Youth Form - Decision Tree

Not-On-Track Feedback Cases

1. Does the youth report low Self-Efficacy?
   - YES → See Youth Self-Efficacy Interventions handout. Proceed to #2.
   - NO ↓
2. Does the youth report low Social Support?
   - YES → See Youth Social Support Interventions handout. Proceed to #3.
   - NO ↓
3. Does the youth report low Motivation for Treatment?
   - YES → See Youth Motivation Interventions handout. Proceed to #4.
   - NO ↓
4. Does the youth report concerns with the Therapeutic Alliance?
   - YES → See Youth Therapeutic Alliance Interventions handout. Proceed to #5.
   - NO ↓
5. Reassess the diagnostic formulation. Is there an effective treatment option that has not been attempted?
   - YES → Consult relevant resources and alter the treatment plan.

Youth Self-Efficacy Interventions Handout

Self-efficacy is broadly defined as a self-perception of one's ability to perform competently and effectively in a particular task or setting (Bandura 1982, 1989). People with higher perceived self-efficacy see themselves as more likely to achieve the desired outcome in tasks they attempt. A wealth of research has examined the effects of perceived self-efficacy across a variety of social, academic, affective, physical and mental health domains (Cervone & Scott, 1995).

According to Bandura, psychotherapeutic interventions have their effects through the mediation of self-efficacy. Efficacious treatment methods enhance the client's perceived self-efficacy, which in turn promote a variety of beneficial behaviors, such as increased coping ability, increased expenditure of effort on tasks and increased persistence with difficult tasks. Increases in these behaviors are expected to bring about more favorable outcomes in a variety of settings.

Although higher generalized self-efficacy has been shown to be related to a variety of positive psychosocial outcomes, it is important to note that this is a multidimensional construct. Particularly in the context of youth treatment, it may be most helpful to examine perceptions of self-efficacy for the specific domains relevant to the reason for referral and treatment goals. For example, self-efficacy items on the TSM-Y focus on self-efficacy for the areas of social behavior skills, behavioral regulation, problem solving, and academics (domains and items shown to be most strongly associated with positive treatment outcomes in community-based treatment settings; Salazar & Warren, 2012; Warren et al., 2008).

Youth Self-Efficacy Subscale

Indications for Action

The youth self-efficacy items (items 1–15) sum to a score between 15 and 75 with a high score indicating higher feelings of self-efficacy. A score at or below 43 has been determined to indicate the need to further explore youth self-efficacy and take steps for improving it. In addition, specific responses to specific items can guide the therapist to consider certain aspects of youth self-efficacy that may be most problematic. Cut-off scores on each item have been established so that therapists can view the items when responses fall below normal responding. The following pages provide information about improving youth self-efficacy.

Youth Self-Efficacy Interventions

Bandura's (1977) original self-efficacy theory points to several important methods through which a person's self-efficacy may be enhanced. Three that are particularly relevant for a therapeutic setting include: 1) personal experience of successes and accomplishments, 2) vicarious experiences of similar others, and 3) verbal persuasion.

Experiencing personal success is the most significant factor that affects self-efficacy (Bandura, 1994). In tasks that are difficult, risky or otherwise perceived as threatening, successful completion leads to an enhanced level of self-efficacy. However, failures at such tasks will often have the opposite effect, causing a person to feel less capable. Self-efficacy can also be altered by the vicarious experience of success or failure from similar others. If a person perceives someone as similar to them and then observes that person failing at a given task, that person's perceived self-efficacy will decrease with respect to that task. On the other hand, if a similar other is successful at a given task, a person

will feel more capable of completing that task successfully as well.

Verbal persuasion from others can also promote or diminish perceived self-efficacy. When a person hears from others that they are capable and likely to be successful at a given task, they will generally exert greater effort into completing the task and dismiss feelings of insecurity. However, according to Bandura, it is more difficult to enhance self-efficacy through verbal persuasion than it is to damage self-efficacy. This is due in part to the notion that people will generally avoid activities which they are told they will not be successful in. In addition, an inflated self-efficacy due to encouragement from others can quickly disappear when a person is unsuccessful at the task (Bandura, 1994).

Given the research cited above, self-efficacy interventions are likely to have the greatest impact on treatment outcomes (and be most likely to prevent treatment failure) when focused on the areas of social behavior skills, behavioral regulation, problem solving, and academic diligence/proficiency. The following recommendations should also be considered:

- Start by directly teaching and practicing any skills that may be required for the youth to be successful in the targeted area of self-efficacy. For example, if the targeted area is behavioral regulation (e.g., problems with anger management), start by teaching and practicing anger management/relaxation skills. Role-playing and feedback as part of skills instruction will also increase self-efficacy and the confidence to use the skills learned.
- Structure activities in therapy and homework assignments to provide opportunities for the youth to experience success in targeted areas.
- Activities and assignments designed to provide personal success in the targeted area should first be designed with a high likelihood of success, then slowly build to more challenging circumstances.
- Use multiple methods for increasing self-efficacy. For example, if targeting self-efficacy for social skills, provide opportunities for successful social skills practice, point out skills and experiences of "similar others" to improve social self-efficacy vicariously, and use verbal persuasion and encouragement for the youth to master these skills in social situations.
- Invite parents (and teachers, as appropriate) to provide encouragement and positive feedback to the youth in the targeted areas of self-efficacy. Encourage them to identify and process successes with the youth.
- At each session, help the youth identify and process successful experiences from the previous week, emphasizing what the youth did well in each situation.
- Regularly highlight areas in which the youth has shown improvement, and use these successes as leverage to extend self-efficacy to other areas.

Youth Social Support Interventions Handout

One of the most widely reported predictors of adaptive behavior in youth has been the presence of a positive social network of family members, peers, and other supportive adults (Masten & Coatsworth, 1998). Definitions have differed among researchers, but it is generally recognized that social support is a multidimensional construct that consists of relationships, perceptions, and transactions that help individuals master emotional distress, share tasks, receive advice, learn skills, and obtain material assistance. Social support is believed to promote adaptive behavior and outcomes by providing the individual with emotional support, resources, or information that facilitate the coping process (Thoits, 1986). A considerable body of evidence suggests that social support provides direct ameliorative benefits for youth under stress, and/or moderates the relation between stress and a broad range of behavioral outcomes.

Social support is clearly a multidimensional construct. Perceived support may come from many different sources and in many different forms. For example, common sources of support include immediate family members, extended family, friends and peers, and adult friends or mentors (e.g., coach, teacher, religious leader). Numerous models of social support exist, proposing various dimensions (i.e., forms or purposes) of support; some of the most frequently emphasized support dimensions include esteem (or emotional) support, informational support, instrumental support, and companionship support. Of particular relevance to social support intervention efforts is that the form or source of support should be tailored to the individual and the situation; different circumstances and individuals call for different types of support. The social support items in the TSM-Y assess perceived support from a variety of sources and dimensions, but were selected from a larger pool of items particularly because they were most predictive of youth treatment outcomes (Dindinger, 2012; Warren et al., 2008).

Youth Social Support Subscale

Indications for Action

The youth social support items (items 16–30) sum to a score between 15 and 75 with a high score indicating higher perceived support. A score at or below 42 has been determined to indicate the need to further explore the youth's social support network and take steps for improving it. In addition, specific responses to specific items can guide the therapist to consider certain aspects of youth self-efficacy that may be most problematic. Cut-off scores on each item have been established so that therapists can view the items when responses fall below normal responding. The following page provides information about improving youth social support.

Youth Social Support Interventions

A variety of methods should be considered in improving youth social support. Youth social support can be improved by enriching existing social relationships, mobilizing social support, intervening to improve dysfunctional social networks, and introducing new members into the support network. The first step in social support interventions for youth is to evaluate the status of the current network in terms of its perceived quality and breadth (from the youth's perspective), and to determine the kinds of supports that the current situation requires. Steps can then be taken to match appropriate supports to the youth's needs. A number of the following principles or interventions may apply:

- Generally speaking, youth need multiple types of support from multiple sources. Begin by identifying important sources or types of support that are missing in the youth's network and seek to address those deficits.

- Youth support networks will change as a function of development stage. Although support from immediate family is always an important component of a youth's social network, support from friends and peers becomes increasingly important given the normal developmental tasks in adolescence of increased autonomy and individuation from parents. Consider the youth's developmental stage and associated needs when evaluating current supports.
- Help youth develop and practice the social skills necessary to effectively recruit support from others, and how to provide support to others. Use role-playing and provide specific feedback to enhance social skills.
- Peer relationships tend to be most supportive when they are stable. Teaching and practicing effective communication and problem solving skills will limit chances that fights and disagreements between friends will result in a permanent disruption in the friendship.
- Encourage participation in school activities, clubs, sports teams, church groups, or other community activities to broaden the youth's social network.
- When appropriate, recruit adults outside the youth's family to provide mentoring and guidance for the youth. For example, discuss with the youth (and parents) whether an adult friend (e.g., a teacher, coach, or religious leader) could provide support. With the consent of the youth and parents, this adult mentor could also be included as an informal member of the treatment team and help the youth work toward one or more treatment goals.
- Periodically re-evaluate the youth's social support needs to determine whether additional sources or types of support are needed based on the circumstances.

Youth Motivation for Treatment Interventions Handout

Unlike most adult psychotherapy patients, youth are rarely self-referred for treatment. Most often, they are brought to treatment because their behavior is a concern for parents or teachers. Consequently, therapists must often deal with youth who have very low motivation for treatment or are openly hostile at the prospect of addressing concerns about their behavior. Relatively little research exists on the relation between youth motivation for treatment and subsequent outcomes; however, low youth motivation for treatment may be a significant barrier to improvement, and is a common occurrence in youth at risk for treatment failure.

In adult treatment settings, many therapists have successfully improved client outcome by incorporating their understanding of motivational stages and how they interact with different types of interventions. The dominant conceptual scheme across this research is based on the Stages of Change model within which clients can be seen to move through motivational stages (*precontemplation, contemplation, preparation, action, and maintenance*; Prochaska & Norcross, 2003). Prochaska and Norcross note that progression through the stages rarely occurs in a linear fashion. The majority of clients may relapse into earlier stages, with many returning to the precontemplation stage when confronted with a failure to change or maintain gains. Although the Stages of Change model has been applied primarily to adults, adolescents with sufficient self-awareness may also benefit from this approach.

An alternative conceptual model for motivation, Self-Determination Theory, asserts that lower levels of motivation are based on the client's locus of motivation (Pelletier, Tucson, & Haddad, 1997). Extrinsically motivated clients, for example, are motivated by the insistence of others that they participate in therapy. Intrinsically motivated clients, however, are highly motivated to make changes in therapy because of the difference they feel in their personal life. The "amotivation" spoken of in Self-Determination Theory may be analogous to the precontemplative stage within the Stages of Change model. As Markland, Ryan, Tobin, and Rollnick (2005) suggest, Self-Determination Theory lends itself well to the interventions in motivational interviewing (see section on "Therapeutic interventions").

Adolescents who are initially brought to therapy against their will may still benefit from treatment, particularly if they learn that there may be real benefits for them, such as increased independence, less nagging from parents, additional privileges, or other benefits. If the therapist is seen as a potential ally rather than a parent "pawn," initially-resistant adolescents may begin to develop a more intrinsic locus of motivation and engage fully in the treatment process.

Youth Motivation for Treatment Subscale

Indications for Action

The motivation items (31–37) sum to a score between 6 and 30 (items 33 and 34 are reverse-scored). Higher scores indicate more positive motivation and responsibility taking. A score at or below 16 indicates problematic motivation and suggests the need to focus on the youth's motivation before moving forward with other therapeutic tasks. Accordingly, scores of 16 and below are signaled as "red."

In general, scores at this cut-off suggest the adolescent is not seeing the need for changes or is

feeling ambivalent about making changes (precontemplative or contemplative), and is not yet taking responsibility for improvement. In addition, specific responses to specific items can guide the therapist to consider certain aspects of motivation that may be most problematic. Cut-off scores on each item have been established so that therapist can view the items when responses fall below normal responding. In considering the following approaches for adolescent clients, the therapist may need to make adjustments to account for the client's developmental level.

Conceptualization of Motivational Problems

Clients in Precontemplation stage (as well as "amotivated" clients) are unaware of their problem behavior or are unwilling to make changes. Prochaska and Velasquez (2002) summarized typical characteristics of those who are in the precontemplation stage in the following four R's:

- Reluctance – Not wanting to consider making changes due to lack of not being fully conscious of their behavior and its effects; being comfortable with where they are.
- Rebellion – Being argumentative and hostile towards the clinician; imagining that the therapist is a part of a coercive social control that is unwanted.
- Resignation – Given up on making changes that are desired but seem beyond the persons grasp.
- Rationalization – Not willing to change because they have somehow figured out that the problem is not theirs; having rationales for not changing; denial and minimization of problems are often common.

The main purpose of interventions with precontemplators is to help them recognize their problem and need for change.

Individuals in the Contemplation stage acknowledge their problems and begin to seriously think about making changes, but are NOT yet ready to make a commitment to change. It is important to note that those who in this stage may talk about making changes, but such change talks do not mean that they are willing or ready to make changes. Individuals in this stage are characterized by ambivalence about making changes (e.g., "I want to change, but I don't want to because..."). The interventions for Contemplators are aimed at developing and amplifying discrepancy, from the client's perspective, between present state and their important goals and values.

Motivation Therapeutic Interventions (see Miller and Rollnick, 2002)

Motivational interviewing (see additional information in the Appendix) can be especially helpful in assessing and encouraging motivation in the context of therapy. Such interventions are especially helpful when desired change is specified in terms of an identifiable behavior (e.g., smoking, alcohol use, drug use, gambling, exercising, viewing pornography, etc). The following may help increase the client's motivation to change that behavior:

> ***Caution:*** *Confrontation and more intensity in treatment often result in client resistance and less positive outcome, especially when working with precontemplators.*

- Assess how important it is for the client to make the targeted change. For example, have the client rate the importance of making specific changes on a scale of 0 to 10, with 0 being "Not important at all" and 10 being "Extremely important." Then follow-

up with such questions as, “Why are you at a ___ and not 0?” and “What would it take for you to go from ___ to [a higher number]? (Miller & Rollnick, 2002).

- Assess the client’s confidence level in terms of resolving the issues dealt with in therapy. For example, have the client rate his or her confidence level in relation to specific problems on a scale of 0 to 10. Then follow-up with such questions as, “Why are you at a ___ and not 0?” and “What would it take for you to go from ___ to [a higher number]?” (Miller & Rollnick, 2002).
- Instead of asking to yourself, “Why isn’t this person motivated?” rather ask, “For what is this person motivated?” (Miller & Rollnick, 2002).
- Discuss the client’s important values, goals, and aspirations.
- Encourage the client to envision and describe how he or she wants his/her life to be. Then have them describe what their life is currently like; clarify the differences.
- Discuss how the client’s problem behavior fits into his/her values and goals.
- Discuss possible effects the client’s behavior is having on their environment, especially those whom they care about the most, such as family and friends.
- Identify discrepancies between the present behaviors and the client’s goals and values. The more clients become aware of contradictions, the more they may feel self-motivated to change.
- Give professional information on the negative consequences of their behavior if the client seems ready to hear it.
- Discuss the positive and negative aspects of the problem behavior. Help the client identify what is good and what is not so good about their behavior (Cost-benefit analysis). List the client’s response on a sheet of paper.
- If the client seems ready, discuss the positive and negative aspects of making a change. Help the client identify what is good and what is not so good about changing. List the client’s responses on a sheet of paper.
- As the therapist, show strong confidence that the client has the inner strength to overcome the problem.
- Avoid giving solutions for the problems at these stages; rather focus on giving clients the opportunity to explore and resolve ambivalence for themselves.
- Avoid focusing on the clients’ apparent problems before making sure that you and the client are focusing on the same issue. The clients may not weigh the problem the same way you do. They may have larger concerns that they have not yet revealed to you, or simply have different priorities.
- Make an action plan that is specific. The client may have sufficient motivation, but may not know where to begin or how to make changes.

- Ask open-ended questions to see if client is ready to make a commitment to change.
- Provide encouragement and support if a client relapses.
- If advice is going to be given, make sure that it is wanted by the client, that you ask permission to give advice, or that the reasons for it are linked with the client's autonomy.

The following may be helpful in dealing with client resistance (refer to Miller & Rollnick, 2002, for more details):

- Reflection—avoid resistance by responding with nonresistance. Reflective-listening statements will often be enough. Client needs to feel that you are on their side and that you are sincerely interested in understanding them.
- Amplified Reflection—reflect back what the client has said in an exaggerated form. *Caution: Do not do this in sarcastic tone or use reflection that is too extreme.*
- Double-Sided Reflection—capture both sides of ambivalence in your reflective statements. If client's statement addressed one side of the ambivalence, acknowledge the client's statement and also add the other side of the ambivalence using his/her past statements (e.g., You feel this way, but there is also this other side of you…) Caution: Do not use the client's words to attack them.
- Shifting focus—shift the client's focus from the issue that seems to be a stumbling block. The idea is to go around the stumbling blocks rather than to climb over them.
- Emphasize that the client has personal choice and control.
- Coming alongside—when an ambivalent person argues against change, instead of defending pro change position, argue for counter-change position.
- Reframing—reframe information that the client is offering with some additional insight to help him or her see the problem from a new perspective.

Youth Therapeutic Alliance Interventions Handout

The therapeutic alliance can be defined as the quality of the helping relationship, an emotional bond between the therapist and the client, the level of agreement between the two parties on the therapeutic tasks, and/or the agreement between the two parties on the expectations and goals of therapy (Bickman et al., 2004; Bordin, 1979). As noted in the section on parent therapeutic alliance, the therapist working with child and adolescent cases must attend to the quality of the alliance with both the parent and the child; disruptions to either alliance often results in premature termination or other negative outcomes.

The literature on therapeutic alliance in youth treatment is considerably smaller than for adult treatment. A recent meta-analysis indicated that there have only been 23 studies examining the therapeutic alliance in psychotherapy with children, as opposed to over 2000 adult studies as of the year 2000 (Kazdin, Whitley, & Marciano, 2006). In evaluating the studies that examined the therapeutic alliance, a correlation of .24 was found between the quality of the youth–therapist alliance and therapy outcome (Kazdin Whitley, & Marciano, 2006; Shirk & Karver, 2003). Although the quality of the youth–therapist alliance does not appear to be as consistent a predictor of outcomes as has been observed in the adult literature, problems in the youth–therapist alliance are often observed in youth whose symptoms show no change or increase during treatment.

Youth Therapeutic Alliance Subscale

Indications for Action

The youth alliance items (items 36-40) sum to a score between 5 and 25 (item 38 is reversed-scored), with a high score indicating a more positive alliance. A score at or below 15 has been determined to indicate the need to further explore the youth–therapist alliance and take steps to improve it. Accordingly, scores of 12 or less are given a warning signal with an associated message. In addition, specific responses to specific items can guide the therapist to consider certain aspects of the alliance that may be most problematic. Cut-off scores on each item have been established so that therapists can view the items when responses fall below normal responding. The following page provides information about improving the alliance.

Youth Therapeutic Alliance Interventions

Initial steps for improving a poor youth–therapist alliance overlap with recommendations for improving youth motivation for therapy. Alliance building involves transforming youths' negative expectations about therapy into the realistic assurance of a collaborative undertaking. Addressed in the initial sessions, this involves helping the youth to recognize that there can be tangible benefits that he or she can get out of therapy, such as increased independence and autonomy from parents, additional privileges, improved interactions with parents, etc. The therapist also gains credibility in the youth's eyes by emphasizing that all family members will be required to make changes and concessions for the good of the family.

In addition, research on what youth view as ideal helping qualities in adults is relevant to developing a strong youth–therapist alliance. Among the most important qualities in adults valued by youth are trust, respect, and openness. Of particular relevance to the therapeutic alliance is youth's appreciation of adults who listen non-judgmentally, without lecturing, and who are open to receiving new ideas from the youth. Youth also like adults who view them as mature, capable, and aware. In addition to considering the ideas below, therapists may also **review the recommendations in the**

section on the parent–therapist alliance, as many of the recommendations provided there are also applicable to repairing alliance ruptures with youth.

- Establishing a strong youth–therapist alliance within the first few hours of therapy is critical to the therapeutic process.
- Review your (therapist) behaviors that may have communicated a lack of trust or respect to the youth.
- Examine whether your goals for the youth are consistent with the youth's current goals for therapy.
- Explore with the youth what positive outcomes might still be a possibility for therapy.
- Accept responsibility and apologize for any behaviors (intentional or otherwise) that may have caused a rupture in the youth–therapist alliance.
- Communicate and use techniques that show your respect for the youth's individuality.