troubleshoot and refine until the reinforcement works.**

• *Reinforce good behavior at every opportunity!* For all these ways of supporting desired behavior, a cardinal rule is to reinforce every step of progress, *even very tiny steps*. Caregivers often expect more improvement, and faster improvement, than is realistic. They often need prompting to detect very small, subtle improvements in youth behavior. When these are detected, a caregiver should jump all over them, showering them with attention, labeling them, giving labeled praise, and (where appropriate) rewarding them with points and/or privileges. The youth who shifts from eye rolling and complaining in response to caregiver instructions to simply saying, "OK," may have turned a subtle but major corner—and this gain is more likely to stay in place if the caregiver says, "Thanks for the good attitude, Max," and "Let's add 5 points to your chart for that positive attitude."

• *Catch the "live show."* The best way to determine whether caregivers are delivering these interventions as they were taught is to watch them try—either in a role play with you, or, better yet, in an interaction with the child that you observe. Then you can troubleshoot specific areas that are challenging, and model praise for positive behavior by telling the caregiver all the (many) things he or she did well!

• *Take it to school.* Desirable school behaviors can benefit from the same reinforcement strategies as those at home, so encourage teachers to try out differential attention in school or to hone in on key behaviors with a tangible rewards system. For teachers who are not able to implement an individualized rewards system in the classroom, caregivers can ask them to keep track of a few key behaviors in school and report home via a "school–home report." A teacher might do an overall rating at the end of the school day on a few such easily observed behaviors as "Stayed in seat," using simple rating scales such as 0 = "not much," 1 = "sometimes," and 2 = "most of the time." The caregiver can then provide points for good ratings, thus connecting school behavior to reinforcement at home.

- *Take it on the road.* Most of these strategies also travel well outside home and school; they can be used to manage disruptive behavior in public. Ensure that the strategies are being used successfully at home first before suggesting their use in public. For example, a caregiver should establish the rules for public places before the caregiver and youth enter them, similar to what is done for house rules. The caregiver should also clarify the consequences: possible rewards for following rules, as well as time out or privilege loss if rules are broken. And then the caregiver should increase the use of monitoring and differential attention during the public outing. This is usually best done at first during some "practice runs" or public outings that aren't important or urgent.

Handout 9 (pages 107–108) is a preparation sheet for caregivers' use during home practice of the Increasing Motivation strategies. Handout 10 (page 109) is an overall guide to Increasing Motivation for caregivers. Handouts 11 through 17 (pages 110–121) are guides for caregivers to various Increasing Motivation strategies (Together Time, praising appropriate behavior, differential attention, effective instructions, tangible rewards and privileges, time out from positive reinforcement, and developing a daily school report, respectively).

Skill Assessment: Increasing Motivation

This assessment is used to determine when a youth has sufficiently grasped the FIRST principle and can use it to manage feelings and behaviors in everyday life. When do you decide that enough is enough, and that the youth is ready to finish treatment or move on to the next FIRST Skill Unit? Keep in mind that there is always room for more improvement, but that the goal of treatment is to help the youth and the caregiver use these principles on their own to handle the challenges that arise in real life.

Anxiety and OCD

What is the goal?

For anxious youths, the goal of Increasing Motivation is to provide reinforcers as powerful as the natural reinforcement that occurs when the youths avoid feared situations and therefore avoid distress. Ultimately, by increasing motivation, anxious youths should engage in exposure situations to feared stimuli and develop a sense of mastery.

Has the goal been sufficiently met?

Is the youth able to face feared situations in a guided, gradual manner, in return for tangible or intangible rewards? Has he or she decreased reassurance seeking as attention to those behaviors has been reduced by the caregiver? Can the youth provide praise to and/or reward him- or herself for behaviors that overcome fear?

What about the caregiver?

Is the caregiver able to recognize and praise independent, brave behaviors, while withholding attention and support from anxious behaviors? Has the caregiver been able to shift attention toward the youth's facing feared situations?

Posttraumatic Stress

What is the goal?

For youths who experience posttraumatic stress, the goal of Increasing Motivation is to incentivize tolerating some distress while the youths face painful memories and trauma reminders during treatment, or practice the use of coping skills. If the Increasing Motivation Skill Unit has focused on improving caregiver–child relationships and decreasing misbehavior, the assessments related to Misbehavior (see below) may be more relevant.

Has the goal been sufficiently met?

Is the youth able to face the traumatic memories and triggers in a guided, slow, gradual manner, in return for tangible or intangible rewards? Is the youth able to follow through on activities discussed and agreed upon in session?

What about the caregiver?

Has the caregiver been able to shift attention toward independent, brave behaviors?

Depression

What is the goal?

Increasing Motivation should result in the increased frequency of the desired behaviors—in this case, participation in reinforcing activities that provide relief from depressive rumination and reengage the youth in pleasant and prosocial activities.

Has the goal been sufficiently met?

Is the youth following through and participating in activities agreed upon in sessions? Is he or she able to recognize and praise progress, and reward him- or herself if a self-reward system exists?

What about the caregiver?

Is the caregiver able to recognize and provide praise and reinforcement for nondepressive behavior? Has he or she been able to selectively ignore unpleasant or lethargic behavior as appropriate? Does the caregiver follow through on providing tangible rewards when they have been earned?

Misbehavior

What is the goal?

The goal of Increasing Motivation is to redistribute attention and reinforcement in the home—specifically, to move it away from noncompliant and disobedient behaviors, and toward compliant, prosocial, appropriate behaviors. Ultimately, the goal is to increase the frequency of positive behaviors while reducing the frequency of disruptive, disobedient behaviors.

Has the goal been sufficiently met?

Is the youth more likely than in the past to comply with adult directives and to show positive, prosocial behavior? Is the youth able to accept a consequence when it is given? Does he or she receive attention, praise, and/or tangible reinforcers for behaving appropriately?

What about the caregiver?

Is the caregiver able to attend appropriately and consistently to the youth's positive behavior, even when the behavior is quite subtle and represents very small steps of progress? Does the caregiver provide labeled praise for compliance and other prosocial behavior, while withdrawing attention from negative behaviors? Is the caregiver able to use time out and point/privilege loss for specific unacceptable behaviors? Can the caregiver articulate how to handle new problems that may arise?

HANDOUT 9

Increasing Motivation: In-Session Preparation for Home Practice

To plan your home practice, fill in the chart below and use it during the days ahead. The chart includes **Target Behaviors** that need to be changed (for example, some parents might write, "Sleeping late on school days"); **Positive Opposites**, the behaviors you want to see instead (for example, "Getting up and dressed by 6:45 A.M."); **Reinforcement**, or how you will reward each positive opposite behavior (for example, "15 minutes of screen time"); and **Consequence**, or what will happen if the target behavior continues (for example, "No screen time that day"). As you fill in the chart, try to include some positive opposites that will be easy for your son or daughter, some that will be moderately difficult, and some that will be especially challenging.

Target Behaviors	Positive Opposites	Reinforcement	Consequence

(continued)

HANDOUT 9 *(p. 2 of 2)*

Target Behaviors	Positive Opposites	Reinforcement	Consequence

HANDOUT 10

Caregiver Guide to Increasing Motivation

INCREASING MOTIVATION

To increase the behaviors you would like your child to show more of, and to decrease the behaviors that are causing problems, we need to reinforce positive behaviors! In session, you have identified the behaviors you'd like to increase and some ways of reinforcing those behaviors. The real work happens at home, where you will reinforce the behaviors on the spot, whenever they occur. Remember, consistency is crucial when we are trying to encourage a positive behavior or decrease a negative behavior—so try to be as consistent as possible from day to day in how you use attention and reinforcement. At first, it may be difficult for your child to practice the new behaviors, so please provide as much praise and encouragement as you can! And remember to watch for even the tiniest steps of improvement, to show your son or daughter that you have noticed, and to use lots of reinforcement to reward those steps!

The Increasing Motivation technique my child and I are practicing this week:
This technique will be used: When, in what situations, how many times?
Some golden opportunities might be:
Some helpful support might be:
To be completed after practicing: How did it go?
Did anything get in the way? If so, what?
Did you learn any new ways to make the practice work well? If so, what?

HANDOUT 11

Caregiver Guide to Together Time

Together Time is a brief period *each day* in which one caregiver spends 5–15 minutes with one child. In some cases, it may work best to schedule a time each day; in others, it may work best for you to join in when your child is already engaged in an enjoyable activity. Pick a time when you are relaxed and when your other children (if you have them) are occupied. Together Time is an opportunity for you to focus on that one child alone, providing positive attention and praise. Together Time cannot be earned or lost by the child—it is always a given.

1. **Allow your child to choose (within reason) the activity.** It should not be a passive activity such as watching TV or reading silently together. If your child needs some suggestions, here are a few favorites:
   - Building (blocks, magnetic tiles, magic sand, marshmallows/toothpicks).
   - Imaginative (dolls, dress-up, doctor kit).
   - Creative (drawing, painting, shaving cream, knitting, clay).
   - Board or card games, puzzles.
   - Active (bike riding, basketball/sports, walk, skateboarding, Nerf target practice, catch, quick trip to park).
   - Painting nails, listening to new music, looking at a popular magazine together, having ice cream, going for a short drive.

2. **During the play, you should**:
   - **Describe** (like a sports commentator) what the child is doing out loud (for example, "Your car is going really fast on the track," "You're using all of the different colors").
   - **Praise** the child with statements that positively evaluate specific behavior (for example, "I love the way you are using so many colors in your picture").

3. **If the child misbehaves in a mild way that doesn't break rules and isn't aggressive,** withdraw attention quickly, but then reengage immediately when the behavior improves or resolves.

4. **Don't do these things during Together Time:**
   - Don't give instructions.
   - Don't ask questions.
   - Don't criticize (it's OK if the child plays something incorrectly during this time).
   - Don't try to include "teaching moments."
   - Don't say "No," "Not," "Don't," "Stop," or "Quit."

5. **Do:** Enjoy this time, do it at least five times a week, learn new things about your child, and give lots of positive attention!

6. **You may be surprised how much your child comes to love Together Time!**

HANDOUT 12

Caregiver Guide to Praising Appropriate Behavior

Actions that are reinforced through attention and praise are more likely to happen and keep on happening! It is important to show your approval for behavior that is appropriate, and for your child's compliance with any rule or adult instruction. Remember also that you can praise your child for stopping inappropriate behavior, so this behavior doesn't start again!

How to provide effective praise:

1. **Offer praise right away**. As soon as the child begins to follow an instruction, switches from inappropriate behavior to appropriate behavior, or does something especially good, immediately give praise. All praise is good, but *labeled* praise—which says exactly what you liked—is best of all!

   "I like it when you follow directions the first time I ask!"

   "Thanks for closing that door."

   "I really like that you are using your fork to eat."

   "You're doing an awesome job waiting your turn."

2. **Give praise regularly.** Don't wait for some sort of rare or exceptional behavior; instead, just use praise for all the behaviors you find acceptable.

3. **"Catch" your child being good.** Increase the amount of monitoring so that you have multiple opportunities to see and praise appropriate behavior throughout the day. For example, if your child has been doing homework for 10 minutes, check in and offer praise for working quietly. Instead of waiting to give attention to negative behavior, try to catch the behavior while it is still appropriate, and offer praise so it will continue.

4. **Be enthusiastic and genuine.** Even though some good behavior might not seem like a big deal, it *is* a big deal when a child *mis*behaves. So take the energy you have been saving for managing misbehavior and turn it into an enthusiastic high-five, hug, or "Nice job!"

5. **Pay special attention to areas of difficulty.** If there are behaviors you really want to decrease, try to notice any occasion when the child isn't doing that behavior—or is doing the opposite, appropriate behavior—and give lots of praise.

Practice this! Get familiar with using praise for a few periods of each day where you look for something praiseworthy every 5 minutes.

HANDOUT 13

Caregiver Guide to Differential Attention: Active Attending and Active Ignoring

Sometimes your child may do things just to get your attention, to get you to stop doing what you are doing, or just to stir things up and see what happens! These are times when you can selectively use your attention to change your child's behavior. Increasing attention to acceptable or appropriate behaviors will make those behaviors more likely to happen and keep happening. By the same token, if you withdraw your attention after a particular behavior, that behavior will eventually happen less and less.

INCREASE ACTIVE ATTENDING FIRST

1. To set the stage for the successful use of differential attention, first make sure that your child is receiving lots of positive attention.

2. Positive attention can include looking at your child, praising your child, describing his or her appropriate behaviors, showing physical affection, and giving your child your undivided attention.

3. Sometimes increasing your monitoring is a good way to make sure you are "catching your child being good," and to show that you are interested in the activities your child is doing.

THEN ADD ACTIVE IGNORING

1. Identify behaviors that are appropriate for active ignoring. Active ignoring can be used for annoying behaviors that are not clearly rule-breaking. Here are some examples of behaviors that can be actively ignored:

   Never use active ignoring for any behavior that is dangerous or involves breaking a known rule.

   - ✓ Complaining.
   - ✓ Attitude.
   - ✓ Whining.
   - ✓ Talking back.
   - ✓ Making disruptive noises.
   - ✓ Repeating things again and again.
   - ✓ Stomping or slamming doors.

2. Identify the behavior you'd like to see *instead* of the behavior you want to ignore. Examples would include seeing your child accept a limit instead of whining, or sitting quietly instead of making annoying noises.

(continued)

3. When the disruptive/annoying behavior occurs, **ignore it!** Look the other way, pick up a magazine, do a chore, get involved with something else, or just leave the room.

4. Stay neutral. Don't get upset or react. Just stay busy and occupy yourself with something else.

5. Be ready to praise the "positive opposite"—the behavior you want to see instead of the behavior you're ignoring. Pay attention as soon as the inappropriate behavior stops, and begin praising and providing attention to the positive opposite behavior.

6. Keep it up. Sometimes when you begin ignoring, your child may try even harder to get your attention. This is called an *extinction burst.* Your child may get louder or more insistent, or may even try doing something worse. When this happens, it's very important to keep ignoring! This is a sign that the active ignoring is working. Just keep ignoring, and eventually your child will learn that this is not the way to get your attention.

7. Remember that in order for active ignoring to work, your child has to be receiving enough praise and positive attention that it's noticeable when this attention is taken away.

HANDOUT 14

Caregiver Guide to Giving Effective Instructions

Whenever you give an instruction to your child, make sure that it follows these guidelines. Giving instructions in an effective way makes it more likely that your child will obey. Remember; always praise your child for complying with your instructions, and only give an instruction if you really mean it and can see it through!

Guidelines	Say/do this . . .	Not this . . .
Make sure you have your child's attention.	Go to the child and make eye contact.	Call from the other room or talk to your child while he or she is watching television.
Make it a statement, not a question.	"Please hang up your coat."	"Would you mind hanging up your coat?"
Direct the instruction to the child.	"Please clear the table."	"Let's clear the table."
Be clear about what you want.	"Keep your hands to yourself."	"Play nicely."
Give one command at a time, not a chain of commands.	"Please put on your shoes. Thank you. Now please put on your coat."	"Go get your shoes and put them on, and then go get your coat and put it on, and then . . ."
Tell your child what to do, not what *not* to do.	"Please walk by the pool."	"Stop running!"
Use a neutral tone, not yelling or pleading.	"Come sit next to me."	"Sit here RIGHT NOW!" "It would make Mommy really happy if you'd sit next to me, please . . ."
Be clear: Make sure your child understands the instruction.	"Please go upstairs and turn off the lights in your bedroom. What did I ask you to do?" (Child repeats.)	"Please go upstairs and turn off the lights in your bedroom."

Practice this! Get familiar with using effective instructions by choosing brief periods several times a day to give simple instructions to your child that you think are very likely to be obeyed (for example, "Please pass the salt"). Don't forget to offer praise for doing what you asked!

HANDOUT 15

Caregiver Guide to Tangible Rewards and Privileges

For some children, praise is not as powerful a reinforcer as something they can actually earn. **Tangible rewards** are another way to increase the frequency of behaviors you would like your child to do more often. Rewards do not have to cost money; they can be privileges your child already receives (such as playdates or time spent on computers or video games). The most important thing is that the rewards should be things the child likes and will work to earn.

HOW TO CREATE A REWARDS SYSTEM

1. Identify the behaviors that will go on the list of responsibilities. These are desirable behaviors you would like your child to keep doing or start doing. Make sure to include some things your child already does most of the time, some things your child does sometimes (but not as often as you'd like!), and some things with which your child really struggles. You want to reward the good behavior that is already present, and to encourage more good behavior!
2. Make a list of rewards and privileges. This might involve a conversation with the child to see what sorts of things the child would like to earn. Make sure that there are some things on the list that can be provided each day (such as television privileges, staying up 15 minutes past bedtime, or having an extra snack). Some things might be more occasional (such as playing with a friend or getting to choose what the family is having for dinner). And always put a few "big-ticket" items on the list as well—things that your child really wants, but that could be provided only occasionally.
3. Decide how to keep track of your child's behavior. Tokens, points, stickers, or even a "checkbook" are all options.
4. Assign point values to the responsibilities and to the rewards. Easier responsibilities earn less, and "big-ticket" rewards cost more.
5. Give the points, token, or sticker as soon as the responsibility is done. Your child will accumulate points over days, weeks, and months, and can trade them for the rewards each day, week, or month. Ideally, your child will "trade in" about two-thirds of the amount he or she earns each day on daily rewards, while saving up one-third for costlier rewards.
6. As your child develops, the rewards system changes. When behaviors are easier, they can be taken off the list and new ones added. When rewards lose their appeal, make sure new ones are identified.
7. Always praise! Even though you're giving a tangible reward, never forget to provide verbal praise.
8. Make sure you also follow the rules of the rewards system. Sometimes you might be in a bad mood, or feel your child does not "deserve" a reward—but if your child does the responsibility you put on the list, then your child has earned the points or token you identified. That's the bottom line!

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EXAMPLES OF REWARDS AND PRIVILEGES

Small to Medium Rewards

- Staying up 30 minutes past bedtime.
- Having an extra book read at bedtime.
- Screen time (TV, video game, computer).
- Cell phone minutes.
- Extra playdate.
- Outside playtime after dinner.
- Trip to a special park.
- Choosing dessert.
- Choosing dinner.
- Collectible cards.
- Baking with caregiver.
- Family game night.
- Braiding hair or painting nails together.
- Getting a manicure or pedicure.
- Going to the movies with family.
- Bringing a friend to the movies.
- Buying a new toy or book.
- Going out for a special dinner.
- Pottery painting.
- Bike ride with family.
- Museum trip.

"Big-Ticket" Items

- Sleepover party.
- Visit to amusement park/water park.
- Sports event.
- Concert.
- Getting ears pierced.
- Cell phone.
- Video game.
- Video game console.

EXAMPLES OF RESPONSIBILITIES

Routine Responsibilities

- Getting up in the morning at first request (or with one reminder).
- Brushing teeth A.M./P.M.
- Taking medicine.
- Packing lunch or snack for school the night before.
- Putting dirty clothes in the hamper.
- Making bed.
- Getting dressed by 7:15 A.M. on school days.
- Doing one load of laundry.
- Doing dinner dishes.
- Clearing table.
- Emptying dishwasher.
- Feeding pet.
- Walking dog.
- Showering and washing hair.
- Taking out trash or recycling.
- Following directions first time they are given.
- Completing homework before dinner.
- Keeping hands to self in the car.
- Keeping napkin on lap during dinner.
- Chewing with mouth closed.
- Not swearing (using "clean" language).
- Mowing lawn.
- Putting toys away after use.
- Cleaning room (with chore card).
- Eating a fruit or vegetable with each meal.
- Dusting.
- Laying out clothes for next day.
- Checking calendar to lay out all items needed for school next day (library books, sneakers, band instrument).

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Random Acts of Kindness or Responsibility (for Bonus Points!)

- Helping out a family member.
- Holding doors or saying "Please" or "Thank you" in the community.
- Asking how you are or how your day was.
- Offering to help out.
- Not whining in a tough situation.
- Keeping calm/safe when frustrated or surprised.
- Problem solving when needed.
- Trying new healthy foods.
- Doing a task without being asked or reminded.
- Complimenting friends or cheering them on.

HANDOUT 16

Caregiver Guide to Time Out from Positive Reinforcement

When children refuse to comply with adult instructions, or when they disobey well-established rules, **time out from positive reinforcement** is a safe and effective way to respond, and to discourage repetition of these behaviors. Remember, once you introduce time out, you should only give an instruction if you're willing to follow it up with a time out for noncompliance!

PREPARING FOR TIME OUT

1. Select a time-out spot. A good spot for time out is a straight-backed chair facing a wall or some other boring view. Laundry rooms and hallways make good time-out spots. Bedrooms usually don't work very well, because there is lots of fun and reinforcing stuff in bedrooms!
2. Introduce your child to the idea of time out. Choose a time when all is calm. Explain to your child that when you give an instruction, the instruction must be followed. If it is not followed, your child will take a time out. Your child can practice sitting appropriately on the time-out chair and earn a token or a reward during this practice.

USING TIME OUT FOR NOT OBEYING AN INSTRUCTION

1. Give an instruction. ("Please sit down at the dinner table.").
2. Wait for compliance—we recommend 5 seconds. If you child complies, give praise! If your child does not comply . . .
3. Give one warning. ("**If** you don't sit down at the dinner table, **then** you will take a time out.")
4. Wait another 5 seconds. If your child complies, give praise! If your child does not comply . . .
5. Instruct your child to go to time out. ("You did not sit down at the dinner table when I asked. Now you will take a time out.")
6. Don't talk, explain, criticize, or say anything else.
7. Keep track of the time. One minute per year of age is usually enough, and more than 10 minutes is not useful.
8. You should ignore any talking, whining, cursing, or crying in time out, but your child must be quiet for 5 seconds before time out can end.
9. Once time out is complete, repeat the original instruction. ("Please sit down at the dinner table.")
10. If your child complies, give praise! If not, go back to step 2 above and begin again.

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USING TIME OUT FOR BREAKING A KNOWN RULE

Some behaviors are so serious that they do not warrant a warning, such as any behavior that causes harm to others or is dangerous. In this type of situation:

1. Identify the behavior and instruct your child to take a time out. ("You hit your brother. Now you will take a time out.")
2. Don't talk, explain, criticize, or say anything else.
3. Keep track of the time. One minute per year of age is usually enough, and more than 10 minutes is not useful.
4. You should ignore any talking, whining, cursing, or crying in time out, but your child must be quiet for 5 seconds before time out can end.
5. Remind your child of the rule before he or she leaves time out. ("Hitting is against our family rules.")

Remember, once time out has been served, you should be on the lookout for the next praiseworthy behavior! The punishment has been served, so the child has a clean slate!

HANDOUT 17

Caregiver Guide to Developing a Daily School Report

A great way to increase motivation for appropriate school behavior is to provide tangible rewards offered at home for behaviors seen during the school day. If the teacher is willing to create an individualized rewards system for the youth within the classroom, that's great, too—but this daily school report is much simpler for busy teachers. It's a great way to increase communication between a teacher and a caregiver, and to make sure a student is getting credit for behaving well in the classroom.

HOW TO CREATE A DAILY SCHOOL REPORT

1. **Identify target behaviors**. Reach out to the teacher (or teachers, if your child has more than one) to find out what behaviors the teacher would most like to see changed. It is wise to be very specific about the nature of the problem behaviors—including exactly what they look like, when they occur, how often, and how long they last. The list should be limited to the two or three most important behaviors.

2. **Identify the target goal behaviors**. In as much detail as possible, learn about the behaviors the teacher would like to see in class—the *positive opposites* of the problem behaviors. For example, if a problem behavior is getting up and walking around during class, a goal behavior would be staying in the seat. If the problem behavior is touching or poking other kids, a goal behavior might be keeping hands to self. If the problem behavior is failing to begin deskwork, a goal behavior would be to start deskwork right away.

3. **Be clear about expectations—and be realistic!** Be sure to set *realistic* goals. If a youth rarely completes any work, setting an initial goal of partially completing one worksheet is probably more realistic than expecting all worksheets to be fully completed. Consider breaking the day into manageable periods for assessment—for example, "Raises her hand and waits to be called on during math" rather than "Raises her hand and waits to be called on all day." As behavior improves, the goals can be adjusted upward.

4. **Design the monitoring system with the teacher.** Create a very low-effort way for the teacher to assess each behavior. A simple "yes" or "no" or a scale that ranges from "never" to "very often" may be easier to complete than a form that requires a lot of explanation. Examples of a simple form are shown below. Consider whether the teacher ratings will be best shared with you via a paper form brought home each day by the youth, or online direct from the teacher to you, or another method the teacher prefers.

5. **Link the target goal behaviors to the home rewards**. If you are using a tangible rewards system at home, assign point values to the school behaviors so that they fit into the existing home rewards system. The harder a behavior is likely to be for the youth, the more value you will assign. Likewise, less preferred rewards and privileges will "cost" less, while more desired rewards will be offered for better performance or more challenging goals.

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6. **Explain the daily school report to the youth.** If possible, you and the teacher(s) should meet with the youth to review the school report procedure. Explain that this is a way to make sure the youth gets rewarded for good behavior at school.

7. **Refine as needed**. Check in to ensure that the system is working as expected, and troubleshoot with the teacher.

EXAMPLES OF DAILY SCHOOL REPORTS

In the morning, Sylvia:			
	Most of the time	Some of the time	Very little
Paid attention	☺	😐	☹
Followed directions	☺	😐	☹

During art class, Sylvia:			
	Most of the time	Some of the time	Very little
Paid attention	☺	😐	☹
Followed directions	☺	😐	☹

Dylan's School Report Please get checkmarks and signatures each day from your teachers.				
Class	Homework from previous night turned in	New assignment recorded in planner	Signature	Comments
	❑	❑		
	❑	❑		
	❑	❑		
	❑	❑		
	❑	❑		
	❑	❑		

8

Using the FIRST Principles

Repairing Thoughts

This principle is used to help youths evaluate the ways they think about themselves, others, and the world, and to help them think in more realistic and helpful ways.

"People are disturbed not by things, but by the view they take of them." This quote, attributed to the Greek philosopher Epictetus, reflects one of the key tenets of modern cognitive-behavioral therapy: The way we think about ourselves, the future, and others influences how we feel—in terms of both emotions and bodily reactions—and how we behave. Using cognitive approaches in therapy involves asking youths to consider their thoughts objectively, critically examine their accuracy and their usefulness, and consider whether there is a better way to view the same situation.

Young people are not passive recipients of information. Instead, they use their own internal information-processing systems to interpret their experiences and what others tell them. The most accessible products of this information processing are *automatic thoughts*—rapid-fire impressions, interpretations, or images that pertain to a given situation and that pass quickly through consciousness, often without much notice. For example, a child who is waiting to be chosen for a team during recess may think, "I'm not good enough," or "They don't like me." Such automatic thoughts may emerge from a higher-order *schema*—a core belief that grows out of basic temperament plus life experience, and lies dormant until activated by a stressor. For example, the core belief "I am unlovable" may reflect both an inherited temperamental style and the experience of a critical home environment. An *intermediate belief,* often a set of rules or assumptions, connects the core belief to the automatic thought—in this case, "If people criticize me, it means they don't love me." When an event triggers the core belief, it may be interpreted through this lens and according to these rules, resulting in the automatic thought and subsequent feelings and behaviors.

Various emotional states may be linked to particular types of thoughts. Depressed youths tend to experience the world via a hypercritical and pessimistic view of themselves, others, and the future. Anxious youths are more likely to overestimate threat and danger. Young people who misbehave or act aggressively toward others are inclined toward hostile attributions—for example, interpreting an ambiguous comment from a peer as an insult, or rules at home as a sign that parents are "on my case" and "out to get me."

In using **Repairing Thoughts,** it is important to take an empathic approach by respecting the young person's beliefs and asking questions about them, rather than dismissing or rejecting the beliefs. The clinician should take a curious stance, acknowledging each existing belief, examining relevant evidence, and exploring with the youth whether the belief fits the evidence or whether other possibilities might be worth considering. Repaired thoughts need not be overly positive; it is important simply to help the youth reduce unrealistically critical, pessimistic, or catastrophizing thoughts and begin to see the world in a more realistic, less extreme way. The young person may seem skeptical at first, but his or her current beliefs may be well entrenched, and it is only natural for new ways of thinking to seem shaky or even inauthentic at the beginning. Over time, with practice, young people can become more adept at examining and critiquing their thoughts and identifying alternatives.

How Repairing Thoughts Is Used for Different Problem Areas

For Anxiety and OCD

Anxious youths often overestimate the likelihood that something bad will happen and underestimate their own ability to cope if that bad thing did happen. These thoughts often come in the form of worries and predictions. Young people struggling with OCD often have thoughts that impel them to perform certain compulsions, and they fear terrible consequences if they fail to carry out the compulsions.

For Posttraumatic Stress

Young people struggling with the aftermath of trauma may feel hopeless about their future and believe that good things will never happen for them, or they may feel guilty about things that are not at all their fault. Others may experience distorted thoughts that are more similar to anxious cognitions: They may interpret certain harmless situations as dangerous, underestimate their ability to cope, and view the world as unsafe.

For Depression

The content of depressed youths' thoughts is often sad and hopeless; they always see the proverbial glass as half-empty. These youths may assume the worst without thinking about other possibilities, or they may fall into "all-or-nothing" thinking, which makes it hard to see life realistically as a mixture of good and bad.

For Misbehavior

Youths who misbehave and disrupt often make negative or hostile guesses about situations that are actually ambiguous, such as assuming that another kid jostled them on purpose rather than by accident. They may also make negative assumptions about their caregivers and other adults who make and enforce rules. Of course, caregivers may make thinking mistakes of their own in response to their children's misbehavior, and those mistakes may also need attention in treatment!

Skill Unit Objectives

Note: Multiple sessions will almost certainly be required to cover the full Skill Unit; therapist and client should continue until the skill of Repairing Thoughts has been mastered.

- The youth will learn how thoughts affect what we do and how we feel.
- The youth will learn to identify distorted, unhelpful thoughts he or she has.
- The youth will learn to weigh the evidence that supports or does not support the distorted thoughts.
- The youth will learn to challenge the distorted thoughts with more realistic thoughts.

Skill Unit Outline: Repairing Thoughts

Remember this in every session:

SESSION COMPONENTS [Note: These should be included in every session.]

- **Create an agenda** of what will be covered in the session.
- **Review practice,** if any was assigned in the prior session.
- **Share the news** of any new skills or information covered in session with the caregiver or the youth at the end of the session (as appropriate).
- **Assign practice** for noticing or challenging distorted thoughts in real life.
- **Assess skill acquisition:** Is progress being made towards goals in a notable way? Is it time to move to another Skill Unit or consider ending treatment?
- **Finish strong:** End the session on a strong positive note that affirms your relationship and positive feelings toward the youth and/or caregiver—perhaps by doing an engaging activity together, praising the youth and/or caregiver for an important accomplishment in therapy or in real life, or noting how much you value the chance to work with the youth and/or family and are looking forward to the next session.

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Thoughts are connected to feelings.	How we feel is often a result of what we are thinking about ourselves, other people, and events that happen. When we think something pleasant, we usually feel OK. When we think something scary, sad, hostile, or grouchy, our feelings change in response to those thoughts.	Consider using a hypothetical ambiguous situation that could cause a person to feel either fine or sad/mad/worried, depending on the thought. You can use thought bubbles, cartoons, or a skit to make this more engaging. **Example Script** "Imagine Joe walked into a room and saw some other kids whispering and laughing. What are some different thoughts Joe might have? He might think, 'Those kids are talking about me. I hate those kids!' Or he could think, 'Those kids look like they are having fun. Maybe I should go talk to them.' What are different feelings each of these thoughts might lead to?
Thoughts are connected to behavior.	What we think inside also affects what we do on the outside. Pleasant thoughts may make us more likely to talk to others, offer to help, join a game, or do our work. Thoughts that are scary, sad, hostile, or grouchy make us react in ways that sometimes make us feel even worse.	Using the same example from how thoughts are connected to feelings, consider the different ways people behave, depending on what is going through their minds. Make sure to go through an example of both a distorted thought and a more realistic thought.
Thoughts are guesses.	The way we think about ourselves, others, and events in the moment may not be accurate. It's just a guess! These guesses can really change how we feel and what we do, so it can be helpful to slow down and really examine our thoughts. Remember: **Just because I think it doesn't mean it's true!**	It can be useful to use a metaphor, such as wearing dark glasses that change how we see the world. When the glasses come off, things look different! Distorted thoughts change how we see things like ourselves, others, and the future. Try using actual dark glasses in session to make the point (see "Tricks of the Trade").
Notice thoughts as they occur.	The first step to changing thoughts is to notice when we're having them. How can we tell when we are having a sad/scared/angry thought? What are the physical clues? What are some of the thoughts we have that make us feel sad/scared/angry/upset?	Youths who grasp this concept easily may be ready to begin noticing and writing down thoughts over the upcoming weeks. Others may need to learn examples of distorted thoughts, play games that involve identifying distorted thoughts, or act out scenarios to stop and notice thoughts. Sometimes youths will tell you a "fact" instead of the thought that is really upsetting them—for example, "I failed my test." Try using the "downward arrow" (see "Tricks of the Trade") to find out "What does that mean about you and your world?" and uncover the true distorted or unhelpful thought.

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Consider the evidence.	Can we be sure this thought is true? Are there other ways to think about the situation? If it is true, so what—how bad would it be? Consider everything we know that supports the thought, and anything we can think of that challenges the thought. Move from generic thoughts to the youth's own. Use the evidence you generate to reconsider the original thought: Maybe it isn't as true as it seemed. Or, if the original thought is true, would that really be so bad? Maybe it's actually OK, and we could live with that thought being true.	"For" and "Against" lists can be useful here, or asking the youth to consider what he or she would tell a friend. You can use a ball and pass it every time you come up with a thought that challenges the distortion (see "Tricks of the Trade"). You can pick cards with distorted thoughts and practice challenging them. Ultimately, youths should understand how to reconsider and challenge their own distorted thoughts. **Example Script** "We are going to be like 'thought judges.' We will hear from both sides about the evidence that supports or argues against this thought. It's important to look at all the evidence. Let's begin with an important question: Do we know for sure that your thought is true?"
Come up with an alternate thought.	What is a thought we could say to ourselves instead of that original sad/anxious/grouchy thought? We need something more helpful and realistic that doesn't cause such extreme negative feelings.	Consider having the youth use a "coping card," with a frequently occurring distorted thought on one side and an alternative thought on the other. Another idea is for the youth to practice "talking back" to the distorted thought (see "Tricks of the Trade").

Additional Suggestions

Developmental Differences

Many 15-year-olds may be able to identify and critique their own thoughts with ease; the process may not seem so natural to an 8-year-old. For those who have difficulty, it may help to describe the process in more concrete and familiar terms, or to notice when feelings change and then use positive self-talk, by silently repeating helpful "coping thoughts" the youth and therapist have created. Some youngsters may be too young to have developed *metacognition* (thinking about thinking), or even to profit from positive self-talk, and in these cases Repairing Thoughts may be less useful than other FIRST principles.

Using Repairing Thoughts in Real Life

Repairing Thoughts in the therapy sessions is only worthwhile if it leads to Repairing Thoughts in everyday life. Thus therapists should assign practice/homework that gets youngsters involved in identifying, evaluating, and repairing thoughts on their own between sessions—and discussing the process afterward in therapy. When a child articulates a distorted/unhelpful thought in session, the therapist should address it right then and there, even if therapy has moved on to other Skill Units. In addition, at the time of termination, it is crucial

to make concrete plans with youths regarding the situations that are most likely to prompt unrealistic/unhelpful thoughts, what the thoughts might be, and the ways the youths will deal with those thoughts. Ideally, Repairing Thoughts will become as routine and automatic a response to negative thinking as the automatic negative thinking was before therapy began.

Involving the Caregiver

Without meaning to, caregivers may be supporting some of their children's unrealistic or unhelpful beliefs, or they may be providing an alternative way of thinking without helping their children arrive at that conclusion for themselves. A caregiver might say, for example, "Of course Chris doesn't hate you. . . ." Teaching caregivers the same process their children are learning for identifying and evaluating unhelpful thoughts can ensure that this skill will be reinforced at home and thus sustained long after treatment ends.

Taking It to School

A typical day at school is packed with events any student may interpret negatively via distorted or unhelpful thoughts (a teacher's comment about schoolwork, a perceived social slight, a collision in the cafeteria, etc.). Clinicians should encourage thought monitoring when these events occur, and should help youths do advance planning—for example, identifying helpful "detective questions" to ask themselves when negative thoughts arise. If there is a school counselor or favorite teacher who can help to reinforce this skill, reaching out to that person can help ensure that Repairing Thoughts is used in the moment when negative thoughts arise.

TRICKS OF THE TRADE:

Repairing Thoughts—Anxiety and OCD

- **Thoughts are connected to feelings.** Anxious youths and those with OCD often worry about negative things that may happen in the future. They often overestimate the likelihood that something bad will happen (e.g., that a dog will bite them, or that harm will come to a loved one), and they underestimate their own ability to handle a negative event (e.g., assuming that they won't know the answer if called on in class). Sometimes these worries are based on reasonable concerns (e.g., worrying about being unprepared for class), but at other times the worries are not realistic (e.g., believing that stepping on a crack will cause a loved one's death, or that answering a question incorrectly would be humiliating beyond belief). A core problem is that youths with anxiety disorders and those with OCD rarely stop to weigh the evidence on whether their anxious thought is true. Instead, they rely on a "feeling" that the scary thought it is true.

- **Thoughts are only guesses.** Many anxious youths and those with OCD have so completely avoided testing whether their worried thoughts are accurate that they have a hard time finding evidence to challenge their scary beliefs. A boy who is afraid of elevators, for example, may never have ridden in an elevator—and thus never learned that it is not so bad!

On the other hand, anxious youths often have a very good memory for events that support their worries—like the one story on TV, 5 years ago, about an elevator that actually *did* break down. Sometimes education about the feared stimuli can help (e.g., learning that elevators are always inspected and are generally safer than stairs, or that people do not have heart attacks from panic). It can also help to ask youths to consider *other* people they know: Has the bad thing they are so worried about happened to others? Does it happen a lot? When it does happen, is it really so terrible? A good way to get at the true worry is to ask, "And then what is the worst thing that would happen?"

- **Make it engaging: Personalizing the "anxious voice."** Externalizing the "worried," "anxious," or "OCD" voice can be a helpful way to get kids to differentiate between the worried, distorted thoughts and more realistic thoughts. Giving the worry or anxiety a name ("Germy," etc.), and identifying the worried thoughts as the voice of this character, can be helpful. In session, a youth can draw a picture of what the character looks like and write down the sorts of worried things the character says (e.g., "Germy says that you can get sick and die from touching doorknobs"). Then the youth can practice "bossing back" the anxious or worried character with more realistic and helpful thoughts.

- **Make it engaging: Coping cards.** A youth can use a stack of blank cards (e.g., index cards), each of which has a distorted thought written on one side and an alternative coping statement on the other. Parents and peers can add coping statements, too, and the youth can carry one or more of these cards in situations where he or she needs a reminder of the coping thoughts.

- **Make it engaging: Mystery game.** Turn the distorted thought into a mystery to be solved. The youth is a detective who gathers clues by interviewing others at the clinic, home, or school (these others should be prepared in advance!). For instance, a youth with separation anxiety might ask clinic staff members if they have ever been to camp, and if so, whether or not it was fun. Tallying the number of "fun" and "not fun" responses can help the youth determine the most likely outcome. Even the process of interviewing others can serve as a good Trying the Opposite exercise (see Chapter 10) for a youth with social anxiety disorder!

- **Practicing Repairing Thoughts.** For anxiety, it is useful to examine each anxious or worried thought carefully for the evidence that supports it or doesn't. As youths also begin practicing facing the feared situations and stimuli, you can check in with them regarding how these experiences challenge their beliefs. For example, "You thought you were going to throw up when you got a tetanus shot. Is that what happened? No? How could you now challenge your thought the next time you have it?" Youths who experience a frequent or recurrent anxious thought can complete a coping card as described above and illustrated here:

My worried thought:	**Coping thoughts:**
When my mom is late to pick me up, it means she has been hurt.	Sometimes she is late because she gets stuck in traffic. She has been late before and was never hurt. She is a careful driver.

It is often important to encourage caregivers of anxious youths to encourage their children to complete coping cards or Repairing Thoughts home practice sheets, rather than simply asking adults for repeated reassurance. Reassurance seeking is one of the anxiety symptoms we want to eliminate.

- **Disengaging from irrational thoughts.** In some cases, the back-and-forth exchanges between the worried thoughts and the coping thoughts can start to seem counterproductive, like a game of ping-pong that goes on too long. For instance, in youths who have OCD or generalized anxiety disorder, the thought repair may become a ritual (in OCD) or an avoidance strategy (in generalized anxiety disorder). In these cases, it may be more useful to practice disengagement from the thoughts; remind the youths that sometimes "anxiety talks, but you don't have to listen." Suggest that they imagine the anxious thoughts like an annoying boy yelling on the playground at school: You can't make him go away, so just do your best to focus on other things, and eventually he will leave on his own.

TRICKS OF THE TRADE:

Repairing Thoughts—Posttraumatic Stress

- **Thoughts are connected to feelings.** Youngsters who have experienced a traumatic event may develop pessimistic beliefs about their future or their safety, worries about future events and their ability to handle them, or self-blaming thoughts about the traumatic event or other events that occurred in the past. These thoughts are understandable, but they often lead to feelings of anxiousness, sadness, hopelessness, or guilt. Sometimes youths who have been abused have also internalized misinformation from their abusers (e.g., that people will never believe them, or that the abuse is normal and acceptable). These thoughts are rarely considered carefully, in part because they originally came from an authority figure, and in part because they so often surface quickly and automatically or are not fully conscious.

- **Thoughts are guesses.** Often youths who have experienced trauma have invested so much energy in *not* thinking about the traumatic event that they also have not had a chance to consider how accurate or helpful the negative thoughts they have really are. Sometimes education about the trauma type can help (e.g., learning that many youths witness domestic violence, or that sexual abuse is never a child's fault).

- **Make it engaging: What would you tell a friend?** Youths who have experienced trauma may find it challenging to think kind thoughts about themselves; they may find it easier to think kindly about other kids who have experienced similar traumatic events. Asking them to repair thoughts for someone else is a good way for them to practice the concept and become comfortable with a new strategy.

- **Make it engaging: Coping cards.** A youth can create and use coping cards as described above in the "Tricks of the Trade" for anxiety and OCD. Again, parents and peers can add coping statements, and the youth can carry one or more of these cards in situations where he or she needs a reminder of the coping thoughts.

TRICKS OF THE TRADE:

Repairing Thoughts—Depression

- **Thoughts are connected to feelings.** Depressed youths often have critical, hopeless, and blaming thoughts about themselves, others, and the future. When things go wrong, they may think that this happened because of some failure on their part, and that things will probably continue to go wrong in the future. On the other hand, when things go well, depressed youths may think this was an accident (or caused by someone else) and probably won't happen again. They have an easier time noticing and remembering information that is consistent with a negative world view, and often overlook events and experiences that are more positive.

- **Thoughts are guesses.** A first step for these youths is helping them identify their distorted thoughts—the sad, blaming, critical thoughts that go through their minds. The "downward arrow" technique involves tracking the steps from the original event ("I didn't make the team") through the cascade of thoughts that followed that event, to better understand the personal meaning the youth ascribed to the event. For example, Grace's thoughts after not making the team were "I'm no good at soccer," then "I've failed again," then "Other kids won't respect me, and I'll never be popular." A useful next step for you as the clinician is to ask Grace to consider these thoughts, or perhaps just the one at the end of the chain, and evaluate how strongly she believes the thought: Is she 100% certain that not making the team means she will never be popular? You can ask Grace to provide evidence that supports the negative thought, and ask as well for any evidence that maybe the thought isn't true (e.g., "Are all the popular kids good at soccer? Are there some popular kids who don't do sports at all?"). You can ask Grace if there is another way to think about this. You can ask her to imagine that she has a friend who didn't make the team and has the same thought, and ask what she would tell that friend. Throughout the process, you should be on the lookout for exaggerations ("always," "everyone," "never") and query whether or not *that* thought is accurate. After these steps, you may be ready to see whether your young client can construct a more helpful, realistic thought to challenge the negative, distorted thought.

- **Make it engaging: Rock and candy**. We all encounter mixtures of good and bad experiences; both happen all the time. A valuable skill is intentionally focusing our attention on the good ones. To demonstrate this, give the youth a rock to put in his or her shoe. Ask the youth to focus on how the rock feels, and to generate some thoughts: "Why would the therapist make me put a rock in my shoe? Maybe I've done something wrong, or the therapist is just mean? This rock hurts, and it isn't fair. What will happen in the future with this rock in my shoe? How can I even walk?" Coach the youth to come up with some negative predictions and attributions. Next, give the youth a piece of candy and ask him or her to focus on how it tastes. Ask about what it means that he or she has a piece of candy, and to come up with thoughts related to the candy. Often youths will note that when they focus on the candy, the rock is easier to tolerate. On the other hand, if they focus on the rock, they can't enjoy the candy! Make the point that we all have "rocks" and "candy" in our lives, but we can try to deliberately focus on the positive (the candy), so that the hardships (or rocks) are easier to bear.

- **Make it engaging**: **Dark glasses**. Have the youth put on dark sunglasses and describe how things look, and then take the glasses off and describe the changes. Use this to explain how depression can distort how we see things, making things seem darker and gloomier than they really are. Although those glasses change our perspective, they don't alter reality. In the same way, our gloomy, dark, or distorted thoughts are not always true reflections of the world.

- **Make it engaging: Personalizing the negative thoughts**. Another way to make the treatment engaging is to externalize, or personalize, the negative thoughts (as described above in the "Tricks of the Trade" for anxiety and OCD). For a depressed youth, the thoughts can be identified as coming from "Little Miss Morbid" or "Mr. Gloom and Doom," and the youth can combat these villains by showing how their negative thoughts are mistaken.

- **Make it engaging: Catching and changing the thoughts**. Another useful exercise involves passing a ball back and forth. You state a distorted thought (e.g., "My car broke down today and I was late to work—my life sucks"). You then throw the ball to the youth, who states an alternative thought (e.g., "But it wasn't the end of the world—your boss was nice about it") and throws the ball back to you. After several rounds of this, switch roles, so that the youth has the chance to play both roles, sometimes stating the distorted thought and sometimes challenging it.

- **Practicing Repairing Thoughts.** It can be useful to practice challenging thoughts together—and being the "thought judge"—in session before asking the youth to practice alone between sessions. You can bring in some examples of distorted thinking you've seen from famous people in the news, and critique them with the youth during the session. The format shown in Figure 8.1 can be used for reappraising depressive beliefs with older youths. Younger children may simply need to come up with a helpful thought, without considering the evidence or rating the thoughts.

Negative thought	Strength of belief (0–100%)	What happened to trigger the belief	Evidence that supports the thought	Evidence that opposes the thought	More realistic, helpful thought	Re-rated strength of belief (0–100%)
My mom never lets me do what I want.	90%	My mom won't let me go to a party.	She said no to this party. She said we can't discuss it any more. She let me go to a party when she knew the family.	She let me go to the mall yesterday.	Sometimes my mom lets me do what I want, when she knows it is safe for me.	60%

Figure 8.1. Sample format for repairing a negative thought.

TRICKS OF THE TRADE:

Repairing Thoughts—Misbehavior

- **Thoughts are connected to feelings.** Boys and girls who misbehave and disrupt often make negative or hostile interpretations of ambiguous events or situations. They may jump to conclusions about the meaning of others' behavior towards them, or assume the worst. For example, when another boy bumps into Kevin in the hallway, Kevin's automatic thought may be "That kid is messing with me," rather than "It was an accident—it's crowded in the hall." These youngsters may need help with stopping and thinking, to get to the more accurate (and more innocent) interpretation.

- **Thoughts are guesses.** An important first step is to practice identifying the thoughts that occur just before the angry feeling surfaces. Learning reminders such as "Stop and think!" or "Count to 10 before you begin!" can help slow the process between a trigger and an action, allowing time for clearer thinking and a calmer reaction. Ask the youth to consider how true or accurate that very common first thought is. Looking for evidence that supports the negative thought is the youth's opportunity to tell you why he or she is certain the thought is true. Next, ask for evidence that maybe the thought isn't true. Is there another way to think about it? Once you have the opposing evidence, see if the youth can construct a more helpful, realistic thought to challenge the negative, distorted thought. In addition, youths with disruptive behavior problems may find it helpful to use calming thoughts, such as "Stay cool," "Take a breath," or "Don't get in trouble." Sometimes the first step is for a youth to think a calming thought as a reminder to take time before reacting. You can then encourage the youth to reappraise and restructure the original negative thought.

- **Make it engaging: "Stop and think" exercises**. A good way to make this skill come to life is to act out several "Stop and think" role plays in which there is a behavioral trigger that might lead to a hostile attribution and bad behavior. Examples might include someone stepping on a youth's foot, or refusing when the youth asks for something. After the situation is acted out, the scene can be frozen to identify the thought that would run through the youth's mind in that moment. That thought can be discussed and then potentially revised to be more realistic. Finally, the appropriate behavioral response can be acted out.

- **Make it engaging: Personalizing the negative thoughts.** As it can for youths with anxiety, posttraumatic stress, and depression, externalizing the negative thoughts through personalization can be a useful approach. For a misbehaving youth, the negative thoughts and hostile attributions can be construed as coming from "Hot Head," "The Hulk," or some other angry character, and combating those thoughts and judgments can be described as "bossing back" this character who gets the youth into trouble.

- **Practicing Repairing Thoughts.** Asking the question "Is there another way to think about this?" is a useful exercise for youths who often jump to hostile or critical conclusions without exploring all the possible interpretations. It is good to remind such a youth that people and situations are "innocent until proven guilty" by the "thought judge," and that they must examine the evidence before declaring the verdict. Completing "Stop and Think" journals, where the youth jots down situations that were aggravating and identifies the hostile or

critical thought in each situation, is a good initial practice. Over time, the youth can practice collecting the evidence that supports or contradicts the thoughts, and can eventually learn to revise the thoughts to make them more realistic and more helpful.

- Caregivers of misbehaving youths may also have unrealistic interpretations of the behaviors their children exhibit—such as assuming that the youths engage in these behaviors because "She doesn't respect me" or "He's trying to push my buttons." Encouraging caregivers to evaluate thoughtfully whether or not this is the correct interpretation can help identify "fixes" for stressful caregiver–child interactions and thus reduce misbehavior. Is it possible that a youth disobeyed because he or she didn't understand the instructions or rules, or has a hard time remembering the exact rule or the consequences of misbehavior when the youth is really excited about something? Is this the kind of youth who is often impulsive, but then later feels bad about breaking rules? Teaching a caregiver the same Repairing Thoughts skills you have taught the youth may help the entire family.

Handouts 18 and 19 (pages 137–138) are home practice sheets that can be used when youths practice catching/fixing negative thoughts and catching positive thoughts, respectively, between sessions. Handout 20 (page 139) is a guide to Repairing Thoughts for caregivers.

Skill Assessment: Repairing Thoughts

This assessment is used to determine when a youth has sufficiently grasped the FIRST principle and can use it to manage feelings and behaviors in everyday life. When do you decide that enough is enough, and that the youth is ready to finish treatment or move on to the next FIRST Skill Unit? Keep in mind that there is always room for more improvement, but that the goal of treatment is to help the youth and the caregiver use these principles on their own to handle the challenges that arise in real life.

Anxiety and OCD

What is the goal?

The goal of Repairing Thoughts for anxiety and OCD is to help youths become "detectives" who can critically examine the evidence that their anxious or worried predictions are true or not true. Youths should be able to answer the questions "What is the evidence on whether my worried thought is true?" and "If it is true, how bad would that be?" in order to generate coping thoughts that alleviate anxiety or OCD.

Has the goal been sufficiently met?

Is a youth more accurately predicting the outcomes of anticipated situations without engaging in catastrophic thinking? When anxious, is the youth better able to generate realistic coping thoughts? Is the youth able to incorporate recent success experiences into his or her evaluations of thoughts?

What about the caregiver?

Does the caregiver understand how Repairing Thoughts can be used to challenge anxious, catastrophic thoughts? Is the caregiver able to use gentle questioning to guide the youth toward more helpful, realistic thoughts?

Posttraumatic Stress

What is the goal?

Youths should be adept at noticing when their emotions have changed and identifying thoughts connected with those changes. They should be capable of asking questions in order to evaluate unrealistic or unhelpful thoughts.

Has the goal been sufficiently met?

Is a youth able to think of him- or herself, others, and the future more realistically? Can the youth generate more realistic thoughts in the face of negative self-talk? Is the youth able to incorporate new information into his or her evaluations of thoughts?

What about the caregiver?

Does the caregiver understand how Repairing Thoughts can be used to challenge overly pessimistic, blaming, or fearful thoughts? Is the caregiver able to use gentle questioning to guide the youth toward more helpful, realistic thoughts?

Depression

What is the goal?

When Repairing Thoughts for depression has been successful, youths have become adept at identifying thoughts that are overly critical, negative, pessimistic, or distorted. In addition, they are able to take a step back from such a thought, recognize that not all thoughts are accurate, and fairly consider the evidence that supports or opposes the thought. Finally, they are able to reappraise the thought, and modify it so that it is more realistic and helpful.

Has the goal been sufficiently met?

Has the frequency of a youth's negative self-statements decreased? Is the youth better able to catch automatic negative thoughts when they happen, accurately assess their validity, and reappraise them in the moment? Is less time spent in negative rumination?

What about the caregiver?

Does the caregiver understand how Repairing Thoughts can be used to challenge overly blaming, critical, and distorted thoughts? Is the caregiver able to help the youth challenge negative thoughts in a constructive and helpful manner when these thoughts arise?

Misbehavior

What is the goal?

The goal of Repairing Thoughts for misbehaving youths is to enable them to assess ambiguous situations and events more accurately, without jumping to conclusions and assuming that other people have bad intentions.

Has the goal been sufficiently met?

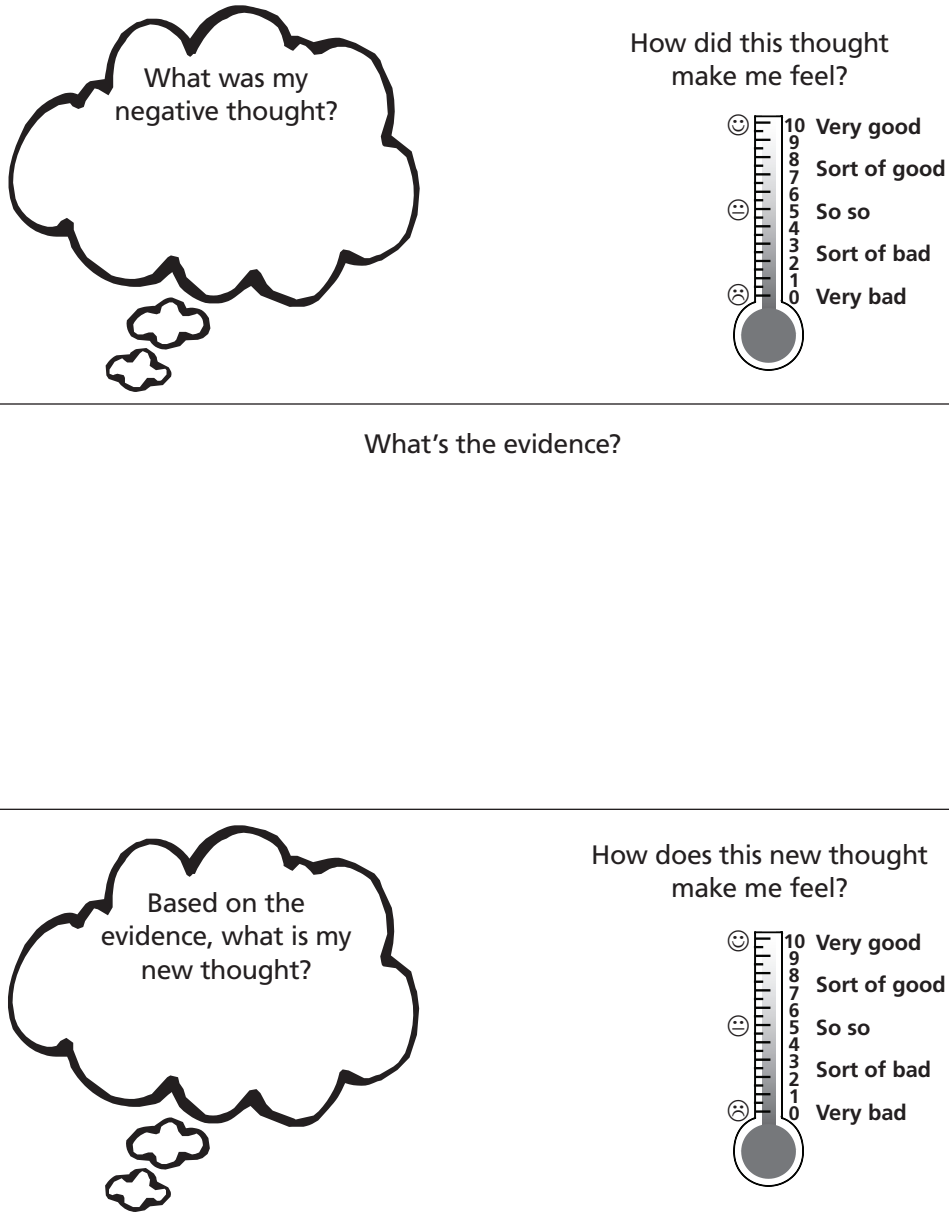
Is a youth, in session and in everyday life, better able to consider alternative explanations for situations—and other people's behavior—that were previously considered hostile? When frustrated, is the youth able to catch him- or herself engaging in hostile attributions without sufficient thought, and to assess the situation more accurately?

What about the caregiver?

Does the caregiver understand how Repairing Thoughts can be used to challenge hostile or defensive attributions? Can the caregiver use gentle questioning to guide the youth toward more helpful, realistic thoughts?

Repairing Thoughts: In-Session Practice

The graphic in this form can be used for practicing Repairing Thoughts during the session. (The graphic is also part of Handout 18, for home practice.) As the graphic shows, the process includes these steps: (1) A youth identifies a negative thought and rates how that thought made him or her feel; (2) next, the youth writes down some of the evidence about that thought, including evidence showing that the thought may *not* be accurate; (3) finally, the youth uses the evidence to write a more realistic version of the original thought, and rates how that new thought makes him or her feel.

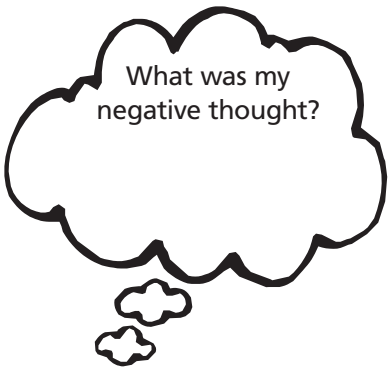


HANDOUT 18

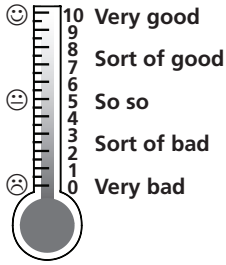
Repairing Thoughts: Home Practice—Catching and Fixing Negative Thoughts

Over the next week, write down **three *negative* thoughts** that pop into your head. For each thought, fill in the form below. Using the form, you will do these things for each thought:

1. Write the thought down (inside the top cloud), and then rate how that thought made you feel.
2. Use the box to write down some of the evidence about that thought; be sure to include evidence showing that the thought may ***not*** be true.
3. Write a more realistic version of the thought (inside the bottom cloud), and then rate how that new thought makes you feel.

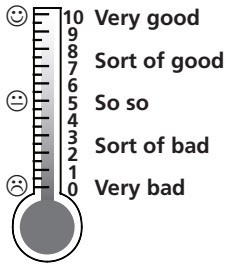


How did this thought make me feel?



What's the evidence?

How does this new thought make me feel?

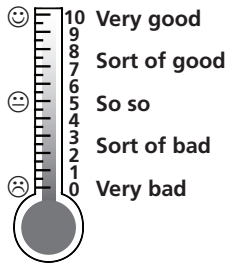
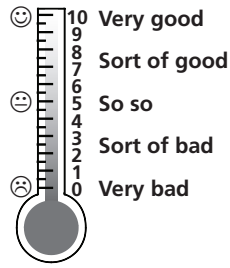
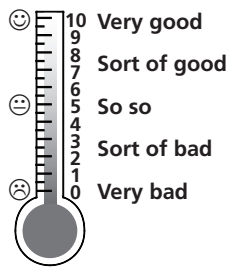


HANDOUT 19

Repairing Thoughts: Home Practice—Catching Positive Thoughts

Over the next week, write down **three *positive* thoughts** that pop into your head. For each thought, fill in the form shown below. Using the form, you will do these things:

1. Write your positive thought.
2. Write what was happening when you had that thought.
3. Rate how that thought made you feel.

One positive thought I had:	How this thought made me feel:
What was happening when I had this thought:	
A second positive thought I had:	How this thought made me feel:
What was happening when I had this thought:	
A third positive thought I had:	How this thought made me feel:
What was happening when I had this thought:	

HANDOUT 20

Caregiver Guide to Repairing Thoughts

REPAIRING THOUGHTS

Repairing Thoughts consists of noticing and evaluating thoughts that may be overly negative, critical, blaming, or gloomy. These thoughts often pop into our heads when we are in a stressful situation, or thinking about something in the future. They make us feel bad about ourselves, others, or the world. In sessions, your child has learned that "Just because I think it doesn't mean it's true!", and that we can examine the evidence to see if our negative thought might be exaggerated or unrealistic. That is your child's practice assignment: to identify negative thoughts and evaluate them. If the thoughts are unrealistic, they need to be "repaired"—in other words, made more realistic and more positive. **At first, it may be difficult for your child to practice Repairing Thoughts, so please provide as much praise and encouragement as you can!**

How my child is practicing Repairing Thoughts this week: My child has agreed to practice this: When, in what situations, how many times? Some golden opportunities might be: Some helpful support might be:
To be completed after practicing: How did it go? Did anything get in the way? If so, what? Did you learn any new ways to make the practice work well? If so, what?

9

Using the FIRST Principles

Solving Problems

This principle is used to help youths systematically identify problems, brainstorm solutions, evaluate the consequences, and make good choices.

We all have to solve problems, every day, multiple times in a day. To be successful in problem solving, we need to clarify what each problem is, identify possible solutions, and select the most viable solution from among the alternatives. These steps can be applied to problems that are personal (emotions, behaviors, health), impersonal (finances or logistical obstacles), or interpersonal (family conflict, peer problems).

Deficits in problem-solving skills are linked to multiple mental health problems, and this may explain why teaching systematic problem solving is featured in evidence-based treatments for youth anxiety, posttraumatic stress, depression, and misbehavior (Chorpita & Daleiden, 2009). Youths with such challenges may develop a belief that problems are threats—unsolvable and beyond their coping capacity. Teaching them systematic problem solving can help them manage their immediate coping dilemmas, and also change the way they perceive problems—as challenges that they are ready to take on and overcome.

Many youths with mental health challenges may instinctually use impulsive or careless problem-solving approaches: They may hurry through attempts to resolve dilemmas, without much thought, or may try only a narrow set of solutions and give up before problems are solved. Others may try to avoid dealing with problems, by procrastinating or remaining passive in the face of coping dilemmas. In FIRST, **Solving Problems** is used to promote a rational problem-solving style that involves clearly defining the problem and then taking a series of steps (called the **S-O-L-V-E** steps, and explained in detail later) to get to an effective coping response. This can boost a young person's track record of successful coping, and in the process reduce stress and boost feelings of mastery and competence.

The critical components of Solving Problems are clearly defining the problem and setting a realistic goal, generating a number of possible solutions, examining each solution in terms of its costs and benefits, and deciding which solution to try first. Finally, the solution is implemented, and its consequences are evaluated. If the first solution tried did not work well, another highly ranked solution can be tried next.

How Solving Problems Is Used for Different Problem Areas

For Anxiety and OCD

Planning in advance for challenging situations, and brainstorming possible solutions to handle those situations, can be a helpful way for young people to manage anxiety-provoking situations *once they have been able to stop avoiding those situations*. It is important not to use problem solving as a way of avoiding anxiety-provoking situations, but problem solving can become very helpful once avoidance has been overcome. Anxious youths may underestimate their ability to manage outcomes when they face feared situations; becoming effective at solving problems can build confidence that the feared situations can be managed and mastered. The situation is similar for youths who struggle with OCD: Problem solving can become an important supplemental skill, once young people have begun to master the cycle of obsessions and compulsions.

For Posttraumatic Stress

Youths who have had traumatic experiences often find themselves navigating highly stressful memories as well as dramatic shifts in their moods, thoughts, and physical systems. They may not have good ideas about how to cope with these challenges, and sometimes may react in ways that are maladaptive—for example, by responding aggressively to ambiguous encounters with other people, or engaging in risky behaviors like substance use or self-injury. Another problem faced by youths following traumatic stress may be worries about personal safety. Solving Problems is a good fit for these concerns. Learning the sequential S-O-L-V-E steps can help instill a sense of control and self-efficacy.

For Depression

Depression is often associated with behavioral avoidance—shying away from activities that may seem challenging in the short term, but that need to be faced and mastered in the long term. Depressed youths often feel hopeless and helpless in the face of problems and may have a difficult time generating good solutions. They may also give up easily when their first attempt to solve a problem does not succeed. Problem-solving skill, combined with courage and perseverance, can change all that. In fact, an important point for depressed youths is that even having a bad or sad mood can be thought of as a problem to be solved!

Misbehavior

Youths who often misbehave may have impulsive temperaments that make it difficult for them to process information, formulate goals, and consider various solutions and their likely consequences before they act. Even those who are not chronically impulsive may not know how to use the time wisely if they do in fact pause before acting. Teaching a systematic approach to problem solving—identifying the problem, generating multiple solution options, evaluating the pros and cons of each option, and choosing a course of action—can make a big difference in the lives of these young people.

Skill Unit Objectives

Note: Multiple sessions will almost certainly be required to cover the full Skill Unit; therapist and client should continue until the skill of Solving Problems has been mastered.

- The youth will learn the S-O-L-V-E steps for effective sequential problem solving.
- The youth will practice generating several solutions prior to evaluating them or acting upon them.
- The youth will understand how to apply this approach to problems that arise in everyday life.

Skill Unit Outline: Solving Problems

Remember this in every session:

SESSION COMPONENTS [Note: These should be included in every session.]

- **Create an agenda** of what will be covered in the session.
- **Review practice,** if any was assigned in the prior session.
- **Share the news** of any new skills or information covered in session with the caregiver or the youth at the end of the session (as appropriate).
- **Assign practice** for problems the youth is trying to solve in real life.
- **Assess skill acquisition:** Is progress being made toward goals in a notable way? Is it time to move to another Skill Unit or consider ending treatment?
- **Finish strong:** End the session on a strong positive note that affirms your relationship and positive feelings toward the youth and/or caregiver—perhaps by doing an engaging activity together, praising the youth and/or caregiver for an important accomplishment in therapy or in real life, or noting how much you value the chance to work with the youth and/or family and are looking forward to the next session.

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Introduce problem solving.	What are some problems that the youth faces, related to the problem area for which he or she is being treated? Solving Problems is a way to feel better and make good choices, and even big problems can be broken down into small steps to make them more manageable.	Make sure to note that everyone has problems sometimes, and sometimes it's hard to think of how to handle problems. You could give an example of a simple problem you had recently. What are some problems the youth has had, and how has he or she handled these problems? You can note that sometimes a problem gets us so upset that it's hard to focus on how to solve it—so today we're going to talk about some steps to use for good problem solving.
Explain the sequential approach to Solving Problems: the S-O-L-V-E steps.	There are five important steps to solving problems. The acronym S-O-L-V-E can help you and the youth remember to: • **Say what the problem is.** [First you need to specifically identify the problem being faced.] • **One goal you're aiming for.** [Next say what you want to accomplish, such as meet new kids in school, end an argument, or get out of a bad situation.] • **List some solutions.** [Make a list of possible solutions, without evaluating them.] • **Vote for the best one.** [Think of the pros and cons—the positive and negative consequences that might come from each solution on the list.] • **Explore what works.** [Based on the pros and cons, pick the solution that seems best, and try it. If it doesn't work, try others until you find one that succeeds.]	It can be fun to begin with an experiential activity, such as a problem that you and the youth need to solve together in the session (see "Tricks of the Trade"). This can be something silly, such as moving an object from a chair to the table without using your hands, or keeping a balloon in the air. Or it can be something more practical, such as helping a hypothetical kid solve a problem with friends or family. Whatever you choose, apply the S-O-L-V-E steps to illustrate how to use them, making sure to cover each step thoroughly. At this early stage, be sure to choose a problem that is modest in scope and readily solvable. **Example Script** "So we have just practiced a way to solve problems, using five steps. The steps spell out S-O-L-V-E. This is a way to think about different possible solutions before you decide which solution to try. We used it to solve a silly [or little] problem, but it can be used for just about any problem, even big ones."
Apply the S-O-L-V-E steps to the youth's own life.	Help the youth identify a problem from his or her own real life and apply the S-O-L-V-E steps to that problem.	Make sure that the brainstorming phase of the sequence (List some solutions) is free of evaluation or criticism. It often helps to add some less-than-optimal solutions (e.g., "Yell really loud"), so that the youth understands that brainstorming is free from judgment, and that the S-O-L-V-E process is for ruling out bad ideas as well as identifying good ones.

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Practice the S-O-L-V-E steps.	Walk through each solution the youth has selected, rehearsing how it will be implemented. Note also that sometimes the first choice doesn't work, and then we just try other solutions from our list until we find one that works.	It is very useful to role-play how the youth will enact the solution, so that the exact approach can be fine-tuned before implementing it in real life. For example, if the solution involves interpersonal communication, practicing and refining the exact wording the youth will use can be very helpful.

Additional Suggestions

Developmental Differences

The procedures described here should work with youths across the 8- to 15-year age range. For a child younger than 8, it may be most useful to teach a family approach to problem solving, so that parents can support their child's use of the S-O-L-V-E steps. It is generally best to begin with a game-like problem to help the child learn the S-O-L-V-E steps before moving into personal, emotionally laden content. With adolescents, it may work best to start by applying the S-O-L-V-E steps to someone else's problem before getting into their own personal concerns.

Using Solving Problems in Real Life

No matter how good a boy or girl is at problem solving in therapy sessions, the real test is whether the skill can be used effectively in real life—at home, in school, and with peers. A key to success in treatment is getting a youth to try the S-O-L-V-E steps in everyday life, then debriefing about the experiences later in therapy, then trying again in everyday life, and so forth. This cycle is crucial to preparing the youth for independent problem solving in real life after therapy has ended. When a youth or caregiver tells you about a problem he or she is facing, you should seize that opportunity to practice applying S-O-L-V-E to a problem that has real-life relevance.

Involving the Caregiver

Teaching a caregiver the S-O-L-V-E steps is a good way to support a youth, Another great strategy is to encourage family problem solving when conflicts arise—for example, when family members cannot agree on a television show to watch, or when a parent and child disagree about curfew. Meeting with the child and caregiver together to teach them how to use the S-O-L-V-E steps together will facilitate the use of problem solving to improve family life.

Taking It to School

Teachers and school support staff can benefit from learning this approach to solving problems as well. The S-O-L-V-E steps can be taught to all students as part of a social-emotional learning curriculum, or used as needed for particular students when they are having a difficult time in the academic setting. For example, the S-O-L-V-E steps can be used to tackle problems related to homework completion or to address disruptive behavior in class.

TRICKS OF THE TRADE:

Solving Problems—Anxiety and OCD

- **Introduce Solving Problems.** Anxious youths and those with OCD often have a history of feeling that they are not able to handle problems that arise in their lives: They underestimate their ability to manage the distress that comes with facing anxious situations, and they overestimate the likelihood that things will go terribly wrong. Although facing feared situations and not using any safety behaviors (such as reassurance seeking or rituals) via Trying the Opposite is the most effective way to address these beliefs, feeling prepared to solve predictable problems can also be extremely helpful. This is true because anxious youths and those with OCD often fear that a threat or a problem might overwhelm them. Planning the steps they can follow to deal with threats and challenges can help make those worries less, well, worrisome.

- **Make it engaging: Using S-O-L-V-E for a silly problem.** It's often helpful to give kids some low-stress experience at solving problems before you and they turn to thinking about problems and worries in their lives. The S-O-L-V-E steps can be introduced with any number of fun, tangible, and interactive activities. For example, youths can be asked to use the S-O-L-V-E steps to figure out how to move a ball from one surface to another without letting it touch the ground and without using their hands. While that is going on, you can highlight each of the S-O-L-V-E steps as the youths use them, to maximize the value of this "practice run."

- **Make it engaging: Using S-O-L-V-E in session**. Make it clear that just about anything can be a "problem to be solved," including feeling too tired to do a therapy practice assignment or wanting to play a fun game instead of learning a new skill in the therapy session. When problems arise in therapy, use S-O-L-V-E to come up with solutions in the moment!

- **S: Say what the problem is.** Youths with chronic anxiety and with OCD are often not so clear about the outcome that would be so terrible if their fears were realized. This vagueness in itself can make it hard for them to cope. Getting to the heart of the problem—what it is that a youth actually fears, deep down—is an important first step toward setting goals and coming up with candidate solutions. Sometimes pushing toward this concreteness can actually help youths see how unrealistic their fears are. Consider a boy who says that the problem is "I have to give a speech in class." Of course, giving a speech in class is not, in and of itself, a "problem." With some gentle querying, the boy might eventually spell out what makes the speech a problem: "I will stutter in class, everyone will laugh at me, and I will lose all my friends." In this case, saying exactly what the problem is could reveal how unrealistic at least

part of the fear actually is. In other cases, saying what the problem is can turn a vague feeling of dread into a specific, concrete fear that can be tackled with specific steps of problem solving.

- **O: One goal you're aiming for.** For many problems, a variety of goals may be appropriate. For the "giving a speech in class" problem, just noted, one goal might be "Don't stutter," and this could call for solutions such as self-calming before the talk, practicing slow and controlled speech flow, and the like. For some youths, though, not stuttering might be an unrealistic goal. An alternative—which might not occur to an anxious youth without prompting—might be "Don't let stuttering stop me from finishing." Another goal might be "Give the speech and don't lose my friends." For these latter two goals, solutions might involve "defusing" the stuttering in advance (perhaps by making a little joke at the beginning, warning kids that stuttering is on the way, etc.), or even learning to smile and pause each time to regain speech flow. In addition, talking to a friend before the speech could be a way to be reassured that friendships won't be lost.

- **L: List some solutions.** In cases involving anxiety, watch out for proposed solutions that involve avoidance or safety behaviors, such as seeking permission *not* to give a talk in class, or taking the stairs rather than the elevator. Although anxious youths may generate such solutions, help them think of other more adaptive solutions in *addition* to these ideas—and during the "Vote for the best one" phase, make sure to note the ways that avoidance will lead to negative consequences (such as preventing a youth from learning to cope with the fear and overcome it).

- **V: Vote for the best one.** What are the positive consequences that may result from the solutions the youth has generated? What about any negatives? Weighing the pros and cons is the heart of problem solving. Since virtually every possible solution has potential benefits and risks, a valuable skill for every youth is sorting through the solution options to identify the one with the best benefit–risk ratio. To help sharpen that skill, we recommend including at least one solution option on the list that the youth will recognize as a bad idea. In some cases, it can be helpful to role-play a solution option with the youth, to provide a glimpse into how it might be done and whether it seems likely to succeed.

- **E: Explore what works.** With an anxious youth, it is helpful to practice the skill that is voted the best one, particularly if it is a solution that hasn't been tried before and may be anxiety-provoking. Make sure to discuss ahead of time how the youth will know if the solution was a success—and have Plan B (and C and D) ready to go, in case the solution tried first doesn't actually work so well. It's important to inoculate the youth against that possibility, and to frame the process as an experiment. We try one solution, and if it doesn't work, we try Plan B—that's the way we all figure out what really works. That's the key take-home message for the youth.

- **Combine S-O-L-V-E with other FIRST Skill Units.** It can be especially useful to include other FIRST skills as solution content within the sequential S-O-L-V-E steps. For example, to enhance other skills the youth has learned in treatment, Trying the Opposite or Feeling Calm can serve as a potential solution to a problem the youth is trying to solve.

TRICKS OF THE TRADE:

Solving Problems—Posttraumatic Stress

- **Introduce Solving Problems**. Youths who have symptoms of posttraumatic stress often experience difficulties managing the mood disturbances that follow the traumatic event. They may feel irritable (which can lead to conflict with others), or they may have feelings of sadness, guilt, or low self-worth (which lead them to pull away from others or from pleasurable activities). Sometimes they may engage in high-risk behaviors such as self-injury or substance use. Often feelings of personal safety are a major concern. All of these are problems—complex problems! Although some of these problems are beyond the youths' control, helping them learn to approach problems in a step-by-step manner, consider a range of potential solutions, and act to resolve problems can lead to increases in self-efficacy and restore a sense of control.

- **Make it engaging: Using S-O-L-V-E in session.** Make it clear that just about anything can be a "problem to be solved," including feeling too tired to do a therapy practice assignment or wanting to play a fun game instead of talking in session about things that are happening in the youth's life. When problems arise in therapy, use S-O-L-V-E to come up with solutions in the moment!

- **S: Say what the problem is.** It is important to work with the youth to articulate a problem that can actually be solved—especially because children who have been exposed to traumatic events have often faced problems that they were powerless to solve. Help to guide the youth toward a manageable problem. For example, "I was physically assaulted" is not a solvable problem, but "It is hard for me to trust others since I was physically assaulted" is a problem for which there might be a number of solutions.

- **O: One goal you're aiming for.** For many problems, a variety of goals may be appropriate. For the "difficulty trusting others" example just mentioned, for example, one goal might be to develop more trusting relationships. Another goal could be to find a way to express concerns that feel safer than confiding in another person, such as journaling. A third goal might be to find others who have had similar experiences to talk with. Because each of these goals will involve different solutions, it is important to make sure that the goal is clearly identified first.

- **L: List some solutions.** In cases involving posttraumatic stress, watch out for proposed solutions that involve avoidance or safety behaviors (e.g., staying away from any trauma reminders, or withdrawing from interpersonal relationships for fear of being hurt emotionally). Although youths with posttraumatic stress may generate such solutions, help them think of other more adaptive solutions in *addition* to these ideas—and, during the "Vote for the best one" phase, make sure to note the ways that avoidance will lead to negative consequences (such as preventing a youth from learning to cope with the trauma reminders).

- **V: Vote for the best one.** What are the positive consequences that may result from the solutions the youth has listed? What about any negatives? As noted above for anxiety and OCD, weighing the pros and cons is the heart of problem solving. To help sharpen the skill

of identifying the solution with the best benefit–risk ratio, we again recommend including at least one solution option on the list that the youth will recognize as a bad idea. It can also be helpful to role-play a solution option with the youth, to provide a glimpse into how it might be done and whether it seems likely to succeed.

- **E: Explore what works.** It is very helpful to practice the skill that is voted the best one, particularly if it is a solution that hasn't been tried before and may be stressful. As described above, make sure to discuss ahead of time how the youth will know if the solution was a success—and have Plans B, C, and D ready to go in case the solution tried first doesn't actually work so well. Again, trying another solution if the first one doesn't work is the key take-home message.

- **Combine S-O-L-V-E with other FIRST Skill Units.** It can be especially useful to include other FIRST skills (e.g., Trying the Opposite or Feeling Calm) as solution content within the sequential S-O-L-V-E steps, as noted earlier.

TRICKS OF THE TRADE:

Solving Problems—Depression

- **Introduce Problem Solving.** Depressed youths often develop a hopeless and helpless perspective; they may come to believe that the situations troubling them cannot be changed or improved. These youths may have a limited repertoire of solutions and may give up in the face of difficulties. Thus we want to ensure that brainstorming solutions is free from evaluation, since we don't want fear of proposing a bad idea to shut these youths down. We also want to be alert to depressed youngsters' belief that their suggested solutions will "never work," and to the risk that they may give up after trying one solution. The objective here is to empower perseverance—keeping on trying until a solution works!

- **Make it engaging: Solving a silly problem.** For some kids, it's helpful to learn S-O-L-V-E by focusing on a silly problem before turning to personal issues with emotional content. The S-O-L-V-E sequence can be introduced with any number of fun, tangible, and interactive activities, as described earlier.

- **Make it engaging: Using S-O-L-V-E in session.** As recommended earlier, try to make it very clear that just about anything can be a "problem to be solved," including various forms of not wanting to participate actively in treatment. In other words, S-O-L-V-E can be used not only for problems in everyday life, but also for problems that arise in therapy.

- **S: Say what the problem is.** Because depression often leads to cognitive errors such as exaggeration or all-or-nothing thinking, it is important to identify the true problem, and this may involve breaking the problem into small parts. The problem "Nothing is fun" might actually be several problems—including, for example, "I am bored on weekends" and "I don't have as many friends as I would like." Make sure to spend time helping the youth define the problem clearly before moving on to setting a goal or generating solutions.

- **O: One goal you're aiming for.** Once a specific problem has been identified, it is time to decide what goal the youth wants to pursue. For "Nothing is fun," the goal might be "Find

one thing to do that is really fun for me." For "I don't have as many friends as I would like," a reasonable goal might be "Make one new friend within the next month." Again, be on the lookout for all-or-nothing thinking that will lead to unreasonable goals; aiming to "Make lots of new friends in the next month" could be a set-up for failure, but "Make one new friend" might be attainable and genuinely helpful to a depressed young person.

- **L: List some solutions.** As observed above, youths who are depressed may need a great deal of help initially with this step, because they have difficulty thinking of new solutions and may be quick to move into a self-critical stance. Encourage them to brainstorm; anything goes! Actually, listing a few bad solutions—even ones so bad they are funny—is good for this exercise; practice in identifying and rejecting bad ideas is valuable.

- **V: Vote for the best one.** What are the positive consequences that might result from each of the solutions listed? What are the possible negative consequences? Help the youth evaluate each solution, considering the impact it will have on the problem to be solved *in the long run.* For instance, taking a nap may be one solution to being bored, but does it result in feeling more engaged, interested, and excited? Once again, the skill we are aiming for here is the heart of effective problem solving: weighing pros and cons to find the solution with the optimum benefit–risk ratio. You can certainly ask questions to help youths identify pros and cons, but let them make the choice—deciding which solution to vote for—based on their own judgment about the pros and cons. Increasing a sense of personal agency and mastery is especially important in work with depressed youths.

- **E: Explore what works.** The final step in S-O-L-V-E is trying solutions out, exploring how well they work in real life outside the therapy room. To prepare for this process, make sure to discuss ahead of time how the youth will know if the first-choice solution was a success—and, as always, have Solutions B, C, and D ready to go if it was not. Depressed youths may tend to be pessimistic and give up easily, so you will need to convey that the process is an experiment: None of us knows what will really work until we try a solution out in real life, and when we do, some of the solutions won't work and others will. Seeing which ones don't work is a part of learning what to rule out in the march toward finding what *does* work. We only find out by persevering. That's a key message for depressed youngsters, who might otherwise give up if the first solution they try doesn't seem to be working.

- **Apply S-O-L-V-E to predictable problems in the youth's own life.** Don't wait for another problem to arise; think with the youth about predictable stressors and daily hassles that have a negative impact on his or her mood. Choose one of these problems, and ask the youth to apply the S-O-L-V-E sequence to it during the session and for home practice.

TRICKS OF THE TRADE:
Solving Problems—Misbehavior

- **Introduce Problem Solving.** Youths who often misbehave may struggle with accurately processing information in their environment, and they may be impulsive and have difficulty tolerating frustration. All this can make them quick to react when problems arise, and the quick reactions may not be helpful ones. Impulsive solutions can lead to negative

consequences. Learning to use the S-O-L-V-E steps can help these young people avoid the reactive choices, made in the heat of the moment, that can lead to trouble.

- **Make it engaging: Solving a silly problem.** Youths prone to misbehavior may need a neutral or even silly introduction to problem solving, to ensure that they get the content without feeling they are being blamed or criticized. Once the S-O-L-V-E skills are in place, they can then be applied to personal problems in real life. The S-O-L-V-E sequence can be introduced with any number of fun, tangible, and interactive activities, as described earlier. As a "lightweight" problem like this is being solved, each step in S-O-L-V-E can be explained and discussed while it is being carried out.

- **Make it engaging: Using S-O-L-V-E in session**. Explain that almost anything can be a "problem to be solved," even things that happen in therapy. Make it clear that when problems arise in therapy, the S-O-L-V-E steps can be used to solve them in the moment!

- **S: Say what the problem is.** Increase the youth's awareness of the early stages of his or her anger or misbehavior. It will be much easier to identify and solve a problem *before* the youth becomes flooded by affect or launches an impulsive overreaction than after the flood has been released. Next, a problem can be identified that tends to push the youth into anger or unacceptable behavior. It is important to zero in on the *specific* aspect of a situation that is in fact the problem. "I get into fights at school" is not nearly as precise as "I get into fights when kids disrespect me" or, even more specifically, "When Max calls me a loser, I punch him."

- **O: One goal you're aiming for.** Different young people may develop very different goals for addressing the same problem, and youths who have behavior problems may not have even thought much about what their goals are. So an important step in S-O-L-V-E is to help a youth identify the goal that makes the most sense to him or her. Is it "Staying out of fights," "Learning a good way to handle kids who disrespect me," or "Letting other kids' words bounce off me"? Each goal could lead to multiple possible solutions, so a critical step is identifying what goal this particular youth wants to pursue before starting to generate solutions.

- **L: List some solutions.** Although you should help the youth generate some adaptive solutions, it's also important to include some less helpful solutions, particularly those the youth may be likely to try or may have used in the past. Although hitting another kid or ditching school may not be the best solutions, they could be added to the list and evaluated as options, and the negative consequences considered—to set the stage for the pros and cons exercise that comes next in the S-O-L-V-E sequence.

- **V: Vote for the best one.** The objective here is to represent the pros and cons of each solution fairly, without judgment. Although acting aggressively will often lead to trouble (and this should be listed as a "con"), it may offer the "pro" of feeling good in the moment. Acknowledging that there may be some benefits to even "bad" solutions is a key part of making this a genuine, dispassionate analysis and not a biased, adult-centric exercise. This honest approach can be critical to achieving the youth's buy-in that this is not just a disguised morality lesson.

- **E: Explore what works.** In this final step of S-O-L-V-E, the youth becomes a scientist, testing the first-choice solution to see if it works. Make sure to discuss ahead of time how the youth will know if that particular solution was a success, and make sure the youth has Solutions B, C, and D ready to go as backup plans. An objective for the misbehaving youth is to avoid reverting to old habits (anger, impulsive responding, etc.) by going into problem situations armed with a plan for which solution to try first, then next, and so on. This will help the youth understand that failed solutions are merely opportunities to learn, and that perseverance will eventually pay off.

- **Apply S-O-L-V-E to the youth's real life.** Try to identify high-risk situations with predictable triggers for the youth. These are excellent targets for identifying solutions in advance, so they are ready when the anticipated problem arises. You and the youth should practice these solutions in session, and in as lifelike a way as is feasible—for example, in a way that actually provokes the burst of frustration, irritability, or anger that typically leads to difficulty for the youth. Examples include setting up (with the youth's consent) a situation in which the youth is struggling with a puzzle that's hard to solve, or losing a game, or role-playing an argument in which you (the clinician) play the role of an irritating peer.

- **Consider motivation.** Remember that youths with disruptive behavior disorders are likely to be less motivated than other youths by intrinsic rewards. You may need to use—and work with caregivers on using—some of the Increasing Motivation procedures to generate interest and active involvement. You may also consider working with a youth to create a personalized "self-reward" procedure, particularly in cases where the caregiver is not very involved in treatment.

- **Say it aloud.** To help misbehaving youths internalize the steps of systematic problem solving, encourage them to memorize the S-O-L-V-E acronym, to rehearse it aloud in session, and to review the S-O-L-V-E steps aloud at home when they are trying to solve problems there.

Handout 21 (page 155) is a home practice sheet that can be used when youths practice Solving Problems between sessions. Handout 22 (page 156) is a guide to Solving Problems for caregivers.

Skill Assessment: Solving Problems

This assessment is used to determine when a youth has sufficiently grasped the FIRST principle and can use it to manage feelings and behaviors in everyday life. When do you decide that the youth is ready to finish treatment or move on to the next FIRST Skill Unit? Keep in mind that there is always room for more improvement, but that the goal of treatment is to help the youth and the caregiver use these principles on their own to handle the challenges that arise in real life.

Anxiety and OCD

What is the goal?

For anxious youths, the objectives of Solving Problems are to become better able to articulate the feared problem or situation that is provoking worry, to learn to set appropriate goals, and to develop a sense of mastery and competence at solving problems in real life.

Has the goal been sufficiently met?

Is a youth able to break the worry or concern down into the core fear? Can he or she come up with possible coping strategies for addressing the problem? Does the youth feel more confident in his or her problem-solving abilities?

What about the caregiver?

Does a caregiver understand the sequential S-O-L-V-E steps? Can the caregiver use these steps to help the youth solve problems that arise outside of therapy sessions?

Posttraumatic Stress

What is the goal?

For youths dealing with posttraumatic stress, the objectives of Solving Problems are to identify one or more problems they can actually solve, to develop reasonable goals for those problems, and to develop confidence in their ability to cope with problems (particularly those related to affect modulation and personal safety).

Has the goal been sufficiently met?

Are these youths able to break the worry or concern down into an identifiable problem that a young person could actually solve? Can they come up with possible coping strategies for addressing the problem? Do they feel more confident in their problem-solving abilities?

What about the caregiver?

Does a caregiver understand the sequential S-O-L-V-E steps? Can the caregiver use these steps to help the youth solve problems that arise outside of the therapy sessions?

Depression

What is the goal?

The objectives of Solving Problems for depressed youths are to become able to break seemingly large problems down into more manageable problems, to learn to set goals, to demonstrate proficiency in generating solutions and evaluating them, and to implement the solutions in real-life situations.

Has the goal been sufficiently met?

Are these youths, in session and in real life, able to use the S-O-L-V-E sequence to brainstorm solutions and choose the best one to try? If the problem is not solved, are the youths able to consider and try another solution? Does the youth feel more confident in his or her problem-solving abilities?

What about the caregiver?

Does the caregiver understand the sequential S-O-L-V-E steps? Can the caregiver use these steps to help the youth solve problems that arise outside of the therapy sessions?

Misbehavior

What is the goal?

The objectives of Solving Problems for misbehaving youths are for them to learn the sequential S-O-L-V-E steps and become able to use them in circumstances where they might otherwise revert to old reactions and make poor decisions.

Has the goal been sufficiently met?

Are the youths, in session and in everyday life, able to identify problems clearly, select appropriate goals, and generate appropriate solutions to problems that come up? Are they able to implement the chosen solutions during heated moments, consider the consequences even during times of frustration, and persevere with alternative solutions when their first choice falls short?

What about the caregiver?

Does a caregiver understand the sequential S-O-L-V-E steps? Can the caregiver use these steps to help the youth solve problems that arise outside of the therapy sessions?

Solving Problems with S-O-L-V-E: In-Session Practice

Use this form to guide your in-session practice of the S-O-L-V-E procedure. You might begin with a funny or hypothetical problem, but then progress to a real problem the youth would like to solve. Do this as many times as needed to prepare the youth for home practice using Handout 21 (a version of this same form for the youth's use).

Say what the problem is:
What is the problem you'd like to solve?

One goal you're aiming for:
What would you like to accomplish?

List some solutions:
Write down several ideas for how to solve the problem and meet your goal. Don't worry if they are good ideas. Just come up with several different solutions.

1.

2.

3.

4.

5.

Vote for the best one:
What are the good and bad things that might come from each solution—the pros and the cons? Considering the pros and cons, which solution do you vote for?

What's good about this solution?	What's bad about this solution?
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

Explore what works:
Did the solution work? If not, choose another solution from your list, and keep trying!

HANDOUT 21

Solving Problems with S-O-L-V-E: Home Practice

Use this form on your own, to figure out a solution to a problem that bothers you.

Say what the problem is:
What is the problem you'd like to solve?

One goal you're aiming for:
What would you like to accomplish?

List some solutions:
Write down several ideas for how to solve the problem and meet your goal. Don't worry if they are good ideas. Just come up with several different solutions.

1.

2.

3.

4.

5.

Vote for the best one:
What are the good and bad things that might come from each solution—the pros and the cons? Considering the pros and cons, which solution do you vote for?

What's good about this solution?	What's bad about this solution?
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

Explore what works:
Did the solution work? If not, choose another solution from your list, and keep trying!

HANDOUT 22

Caregiver Guide to Solving Problems

SOLVING PROBLEMS WITH S-O-L-V-E

A procedure we call **S-O-L-V-E** is a way to break a complicated problem into simple steps, to figure out a solution:

1. **S: Say what the problem is.** You'll need to make it clear what's wrong.
2. **O: One goal you're aiming for.** Make sure it's a realistic goal.
3. **L: List some solutions.** This is just brainstorming, so don't judge the solutions yet.
4. **V: Vote for the best solution.** Write down the pros and cons of each one, and pick the one that's most likely to help.
5. **E: Explore what works.** If the first solution doesn't work, pick another solution and try again!

In session, we practiced solving problems by using the S-O-L-V-E procedure, and we came up with a problem for your child to solve this week at home. **At first it may be difficult for your child to practice this new skill, so please provide as much praise and encouragement as you can!**

The problem my child is using for Solving Problems this week:
My child has agreed to practice this: When, in what situations, how many times?
Some golden opportunities might be:
Some helpful support might be:
To be completed after practicing: How did it go?
Did anything get in the way? If so, what?
Did you learn any new ways to make the practice work well? If so, what?

10

Using the FIRST Principles

Trying the Opposite

This principle is used to help young people try new actions that directly challenge their symptoms.

Each of the problem areas addressed in FIRST—anxiety and OCD, posttraumatic stress, depression, and misbehavior—has a core set of behavioral symptoms that lead to functional impairment for young people. In anxiety, OCD, and posttraumatic stress, core symptoms include attempts to avoid experiencing feared situations or memories—avoidance that results in a failure to learn that the fear and distress can be tolerated and thus defeated. In depression, the core symptoms may involve withdrawal from others, an increase in sedentary behavior, and avoidance of tasks that are seen as onerous or too challenging. For misbehaving youths, behaviors such as disobeying, breaking rules, or being disruptive or aggressive are characteristic. The idea of **Trying the Opposite** is to help boys and girls engage in behaviors that *directly challenge* the problem behaviors.

The goals of Trying the Opposite are for youths to identify the positive opposites of the problem behaviors; to practice those behaviors in session and at home, at school, or with peers; and to keep track of the consequences of these new actions. The last part—keeping track—is essential, because a key objective of Trying the Opposite is for young people to learn that changing their behavior can change their lives in positive ways.

It sounds simple: *Just do the opposite of the behaviors that are causing problems!* In reality, it's not so easy to "do a 180," especially when the problem behaviors have been reinforced for a long time and have become habits. Sometimes it helps to identify the ultimate goal (sleeping alone vs. with parents, getting more involved in extracurricular activities, earning parents' trust, keeping curfew) and then start with fairly easy first steps toward the goal.

Rewards (Increasing Motivation) may need to be worked into the plan in order to boost motivation, because Trying the Opposite can be hard work!

How Trying the Opposite Is Used for Different Problem Areas

For Anxiety and OCD

Anxious youths often avoid situations that make them feel tense and scared. The key to Trying the Opposite is to face the avoided situation, in order to learn that it can be tolerated, that nothing bad typically happens, and that it often gets less scary with practice. The trick is to repeat the exposure over and over in ways that promote new learning, often beginning with a less challenging situation and moving toward more difficult ones. The procedure for OCD is similar, but it differs in one way: Trying the Opposite involves exposure to situations that increase obsessions, *plus* preventing the compulsive rituals that have been used to neutralize the fear. The key goal in Trying the Opposite for both anxiety and OCD is expectancy violation—that is, learning that the feared bad outcomes do not actually happen or can be managed, and thus that avoidance and obsessive–compulsive cycles are not actually protecting the youths from any real danger.

For Posttraumatic Stress

Posttraumatic stress can offer challenges similar to those of anxiety, but in addition to avoiding physical reminders of the traumatic event, youths may also try to avoid their own traumatic memories. Because these memories can plague the youths in such forms as nightmares, flashbacks, and intrusive thoughts, Trying the Opposite for traumatic stress involves helping youths gradually confront their memories so that they can be in control of them, instead of controlled by them. Exposure to avoided people, situations, and places that remind them of the traumatic event, but are actually safe, is another form of Trying the Opposite for posttraumatic stress.

For Depression

Depression can make girls and boys want to isolate themselves, sleep, slow down, and stop doing activities—even activities that would be rewarding if they tried them. Sometimes this isolation and avoidance bring relief in the short term, but over time they wipe out opportunities for reinforcement. Reducing physical activity also limits the natural biological processes that enhance mood. Withdrawal from peer activities reduces opportunities to have fun. Failing to complete homework or home responsibilities reduces opportunities for mastery, for praise from others, and for the intrinsic satisfaction of personal accomplishment. The world can end up being a bleak or even punishing place, and the isolation and avoidance can cause new problems of their own. The key to Trying the Opposite for depression is to introduce the idea of acting from the "outside in" (trying out behaviors and checking how they make youths feel) instead of from the "inside out" (letting moods dictate behavior; see Martell, Dimidjian, & Herman-Dunn, 2010).

For Misbehavior

Youths who often misbehave need to practice doing the opposite of what is often their first impulse—to disobey, break a rule, or strike out in anger. Trying the Opposite for these youngsters may involve practice in handling potentially conflictual situations without getting angry, blowing up, or violating a house rule. It's useful to have these youths identify common scenarios in which misbehavior is most likely to arise, and then practice adaptive ways to deal with them, including the kinds of verbal and nonverbal behaviors that are incompatible with the problem behavior. Often the problems arise during conflictual interpersonal interactions, so rehearsing calm responses to such not-so-calm situations can be very useful. The role plays may begin with relatively easy situations, then move to more and more challenging ones. The closer each rehearsal comes to replicating a real-life situation, the more likely the practice is to be translated into behavior change in real life.

Skill Unit Objectives

Note: Multiple sessions will almost certainly be required to cover the full Skill Unit; therapist and client should continue until the skill of Trying the Opposite has been mastered.

- The youth will understand the way his or her behavior causes problems for self and others, and makes it hard to reach personal goals.
- The youth will develop a plan for using Trying the Opposite in situations where the problems have happened in the past, or when symptoms arise.
- The youth will practice trying the opposite behavior, moving from easy to more challenging situations.

Skill Unit Outline: Trying the Opposite

Remember this in every session:

SESSION COMPONENTS [Note: These should be included in every session.]

- **Create an agenda** of what will be covered in the session.
- **Review practice,** if any was assigned in the prior session.
- **Share the news** of any new skills or information covered in session with the caregiver or the youth at the end of the session (as appropriate).
- **Assign practice** for one Trying the Opposite behavior that the youth is learning to carry out in real life.
- **Assess skill acquisition:** Is good progress being made toward treatment goals? Is it time to move to another Skill Unit or consider ending treatment?
- **Finish strong:** End the session on a strong positive note that affirms your relationship and positive feelings toward the youth and/or caregiver—perhaps by doing an engaging activity together, praising the youth and/or caregiver for an important accomplishment in therapy or in real life, or noting how much you value the chance to work with the youth and/or family and are looking forward to the next session.

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Talk about the way(s) the problem manifests itself behaviorally.	What are the situations where anxiety/OCD, posttraumatic stress, depression, or misbehavior shows up, and how does the youth look, talk, and act when these problems arise? How can we tell the problem is happening? (The behavior may be avoidance in the case of anxiety, acting out a compulsion in the case of OCD, attempts at thought stopping with posttraumatic stress, or aggression or rule breaking in the case of misbehavior.) The goals are to find out the behavioral manifestation of the problem in the youth's life, and to identify specific ways it is causing difficulty for him or her.	Depending on the problem area, different behaviors will be the focus. it may be useful to begin the discussion by talking about how other boys or girls respond to feeling scared/sad/mad/cranky/angry, or acting out scenarios or play charades in which different behaviors in response to these feelings are acted out (see "Tricks of the Trade"). Moving from examples for "other kids" to examples for the client can be a good way to introduce this topic.
Explain that what we do affects how we feel (and think).	Explain that our behavior, thoughts, and feelings are all connected, like the points of a triangle, and that our actions have a big effect on how we feel physically and emotionally, and how we think. Connect this reasoning to the youth's specific problem behavior and how it relates to his or her emotions, body sensations, and thoughts. Make the key point that if the behavior changes, the other parts of the triangle will change as well.	Tailor this explanation to the problem area. For a youth with anxiety, avoiding the feared situation usually brings immediate relief from the physical sensations of fearful arousal, but it can mean that the feared situation continues to seem terrible and beyond the youth's ability to cope. A depressed youth may feel fatigued and decide to skip homework and nap instead. This leads to immediate relief, but later feelings of guilt or anxiety—maybe to the thought "I messed up again, and now I am going to be in trouble." A youth prone to misbehavior might get louder and louder during disagreements, and the raised voice might send a message to the body that it's time to fight—and then trouble ensues. It may help to diagram the relationships, as discussed in "Tricks of the Trade."
Explain what Trying the Opposite means.	Trying the Opposite means doing the exact opposite of what feeling scared, sad, or angry tells us to do. It is a way to help us move toward the things we want to accomplish in life without letting our problems get in our way. For example, the opposite of avoiding something scary is to facing it. The opposite of just sitting and not doing things is getting active and using our energy. The opposite of arguing or fighting with people is staying calm and being polite.	**Example Script** "If you didn't feel [scared/sad/mad/cranky], what would you be doing instead? That's the opposite behavior! So, specifically, if you weren't [afraid of bugs/sad all the time/always getting angry], what would I see you doing? For some kids, this might be trying things they have been avoiding, doing things they've been afraid to try, or controlling an impulse they've always given in to." The opposite behavior may sound like a very bad idea to many youths. Impress upon them that the times when it is most important to try the opposite behavior may be exactly when they least want to do so.

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Identify the challenging behaviors, the situations when they occur, and some opposite behaviors.	What are the things right now that are hard to do, but that the youth really needs to do (or others wish the youth would do)? What are the different aspects of these situations that are difficult to do successfully, or that the youth doesn't want to do?	This identification may take the form of a list, or you might use separate index cards for each challenge. The items might be situations that are avoided, reinforcing activities that the youth has withdrawn from, or interpersonal situations where it is hard to stay out of trouble.
Rate the opposites.	Considering what the youth is currently able to do, rank the alternative opposite behaviors from easiest to most difficult. How hard would it be to try each behavior? Would another one be easier? Would it be easier or harder in a different location, or with different people? Remind the youth that these behaviors will be approached one at a time, typically moving from easiest to more challenging, and that the youth will get used to each one before moving on.	The youth will need a way to rate the difficulty of the action or the strength of the feelings (e.g., 0 = "not angry . . . easy to do," 10 = "very angry . . . hard to do"). Make sure the youth has a good understanding of which opposite actions will be easier or more challenging to do. Create a hierarchy from the easiest activities or situations to the hardest or most demanding.
Develop a plan.	How will the youth practice the opposite behavior outside of the session? When and where, and how many times, will the youth try it? What arrangements can be made to make the practice most workable and likely to succeed? How will the youth know when the opposite action has been established and is working well, so that he or she is ready to move forward?	It's always best to begin practicing in session, so that you can support the young person's first attempts, and assist with any fine-tuning. The practice may involve facing a fear, trying a reinforcing activity, or using prosocial interpersonal skills. Then consider together how the youth can practice over the next week, outside the session. **Example Script** "Let's try it out together. You've said that [taking the elevator/going for a walk/asking for help] is something that will be sort of hard for you. How hard will it be? Let's try it together and find out. . . . Now that we've done it once, let's do it again and see if it gets easier."

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Practice makes perfect!	Like any new skill, any form of Trying the Opposite is likely to require lots of practice. At first the new behavior may feel artificial, and may even cause the feelings of anxiety, sadness, or irritability to get worse. Over time, however, the new behavior will become easier and feel more natural. Make sure that the youth works toward newer and harder opposite behaviors after the easy ones are mastered, repeating them until they are well established. And stay in close touch with your young client about how the process is going.	What are some things the youth can do now that seemed really hard at the beginning? These might include skills that are academic (e.g., a specific math procedure), athletic (e.g., a soccer move, a batting skill in softball), or musical (e.g., playing an instrument). Ask for examples of how the youth first learned to do these things. The youth will probably say that the steps included deciding to try the skill, and then practicing it.
Reflect on new information.	Ideally, trying out the new positive opposite behavior will be a corrective educational experience, teaching the youth new things about what actually happens when the new behavior is used, and how practice makes perfect. You can help ensure that this learning takes place by teaming up with the youth frequently to summarize the new information he or she is learning. This should happen in real time when practice is done in the treatment session. It should also happen after the fact, when you discuss how things went when the positive opposite behavior was practiced in real life.	It's a good idea to help youths make predictions before trying out the positive opposite behavior ("I'll pass out if I see a snake," "I won't have any fun at the party," "My mom won't listen to me anyway") and then compare these predictions with the actual experience. How was the actual experience different from what they had expected? What did they learn about fear, or about how exercise makes them feel physically, or about the use of an emphatic statement when talking with a parent? What did they learn about their own abilities?

Additional Suggestions

Developmental Differences

Trying the Opposite involves doing the opposite of what comes most naturally, and what may have been actively reinforced for years. So a motivational boost may be needed to get youngsters to try these activities. For children, the procedures described in this section may need to be supplemented by concrete incentives, as described in Chapter 7 on Increasing Motivation. With very young children who lack insight, much of the work can be mediated through their caregivers—for example, planning for "sleeping challenges" for a 6-year-old with separation anxiety, where the therapist works primarily with the adults to develop and implement the treatment.

Using Trying the Opposite in Real Life

A critical goal is to ensure that a youth practices Trying the Opposite in real life outside the therapy sessions—in other words, where a problem behavior actually interferes with the youth's life. At termination, it is critical to ensure that the youth has practiced the skill successfully multiple times outside therapy, and has made clear plans for continuing to use Trying the Opposite in everyday life after therapy has ended (including anticipating new challenges that will arise, and determining how Trying the Opposite will be used to respond to them).

Involving the Caregiver

A key to treatment is enlisting the caregiver to ensure that the youth adequately practices trying the opposite behavior when it is most needed—when anxiety, OCD, posttraumatic stress, depression, or disruptive conduct is most likely to surface in real life. The caregiver will need to learn from the therapist how to coach the child through these situations; for example, an anxious caregiver must resist the urge to "rescue" an anxious youth when anxiety arises, and instead must note and encourage brave behaviors. Parents of depressed and disruptive youths will want to pay particular attention to (and praise!) new, adaptive behaviors. Although adaptive behaviors may seem normal and expectable for many youths, and perhaps not worthy of lots of attention, the behaviors may be much harder for youths in treatment. So caregivers should reinforce any efforts in the right direction. In some cases, a therapist may need to shift a caregiver's energy and attention *away* from the problem behaviors and toward new, more positive behaviors, thus helping the caregiver use differential attention as a reinforcer (again, see Chapter 7 on Increasing Motivation).

Taking It to School

If the problem behaviors are manifested at school, then that is where the practice needs to take place. Teachers can and should (if possible) be enlisted to support youths' efforts to increase positive actions. It may help to provide some details about the strategy to help parents and teachers develop patience; for example, a youth who is avoiding school altogether may need to begin with just 1 hour of attendance a day. A student who has stopped doing homework during an episode of depression may need to collaborate with the teacher to develop a makeup plan. Saying "Hi" to a teacher and making eye contact may not seem like much, but it could be a great first step for a youth who has frequently responded in a hostile way to teachers.

TRICKS OF THE TRADE:

Trying the Opposite—Anxiety and OCD

- **Identify the behavioral manifestations.** Youths who have anxiety-related problems or disorders (such as specific phobias, separation anxiety disorder, social anxiety disorder/social phobia, or panic disorder), or even OCD, often display behavioral avoidance, going

out of their way to avoid situations or stimuli that make them feel anxious. If these situations can't be avoided, they are often endured with great distress, and sometimes youngsters try to make the situations more tolerable by using safety behaviors (such as carrying a lucky object or repeating a neutralizing ritual over and over). Youths with generalized anxiety disorder may not avoid situations, but instead spend much of their time worrying about scary events that are highly unlikely or may be quite manageable. They may experience muscle tension and other somatic concerns and may repeatedly ask others for reassurance about their worries.

- **Explain that what we do affects how we feel (and think).** It can be helpful to share the cognitive-behavioral model of anxiety, whereby misinterpretation of threat leads to anxious arousal and fear, typically followed by avoidance and relief. Explain how the act of avoidance reinforces the fear and prevents us from learning that what we fear will not actually happen, and that we can tolerate the feelings of anxiety anyway! Anxiety is the body's built-in alarm signal, and anxiety disorders are the result of false alarms (the signal goes off even when there is no actual danger). Facing the fear and learning that it can be tolerated constitute a crucial corrective experience, changing how we will think and feel in the future.

- **Introduce exposure or exposure plus response prevention.** For anxiety disorders that involve behavioral avoidance, Trying the Opposite involves facing feared situations—often starting with relatively easy ones until a youth can tolerate those, then moving on to the next item on the youth's fear hierarchy, and so forth. This is called *exposure*, and many experts agree that it's *the* most important and effective treatment procedure for anxious avoidance. For a youth who does not show avoidance but instead engages in frequent worry, trying the opposite behavior is twofold: (1) to introduce focused "worry periods" when the youth engages in imaginal exposure to the worst-case scenario, and (2) to reduce reassurance seeking by removing the reassurance (e.g., from parents). For a youth with OCD, facing the feared stimuli (exposure) is paired with preventing the ritual that typically accompanies it. This is called *exposure and response prevention.* Just as fears should be graded and approached systematically, some rituals will be easier to prevent than others, and the easier ones are typically addressed first.

- **Make it engaging: Bravery Box**. Give the youth a shoebox or other small container to decorate as a "Bravery Box." The youth writes down each Trying the Opposite activity completed on one side of a slip of paper, and what he or she learned from the activity on the other side. Storing these slips of paper makes the accomplishments tangible, reinforces accomplishments, and helps to consolidate new learning. The slips are also good to review if a youth gets "stuck" and needs reminders of what he or she has done and learned already.

- **Develop a plan.** Tell the youth that the two of you will develop a list of all the different situations and things that cause fear, so that you can begin working together to overcome these fears. Reassure the youth that you'll decide together which situations to face and when: "It's like going into a swimming pool. First you dip a toe in; then you wade in up to your knees; and after that's comfortable, you go a little deeper." Develop a "fear ladder" of all the youth's worries and avoided situations that are not realistic. Sometimes a youth might have a "master" fear ladder with broad categories (e.g., "Going to school," "Bedtime") and additional,

more specific fear ladders that break these broad categories into smaller steps (e.g., "Sleeping in my mom's room in a sleeping bag on the floor," "Sleeping in my room with my mom checking every 10 minutes," "Sleeping alone in my bed all night"). Don't list any *realistic* fears or worries about events that are likely to occur; it's only the unrealistic ones that the youth needs therapy for. For a youth with OCD, also make a list of the accompanying compulsions and how scary or difficult it would be to face the avoided situation without engaging in the compulsion. Some youths may not be aware of all the different rituals they engage in, so you'll need to monitor them carefully for a week or so, building up your picture of each individual youth's specific behaviors.

- **Make it engaging: A map of the anxiety.** As an alternative to making a fear hierarchy, create a "map" of the youngster's life, showing the "territory" that is currently controlled by the anxiety (e.g., "The anxiety controls my friendships, because I feel scared to talk to new people"). Then show another territory that the child controls, without much anxiety (e.g., a sport or school subject in which the child excels). The goal is to move more and more activities or domains into the territory that the child controls.

- **Practice together.** For anxiety, it is always best to begin with an *in vivo* exposure in the session. Start with something that is not too difficult for the youth, but that still increases anxiety. Do the behavioral exposure, and then check on how fearful the youth is now relative to what was expected, using a formal rating scale (we recommend a scale of 0–10, where 0 indicates no fear and 10 is the highest level of fear). Do it again! And again! The key to successful exposure is repeating it so that youths begin to learn what **actually and typically** happens in the presence of the feared stimulus—what happens to them emotionally and physiologically, and how able they are to handle it. If it is not possible to have the actual feared object in the session, consider either doing actual exposure during a field trip, doing an imaginal exposure (in which the youth visualizes the feared item or views it on YouTube), or conducting a role play of the exposure to the feared object that the youth will carry out independently after the session. Because successful exposure requires tolerating anxious arousal, the youth should *never* use calming, relaxing, or distracting procedures during exposure; those would reduce the anxious arousal and thus undermine the exposure.

- **Practice together: Worry exposures**. For generalized anxiety disorder (where there is no behavioral avoidance, but intense worry and associated somatic symptoms), worry exposures can be used. In this disorder, verbal worry may often be used as a distraction from the fear. By focusing intensively on the worst outcome of the worry without permitting verbalizations and reassurance seeking, the youth can expose him- or herself to overestimation of threat and underestimation of the youth's own ability to manage the situation. The steps in a worry exposure are as follows:

1. Select one of the situations the youngster most often worries about.
2. Identify the most feared outcome of this situation by continually asking, "And then what?" until you've arrived at the worst-case scenario.
3. Conjure up an image of the most feared outcome. Make it vivid—for example, by asking the youth to write a story about it in session.

4. Ask the youth to focus on the feared outcome for 25 minutes as intensely as possible, perhaps by reading and rereading the story or having you (the therapist) read it aloud.
5. After the exposure is complete, ask the youth to identify alternative outcomes or explanations/coping thoughts. Many of these may have come to mind while the youth was doing the exposure.

■ **Practice together: Exposure plus response prevention.** Exposure for OCD will involve gradually facing the situations that typically provoke the compulsion while preventing the compulsion from happening. Although it may be too hard to eliminate the compulsion completely at first, delaying it or changing it in some way (e.g., waiting 10 minutes before handwashing, or repeating a phrase two times instead of three) can be a good start. Eventually, you will want to prevent the compulsion altogether while facing situations that provoke the obsession or the discomfort. Figure 10.1 is an example of what a fear ladder that guides exposure plus response prevention might look like for a youth who has contamination obsessions.

■ **Assign practice.** For practice between therapy sessions, the youth completes repeated exposures to the feared object or situation several times (repetitions) and on multiple occasions, monitoring how fearful he or she is each time. These repetitions need to be structured so that they genuinely *bring on the fear!* It is critical that exposure *not* be mingled in any way with calming exercises or relaxation, and that it be repeated again and again, both in the immediate moment and across time. This is because exposure only works its magic if it produces distressing arousal at the beginning, and if the youth learns that he or she can tol-

Situation	Fear rating	Ritual that follows	Fear rating if ritual is prevented
Reading the word "sick" or an illness word in class.	3	Use antibacterial gel; say the word "healthy" 5 times.	6
Seeing a commercial about disease or illness.	5	Wash hands until feeling goes away.	7
Hearing someone sneeze.	8	Wash hands or shower.	8
Sitting in a doctor's office.	9	Apply antibacterial gel and repeat the word "healthy" the entire time. Shower when home.	10

First exposure might be to read the word "sick" and delay applying antibacterial gel or eliminate saying "healthy."

Figure 10.1. Sample fear-producing situations, rituals that follow, and fear ratings.

erate these feelings. A sampler of possible exposure practice assignments for various anxiety disorders and OCD is provided in Figure 10.2.

■ **Try practice variations.** Maximize exposure! Although traditional graduated exposure is a tried and true method, there is evidence that some other approaches may prevent relapse and lead to lasting change. Exposure that focuses on the violation of expectancies (e.g., finding out that predictions don't come true), rather than on fear reduction, may increase the new learning that is needed for long-term relief from anxiety (Craske et al., 2008; Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014). To violate expectancies, find out what the youth is predicting will happen (e.g., "If I stutter everyone will reject me," or "I will faint if I have a panic attack"), and design exposures that explicitly test these expectancies. This is a good reason to avoid Repairing Thoughts prior to exposure: The expectancies need to be as irrational as possible, to highlight the contrast between the expected and actual results of exposure. Combining different feared stimuli in an exposure, after each has been separately extinguished, is another way to maximize exposure. For example, a person who was first exposed to elevators and separately exposed to feeling lightheaded from spinning would eventually try the combined exposure of spinning while on an elevator. Finally, variability—moving around the fear ladder from one hierarchy item to the next (repeating each many times), rather than proceeding in the standard low-to-high sequence—may also prevent spontaneous relapse.

■ **Develop a contract for following through, if necessary.** How is the youth's motivation? Consider whether or not Increasing Motivation via self-praise or tangible rewards will be helpful.

TRICKS OF THE TRADE:

Trying the Opposite—Posttraumatic Stress

■ **Identify the behavioral manifestations.** Youths who are coping with posttraumatic stress often go out of their way to avoid thinking about the traumatic events they experienced—engaging in efforts to push the memories away, sometimes becoming detached or emotionally blunted, and at other times remaining on guard and vigilant for possible threats. Sometimes youths will engage in risky behaviors as a way to distract themselves from thinking about the traumatic event or feeling a loss of control. Some youths may also physically avoid people, places, or things that remind them of the trauma. Despite best efforts, the memories often force their way in, through flashbacks, nightmares, or intrusive thoughts.

■ **Explain that what we do affects how we feel (and think).** It can be very helpful to explain to young people that the human body's built-in alarm system automatically goes into fight, flight, or freeze mode when it senses danger. This is a good thing in many ways, because it can help keep us safe. However, the alarm system may malfunction in some cases following traumatic events. Traumatic situations involving real danger may trigger the alarm, and afterward the system may work overtime, even when there is no longer a real danger. Whenever the alarm system senses that the trauma may be about to happen again—perhaps triggered by a memory or a trauma reminder—it goes into fight, flight, or freeze mode again.

Separation anxiety disorder	1. Remain in different room of house than caregiver for *X* time. 2. Remain on different floor of house than caregiver for *X* time. 3. Refrain from phoning caregiver excessively when apart. 4. Stay with a babysitter. 5. Separate before school in the morning with bravery (e.g., no clinging and no crying or begging). 6. Do an extracurricular activity without caregiver. 7. Go on a drop-off playdate. 8. Sleep in own bed, rather than with caregiver. 9. Go to a sleepover at a friend's house. 10. Go to sleep-away camp.
Social anxiety disorder (social phobia)	1. Order for self in a restaurant. 2. Ask a store clerk a question. 3. Answer the phone. 4. Call a friend or family member on the phone. 5. Take a survey of others in the clinic. 6. Have a conversation with a new person for *X* minutes. 7. Give an *X*-minute speech in session, topic of own choice, with prep time. 8. Give an *X*-minute speech in session, topic of clinician's choice, with limited prep time. 9. Give a book report in front of a small group of students or teachers. 10. Give a book report in front of the class.
Specific phobia of dogs	1. Look at cartoon images of dogs. 2. Look at real images of dogs. 3. Watch videos of dogs. 4. Look at a dog across the street; move progressively closer. 5. Pet a dog on a leash (repeat with dogs of increasing "difficulty"). 6. Stand outside an off-leash dog park for increasing periods of time. 7. Sit in an off-leash dog park; pet at least *X* dogs.
School refusal	1. Drive (or have caregiver drive) to school; sit in car in front of building. 2. Walk around school building when students are not present. 3. Attend 1 hour of school in preferred location. 4. Attend one class. 5. Attend a half day of school in classroom. 6. Attend a full day of school (half in class, half in preferred location). 7. Attend a full day of school, in classroom.

Figure 10.2. Examples of fear hierarchies for various forms of anxiety and for OCD.

Panic disorder with agoraphobia	1. Practice "bringing on" symptoms of panic (e.g., run in place, hyperventilate, spin in a circle). 2. Remain in previously avoided situations (e.g., enclosed/crowded places, open spaces) for increasing periods of time. 3. Remain in avoided situations *while* bringing on symptoms of panic for increasing periods of time.
OCD (compulsions/ rituals)	1. Change one aspect of a ritual in a way that breaks the rule (e.g., don't wash fingers in order). 2. Shorten the ritual (e.g., wash for 10 rather than 15 minutes). 3. Postpone the ritual for longer and longer predefined periods of time until eventually "waiting it out" (e.g., delay washing hands for 1 hour).
OCD (obsessions only)	1. If present, gradually reduce safety/checking behaviors (e.g., if fear is "My front door may not be locked—a kidnapper might get in," these behaviors might include going downstairs to check the door, over and over again). 2. Write down the fear/obsession (e.g., "The door may not be locked—a kidnapper might get in."). 3. Read the fear/obsession aloud. 4. Make recording of self stating the fear/obsession; listen repeatedly. 5. Listen to the recording repeatedly in relevant context (e.g., while sitting in bedroom upstairs) without engaging in safety/checking behaviors.
Generalized anxiety disorder	1. Change the way reassurance is provided (e.g., caregiver writes down reassurance for later reading, or reassurance is given after a 5-minute delay). 2. Gradually reduce number of times reassurance is provided. 3. Engage in repeated imaginal exposure to worst-case scenario (e.g., "I did not study enough, and so I failed the test"). 4. Engage in repeated imaginal exposure to worst-case scenario with little to no reassurance provided.

Figure 10.2 (*continued*)

That can make us feel very unsafe. Young people who try to avoid the memories or situations that carry trauma reminders may miss the chance to discover that they are now safe—that what happened is in the past *is* in the past and no longer poses a threat.

■ **Introduce exposure.** For posttraumatic stress, Trying the Opposite consists of extended exposure to the traumatic memories—often starting with a relatively easy part of the story until the youth can manage the feelings it generates, and then moving on to the next part of the story. For youths who also show behavioral avoidance of nonharmful trauma reminders, Trying the Opposite includes gradually exposing themselves to those reminders, as in the case of the planned exposure described previously for anxiety. In the case of exposure to traumatic memories, the goal is to learn that the memories are painful but not dangerous, and to gain control *of* them rather than being controlled *by* them.

- **Develop a plan.** An important preliminary step may be needed before delving into the traumatic memory: Youths may need to be taught how to manage the feelings of anxious arousal and dysregulation that can come from talking about traumatic events. In order to process the traumatic event adequately through exposure to the memories, a youth needs to be able to integrate an awareness of the safe present moment with the experience of revisiting a situation in the past that was clearly not safe. If revisiting the past produces too much arousal, a result can be dissociation or panic, preventing the necessary integration. Too little arousal can prevent the youth from engaging the emotional and physical experience of the traumatic memory, which is also needed to complete processing. Feeling Calm can be used to strike the right balance between too much arousal and too little, and is used as a complement to Trying the Opposite for traumatic stress. Without going into depth, explore with the youth the memories related to the traumatic event that are causing distress. It is good to use brief phrases (e.g., "when Frank hit Mom") as "place holders" for these memories. For youths who had an isolated traumatic experience, the entire experience may be the focus, but perhaps particular aspects of the event are especially distressing while others are easier to bear. For youths who have experienced repeated traumatic events, the worst memory will be the focus of the work, in order to ensure that excessive time is not spent revisiting multiple traumatic events. If the worst memory can be faced, the others can all be faced. However, that worst memory may need to be approached gradually—starting with the easiest aspect of the worst memory, skipping over particularly challenging parts to be saved for another day, and facing the most painful aspects of the memory only after the easier parts can be tolerated. Ask the youth to rate the anticipated difficulty in talking about each of the different aspects of the traumatic event. It is fine to go out of chronological order while writing the story; you and your young client will eventually put it into the correct sequence.

- **Practice together.** The process of exposure to the memories involves having the youth tell the story of the traumatic event. A therapist often writes the story as a youth tells it, so that the youth is not distracted and so that the story can be read again and again. It's good to begin by having the youth describe something neutral that is unrelated to trauma—simply to acquaint the youth with the process of producing a self-focused narrative—and then asking him or her to read and reread it. For example, a good beginning might be a paragraph about the youth's likes and dislikes, closest friend(s), and hobbies. In subsequent sessions, the youth will construct an account of the traumatic event and then engage in repeated exposure by reading and rereading what has been written, until the reading can be done without hesitation, excessive distress, or fearful arousal. Relaxation is often used at the start and finish of the session, in order to help the youth revisit the event while maintaining awareness that things are safe at present. The writing may begin with the parts of the story that are easiest to write about, and then move toward those that are more challenging. Difficult sections can be "skipped" in one session and returned to later. Some youths may find that they are very activated during the writing and reading; it may feel as though it's all happening again. To reduce the risk that this might happen, it can be useful to switch to the past tense, to remind youths that "You are safe here in the room with me," and to encourage them to keep their eyes open. In contrast, some youths' affect during the reading may be flat or blunted, and

need to increase their emotional engagement with the material. For these youths, it can be helpful to ask them to close their eyes and use the present tense. During the writing, prompt the youths to tell you what they saw, felt, smelled, and heard, and what they were thinking.

- **Practice together with caregivers.** It is very important to involve a nonoffending caregiver throughout treatment, in order to help the caregiver understand what the procedure is, and to enlist his or her support. The caregiver needs to know that the process entails having the youth tell the story of a traumatic experience, and learn by telling that story that the feared memories are not a current threat. Ideally, the treatment plan will include having the youth eventually share the story with the caregiver—to generate support for the youth, strengthen the caregiver–youth relationship, and encourage the youth to come to the caregiver when bad things happen. It is critical, however, to prepare the caregiver to hear the story, by meeting separately (without the youth) and sharing portions of the story as it is being written. This will give the caregiver advance warning about what may be a painful story, and enable the caregiver to process his or her own emotions about the story, so that the caregiver can be strong and supportive when the youth shares the story—and can praise the youth for the courage it took to do that. The caregiver's response is so important that it would be wise to rehearse with the caregiver what the specific praise and feedback will be. That will help set the stage for a corrective experience wherein the youth shares the story, learns that he or she and the caregiver can tolerate it, and grows closer to the caregiver through that process.

- **Assign practice.** Typically, the repeated exposure to a traumatic story occurs *only* in session. For practice assignments, youths should use the other coping skills from FIRST that they have learned and found helpful in managing strong emotions (e.g., Feeling Calm).

- **Reflect on new information.** Once the story has been written and the youth has read it many times and can do it without distress or fearful arousal, look through the story to identify any thoughts, feelings, or perspectives that have shifted since the youth has been in treatment. Perhaps the youth wrote, "It was all my fault," but has since come to recognize that abuse is always the fault of the abuser. Taking a nonjudgmental stance, you and the youth should look through the story to identify any cognitive distortions, negative attributions, or other unhelpful thoughts, and work to make them better reflect the youth's current perspective.

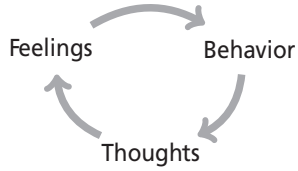
- **Contract for following through.** How is the youth's motivation? Consider whether or not Increasing Motivation via self-praise or tangible rewards might be helpful.

TRICKS OF THE TRADE:
Trying the Opposite—Depression

- **Identify the behavioral manifestations.** Depression often presents in youths as decreased involvement in or pleasure from activities that once were enjoyable. Other symptoms may include feelings of fatigue, irritable or hopeless mood, or social withdrawal and isolation. Depressed youths may complain that "nothing is fun," or say they don't feel like doing much of anything. Suggestions for activities or interactions are often met with resis-

tance, avoidance, or protests that "it won't work." Some of the symptoms (such as disengagement) may provide a bit of relief at first, but will soon lead to problems with school, parents, and peers, and can serve to perpetuate the cycle of depression. Explain what the pathway into depression looks like and what the pathway out might be, using examples garnered from the individual youth. For example, withdrawing into solo video games may have led to poor grades, which led to punishment and missed opportunities for fun, which in turn led to feelings of fatigue and disengagement from friends. The way out of depression in this case can begin with a single positive opposite behavior (e.g., getting out of bed or calling a friend).

- **Introduce behavioral activation and reengagement in pleasant events.** To combat feelings of lethargy and withdrawal, the opposite behavior is challenging avoidance through reengagement in pleasant events and behavioral activation. Introduce the notion that what we do affects how we feel. This is an excellent time to demonstrate how behaviors, feelings, thoughts, and consequences are all related in a reciprocal cycle:



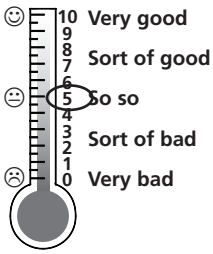
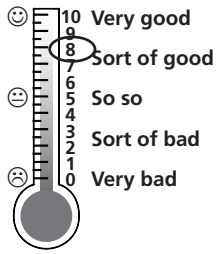
- **Make it engaging: Mood boosters.** Show the youth *in session* how feelings and behaviors are connected. First, induce a negative mood by asking the youth to think of a bad day or to focus on a sad story, song, imagined situation, or (brief) video. Ask the youth to describe what effect this experience would have on mood, on feelings in the body, and on what he or she would feel like doing. Next, introduce a brief, enjoyable physical activity in session—something you are confident your young client will like, or at least laugh about. This might involve doing something silly like hula-hooping, shooting hoops (or maybe just trash can basketball), going for a quick walk outside, playing an uplifting song, or anything else that seems pretty certain to be a quick mood booster. Now ask the youth to compare how he or she is feeling at this moment to how he or she felt before, using the same questions as before. How have the mood, bodily sensations, and so on changed? Use this contrast to illustrate how doing something—even something quite simple, and even when we don't necessarily want to—can make us feel better. Use this same strategy for times when the youth shows up for the session in a grumpy mood, appears uninterested or fatigued, or can't get his or her mind off of something bad. The idea is that increasing reinforcing activities helps the youth to feel better, think about his or her problems more productively, and prevent a return of symptoms.

- **Make it engaging: Daily mood monitoring**. As another approach, ask the youth to log his or her activities and mood on a 0–10 scale over a week or more. Look for patterns in mood related to behaviors. This can go a long way in demonstrating to young people that some of their everyday behaviors—in some cases, behaviors they have hardly noticed—are influencing their mood in significant ways. When the log shows a sudden boost in mood, what was happening just before that? Finding out can reveal actions that resulted in a better mood (e.g., maybe completing homework led to relief and a pleasant sense of calm, even though it

was boring). Conversely, when the log shows behaviors followed by plummeting mood, this is useful information as well (e.g., the youth hit the snooze button repeatedly, so overslept, was late to school, and felt embarrassed and down).

■ **Develop a plan.** What are some things the youth used to do for fun, but is now doing much less or not at all? What are some new things, not yet tried, that might be enjoyable? Who are some people with whom the youth once enjoyed spending time? It can be helpful to make lists of easy, fun, active things the youth can do, even if he or she is skeptical that they will really help. Then select some of these positive opposites and schedule them into the youth's week, as in the example below. The sample calendar below can be used to rate how difficult the youth thinks each activity will be, which will enable him or her to begin by scheduling those that are fairly easy. Once the youth has some successes, consider adding more challenging opposite behaviors to the weekly schedule. It can be interesting to compare the youth's predictions of what doing the activity will be like to the reality once the activity has been tried—this can help the youth consolidate information about expectations versus what actually happens when Trying the Opposite is actually tried. Depressed youths may be quite skeptical about whether this will work—encourage them to treat Trying the Opposite as a series of "experiments."

Sample Calendar for Developing a Trying the Opposite Plan for Depression

Day	How I Felt Before (0–10)	My Trying the Opposite Assignment:	How I Felt After (0–10)
 Monday		Instead of going to my room, hang out in the living room with my dog and my mom for 30 minutes and play cards.	

■ **Develop the plan further: Contrast short-term with long-term results.** For some youths, the avoided activities aren't exactly "fun" in and of themselves, but these activities may increase opportunities to experience reinforcement. For example, doing homework increases the likelihood of receiving praise from a teacher, experiencing confident feelings in class, or earning privileges at home. Although completing homework may not be "fun" in the short term, what are the long-term benefits? It can be helpful to consider various actions with regard to the long- and short-term results. Sometimes it is worthwhile to endure a short-term hassle if the benefits in the long run improve mood or open up access to valued reinforcers. Likewise, some of the behaviors that make youths feel better in the short run can be punishing over time, and it is helpful to put this on the "radar" of your young clients. Helping them consider possible activities with regard to their long- and short-term consequences, as in the example below, may help them better understand how behavior influences mood.

Behavior	Short Term	Long Term
Cleaned my room	– (Annoying, boring)	+ (Parents stopped nagging, my room is a nicer place to be)
Made curfew at 10 p.m.	– (Missed out on fun)	+ (Wasn't grounded, can go out next weekend)
Answered my mom's questions without showing attitude	+ (Avoided nagging)	+ (She offered to give me a ride)

■ **Assign practice.** For practice, the youth will try to do the scheduled activities and note how the activities change his or her mood overall.

■ **Develop a contract for following through.** How is the youth's motivation? Consider whether or not Increasing Motivation via attention, praise, or tangible rewards is needed to get the youth to try the activities and complete the practice assignment.

TRICKS OF THE TRADE:

Trying the Opposite—Misbehavior

■ **Identify the behavioral manifestations.** Youths who misbehave may react impulsively to behavioral triggers, failing to evaluate all the available information around them that could help them react appropriately. For example, they may—without being aware of it—find it hard to tolerate frustration, consider possible consequences, delay gratification, or understand that unpleasant things that happen to them may be accidental (not intentionally caused by other people who are trying to harm them). As a result, they may disobey, break rules, or be defiant or aggressive.

■ **Introduce awareness of problem behaviors and use of adaptive, incompatible behaviors.** Positive opposites of these patterns include first becoming aware of them—aware of feeling frustrated, impatient, irritated, or angry—and then practicing strategies for tolerating those feelings and practicing adaptive behaviors that are incompatible with the problem behaviors. In the case of anger, for example, the youth can use Feeling Calm and Repairing Thoughts skills to reduce irritation and anger, and then practice adaptive behaviors that are incompatible with misbehavior—for example, using self-talk as a reminder to stop and think before reacting, and then presenting a positive, friendly self to others instead of an aggressive self.

■ **Make it engaging: "When does your water boil?"** A good analogy for becoming angry or disruptive can be a pot of water coming to a boil. Water doesn't go from cold to boiling hot right away; instead, it grows warmer and warmer through various stages, begins to bubble, and then boils over. In the same way, most people heat up gradually on their way to boiling over, and there are early warning signs before they hit the boiling point. Identifying the situations that pose a risk, and the early physical signs (hot ears, tense jaw, etc.) that signal anger, can be very helpful: It can create an awareness of when it's time to put the positive opposite

behavior into action. Similar forms of awareness can be helpful in dealing with disobedience, rule breaking, and other forms of misbehavior.

- **Make it engaging: Self-observation.** Often misbehaving youths are unaware of the verbal and nonverbal messages they are sending to others that provoke negative reactions, thus setting off a series of misunderstandings and conflict. You can show your young client what it is that others see—perhaps by making a smartphone video in the session and reviewing it together, or by mirroring the behavior back to the youth—and this can be the starting point for thinking about opposite behaviors in social interactions. The goal here is to clarify the different types of self-presentation that may need attention, such as eye contact, posture, tone, and the content of statements to others. You should never criticize the youth's presentation; doing that would risk damaging the therapeutic connection. Instead, you should convey simple curiosity: "Let's see what it might look like when the argument starts." In fact, it can be very helpful to demonstrate or record how *you* look and act when *you* are irritable or angry, to show that the point of the exercise is to think about the behavior, not to criticize your young client. The idea is to put some specific behaviors on the table for discussion, and to think together about some specific alternative self-presentation strategies—sometimes with changes that are quite subtle. Do you have a different feeling, for example, if you talk while making eye contact and keeping your hands open and calm? Does that prevent you from getting tense and angry?

- **Make it engaging: Role plays**. Doing realistic role plays can be an effective way for a youth to practice alternatives to impulsive, disruptive, disobedient, angry, or aggressive behavior. The youth describes the triggers for such unwanted behavior in enough detail that you can recreate them in the session. This may include, for example, the exact words used by a provocative peer, and even the facial expression that sparks the youth's reaction. In some role plays, the youth can model the provocative behavior and you can model appropriate responses, including even the thought process that leads to the appropriate behavior. Then the two of you can switch roles. The more lifelike the role play, the more likely it is to build skills that will work in real life.

- **Develop a plan.** Tell the youth that the two of you will develop a list of all the different situations and "triggers" that cause him or her to feel irritated, angry, defiant, or tempted to disobey or break rules. How difficult is it for the youth to manage his or her anger or impulses in these different scenarios? What strategy would work best for each of these situations? Identify the best strategy for each scenario, and be very specific. What can the youth use for a distraction? What are the specific silent self-statements the youth can use to stay calm, or think before acting? What are the self-presentation skills the youth can use to send a positive message to self and to others? In short, what are the positive opposite behaviors the youth can practice in session and in real life, to gain control over the misbehavior that is causing problems?

- **Develop the plan further: Contrast short-term with long-term results.** For some youths, the temptation involved in violating rules or disobeying instructions can be hard to resist. It can be helpful to consider some of these behaviors with regard to the long- and

short-term results. Sometimes it is worthwhile to endure a short-term hassle if the benefits in the long run improve mood or open up access to valued reinforcers. Likewise, some of the behaviors that reward youths in the short run can lead to major punishment in the long run, and it is helpful to make young clients aware of this. Using examples like those shown below can help young people think about the long-term versus short-term consequences of rule breaking and disobedience versus their positive opposites.

- **Practice together.** Choose activities in the role plays that will elicit the moods and impulses leading to misbehavior. If the targeted misbehavior is anger, then the role plays in session should generate mild to moderate anger. This could be accomplished via playing a stressful game, acting out a real-life trigger, enduring an irritating noise, or engaging in other exercises that you know your young client will find especially irritating. This will create a lifelike context for practicing the anger control strategy you and the youth have selected. Analogous procedures can be used for effective role plays to address disobedience, rule breaking, and other forms of misbehavior.

- **Assign practice.** For practice, the youth implements the self-control strategy you have practiced in the session, but this time in real-life trigger situations. Ideally, the practice begins with a relatively easy situation, and then progresses to more challenging ones. These experiences are discussed in subsequent sessions, with a focus on what went well and what adjustments are needed to produce better outcomes.

- **Develop a contract for following through.** How is the youth's motivation? Consider whether or not Increasing Motivation via self-praise or tangible rewards will be helpful.

Handout 23 (page 180) is a home practice sheet that can be used when youths practice Trying the Opposite skills between sessions. Handout 24 is a guide to Trying the Opposite for caregivers.

Skill Assessment: Trying the Opposite

This assessment is used to determine when a youth has sufficiently grasped the FIRST principle and can use it to manage feelings and behaviors in everyday life. When do you decide that enough is enough, and that the youth is ready to finish treatment or move on to the next FIRST Skill Unit? Keep in mind that there is always room for more improvement, but that the goal of treatment is to help the youth and the caregiver use these principles on their own to handle the challenges that arise in real life.

Anxiety and OCD

What is the goal?

The goal of Trying the Opposite for anxious youths and those with OCD is twofold: to eliminate behavioral avoidance of feared situations (while resisting the urge to use rituals or safety behaviors), and to help youths and caregivers understand that the threat they perceive in these situations is overestimated and inaccurate.

Has the goal been sufficiently met?

Is the youth, in session and in everyday life, able to face previously feared situations with a minimum of distress? Is the youth able to articulate that facing up to the fears gets easier with practice, or to describe new learning about ability to tolerate the fear? When a new worry or fear surfaces, can the youth develop a plan to practice facing that fear without avoidance or safety behaviors?

What about the caregiver?

Does the caregiver understand how avoiding feared situations or providing reassurance maintains anxiety and avoidance? Is the caregiver able to recognize and praise the youth for facing his or her fears, and to help the youth develop a "practicing strategy" for new fears that may arise?

Posttraumatic Stress

What is the goal?

The goal of Trying the Opposite for youths with posttraumatic stress is to help them face troubling, intrusive memories in order to learn that they are no longer in danger, and to effectively process the memories effectively so that the trauma can be placed firmly in the past. When there is also avoidance of physical trauma reminders, the goal is to eliminate behavioral avoidance and to help youths and caregivers understand that the threat they perceive in these situations is overestimated and inaccurate.

Has the goal been sufficiently met?

Is the youth able to differentiate remembering traumatic events from reexperiencing them? Can the traumatic memories be endured without acute fear, even if there will also be some pain? Does the youth feel able to exert control over the memories, rather than being controlled by them?

What about the caregiver?

Has the caregiver been able to support the youth throughout the process of Trying the Opposite, including when the youth has shared the traumatic memories? Has the caregiver shown the youth that the caregiver can be trusted to help in the future if other stressful events occur?

Depression

What is the goal?

The goal of Trying the Opposite for depressed youths is twofold: to increase the frequency of participation in rewarding, prosocial, pleasant activities; and to help youths and caregivers understand that doing something active, engaging, enjoyable, fun, helpful or distracting, *even when youths don't feel like it*, can improve mood.

Has the goal been sufficiently met?

Is the youth now often doing social or physical activities that are engaging and rewarding? Does he or she agree that these activities help boost mood? When he or she is in a bad mood, does the youth now regularly try coping by doing something pleasant or active?

What about the caregiver?

Does the caregiver understand how trying positive opposite behaviors (e.g., getting active) can help the youth combat feelings of sadness, boredom, or fatigue? Is the caregiver able to recognize and praise these behaviors when the youth uses them, or to coach the youth to use this strategy when the youth is feeling sad or down?

Misbehavior

What is the goal?

The goal of Trying the Opposite for youths who misbehave is to enable them to gain practice and mastery through responding in prosocial ways to situations that once provoked an aggressive, defiant, or rule-breaking response.

Has the goal been sufficiently met?

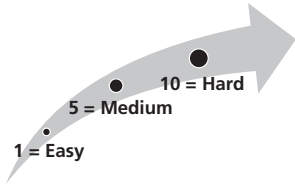
Is the youth, in session and in everyday life, able to implement appropriate behaviors even in the face of situations that once triggered disruptive behavior? Is he or she able to articulate that reacting in a more appropriate, prosocial way is a good strategy for staying out of trouble? Can the youth identify potential trigger situations and rehearse appropriate response strategies?

What about the caregiver?

Does the caregiver recognize and praise the positive opposite behaviors, even if they are subtle? Can the caregiver coach the youth to recognize potentially triggering situations that may arise, and work with the youth to rehearse response strategies?

Trying the Opposite: In-Session Practice

Use this form to guide the in-session discussion of what the problem behaviors are, what opposite actions the youth might practice, and how hard each opposite action will be. Arrange the list so that the easiest opposite actions will be at the top of the list, and the most difficult ones at the bottom.

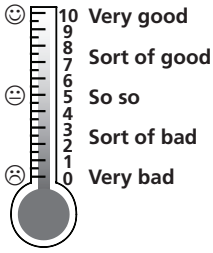


Problem behaviors	Opposite actions	How hard the opposite action will be (0 = easy, 10 = very difficult)

HANDOUT 23

Trying the Opposite: Home Practice

This week, you will practice Trying the Opposite when you are in this situation (_____) or when you feel this way (_____). Each time you practice Trying the Opposite, use this chart to show (1) how you felt *before* you did the practice, (2) what your opposite action was, and (3) and how you felt *after* doing it.



Day	How I Felt Before (0–10)	What I Did to Try the Opposite	How I Felt After (0–10)

HANDOUT 24

Caregiver Guide to Trying the Opposite

Trying the Opposite consists of introducing and practicing behaviors that challenge the difficulties your child is experiencing. In short, it involves trying out behaviors that are the positive *opposites* of the behaviors that have been getting in your child's way at home, in school, or with peers. In session, we've identified situations your child is struggling with, and we've developed a plan for Trying the Opposite in those situations. We're starting with situations that we think will be fairly easy, but we will move toward more difficult ones once your child has had some success. Your child will be using the chart shown in a handout titled "Trying the Opposite: Home Practice." Your help may be needed as your child fills in this chart. **At first it may be hard for your child to practice the new behaviors, so please provide lots of praise and encouragement!**

The Trying the Opposite skill my child is practicing this week: My child has agreed to practice this: When, in what situations, how many times? Some golden opportunities might be: Some helpful support might be:
To be completed after practicing: How did it go? Did anything get in the way? If so, what? Did you learn any new ways to make the practice work well? If so, what were they?

11

Skill Units for Continuing Treatment, Boosting Engagement, and Ending Treatment

Continuing Treatment

This Skill Unit is designed to help you structure sessions once treatment is underway. This may include strengthening skills already introduced, combining Skill Units for multiple FIRST principles, and tailoring treatment to fit each individual youth and family.

Some youths may enter treatment with one clear area of difficulty that can be resolved in a fairly straightforward way, by use of the primary principle shown in the decision tree for the youth's primary problem. An intensive focus on that principle—for example, several sessions of Trying the Opposite for an anxious youth, or teaching a parent how to use Increasing Motivation with a misbehaving child—may be all that's needed. Other youths will have more complex treatment needs, due to comorbidity, life stressors, and/or treatment barriers. The Skill Unit for Continuing Treatment does not specify other Skill Units or the sequence in which to use them, but provides a guide for how to structure treatment sessions once treatment is underway—including how to integrate content from multiple FIRST Skill Units into a comprehensive episode of care.

How Continuing Treatment Is Used for Different Problem Areas

For Anxiety and OCD

Trying the Opposite, in the form of exposure to feared stimuli, is the most important component of treatment for anxiety. For OCD, the component of response prevention (refraining from compulsions meant to neutralize the fear) is added. During therapy, creating fear

hierarchies, revising them as fears are faced, and designing and implementing new exposures to fit the new hierarchies will form the foundation of most sessions. The contents of other Skill Units should be introduced and then combined as needed to reinforce brave behaviors (Increasing Motivation), plan in advance for likely challenges (Solving Problems), manage physical arousal when exposure is not the focus (Feeling Calm), and challenge faulty threat appraisals (Repairing Thoughts). Repairing Thoughts is especially powerful once the Trying the Opposite exposures have directly tested some of the youth's beliefs; that is, successful exposures can reveal that the bad things the youth feared do not actually happen when the feared behavior is actually tried.

For Posttraumatic Stress

Following psychoeducation and an introduction to Feeling Calm, Trying the Opposite is the essential component in treatment of posttraumatic stress; it takes the form of prolonged exposure to traumatic memories. Once the youth is able to achieve physiological relaxation in session with some confidence, the focus shifts to identifying what traumatic memory or parts of a memory cause the most distress; agreeing upon the order in which the story will be written (e.g., beginning with easier content, then moving into more upsetting aspects); and writing, reading, and rereading the story of the traumatic event. If behavioral avoidance of safe trauma triggers is also a problem, Trying the Opposite can also be applied, much as it would be for anxiety more generally. The content of other Skill Units should be introduced and then combined as needed to reinforce facing the traumatic memories or to manage misbehavior (Increasing Motivation), plan in advance for likely challenges to increase mastery (Solving Problems), manage physical arousal and hypervigilance (Feeling Calm), and challenge faulty appraisals (Repairing Thoughts).

For Depression

The core Skill Unit for treating depression, unless there is interference, is Trying the Opposite. After the introduction of this unit, it is important to use subsequent sessions to monitor the impact of scheduling reinforcing events on the youth's mood, problem-solve barriers that interfered with completing the opposite behaviors, and add increasingly active and pleasant events to the youth's routine. Helping the youth recognize that *what we do influences how we feel* is a central goal. Toward this end, combine the content of this Skill Unit with other FIRST Skill Units to improve participation (Increasing Motivation); challenge the youth's beliefs about self, others, and the future (Repairing Thoughts—note in particular those beliefs that are challenged by the Trying the Opposite strategies the youth has tried); handle challenges that arise (Solving Problems); and improve sleep and physical symptoms (Feeling Calm).

For Misbehavior

Working directly with caregivers to improve young people's behavior by Increasing Motivation is the central goal, whenever caregivers are able to participate. In cases where caregivers

do not participate, helping youths to "stop and think" via Solving Problems is the primary Skill Unit. All sessions with caregivers should review any skill previously implemented, review the new skill, practice it in session via a role play, and plan for home implementation—building one skill upon another systematically. The other Skill Units can be combined to address youths' angry arousal (Feeling Calm), to help them rehearse prosocial behaviors (Trying the Opposite), and to challenge hostile assumptions that lead to misbehavior or otherwise interfere with the youths' functioning (Repairing Thoughts).

Skill Unit Objectives

- The youth will understand the rationale for all interventions introduced.
- The youth will know how what was done or discussed in session can be applied in real life.
- The youth will have a plan for practicing the skills at home.

Skill Unit Outline: Continuing Treatment

Remember this in every session:

SESSION COMPONENTS [Note: These should be included in every session.]

- **Create an agenda** of what will be covered in the session.
- **Review practice,** if any was assigned in the prior session.
- **Share the news** of any new skills or information covered in session with the caregiver or the youth at the end of the session (as appropriate).
- **Assign practice** of skills the youth is refining and strengthening for use in real life.
- **Assess skill acquisition:** Is progress being made toward goals in a notable way? Is it time to move to another Skill Unit or consider ending treatment?
- **Finish strong:** End the session on a strong positive note that affirms your relationship and positive feelings toward the youth and/or caregiver—perhaps by doing an engaging activity together, praising the youth and/or caregiver for an important accomplishment in therapy or in real life, or noting how much you value the chance to work with the youth and/or family and are looking forward to the next session.

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Discuss the main Skill Unit and the youth's progress.	How have the symptoms of the youth's main problem area been over the past week? How has practice been going? Does the youth understand the purpose of treatment?	It can be very interesting for a youth and caregiver to see their progress, presented in the form of a graph of their ratings over time. (You might use the brief Behavior and Feelings Survey and the Top Problems Assessment, both available for free at *www.guilford.com/weisz-lab*.) Improvements will increase the sense of mastery, while worsening problems can lead to important conversations about life stressors, difficulties with practice, and the like.
Check in on the therapeutic rationale of the core Skill Unit.	Does the youth and/or the caregiver understand the conceptual model of the problem being treated? For anxiety and OCD, it is critical that the role of avoidance in maintaining the problem is understood. For posttraumatic stress, the key concept is that intentionally facing the memories makes it possible to fully process them, so that the youth is controlling the memories rather than vice versa. For depression, the model is that behavior influences thoughts and feelings. For misbehavior, a caregiver should understand that the key to improvement is increasing the youth's motivation to cooperate, follow rules, and obey instructions, and that there are multiple ways caregivers can boost such motivation in their children.	Even though the family has already received information about the problem area, each meeting is a chance to emphasize the working model of the problem. The more the youth and caregiver understand, the more motivated they will be to engage actively in the treatment. **Example Script** "This week, your mood was pretty good most days, but on Wednesday there was a little dip. What happened on Wednesday? Ah, so what do you think it means that this was the day you were too busy to do your positive activity? Can you explain to me how what you do is related to your mood?"
Address any barriers to home practice completion.	If home practice is not happening, or is not going well, work with the youth and/or caregiver to understand what is getting in the way. Sometimes noncompliance reflects skepticism or confusion about how the intervention is related to the problem. At other times, it may be due to an interfering problem that should be addressed by using another Skill Unit. The home practice may need to be shortened, or made easier, but practice is genuinely needed for improvement.	It is sometimes helpful to directly address skepticism or confusion regarding the purpose of practice assignments; better yet, doing the practice together in some way, so that the youth or caregiver can experience how it feels, can be very powerful. Be very specific about when the practice will take place: Before dinner? After school? Monitoring it in some way and having a visual reminder will also increase the likelihood of completion. Sometimes it can be helpful to ask the youth and/or the caregiver to explain to you the pros and cons of participating actively in treatment; there are costs with regard to time and effort, but asking them to articulate the potential benefits can increase their commitment.

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Manage "crises of the week" (COWs) as needed.	If the caregiver or the youth comes to the session with a crisis to discuss, or a pressing concern, consider how it can be linked to the Skill Units being implemented in treatment already or to those on the verge of being introduced. Applying one of the FIRST skills to a current, pressing, real-life problem is an excellent way to demonstrate the real-life relevance of the Skill Unit being discussed.	It is always important to address the concerns and issues that caregivers and youths bring to session, while also helping them to gain the strategies that will help them handle problems on their own once treatment ends. Balancing these demands is a critical component of skillful treatment implementation.
Introduce new content or review prior content.	Using the appropriate FIRST Skill Unit to continue treatment or address interference, share the content with the youth or caregiver.	As always, make sure the session is lively and engaging, with as many active components (role plays, *in vivo* exposures, or experiential activities) as possible!
Design appropriate practice.	Regardless of whether the content of the session is one Skill Unit or more, assign practice that relates to the session and/or builds on prior sessions.	More than one practice assignment can be given, or contents of two or more Skill Units can be merged into one assignment. **Example Script** "For next week, you should continue to practice asking one question aloud in class every day, even if you know the answer. Also keep track of what thoughts you have right before you ask the question—just jot them down on your practice sheet. Next week, we can think together about how to tell whether these thoughts are true alarms or false alarms."

Additional Suggestions

Developmental Differences

As a youth progresses through FIRST treatment, it is appropriate to begin to shift some of the decision-making and session planning to the youth, and for treatment to be less directive and more collaborative. Whereas a 12-year-old may be very capable of increasingly taking responsibility for setting agendas or selecting practice assignments, the same may not be true for a 6-year-old. For younger children, it may be more important to shift the responsibility onto caregivers, increasing their role as "home coaches."

Involving the Caregiver

A caregiver is often the key to the success of treatment, because what happens in session is a very small percentage of the youth's life; what happens in the hours and days between sessions really determines whether the skills learned in treatment are actually being tried

and practices in real life. As treatment continues, working to increase caregiver involvement and expertise is a very wise use of time: It can hasten progress in treatment and can help to sustain gains after treatment ends.

Boosting Engagement

This Skill Unit provides strategies you can use if youths and/or caregivers appear to have low interest or engagement in treatment, or if their participation in sessions or in-home practice seems to be fading.

An ongoing task for any clinician during treatment is monitoring engagement of the youth and/or caregiver. Problems with engagement may be reflected in inattentiveness during sessions, missed sessions or tardiness, failure to complete home practice assignments, or other signs of reduced interest or investment. Some strategies for increasing engagement when problems arise are found in the Skill Unit Outline below.

Skill Unit Objectives

- The youth and/or caregiver will understand the engagement issue to be discussed.
- The youth and/or caregiver will consider factors related to the issue (e.g., motivation, beliefs, goals).
- The clinician will seek to generate a commitment to change.

Skill Unit Outline: Boosting Engagement

Remember this in every session:

SESSION COMPONENTS [Note: These should be included in every session.]

- **Create an agenda** of what will be covered in the session.
- **Review practice,** if any was assigned in the prior session.
- **Share the news** of any new skills or information covered in session with the caregiver or the youth at the end of the session (as appropriate).
- **Assign practice** of the specific goal agreed upon at the end of the session, or of a prior coping skill that is still being mastered.
- **Finish strong:** End the session on a strong positive note that affirms your relationship and positive feelings toward the youth and/or caregiver—perhaps by doing an engaging activity together, praising the youth and/or caregiver for an important accomplishment in therapy or in real life, or noting how much you value the chance to work with the youth and/or family and are looking forward to the next session.

SKILL UNIT **COMPONENTS**	**In more detail**	**Activities and ideas**
Begin with open-ended questions.	Note the pattern of behavior that you have observed (e.g., lack of in-session participation, practice assignment completion, poor attendance), or reflect the expressed ambivalence about therapeutic activities. Then use an open-ended question to generate the youth's and/or caregiver's perspective. Take care to appear curious and to communicate positive regard toward the youth and caregiver.	**Example Script** "You've missed a number of sessions recently. Tell me about that." For some youths or caregivers who directly express skepticism or ambivalence, restate what they have said and ask them to elaborate. For instance: "You're not sure you're able to do the practice assignment. Tell me more."
Listen without judgment.	Listen carefully to whatever the youth and/or the caregiver is telling you, without trying in any way to correct, argue, or persuade. Make sure you use lots of active listening (listening without interruptions, leaning in physically, reflecting their statements).	Keep in mind that your goal is not to convince the youth or the caregiver, but to highlight their own mixed feelings about commitment to change. Listen carefully for opportunities to empathize with what they are sharing. **Example Script** "I can see how difficult it has been to come, feeling as hopeless as you do. I would find that really challenging, too. You are really exhausted from work and trying to take care of your family."

SKILL UNIT **COMPONENTS**	**In more detail**	**Activities and ideas**
Evoke change talk.	*Change talk* is language from a youth and/or caregiver that conveys a desire to change their behavior or situation, their capacity to make changes, the reasons that they may want to change their behaviors or situation, or their commitment to changing their behavior or situation. Change talk can also take the form of recognition of the problem, concern about future outcomes, and confidence in their ability to change behavior. Your goal is to elicit change talk related to the specific concern or to the therapy in general, while softening *sustain talk*—talk that emphasizes the status quo, or reasons why change is difficult or unlikely. A number of different strategies can be used to initiate and promote change talk. • **Open-ended questions** can help to generate change talk and to shift focus when you begin to hear the youth and/or caregiver ruminating on the reasons why they *cannot* change. • **Affirmations** are reflections of the youth's and/or caregiver's strengths or values, and build confidence in the ability to make changes, which can help to resolve ambivalence. • **Reflections of change talk** can continue momentum in the direction of change. • **Summaries** can be used skillfully to focus on the parts of the conversation that favor change and to move the discussion forward.	Below are some good ways to get a youth and caregiver talking about change. Use whichever of these seem most appropriate. • **Open-ended questions.** Ask questions that are evocative ("Why did you originally want to work on this problem?"), that seek more detail about the desire for change ("Can you tell me more about that?"), that call for examples about behavior change ("Can you tell me about times where you have been successful or were able to change?"), that tap into the past or the future ("How were things different before/how would you like them to be different in the future?", "What has worked in the past to help you make changes?"), that look for hypothetical scenarios ("What is the worst thing that might happen? The best?"), or that connect with goals and values ("How does this fit in with your goals for yourself/your child or with the qualities you value?"). • **Affirmations.** Provide acknowledgment of the positive steps towards change the youth and/or caregiver have already taken, as well as of their contemplation of change. For example, "Even coming into therapy made you confront a lot of fears—not everyone could do that." • **Reflections of change talk.** Use *simple reflections* that restate and emphasize what the youth and/or caregiver have said about their reasons for change, desire for things to be different, or dissatisfaction with their current situation. Or use *double-sided reflections* that reflect current resistant statements, but end with previous contradictory statements in favor of change ("On the one hand, you find it really hard to spend 5 minutes of special time with him on a day when he's been so difficult, and on the other hand, you really want for your relationship with him to be more positive"). • **Summaries.** State that you are going to summarize what you've heard. Then list the selected elements of the conversation, softening the sustain talk and emphasizing the change talk; invite the youth or caregiver to correct anything that isn't accurate. End with an open-ended question to move the conversation forward. **Example Script** "I want to recap what I've heard so far. You've missed the last three sessions because you've been feeling really hopeless and not sleeping well, and it's been hard to get the energy to come. It's reminding you of when you were really depressed before, and how much you missed out on, and you don't want it to get that bad again. You know that you don't want to keep feeling so sad. Did I miss anything? Where do you want to go from here?"

SKILL UNIT **COMPONENTS**	**In more detail**	**Activities and ideas**
Highlight the ambivalence.	Motivation for change increases when individuals recognize these contrasts: (1) their own values and future goals versus their current behavior, and (2) where they are now versus where they want to be in the future. Increasing the youth's and/or caregiver's awareness of these contrasts can help them to resolve ambivalence and move toward change.	In addition to contrasting future goals with current behavior, an exercise that can highlight ambivalence is to map out the costs and benefits of changing versus not changing. For example, what are the costs and benefits of not doing home practice? What are the costs and benefits of doing the home practice? Making a list so that the youth and/or caregiver can see all the potential costs and benefits can make it easier to decide if the change is worthwhile.
Use self-evaluation rulers.	Depending on the nature of the conversation, different self-evaluation "rulers" can help the youth and/or the caregiver to think about change in a very concrete way, by rating themselves on different scales that range from 0 (low) to 10 (high). This allows them to reflect on the importance of the change, their confidence in their ability to do it, and their readiness to engage in the behavior. Use the ruler exercises to elicit more change talk by asking them: • Why didn't they rate the importance/confidence/readiness *lower*? For instance, if they rated importance at 5 out of 10, why not at 3 or 4? What makes it that important? If they rated it at 0, feign surprise: "I thought for sure it would be a negative 5!" • For confidence and readiness, ask specifically: What would it take to move them even higher on the scale? Whatever they tell you may point you in the direction of the next immediate action.	**Importance ruler:** "On a scale of 0 (not at all important) to 10 (very important), how important is it to you to change the target behavior?" **Confidence ruler:** "On a scale of 0 (not at all confident) to 10 (very confident), how confident are you that you can change the target behavior?" **Readiness ruler:** "On a scale of 0 (not at all ready) to 10 (ready to take action), how ready are you to change the target behavior?" **Example Script** THERAPIST: On a scale of 0–10, how confident are you that you can get back on track with using these parenting practices at home? CAREGIVER: Maybe a 4? THERAPIST: Why a 4—why not a 1 or a 2? CAREGIVER: Well, I guess because we were doing it OK for a while before the holidays. THERAPIST: OK, so you know you can do it because you did it before. Tell me more. CAREGIVER: I guess because I'm just at the end of my rope. THERAPIST: So another reason you feel confident is because the way things are going now is not working for you. What do you think would help to move you from a 4 on confidence to a 5 or a 6?

SKILL UNIT **COMPONENTS**	**In more detail**	**Activities and ideas**
Offer to provide information or support.	If it seems appropriate to do so, ask if the youth and/or caregiver would like more information or to hear some ideas about ways to move forward. For example, perhaps it would be helpful for them to know the therapeutic reason for a particular activity, or to learn about how behavior sometimes worsens before it improves. Importantly, you should ask permission before you provide any information.	**Example Script** "So you feel like you'd be more ready to fully commit to this program if you knew what else we were going to be doing. Would now be a good time for me to tell you more about what will come next in our work together?"
Generate commitment.	When the youth and/or caregiver begin to talk about change, consider formulating an action plan.	Although it may seem ideal for a youth and/or caregiver to commit to always attending sessions or always completing their practice assignments, it may set them up for failure. Instead, encourage a goal that is specific (e.g., to do a particular practice assignment), can be easily measured with regard to success (any effort would be considered success!), is realistic, and is time-limited (e.g., before the next session).

Ending Treatment

As treatment comes to an end, use this Skill Unit to review progress and focus on relapse prevention.

As youths and caregivers progress through treatment, the youths will ideally experience improvement in functioning and reductions in impairment. A goal of FIRST throughout treatment is to steadily increase each caregiver's and youth's expertise, mastery, and confidence in the intervention strategies, so that by the end of treatment, they are ready to maintain gains on their own. Ending treatment is often not completed in just one meeting; it can be helpful to identify specific goals that will signal treatment is ready to end (e.g., success in the skill assessments included in FIRST might be one indicator). We recommend planning a date for the final session, celebrating the end of treatment with a ceremony or certificate, and having the young client complete some sort of project (e.g., a book, poster, art project, or video commercial) that summarizes and symbolizes his or her new knowledge and abilities. An essential part of ending treatment is reviewing progress and highlighting all that the youth and/or caregiver have learned.

For many problems, even a successful course of FIRST treatment may not prevent the dif-

ficulties from recurring. For example, an episode of major depression significantly increases the risk that a second episode will occur. Youths who are sensitive to anxiety will similarly often experience more anxiety than their peers, even after treatment. A component of ending treatment, therefore, should be an acknowledgment that the symptoms that brought the youth into treatment may recur, but with a key difference: Now the youth and family have tools to manage them! In FIRST, we recommend taking time to consider particular situations that may increase the risk of a recurrence (e.g., leaving home for summer camp, making the transition to a new school), and to make plans for managing them. It's also useful to consider what might prompt a young client to return to treatment—for example, if the problems recur and cannot be managed with the strategies already learned.

How Ending Treatment Is Used for Different Problem Areas

For Anxiety and OCD

It is important to ensure that both youths and caregivers fully understand how anxiety and OCD are maintained by avoidance, and to confirm that they have a plan to manage anxious feelings and behavioral avoidance when these return. It can be helpful to remind them that treatment is not an "anxiety-ectomy" that removes anxiety altogether, because we need our built-in alarm system to stay safe and perform well. However, since a youth's anxiety alarm system may continue to be more sensitive than other people's, a key concept is that successful coping with anxiety involves living "the exposure lifestyle"—a lifelong pattern of identifying challenges and taking them on. The exposure lifestyle means recognizing when a situation or a stimulus isn't dangerous but still provokes some discomfort, and then deliberately approaching instead of avoiding that situation or stimulus. Remind youths and caregivers that anxiety is like a weed: It will grow back if they stop tending the garden! The exposure lifestyle is a way to ensure that anxiety doesn't grow back.

For Traumatic Stress

The goal of treatment for posttraumatic stress is to help a youth reclaim control over the memories of the traumatic event; process the event more fully; and place it properly in the context of the past, present, and future. It is important to remind the youth that the memory will never be pleasant, but that it need not be feared. A key aspect of ending treatment is helping the youth share his or her story with a trusted caregiver, and then begin to focus on the future, while placing the traumatic event firmly in the past.

For Depression

Because depression is a recurrent condition that often can emerge in response to daily hassles and major life stressors, it is important to review the signs and symptoms of depression, and to consider predictable upcoming challenges and do careful advance planning for how the youth can handle these challenges.

For Misbehavior

In addition to reviewing any skills that youths have learned, it will be critical to review with caregivers the types of new behaviors that may arise as the youths develop and to consider together what approaches will work best in addressing new disruptive behaviors.

Skill Unit Objectives

Multiple sessions may be used to cover the full Skill Unit.

- The caregiver and youth will review and consolidate the skills they have learned in therapy.
- The caregiver and youth will consider the progress and gains made in therapy.
- The caregiver and youth will plan for future challenging events.

Skill Unit Outline: Ending Treatment

Remember this in every session:

SESSION COMPONENTS [Note: These should be included in every session.]

- **Create an agenda** of what will be covered in the session.
- **Review practice,** if any was assigned in the prior session.
- **Share the news** of any new skills or information covered in session with the caregiver or the youth at the end of the session (as appropriate).
- **Finish strong:** End the session on a strong positive note that affirms your relationship and positive feelings toward the youth and/or caregiver—perhaps by doing an engaging activity together, praising the youth and/or caregiver for an important accomplishment in therapy or in real life, or noting how much you have valued the chance to work with the youth and/or family.

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Review progress.	Think back over the behaviors or symptoms the youth was struggling with when treatment began. Which of those things that were so hard to do are now being done with ease? Do the mood or thought records reflect improvement? Have there been fewer behavioral problems? What are some other tangible signs of improvement that can be noted?	Consider documenting these changes with a "What I *Used* to Do/What I Do *Now*" comparison table, reviewing the original goals and noting the youth's achievements in regard to these goals. Look back over any data you have collected (symptom measures or weekly ratings—perhaps on the brief Behavior and Feelings Survey and Top Problems Assessment, available for free at *www.guilford.com/weisz-lab*) that show the improvements, and consider sharing these with the youth and caregiver.

SKILL UNIT COMPONENTS	In more detail	Activities and ideas
Review skills.	Make sure the youth and any caregiver involved in treatment have a solid understanding of the skills that were targeted in treatment, and can demonstrate mastery in applying these skills appropriately and effectively.	Consider presenting hypothetical scenarios and asking the youth and/or caregiver how the skills learned in treatment could be used in these scenarios. This can be done via role plays. As an alternative, try a *Jeopardy!*- type game with skill-based questions, or ask the youth to be the "therapist" and help the caregiver or you with a series of dilemmas using the skills.
Consolidate skills.	Ask the youth to identify the most valuable thing he or she learned in treatment. What would the youth want another person with the same problems to know? The idea is to have the youth step back from each of the individual skills and sessions, and consider the big picture. An anxious youth may have learned that he or she can challenge false alarms. A depressed youth may have learned that doing physical activities, or changing thoughts, can help to change mood. A youth treated for misbehavior may have learned to control angry outbursts, using Feeling Calm and Repairing Thoughts skills.	A final project is a good way to bring all the lessons learned in therapy together. This offers the youth an opportunity to create a "product" that can serve as a tangible reminder of therapy. The project can be a poster, a book, a letter written by the youth to his or her future self, a video commercial "selling" the treatment, or any other idea that gives the youth a chance to work with you to celebrate the treatment.
Plan for new challenges—how the skills will be used in real life.	Relapse prevention is an important aspect of ending treatment. Youths will continue to face life stressors, but they have now learned skills for handling these stressors, and they have practiced the skills in real life. It is now important to (1) identify predictable challenges in their future, (2) note early warning signs that the problems are trying to make a comeback, and (3) plan how the new skills can be applied when the early warning signs appear.	Youths who enjoy acting may find role plays engaging. Others may find it helpful to make formal written plans for how to handle predictable future challenges. A "Quiz the Kid/Caregiver" game can be an interesting way to demonstrate all that has been learned, while also assessing how well the youth or caregivers understand how to manage future challenges.
Plan for ending treatment.	Discuss with the caregiver and the youth whether there are goals that remain unmet and whether it will be helpful to continue treatment or move toward ending treatment.	Remind the youth and the caregiver that a major goal of treatment is for the youth and family to use these skills on their own! Tell them that of course they can always return for a checkup or "booster session."

Additional Suggestions

Developmental Differences

No matter the client's age, making so much progress that therapy can come to an end should be seen as an accomplishment and a milestone. The youth's behavior has changed in some important ways, and this should be celebrated! The form of celebration may vary, depending on the youth's age and interests—and the mixed emotions about ending treatment may also vary. Some youths are excited to have more time to spend with friends and other activities, while others may be sad to say goodbye to a helpful adult. It is good to acknowledge that you share these mixed emotions, because you feel proud and excited for the youth, but that you will also miss seeing him or her.

Involving the Caregiver

Some caregivers may have been very involved in therapy, and others less involved—but it is very important to review with each caregiver the progress the youth has made and anticipate new challenges on the horizon. A caregiver may be concerned about relapses and may want the youth to remain in treatment "just in case." Reassure the youth and caregiver that they have learned how to handle many situations and feelings, and that they can always return for a check-in as needed.

Appendix I

Published Studies Testing Independent Effects of the Five FIRST Principles

FIRST principle	Study	Treatment	Age	Format	Control group	Outcome measures
			Anxiety domain			
Feeling Calm	Laxer et al. (1969)	Relaxation for test anxiety	High school	Group	No-treatment control	Taylor Manifest Anxiety Scale
	Laxer & Walker (1970)	Relaxation for test anxiety	High school	Group	Attention control, no-treatment control	Alpert–Haber Achievement Anxiety Scale
Increasing Motivation	Clement & Milne (1967)	Reward shy kids to talk and play with others	8–9 years	Group	Play therapy, play without therapist	BPC; Direct observations of social proximity, talk, and play
Repairing Thoughts	Ahrens & Rexford (2002)	Cognitive processing therapy for PTSD	15–18 years	Individual	Wait-list control	BDI, PTSD Symptom Scale, Impact of Event Scale
	Warren et al. (1984)	RET for social anxiety	12–16 years	Group	Relationship-counseling, wait-list control	Teacher-reported anxiety and child-reported irrational cognitions
	Kanfer et al. (1975)	Positive self-talk re: darkness	5–6 years	Individual	Neutral self-talk	Behavioral avoidance test (time child stayed in dark)
	Leal et al. (1981)	Modifying test cognitions	10th grade	Group	Systematic desensitization, wait-list control	State–trait anxiety inventory

FIRST principle	Study	Treatment	Age	Format	Control group	Outcome measures
Solving Problems	Found in EBTs, but not solo					
Trying the Opposite	Dewis et al. (2001)	Exposure for spider fears	10–17 years	Individual	Wait-list control	Phobia Questionnaire, distress ratings
	Muris et al. (1998)	Exposure for spider fears	8–17 years	Individual	EMDR, computerized exposure	Phobia Questionnaire, behavioral avoidance test
	Ost et al. (2001)	Exposure for specific phobias	7–17 years	Individual	Wait-list control	Behavioral avoidance test
	Sheslow et al. (1982)	Exposure for fear of dark	4–5 years	Individual	Minimal-contact control	Behavioral avoidance test
			Depression domain			
Feeling Calm	Reynolds & Coats (1986)	Relaxation training	Mean = 16 years	Group	Wait-list control	BDI, RADS, BID, STAIC, Self-Esteem and Academic Self-Concept Scales
	Kahn et al. (1990)	Relaxation training	10–14 years	Group	Wait-list control	BDI, RADS
Increasing Motivation	Found in EBTs, but not solo					
Repairing Thoughts	Ackerson et al. (1998)	Cognitive bibliotherapy	Mean = 16 years	Bibliotherapy	Wait-list control	CDI, HRSD, CBCL, Dysfunctional Attitudes Scale
	Butler et al. (1980)	Cognitive restructuring	Grades 5–6	Group	Attention placebo, classroom control	CDI, Self-Esteem Scale, Piers–Harris Self-Concept Scale
	Clarke et al. (1995)	Coping with Stress course	Mean = 15 years	Group	Usual care	CESD, GAF, depressive disorder at follow-up
Solving Problems	Butler et al. (1980)	Problem-solving role play	Grades 5–6	Group	Attention placebo, classroom control	CDI, Nowicki–Strickland Locus of Control Scale
Trying the Opposite	McCauley et al. (2016)	Behavioral activation	12–18 years (mean = 14.9)	Individual	Uncontrolled evidence-based practices for depression	KSADS, CDRS-R, CDI, SMFQ, MASC, C-GAS, BADS

FIRST principle	Study	Treatment	Age	Format	Control group	Outcome measures
			Misbehavior domain			
Feeling Calm	Oldfield (1986)	Relaxation and meditation training	Grades 4–6	Individual	Behavior charting	Acting-out incident count
	Schlichter & Horan (1981)	Relaxation training for anger	13–18 years	Individual	No-treatment control	Anger Inventory, Imaginal Provocations Test
Increasing Motivation	Forman (1980)	Response cost	8–11 years	Group	Attention control (reading tutoring)	DBRS (Disrespect, Defiance, Class Disturbance)
Reparing Thoughts	Forman (1980)	Cognitive restructuring	8–11 years	Group	Attention control	DBRS (Class Disturbance, Aggression)
	Snyder & White (1979)	Cognitive self-instruction	14–17 years	Group	Assessment control	Frequency of aggression, theft, property destruction, truancy
	Block (1978)	RET	Grades 10–11	Group	No-treatment control	Frequency of disruptive behaviors in class, truancy
Solving Problems	Kazdin et al. (1987)	Problem-solving skills training	7–13 years	Group	Treatment-contact control, relationship therapy	CBCL School Behavior Checklist
	Kazdin et al. (1989)	Problem-solving skills training	7–13 years	Individual	Relationship therapy	CBCL School Behavior Checklist
	Klarreich (1981)	Problem-solving skills training	16–19 years	Group	Group counseling	Interpersonal Relations Checklist, TSCS, LSPC
Trying the Opposite	Deffenbacher et al. (1996)	Practice coping with social provocations	Grades 6–8	Group	No-treatment control	Trait Anger Scale, Anger Rating Scale, Anger Expression Inventory

Note. BADS, Behavioral Activation for Depression Scale; BDI, Beck Depression Inventory; BID, Bellevue Index of Depression; BPC, Behavior Problem Checklist; CBCL, Child Behavior Checklist; CDI, Children's Depression Inventory; CDRS-R, Children's Depression Rating Scale—Revised (semistructured interview patterned after the HRSD); CESD, Center for Epidemiologic Studies Depression Scale; C-GAS, Children's Global Assessment Scale; CGI, Clinical Global Impression Improvement Scale; DBRS, Devereux Behavior Rating Scale; EBTs, evidence-based treatments; EMDR, eye movement desensitization and reprocessing; GAF, Global Assessment of Functioning; HRSD, Hamilton Rating Scale for Depression; KSADS, Kiddie-SADS Diagnostic Interview; LSPC, Life Skills Problem Checklist; MASC, Multidimensional Anxiety Scale for Children; RADS, Reynolds Adolescent Depression Scale; RET, rational–emotive therapy; SMFQ, Short Moods and Feelings Questionnaire; STAIC, State–Trait Anxiety Inventory for Children; TSCS, Tennessee Self-Concept Scale. Full references for the citations in this appendix can be found in the References list at the end of the book.

Appendix II

Sample Progressive Muscle Relaxation Script

Here is one example of the kind of language that can be read to a young person during a session, or recorded for the youth's personal use between sessions, to induce deep muscle relaxation. As in other therapy procedures, the exact language used should be tailored to fit the youth's developmental level and individual style.

"Go ahead and settle back so you feel comfortable. Let all your muscles go loose and heavy. Close your eyes and take three deep, slow breaths. As you breathe in slowly, concentrate on the air as it fills your lungs, and as you breathe out slowly, notice your breath rushing out through your nose and mouth. Breathe in slowly, thinking about the feeling of air passing in and out of your body.

"Now I want you to clench your right fist as tight as you can and hold it while I count down from 5 . . . pay attention to the tight feeling in your fist as I begin to count—5, 4, 3, 2, 1. Relax your fist, and notice the feelings of warmth and relaxation that flow through your fingers into your arm. Pay attention to the feeling of relaxation that fills your arm. Now clench your left hand into a fist and hold it while I count down from 5. Pay attention to the tight feeling in your arm as I begin to count—5, 4, 3, 2, 1. Release your fist, and notice how the tight feeling leaves your arm and is replaced by the warm, heavy feeling of relaxation.

"Now hunch your shoulders so they press against your head and neck, and pay attention to the tight feeling this causes as I count down from 5—5, 4, 3, 2, 1. As you relax your shoulders, pay attention to the warm, soothing feelings of relaxation that run down your head, neck, and shoulders. Hunch your shoulders again, paying attention to the tight feeling this creates as I count down from 5—5, 4, 3, 2, 1. As you relax your shoulders again, notice the feelings of relaxation that flow down your neck and through your body.

"We're moving to your stomach now. Squeeze your stomach as hard as you can, as if you are getting ready for someone to step on it. Now squeeze, squeeze, squeeze. Now slowly relax it as I count down—5, 4, 3, 2, 1. Notice how the feelings of warmth and calmness spread through your stomach. Let's do it one more time. Squeeze your stomach tight and hold it that way for a little while, and then relax it—5, 4, 3, 2, 1. Now feel that warm, calm feeling again.

"Next, pretend you're on a sandy beach. Squeeze your toes into the sand. Feel the wet sand between your toes, using the muscles in your legs to push your toes and feet into the sand. Push for a

little while, and then relax your legs, feet, and toes as I count down from 5—5, 4, 3, 2, 1. Feel the tension wash away into the ocean, and feel the warmth in your legs, feet, and toes. Now let's do it again, this time digging even deeper into the sand, using your legs again to help you grip with your toes. As I count down, relax your toes, relax your feet, and relax your legs—5, 4, 3, 2, 1. Feel the relaxation and the warmth.

"Now I want you to scrunch up your face like you bit something really sour, like a lemon. Wrinkle up your forehead, and hold it while I count down from 5. Pay attention to the tightness in your forehead while I count down from 5—5, 4, 3, 2, 1. Relax your forehead again, smoothing out all the wrinkles. Notice how smooth and relaxed you feel. Now clench your jaws, bite your teeth together, and hold it while I count down—5, 4, 3, 2, 1. Relax. Let your lips open a little bit, and breathe deeply. Notice the warm, heavy feelings of relaxation in your body.

"Now it's time to tighten up your whole body, from your scrunched-up face, to your hunched-up shoulders, your tight fists and arms, your stiff back and tight stomach, to your tight legs and curled-up toes and feet. Make your whole body tense and stiff as a board, and hold it for a little while. Now you can begin to relax all over while I count down from 5—5, 4, 3, 2, 1. Let go and relax. Just relax, let go, and notice how warm and heavy your whole body feels. . . . Breathe calmly and relax."

Appendix III

Using FIRST for Panic Attacks and Tic/Habit Behaviors

The decision trees, Skill Units, and procedures described in the main manual reflect an effort to build on research findings with the most common youth problem presentations. However, some less common disorders and problems may require modifications to these procedures, even though the core treatment model remains unchanged. Here we focus on some of these rarer disorders and problems.

Using FIRST with Panic Attacks

Youths with panic attacks and diagnosable panic disorder are frightened by the sudden, "out of the blue" onset of physical sensations (e.g., racing heart, rapid or difficult breathing, difficulty swallowing, sweaty or tingling palms, dizzinesss). Although these sensations are typically harmless, they can be scary; individuals with a diagnosis of panic disorder are excessively alarmed by these sudden physiological surges and may radically change their routines in an attempt to avoid future panic attacks. Assuming that a medical cause has been ruled out, it is important to educate the youth and caregiver about anxiety in general (see the Clinician Guide: Facts About Anxiety and OCD in Chapter 4) and also about panic attacks specifically. Although diagnosable panic disorder is rare in children, it is somewhat more common in adolescents, and it is highly impairing regardless of the prevalence. Panic attacks that do not meet full DSM-5 diagnostic criteria for panic disorder may also be targets for treatment if they are sufficiently troubling to a youth and/or caregiver.

Beginning Treatment

Youths and caregivers should learn that panic attacks are associated with *anxiety sensitivity* (being more aware of and bothered by physical signs of anxiety than other people), with *misinterpretation of harmless bodily signs* (a tendency to interpret physical sensations as signs of danger), and with *sympathetic nervous system arousal* (the body's preparation for fighting, fleeing, or freezing—even though there is no real danger!). Panic attacks are very much like other forms of anxiety, except that the stimuli youths try to avoid are their own bodies' internal actions and their own fearful responses. Additional information to convey at the beginning of treatment is essentially "myth busting": Make

it clear to the youth or caregiver that despite what they may have heard, panic attacks do not cause people to pass out or have heart attacks.

Trying the Opposite

For the most part, Trying the Opposite for panic attacks and panic disorder is very much like that for other forms of anxiety; it consists of repeated exposure to the feared stimuli in a gradual and incremental manner. However, there are two distinctions. First, because youths are often not able to identify which of the physical sensations of panic are most distressing (because they all occur simultaneously), an *interoceptive assessment* is required to create a hierarchy of the sensations. Second, the exposures will consist of *interoceptive exposure:* repeating various exercises intended to mimic the specific sensations of the panic attack.

Interoceptive Assessment

Figure III.1 includes an illustrative list of various physical exercises you might have the youth do, one at a time in session, in order to form a fear hierarchy (aka "fear ladder"). Most youths will find some of these exercises easy and others tremendously frightening. The exercises that the youth rates highly in terms of fear and similarity to panic are those that will be the focus of exposure practice in sessions and at home. It is important to make clear that exposure practice is *not* likely to reduce discomfort. There is an important distinction to be made between discomfort, which will probably not be reduced, and fear, which will be reduced via repeated exposure. Likewise, something that induces fear but isn't at all like a panic attack for the youth is not likely to be an important focus of treatment.

Interoceptive Exposures: In-Session and In-Home Practice

Both in sessions and later for home practice, the youth will do repeated rounds of interoceptive exposure, beginning with those rated low in the fear hierarchy (established via the interoceptive assessment) and gradually moving upward to those rated highest. As one example, a youth who rates dizziness as highly fear-provoking and highly similar to a panic attack might eventually be given this home practice assignment: "This week, you will practice putting your head between your knees for 1 minute and then sitting up quickly. Repeat this five times in a row, once a day, or until your fear decreases by 50%."

Using FIRST with Tic/Habit Behaviors

Youths identified as having tics, Tourette's disorder, other tic disorders as defined in DSM-5, or other habit disorders or behaviors (e.g., trichotillomania, excoriation disorder, nail biting) engage in repetitive, unwanted, body-focused movements or noises that cause distress or functional impairment. Although these behaviors may sometimes happen without a youth's full awareness, it is nonetheless possible to exert control over them with practice. One thing that all these problems have in common is that they are motivated by some form of automatic reinforcement. Such reinforcement may take the form of relief from a sense of pressure or stress that precedes the movement (e.g., feeling a "prepotent

Exercise	Sensation it mimics	Fear (0–10)	Discomfort (0–10)	Similarity to panic attacks (0–10)	
Holding breath for 1 minute.	Feeling short of breath	3	3	6	Will be low on the hierarchy, due to low fear but some similarity to panic attack.
Placing head between knees for 1 minute, then coming up (or standing up) quickly	Lightheadedness	4	3	6	
Spinning 10 times with eyes open	Dizziness	8	8	0	Will not be on the hierarchy, because not similar to panic attack.
Running in place/doing jumping jacks for 2 minutes	Rapid pulse	0	0	0	
Rapid, shallow breathing in and out quickly for 1 minute	Hyperventilation	4	6	6	
Breathing through a thin straw while holding nose for 30 seconds	Lack of air	10	10	10	Will be high on the hierarchy, because of high fear and high similarity to panic attack.
Staring at an index finger for 1 minute while silently repeating one's own name	Derealization	0	0	0	
Shining a light quickly into the eyes, then looking at a white piece of paper	Spots in front of eyes from dilated pupils	0	10	0	

Figure III.1. Sample interoceptive assessment.

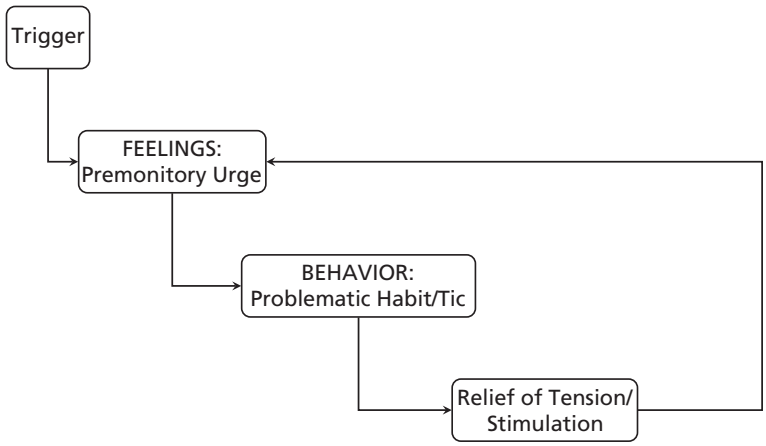
urge" prior to a motor or vocal tic or before pulling out a hair), or a pleasurable sensation after the act (e.g., feeling a positive feeling after biting nails). Transient tics are relatively common among school-age children, but about 3–4% of children meet diagnostic criteria for any tic disorder and fewer than 1% meet criteria for Tourette's disorder, which peaks in early adolescence and then improves for many over the course of adolescence and adulthood. For many youths, tics are relatively benign; comorbid conditions (such as ADHD and OCD) often cause more impairment. However, for those who are bothered by their tics or other habit behaviors, a variant of Trying the Opposite called *habit reversal training* may be helpful and has been shown to be effective.

Beginning Treatment

Psychoeducation about tics and similar habits should include information regarding their medical basis, in order to reduce blame, stigma, and negative feelings. Youths with tics or tic disorders and their caregivers should learn that tics (much like asthma or diabetes) have a biological basis rooted

in genetics, but can also be influenced by our environment and our behavior. Encourage caregivers to engage in "educated observation" of the tics or other habit behaviors, noticing them but not giving them much overt attention. It can be helpful for caregivers to spend a week or two noticing the events that precede the tics or habit behaviors (e.g., fatigue or screen time) and the consequences that follow them (e.g., attention or teasing). During this same time, it can be useful to provide education about tics or other habit behaviors to caregivers and other adults who are important parts of the youth's social environment (e.g., teachers, coaches).

Here is a metaphor that may be helpful in conveying how tics or other habit behaviors work: Encourage a youth and caregiver to think of the urge to engage in the repetitive behavior as a wave. The urge grows inside the youth much as a wave builds in the ocean, and at its peak the youth engages in the behavior (e.g., performing a tic or pulling a hair). This brings the wave crashing down and relieves the pressure. However, by giving in, the youth fails to learn that the urge would actually have receded all on its own—just like a wave—if he or she didn't give in. Encouraging youths to "surf the urge" by staying on the wave until it recedes can help them understand the process of treatment.



Trying the Opposite

The first step of Trying the Opposite for tics and other habit behaviors is increasing awareness of these tic behaviors. Help the youth and caregiver deconstruct and describe every aspect of the tic or other habit; for example, have the youth do it in slow motion, or make a video of it, to increase awareness of all the steps and components of the behavior. Next, work with the youth to hone in on the feeling or "urge" that happens prior to the tic/habit behavior. To familiarize the youth with the type of feeling a prepotent urge creates in the body, ask the youth to try to keep his or her eyes open without blinking for 60 seconds. The pressure to blink begins to build up internally, and feels similar to the sensation of a premonitory urge. Next, you want him or her to link this feeling to the tic or habit behavior. One way to do this is to have a conversation *about* the behavior, while you (the therapist) hold up a finger every time you notice the behavior. Then the youth begins to hold up a finger when he or she notices the behavior. Over time, the youth begins to hold up a finger before the behavior occurs, when he or she feels the "urge." For youths with habit behaviors, a way to trigger the urge may be to increase attention to the behavior (e.g., having a youth with excoriation disorder look at his or her skin in a mirror).

After the youth has become aware of the urge that precedes the behavior and of the behavior itself, he or she can begin the process of *habit reversal.* This involves selecting a behavior that is incompatible with the tic or other problematic behavior, sometimes known as a *competing response.* For example, if the youth has a shoulder shrug tic, a competing response may be flexing the shoulder muscles to hold them still. A competing response for a vocal tic may be slow, controlled breathing or blowing air through one's lips. The key to a successful competing response is that it makes doing the problem behavior more difficult; it is not more noticeable than the problem behavior; and it can be performed for 1 minute or until the urge decreases.

Ultimately, the goal of Trying the Opposite for tic/habit behaviors is for young people to learn to tolerate the uncomfortable urge that precedes these problematic, repetitive behaviors and to "surf the wave" until it recedes or goes away entirely. Because this is hard work, consider pairing Trying the Opposite with Increasing Motivation; praising the effort (not the outcome); providing tokens or rewards for practicing the competing response; and ensuring reinforcement. Again, keep in mind that many young people are not bothered by their tics or similar habits; in such cases, there may be no need to treat them, unless the habits cause serious social or functional impairment.

Appendix IV

Frequently Asked Questions About Using FIRST in Clinical Practice

Although FIRST may be used for a variety of clinical problems, a number of questions arise in relation to everyday clinical use. Here are some of those questions.

What about psychotropic medications for youths treated with FIRST?

As with any other treatment approach, therapists should use best practices suggested by the scientific evidence base regarding pharmacological intervention. For example, there is very clear evidence that stimulant medication is helpful in addressing inattention and hyperactivity for youths diagnosed with ADHD. For anxiety and depression, some studies show that combining medication with therapy leads to superior outcomes, while others have shown mixed results. When youths are already being treated effectively with medication, it is not necessary to change the course of treatment in order to use FIRST. When youths being treated with FIRST do not show the expected improvements in symptoms and functioning after a reasonable amount of time, despite their active participation in the FIRST activities, a pharmacological consultation may be helpful. The therapist should work closely with the prescribing physician to ensure that all members of the treatment team understand the goals and process of the care provided.

What about suicidal ideation, suicide attempts, or nonsuicidal self-injury?

Thoughts of death and suicidal ideation are not uncommon among depressed youths and may also occur among youths with anxiety disorders and conduct problems. FIRST is not designed to treat nonsuicidal self-injury or to prevent suicide attempts. In each case, a therapist should carefully and sensitively assess the frequency and severity of such thoughts, and note how strong the intent to die is for each youth. *Any* intent to die is a cause for concern. When such an intent is noted, the therapist should work with the youth to create a safety contract, share ideation or attempts with caregivers, and ensure safety as needed by referring the youth to a higher level of care (such as hospitalization). Youths who are currently engaging in self-injurious behaviors also face an increased risk of morbidity, even if the current behaviors are "nonsuicidal." Accordingly, active self-harm behaviors may also require a referral to a higher level of care that more directly addresses the self-injurious behavior. When there

is no risk of suicide or self-injury, FIRST may certainly be used to address painful thoughts and feelings, and to help young people work through distressing problems and find solutions.

What about youths who are in out-of-home placements?

Youths in foster care or with child welfare system involvement face increased likelihood of referral for mental health treatment, and many of the principles in FIRST have been tested and shown to work for this population. For youths who have serious misbehavior, the parenting skills included in FIRST may be needed by the birth parents or the foster caregivers to regulate stress at home and to prevent future placement disruptions. If children have been placed apart from their birth parents but reunification is likely, working separately with both the foster parents and the birth parents may improve prospects for a smooth transition. For youths with depression and anxiety disorders, caregiver involvement can serve as a way to better support the youths' treatment and provide reinforcement at home for the young persons' treatment gains.

Can FIRST be used for youths with autism spectrum disorder (ASD)?

FIRST incorporates well-supported treatment principles to address symptoms of anxiety and OCD, posttraumatic stress, depression, and misbehavior. To the extent that youths on the autism spectrum have comorbid conditions within these categories, the FIRST skill units may be helpful. It is important, however, to look beneath the surface of "symptoms" to gauge the potential usefulness of FIRST. For example, a youth with social anxiety disorder (social phobia) and a youth with ASD may avoid social interactions, but the reasons may be different for the two youngsters. The therapist must assess whether the youth with ASD avoids these situations due to a fear of being embarrassed (which would be appropriately treated with FIRST), or due to a lack of interest and enjoyment in shared social interactions (which might require more specialized treatment for ASD). Likewise, the preoccupation with specialized topics that is sometimes seen in youngsters with ASD is not the same as the repeated, intrusive thoughts seen in youths with OCD, and will not be likely to respond to the treatment procedures of FIRST. Scientifically supported treatments for the symptoms associated with ASD are available, and a referral should be made for those treatments unless the goal of treatment is to address comorbid anxiety, OCD, posttraumatic stress, depression, or misbehavior.

Can FIRST address substance abuse?

The treatments with the best support to address substance abuse as a primary problem in youths share some similarities with FIRST, but are more intensive, more comprehensive (targeting the youth's community on multiple system levels), and more likely to require work with the whole family. Treatments such as multidimensional family therapy, functional family therapy, or group cognitive-behavioral therapy for substance abuse have been developed or adapted specifically for treatment of substance abuse. The principles of FIRST may be applied to address misbehavior that includes occasional *use* of substances, provided that substance abuse is not the primary problem for which a family seeks treatment.

References

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA School-Age Forms & Profiles.* Burlington: University of Vermont, Research Center for Children, Youth, and Families.

Ackerson, J., Scogin, F., McKendree-Smith, N., & Lyman, R. D. (1998). Cognitive bibliotherapy for mild and moderate adolescent depressive symptomatology. *Journal of Consulting and Clinical Psychology, 66,* 685–690.

Ahrens, J., & Rexford, L. (2002). Cognitive processing therapy for incarcerated adolescents with PTSD. *Journal of Aggression, Maltreatment and Trauma, 6,* 201–216.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Asarnow, J. R., Rozenman, M., Wiblin, J., & Zeltzer, L. (2015). Integrated medical–behavioral care compared with usual primary care for child and adolescent behavioral health: A meta-analysis. *JAMA Pediatrics, 169,* 929–937.

Bearman, S. K., Ugueto, A., Alleyne, A., & Weisz, J. R. (2010). Adapting CBT for depression to fit diverse youths and contexts: Applying the deployment-focused model of treatment development and testing. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 466–481). New York: Guilford Press.

Bearman, S. K., & Weisz, J. R. (2015). Comprehensive treatments for youth comorbidity: Evidence-guided approaches to a complicated problem. *Child and Adolescent Mental Health, 20*(3), 131–141.

Becker, K. D., Boustani, M., Gellatly, R., & Chorpita, B. F. (2018). Forty years of engagement research in children's mental health services: Multidimensional measurement and practice elements. *Journal of Clinical Child and Adolescent Psychology, 47*(1), 1–23.

Block, J. (1978). Effects of a rational–emotive mental health program on poorly achieving, disruptive high school students. *Journal of Counseling Psychology, 25,* 61–65.

Burlingame, G. M., Mosier, J. I., Wells, M. G., Atkin, Q. G., Lambert, M. J., Whoolery, M., & Latowsky, M. (2001). Tracking the influence of mental health treatment: The development of the Youth Outcome Questionnaire. *Clinical Psychology and Psychotherapy, 8*(5), 315–334.

Butler, L., Miezitis, S., Friedman, R., & Cole, E. (1980). The effect of two school-based intervention programs on depressive symptoms in preadolescents. *American Educational Research Journal, 17,* 111–119.

Chorpita, B. F., & Weisz, J. R. (2009). *Modular approach to therapy for children with anxiety, depression, trauma, or conduct problems (MATCH-ADTC).* Satellite Beach, FL: PracticeWise.

Christopherson, E. R. (1990). *Beyond discipline: Parenting that lasts a lifetime.* Kansas City, MO: Westport.

Clarke, G. N., Hawkins, W., Murphy, M., Sheeber, L. B., Lewinsohn, P. M., & Seeley, J. R. (1995). Targeted prevention of unipolar depressive disorder in an at-risk sample of high-school adolescents: A randomized

trial of a group cognitive intervention. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*, 312–321.
Clement, P. W., & Milne, D. C. (1967). Group play therapy and tangible reinforcers used to modify the behavior of 8-yr-old boys. *Behaviour Research and Therapy, 5*, 301–312.
Craske, M. G., Kircanski, K., Zelikowsky, M., Mystkowski, J., Chowdhury, N., & Baker, A. (2008). Optimizing inhibitory learning during exposure therapy. *Behaviour Research and Therapy, 46*, 5–27.
Craske, M. G., Treanor, M., Conway, C. C., Zbozinek, T., & Vervliet, B. (2014). Maximizing exposure therapy: An inhibitory learning approach. *Behaviour Research and Therapy, 58*, 10–23.
Deffenbacher, J. L., Lynch, R. S., Oetting, E. R., & Kemper, C. C. (1996). Anger reduction in early adolescents. *Journal of Counseling Psychology, 43*, 149–157.
Dewis, L. M., Kirkby, K. C., Martin, F., Daniels, B. A., Gilroy, L. J., & Menzies, R. G. (2001). Computer-aided vicarious exposure versus live graded exposure for spider phobia in children. *Journal of Behavior Therapy and Experimental Psychiatry, 32*, 17–27.
Ferguson, K. E., & Sgambati, R. E. (2009). Relaxation. In W. T. O'Donohue & J. E. Fisher (Eds.), *General principles and empirically supported techniques of cognitive behavior therapy* (pp. 532–542). Hoboken, NJ: Wiley.
Forman, S. G. (1980). A comparison of cognitive training and response cost procedures in modifying aggressive behavior of elementary school children. *Behavior Therapy, 11*, 594–600.
Goodman, R. (2001). Psychometric properties of the Strengths and Difficulties Questionnaire. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*(11), 1337–1345.
Haine-Schlagel, R., & Walsh, N. E. (2015). A review of parent participation engagement in child and family mental health treatment. *Clinical Child and Family Psychology Review*, *18*(2), 133–150.
Hankin, B. L., Young, J. F., Abela, J. R. Z., Smolen, A., Jenness, J. L., Gulley, L. D., . . . Oppenheimer, C. W. (2015). Depression from childhood into late adolescence: Influence of gender, development, genetic susceptibility, and peer stress. *Journal of Abnormal Psychology, 124*, 803–816.
Kahn, J. S., Kehle, T. J., Jenson, W. R., & Clark, E. (1990). Comparison of cognitive-behavioral, relaxation, and self-modeling interventions for depression among middle school students. *School Psychology Review, 19*, 196–211.
Kanfer, F. H., Karoly, P., & Newman, A. (1975). Reduction of children's fear of the dark by competence-related and situational threat-related verbal cues. *Journal of Consulting and Clinical Psychology, 43*, 251–258.
Kazdin, A. E., Bass, D., Siegel, T., & Thomas, C. (1989). Cognitive-behavioral therapy and relationship therapy in the treatment of children referred for antisocial behavior. *Journal of Consulting and Clinical Psychology, 57*, 522–535.
Kazdin, A. E., Esveldt-Dawson, K., & French, N. H. (1987). Problem-solving skills training and relationship therapy in the treatment of antisocial child behavior. *Journal of Consulting and Clinical Psychology, 55*, 76–85.
Klarreich, S. H. (1981). A study comparing two treatment approaches with adolescent probationers. *Corrective and Social Psychiatry and Journal of Behavioral Technology Methods and Therapy, 27*, 1–13.
Laxer, R. M., Quarter, J., Kooman, A., & Walker, K. (1969). Systematic desensitization and relaxation of high-test-anxious secondary school students. *Journal of Counseling Psychology, 16*, 446–451.
Laxer, R. M., & Walker, K. (1970). Counterconditioning versus relaxation in the desensitization of test anxiety. *Journal of Counseling Psychology, 17*, 431–436.
Leal, L. L., Baxter, E. G., Martin, J., & Marx, R. W. (1981). Cognitive modification and systematic desensitization with test anxious high school students. *Journal of Counseling Psychology, 28*, 525–528.
Lohaus, A., Klein-Heßling, J., Vögele, C., & Kuhn-Hennighausen, C. (2001). Psychophysiological effects of relaxation training in children. *British Journal of Health Psychology*, *6*(2), 197–206.
Lundahl, B., & Burke, B. L. (2009). The effectiveness and applicability of motivational interviewing: A practice-friendly review of four meta-analyses. *Journal of Clinical Psychology*, *65*(11), 1232–1245.
Martell, C. R., Dimidjian, S., & Herman-Dunn, R. (2010). *Behavioral activation for depression: A clinician's guide*. New York: Guilford Press.
McCauley, E., Gudmundsen, G., Schloredt, K., Martell, C., Rhew, I., Hubley, S., & Dimidjian, S. (2016). The

Adolescent Behavioral Activation Program: Adapting behavioral activation as a treatment for depression in adolescence. *Journal of Clinical Child and Adolescent Psychology, 45*(3), 291–304.

Merikangas, K. R., He, J., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., . . . Swendsen, J. (2010). Lifetime prevalence of mental disorders in US adolescents: Results from the National Comorbidity Survey Replication—Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry, 49,* 980–989.

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York: Guilford Press.

Muris, P., Merckelbach, H., Holdrinet, I., & Sijsenaar M. (1998). Treating phobic children: Effects of EMDR versus exposure. *Journal of Consulting and Clinical Psychology, 66,* 193–198.

Ng, M. Y., & Weisz, J. R. (2016). Building a science of personalized intervention for youth mental health. *Journal of Child Psychology and Psychiatry, 57*(3), 216–236.

Nock, M. K., & Kazdin, A. E. (2005). Randomized controlled trial of a brief intervention for increasing participation in parent management training. *Journal of Consulting and Clinical Psychology, 73,* 872–879.

Oldfield, D. (1986). The effects of relaxation response on self-concept and acting out behaviors. *Elementary School Guidance and Counseling, 20*(4), 255–260.

Ost, L, Svensson, L., Hellstroem, K., & Lindwall, R. (2001). One-session treatment of specific phobias in youths: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 69,* 501–502.

Reynolds, W. M., & Coats, K. I. (1986). A comparison of cognitive-behavioral therapy and relaxation training for the treatment of depression in adolescents. *Journal of Consulting and Clinical Psychology, 54,* 653–660.

Russo, D. C., Bird, B. L., & Masek, B. J. (1980). Assessment issues in behavioral medicine. *Behavioral Assessment, 2*(1), 1–18.

Sauer-Zavala, S., Cassiello-Robbins, C., Ametaij, A. A., Wilner, J. G., & Pagan, D. (2019). Transdiagnostic treatment personalization: The feasibility of ordering unified protocol modules according to patient strengths and weaknesses. *Behavior Modification, 43*(4), 518–543.

Schleider, J. L., & Weisz, J. R. (2017). Little treatments, promising effects: Meta-analysis of single-session interventions for youth psychiatric problems. *Journal of the American Academy of Child and Adolescent Psychiatry, 56,* 107–115.

Schlicter, K. J., & Horan, J. J. (1981). Effects of stress inoculation on the anger and aggression management skills of institutionalized juvenile delinquents. *Cognitive Therapy Research, 5,* 359–365.

Sheslow, D. V., Bondy, A. S., & Nelson, R. O. (1982). A comparison of graduated exposure, verbal coping skills, and their combination in the treatment of children's fear of the dark. *Child and Family Behavior Therapy, 4*(2–3), 33–45.

Snyder, J. J., & White, M. J. (1979). The use of cognitive self-instruction in the treatment of behaviorally disturbed adolescents. *Behavior Therapy, 10,* 227–235.

Thorndike, E. L. (1898). Animal intelligence: An experimental study of the associative processes in animals. *Psychological Review: Monograph Supplements, 2*(4), 1–109.

Warren, R., Smith, G., & Velten, E. (1984). Rational–emotive therapy and the reduction of interpersonal anxiety in junior high school students. *Adolescence, 19,* 893–902.

Weisz, J. R., Bearman, S. K., Santucci, L., & Jensen-Doss, A. (2017). Initial test of a principle-guided approach to transdiagnostic psychotherapy with children and adolescents. *Journal of Clinical Child and Adolescent Psychology, 46*(1), 44–58.

Weisz, J. R., Bearman, S. K., Ugueto, A. M., Herren, J. A., Evans, S. C., Cheron, D. M., Alleyne, A. R., Weissman, A. S., Tweed, J. L., Pollack, A. A., Langer, D. A., Southam-Gerow, M. A., Wells, K. C., & Jensen-Doss, A. (in press). Testing the robustness of Child STEPs effects: A randomized controlled effectiveness trial. *Journal of Clinical Child and Adolescent Psychology.*

Weisz, J. R., Chorpita, B. F., Frye, A., Ng, M. Y., Lau, N., Bearman, S. K., . . . the Research Network on Youth Mental Health. (2011). Youth top problems: Using idiographic, consumer-guided assessment to identify treatment needs and track change during psychotherapy. *Journal of Consulting and Clinical Psychology, 79*(3), 369–380.

Weisz, J. R., Hawley, K. M., & Jensen Doss, A. (2004). Empirically tested psychotherapies for youth internalizing and externalizing problems and disorders. *Child and Adolescent Psychiatric Clinics of North America, 13*, 729–816.

Weisz, J. R., & Kazdin, A. E. (Eds.). (2017). *Evidence-based psychotherapies for children and adolescents* (3rd ed.). New York: Guilford Press.

Weisz, J. R., Krumholz, L. S., Santucci, L., Thomassin, K., & Ng, M. (2015). Shrinking the gap between research and practice: Tailoring and testing youth psychotherapies in clinical care contexts. *Annual Review of Clinical Psychology, 11*, 139–163.

Weisz, J. R., Kuppens, S., Ng, M. Y., Eckshtain, D., Ugueto, A. M., Vaughn-Coaxum, R., . . . Fordwood, S. R. (2017). What five decades of research tells us about the effects of youth psychological therapy: A multilevel meta-analysis and implications for science and practice. *American Psychologist, 72*, 79–117.

Weisz, J. R., Vaughn-Coaxum, R. A., Evans, S. C., Lee, E. H., Thomassin, K. T., Hersh, J., . . . Mair, P. (2019). Efficient monitoring of treatment response during youth psychotherapy: The Behavior and Feelings Survey. *Journal of Clinical Child and Adolescent Psychology.* [Epub ahead of print].

Index

Active attending. *See* Attention; Differential attention
Active ignoring
  anxiety and OCD and, 95
  caregiver guide to, 112–113
  misbehavior and, 100
  posttraumatic stress and, 96–97
Acute stress disorder, 20. *See also* Posttraumatic stress
Adaptive behavior rehearsal, 7. *See also* Trying the Opposite principle
Adjustment disorders. *See also* Anxiety/anxiety disorders
  with depressed mood, 24
  FIRST approach and, 5
  overview, 16
Affirmations, 10, 189
Aggression
  conduct problems and, 31
  overview, 51–53
  Solving Problems principle and, 7
Agoraphobia, 16, 169*f*. *See also* Anxiety/anxiety disorders
Aids to support practice and regular use of skills, 76
All-or-nothing thinking, 123. *See also* Thoughts
Ambivalence towards treatment. *See also* Treatment barriers
  boosting engagement and, 190
  misbehavior and, 53
  overview, 40
Anger management
  Feeling Calm principle and, 6, 81
  Solving Problems principle and, 7
Anxiety
  beginning treatment for, 37
  Clinician Guide for, 45–47
  continuing treatment for, 182–183
  ending treatment and, 192
  Feeling Calm principle and, 68, 73, 78–79, 82
  FIRST Interview—Caregiver and, 33–35
  FIRST Interview—Youth and, 35–37
  Help for Caregivers: Understanding Anxiety and Obsessive–Compulsive Disorder handout, 55–56
  Increasing Motivation principle and, 69, 88, 94–95, 95*f*, 104–105
  overview, 45–47, 55–56
  panic attacks and, 202–203, 204*f*
  Repairing Thoughts principle and, 69, 122, 127–129, 133–134
  Skill Assessment: Feeling Calm, 82
  Skill Assessment: Increasing Motivation, 104–105
  Skill Assessment: Repairing Thoughts, 133–134
  Skill Assessment: Solving Problems, 152
  Skill Assessment: Trying the Opposite, 176–177
  Solving Problems principle and, 70, 141, 145–146, 152
  studies testing effects of FIRST principles, 197–198
  treatment planning and, 63–67
  Trying the Opposite principle and, 71, 158, 163–167, 166*f*, 168*f*–169*f*, 176–177
Anxiety/anxiety disorders
  fear hierarchy example for, 168*f*–169*f*
  Feeling Calm principle and, 6
  FIRST approach and, 4
  overview, 45
  Repairing Thoughts principle and, 6–7
  Solving Problems principle and, 7
  treating with FIRST, ix, 16–20, 17*f*
Arousal
  anxiety and OCD and, 73
  Feeling Calm principle and, 68, 81
  posttraumatic stress and, 48, 73
Assessment
  conduct problems and, 32
  ending treatment and, 15
  FIRST Interview—Caregiver, 33–35
  FIRST Interview—Youth, 35–37
  identifying treatment needs and, 9
  intake assessment, 13–14
  interoceptive assessment, 203, 204*f*
  skill acquisition and, 12
  Skill Assessment: Feeling Calm, 82–85
  Skill Assessment: Increasing Motivation, 104–106
  Skill Assessment: Repairing Thoughts, 133–135
  Skill Assessment: Solving Problems, 151–153
  Skill Assessment: Trying the Opposite, 176–177
  treatment planning and, 63–64
  weekly monitoring, 14
Attention
  anxiety and OCD and, 89, 94–95
  caregiver guide to, 112–113
  conduct problems and, 28
  depression and, 98, 98*f*
  directed attention, 80
  Increasing Motivation principle and, 6
  misbehavior and, 90, 99–100

Attention (*continued*)
overview, 69
posttraumatic stress and, 96, 97
Attention-deficit/hyperactivity disorder (ADHD), 5, 51
Attributions, hostile. *See* Hostile attributions
Autism spectrum disorder (ASD), 208
Automatic thoughts, 26–27, 122–123. *See also* Repairing Thoughts principle; Thoughts
Avoidance
anxiety and OCD and, 18–19, 56, 71, 89, 94–95, 127–128, 176–177
depression and, 89, 141
obsessive–compulsive disorder (OCD) and, 46, 47
overview, 69
posttraumatic stress and, 48, 49, 89, 96
Solving Problems principle and, 141
Trying the Opposite principle and, 71, 158, 163–164
166*f*, 168*f*–169*f*, 176–177

Barriers to treatment. *See* Treatment barriers
Beginning treatment, 8–10, 37–40. *See also* Treatment
Behavior and Feelings Survey, 14
Behavior charts, 13
Behavioral activation, 24, 26, 172
Behavioral contingencies, 6
Behavioral contract, 98, 98*f*
Behavioral problems. *See also* Conduct problems; Misbehavior
beginning treatment for, 38
Clinician Guide for, 51–53
depression and, 50–51, 172
FIRST Interview—Caregiver and, 33–35
FIRST Interview—Youth and, 35–37
Help for Caregivers: Understanding Misbehavior handout, 61–62
identifying behaviors to target, 91, 94, 95, 97, 98
Increasing Motivation principle and, 6
overview, 51–53
Repairing Thoughts principle and, 6–7, 125
Solving Problems principle and, 7
treating with FIRST, ix, 27–32, 29*f*, 30*f*
Trying the Opposite principle and, 7
Behavioral rehearsal. *See* Adaptive behavior rehearsal
Biological factors
anxiety and OCD and, 55
depression and, 59
posttraumatic stress and, 57
Blaming thoughts. *See also* Thoughts
depression and, 130
posttraumatic stress and, 23–24
Boosting Engagement skill, 12
Bravery Box activity, 164
Breathing exercises. *See also* Feeling Calm principle; Relaxation techniques
for anxiety and OCD, 78
for depression, 80
for misbehavior, 82
overview, 6
for posttraumatic stress, 80
Skill Unit Outline: Feeling Calm, 75

Calm, feeling. *See* Feeling Calm principle
Caregiver engagement. *See also* Engagement; Family engagement
beginning treatment and, 9–10
boosting engagement, 187–191
conduct problems and, 28, 31–32
continuing treatment and, 186–187
ending treatment and, 195
Feeling Calm principle and, 77
Increasing Motivation principle and, 93–94, 109–121
misbehavior and, 52–53
Repairing Thoughts principle and, 127, 133, 139
Skill Units in FIRST and, 38–40
Solving Problems principle and, 144, 156
treatment planning and, 64–67
Trying the Opposite principle and, 163, 171, 181
Caregiver Problems and Coping Form
complete form, 41–42
FIRST Interview—Caregiver and, 35
overview, 9, 12, 63
treatment planning and, 65
Caregiver training, 28, 31–32
Caregiver–youth interactions, 61. *See also* Parent–child relationship
Celebration at the end of treatment, 195. *See also* Ending treatment
Change principles. *See* FIRST approach; Principles of change
Change talk, 10, 189
Child welfare system, 208
Clinician Guides. *See also* Skill Units in FIRST
anxiety and OCD, 45–47
depression, 49–51
misbehavior, 51–53
overview, 7–8
posttraumatic stress, 47–49
Cognitive factors, 61. *See also* Thoughts
Cognitive restructuring. *See* Repairing Thoughts principle
Collaborative processes, 10
Commitment, 191
Comorbidity
anxiety and OCD and, 20
conduct problems and, 32
overview, 14–15
Compulsions. *See also* Obsessive–Compulsive Disorder (OCD)
fear hierarchy example for, 169*f*
FIRST approach and, 4
overview, 46
Conduct disorder, 52
Conduct problems. *See also* Behavioral problems; Misbehavior
beginning treatment for, 38
Clinician Guide for, 51–53
Help for Caregivers: Understanding Misbehavior handout, 61–62
overview, 51–53
Solving Problems principle and, 7
treating with FIRST, 27–32, 29*f*, 30*f*
Confidence ruler, 190
Consequences. *See also* Increasing Motivation principle; Rewards
anxiety and OCD and, 94–95
depression and, 97–98
developmental factors, 93
misbehavior and, 99, 175–176
overview, 88
posttraumatic stress and, 96
Skill Unit Outline: Increasing Motivation, 91
Continuing Treatment skill, 12
Coping cards, 128, 129
Coping responses
conduct problems and, 31
Increasing Motivation principle and, 69

posttraumatic stress and, 23–24, 89
Solving Problems principle and, 140–141
Cost–benefit analyses, 10
Crises, 15, 186
Critical thoughts, 130. *See also* Thoughts

Daily mood monitoring, 172–173. *See also* Monitoring
Dark glasses strategy, 131
Decision points, 10
Decision trees
for anxiety and OCD, 17*f,* 65
for depression, 25*f,* 66
for misbehavior, 29*f,* 30*f,* 66, 67
overview, 10, 63–67
for posttraumatic stress, 22*f,* 65
Deep breathing. *See also* Feeling Calm principle; Relaxation techniques
for anxiety and OCD, 19, 78
for conduct problems, 31
for depression, 27, 80
for misbehavior, 82
overview, 6
for posttraumatic stress, 80
Skill Unit Outline: Feeling Calm, 75
Depression
beginning treatment for, 37
Clinician Guide for, 49–51
continuing treatment for, 183
ending treatment and, 192
Feeling Calm principle and, 6, 68, 73, 80–81, 83
FIRST approach and, 5
FIRST Interview—Caregiver and, 33–35
FIRST Interview—Youth and, 35–37
Help for Caregivers: Understanding Depression handout, 59–60
Increasing Motivation principle and, 69, 88, 97–98, 105
overview, 49–51, 59–60
Repairing Thoughts principle and, 6–7, 70, 122, 130–131, 131*f,* 134
Skill Assessment: Feeling Calm, 83
Skill Assessment: Increasing Motivation, 105
Skill Assessment: Repairing Thoughts, 134
Skill Assessment: Solving Problems, 152–153
Skill Assessment: Trying the Opposite, 177–178
Solving Problems principle and, 7, 70, 141, 148–149, 152–153
studies testing effects of FIRST principles, 198–199
treating with FIRST, ix, 24–27, 25*f*
treatment planning and, 63–67
Trying the Opposite principle and, 7, 71, 158, 171–174, 177–178
Developmental factors
continuing treatment and, 186
ending treatment and, 195
Feeling Calm principle and, 77
Increasing Motivation principle and, 93
Repairing Thoughts principle and, 126
Solving Problems principle and, 144
Trying the Opposite principle, 162
Diagnosis, 13–14, 48
Differential attention. *See also* Attention
anxiety and OCD and, 89, 94–95
caregiver guide to, 112–113
misbehavior and, 100
posttraumatic stress and, 97
Directed attention, 80. *See also* Attention
Discipline, 102–103. *See also* Consequences; Punishment
Disengaging from irrational thoughts, 129
Disruptive behavior disorders, 61. *See also* Misbehavior
Distorted thoughts, 130. *See also* Thoughts
Dysthymia, 24, 50. *See also* Depression

Effective instructions
caregiver guide to, 114
misbehavior and, 101–103
posttraumatic stress and, 97
Emotion regulation, 6
Empowering caregivers, 8
Ending treatment, 12–13, 15, 191–195. *See also* Treatment
Engagement. *See also* Caregiver engagement; Family engagement; Youth engagement
anxiety and OCD and, 18–19, 165
boosting, 187–191
depression and, 148, 172–173
Increasing Motivation principle and, 93–94
misbehavior and, 132, 150, 174–175
ongoing, 10
posttraumatic stress and, 89, 129, 147
rewards and privileges and, 13
Skill Units in FIRST and, 38–40
skills building and, 11–12
S-O-L-V-E steps and, 145
treatment planning and, 63, 64–67
Environmental triggers
misbehavior and, 100–101, 149–150
obsessive–compulsive disorder (OCD) and, 46
Evidence for a thought, 126
Evidence-based psychotherapies, ix–x, 3
Evocative questions, 10
Excoriation disorder. *See* Tic/habit behaviors and disorders
Explore what works step. *See also* S-O-L-V-E steps
for anxiety and OCD, 146
for depression, 149
for misbehavior, 151
overview, 143
for posttraumatic stress, 148
Explosive behavior, 7
Exposure plus response prevention (ERP), 18, 164, 166, 166*f.* *See also* Exposure techniques
Exposure techniques. *See also* Trying the Opposite principle
for anxiety and OCD, 18–20, 56, 73, 164–167, 166*f,* 168*f*–169*f,* 169–171
Feeling Calm principle and, 78
for panic attacks, 203
for posttraumatic stress, 21, 23–24
Solving Problems principle and, 7
treatment planning and, 64
Trying the Opposite principle and, 7, 169–171
Exposure to memories, 21. *See also* Exposure techniques

Family engagement. *See also* Caregiver engagement; Engagement
beginning treatment and, 8, 9–10
conduct problems and, 28, 31–32
boosting engagement and, 187
Fear hierarchies
continuing treatment and, 182–183
examples of, 168*f*–169*f*
Increasing Motivation principle and, 94
overview, 13
Fear ladder, 164–165, 166*f. See also* Hierarchy of feared situations

Fear triggers, 46, 49
Fears, 23–24, 69
Feeling Calm principle. *See also* FIRST approach; Relaxation techniques; Skill Units in FIRST
  for anxiety and OCD, 68, 73, 78–79
  for conduct problems, 31
  continuing treatment and, 182–187
  crises and, 15
  for depression, 27, 68, 73, 80–81
  ending treatment and, 194
  handouts for, 86–87
  for misbehavior, 68, 73, 81–82
  overview, ix–x, 2, 6, 7–8, 68, 72–73, 77
  for posttraumatic stress, 21, 68, 73, 79–80
  progressive muscle relaxation script and, 13
  in-session practice for, 85
  skill assessment for, 82–85
  Skill Unit Outline: Feeling Calm, 74–76
  studies testing effects of FIRST principles, 197–199
Feelings
  depression and, 50–51, 59, 60, 89, 172
  posttraumatic stress and, 48
  Skill Unit Outline: Repairing Thoughts, 125
  Skill Unit Outline: Trying the Opposite, 160
  thoughts and, 127, 130, 132, 164, 167
Feelings thermometer activity
  depression and, 173
  handouts for, 86, 137–138
  overview, 85
Fight, flight, or freeze response, 21, 167, 169
FIRST approach. *See also* Feeling Calm principle; Increasing Motivation principle; Principles of change; Repairing Thoughts principle; Skill Units in FIRST; Solving Problems principle; Trying the Opposite principle
  for anxiety and OCD, 16–20, 17*f*
  beginning treatment, 8–10, 37–40
  decision points and, 10
  for depression, 24–27, 25*f*
  frequently asked questions regarding, 207–208
  for misbehavior, 27–32, 29*f*, 30*f*
  overview, ix–x, 2–4, 7–15, 68–71
  for panic attacks, 202–203, 204*f*
  for posttraumatic stress, 20–24, 22*f*
  as a principle-guided intervention, 1–2
  studies testing effects of FIRST principles, 197–199
  for tic/habit behaviors, 203–206
  using decision trees and, 10
  who can be treated with, 4–6
FIRST Interview—Caregiver, 33–35, 63, 65
FIRST Interview—Youth, 35–37, 63
Focus of treatment
  changes in, 14–15
  identifying, 8–10
  treatment planning and, 63–67
Foster care, 208

Generalized anxiety disorder, 16, 169*f*. *See also* Anxiety/anxiety disorders
Goals for treatment
  anxiety and OCD and, 83, 104, 133, 152, 176–177
  depression and, 84, 105, 134, 152–153, 177–178
  ending treatment and, 194
  misbehavior and, 84, 106, 135, 153, 178
  overview, 39
  posttraumatic stress and, 83, 105, 134, 152, 177
Guided imagery
  for anxiety and OCD, 19, 78
  for conduct problems, 31
  for depression, 27, 81
  for misbehavior, 82
  overview, 6
  Skill Unit Outline: Feeling Calm, 75
Guides for clinicians. *See* Clinician Guides

Help for caregivers handouts
  overview, 54
  Understanding Anxiety and Obsessive–Compulsive Disorder handout, 55–56
  Understanding Depression handout, 59–60
  Understanding Misbehavior handout, 61–62
  Understanding Posttraumatic Stress handout, 57–58
Helplessness, 148
Hierarchy of feared situations, 18. *See also* Exposure techniques; Fear ladder
Homework assignments
  beginning treatment and, 8
  continuing treatment and, 185
  Feeling Calm principle and, 86–87
  Increasing Motivation principle and, 93, 107–108
  panic attacks and, 203
  Repairing Thoughts principle and, 126–127, 137–138
  Solving Problems principle and, 144, 155
  Trying the Opposite principle and, 163, 176, 180
Hope, 10, 40
Hopelessness, 27, 70, 89, 130, 148
Hostile attributions, 31, 124. *See also* Thoughts
House rules, 97, 102, 175–176
Hyperarousal, 73. *See also* Arousal

Ignoring, active
  anxiety and OCD and, 95
  caregiver guide to, 112–113
  misbehavior and, 100
  posttraumatic stress and, 96–97
Importance ruler, 190
Impulsivity, 70, 142, 149–150
In vivo exposures. *See also* Exposure techniques
  for anxiety and OCD, 18, 165
  conduct problems and, 31
  Increasing Motivation principle and, 93
  for posttraumatic stress, 21, 23
Increasing Motivation principle. *See also* Consequences; FIRST approach; Motivation; Rewards; Skill Units in FIRST
  for anxiety and OCD, 69, 89, 94–95, 95*f*, 104–105
  for conduct problems, 28, 31–32
  continuing treatment and, 182–187
  for depression, 69, 89, 97–98
  handouts for, 104, 107–121
  for misbehavior, 53, 69, 90, 98–104, 101*f*
  overview, ix–x, 2, 6, 7–8, 69, 88–89, 93–94
  for posttraumatic stress, 23, 69, 89, 95–97
  skill assessment for, 104–106
  Skill Unit Outline: Increasing Motivation, 90–93
  studies testing effects of FIRST principles, 197–199
In-session practice activities
  beginning treatment and, 8
  Feeling Calm principle and, 85
  panic attacks and, 203
  Repairing Thoughts principle and, 136
  S-O-L-V-E steps and, 145, 147, 148, 150, 154

Solving Problems principle and, 154
Trying the Opposite principle and, 179
Instructions, effective
caregiver guide to, 114
misbehavior and, 101–103
posttraumatic stress and, 97
Intake assessment. *See also* Assessment
FIRST Interview—Caregiver, 33–35
FIRST Interview—Youth, 35–37
overview, 13–14
Interest in activities, 50, 59–60
Intermediate belief, 122
Interoceptive assessment, 203, 204*f*. *See also* Assessment
Intrusion symptoms, 48
Irrational thoughts, 129. *See also* Thoughts

Labeled praise. *See also* Praise
anxiety and OCD and, 95
misbehavior and, 99
posttraumatic stress and, 96
Law of effect, 88
Life experiences, 59
Limits, 89
List some solutions step. *See also* S-O-L-V-E steps
for anxiety and OCD, 146
for depression, 149
for misbehavior, 150
overview, 143
for posttraumatic stress, 147
Listening, 188

Major depressive disorder (MDD), 24, 50. *See also* Depression
Manuals, treatment, 3–4
Medications
FIRST approach and, 5
misbehavior and, 52–53
overview, 5, 207
Misbehavior. *See also* Behavioral problems; Conduct problems
anxiety and OCD and, 163–164
Clinician Guide for, 51–53
continuing treatment for, 183–184
depression and, 171–172
ending treatment and, 193
Feeling Calm principle and, 68, 73, 81–82, 83
FIRST approach and, 5
handouts for, 104
Help for Caregivers: Understanding Misbehavior handout, 61–62
Increasing Motivation principle and, 69, 88–89, 89, 98–104, 101*f*, 106
overview, 51–53, 61–62
posttraumatic stress and, 167
Repairing Thoughts principle and, 70, 123, 125, 132–133, 135
Skill Assessment: Feeling Calm, 83
Skill Assessment: Increasing Motivation, 106
Skill Assessment: Repairing Thoughts, 135
Skill Assessment: Solving Problems, 153
Skill Assessment: Trying the Opposite, 178
Skill Unit Outline: Increasing Motivation, 90–93
Skill Unit Outline: Trying the Opposite, 160–162
Solving Problems principle and, 70, 142, 149–151, 153
studies testing effects of FIRST principles, 199
treating with FIRST, ix
treatment planning and, 63–67
Trying the Opposite principle and, 71, 159, 160–162, 174–176, 178
Monitoring. *See also* Progress monitoring
beginning treatment and, 8
daily mood monitoring, 172–173
Skill Unit Outline: Increasing Motivation, 92
weekly monitoring, 14
Mood boosters, 172
Mood problems
depression and, 50
Repairing Thoughts principle and, 6–7
Solving Problems principle and, 7
Trying the Opposite principle and, 7
Motivation. *See also* Increasing Motivation principle
anxiety and OCD and, 18–19
crises and, 15
depression and, 27
handouts for, 107–121
misbehavior and, 151
motivation enhancement, 6, 10, 69
overview, 10
rewards and privileges and, 13
treatment planning and, 63
Trying the Opposite principle and, 171
Motivational interviewing, 10
Muscle relaxation. *See* Progressive muscle relaxation; Relaxation techniques
Mystery game, 128

Nail biting. *See* Tic/habit behaviors and disorders
Narrative exposure, 21. *See also* Exposure techniques
Negative thoughts, 26–27, 131, 131*f*, 137. *See also* Repairing Thoughts principle; Thoughts
Noncompliant behavior, 52. *See also* Misbehavior
Nonsuicidal self-injury, 207–208

Obsessions. *See also* Obsessive–Compulsive Disorder (OCD)
fear hierarchy example for, 169*f*
FIRST approach and, 4
overview, 45–46
Obsessive–compulsive disorder (OCD)
beginning treatment for, 37
Clinician Guide for, 45–47
continuing treatment for, 182–183
ending treatment and, 192
fear hierarchy example for, 169*f*
Feeling Calm principle and, 68, 73, 78–79, 82
FIRST approach and, ix, 16–20, 17*f*, 197–198
FIRST Interview—Caregiver and, 33–35
FIRST Interview—Youth and, 35–37
Help for Caregivers: Understanding Anxiety and Obsessive–Compulsive Disorder handout, 55–56
Increasing Motivation principle and, 69, 88, 94–95, 95*f*, 104–105
overview, 45–47, 55–56
Repairing Thoughts principle and, 6–7, 69, 122, 127–129, 133–134
Skill Assessment: Feeling Calm, 82
Skill Assessment: Increasing Motivation, 104–105
Skill Assessment: Repairing Thoughts, 133–134
Skill Assessment: Solving Problems, 152
Skill Assessment: Trying the Opposite, 176–177
Solving Problems principle and, 70, 141, 145–146, 152
treatment planning and, 63–67
Trying the Opposite principle and, 71, 158, 163–167, 166*f*, 168*f*–169*f*, 176–177

One goal you're aiming for step. *See also* S-O-L-V-E steps
for anxiety and OCD, 146
for depression, 148–149
for misbehavior, 150
overview, 143
for posttraumatic stress, 147
Open-ended questions, 188, 189
Opposites, trying. *See* Trying the Opposite principle
Oppositional defiant disorder, 51–52
Out-of-home placements, 208
Overestimation of threat, 69

Panic attacks/panic disorder. *See also* Anxiety/anxiety disorders
fear hierarchy example for, 169*f*
FIRST approach and, 5, 13, 202–203, 204*f*
overview, 16
Parent–child relationship, 23, 61, 89
Parenting, 23, 77
Persistent depressive disorder (dysthymia), 24, 50. *See also* Depression
Personality factors
depression and, 59
misbehavior and, 61
Personalized care, 3
Personalizing techniques
anxiety and OCD and, 128
negative thoughts and misbehavior and, 132
Skill Unit Outline: Feeling Calm, 76
Pharmacological interventions, 5. *See also* Medications
Pleasant events scheduling, 24, 26
Pleasure in activities
depression and, 50, 59–60
Trying the Opposite principle and, 177–178
Positive opposites, 7, 92. *See also* Trying the Opposite principle
Posttraumatic stress
beginning treatment for, 37–38
Clinician Guide for, 47–49
continuing treatment for, 183
ending treatment and, 192
Feeling Calm principle and, 68, 73, 79–80, 82
FIRST approach and, 4
FIRST Interview—Caregiver and, 33–35
FIRST Interview—Youth and, 35–37
Help for Caregivers: Understanding Posttraumatic Stress handout, 57–58
Increasing Motivation principle and, 69, 88, 95–97, 105
overview, 47–49, 57–58
Repairing Thoughts principle and, 6–7, 69, 122, 129
Skill Assessment: Feeling Calm, 82
Skill Assessment: Increasing Motivation, 105
Skill Assessment: Repairing Thoughts, 134
Skill Assessment: Solving Problems, 152
Skill Assessment: Trying the Opposite, 177
Solving Problems principle and, 70, 141, 147–148, 152
treating with FIRST, ix, 20–24, 22*f*
treatment planning and, 63–67
Trying the Opposite principle and, 71, 158, 167, 169–171, 177
Posttraumatic stress disorder (PTSD), 20, 48, 57. *See also* Posttraumatic stress
Posttreatment planning, 12–13
Praise
anxiety and OCD and, 19, 89, 94–95
caregiver guide to, 111
conduct problems and, 28
depression and, 89
Increasing Motivation principle and, 6
misbehavior and, 99, 102
overview, 69
posttraumatic stress and, 96
Principles of change, ix, 10. *See also* Feeling Calm principle; FIRST approach; Increasing Motivation principle; Repairing Thoughts principle; Solving Problems principle; Trying the Opposite principle
Privileges. *See also* Rewards
anxiety and OCD and, 19
caregiver guide to, 115–117
misbehavior and, 100, 101*f*, 103
overview, 13
posttraumatic stress and, 97
Problem summary, 39
Problems, solving. *See* Solving Problems principle
Problem-solving steps. *See also* Sequential problem solving; S-O-L-V-E steps; Solving Problems principle
for anxiety and OCD, 20, 145–146
caregiver guide to, 156
conduct problems and, 31–32
for depression, 148–149
for misbehavior, 149–151
overview, 7, 140–141
for posttraumatic stress, 23, 147–148
Skill Unit Outline: Solving Problems, 142–144
Progress Assessment in Therapy (PATH), 14
Progress monitoring. *See also* Monitoring
anxiety and OCD and, 19
ending treatment and, 193
overview, 10
skill acquisition and, 12
Progressive muscle relaxation. *See also* Relaxation techniques
for conduct problems, 31
for depression, 27, 81
developmental factors, 77
for misbehavior, 82
overview, 6
script for, 13, 200–201
Skill Unit Outline: Feeling Calm, 76
Psychoeducation
for anxiety and OCD, 16, 55–56
boosting engagement and, 191
for depression, 24, 59–60
help for caregivers handouts, 54–62
Increasing Motivation principle and, 109–121
for misbehavior, 28, 61–62
overview, 39
for posttraumatic stress, 20–21, 57–58
Skill Unit Outline: Feeling Calm, 75
tic/habit behaviors and disorders and, 204–205
Psychological factors, 55
Public behavior, 104
Punishment, 88, 102–103. *See also* Consequences; Discipline

Questions, evocative, 10
Questions, open-ended, 188, 189
Questions regarding treatment, 40
"Quick cooling"
for anxiety and OCD, 79
for depression, 81
for misbehavior, 82
Skill Unit Outline: Feeling Calm, 76

Rapport, 39, 188
Rate the opposites technique, 161
Reactivity, 48
Readiness for change, 10
Readiness ruler, 190
Reassurance seeking, 89
Reflections, 10, 189
Reframing, 10
Rehearsal, behavior. *See* Adaptive behavior rehearsal
Reinforcement. *See also* Rewards
  anxiety and OCD and, 18–19
  caregiver guide to, 115–117, 118–119
  depression and, 89, 97–98, 98*f*
  misbehavior and, 99–103, 101*f*
  overview, 88
  Skill Unit Outline: Increasing Motivation, 92–93
  tic/habit behaviors and disorders and, 203–204
Relapse prevention, 194
Relaxation techniques. *See also* Feeling Calm principle
  anxiety and OCD and, 19, 73, 78–79, 170–171
  conduct problems and, 31
  depression and, 27, 73
  developmental factors, 77
  misbehavior and, 73, 81–82
  overview, 6, 68, 72–73
  posttraumatic stress and, 21, 73, 79–80
  sample script for progressive muscle relaxation, 13, 200–201
  Skill Unit Outline: Feeling Calm, 75–76
Repairing Thoughts principle. *See also* Cognitive restructuring; FIRST approach; Skill Units in FIRST; Thoughts
  for anxiety and OCD, 19, 69, 122, 127–129, 133–134
  for conduct problems, 31
  continuing treatment and, 182–187
  crises and, 15
  for depression, 26–27, 70, 122, 130–131, 131*f*, 134
  ending treatment and, 194
  handouts for, 133, 136–139
  for misbehavior, 70, 123, 132–133, 135
  overview, ix–x, 2, 6–8, 69–70, 122–123, 126–127
  for posttraumatic stress, 24, 69, 122, 129, 134
  Skill Assessment: Repairing Thoughts, 133–135
  Skill Unit Outline: Repairing Thoughts, 124–126
  studies testing effects of FIRST principles, 197–199
Resistance, 10
Response cost, 97
Responsibilities
  caregiver guide to, 115–117
  misbehavior and, 101*f*
  rewards and privileges and, 13
Rewards. *See also* Consequences; Increasing Motivation principle
  anxiety and OCD and, 18–19, 89, 94–95, 95*f*
  caregiver guide to, 115–117
  conduct problems and, 28
  depression and, 89, 98
  Increasing Motivation principle and, 6
  misbehavior and, 100, 101*f*, 102–103
  overview, 13, 69, 88
  posttraumatic stress and, 96, 97
Ritualized behaviors
  fear hierarchy example for, 169*f*
  overview, 46
  Trying the Opposite principle and, 18
Rock and candy strategy, 130
Role plays
  misbehavior and, 103, 159, 175
  Skill Unit Outline: Feeling Calm, 76
Rules
  misbehavior and, 102, 175–176
  posttraumatic stress and, 89, 97

Safety, feelings of, 79
Safety behaviors, 47
Say what the problem is step. *See also* S-O-L-V-E steps
  for anxiety and OCD, 145–146
  for depression, 148
  for misbehavior, 150
  overview, 143
  for posttraumatic stress, 147
Scheduling of pleasant events, 24, 26
Schemas, 122
School context
  caregiver guide to developing a daily school report, 120–121
  Feeling Calm principle and, 77
  Increasing Motivation principle and, 94
  misbehavior and, 103
  Repairing Thoughts principle and, 127
  school refusals, 168*f*
  Solving Problems principle and, 145
  Trying the Opposite principle and, 163
Self-calming skills, 77
Self-efficacy, 10
Self-evaluation rulers, 190
Self-observation, 175
Separation anxiety disorder, 16, 168*f*. *See also* Anxiety/anxiety disorders
Sequential problem solving, 31–32, 142–144. *See also* Problem-solving steps; S-O-L-V-E steps; Solving Problems principle
Shaming thoughts, 23–24. *See also* Thoughts
Shared-mechanism approach, 3
Skill acquisition, 12–13
Skill Units in FIRST. *See also* Clinician Guides; Feeling Calm principle; FIRST approach; Increasing Motivation principle; Repairing Thoughts principle; Solving Problems principle; Trying the Opposite principle
  beginning treatment and, 38–40
  boosting engagement, 187–191
  combining with S-O-L-V-E steps, 146, 148
  continuing treatment, 182–187
  Feeling Calm principle and, 74–76
  Increasing Motivation principle and, 90–93
  overview, 11–12
  Repairing Thoughts principle and, 124–126
  Solving Problems principle, 142–144
  Trying the Opposite principle and, 159–162
Skills building, 11–12, 192–193
Social anxiety disorder, 168*f*
Social phobia, 16, 168*f*. *See also* Anxiety/anxiety disorders
Socratic questioning, 10, 12
S-O-L-V-E steps. *See also* Problem-solving steps; Sequential problem solving
  for anxiety and OCD, 145–146
  caregiver guide to, 156
  for depression, 148–149
  handouts for, 154–156
  for misbehavior, 149–151
  overview, 140–141
  for posttraumatic stress, 147–148
  posttraumatic stress and, 141
  Skill Assessment: Solving Problems, 152–153
  Skill Unit Outline: Solving Problems, 142–144

Solving Problems principle. *See also* FIRST approach; Sequential problem solving; Skill Units in FIRST
for anxiety and OCD, 20, 70, 141, 145–146, 152
conduct problems and, 31–32
continuing treatment and, 182–187
crises and, 15
for depression, 26, 70, 141, 148–149, 152–153
handouts for, 151, 154–156
for misbehavior, 70, 142, 149–151, 153
overview, ix–x, 2, 7–8, 70, 140–141, 144–145
for posttraumatic stress, 23, 70, 141, 147–148, 152
skill assessment for, 151–153
Skill Unit Outline: Solving Problems, 142–144
studies testing effects of FIRST principles, 197–199
Somatic arousal, 73. *See also* Arousal
Specific phobia, 16, 168*f*. *See also* Anxiety/anxiety disorders
Stop and think exercises, 132
Strengths, 10
Stress. *See also* Posttraumatic stress
depression and, 26, 59
Feeling Calm principle and, 21, 79–80, 85
misbehavior and, 61
reactions to, 79–80
in-session practice for, 85
Substance abuse, 208
Suicidal ideation/attempts, 207–208
Summarizing, 10, 189
Sustain talk, 189. *See also* Change talk
Symptoms, 75

Tangible rewards. *See* Rewards
Temperamental factors, 61, 142
Termination, 126–127
Thoughts. *See also* Repairing Thoughts principle
all-or-nothing thinking, 123
anxiety and OCD and, 89
caregiver guide to repairing, 139
depression and, 50–51, 59, 60, 172
hostile attributions, 31, 124
misbehavior and, 61
posttraumatic stress and, 48, 80, 177
Skill Assessment: Repairing Thoughts, 133–135
Skill Unit Outline: Repairing Thoughts, 124–126
Skill Unit Outline: Trying the Opposite, 160
Threat overestimation, 69
Tic/habit behaviors and disorders, 5, 13, 203–206
Time out from positive reinforcement. *See also* Reinforcement
caregiver guide to, 118–119
Increasing Motivation principle and, 102–103
Together Time
anxiety and OCD and, 95
caregiver guide to, 110
misbehavior and, 99
posttraumatic stress and, 96
Top Problems Assessment, 8, 9, 14
Tourette's disorder. *See* Tic/habit behaviors and disorders
Transdiagnostic treatments, ix–x, 3–4
Trauma. *See also* Posttraumatic stress
misbehavior and, 95
overview, 48–49, 57, 58
Repairing Thoughts principle and, 69
Solving Problems principle and, 70, 141
Trying the Opposite principle and, 71
Treatment. *See also* Treatment barriers
ambivalence towards, 40
anxiety and OCD and, 56
beginning treatment and, 8–10, 37–40
continuing treatment, 182–187
depression and, 51, 60
ending treatment and, 12–13, 15, 191–195
goals for, 39
misbehavior and, 52–53, 62
obsessive–compulsive disorder (OCD) and, 47
panic attacks and, 202–203, 204*f*
posttraumatic stress and, 49, 58
providing an overview of, 39
tic/habit behaviors and disorders and, 203–206
treatment planning and, 10, 63–67
youth and caregiver roles in, 39
Treatment barriers
ambivalence towards treatment, 40, 53, 190
anxiety and OCD and, 18–19
continuing treatment and, 185
overview, 12, 39
posttraumatic stress and, 23–24
Treatment focus. *See* Focus of treatment
Treatment manuals, 3–4, 8
Trichotillomania. *See* Tic/habit behaviors and disorders
Triggers
misbehavior and, 175
obsessive–compulsive disorder (OCD) and, 46
posttraumatic stress and, 49, 167, 169
Trying the Opposite principle. *See also* Adaptive behavior rehearsal; Exposure techniques; FIRST approach; Skill Units in FIRST
for anxiety and OCD, 18–20, 71, 145, 158, 163–167, 166*f*, 168*f*–169*f*
for conduct problems, 31
continuing treatment and, 182–187
for depression, 24, 26–27, 71, 158, 167, 169–174
handouts for, 176, 179–181
for misbehavior, 71, 159, 174–176
overview, ix–x, 2, 7–8, 71, 157–158, 162–163
for panic attacks, 203
for posttraumatic stress, 21, 23–24, 71, 158
skill assessment for, 176–178
Skill Unit Outline: Trying the Opposite, 159–162
studies testing effects of FIRST principles, 197–199
for tic/habit behaviors and disorders, 205–206
treatment planning and, 64

Values, 10
Vote for the best solution step. *See also* S-O-L-V-E steps
for anxiety and OCD, 146
for depression, 149
for misbehavior, 150
overview, 143
for posttraumatic stress, 147–148

Weekly monitoring, 14. *See also* Monitoring
Worry
compared to anxiety disorders, 46–47
exposures and, 165–166
Repairing Thoughts principle and, 127–129

Youth engagement. *See also* Engagement
beginning treatment and, 9–10
boosting engagement, 187–191
Skill Units in FIRST and, 38–40
Youth Problems and Coping Form
complete form, 43–44
FIRST Interview—Youth and, 37
overview, 9, 12, 63