Bachelor Thesis: The Role of Tact in Cognitive Behavioural Therapy for Adolescents

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Abstract

This scoping review focuses on the role of tact in evidence-based practices (EBPs), specifically cognitive behavioural therapy (CBT). While CBT is the "golden standard" for treating mental health issues, its structured nature may not always meet the unique needs of adolescents, especially when resistance arises. Tact is examined as a dynamic, context-sensitive ability that aids in adapting CBT to individual clients, enhancing therapeutic alliances, and exploring motivation. The goal of this review was to explore what tact looks like in CBT manuals for adolescents and how specific the instructions for tact can be. Three CBT manuals covering various disorders were coded using predetermined themes — 'focusing on the individual', 'building a therapeutic alliance', and 'motivation' — derived from existing literature, with the flexibility to adjust these themes during the coding process. Based on the manuals, tact can be taught and practiced but cannot be fully mastered or formalized into a set of instructions, as it must be tailored to each client's unique circumstances.

Keywords: CBT, tact, adolescent, individualization, therapeutic alliance, motivation

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Imagine a therapist sitting across from a teenager, who avoids eye contact and responds with short, dismissive answers. Despite using a proven therapeutic approach, the therapist struggles to engage the teen, leading to the question: Why do some evidence-based practices fall short in certain cases? This scenario underscores the dynamic interplay between structured methodologies and the nuanced human connection required in therapy.

Evidence-based practices (EBPs) are the cornerstone of contemporary psychological treatment, providing structured, scientifically validated methods to address a variety of mental health concerns. Cognitive Behavioural Therapy (CBT), recognized as the "golden standard" in psychotherapy, exemplifies the success of these approaches. Yet, the growing focus on individualization highlights an important gap in rigidly standardized therapies: the role of intuition, or "tact." This paper explores how tact can complement evidence-based approaches, particularly in addressing resistance among adolescents, and explores research questions aimed at understanding the integration of tact into therapeutic protocols.

Evidence-Based Practices and CBT

EBPs rely on rigorous research to guide therapeutic interventions. CBT, the most widely used and studied EBP, is a structured, goal-oriented therapy that focuses on changing maladaptive thoughts and behaviours (Fordham et al., 2021). According to David and colleagues (2018), CBT has earned its status as the "golden standard" due to robust evidence supporting its efficacy. The authors highlight CBT's evolution toward trans-diagnostic and personalized approaches, which aim to address the complexities of individual cases. Trans-diagnostic approaches center on the individual's specific problems rather than their diagnosis, acknowledging the variability in challenges faced by individuals with the same diagnosis.

Hofmann and colleagues (2012) provide further evidence of CBT's effectiveness through a meta-analysis of reviews, noting its superiority in treating anxiety disorders,

somatoform disorders, bulimia, anger control problems, and general stress. For children and adolescents, CBT is especially effective for anxiety and OCD, surpassing pharmacological approaches like SSRIs in cost-effectiveness and safety. However, Hofmann and colleagues (2012) also acknowledge areas for improvement, since this treatment has comparable efficacy to other psychotherapies in treating depression and has reduced effectiveness in certain cases, like attention deficit hyperactivity disorder (ADHD) and substance use disorders.

Despite its structured nature and proven success, CBT does not work for all clients, as David and colleagues (2018) point out. This gap underscores the potential importance of tact, a sensitive and intuitive skill, in tailoring treatments to individual needs.

Understanding Tact

Tact, as Heyd (1995) describes, is a dynamic, context-sensitive ability that combines intuition, empathy, and situational awareness. It involves understanding a specific situation and responding appropriately, often without the guidance of explicit rules. This requires intuition to choose the right response, empathy to address another person's feelings appropriately, and situational awareness to navigate when and how to express oneself tactfully. According to Duggan (2024), tact can be taught and practiced, but its dynamic nature means it can never be fully mastered.

Holmes (2018) describes tact as a therapist's ability to "find their own way," which aligns with the intuitive, adaptive responses necessary in clinical settings. This situational sensitivity is particularly vital when working with adolescents, since they experience complex dynamics, such as developmental changes in autonomy. Situational sensitivity allows therapists to navigate these complex dynamics and foster therapeutic alliances without rigidly adhering to predetermined protocols, like CBT manuals.

The necessity of tact becomes even more apparent when addressing resistance, a common challenge in adolescent therapy. Effective use of tact can bridge the gap between

evidence-based methods and the individualized care adolescents often require.

Resistance in Adolescents

Resistance is a significant barrier to successful therapy, particularly in adolescents. Amodeo and colleagues (2011) identify resistance in adolescents as a frequent challenge in addiction treatment programs. Furthermore, adherence to therapy, which is the opposite of resistance, fosters good treatment expectation (Puls et al., 2018), adherence to family therapy bettered outcomes in violent and chronic juvenile offenders (Henggeler et al., 1997). Adherence in multisystemic therapy improved the relationship to the parent and decreased delinquent peer affiliation and by that delinquent behaviour (Huey et al., 2000), and adherence is an important factor in the outcome of individual CBT for anxiety (Bjaastad et al., 2023).

Oetzel and Scherer (2003) attribute adolescent resistance to factors such as developmental immaturity, stigma, and the perception of being coerced into therapy. Adolescents' unique developmental and psychological needs require tailored interventions. Research by Jungbluth and Shirk (2009, 2013) shows that personalizing therapy, attending to adolescents' experiences, and allocating time to explore motivations can resolve resistance and bolster adherence.

The Role of Tact in Overcoming Resistance

To overcome resistance, it is important to focus on the individual, to build a therapeutic alliance and to explore and enhance the adolescent's motivation.

Focus on Individual

As mentioned earlier, tailoring therapy to the individual is essential. First, it's crucial to adapt therapy to the specific disorder the adolescent is experiencing. For instance, Andersen and colleagues (2021) found that adolescents with ADHD show resistance to standard CBT, but respond more positively to CBT tailored specifically to ADHD.

Tact can be expected to play a vital role in tailoring therapy to individual needs in two key ways: by helping therapists focus on the adolescent's experience and by reducing the level of structure in therapy sessions. Greater attention to the adolescent's experience has been shown by Jungbluth and Shirk (2009) to correlate with increased engagement in therapy. This involves exploring "events, situations, thoughts, feelings, [and] internal states" (p. 1182) and summarizing these insights (Jungbluth & Shirk, 2009). Tact can be expected to be crucial here, as it allows therapists to intuitively assess how much to explore and address the adolescent's experience. Additionally, reducing structure in therapy sessions is linked to greater adolescent involvement. Less structured sessions enable therapists to elicit more information about the adolescent's experiences (Jungbluth & Shirk, 2009). Tact is needed for this, since it helps to determine how much structure is needed.

So, in order to reduce resistance, it is important to focus on the individual during therapy by attending to their personal experience, even if that means that there is less structure.

Therapeutic Alliance

A strong therapeutic alliance is crucial for reducing resistance in therapy, particularly for adolescents. Tact is essential in fostering this alliance.

Oetzel and Scherer (2003) highlight that tact, which they call "empathy and genuineness", reduces stigma and fosters the client's trust in the therapist. In practice, this involves sincere understanding of the adolescent's experiences, tailoring interventions to the client's maturity level, addressing stigma, offering options in treatment and respecting the adolescent's boundaries. All these tactics together foster a strong therapeutic alliance and thereby minimize resistance, since the adolescent will feel respected and their sense of agency will increase.

Zimmermann and colleagues (2021) found that movement synchrony enhances

therapeutic alliance, particularly with patients with BPD (bipolar disorder). This subtle mirroring requires tact to balance synchrony and individuality, avoiding intrusiveness and fostering connection.

Russell and colleagues (2007) discovered that tailoring therapy in early sessions to align with adolescents' personal lives, and then transitioning to structured techniques over time, is associated with better therapeutic alliance. Tact ensures trust by the client is maintained during this shift, while addressing therapeutic goals.

So, the therapeutic alliance is built by using tactful communication, movement synchrony, and knowing when to shift from personal to structured therapy. The therapeutic alliance fosters trust, engagement, less resistance and better therapy outcomes.

Motivation

Jungbluth and Shirk (2009) emphasize that exploring an adolescent's motivation is closely linked to increased engagement in treatment and reduced resistance. This process involves discussing the adolescent's "reasons for working in therapy or challenges to their investment in therapy" (p. 1182). Employing tact is crucial in this context, as it allows therapists to ask the right questions at the right time to uncover and understand the adolescent's underlying motivations.

Another way to increase motivation is by using adherence promoting interventions. Schwalbe and Gearing (2012) found that adherence-promoting efforts yielded greater effect sizes in males, particularly when these efforts were more intensive. However, for youths diagnosed with externalizing disorders, adherence-promoting strategies were associated with lower effect sizes, suggesting a nuanced response to these interventions based on diagnosis and individual factors. Furthermore, therapy that focuses on conduct disorders requires more adherence promoting and for adolescents counts, more promoting is better (Gearing et al., 2011). These findings underscore the importance of tact in tailoring adherence strategies to

the unique needs of each client.

By skillfully addressing motivation through tact and evidence-based methods like adherence promoting interventions, therapists can create a foundation for meaningful engagement and sustained progress in treatment, ultimately empowering adolescents to take an active role in their own healing journey.

Systematic Literature Review

The integration of tact into EBPs raises several important questions: “What forms of tact do the manuals advise therapists to use when dealing with a client’s resistance?” and “How specific are the instructions on tact in the manuals?”

To address these questions, a scoping review of therapeutic manuals will be conducted to identify guidelines for tact. This review will examine how therapeutic guidelines advise therapists to use tact in building a therapeutic alliance, focusing on the individual situation, and increasing motivation, with the ultimate goal of determining whether tact can be operationalized within standardized frameworks. By understanding the role of tact in therapy, particularly with resistant adolescent clients, this research aims to bridge the gap between evidence-based practices and the personalization of care for effective treatment outcomes.

Method

Study Design

To study whether manuals include instructions for tact, a scoping review will be conducted. That means that there are no hypotheses and that additional codes may emerge during the coding process. For this, the scoping review framework by Wislocki et al. (2023) will be used, since they also studied psychotherapy manuals. They used the guidelines from the Joanna Briggs Institute Scoping Review Methodology Group (Munn et al., 2022). Theories are used to define tact and the coding is based on these definitions. There are three themes in which tact will be categorized, namely focusing on the individual, building

therapeutic alliance and exploring motivation. Themes and codes may be edited or added during the coding process. Hence, this coding process is based on theory, but also partly inductive.

Manual Search

An advanced search took place while looking for manuals. The prompts were "manual" AND "cbt or cognitive behavioural therapy or cognitive behavioural therapy" AND "adolescence or adolescent". The databases that were used were PsychInfo and Smartcat, since these PsychInfo has books and articles that come only from the field that focuses on psychology and Smartcat can showcase books and articles that are available within the university of the researcher of this paper. The search for manuals took place in January 2025 and February 2025.

Manual Inclusion

Manuals in this research are defined as books that give therapists advice and instructions on how to conduct therapy. Articles are excluded, since they do not go through the whole process of treatment. The manuals have to be about CBT for adolescents. There are no sorts of CBT excluded. However, when it is a manual for family therapy, the instructions for treating other family members are excluded. Manuals are only included when they are available in Dutch or English, since the author of this paper only understands these languages. The manuals are included based on the title and the description. If the manual turns out not to meet the inclusion while coding, it will still be excluded. When a manual is partially useful for the study, only the sections that have instructions in them will be coded. The maximum number of manuals that will be included is 3 due to the feasibility, since there is only one coder and one month of time for coding. Furthermore, 3 manuals should be enough to figure out if there are instructions for tact. The manuals that will be included, will be uploaded to the program Atlas.ti, where the coding will take place.

Selected Manuals

There are 3 manuals that were included. The first manual focuses on CBT for clients with ADHD (Safren &Sprich, 2020), the second manual gives instructions for CBT for multiple disorders (Kendall, 2018), and the third manual focuses on CBT for clients with OCD (Franklin et al., 2019). These manuals were all published between 2018 and 2020.

Coding

The coding will be partly inductive, since additional codes can emerge during the coding process. The coding will also be partly deductive, since a part of the codes came from existing literature. The only requirement for sections being coded is when it is an instruction to reduce or prevent resistance in the adolescent or to promote engagement. The eventual coding book can be found in the Appendix A. Only instructions will be coded, so sections like the introductions and theoretical frameworks will be ignored. Coding will be done by the author who has no experience with coding qualitative data. Furthermore, the coding will be subjective, since it is the author's opinion whether sections are instructions for reducing resistance. However, to ensure the coding is done thoroughly, each manual will be coded twice. There will also be a coding diary in which the author writes down the new perspectives and ideas they gain during coding. This coding diary can be found in Appendix B. The coding will take place in Atlas.ti, since this program allows for clear annotation, note-taking and making networks of the codes and themes.

Data Analysis

There are three themes in which the codes will be sorted: focusing on the individual, forming a therapeutic alliance, and exploring motivation. However, these themes can be adjusted according to the data. Thus, the analysis will be both theory-driven and data-driven. The themes will be changed based on the frequency of recurring themes that were not

included as initial themes. The results will be presented in different themes with illustrative examples.

Ethical considerations

This study went through an ethics approval. There were no problems, since only published materials are used. This means that there is no sensitive data.

Results

The 3 themes that were described in the introduction turned out to be adequate descriptions of forms of tact found during the data analysis. Even though some codes were added to the themes, there was no need for an extra theme. The themes and codes will be further explained in this results section by giving examples of excerpts of the manuals that portray these forms of tact. Only the most helpful codes will be elaborated on in this results section. For the whole codebook, see Appendix A.

Theme 1: Focusing on the Individual

'Focusing on the individual' occurs a lot in the manuals. In the manuals, this is mainly done by integrating the interests of that specific client into the treatment and by being aware and taking the specific context of a client into account when making the treatment plan, instead of following the standardized treatment plan. The ADHD manual and the multi-disorder manual mention that the same symptoms can have different causes in different clients, which requires different treatment techniques.

Code 1.5: Match Treatment With Client's Goals

Although the manuals do mention that it is important to adapt the treatment to the client's goals, they do not say how to do that. They only focus on how the goals of the client can be discovered or talk about "what if"-situations. This can be illustrated by a quote from the manual about OCD:

"Another issue we would suggest grappling with at the end of the intake is whether

> family discord or other such factors are likely to negatively affect CBT delivery for OCD. For families that spent much of the time arguing in the waiting room or in the intake, we suggest some explicit discussion of that process, without descending into blaming anyone for it, and we emphasize how important it is to change everyone's approach to the journey on which they are about to embark" (Franklin et al., 2019, p. 87).

This quote illustrates that an additional goal of the client might be to have the family argue less, which is not a goal every client has. However, for this specific situation it is already mentioned in the manual that this particular goal should be integrated into the session.

Code 1.6: Integrate Client's Interests

According to the manuals, the treatment can also be personalized by integrating the client's interests. The client's interests are mostly used as metaphors to explain the treatment or the client's problems, as is showcased in this example":

> "The idea of the "Worry Monster" was introduced to Madelyn as a way of externalizing her worries, and, to increase engagement with this idea, it was relabeled as the "Creeper," a foe in the Minecraft game. She was told that she, her family, and her therapist were all on the same team fighting against the Creeper" (Kendall, 2018, p. 186).

This quote illustrates that the therapist has integrated the interest of the client, which is Minecraft, into the explanation of a treatment technique.

This code is especially salient in the chapter about autism in the multi-disorder manual. According to the manual, clients with autism can be very passionate about certain topics which is why it is important to integrate these into the treatment (Kendall, 2018).

Code 1.7: Adapt to Skills and Code 1.8: Tailoring to Maturity

A salient topic in the manuals is that not every client has the skills that are needed for the treatment. When a client does not have the skills that are needed, the treatment has to be adapted, so the client can still get treated. In the manuals, this usually focuses on making the treatment more understandable. An example of such an adaptation looks like this:

> "The therapist tried to explain "thinking traps" to Madelyn, but she quickly became frustrated because she did not understand what the therapist meant by "thoughts." Instead of explaining all of the details of thinking traps, the therapist instead incorporated language and examples from Minecraft when explaining content" (Kendall, 2018, p. 185).

This quote illustrates that the therapist adapted the explanation to the skills of the client in understanding the explanation of the treatment by using language that the client did understand.

Skills could also not yet be developed due to the maturity level of the adolescent. One of the developmental factors that should be taken into account is the level of autonomy the clients can have during treatment, as can be seen in the following quote:

> "Modifications primarily aim to address the developmental issues discussed earlier, such as involvement of parents and adjusting treatment to suit the teen's emotional and cognitive level" (Kendall, 2018, p. 236)

The multi-disorder manual mentioned that a little tailoring to maturity is needed for depression. Furthermore, that manual mentions that parental involvement is especially important for autism and eating disorders (Kendall, 2018).

Theme 2: Building Therapeutic Alliance

All the manuals mention that it is important to build a therapeutic alliance. However, steps to achieve a therapeutic alliance are not directly mentioned in the ADHD manual and the multi-disorder manual. They mainly give examples of conversations therapists had with

their clients. However, the manual about OCD provides a complete chapter on how to build a therapeutic alliance, called “Being the Best Guide You Can Be” (Franklin et al., 2019).

Code 2.3: Movement Synchrony

Even though the literature mentioned that movement synchrony could be helpful in establishing a therapeutic alliance, the manuals do not mention anything about this.

Code 2.4: Respecting Boundaries

The manuals mainly focus on respecting boundaries regarding confidentiality and cultural values that might clash with the way treatment is carried out. The therapy can be adapted to these values. An example of such an adaptation can be seen in this quote:

> “For example, one mother once said it was OK to do exposures regarding sinful images because “OCD puts these in his head all day anyway.” In some cases, collaborative discussions with the family’s clergy could also be useful” (Kendall, 2018, p. 63).

This quote highlights the importance of respecting cultural boundaries and finding a middle ground, ensuring the client can receive therapy without violating those boundaries.

Code 2.5: Shifting From Experience to Structure

The manuals almost never describe tactful ways of transitioning the conversation from the client’s personal experiences to discussing the structure of the therapy, except for the manual about ADHD. This manual advises therapists to focus on clearly explaining why it is important to adhere to the structure of the treatment and to make an agreement with the client regarding when it is time to adhere to the structure. An example of this can be seen in this quote:

> “Therefore, you will need to aid in refocusing if and when the topic of importance is no longer the focus of attention in the session. Discuss this upfront with clients so that

they can agree with this plan and not take this refocusing personally. Some potential aids may include:

■ Asking the client to give you permission to utilize a hand signal when it's time to refocus.

■ Saying to the client, "This is one of those times where I am now going to interrupt."

■ Discussing ways that the client can communicate the need to take a break.

■ Reminding the client of how much more time is required and what further topics need addressing" (Safren & Sprich, 2020, p. 30).

The ADHD manual mentions that it is especially important for clients with ADHD to remind them to focus on the treatment and their goals instead of straying to irrelevant topics (Safren & Sprich, 2020).

Code 2.10: Confidence and Code 2.12: Humility

According to the OCD manual, it is important for the therapeutic alliance that the therapist comes across as confident, which can be achieved by knowing what the treatment, the disorder and the situation of the client entails. A confident therapist could sound like the following quote: "The therapist then explains that learning how to monitor mood will enable the adolescent to figure out what situations, activities, and thoughts are connected with feeling better or worse" (Kendall, 2018, p. 104). This quote illustrates that the therapist has knowledge of the effects of the treatment.

However, according to the OCD manual, the therapist should not be overconfident in the treatment, but instead show humility in order to give the client realistic expectations. In the manuals, humility looks like explaining the limitations of the therapy on top of the benefits and explaining that it is going to take a lot of effort and time to see some changes, like in this following quote:

> "The therapist discussed the process and rationale for upcoming exposure exercises. She explained that he would likely experience some fear or anxiety, much like he already did, but that with practice his anxiety would go down, and he would start to feel better" (Kendall, 2018, p. 86).

This quote demonstrates how the therapist helps the client anticipate upcoming fears without sugarcoating, ensuring they are not caught off guard during treatment and fostering more realistic expectations.

Code 2.14: Support Client

The manuals mention quite often that it is important to support the client through the treatment process, and also give examples of how a therapist might support their client. This is mostly done by assuring the client that they will be supported through the treatment and techniques until the client can handle these techniques alone. This can look like the following quote: "Therapist: So we're in for a good game here, and my job as coach is to get you ready to play your best, learn from mistakes, and keep going. We'll involve your parents in this too, OK?" (Franklin et al. 2019, p. 93).

However, while supporting the client is important, the client will have to eventually do the techniques by themselves, so the support should lessen overtime by offering the client more autonomy during the later stages of treatment.

Theme 3: Motivation

All the manuals advise therapists to actively ask about why the clients are motivated to engage in this treatment, to ask what potential barriers there are to adherence to the treatment and to problem-solve around these barriers. Moreover, they mention that it is crucial to clarify the reasons why adherence to this treatment is important.

Code 3.5: Explain Treatment

The manuals emphasize the importance of explaining why the treatment works, as this can provide hope. In the following quote, you can see how the multi-disorder manual advises therapists to explain the rationale behind the treatment: “The importance and benefits of self-monitoring and regular eating (e.g., three meals and three to four snacks a day) were explained.” (Kendall, 2018, p. 251) This quote illustrates that the multi-disorder manual mentions that the therapist has to explain the rationale behind the treatment of eating disorders.

Explanation of why the treatment works is part of the instructions for every disorder, but is stressed more in case of resistance from the client. Codes that co-occur with this code are confidence and sometimes humility.

Code 3.8: Problem-solve Issues

In the manuals, the therapists are often advised that they should solve problems regarding the issues that clients bring up when they have not adhered to the treatment. There are also a few examples of what problem solving can look like, but there are so many reasons that the client has not adhered to the treatment, that it is not possible to discuss all the tactics in problem-solving. However, here is an example:

> “Joanna again raised a number of objections—some of which were genuine barriers (e.g., inability to arrange transportation), whereas others were suggestive of comorbid anxiety (e.g., worry about what she would say). She decided to make plans with a friend for the upcoming weekend. The therapist and Joanna then role-played this interaction several times until Joanna felt comfortable with a number of variations in the course of the conversation.” (Kendall, 2018, p. 112)

This quote is an example of a client experiencing problems and the therapist helping them solve these by roleplaying the interactions until the client felt comfortable and the problem was solved.

Especially the ADHD manual repeatedly mentions that problems should be solved every session, but it does not give specific instructions on how to solve problems, nor does it give many examples of this.

Code 3.9: Offering Autonomy

In the manuals, the amount of autonomy that is given to the client is based on two factors: how well the client can apply the techniques they are taught in the treatment, and on the maturity level. The therapist is advised to increase the autonomy of the client by supporting them throughout the techniques until they understand them and can apply them themselves. Furthermore, according to the manuals, the therapist should also offer autonomy by asking the client about their opinion and valuing this. An example of this is: "...talk with the adolescent about the role that parents can play in maintaining treatment gains. You can discuss ideas about how parents might support skills use or point out when a booster session might be helpful" (Safran & Sprich, 2020, p. 154). This quote highlights a conversation about the role of the parents and a booster session, allowing the client to have a say in what happens, rather than simply being told.

Discussion

The themes that were discussed in the introduction, namely 'focusing on the individual', 'building therapeutic alliance', and 'motivation', are indeed the themes that can be found in the manuals. Based on the content of the manuals, the discussion section introduces a distinction between two types of resistance. This categorization emerged from patterns in the manuals themselves and allows for a more detailed analysis of the different therapeutic approaches to resistance. One type, which will be called skill-based resistance, is where the client is stuck in the treatment, because they do not understand what they need to do or they do not have the skill set to do what the treatment requires of them. The second type, which will be called motivational resistance, is when the client does not want to engage

in treatment. In all three of the themes, it will be discussed how these forms of tact can reduce or prevent these types of resistance. Most of the codes that were based on the literature on tact can be found in the manuals, except for movement synchronicity, which will be discussed further in this discussion. New codes were added to these themes during the coding process. This discussion section will dive deeper into why some of these codes possibly cannot be found in the literature and why it is still important to use them in therapy when dealing with resistance. At the end of this discussion, links will be made between the different themes, limitations will be discussed and research recommendations will be made.

Focusing on the Individual

According to the manuals, it is important to focus on the individual, rather than just follow a rigid treatment plan that does not leave room for adaptations according to the client's skills and needs. Therapy sessions that are less structured and focus on the experience of the client result in more information about the client's unique factors that are important for treatment (Jungbluth & Shirk, 2009). This could give more insight into what kind of tailoring is needed.

An example of an adaptation to CBT is the manual that is tailored to clients with ADHD. Clients with ADHD tend to show more resistance to CBT unless the treatment is tailored to their disorder (Andersen et al., 2021). In the manual for ADHD, tailoring primarily involves guiding clients to stay focused on relevant topics without getting sidetracked, and emphasizing that progress takes time. This is especially important for clients with ADHD, as they often drift off-topic or expect immediate results, which can lead to demotivation, when these results are not achieved immediately (Safren & Sprich, 2020).

Specificity of Instructions

The manuals mention when it is important to reduce the structure of the therapy in order to focus on the individual, but not how to reduce this structure. Something noticeable

about this, is that the manuals leave room for adjustments to the treatment, but only mention when it is possible and when it is not. This could be because there are many different situations that require different adjustments in those moments. For example, the ADHD manual is already tailored to the client's disorder, but it still allows for adjustments based on factors such as age, parental involvement, specific symptoms, and more. Hence, adaptations can be specified for unique situations, but not universally, given the wide range of individual differences.

Types of Resistance

Focusing on and tailoring to the individual could reduce both types of resistance. Skill-based resistance may decrease as therapy is adjusted to the client's existing skills. Motivational resistance could be reduced by integrating the client's interests and goals, helping them connect more to the treatment.

Building Therapeutic Alliance

According to the manuals, therapeutic alliance helps with engaging the client in the treatment. The manuals offer a wide range of techniques for building this therapeutic alliance. While not all of these codes can be discussed here, Appendix A provides an overview of these various techniques. In this section, only the most salient or interesting findings shall be discussed.

Movement Synchrony

Even though the literature mentions that movement synchrony is important in building a therapeutic alliance, the manuals mention nothing about this. The reason for this could be that the literature mentioned that this helped especially for clients with BPD (Zimmermann et al., 2021) and none of the manuals discussed this disorder. However, this article mentioned that it helped universally, so it could be incorporated in other manuals.

Confidence and Humility

There is not a lot of research done on the influence of confidence and humility on the therapeutic alliance. However, the OCD manual does mention the importance of coming across as confident while maintaining humility when explaining why the treatment works (Franklin et al., 2019). The explanation should show a balance between offering hope and realism, because overexaggerating the positive outcomes will lead to unrealistic expectations and frustration in the patient, which might decrease motivation in the long run. According to the OCD manual, achieving this balance becomes easier when the therapist has a solid understanding of the treatment's theoretical framework and the disorder itself, and that this ability also improves with experience.

Specificity of Instructions

Building a therapeutic alliance has so many factors and techniques that it is hard to make a guideline with the exact steps that are necessary to build this alliance. Furthermore, each client differs in what they need to be able to build a relationship with someone and trust them. Building a therapeutic alliance involves numerous factors and techniques, making it difficult to create a step-by-step guideline. Additionally, each client has different needs when it comes to forming relationships and building trust. When it comes to building a therapeutic alliance, a personalized guide is possible, but a universal one is not.

Types of Resistance

A therapeutic alliance can be important for decreasing motivational resistance, since the client might feel more respected, and understood. They could also gain more trust in the treatment, which might make them more motivated. A therapeutic alliance can also be important for skill-based resistance, since they could trust the therapist more and feel safer to fail. The manuals also advise therapists to support the client as much as needed throughout the difficult parts of treatment, which could even help with increasing the client's skills.

Motivation

Increasing motivation helps to get the client engaged in the treatment and to reduce resistance in adolescents (Jungbluth & Shirk, 2009). In the manuals this is mostly done by exploring what the motivation of the client is, by problem-solving around certain problems the client has with the treatment, and by offering some autonomy to the client.

Offering Autonomy

According to the ADHD manual, a lot of adolescents do not voluntarily participate in therapy, which might be another reason why the motivation is low and the client shows resistance. In the manuals, offering autonomy looks like integrating the opinion of the client into the treatment and offering the client options in their treatment. This may help the client feel that their opinion is valued, especially after having it overridden by being placed in treatment against their will.

Specificity of Instructions

The manuals all mention that it is important to explore the motivation, or the lack thereof, and to problem-solve around the issues the client might have with motivation, however they do not mention what the exact questions are that could be asked. Some mention that motivational interviewing (MI), which is a technique to figure out what the client wants to get out of the therapy, is helpful. However, MI is a certain way of questioning, but the questions could still differ per client and what kind of issues they experience with motivation. The same principle applies for problem-solving, since the problems vary a lot between clients, which makes it hard to make instructions for solving each problem. Even though instructions for specific situations can be worked out step by step, it is hard to do this for every situation that could occur.

Furthermore, it was noticeable that the clients in the examples of the manuals were highly cooperative. When the therapist came up with a solution, the clients immediately

agreed, while in practice, clients can be even more resistant. The manuals did not take this into account.

Types of Resistance

Increasing motivation helps to decrease motivational resistance. When the motivation is increased, the client will want to engage in treatment more. It is also important that the client is motivated for decreasing skill-based resistance, since an unmotivated client will put in little to no effort to learn new skills that are useful in therapy.

Connections Between Themes

The theme 'focusing on the individual' could contribute to the theme 'building a therapeutic alliance', since paying attention to the experience of the client and tailoring the treatment to this could help to make the client feel safe and heard by the therapist, which could foster a better relationship between the client and the therapist.

The theme 'building a therapeutic alliance' could then in turn contribute to the theme 'motivation', since a good therapeutic relationship could help to get the client engaged.

Limitations

This qualitative research has been conducted by a researcher that has no experience with coding. Another limitation is that the researcher was the only person that coded the manuals, which means that there is more subjectivity than if another person also coded the same text. However, the codes did get discussed in the Bachelor Thesis group.

Another limitation was the number of manuals. Only manuals that were either accessible for the University of Groningen or for free were used. To add to that, the amount of time the researcher had was also a limitation in how many manuals could be coded, since there ended up being three instead of ten, which was the original plan. This would have given more data, possibly also on different more disorders.

Lastly, a limitation of this research was that this scoping review does not account for how these techniques are applied by therapists in real life situations. This means that even though the manuals state that these techniques are important, they could not be applied in practice.

Research Recommendations

Future research could focus on how all these forms of tact, that are described in Appendix A, are applied in real life situations and how they are correlated with resistance, since this could be helpful in increasing the efficacy of CBT.

Another point that could be researched in the future, is how treatment can be tailored and when the therapist deviates too much from the treatment. This can help establish boundaries for the therapist, defining the extent of flexibility they have in tailoring the treatment.

Conclusion

As noted in the introduction, tact can be taught and practiced to a certain extent, but it can never be fully mastered due to its dynamic nature (Duggan, 2024). The data from the manuals support this claim, as they do not offer a step-by-step guide for the types of tact described, but instead provide examples of situations that illustrate these forms of tact. So, based on the instructions in the manuals, tact cannot be formalized into a prescribed set of instructions, but it can be structured for specific situations. This is because each client presents a unique combination of circumstances, requiring a tailored approach and, consequently, a different application of tact.

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Appendix A

Code Book

Themes and Codes	Description and Application	Example
Theme 1: Focusing on the individual	Focusing on the individual means that the therapist takes the experience and context of the individual into account during treatment instead of focusing on how the treatment works on average.	
Code 1.1: Focus on disorder	Focusing on the disorder can look like explaining how the disorder affects the client's life or like asking questions about how the disorder affects a specific client.	"During the initial two sessions, Joanna and her parents were provided psychoeducation about symptoms of depression and the availability of effective treatments (with a focus on CBT), as well as information on depression's course and duration." (Kendall, 2018, p.110)
Code 1.2: Focus on experience	Focusing on the experience entails asking questions about how the client experiences symptoms and the treatment itself. This also gives the therapist information on how to adapt the treatment to that specific client.	"Parents and patients are encouraged to discuss their fears, expectations, and hopes for this process and for role transitions." (Kendall, 2018, p. 33)
Code 1.3: Reduce structure	Reduction of the structure usually happens when there are situations that require an adaptation of the treatment. It is up to the therapist to decide when a deviation from the original treatment plan is needed.	"With adolescent clients, parent involvement is important. However, if parents are feeling very frustrated and burned out from dealing with their child's problems, it may be advisable to have them play a more limited role in the therapy. If, on the other hand, the parents seem to have a strong relationship with the adolescent and display patience toward their child's difficulties, they may prove helpful in coaching the

		adolescent to implement skills at home and at school." (Safren & Sprich, 2019, p. 40)
Code 1.4: Focus on interactions	Focus on interactions entails asking questions about the interactions the client has with their environment, for example with their parents. This gives context-specific information, which helps the client with understanding their own patterns better.	"Following the skills training sessions, parents are included in this session to address ongoing overprotective patterns and to further reinforce disengagement and transfer of responsibility to the patient." (Kendall, 2018, p. 32)
Code 1.5: Match treatment with client goals	Matching the treatment with the goals of the client means that the therapist asks questions about what the client wants to achieve by getting treatment and integrating these goals in the treatment plan. This also means that the pre-formulated goals described by the manual do not always have to be attained if this is in contrast with the goals of the client.	"Another issue we would suggest grappling with at the end of the intake is whether family discord or other such factors are likely to negatively affect CBT delivery for OCD. For families that spent much of the time arguing in the waiting room or in the intake, we suggest some explicit discussion of that process, without descending into blaming anyone for it, and we emphasize how important it is to change everyone's approach to the journey on which they are about to embark." (Franklin et al., 2019, p. 87)
Code 1.6: Integrate client's interests	By integrating the client's interests in the treatment, the treatment will be more personalized. The client will understand the treatment better when metaphors are used that involve their personal interests.	"The idea of the "Worry Monster" was introduced to Madelyn as a way of externalizing her worries, and, to increase engagement with this idea, it was relabeled as the "Creeper," a foe in the Minecraft game. She was told that she, her family, and her therapist were all on the same team fighting against the Creeper." (Kendall, 2018, p. 186)
Code 1.7: Adapt to skills	Adapting to skills means that the skills of the client are taken into account when	"The therapist tried to explain "thinking traps" to Madelyn, but she quickly became

	giving treatment. For example, some clients might understand the explanation of their disorder sooner than others or some clients might be better at planning their exercises than others. Adapting to skills does not entail skills that develop through aging. For that code, see "Code 1.8: Tailoring to maturity".	frustrated because she did not understand what the therapist meant by "thoughts." Instead of explaining all of the details of thinking traps, the therapist instead incorporated language and examples from Minecraft when explaining content." (Kendall, 2018, p. 185)
Code 1.8: Tailoring to maturity	Since adolescents vary a lot in their developmental maturity, the treatment needs to be adapted to this. For example, young adolescents have less autonomy than older adolescents, which means that a parental figure might be more or less integrated into the treatment plan.	"Modifications primarily aim to address the developmental issues discussed earlier, such as involvement of parents and adjusting treatment to suit the teen's emotional and cognitive level" (Kendall, 2018, p. 236)
Theme 2: Building therapeutic alliance	Building therapeutic alliance means that you build a relationship with your client in which they can trust you and feel comfortable with you as their therapist.	
Code 2.1: Addressing stigma	Addressing stigma entails that the therapist normalizes the struggles, which the client is going through. This makes the client feel less alone in their experience with their disorder. This is usually done by giving examples of peers going through the same situations.	"You should set the stage for a constructive session by acknowledging that ADHD does not mean that a person is lazy, stupid, or weak. Rather, individuals with ADHD must use skills and strategies to cope with symptoms effectively." (Safren &Sprich, 2020, p. 45)
Code 2.2: Celebrating successes	Celebrating successes is about noting and complimenting the client on their achievements during the therapy, but also complimenting them on their understanding of their disorder and the treatment.	"The young man, an excellent student and astute listener, made note of the caveats in the therapist's language as he explained the process, saying, "I noticed that you didn't say that I would never,

		ever act upon such thoughts—did you do that on purpose?" "I did," said the therapist, "and I'm proud of you for noticing." "Because if you gave me a guarantee it would be like reassurance, right?" "Spot on, man—great job!" (Franklin et al., 2019, p. 88)
Code 2.3: Movement synchrony	Movement synchrony means that the therapist copies the moves of their client. This enhances the bond the client feels with their therapist. It should not be overdone, because then the client might think that the therapist is mocking them.	This code did not occur in the manuals.
Code 2.4: Respecting boundaries	Respecting boundaries means that the therapist will not overstep clear boundaries in, for example, client confidentiality. It also means that the therapist should keep in mind that clients with different (cultural) backgrounds might have different norms and values and these should be respected. In order to do this, the therapist has to hold an open dialogue on what the client and their family wants and adapt the therapy to this.	"The family must provide guidance on the boundaries of what their faith considers intentionally sinning (e.g., worshiping the devil) as opposed to doing things that elicit anxiety because they increase the person's risk of sinning (e.g., saying out loud the word "devil"). For example, one mother once said it was OK to do exposures regarding sinful images because "OCD puts these in his head all day anyway." In some cases, collaborative discussions with the family's clergy could also be useful." (Kendall, 2018, p. 63)
Code 2.5: Shifting from experience to structure	It is important to focus on the experience of the client in the beginning, but there is also the structure of the therapy that needs to be adhered to. The shift from focusing on the experience to going into treatment steps requires tact and is usually	"Therefore, you will need to aid in refocusing if and when the topic of importance is no longer the focus of attention in the session. Discuss this upfront with clients so that they can agree with this plan and not take this refocusing

	done by explaining the rationale of the structure.	personally. Some potential aids may include: ■ Asking the client to give you permission to utilize a hand signal when it's time to refocus. ■ Saying to the client, "This is one of those times where I am now going to interrupt." ■ Discussing ways that the client can communicate the need to take a break. ■ Reminding the client of how much more time is required and what further topics need addressing." (Safren & Sprich, 2020, p. 30)
Code 2.6: Understanding experience	When a client feels that their therapist truly understands them, they might feel more confident in the treatment and build a better relationship with their therapist. The therapist might showcase that they understand the experience of the client by giving clear examples of experiences of other clients or explaining the experience of the client through a clear and interesting metaphor.	"Then he sat on the floor with the child and told her that the teddy bear, whose name was Horace, wanted her to know that lots of other kids experienced these initial visits as scary at first but then things got easier as they held onto him; Horace lived at the clinic to help kids feel better, and he would do that for her as well." (Franklin et al., 2019, p. 80)
Code 2.7: Humor	Humor helps to alleviate the tense feeling most clients feel when they get treatment. This can help in building a sound relationship between the therapist and the client.	"To modify worry schemas, children may create a story or picture of the feared event (e.g., someone breaking into their home) and then add a ridiculous twist generated by the child (e.g., the burglar transformed into a unicorn bringing jelly beans to the child). As the child repeatedly reviews the story or picture, the emotional state associated with the cognitive content of the worry shifts, and anxiety tends to dissipate." (Kendall, 2018, p. 76)

Code 2.8: Validating	Validating the feelings and experiences of the client helps to build a therapeutic alliance, since the client will feel safe to express these feelings during the session.	"Remind adolescents that, at first, when they are learning a new skill, it may feel awkward, may be confusing, and may require effort to implement. That's ok! The more they practice, the easier it will become."(Safren & Sprich, 2020, p. 109)
Code 2.9: Non-judgement	When clients do not feel judged, they tend to share more information and are more comfortable with trying out new methods, because they are not as scared to show failure.	"Carl Rogers emphasized in his work with patients the importance of unconditional positive regard, and we would add to that the importance of genuine curiosity about other people and their hopes, struggles, and chosen approaches to managing the difficulties that life foists upon us all." (Franklin et al., 2019, p. 55)
Code 2.10: Confidence	When the client perceives the therapist as confident in what they are doing, they feel more confident in the result they might achieve during therapy. This confidence can be achieved by understanding the theoretical models and the situation of the client thoroughly.	"The therapist then explains that learning how to monitor mood will enable the adolescent to figure out what situations, activities, and thoughts are connected with feeling better or worse." (Kendall, 2018, p. 104)
Code 2.11: Taking responsibility	When the treatment does not work as intended or is harder for the client than expected, the therapist should take responsibility for this and not blame the client for "failing".	"Rather than pointing the finger of scorn at the patient, the therapist stepped in and took responsibility: "I'm really sorry that happened, as I know we did a lot of good work last session on trash cans and I thought this would be attainable during the week. Can you help me figure out how I miscalculated that?" The patient replied that when he opened the trash can outside the family's home, he noticed an extensive collection of maggots at the bottom, "and then I just freaked." "My bad," the

		therapist replied, “I hadn’t taken the time of year into account, and I messed up. So, how can we work together now to try to make up that ground?” The therapist in this case was unafraid of admitting to a mistake, shouldered the responsibility for the negative outcome, but then also invited the patient to participate in thinking through how to get back on track.” (Franklin et al., 2019, p. 59)
Code 2.12: Humility	Humility in therapy manuals means that the therapist does not exaggerate the possible outcomes of the treatment and also mentions the limitations. They will also set realistic expectations for the client, for example that it might take a while for the client to see changes due to the treatment. Lastly, it also means that the therapist will acknowledge when they do not have an answer for a question from the client instead of coming up with a fabricated answer that could be false.	“The therapist discussed the process and rationale for upcoming exposure exercises. She explained that he would likely experience some fear or anxiety, much like he already did, but that with practice his anxiety would go down, and he would start to feel better.” (Kendall, 2018, p. 86)
Code 2.13: Work through discomfort	Some situations in therapy might make the therapist uncomfortable. The therapist should take note of this and work through it in order to model the right behaviour for their client.	“In supervision, it became apparent that the therapist would likely struggle with providing corrective information through modeling corrective behaviour for the patient, which led to a suggestion to reassign the case. To his credit, the therapist noted that exposure ought to reduce his fear just as it would the patient’s, and that he should set up an ambitious exposure plan to confront vomit-related stimuli before having to do so

		in earnest with the patient. The therapist followed the hierarchy he created diligently, and by the time the patient was ready to confront the most anxiety-inducing stimuli in treatment (e.g., fake vomit, watching people vomit on screen), the therapist's discomfort was greatly reduced and treatment proceeded without complication." (Franklin et al., 2019, p. 61)
Code 2.14: Support client	In manuals, supporting the client means helping them navigate situations they're not yet able to handle on their own by thinking together about how they can approach the situation more effectively. This code also means that the therapist will make the client feel less alone by emphasizing that they will go through the process of the treatment together.	"Therapist: So we're in for a good game here, and my job as coach is to get you ready to play your best, learn from mistakes, and keep going. We'll involve your parents in this too, OK?" (Franklin et al. 2019, p. 93)
Theme 3: Motivation	Exploring motivation means that the therapist has to figure out what the client thinks they might gain from treatment and to figure out what difficulties the client might encounter in adhering to treatment and solve the problems that come up regarding the adherence to the treatment.	
Code 3.1: Adherence promotion	Adherence promotion entails techniques that encourage the client to keep showing up to therapy and to execute the assignments the therapist gives them. The manuals about ADHD and OCD gave specific instructions for this, while the manual about multiple disorders only mentioned	"Children and adolescents in particular are often better able to relate to and profit from the stories of others their own age who have grappled with similar symptoms. Thus, the clinician should make generous use of any such opportunities. These clinical tales are often most valuable at "stuck points" in treatment,

	that the client should be engaged by the therapist.	such as when patients feel they are unable to move forward with the most difficult exposures." (Franklin et al., 2019, p. 64)
Code 3.2: Anticipate difficulties	Anticipating difficulties in adherence can help to prevent non-adherence beforehand. It also gives the client more confidence that they will be able to do the exercises that the therapist prescribes.	"To minimize relapse, the therapist and adolescent review the strategies in treatment that were helpful, establish realistic expectations for the future, prepare for setbacks, and discuss the difference between a "lapse" and a "relapse"." (Kendall, 2018, p. 247)
Code 3.3: Explain structure	By clarifying why it is important to follow the structure of the therapy when the client wants to stray from this to focus on topics that are irrelevant for the treatment, the client might feel like their feelings are less overlooked than when this is not explained.	"It is important to begin each session by setting an agenda. Review the session outline with the adolescent and parents. It may be helpful to review the rationale for agenda setting with the parents. Explain that you will be setting an agenda so that everyone will know what to expect in the session and to ensure that you remain focused on helping the adolescent and parents learn more about managing ADHD." (Safren & Sprich, 2020, p. 38)
Code 3.4: Explain to parents	Explaining the disorder and treatment to the parents helps to involve them in the therapy and to create more understanding for the client. This could help with the client's motivation.	""...Your support of your adolescent's efforts may be very useful. Thus, throughout the course of treatment, I will be working with [youth's name] to determine how you might be able to best support [youth's name]."" (Kendall, 2018, p. 239)
Code 3.5: Explain treatment	By explaining why the treatment works, the client might become more motivated, since their confidence in the treatment might grow.	"The importance and benefits of self-monitoring and regular eating (e.g., three meals and three to four snacks a day) were explained." (Kendall, 2018, p. 251)
Code 3.6: Explore willingness to change	By exploring the client's willingness to change, the	"If you did not have problems with ADHD, what do you

	therapist will come to know why the client shows signs of resistance to the therapy. This also allows for these blockages to be resolved.	think would be different in your life?" (Safren & Sprich, 2020, p. 26)
Code 3.7: Normalize willingness to change	Normalizing willingness to change can be done by saying that a lot of peers in the same situation experience the same struggle. When the therapist normalizes this, the client might feel like the therapist knows how to handle these situations and be more motivated.	"Therapist: For most people, change is hard, and change takes time. With ADHD, it can be especially difficult to stay motivated long enough to let the skills sink in and really work." (Safren & Sprich, 2020, p. 35)
Code 3.8: Problem-solve issues	When the client runs into problems with adherence, the therapist should problem-solve these issues, preferably in collaboration with the client. When these issues are solved, the client will feel more motivated to adhere to the treatment.	"Joanna again raised a number of objections—some of which were genuine barriers (e.g., inability to arrange transportation), whereas others were suggestive of comorbid anxiety (e.g., worry about what she would say). She decided to make plans with a friend for the upcoming weekend. The therapist and Joanna then role-played this interaction several times until Joanna felt comfortable with a number of variations in the course of the conversation." (Kendall, 2018, p. 112)
Code 3.9: Offering autonomy	Offering autonomy means that you value and integrate the opinion of the client into the therapy, which might even look like directly offering the client options in their treatment. It also means that you offer them tips and tools, so the client will eventually be confident and able enough to apply the tactics that they learnt in their treatment by themselves.	"...talk with the adolescent about the role that parents can play in maintaining treatment gains. You can discuss ideas about how parents might support skills use or point out when a booster session might be helpful." (Safran & Sprich, 2020, p. 154)

Appendix B

Diary

Day 1

Monday 10th of February was the first day of coding. I completed chapters 1, 2 and 3 of the ADHD manual. The first chapter, I had a hard time with coding. Almost every sentence seemed to hold some content that went well with one or more codes. It also took me 2 hours. Even though I pre-made the codes.

After having so much trouble with coding, I asked people from my bachelor thesis group if they had tips. One said that he also had that problem and that he was basically summarizing the text. He said that he picks a whole paragraph and codes that. That is what I started doing. I also think that the first chapter was harder, because it is more about explaining the treatment to the client and exploring their motivation. This could also be a reason why there was so much text that I coded in the first chapter. However, once I have finished coding the whole manual, I want to go over all the chapters again. but especially chapter 1. Something another thesis member said was that it might also just be a very good manual that has lots of tact described in it.

Another thing I noticed was that there are instructions that skills that I defined as "tact" should be used, but that there are no clear steps described for this. Sometimes there are examples but a lot of the time there aren't. in this manual. Only at the end of every chapter there is an example of a conversation with the client that uses the things described in the chapter, but not all skills are used there and it is only an example of a specific situation, so not necessarily a guide to "tact". So I still think that "tact" is a skill that is hard to conceptualize and formalize, maybe even impossible, but I'll try and find as many instructions for "tact" to see if this is actually true.

Day 2

Today I coded the ADHD manual. What I noticed is that every session, you as a therapist have to start with looking at the progress the client has made. In this, the client has to be praised for their improvements (part of understanding experience?). The therapist, together with the client, has to problem-solve any issues (explore and resolve willingness to change) at the beginning of each session.

Furthermore, maybe "understanding experience" might be changed to empathy or sympathy. Focusing on what the individual wants is also part of autonomy, so these themes are interlocked in a way. I also have noticed that the ADHD manual has clear and concrete goals that should be obtained by the client each session (in each chapter called "signposts for change").

It is emphasized a lot that these skills in this book are developed over time and not in one day and that a lot of practice is needed.

Day 3

Today I coded the ADHD manual. Chapter 8 gave more of a theoretical framework. I also noticed that there is a lot of explaining done when the client shows resistance in not knowing how a certain technique might help. So, this might become part of the code "resolving willingness to change".

Day 4

Today is the first day I start coding again after being sick for a week. This might affect how well I code, since I have to get into it again.

I coded the ADHD manual. What I noticed today is that this manual has a lot of structure that every client has to follow, but in session 10, they evaluate the progress of the client and after that, the therapist reviews what else the client needs and bases the kind of sessions the client needs after that on the progress of the client. Session 11 only applied learned skills to procrastination, so it isn't additive to do this session if people do not procrastinate.

Day 5

Today I coded the ADHD manual. Session 12 is the last session. After that, the last two chapters are devoted to potential parent sessions that can be scheduled in between, which leaves room for restructuring the treatment.

The parent sessions are way less structured. Furthermore, session 13 really focuses on the specific issues the parent has with their child's ADHD and helps them understand. This means that there is less tact coded regarding the adolescent.

Day 6

Today I coded the last chapter of the ADHD manual. This last chapter is also less structured than the sessions with only the adolescent and this book emphasizes on how important celebrating successes is.

Day 7

Today, I reviewed the codes I have so far, since I finished coding the first manual today. I will change them in the first manual during the second round, so not today, but I will make new codes/merge codes that seem like they need changing. The codes I have right now, divided into themes, are:

- Building therapeutic alliance: addressing stigma, movement synchrony, offering autonomy, offering options, respecting boundaries, shift from experience to structure, tailoring to maturity, understanding experience
- Exploring motivation: adherence promotion, explore willingness to change, normalize willingness to change, resolve willingness to change
- Focusing on individual: explain structure (this one was created during the coding process), focus on disorder, focus on experience, reducing structure

What I already see here is that "explain structure" can be moved from focusing on the individual to exploring motivation, since the explanation of why structure needs to be used is to increase motivation to keep participating in therapy.

Another thing I noticed is that the code "resolve willingness to change" is vague, since that is the whole point of tact, to reduce resistance / willingness to change. I will have a look at that code and see if I can add some codes that are more concrete.

Furthermore, another thing I noticed was that "celebrating successes" was missing from my codes, while that builds therapeutic alliance. For now, I coded it as "understanding experience" but I will change that into celebrating successes.

What I have changed:

- Resolve willingness to change is split up into: Problem-solve issues, Anticipate difficulties, Match treatment with client goals, Motivational interview strategies, Explain why strategies work (This also includes explaining that minor setbacks are part of life and that that does not

mean the strategies aren't working}, Support the client (Make clear that they are not alone in this process and that you will help them), Explain to parents (This includes explaining why the client acts like they do and help them engage in the treatment of the client).

- "Explain structure" is moved to exploring motivation.
- Celebrating successes is added to building therapeutic alliance and it has also been changed in the ADHD manual codes, although the first few chapters without the memo's do need some revision for this code. This will happen in the second round of coding.

Day 8

Today I started coding the manual about multiple disorders. There are some parts that I skipped: assessment (since I focus on treatment) and group therapy (since I focus on individual therapy, except for when parents are involved, because parents usually still play a big role in adolescents' life).

I changed the theme "focusing on the individual" to "focusing on the individual". I also added the code "focus on interaction with others" under the theme "focusing on the individual".

Day 9

Today I coded the manual about multiple disorders. I found that this manual has case examples, but that those focus mainly on what the procedures are that were used and on the client's progress, less on stuff like tact or how the therapist dealt with certain situations.

Day 9

Today I coded the manual about multiple disorders. I added the code "validating" to "building therapeutic alliance", which came from "addressing stigma" and it means validating the experiences and feelings of the adolescent.

"Externalizing" is placed under "addressing stigma", since it lowers stigma around the disease such as OCD, since the blame is less on the adolescent and more on the disease. Addressing stigma might be changed to lowering stigma OR externalizing might become its own code instead of memo's. "Humor" was added under "building therapeutic alliance". "Acting it out yourself" OR "modelling" might be added under "support client", right now they are memos.

I have to look over "offering autonomy" again and see whether some codes should be changed to "matching to client goals".

Day 10

Today I coded the manual about multiple disorders. Chapter 6 did not end up being coded, since it was mostly about the treatment of children and not adolescents and when it was about adolescents, it was about the efficacy rather than the procedure. Chapter 9 did not end up being coded since there was no individual CBT mentioned for ADHD.

“Integrate client’s interests” and “adapt to skills” were added to the theme “focusing on the individual” as new codes.

Where the codes “support client” and “autonomy” co-occur, that might be changed into “collaboration”.

I was doubting to add “externalizing” as a code, but I did not end up doing this, since this is a therapeutic technique with instructions. The tact in this phenomenon is in making the externalization of the disorder personal by integrating interests of the client.

I also realized that there are two kinds of resistance: the one where the client gets stuck and does not know how to apply the techniques they learn in therapy and the one where they really do not want to participate.

Day 11

Today I coded the OCD manual. “Non-judgement”, “confidence”, “taking responsibility”, and “sit with discomfort” were added to the theme “building alliance”. These codes all came from the chapter in the OCD manual about “being the best guide you can be”, which gave instructions on how to deliver therapy rather than just mentioning what you have to deliver to the client.

Day 12

Today I coded the OCD manual. I might still want to look at how therapy structure is reduced and make separate codes for that. What I also noticed was that in the OCD manual, a lot of metaphors are used and they give advice to integrate the client’s interests in these metaphors to increase understanding and motivation of the client.

The code “celebrating successes” can be about achievements in therapy, but also about the client’s understanding of the disorder or treatment. This is important for alliance building and confidence or motivation in the treatment.

Day 13

Today I coded the OCD manual. The code “MI strategies” has been removed, because this is more of a technique with clear steps than tact. However, how MI strategies get delivered is tact.