CBTFrame
Course Handbook

Partnership to End Addiction

Development of the FamilyFrame Course Handbook was supported by grants from the National Institute on Drug Abuse (R34DA044740) and National Institute of Mental Health (R34MH117212).

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I. Introduction

The *CBTFrame Handbook* is designed to provide learners with a comprehensive guide to support engagement with the CBTFrame course and for scoring video vignettes. The handbook serves as a companion document for training learners to use CBTFrame as well as a reference to use while scoring vignettes. It contains a description of each technique and provides additional information to help therapists make scoring decisions in an informed and reliable manner.

The General Instructions section provides an overview of CBTFrame and scoring strategies and procedural guidelines to help establish reliability in rating the Cognitive Behavioral Therapy techniques. The Technique Descriptions section provides detailed descriptions and examples for each technique.

II. Design of Training System

CBTFrame is grounded in brief (5-8 minute) vignettes featuring a variety of real therapists demonstrating techniques in sessions. The clients are actors, but the content is based on real cases.

The learning management system (LMS) exists on a platform called LearnDash. You will have the opportunity to access the training material on a self-paced basis, on your own time.

The LMS will support you moving through each training exercise. The exercise will begin with brief text describing three CBT treatment techniques.

You will then watch a 5–8-minute video vignette of a clinician delivering treatment techniques in session, followed by a short coding activity (5 techniques) on which you will rate, or score, the extent to which various CBT techniques were used in the vignette you just viewed.

Finally, you will receive immediate feedback presenting expert consensus scores, your scores, and summaries of utilized techniques.

Each exercise within this course takes 10-15 minutes to complete.

III. Coding Instructions

A. Scoring Strategies:

1. Avoiding Halo Effects: Be mindful of the "halo" effect. The halo effect refers to situations wherein a score for a given technique is biased or influenced by a rating awarded to another technique or by a global judgment about the vignette as a whole. Halo effects come in many shapes and sizes—here are some relevant examples:

    (a) A learner decides that they really like the client or therapist in the vignette and/or believes the client is benefiting from the therapy. As a result, they tend to give high scores to many techniques.

(b) A learner recalls a particularly powerful or thorough therapeutic intervention that deserves a high score. They then proceed to score other, non-related interventions more highly than merited.

(c) A learner recalls that the vignette was a good/important session, or that many interventions were extensively used in the session. They then proceed to give high scores to many techniques across the board, without giving separate consideration to whether each individual intervention was extensively used.

2. Call It Like You See It: Generally, vignettes will contain two techniques that have been scored 0 [Never/Not at all]. This does not reflect poorly on the therapist or client in the vignette. Also, not every intervention during a vignette will correspond to a technique by which it can be scored. The techniques in CBTFrame are not an exhaustive list of treatment techniques and cannot capture every interaction that may occur in a vignette or real-life session. Therefore, learners should be careful not to "stretch" judgment about a particular intervention in order to make it "fit" one of the techniques.

B. Procedural Rating Guidelines:

1. Rating the Extensiveness (Degree) of Interventions, NOT their Quality: Learners should consider the degree to which each intervention is used in the session vignette, specifically, the extent to which the intervention is delivered. Accordingly, the Likert rating scale contains “Never/Not at All”, “A little bit”, “Moderately”, “Quite a bit”, and “Extensively” as anchor points. The scale is designed to assess the extent to which interventions are used, not how well or how effectively they are used. ***Learners should avoid making judgments about the quality of an intervention, appropriateness of the intervention for the given situation, or the success/impact of the intervention.***

2. Extensiveness = Thoroughness + Frequency: As indicated above, scoring each CBTFrame technique requires learners to judge the extensiveness of therapist behavior. "Extensiveness" refers to two separate dimensions of therapist behavior: the thoroughness of the intervention, and the frequency of the intervention. Generally speaking, *thoroughness* is defined as the completeness and intensity with which interventions are executed, whereas *frequency* is the amount of time and number of instances in which interventions are employed. Thus, it is possible to score highly for thoroughness based on a focused interaction that occurs during a relatively brief segment of the vignette. On the other hand, high scores may be given for an intervention that arises frequently, albeit briefly, throughout a session. It is difficult to provide more precise guidelines at the general level. Each technique targets a unique CBT intervention, so that techniques differ in the degree to which thoroughness versus frequency is the more relevant dimension. In one vignette a technique might be scored highly because it is intensely executed for a short period of time, whereas in the very next vignette that same technique is scored highly because it is frequently executed in a less intense manner.

3. Exemplar Therapist Statements: The CBTFrame handbook technique descriptions contain examples of therapist statements for certain techniques. These statements, called “exemplars”, serve as prototypes for categorizing interventions according to the criteria described for each technique. Exemplars are intended to help learners identify techniques by presenting some prototypical content/style of intervention for the given technique. Because most interventions typically involve complicated and/or lengthy exchanges between therapists and clients, exemplars are not meant to reflect extensiveness; they are simply prototypes of the kinds of behaviors that fall under a given technique. As a result, the handbook does not attempt to provide examples of interventions that reflect a specific score for a technique.

4. Technique Overlap: CBTFrame techniques are designed to identify unique therapeutic interventions. As such, these techniques are theoretically independent of one another, in that no technique covers exactly the same territory as any other technique. However, it is common for a single intervention to have multiple features corresponding to multiple techniques. In this sense, the techniques may "overlap" in describing different features of the same intervention. Techniques can also overlap because the techniques themselves are similar, as in they assess various facets of a general behavioral category. To account for this, we sorted techniques into Clusters, with each technique under a given Cluster overlapping to some degree with every other technique of that Cluster. However, even for techniques contained within the same Cluster, it is common for therapists to use one intervention extensively without using any other interventions from that Cluster. Therefore, learners should consider every technique independently for each session they are rating. Note that several techniques in the handbook contain guidelines for recognizing technique overlap and distinguishing between similar techniques.

C. Technique Descriptions – Scoring:

Each of the 13 techniques that comprise CBTFrame are presented in the following format:

(a) The technique as it appears in the LMS
(b) Brief description of the technique
(c) Intervention steps and implementation tips (when indicated)
(d) Technique overlap and distinction guidelines (when indicated)

Every technique is scored according to the same 5-point Likert scale:

0	1	2	3	4
Never/Not at all	**A little bit**	**Moderately**	**Quite a bit**	**Extensively**

Cluster 1: BEHAVIORAL ASSESSMENT AND CBT PSYCHOEDUCATION

Behavioral analysis procedures are based on structured or semi-structured behavioral interviews and provide basic information about the antecedents and consequences of specific behaviors, including the "presenting problem" along with any number of treatment-relevant behaviors. The first purpose of behavioral analysis is to uncover information about reinforcers of behavior problems that therapists can utilize throughout treatment to render interventions personally relevant and effective for given clients. A second purpose is to help clients themselves recognize and understand the behavioral chains of antecedents and consequences that maintain problems, with the intent of illuminating motivations and circumstances that could be changed in order to modify existing chains and move clients toward healthier behavior. This affords adolescents a structured setting in which they can formulate and communicate about the function(s) of behavior symptoms within key ecological contexts. A structured "functional analysis" of the primary presenting problem is usually completed during the earliest stages of treatment for primary assessment purposes, then revisited throughout treatment and continuing care services to demarcate changes in client behavior and re-formulate treatment goals and interventions. A key concept in CBT that is meant to promote positive change in people's lives is the Three-Part Model. We can imagine that on autopilot mode we are feeling emotions, thinking automatically, and behaving reactively without full awareness of the connections between our feelings, thoughts, and behaviors. The Three-Part model, or triangle, is meant to describe how feelings, thoughts, and behaviors are all connected and can influence each other. Clients can change one and change the others.

1. **Functional Analysis of Behavior Problems:** Explores behavior problem(s) by asking teen to describe typical chains of antecedents-behaviors-consequences (A-B-C's)

2. **Three-Part Model of CBT:** Discusses the link between Thinking, Feeling, and Doing

1. *Functional Analysis of Problem Behavior:* Explores behavior problem(s) by asking teen to describe typical chains of antecedents-behaviors-consequences (A-B-C's)

Functional analysis begins with therapists asking clients to describe a typical situation in which a given problem or behavior occurs. Therapists then pursue follow-up questions to detail a typical chain of antecedents-behavior-consequences (i.e., A-B-Cs) associated with the situation, working to identify stimuli that give rise to the problem and rewards that strengthen its continued expression. Depending on the cognitive and attentional capacity of the adolescent, worksheets might be used to document the behavioral chains of A-B-Cs associated with a given problem, modeling the functional analysis process for clients in order to encourage self-analysis of current and future behaviors. Therapists can use discretion to determine how many behaviors to analyze and when to group discrete behaviors into holistic patterns.

"Triggers" are thoughts, feelings, or behaviors that regularly precede a problem behavior and are instrumental in the behavior occurring. That is, triggers lead to behaviors, which in turn lead to consequences. External triggers are associated with the environment (whom they are with when the behavior occurs, where it typically occurs, when it typically occurs), whereas internal triggers are associated with internal states (thoughts, physical sensations, and emotions experienced before and during the problem behavior). Internal triggers include feelings like anger, cravings, frustration, and depression. Even positive feelings, such as excitement or the desire to celebrate an accomplishment, can be a prelude to problem behavior.

A-B-C Behavior Chain

A: Antecedents (factors that precede or trigger behavior)
B: Behavior (presenting problem-behavior)
C: Consequences (what happened after the behavior)

Key Strategies

- A therapeutic style of non-judgmental curiosity is often used to solicit meaningful information and understanding regarding how behavior problems have led to negative consequences, changes in relationships, and so on. A facilitative and authentically non-confrontational manner also invites adolescents to elaborate on their experiences. Anytime a youth shares openly about behavior problems, a therapist can validate the feelings that emerge and reflect appreciation for the fact that the youth is sharing.
- Therapists can engage in functional analysis without addressing both antecedents and consequences- either being discussed in the context of a given behavior is working to understand the chain.
- Worksheets are often used to help conduct functional analysis. Worksheets can be used as guides for the therapist to gather as much information as possible. Therapists need not use the exact wording on a given worksheet, but rather, phrase questions in an open-ended manner.
- A primary goal of functional analysis is for the therapist and the adolescent to begin to determine what is powerful enough to help the adolescent change their behavior. For example, a powerful reinforcer can be to avoid going back to probation or detention. The therapist may also begin to assess the teenager's internal or external motivations (e.g., Are they in treatment because of probation or caregivers?). During this process, the therapist can also learn about the adolescent's friends and how those relationships are

conducive or not to the adolescent's goals. Another option is to ask who is an admired figure or positive influence in their life, and who might therefore serve as a change agent.

2. *Three-Part Model of CBT:* Discusses the link between Thinking, Feeling, and Doing

There are three main elements at the foundation of CBT (sometimes referred to as the cognitive triangle): Thinking, Feeling, Doing. Cognitive elements ('thinking') are the thoughts, beliefs, interpretations, processing styles, and mental coping skills that a person maintains. Emotional elements ('feeling') are the feelings and the physiological processes that may be associated with such emotions. Behavioral elements ('doing') represent the actions a person takes or their response to a particular situation. These three elements lay the groundwork for the cognitive triangle, which can be helpful in examining a client's presenting problem. Each element can be thought of as occupying one point of the triangle, where back and forth interactions occur. Rather than thinking about these elements as functioning in a sort of domino effect (e.g., thoughts affect feelings, feelings affect behaviors), they can be understood to both influence and be influenced by the other points in the triangle in an ongoing process.

Identifying the elements of the cognitive triangle may be helpful in understanding the continuous dynamic between one's thoughts, feelings, and behaviors that surround a particular event. CBT interventions serve to break the cycle through targeting the thoughts, beliefs, and interpretations that maintain presenting problems.

Steps in breaking down the Cognitive Triangle: Help the client to…

1. Identify the event or 'problem' that the client has chosen to focus on, listing out exactly what happened (or typically happens).
2. Identify the thoughts that accompany that event, listing out the thoughts that pop into a client's head as well as the recurring thoughts the client may routinely tell themselves.
3. Identify the feelings associated with the event and accompanying thoughts.
4. Identify the resulting behaviors/actions by the client in the context of this event/situation.

To introduce adolescent clients to this concept, it may be helpful to apply it to a benign everyday event, for example:

1. Event: Kate sees a puppy
2. Thought: "That puppy is so cute!"
3. Feeling: Kate feels happy
4. Behavior: Kate pets the dog

Cluster 2: CBT INTERVENTIONS

Cognitive, Emotional, and Behavioral interventions are core to the CBT approach. Interventions are often chosen and implemented following a thorough Functional Analysis of the presenting problem(s). The following item descriptions are intended to serve as a general overview of the theoretical purpose and implementation of each intervention. Example worksheets and more thorough implementation descriptions can be found in the accompanying Appendix.

Cognitive interventions are delivered with the ultimate goal of encouraging adolescents to monitor their cognitions and become aware of how cognitions influence emotions and behaviors—that is, the dispositional role that cognitions play within the "cognitive triangle" of thinking, feeling, and doing. Cognitive interventions can be directed at specific thoughts or more global thinking habits; this applies whenever the thoughts of the client become the direct targets of the session and main objects of the intervention. Understanding thought patterns and internal dialogue gives rise to cognitive restructuring interventions in which adolescents are asked to view key events or behaviors in a new light, reason things out before jumping to conclusions, and consider alternatives to routine behavior choices, among other options.

Emotion regulation interventions help clients to identify and understand their emotions by slowing down this process and recognizing their body talk. This process can help clients feel more in control of their emotions, thoughts, and actions and prevent emotions from spiraling out of control, so that they can use new skills to work through problems. For simplicity, this manual does not attempt to make conceptual or clinical distinctions among various related constructs such as affect regulation, self-regulation, behavioral control, and neurobehavioral dysregulation. At a fundamental level, all CBT models for adolescent behavior problems contain coping-focused interventions designed to help clients recognize and modulate their anger and explosiveness, impulsiveness, depressed and anxious moods, and stress reactivity.

A feature of the CBT approach is teaching clients practical **behavioral skills** that can help them function more adaptively in their environment. The concepts of decision-making, problem-solving, coping, and communicating are highly related to one another. The therapist is interested in helping clients tackle everyday problems in an efficient and appropriate manner, deal effectively with stressors, and communicate constructively so that their needs and desires can be met. For these purposes, adolescents are taught general strategies for effective functioning, so that they can attain personal goals and be evaluated more positively by others.

Behavioral interventions often contain three core features: (1) Therapist is engaged in an active manner (teaching, recommending, exhorting) rather than a passive manner (listening, reflecting, suggesting); (2) The skills being taught will be effective in various situations, and they would be useful for most people; (3) The skills are tailored to the unique circumstances of the client: Therapist teaches the general skill by making it relevant to the particular situation at hand. This kind of skills training is often guided by worksheets and reinforced via assigned homework and ongoing review to facilitate gains in client functioning.

Behavioral family interventions present an opportunity for adolescents, their caregivers, and other family members to develop new ways of relating to each other to reduce conflict and produce more skillful behavior. To that end, therapists can teach and direct the practice of

new, family-based skills, including the new skill of communicating differently. This applies equally to working with caregivers alone (including discussion of parenting strategies and skills) and working with caregivers and teens together.

3. Cognitive Restructuring: Helps teen to counteract unhelpful cognitions

4. Emotion Regulation: Focuses on client's feelings and/or deeper emotional reactions

5. Activity Sampling: Helps teen to activate new, prosocial behaviors through activities and every day environment restructuring

6. Decision Making & Problem Solving: Challenges clients to generate more positive options for resolving difficult situations and helps to expand the ways in which they solve problems

7. Communication and Assertiveness: Identifies client's communication skills and habits and explores opportunities for improving unfavorable outcomes by using alternative skills

3. *Cognitive Restructuring:* Helps teen to counteract unhelpful cognitions

Therapists can help adolescents become better consumers of their cognitive output. Clients learn to identify and interrogate their thoughts rather than implicitly accept them. This active and iterative process acknowledges that some challenging beliefs and thoughts are resistant to change efforts; even so, clients can develop better ways of recognizing and coping with them when they arise. This includes arousing and anxiety-related cognitions that have developed in compensatory fashion during past (sometimes traumatic) experiences and thus were functional in the previous context. It also includes thoughts known as “cognitive distortions” that are deemed exaggerated, overly negative or positive, premature or partially considered, or inherently inconsistent.

Cognitive Monitoring: Understanding Overt Thinking, Core Beliefs, and Cognitive Distortions

Cognitive interventions, as applied to adolescents, begin with teaching clients to observe and enhance their self-talk. The aim is to make clients aware that their cognitions do influence their behavior and emotions. Clients are helped to detect both overt conversations they have with themselves and the tacit, deep structural rules (“core beliefs”) that guide their thinking. Therapists may point out examples of behavioral tendencies, entrenched emotional positions, or cognitive predispositions and biases as being representative of the client's core beliefs and attitudes. In each case, the therapist's primary intention is to identify and explore the client's underlying cognitions about life and relationships. In effect, therapists ask directly or indirectly, "So, you act/feel/think this way *because* you believe that...?". It may also be helpful to educate the teen that beliefs are like onions in the sense that there are often many layers, and just like an onion, there is usually a “hot thought” or core belief deep down. Sometimes those core beliefs make you cry, like onions. Note that “hot thoughts” are usually judgments about the self, the situation, or the future.

Cognitive distortions are a particular type of cognition: exaggerated, overly negative or positive, not carefully considered, or containing inherent contradictions. They are habitual ways that teens editorialize environmental information. Often, clients with emotional or behavioral problems engage in more exaggerated distortions. See the handout for the most common types of cognitive distortions to review with clients. What we think and how we think can play a major role in determining the feelings we experience and the decisions we make. In most cases, clients do not fully understand the strong connection between distorted thinking and the undesirable feelings/situations that result. Thus, therapists help clients rectify and avoid cognitive distortions using various self-monitoring techniques: taking stock of unrealistic or negative beliefs, exposing exaggerated or contradictory viewpoints, and practicing positive self-statements.

In dealing with any cognitive distortion in particular, the task of the therapist is four-fold:

1. Demonstrate that the client holds an irrational belief.
2. Explain why the distortion is irrational/problematic/unhelpful, if this is not self-evident.
3. Identify how the distortion leads to unwanted outcomes.
4. Once distortions are identified, the client can be challenged via cognitive restructuring techniques (see below) to adopt more rational and helpful beliefs, which results in more self-promotion.

Basic Guidelines of Cognitive Restructuring

To help clients restructure unhelpful cognitions, therapists attempt to illustrate how they may be associated with unwanted behavioral tendencies, entrenched emotional positions, or problematic biases. In so doing, therapists are careful to emphasize not that given beliefs are flawed and/or irrational, but rather, anxiety-provoking and/or unhelpful.

The two basic steps in cognitive restructuring are: (1) Showing the client how negative thought patterns (some of which may be noted in the internal triggers sections of functional analyses) have led to troublesome behavior in the past; (2) Teaching the client adaptive ways to respond to these triggers. The overarching goal is to restrict negative thoughts. Adolescents need to learn to use positive self-statements to counteract the negative ones. To help clients generate positive statements, therapists ask questions that examine the evidence supporting those thoughts. Once therapists help clients examine the evidence behind negative statements, clients should be encouraged to substitute new, positive thoughts that are not associated with the problem behavior. Therapists can encourage them to consider these thoughts several times and then examine the feelings associated with the new thoughts.

Examples

- Speaking aloud and role-playing negative self-talk in session (i.e., externalization)
- Teaching clients to question the evidence used to maintain or strengthen problematic beliefs
- Helping clients re-attribute personal versus external responsibility for negative outcomes in a more balanced and/or realistic manner
- De-catastrophizing problematic behaviors or situations
- Helping teens understand the cognitions or feelings of others (i.e., perspective-taking)
- Examining hostile attribution bias, whereby automatic thoughts attributing hostile intentions to others are exaggerated and tend to prompt negativity and even hostility in response
- Specific examples include: Triple Column Strategy, Externalization of Voices, and ABCDE worksheet (see Appendix)

Key Strategies

- Avoid appearing cold or judgmental, even for very damaging automatic thoughts.
- Avoid engaging in black-and-white disputes (“Do/Think X rather than Y”). Instead, simply ask “What would you tell a friend?”

4. ***Emotion Regulation:*** Focuses on client's feelings and/or deeper emotional reactions

This skill is focused on helping clients (teens and/or caregivers) better recognize their feelings and deeper emotional reactions, with the ultimate aims of (1) developing practical plans for coping with emotional arousal and (2) supporting related efforts to change thoughts and behaviors. This begins by helping clients become more aware of the triggers and signs of affect arousal and develop appropriate coping skills.

Adolescents in particular often get caught up in ruminative thoughts or distracting emotions, which can result in their not being fully aware of what they are doing or why they are doing it. This is even more true for adolescents with conduct, mood, and/or substance use problems. Not focusing on the present moment—the details of internal sensations and the external environment—is like being on autopilot. Teens often focus too much on unhelpful ideas about the past (depressive thinking) or future (anxious thinking) and/or become captivated by (re)experiencing strong emotions. Mindfulness (aka present-moment awareness) practices are designed to help adolescents get out of autopilot mode by slowing down their thoughts and helping them become aware of what is actually occurring internally and externally. The goal is to focus on the here-and-now rather than the past (which can't be changed) or the future (which hasn't happened yet).

One key way to focus on emotion regulation is supporting adolescents in becoming more aware of their emotions- including being able to observe, label and describe their emotions. The skill of recognizing feelings is often a part of emotion regulation.

<u>The Basics:</u>

1. ***Introduce the Skill***: Provide the client with a rationale for emotion regulation, for example: "We've talked about how negative beliefs can trigger negative thoughts. This is also true for feelings. For example, someone may experience increased heart rate, tense muscles, or shortness of breath without even realizing it. The more the body feels out of control, the harder it is to cope or get things done. And the longer you feel out of control, the harder it all gets."
2. ***Recognize Physiological Arousal***: Define body reactions or 'Body Talk' as changes in the body that occur with negative feelings. Present the Feelings Thermometer worksheet as an overview of many potential emotional reactions and ask the client to identify how they felt when a recent trigger of a key problem happened (for example, a teen who is upset about fighting with a friend could be encouraged to identify a feeling that emerged during that interaction). Then present the Body Talk handout as an overview of common symptoms that people have when experiencing intense emotions. Ask the client to go through each column and circle when they experience the emotion selected on the feelings thermometer.
3. ***Avoid the Risky Zone***: Explain that physical symptoms typically occur gradually, not all at once. Help the client complete the Feelings Thermometer, using body reactions identified on the Body Talk handout. Instruct the client to list body talk symptoms by what happens first, and what happens as the feeling becomes more intense. Examples of low-level reactions are feeling tense or clenching fists; higher-level reactions include yelling, punching, and urges to self-harm or use substances. Help the client identify a point on the thermometer when the body spirals so far out of control that they have trouble controlling behavior; this point is the *Risky,* or *Danger* Zone. Indicate that the

main goal of emotion regulation is to recognize early body talk and address it before it escalates to the Danger Zone.

4. ***Make a Coping ("Stay Cool") Plan***: Ask the client to brainstorm what they can do when they begin to notice early body talk to prevent reaching the Danger Zone. Note clearly that the goal is to create a coping plan for early warning signs of the target issue(s). Encourage the client to identify examples of things they can do to feel better and also things that they can tell themselves.

Relaxation Training

Relaxation training can be used to cope with stress, tension, anxiety, trauma, and anger. Relaxation techniques aim to prevent or reduce arousal levels that render adolescents susceptible to compromised reasoning and decision-making, difficulty with concentration, sleep problems, and reliance on substance use to moderate stress. There is an abundance of relaxation techniques that can be implemented in a step-by-step fashion with willing adolescents, including progressive muscle tense-and-release exercises and pleasant mental imagery exercises. Relaxation interventions invariably begin with substantial in-session modeling and guided practice, followed by assignments for ongoing practice at home.

Introducing the topic of Relaxation Training

It is often helpful to impart a knowledge base about relaxation training to clients in order to enhance their motivation to practice and benefit from it. Explain that anxiety is the sum of physical and cognitive tension that the person is experiencing. Felt tension in either the physical or cognitive domain can lead to tension in the other domain and, via a feedback loop, feed on each other and escalate. Reduction in anxiety can be achieved by intervening in either domain. Progressive relaxation operates to reduce tension in the physical domain. Pleasant mental imagery works in the thinking domain. Whatever procedure is chosen, it is important for teens to practice 15-20 minutes every day, in session and then at home.

Anger Management

Anger management is a commonly practiced category of affect regulation interventions for adolescent behavior problems. It is intended to reduce or interrupt expressions of anger and/or aggression that yield maladaptive outcomes: "acting out" in a physically or verbally aggressive manner, passive behaviors followed by explosions of rage, frequent physical altercations, rancorous interactions with others, etc. The CBT conceptualization of anger management problems falls squarely in line with the overarching A-B-C framework: Triggers that are direct (e.g., observing someone aggress against you) and indirect (e.g., inferring someone is angry or disappointed with you) give rise to defensive and/or hostile cognitions and physiological arousal, which carry forward to emotional and behavioral expressions of anger and aggression. Many other CBT skills learned in therapy can be brought to bear for effective anger management.

Key Strategies:

- Try to remind clients to remain kind, compassionate, and accepting of both internal and external stimuli. That is, clients can treat their bodily, cognitive, and emotional experiences as if they are happening to their close friends. A starting point is

transitioning from labeling experiences as “good” or “bad” toward remaining resolutely neutral or factual.

- Start with emotions that clients can easily identify, for example anger or sadness.
- Once there has been some basic practice (and success) at mindful and nonjudgmental awareness, teens can practice applying these techniques during times when they are feeling strong emotions, for example, when listening to music or watching a video. These opportunities can be used to notice the various elements of thoughts and feelings, and also, to practice remaining appreciative but neutral about them. As practice improves, teens might find it helpful to write a brief anecdote/story about a significant moment in their lives when they experienced a very strong emotion—and then when reading through it, exercise a stance of nonjudgmental awareness.
- Therapists can create different coping plans for different emotions.
- When completing the Feelings Thermometer, therapists can encourage clients to identify and include trigger thoughts. For example, ‘Here we go again’ or ‘I can’t handle this’.
- For clients who struggle with the Stay Cool plan, therapists can start with strategies that have worked for the client in the past, and/or build on problem-solving skills learned in treatment.
- Caregivers can essentially learn and follow the same steps as teens; often, parents benefit from focusing on the importance of managing negative affect when parenting.

5. *Activity Sampling:* Helps teen to activate new, prosocial behaviors through activities and every day environment restructuring

This intervention derives from the functional analysis that is completed early in treatment and involves helping teens activate new, prosocial behaviors that compete with and eventually replace problem behaviors. To do so, therapists support teens in sampling new activities and restructuring their everyday environments, a form of "stimulus control" in which they avoid high-risk persons and situations with established links to the problem and seek new, positive outlets for social and recreational activities.

Adolescents in treatment for behavior problems sometimes have social and recreational lives characterized by disruptive behavior and/or substance use, making it a challenge to develop friendships and find activities unrelated to the given behavior problem(s). These behaviors may then trigger thoughts about being isolated from others that increase negative moods and thoughts. Activity sampling aims to introduce and reinforce prosocial or more positive behaviors that compete with or replace habitual problem behaviors, boost positive mood and cognitions, increase positive social support, and enhance feelings of positive self-efficacy.

Therapists may nominate activities meant to directly counter aspects of the A-B-Cs detailed in functional analysis (e.g., enrolling in a midnight sports league that conflicts with more risky habits or texting a friend when depressed rather than isolating from others) and/or to introduce activities with potential new positive reinforcers. The goal is to replace an activity that leads to negative emotional state or suboptimal consequence. Sampling new activities also helps teens set reasonable and attainable goals. Meeting these goals promotes self-efficacy, the belief that they can complete certain tasks. When people believe they can follow through with one task, they are usually more successful at following through with other tasks.

Activity Sampling Cascade

1. **Introduce:** Convey understanding that many of the teen's activities may involve risky or unproductive behavior; set a positive tone about potential alternatives; acknowledge that the teen might miss the activities that were enjoyed while engaging in problem behaviors in the past. Emphasize the importance of positive activities for ongoing emotional/behavioral/physical health.
2. **Inventory & Invite:** Help teen identify activities to sample and assign good candidates as homework; reinforce CBT skills needed to help engage with new peers; determine whether a friend or family member can actively support/accompany activity engagement.
3. **Recap & Revisit:** On a weekly basis, review sampled activities to assess their experienced reward values, identify personal preferences that can be accessed as ongoing activities and rewards, and problem-solve solutions for accessing and maintaining future attempts.
4. **Reinforce:** Use systematic encouragement (brainstorming, role-playing and feedback) to help teens maintain their commitment to engaging with promising options.

Key Strategies

- Engage in activity sampling early in treatment to build rapport and gain insight.

- Maintain an archive of recreational opportunities from which to draw candidates tailored to a given youth's age group and social preferences. *(See Appendix for Handout: Big List of Pleasurable Activities)*
- Encourage use of technology to schedule and track new and recurring events. *(See Appendix for Handout: Weekly Plan for Pleasant Activities)*
- Enlist family/mentors/peers in session or via phone to identify and support new activities. Engaging family members on a regular basis, and encouraging parent-teen and/or family-wide activities, increases the potential for success. Parents should approve selected activities. Use family sessions to have caregiver and teen plan and problem-solve activities together.
- Use sampling as an opportunity to discuss application of skills learned in treatment (cognitive, affective, behavioral) to increase positive and decrease negative experiences.
- Activity sampling should be a frequent homework assignment. Stress patience and practice.

6. ***Decision Making and Problem Solving:*** Challenges clients to generate more positive options for resolving difficult situations and helps to expand the ways in which they solve problems

Training in decision making and problem solving is a cornerstone CBT activity for enhancing self-efficacy as well as life skills. A conventional starting point is introducing the fundamental processes of decision making, a less formal process that involves helping clients understand how everyday decisions exert a powerful impact on life quality and direction—a direct and often predictable connection between choices and short- or long-term consequences. This includes decisions made with and without direct awareness, as well as those made actively or passively. Clients can then consider how sound decision making buttresses effective problem solving.

Problem solving is usually a more formal process that involves predetermined steps. The basic formulation for problem solving involves teaching youth to adopt a systematic approach that begins with disaggregating decisions or problems into component parts/goals for which manageable solutions are more readily monitored and achieved. It is valuable to focus on decisions and problems that have immediate, significant relevance in the client's life.

Problems with self-harm and substance use can be conceptualized as limitations in problem solving in the sense that people often feel stuck if they don't have enough options for how to resolve difficult situations. This skill challenges clients to generate more positive options and expand the ways in which they solve problems. It also helps teens understand tendencies to overvalue and choose negative options. For example, they may overvalue the short term benefits of substance use but not consider the long term ramifications of this behavior.

Conventional steps in effective problem solving

1. Define the given problem in situational detail, describing typical A-B-C chains along with connections among thoughts, feelings, and actions. Be as specific as possible—it may help to use a "how to" statement to help operationalize the statement (e.g., "how to get along better with my sister"; "how to get to school on time").
2. Delineate preferred outcomes of the problem situation. The bigger the "pros and cons" list, the greater the chances of finding a preferred outcome. Be sure to include key negative outcomes that the client has actually selected in the past. Consider short- and long-term.
3. Brainstorm numerous solutions for achieving preferred outcomes, including those likely to yield negative as well as positive results (even far-fetched solutions), and then specify behaviors that need to be increased or decreased to garner success.
4. Evaluate the relative merits of solutions (e.g., positive vs. negative vs. mixed); eliminate undesirable ones; select one "goal" (or a combination) with best potential for reaching preferred outcomes.
5. Practice the new solution in session, with modeling and feedback.
6. Devise a plan to practice the solution in vivo, anticipating potential obstacles and subsequent accommodations.
7. Monitor and revise the solution and practice the plan based on observed real-world results. As plans evolve, new goals may emerge that should then be subjected to all of the above steps.

Key Strategies

- Therapists support the development of decision making and problem solving skills in session in dialogic ways, usually delineating more than one potential option or solution, and with the goal of skill development- not just resolving one dilemma in the moment.
- One common way of emphasizing decision-making skills is discussing the idea of choices as something that everyone has to make, and that choices are associated with consequences, both positive and negative, immediate and long-term. The goals herein are that: (a) Teens consider outcomes as a function of choices that are made; (b) Teens understand the benefits of adequate reasoning skills and responsible decisions.
- A-B-C information about client-specific “triggers” for problem behavior can be very useful in identifying meaningful problems to solve; see worksheet in Appendix.
- When narrowing down to a single goal/solution, help the client brainstorm any obstacles to carrying out that solution, with the same expansive attention used to brainstorm solutions.
- Always specify exactly when a given solution will be practiced, and under what conditions.
- If the client does not practice as planned, this can be identified as its own problem to solve.

7. ***Communication and Assertiveness:*** Identifies client's communication skills and habits and explores opportunities for improving unfavorable outcomes by using alternative skills

Communication training is another CBT cornerstone for helping youth avoid negative interactions that create problems and exacerbate stress. Strong communication skills can also foster healthier interactions with significant others in support of achieving treatment goals. Although training usually introduces several generic principles of effective communication (e.g., using "I" statements when engaged in difficult conversations), it remains essential to tailor training to each client's real-world circumstances. This can be accomplished by asking clients to recount typical or recent conversations with specific persons (e.g., parent, teacher, friend), allowing for collaborative review of the communication anatomy of both benign and problematic conversations. During this interactive process the client's communication skills and habits can be identified, along with opportunities for improving unfavorable outcomes by using alternative or newly learned skills. Importantly, during this process therapists also model effective skills (e.g., active listening, collaborative questioning, respectful disagreement).

A wide variety of communication skill sets is commonly taught to adolescents with behavioral problems. Some examples include:

- Active listening: listen, rephrase, ask questions, show understanding
- Positive communication about problematic situations: state understanding of different perspectives, take partial responsibility, offer willingness to help, suggest possible solutions
- Assertiveness and additional generic behaviors that promote effective communication: maintain positive body language, value compromise

Educational materials (e.g., assertive versus aggressive or defensive communication, constructive versus destructive criticism), scripted lesson plans, and stock role-play scenarios can be employed. *Note that drug or alcohol refusal skills are a particular variety of assertiveness training (See Appendix for an assortment of communication training supports).*

Cluster 3: GLOBAL TREATMENT PRINCIPLES

CBT treatment operates under the premise that clients cannot be expected to adopt the skills and concepts learned in therapy without first mastering the skills in sessions. To that end, CBT is often characterized by in-session teaching and practicing of the core interventions and techniques described above. Moreover, to ensure generalization and mastery in the teen's day-to-day life, it is vital for clinicians to collaborate with the family to create Action Plans that encourage and support out of session practice of those same skills. Action Plans include specific plans to practice skills taught in therapy, discussion and problem solving of potential barriers to carrying out the homework, and continued follow-up week to week by the therapist to monitor completion.

To promote positive outcomes and increase parental involvement in treatment, clinicians are encouraged to invite parents and other caregivers to participate in treatment. Parental participation includes consultation to collaborate on treatment goals and monitor the teen's progress in therapy and also supporting parenting skills, focusing specifically on parenting issues and practices that are a good developmental fit for the teenage years. The goal is to provide education and support in basic skills for parenting adolescents by presenting and discussing knowledge about normative adolescent development; building or exploring parental involvement in the adolescent's ecosystem; discussing parental monitoring strategies and limit setting; and establishing behavior management plans to reinforce desired behavior at home.

8. *In-Session Practice:* Introduces CBT treatment techniques in session and/or utilizes role plays

9. *Action Plan:* Assigns/Reviews a specific task to client to be completed in between sessions

10. *Parent Participation:* Recruits caregivers in session to behave in ways that reinforce or supplement specific aspects of the treatment agenda

8. ***In-Session Practice:*** Introduces CBT treatment techniques in session and/or utilizes role plays

CBT treatment techniques are designed to be introduced in session by the therapist via didactic instruction, modeling, rehearsal and coaching, and when indicated, role play. These tasks are often aided by the use of a worksheet that depicts the relevant information, skills, or tasks in a step-by-step fashion. Particularly when utilizing structured worksheets as in-session guides, CBT therapists follow a semi-structured sequence for in-session practice: (1) *Review* the content of the skill/task; (2) *Model* performance of the task/skill, and/or, supply relevant and developmentally appropriate examples; (3) *Rehearse* the client in performing the task/skill; and (4) *Coach* the client over (several) performance repetitions.

Please score both this item AND the item representing the skill that is being practiced—that is, if the in-session training involves rehearsing a future dinner-table conversation with a parent, score Communication and Assertiveness as well as this item. In general, this item will almost always be co-scored with one of the other items in the manual.

Rehearsal for many CBT techniques takes the form of role plays, wherein the client "practices" what might be said or done in some specified future situation. In the case of *role-playing* per se, clients and/or therapists pretend to be other people, speaking and acting as they imagine the other people might. In so doing, the therapist hopes to elicit new perspectives or behavioral strategies on the part of the client for a given circumstance, either one intended to occur in the future or (less often) in past situations. In the case of *hypothetical questioning*, the therapist asks the client to imagine a specific future circumstance; to generate in session the feelings, thoughts, and behaviors that might arise in that circumstance; and to consider potential perspectives and behavioral strategies for that circumstance. Hypothetical questioning is more common than full-blown role playing and generally takes the form: "What will you do if...?". Note that rehearsals of all kinds are meant to be accompanied by frequent coaching and positive reinforcement.

9. ***Action Plan:*** Assigns/Reviews a specific task to client to be completed in between sessions

Virtually all CBT techniques are designed to be first learned in session (via In-Session Practice, per above) and then practiced outside of session on a routine basis. Most sessions in CBT begin with review of the prior session's assignment and end with an assignment for the next session, usually guided by reference to a worksheet for the given skill/task. There are two basic classes of homework: (1) *Behavior Prescription*: A clear directive to complete a specific task and to report back about the execution of the task at the beginning of the next session. These assignments take the generic form: "I want you to do this when you get home" or "Between now and next week, you should follow this up on your own". This is the most common form of homework. (2) *Behavior Program*: An ongoing assignment to continue participation in a structured task. These assignments are usually part of a structured protocol of activity that is first outlined in session, and then practiced out of session over time (e.g., keeping an emotions/cognitions log, participating in a behavior reward system, practicing relaxation techniques). Therapists use the current, in-session problem focus as the basis for assigning homework for next session. In so doing, therapists relate the homework task to important therapeutic themes.

Action Plans can be assigned and reviewed for any of the CBT techniques previously described—activity sampling, cognitive interventions, affect regulation, and/or behavioral skills. Of course homework assignment and review is also specifically described as a key component of several of the above techniques.

Please score both this item AND the item representing the skill that is being assigned or reviewed as homework—that is, if the homework assignment involves practicing deep- breathing exercises at home, score Emotion Regulation as well as this item. In general, this item will almost always be co-scored with one of the other items in the manual.

In general, this item should be scored anytime a client is asked to complete a specific task in between sessions. That is, this item refers to concrete directives that the therapist expects will be carried out as discussed (e.g., "This week, when your sister comes in your room without your permission, your job is to get your mother right away, and not to hit her or start any fights."). This item does not refer to: (1) general suggestions for doing things differently (e.g., "When your sister comes into your room, have you thought about just telling your mother, rather than hitting her and starting fights?"); (2) discussions about general problem-solving skills (e.g., "Let's talk about all the things you can do when your sister comes into your room without your permission."). Of course, if discussions about general problem-solving lead to a specific task assignment, then score this item.

Score this item for review of homework as well as the development of the prescription or program.

10. *Parent Participation:* Recruits caregivers to behave in ways that reinforce or supplement specific aspects of the treatment agenda

One key aspect of parent participation is home-environment support, wherein caregivers are recruited in session to behave at home in ways that reinforce or supplement specific aspects of the treatment agenda. Caregivers may be asked to extend or enhance interactions with their teens that fall under normal parenting duties, such as assisting with new activity engagement or interacting with other parts of the youth ecosystem (e.g., contact a school counselor). Caregivers may also be recruited to prompt and help their teens practice new skills in the home or another environment. This level of family involvement is routine in virtually every CBT model that targets adolescents, though in many instances older adolescents will have achieved sufficient autonomy to function as emancipated clients who need (or want) little caregiver involvement in treatment. The most intensive version of home-environment support involves caregivers attending multiple treatment sessions to help plan, manage, and reinforce new therapy-learned skills at home.

Categories of Caregiver Consultation

Please keep in mind that if the session includes explaining or practicing interventions from an item in one of the other CBT clusters (e.g., emotion regulation, problem solving, communication training), then co-score the corresponding item along with this item. Please note that this item should not be automatically given a high score just because a caregiver is present; try to keep in mind the *degree* to which caregivers are being invited to reinforce the treatment agenda.

A. Coaching youth in accessing caregiver support

Therapists may meet with adolescents individually to discuss family conversations related to CBT goals and/or skill development. In individual sessions, therapists can invite, encourage or reinforce youth including their caregivers in CBT focused treatment goals and progress. Youth conversations with caregiver(s) could take place: (1) **In Session:** interactions that are scheduled to take place at a later point within same session, or in the very next session; (2) **Out of Session:** interactions that are meant to happen at home, or wherever family members may be in conversation with each other outside of the therapy room. Therapists either prepare youth or reflect with youth the ways in which caregivers are reinforcing changes in thoughts, feelings, or behaviors.

B. Updating caregivers

Conversations with caregivers about ongoing treatment progress and/or instructing and garnering caregiver support to help the teen practice therapy-learned skills at home or complete action plans/homework assignments. This often takes place at the end of sessions.

C. Family or caregiver practice

Sessions in which any of the interventions specified in another CBT cluster (activity sampling, cognitive interventions, emotional regulation, behavioral skills training) are described (or even practiced) in session with a caregiver, including the use of worksheets. For example, if you work with a caregiver alone on problem solving skills

and use the SOLVE worksheet, score this item; if you work with a caregiver and teen together, score this item and also score Decision Making and Problem Solving.

D. Parenting adolescents

Debunking Myths about Adolescent Development

Therapists who work with caregivers of teens can seek to defuse powerful stereotypes about adolescent development that negatively affect how teens are viewed and treated by others. Debunking inaccuracies about adolescent maturity and normative family relations can set the stage for establishing effective family-oriented treatment goals. Specifically, therapists often look to dispel these primary "myths" about adolescence and family life:

1. Adolescence is necessarily jarring to the emotional stability of the family
2. Parental displays of affection need to be curtailed or abandoned
3. Adolescents need to completely separate from their families and "grow up"

Framework for Introducing Corrective Information about Development

- Look to provide a developmentally informed perspective on salient family issues. The knowledge presented varies greatly across families with respect to topic and detail.
- Common topics include the importance of interpersonal relationships, how strong needs can lead to impulsive behaviors, information on the developmental stages of life and changes that occur in these stages, and the typical wishes, aims, and needs that teens have in the context of various relationships.
- Attempt to ‘normalize’ typical adolescent behavior, including perceived negative behavior like moodiness and uncommunicativeness, in the eyes of both parent and teen.
- Emphasize the ways parents and teens must remain connected during adolescence, especially focusing on the importance of a positive parent-teen attachment that promotes the individuality of teens but does not cut them off from love, support, and firm guidance.

Parental Monitoring

Therapists discuss with parents and teens the crucial importance of parents remaining knowledgeable about, and directly involved in, the life of their teen outside the family. Interventions to promote parental monitoring can take two forms:

1. Discussions about the parent’s direct involvement in, contacts with, or knowledge of the teen’s life outside the family
2. Working to help the parent think about their teen’s perspectives, ideas, or opinions concerning how he or she thinks about life outside the family

Whereas teens gain more freedom and autonomy as they grow older, it remains important that parents continue to monitor their teen’s behavior and set clear and fair limits. Therapists help parents initiate or reshape parenting practices related to monitoring their teen’s behavior, setting and enforcing rules in their home, and providing guidance and structure. Examples include setting curfews, maintaining a consistent household routine, knowing their teen’s whereabouts, knowing which friends their teen spends time with, and administering fair and consistent consequences for inappropriate behaviors.

Behavior Management

Behavior management is a parenting intervention intended to change youth behaviors by altering the existing schedule of behavior reinforcement in the home—that is, instituting rewards for desired behaviors and consequences (punishments) for undesired ones.

Cluster 4: MOTIVATIONAL TECHNIQUES

Motivational techniques seek to bolster motivation and participation in treatment though understanding and acknowledging ambivalence to change behavior. This can be accomplished in several ways including building a supportive relationship with adolescent clients who may be reluctant to engage in treatment as well as understanding, acknowledging and validating ambivalence to change behavior. As therapy progresses, it is important for therapists to continue to implement motivational techniques via praise and affirmation of change effort.

11. **Joins with Adolescent:** Builds a supportive relationship with the adolescent.

12. **Motivation to Change:** Explores client concerns about problematic behavior, readiness to change behavior, and optimism about success.

13. **Affirms Self-Efficacy:** Affirms client's ability to change problematic behavior and praises change efforts.

11. ***Joins with Adolescent:*** Builds a supportive relationship with the adolescent
(Score zero [Never/Not at all] if index youth does not attend session)

This technique focuses on therapists establishing and maintaining positive therapeutic relationships with adolescents by presenting themselves as allies and attending to adolescents' experiences. Adolescents may be accustomed to treatment that is authoritarian rather than cooperative; thus, it is important for teens to feel a sense of agency in treatment. Emphasis is placed on fostering a supportive team alliance with the adolescent and underscoring the importance of the teen's unique voice in the therapeutic process, such that youth feel comfortable to share their experiences, world views, hopes, dreams, and needs with therapists and families.

Therapists seek to earn trust and acceptance from adolescents and to help them to know that they clearly have something to gain by participating in individual as well as family sessions. At the beginning of treatment, therapists may acknowledge that it is natural for adolescents to feel cautious and should actively encourage teens to participate and share their perspectives with family members to work toward family change. Also, therapists may regularly deliver joining interventions with adolescents throughout the course of treatment in order to shore up a flagging alliance, prepare for a difficult patch in treatment, or simply maintain a continuously strong working relationship.

Careful consideration of developmental level and age appropriateness is paramount to joining with adolescents. Joining interventions should demonstrate respect, acceptance, and trust to teens in the session; use relevant, minimal self-disclosure; and work to avoid appearing partial to any one person or segment of the family.

<u>Exemplar Statements</u>

"I want you to come here and talk about things happening in your life. I'm trying to be someone who supports you and helps you reach the goals you want to reach."

"I hear that you're confused and frustrated that Claudia thinks she doesn't want to go to college. Claudia, I'm wondering, what are you interested in and what do you see for yourself in the future?"

"I appreciate you sharing about your substance use with your family. Your honesty is going to be important in the work that we all do here together."

"Don't leave me here. I'm pushing you because this is important stuff. I hear you saying 'Get off my back; things are getting better'. What I'm telling you to do is the hard stuff. Don't bail out here."

"I'm an expert in helping mothers to hear their daughters. I'll push you to be as clear as possible but I'll also push her to do a better job listening. I'll be right there in the room with you to help her hear what has made you so upset."

12. ***Motivation to Change:*** Explores client concerns about problematic behavior, readiness to change behavior, and optimism about success

Therapists often try to elicit client discussion of change (self-motivational statements), encourage motivation to change, and/or discuss the general issue of therapeutic change. This is often accomplished through questions or comments designed to promote greater awareness or concern for a problem, increase intent or optimism to change, or encourage elaboration on a topic related to change.

When delivering motivational interventions, therapists endeavor to focus on eliciting personal statements from clients that specifically identify a need or intent to change. These interventions will typically lead to "change talk" and/or self-motivational statements and movement toward the negotiation of specific plans for change. In some cases, therapists initiate a formal discussion about the stages of change (readiness to change), or, explore how the client's motivation to change might be strengthened. The therapist might also explicitly assess the client's current motivation to change current problem behaviors, especially if the client continues the behaviors in question.

Client here can refer to anyone in the therapy session (i.e. adolescent client and/or additional family/friends/significant others). For example, if a therapist speaks with an adolescent's father about his own motivation to change related to the presenting problematic behavior, this item should be scored.

Exemplar Statements

"Based on the concerns you've raised, what do you think about your current use of substances—does that contribute to these problems you've identified?"

"What are some reasons you might see for making a change? What do you think would work for you if you decide to change?"

"What are some reasons you see for changing how you manage your school work?"

"Usually, the first thing is that a person has to believe there's a problem to begin with. What do you think is the real issue between you and mom, or do you think it's all in her head?"

"OK, try to think of three things in your life that would be better if you could do what the probation officer is asking you to do."

Technique Distinction

Technique #16 *Affirms Self-Efficacy* focuses in part on therapist affirmation and encouragement about client change. The therapist is basically a *complimenter* of change (about something the client has already accomplished) or *cheerleader* for change (about something the therapist believes the client can or should accomplish). That is, in Technique #16 the "change talk" is meant to support the client, and it emanates from the therapist. In contrast, in Technique #15 *Motivation to Change* the therapist plays the role of *skeptic* (about degree of client motivation for change) or *detective* (about what the client sees as the conditions for, or consequences of,

change). That is, in Technique #15 the “change talk” is meant to prompt and challenge the client, with the focus on eliciting change talk from the clients themselves.

13. ***Affirms Self-Efficacy:*** Affirms client's ability to change problematic behavior and praises change efforts

Therapists often verbally reinforce the client's strengths, abilities, and efforts to change behavior—that is, affirm the client's self-efficacy to *make therapeutic changes* (not just confirm self-efficacy in a general sense). Therapists can affirm client self-efficacy using many different approaches: (a) Using compliments or praise; (b) Acknowledging the client's personal qualities, competencies, or abilities that might promote change; or (c) Recognizing effort or small steps taken by the client to change. By complimenting, positively reinforcing, and validating the client, the therapist fosters the belief that there is hope for overcoming problems and that the client can change their own behaviors.

Client here can refer to anyone in the therapy session (i.e. adolescent client and/or additional family/friends/significant others). For example, if a therapist speaks with an adolescent's father about his own ability to change related to the presenting problematic behavior, this item should be scored.

Exemplar Statements

"It sounds as if you've really thought a lot about this and have some good ideas about how you might want to improve your grades in school. You're really on your way!"

"That must have been very hard for you. You're really trying to work on things."

"You wouldn't be coming down here to see me—or talking to your guidance counselor at school—if you didn't have some faith that things can get better with your family. You can't change everything, but you can always make things better for yourself. You're a smart guy, and you think about things carefully."

"You seem to have a talent for writing, and you express yourself really well that way. That can be a really powerful tool in your progress."

"I know it hasn't been easy for you to discuss some of these issues in here, but you've faced some difficult topics head on, and made great strides in our sessions together."

Technique Distinction

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Acknowledgements

The authors extend their sincere gratitude to Lila Bruynesteyn and Michelle Martinez for their essential contributions to this manual.

The source material for the ITT-CBT derives from the following primary sources:

Donohue, B., & Azrin, N. H. (2012). *Treating adolescent substance abuse using Family Behavior Therapy: A step-by-step approach*. Hoboken, NJ: John Wiley & Sons

Godley, S. H., Smith, J. E., Meyers, R. J., & Godley, M. D. (2016). *The adolescent community reinforcement approach: A clinical guide for treating substance use disorders*. Bloomington, IL; Chestnut Health Systems.

Hogue, A., Dauber, S., & McSpadden, E. (2016). *Inventory of Therapy Techniques for Adolescent Behavior Problems (ITT-ABP): Therapist Self-Report Scoring Manual*. Center on Addiction, New York, NY.

Hogue, A., Rowe, C., Liddle, H. A., & Turner, R. (1994). Scoring Manual for the *Therapist Behavior Rating Scale*. Center for Treatment Research on Adolescent Drug Abuse, Temple University, Philadelphia, PA.

Webb, C., Scudder, M., Kaminer, Y., & Kadden, R. (2002). *The Motivational Enhancement Therapy and Cognitive Behavioral Therapy Supplement: 7 Sessions of Cognitive Behavioral Therapy for Adolescent Cannabis Users.* (Volume 2 of the Cannabis Youth Treatment (CYT) manual series, 162 pp). Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.