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All About FIRST

FIRST: Origin, Content, and Purpose

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

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

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

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

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

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

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

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

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

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

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

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

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

Who Can Be Treated with FIRST?

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

Anxiety, Obsessions, and Compulsions

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

Posttraumatic Stress

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

Depression

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

Misbehavior

- Oppositional defiant disorder
- Conduct disorder
- Problems involving misbehavior

Related Problems and the Relevance of FIRST

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

What About ADHD?

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

What About Medication?

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

The Role of Specialty Clinics

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

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

The Five FIRST Treatment Principles

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

F: Feeling Calm

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

I: Increasing Motivation

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

R: Repairing Thoughts

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

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

S: Solving Problems

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

T: Trying the Opposite

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

How to Use FIRST

Overview of FIRST and Its Skill Units

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

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

Identifying the Initial Treatment Focus and Beginning Treatment

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

What to Expect

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

Using Assessment to Identify Treatment Needs and Monitor Treatment Response

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

Engaging Youths and Caregivers, and Addressing Potential Barriers to Treatment

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

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

Strategies to Support Ongoing Engagement

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

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

Using Decision Trees to Decide Which Principles to Use and When

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

Decision Points

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

Skill Units and How to Use Them

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

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

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

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

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

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

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

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

Assessing Skill Acquisition

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

Addressing Treatment Barriers

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

Putting It All Together: Continuing Treatment

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

Ending Treatment and Posttreatment Planning

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

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

Examples of Fear Hierarchies and Behavior Charts

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

Sample Script for Progressive Muscle Relaxation

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

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

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

Frequently Asked Questions About Using FIRST in Clinical Practice

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

Assessment at Intake and Weekly Monitoring

Intake Assessment

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

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

Weekly Monitoring

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

Dealing with Comorbidity

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

Dealing with Changes in Treatment Focus

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

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

Coping with Crises by Turning Them into Teaching Moments

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

Ending Treatment

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