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Treatment for Adolescents with Depression Study (TADS)

Cognitive Behavior Therapy Manual

Introduction, Rationale, and Adolescent Sessions

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Acknowledgements, Source Material and Background References

The TADS adolescent and parent/family session manuals were written with the support of NIMH contract 98-DS-0008. In developing these manuals, we have relied upon existing treatment manuals that have been used successfully in the treatment of adolescent depression. We have also relied upon the active involvement of co-authors who are experts in the treatment of this disorder in young people. Since TADS is designed as an effectiveness study, it was important to base the cognitive behavioral intervention on earlier efficacy studies. The major adolescent studies were those conducted by David Brent and colleagues and by Peter Lewinsohn, Greg Clarke and their colleagues. These treatment studies applied cognitive behavioral therapies based on the seminal works of Aaron Beck and of Peter Lewinsohn, to adolescent depression. David Brent generously provided to TADS his individual treatment manual for adolescent depression (Brent & Poling, 1997) to be used as background and context for the TADS CBT. This manual delineates key issues specific to the treatment of adolescents, critical findings regarding the associated and complicating variables linked to adolescent depression, a clear description of elements of a collaborative working relationship with the depressed adolescent, and developmental phases in the cognitive therapy of adolescents. In the TADS project, CBT therapists are required to read the Brent and Poling manual as a basis for TADS treatment, particularly the cognitive aspects of the treatment.

Greg Clarke, Peter Lewinsohn, Hyman Hops, and Paul Rohde (1990, 1999) have graciously permitted us to adapt concepts and techniques from their group cognitive behavioral treatment manual for adolescent depression. Among the key concepts adapted for use in the TADS overall treatment rationale are the "triangle" model of the three parts of the personality, and the notion of downward and upward spirals. Among the techniques are methods to increase pleasant activities, to improve social interaction and communication skills, to generate positive, realistic thoughts about self, and to anticipate and plan to cope with post-treatment stress. With their permission, the TADS Teen Workbook includes the “Triangle” and their form to monitor and increase pleasant activities.

A third source for the TADS adolescent and complementary parent/family manuals were the group and family therapy manuals developed by Curry, Wells, Lochman, Nagy, and Craighead (1997) and Wells & Curry (1997) in an NIDA-funded study of depressed, substance abusing adolescents (DA-08931). This pair of manuals was in turn based on adaptations from a number of sources including Clarke, Lewinsohn & Hops' (1990) group manual, Botvin’s (1989) Life Skills Training manual, and books by Beck, Rush, Shaw, and Emery (1979), Beck, Wright, Newman, and Liese (1993), and Wilkes, Belsher, Rush, & Frank (1994). The reader is referred to these sources for more extensive coverage of topics included in the TADS manual, at points where those topics are introduced.

Eva Feindler graciously permitted us to adapt sections on relaxation methods from her manual on Adolescent Anger Control (Feindler and Ecton, 1986). Michael Otto gave us permission to adapt his "Contrasting Coaches" metaphor related to parental expressed emotion (Otto, 2000). Arthur Robin gave permission for us to reproduce part of his table on negative communication patterns in our Parent and Family Sessions manual (Robin & Foster, 1989). Kathleen Carroll's (1998) manual for the cognitive-behavioral treatment of cocaine abuse has served as a very valuable guide in clarifying CBT session structure and manual organization for TADS. John March, Edna Foa, Marty Franklin, and Michael Kozak's treatment manual for pediatric obsessive-compulsive disorder (1998) was helpful in articulating the role of parents in CBT directed toward treatment of their child's disorder.

The development of the TADS treatment manuals was an iterative and collaborative process. The moderate degree of structure in TADS CBT, the integration of family sessions with individual adolescent sessions, and other fundamental decisions about the treatment were made in early 1999 by John Curry, Karen Wells, and John March, in collaboration with David Brent and Greg Clarke. Curry and Wells wrote initial drafts of the adolescent and parent manuals, relying upon the source material noted above. These drafts were then reviewed extensively by David Brent, Greg Clarke, John March, Mark Reinecke, Paul Rohde, Nili Benazon, and Anne Marie Albano. Modifications were then introduced, based on these reviews, prior to the TADS Feasibility study. Other site supervisors (Betsy Kennard, Randy LaGrone, Jeanette Kolker) contributed to decisions regarding "required" and "optional" components of the CBT.

Further revisions and improvements were based on CBT supervisor conference calls during Feasibility and on contributions made by the co-authors during a TADS project meeting in October, 1999. Among many examples, we list some of the major ones. Mark Reinecke contributed to the manual guidelines for fostering the therapeutic relationship and conducting intervention interviews. Paul Rohde contributed the model of "tools in the backpack", and the substance of the Week 12 session. Anne Simons and Michael Sweeney contributed to the integration of cognitive work within the treatment sequence, and to various methods for mood monitoring. Betsy Kennard, Golda Ginsburg, and Nili Benazon made significant contributions to the model of family intervention. Anne Marie Albano contributed the "contrasting coaches" model, based on Michael Otto's work, for use with parents and adolescents and additional treatment aspects pertinent to comorbid anxiety. John March kept the overall study design in the forefront and helped to tailor the manuals to the Stages of treatment and intermediate transitions. Norah Feeny also contributed to scripting the transitions. These and other contributions were made in the context of group discussions, under the leadership of the first two authors.

We also want to acknowledge the assistance of those who helped with the final editing of the manuals, including Marla Bartoi, and with their production: Deborah Hilgenberg, Stuart Mabie, Patsy Martin, Linda Roberts, Marsha Brooks, and Deborah Bender.

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TADS CBT TREATMENT MANUAL

Theoretical and Empirical Foundations of TADS CBT

Social cognitive learning theory

Cognitive behavior therapy (CBT) for adolescent depression is based on social cognitive learning theory. According to this model of personality and psychopathology, complex human behavior is based on previous learning, especially the learning of social or interpersonal behavior and of central or core thoughts and beliefs. In addition to learning experiences based on operant (reward and punishment) and classical (association) conditioning, social learning is based on social reinforcement and modeling by significant others (Carver and Scheier, 1996). Social behaviors that reflect these learning processes include social communication and problem-solving (Alexander, 1973), and ways of relating to peers and authority figures (Youniss and Smollar, 1985). Complex cognitions are also learned over the course of development, including general expectancies for control and competence (Rotter, 1966; Bandura, 1977), attributional preferences or biases (Abramson, Seligman, & Teasdale, 1978), and schemas pertaining to the self, other people, and the future (Beck, Rush, Shaw & Emery,1979).

Because social cognitive learning processes involve both complex behaviors and complex cognitions, cognitive behavior therapy emphasizes **both** behavior change methods and cognitive information processing methods to modify symptoms of disorders (March, 2000).

Social Cognitive Factors in Adolescent Depression

A number of social cognitive factors have been demonstrated to characterize depressed adolescents. Depressed teenagers experience more negative automatic thoughts about self and others, lower self-esteem, greater hopelessness, and more cognitive distortions leading to misperception of events, than non-depressed adolescents (Garber, Weiss, & Shanley, 1993; Haley, Fine, Marriage, Moretti, & Freeman, 1985). Weisz, Stevens, Curry, Cohen, Craighead, Burlingame, Smith, Weiss, & Parmelee (1989) found that low levels of perceived competence were particularly characteristic of depressed adolescents. In addition, depressed teens tend not to make internal, stable, global attributions to explain positive events; but they do so for negative events (Curry & Craighead, 1990a; 1990b). Depression is the diagnostic category most often associated with suicidal ideation and behavior in teenagers (Brent & Poling, 1997).

In the social domain, depressed teenagers show deficiencies in participation in pleasant activities, sensitivity to negative stressful events, and more frequent perceptions of family conflict than non-depressed adolescents (Clarke, Lewinsohn, & Hops, 1990). Marital discord, high parental expectations with low levels of

positive social reinforcement, and high parental criticism have also been found in families of depressed adolescents (Forehand, McCombs, Long, Brody, & Fauber, 1980; Cole & Rehm, 1986; Schwartz, Dorer, Beardslee, Lavori, & Keller, 1990).

Cognitive Behavior Therapy

Cognitive behavior therapy addresses these social cognitive processes in the context of a therapeutic relationship. Prior studies have shown that cognitive behavior therapy is effective in the treatment of adolescent depression (Reinecke, Ryan, & DuBois, 1998). For instance, two studies by Lewinsohn, Clarke, and their colleagues (1990; 1999) demonstrated that a skills building psychoeducational course, with a strong emphasis on behavioral skills training, reduced depression significantly more than a wait list control condition. A study by Brent and colleagues (1997) showed that cognitive behavioral intervention based primarily on Beck's model of cognitive therapy (Beck, Rush, Shaw, & Emery, 1979), with strong emphasis on recognizing and challenging maladaptive thoughts and beliefs, was effective for teen Major Depression.

Recent reviews by Kazdin and Weisz (1998) and by Kaslow and Thompson (1998) concluded that cognitive behavior therapy for adolescent depression was one of relatively few childhood or adolescent treatments that met the criteria for at least probable efficacy as an empirically supported treatment. Kazdin and Weisz (1998) noted that such treatment is based on the view that depressed youngsters are characterized by: 1) negative cognitive processes; 2) a lack of important behavioral skills, particularly those needed for social support and for affect regulation. Thus, in the present treatment program, we have included both cognitive and more behavioral components.

Kazdin and Weisz (1998) and Kaslow and Thompson (1998) have pointed out that components of successful cognitive behavioral interventions for depression in young people include methods:

1. to increase participation in pleasant, mood enhancing activities
2. to increase and improve social interactions
3. to improve conflict resolution and social problem-solving skills
4. to reduce physiological tension or excessive affective arousal
5. to identify and modify depressive thoughts and attributions

In addition, programs such as those of Brent and colleagues (1997) and Lewinsohn, Clarke and colleagues (1990, 1999) include:

1. mood monitoring
2. goal-setting
3. presentation of a clear treatment rationale and socialization of the adolescent and parents to the treatment model based on this rationale.

Finally, Brent's model (Brent & Poling, 1997), the only model used thus far in a controlled treatment trial of individual cognitive behavior therapy for adolescent Major Depression, places great emphasis on collaborative empiricism, the establishment of a trusting, open, and collaborative relationship between the therapist and the adolescent. In the context of this relationship, depressive cognitions can be identified, questioned, and challenged.

Summary

To summarize, the present treatment falls in the cognitive behavioral category of interventions because it includes emphases both on cognitive processing and on amelioration of skill deficits in the social behavioral arena. It builds upon earlier work, and upon the reviews of successful studies by including attention to domains that have been addressed in those studies. It requires that the therapist understand and communicate to the teen and the parents the model of depression and the model of treatment for depression used over the course of sessions. (These are included in the manual and in the Teen Workbook handouts for the initial Rationale and Goal-Setting Session). It requires that the therapist establish, monitor, and maintain a collaborative therapeutic alliance with the teenager and the parents.

The Therapeutic Relationship

As is true for any psychotherapeutic intervention, TADS CBT can be conducted only within the context of a working alliance between the adolescent and the therapist. An alliance with the parents is also necessary. At times the therapist who works with adolescents must maintain an alliance both with the teenager and with the parents in the face of conflict between the adolescent and the parents. Key requirements for CBT therapists include capacity for accurate empathy, warmth, genuineness, and rapport with diverse patients and parents. In addition, collaboration in setting the agenda for sessions, in testing the accuracy of cognitions, and in implementing "Homework" assignments with the patient is essential for the conduct of CBT.

Both Beck (1979, Chapter 3) and Brent and Poling (1997) have written about the therapeutic relationship in cognitive therapy. In summary, the essential personal characteristics of the therapist, first described by Rogers (1951) are described below:

Essential Characteristics of the Therapist

1. **Accurate Empathy:** This refers to the therapist's ability to take the patient's perspective, see things as the patient does, and understand the patient's distress. The therapist recognizes and verbalizes an understanding of what the patient is feeling. Challenges to empathy with adolescents can occur when the therapist identifies with the patient (often against the parents),

sympathizes with (rather than empathizing with) the patient, or becomes irritable toward the (oppositional/angry) adolescent.

2. **Warmth**: this refers to the therapist's ability to convey a caring concern for the patient. Tone of voice, manner, phrasing of comments can all convey warmth. Challenges to warmth occur when the therapist is too demonstrative or active in conveying concern or too abrupt or distant. In the former case, the teenager may perceive the therapist as lacking in genuineness, as not appreciating the negative aspects of the patient, or as "too close" emotionally. In the latter case, the teenager may feel rejected or "disrespected."

3. **Genuineness**: this refers to the therapist's honesty with self and with patient. Genuineness requires self-awareness and self-monitoring on the part of the therapist. As Beck (1979) points out, genuineness must be accompanied by the ability to convey feedback to the patient without being too blunt or perceived as critical. Promises about "cure" or recovery can threaten the therapeutic relationship on the grounds of lack of genuineness.

In addition to characteristics of the therapist, characteristics of a positive therapeutic relationship, have been outlined by Beck (1979) and by Brent and Poling, 1997).

<u>Characteristics of a Positive Therapeutic Relationship</u>

1. **Rapport**: this refers to the therapist's ability to establish "harmonious accord" (Beck, 1979, p. 51) with the patient. There is a lack of defensiveness on the part of each party, and the patient feels accepted (despite all his or her faults) by the therapist, and able to express himself or herself without belaboring feelings, explanations or comments. Developing rapport is facilitated by the therapist factors mentioned above, and by behaviors such as courtesy, timeliness, appearance, active listening, eye contact, tone of voice, and timing of verbalizations during sessions.

   Brent and Poling (1997) note other therapist initiatives that can facilitate the development of rapport. The therapist can ask the teenager to discuss his or her interests, hobbies, or activities. During treatment the therapist should explain the rationale for specific interventions. In particular the rationale for homework assignments needs to be explained, so that the teenager can see how these might be of benefit to her or him.

   Rapport is also enhanced when the therapist explains any transitions in sessions introduced by the therapist. These include changes of topic or agenda items under discussion, and shifts from one part of the session to the next.

2. **Collaborative empiricism**: this refers to the therapist's ability to "work with" the patient in looking for evidence regarding accuracy of thoughts, establishing the session agenda (Issues and Incidents), choosing and planning Homework. An active, interactive model of conducting sessions helps to develop collaborative empiricism. The balance of activity and responsibility, however, changes over the course of treatment, with the therapist assuming more directive responsibility early and the patient assuming more over time.

The Alliance with Adolescents

Wilkes and Rush (1988) discussed issues of particular importance in the therapeutic alliance with adolescents. **They warn against confronting dysfunctional thoughts too quickly during treatment**. Particularly because adolescents tend to think in the here and now, and to be less reflective upon their own thoughts than many adults, it takes more time for them to learn how to get perspective on their thoughts in an "objective" way. Challenging negative automatic thoughts too early in treatment risks damaging the alliance. These authors also recommended use of more active methods, especially role-plays, and figural methods, such as drawings or charts, in addition to or instead of traditional triple column or multiple column techniques. **TADS therapists are expected to use role playing and/or modeling relatively frequently, and may use figural methods or other active methods as these seem appropriate for their adolescent patient. Hypothetical scenarios, in the form of "letters from teenagers" are incorporated into the TADS manual as an example of a method that differs from some of the more typical CBT techniques**.

The therapeutic relationship with the resistant or angry adolescent

Most adolescents do not enter treatment of their own volition. They are typically brought into treatment by parents, sometimes at the urging of the school or social agencies. It is not at all unusual for the adolescent to be angry about this, or to let the therapist know, often in non-verbal ways, that they are less than delighted to be present. It is critical at such times for the therapist to recognize and empathize with the adolescent's feelings. This is often best done in an individual portion of the session, after the parents have left the room. In such a setting, the teenager is free to discuss what is bothering her or him, and also free to relax and talk openly with the therapist without "losing face" in front of the parents. **At any rate, angry or oppositional reactions to therapy or to the therapist must be dealt with very early in treatment, by recognition, empathy, and active listening.**

The Therapist's Relationship with the Parents and Parental Psychoeducation

The therapist must also establish a cooperative, trusting relationship with the parents, and keep them apprised of the nature of the treatment and progress toward goals. **The overall role of parents in TADS CBT is as members of a team that is joined together against a common enemy, the teenager's depression**. Parents in the TADS protocol meet with the therapist for psychoeducational sessions, which include time devoted to obtaining the parents' views about factors contributing to their child's depression. Interactive (conjoint) family sessions are also included so that family members can work together to identify and improve problem areas. At the time of individual sessions for the adolescent, TADS therapists may have a "check in" with parents for up to 10-15 minutes at the start of the adolescent's session. The adolescent should be present during this time. Finally, parents are to be included as appropriate during the optional adolescent session on Affect Regulation, in the Week 12, "Taking Stock" session, and in the Week 18 "Relapse Prevention" session.

At the beginning of treatment, including a portion of the initial Rationale and Goal-Setting session and subsequent psychoeducational sessions, parents are asked to indicate what may be contributing to their teenager's depression. Among the possible causal or maintaining factors, it is important to attend to parental beliefs and behaviors as possible social contexts for emergence of or maintenance of adolescent depression. Any relevant parent-adolescent conflict, and any relevant parental beliefs, should be addressed during treatment. It is critical, however, to maintain the therapist-parent-adolescent team approach, and to avoid blaming the parents for the adolescent's depression.

Common conflict-related issues in the families of depressed teenagers include high parental expectations and little positive reinforcement; negative (hostile, blaming, "zapping") adolescent-parent communication; and marital distress between the parents. Other common issues are limited family pleasant activities, lack of conflict resolution (problem-solving and negotiation) skills, and parental reinforcement of adolescent negative cognitions about the self, other people, or the future. Except for marital distress, all of these issues can be directly addressed during TADS sessions. Once the TADS therapist has an understanding about which of these areas may be salient for their particular case, they can focus family sessions on amelioration of those problem areas.

The therapist should be alert, during the initial Rationale and Goal-Setting session, during Psychoeducational sessions, and during other treatment sessions, to parental beliefs and attitudes that can interfere with treatment progress. Since depression is often mystifying to observers of the depressed individual, parents, like other observers, might be expected to fall into a number of common traps. The first of these is the judgment that the adolescent is just

lazy, or could “pull himself/herself up by the bootstraps” with enough effort. In other words, the parents may think that the adolescent’s problems are intentional or under conscious control of the teenager. It is critical for the therapist to help the parents to understand that depression is a disease, and that the symptoms and associated dysfunction are not under the teenager’s control.

Another belief that can interfere with treatment progress is the belief that depression is entirely a biological disorder and that only biological treatment is effective. The psychoeducational component of TADS CBT includes discussion of the range of depressive symptoms and possible contributory factors. It is important to reinforce for the parent that depression is a biopsychosocial disorder, with symptoms that affect biology, cognition, emotions, and social behavior. There is usually more than one “cause” of a depressive disorder. Similarly, treatments that are biological and treatments that are psychosocial have each been found to produce positive symptom change in the biological domain as well as in the psychosocial domain.

A third belief that can interfere with treatment progress is the belief that, once initial relief from symptoms is evident, active treatment is no longer necessary. Again, this can be countered by reinforcing the understanding that depression is an illness with a high rate of relapse or recurrence. It is very important for the adolescent and parents to complete the full treatment program in order to obtain the skills needed to reduce the risk of relapse.

Conjoint Family Sessions, Referrals for Treatment, and Sibling Involvement

Treatment of parental psychopathology or marital distress is outside the scope of TADS CBT for the adolescent. If the therapist makes a judgment that these problems are present, and especially if they are having an influence on the depressed teenager (as would almost certainly be the case), referral of the parent(s) for their own treatment is indicated, and is not a protocol violation. All such referrals should be discussed on the ASAP call, however, in order to determine whether an ASAP session is needed to make the referral and in order to prevent systematic site biases in making referrals.

Family sessions in TADS typically involve the parents and the depressed adolescent**. The goal of family work is to alleviate the teenager’s depression, and not to modify the family system as a whole.** Siblings may be included in conjoint family sessions (but not psychoeducational parent sessions) under certain conditions. First, inclusion of a sibling is judged to be in the interest of alleviating the adolescent’s depression. Second, the adolescent supports involvement of the sibling in one or more sessions. Third, the therapist makes the judgement that this does not represent an indirect way to obtain treatment for the sibling, or otherwise to shift the focus of TADS CBT from the identified adolescent patient.

In general, a conjoint family session is one in which both the adolescent and the parent(s) are present together for most of the session. There may be occasions in which the therapist makes the judgment that a conjoint session will be more productive if part is spent with the teenager alone, part with the parents alone, and part with all together. This may be quite reasonable, and may accurately mirror clinical practice, but the general guideline in TADS is that at least half of such sessions should involve parent(s) and adolescent together. Requests for exceptions must be discussed on the CBT conference call.

Confidentiality

Confidentiality is a major issue in the treatment of adolescents. The guidelines for confidentiality in TADS are presented in the material covered in the pre-treatment Gate C interview, and are included in the study consent form. Essentially, the parents are advised of any dangerous behavior in which the teenager may engage (including suicidal thoughts, impulses, or activities), and are kept informed about the nature of treatment, including what skills are being taught to the teenager, and about progress toward goals. If parents call between sessions to talk with the therapist, the adolescent is informed about this. Therapists are permitted and encouraged to "check-in" with parents at the start of individual CBT sessions for the adolescent for up to 10-15 minutes. This helps the therapist to be informed about current concerns in the family and to assist the parents in positively reinforcing gains made by the teenager. In general the teenager should be present for this portion of the session to enhance open communication and trust.

Working with adolescents and parents can lead therapists to experience conflicted loyalties and boundary problems. One is sometimes tempted to identify with the teen or, conversely, with the parent, in cases of family conflict. It is important to be clear about the overall goal of treatment (remission of the adolescent's depression) and the proposed steps along the way to that goal. The therapist must maintain the stance of the adolescent's therapist and not become an advocate for one side against the other. Rules about confidentiality need to be clear to all parties at the outset. The treatment should be expected to enhance open communication rather than age-inappropriate independence or secretiveness.

Model of Depression

Within the therapist's manual for the initial Rationale and Goal-Setting Session and on the handout "What is Depression" in the Teen Workbook, there is a more extensive section on the following psychoeducational material, with suggestions for making it relevant to the teenager and parents:

1. Depression is a <u>disorder</u> or <u>disease</u> that affects our mood and feelings, our behavior, our thoughts, and our physical condition. Although everyone has

times of sadness, irritability, or boredom, depression differs from these times because the sad or angry/irritable mood or the boredom is much worse, or goes on much longer. Depression ("moodiness") is not something intentional that the teen can control or "snap out of."

2. Also, depression differs from these brief times of normal "bad mood", because it is associated with symptoms. To fit within the model of CBT, symptoms are clustered on the adolescent's handout according to their primary experiential area. Symptoms are clustered as pertaining to Emotions (sad, irritable, bored, guilty), Thoughts (poor concentration, memory, decision-making; self-criticism; loss of interest; thoughts of death or suicide), Behavior (crying, avoiding people, slow movement or agitation, self-harm), or Biology (sleep disturbance; appetite or weight disturbance; fatigue; loss of sex drive).

3. Depression has many possible causes. These can include biological causes, such as inheriting a risk to become depressed from parents or other close relatives who become depressed. Causes can include social or psychological ones, such as bad experiences growing up, bad experiences in current relationships with peers or parents, negative thoughts and beliefs we may develop as a result of bad experiences, and lack of friends or family to support us when we get "stressed out." In many cases, there are several different causes.

4. Because of negative experiences and possible biological factors, the depressed person has learned negative ways of coping with stress. When faced with problems, the depressed person often becomes self-critical, withdrawn from people; feels sad, angry, or hopeless; stops doing things that are enjoyable or pleasant. These patterns have been learned over time. They lead the depressed person to have less enjoyment or fun than other people have. It takes time to learn new ways of coping with stress, and it takes practice, just as it does to learn any new skill.

5. However depression may have been caused or started for any one of us, it keeps going or comes back again, for two major reasons associated with poor coping under stress. First, when we get stressed we think in old, negative ways about ourselves, about other people, or about our future. Second, we do not use more effective ways of behaving to deal with stress. These are the two areas through which this program will help the teenager to overcome depression. In the program they will learn how to think and how to behave in new ways that combat depression.

6. However depression may have been caused in a person, it can be treated in different ways. Studies with adults and with teenagers show that two of the best treatments for depression are cognitive behavior therapy and anti-depressant medication. Each of these treatments leads to positive changes in the four symptom areas discussed above: emotions, thoughts, behavior, and biology.

For example, medication can lead to improvements in biology, such as having more energy, and to less negative thinking. Cognitive behavior therapy can lead to less negative thinking and to improvements in biology. In this study we are comparing these two treatments to each other, and to their combination, to see which treatment or combination of treatments works best for which teenagers.

Model of Cognitive Behavior Therapy

Cognitive behavior therapy is an effective treatment for adolescent depression. This is how it works:

1. There are many different ways to think about our personalities. One way is to think about three major parts of any person's personality: behavior, thoughts, and emotions (Clarke, Lewinsohn, & Hops, 1990). Usually, these three parts work together when we are involved in some activity. (An example is given that is applicable to this particular teenager.)

2. Each of the three parts of our personalities affects the other two parts. Behavior affects our thoughts and emotions. Thoughts affect our emotions and our behavior. Emotions affect our thoughts and behavior. Positive thoughts or positive behavior lead to good emotions or feelings like joy, happiness, self-esteem, pride. Negative thoughts or negative behavior lead to negative emotions or feelings, like depression, low self-esteem, or hopelessness.

3. It is hard to change our emotions just by trying to change the way we feel. It is easier to change our negative thoughts or our negative behavior, which will then change our emotions.

4. However depression may have been caused or started for a particular teenager, once it starts it affects the three major parts of the teenager's personality: thoughts, emotions, and behavior. What the depressed teenager experiences are bad mood, negative thoughts, and a lack of skills or behaviors that would help them to feel better. The thoughts, behaviors and emotions then work together in a "downward spiral."

5. However, change is possible. We can turn a "downward spiral" into an "upward spiral" by changing the way we behave or the way we think about something (Clarke, Lewinsohn, & Hops, 1990).

6. Change requires that we do several things in CBT sessions and between CBT sessions.

First the teenager works with the therapist to pay close attention to how the teen is feeling, what the teen is thinking, and how the teen behaves in situations that are connected with depressed mood. In other words, we have to understand how, for

this particular teenager, the three parts of the personality work together to keep her or him depressed. In working with the therapist, the teenager will figure out especially what are the negative, depressing thoughts that keep him or her feeling down.

Second, the therapist will work with the teen to test those thoughts, to see if they are really accurate, and to help the teen to think more positively and realistically.

Third, the therapist will work with the teenager to help them learn new skills for behaving in ways that are positive and not depressing.

Fourth, because the teenager is learning new skills and new ways of thinking, parts of sessions are spent on learning these, and there are "Homework" assignments between sessions. It is important to do the "Homework" assignments because they help the adolescent to learn new skills and this leads to better results.

7. If the teenager learns new skills for behaving differently and new ways to think about things that stress them, they can solve problems better and overcome or at least significantly reduce depression. In other words, the teenager will become their own therapist, will feel better, and will have new skills to prevent or reduce future depression.

8. Take the long view. Change takes time. It is important to stay in the program for the whole treatment period, to get most benefit. Also, trying to get absolutely, perfectly better in every way can get in the way of real improvement. Some improvement is better than no improvement, and more improvement can continue to occur after the first three months of CBT are finished. The teen will have new skills by the end of acute (Stage I) treatment that he or she can continue to use after Stage I treatment has ended, to cope with situations that could lead to depression. These skills can continue to improve the teenager's mood in the time period after the first part of treatment has ended. In the second part of treatment, the teenager will be able to see the CBT therapist for some additional sessions to keep up or increase the improvement.

Model of Parent Involvement

1. Depression is the target of this treatment. The teenager, parents, and therapist combine to form a team that fights against depression**. It is not helpful to "blame" anyone for the teenager's depression.** Sometimes parents blame the teenager; sometimes the teenager blames the parents. Sometimes parents or teens blame themselves. This does not help the teenager to overcome the depression**. It is better for the therapist, the teenager, and the parents to work together against the common enemy, which is the adolescent's depression.**

2. The parents are involved in treatment for several reasons:
    a. they need to know how depression works and how this treatment for depression works, so that they can support the teenager in trying out new ways of thinking and behaving;
    b. if they are unsure about how to respond to the teenager's depression, they will receive help on this topic;
    c. if negative things going on in the family, or a lack of positive things going on in the family are contributing to the teenager's depression, they will receive help in understanding this and in making changes in the family;
    d. if family conflict or communication problems between the parents and the teenager are contributing to the teenager's depression, the teen and parents will work together in some sessions to resolve these problems.

General Session Structure in TADS CBT

CBT in TADS is moderately structured. The therapist strives to balance skills training with supportive, empathic listening (Carroll, 1998). TADS CBT is delivered in an individual therapy format, which permits more tailoring of the treatment to the specific needs of the individual adolescent than group skills training. At the same time, there is an emphasis on learning skills and on the discovery and modification of negative, depressive cognitions. This necessitates use of sufficient structure to insure efficient use of time. Sessions are typically one hour in length (60 minutes of contact time), except when the teenager and the parents have back-to-back meetings totaling 90 minutes. This occurs in Weeks 3 and 5 of treatment when parents are involved in psychoeducational sessions.

Following the guidelines used by Carroll (1998) in the CBT of substance abusing patients, we suggest dividing each hourly session into three portions. Skills-training occupies the middle portion and should take 20 to 30 minutes of time. Components of each portion are outlined below.

1. In the first third of the hour, the therapist devotes some time (at least 5 minutes) to review of the homework assignment (Homework Review). The therapist sets the agenda with the adolescent (Issues and Incidents) and checks on how the adolescent has been feeling since the last session. Using the Mood Monitor, this can be accomplished by asking about incidents that have occurred since the previous session and looking for incidents or situations that have been associated with changes in mood. The therapist inquires about any other issues or incidents that the adolescent wants to discuss in this session. In TADS the therapist will also have access in each session to the adolescent's completed Affective Disorders Screen (ADS), a recent symptoms checklist, to aid in mood monitoring.

In some sessions, the therapist checks with the adolescent on progress toward the broader goals they have agreed to work on in treatment.

After the adolescent's concerns have been elicited, the therapist and adolescent work together to put these in priority, so they can be addressed as the session proceeds. The therapist should be alert to topics or concerns of the adolescent that can be tied directly to the skills training section of the session. Following the guidelines suggested by Brent and Poling (1997), first priority is assigned to issues of hopelessness or suicidal ideation. In moderately to severely depressed adolescents, inquiry about these should be made if the teenager does not mention them. Issues related to behavioral activation have the next priority, followed by incidents that demonstrate maladaptive cognitions.

2. The middle third of the session is typically devoted to learning a skill, which is the "Topic" of the session (Skills). New skills may be introduced, or the adolescent may continue to work on a skill previously introduced. The therapist seeks to link the skill to the issues, incidents, or concerns raised earlier in setting the agenda for the session. A variety of methods to help the teenager learn the skills for the particular session are included in the manual. However, the therapist is not restricted to the specific methods contained in the manual, provided there is a clear rationale for the alternative technique chosen. It is more important to "teach the topic," the generalizable skill, than to follow the specific methods in the manual. In general, the therapist should use a combination of **didactic teaching, modeling, role-play, and questioning** to convey the material, checking with the teen to assure that he or she understands the skill and its relevance.

3. The final third of the session is devoted to completing the items on the session agenda (Working on Issues and Incidents), and to planning the homework assignment (Homework). As treatment proceeds, the adolescent will have been exposed to more skills, and the therapist may develop a sense for which ones are particularly helpful to this teenager. Identifying automatic thoughts and cognitive distortions, and formulating positive counter-thoughts are among the skills covered in the treatment. The first of these can often be conveyed through the early homework exercises on mood monitoring and through focusing on here-and-now mood shifts during sessions, and may not require a full session. As treatment progresses, the cognitive component moves from therapist-assisted to self-initiated identification of automatic thoughts, attributional biases and cognitive distortions, and from identification to challenge of these cognitions. Optimally, underlying dysfunctional attitudes or beliefs can be identified in the short-term treatment, but it is critical to build a strong therapeutic relationship and an understanding of the role of cognitions in depression before challenging these beliefs (Brent & Poling, 1997, p.15).

The homework assignment requires at least 5 minutes of planning and explanation in the session. It is important that the rationale for the homework be explained so that the teen can see its relevance. As in the selection of teaching methods, the therapist can modify the suggested homework assignments in the

manual to meet the needs of the teenager, provided there is a clear rationale for doing this. In addition, the therapist should work with the teenager to plan specifically how the homework will be done, and to anticipate and "problem-solve" any barriers to completion.

The homework assignment should be consistent with the overall approach to tasks and goals in CBT. Assignments should be tasks that the teenager is likely to be able to complete. Partial completion is better than no completion and the therapist should positively reinforce partial completion. Reasons for not doing homework should be explored, with an eye toward discovering behavioral skill deficits or maladaptive cognitions. When teenagers accomplish a homework task, they should be encouraged to make internal attributions for that positive outcome.

In addition to the five components of sessions (Issues and Incidents, Homework Review, Skills, Working on Issues and Incidents, and Homework), clustered into three broad sections of a session, therapists are asked to help the teenager to summarize main points during and near the end of sessions. To enhance the therapeutic relationship, CBT therapists are also encouraged to "check-in" with the adolescent to assure that the teenager feels understood by the therapist. More generally, the therapist must maintain a working therapeutic relationship and a cognitive behavioral model of treatment.

The sequence of a TADS CBT session, including review of the Affective Disorders Screen, components of the session, and post-session therapist ratings, is included in the CBT Session Checklist (CBTA), to be completed after each session and sent to the Coordinating Center.

Adherence to Protocol and Flexibility

In manual-guided treatment, there can be tension between therapist flexibility and adherence to the manual. TADS CBT is designed to enable experienced clinicians to conduct treatment with a range of adolescents suffering from Major Depression. A number of features are incorporated into the treatment to enhance flexibility. For example, each individual session includes an agenda (Issues and Incidents) to be set jointly by the teenager and the therapist. Although certain skill training modules are required, i.e., those in the first six weeks, other skill training modules are optional depending on the needs of the adolescent and the parents. Even within the required modules, therapists are encouraged to apply the skill to material that this particular adolescent has brought up in the present session or in previous sessions.

Nevertheless, deviation from the proposed timing of skill training can be expected to occur with some adolescents. Crises related to family, school, suicidal ideation, or hopelessness about treatment take priority over scheduled skill training components of sessions. The adolescent may demonstrate verbally or non-

verbally a reluctance to participate in treatment, or signal that the therapeutic relationship is weak. Under such circumstances, the therapist may defer a planned skill training component until the following session or at least until the crisis has been reasonably addressed in the session. The clinical judgment of the therapist will guide this decision. Some of the optional skill training modules can be brought to bear in these circumstances, such as relaxation and affect regulation for anxious or impulsive adolescents. Whenever possible, the therapist should use skills included in the TADS CBT manuals to address problems brought into sessions by the adolescent or the parents. In addition, the therapist should make explicit to the adolescent or parents what skills may be helpful in dealing with the problem at hand. This is intended to help the adolescent to become his or her own therapist over time, and to internalize the learning of skills.

Delaying or altering skill training should not be done for reasons that have more to do with therapist orientation or preference, than with the needs of the child or family. Since TADS is a multi-site study, it is important to minimize the likelihood of treatment-by-site interaction effects. Some sites may have therapists who are more "behavioral," and some may have therapists who are more "cognitive" in orientation. Adjusting the protocol to fit these preferences would risk creating substantially different interventions.

Using the TADS CBT Manuals, Teen Workbook, and Parent Handouts

This manual contains background material, session-by-session guidelines and scripts for the initial Rationale and Goal-Setting Session and for individual adolescent sessions. It also includes general, stage, and phase (of Stage I) treatment guidelines, references and appendices. The accompanying parent/family session manual includes guidelines and scripts for parent psychoeducational sessions and conjoint family sessions.

The TADS manuals include sample questions, comments, or explanations that therapists may use. These are italicized. However, therapists are not required to use these and may substitute their own phrasing.

The major and minor headings within sessions are printed in bold to facilitate use of the manuals during sessions. These headings can serve as an outline to follow during sessions.

Boxes are used in the text to set off selected material, and shadow boxes with box bullets indicate that the therapist should refer to a page in the Teen Workbook.

General boxes are used to set off text.

- Shadow boxes preceded by, or including box bullets refer the therapist to pages in the Teen Workbook

The Teen Workbook contains forms used during treatment by the adolescent. Forms are included, and lettered, in the order in which they are used in the recommended sequence of sessions. Copies of forms used in multiple sessions, Emotion Thermometer forms (labeled and unlabeled), and four different mood monitoring forms, are also included in a section at the back of the Teen Workbook. These should be Xeroxed as needed by the sites. Index cards are also included with the Workbook, so the adolescent can write down Homework or other material.

Since it is easy for adolescents to forget to bring the Workbook to each session, we recommend that each adolescent's Workbook stay in the clinic during Stage I of treatment. The therapist should take session-related or Homework-related pages out of the Workbook binder and ask the adolescent to take the necessary forms home for use during the week. All forms included in the Workbook on white paper are also included in this manual on yellow paper, within the session where they are first used. This assures that the therapist will have available any needed forms even if the adolescent forgets to bring back Homework papers. Manual pages are numbered in sequence; Workbook pages are lettered in sequence

A similar arrangement pertains to the Parent/Family Manual and related handouts. The manual is numbered and the handouts lettered. The handouts are included in a folder that accompanies the manuals and Teen Workbook.

Topic Codes

Each major content area included in the TADS CBT manual has been designated with a two-letter or letter-number Topic Code. The Topic Code indicates the main skill (e.g., Goal-Setting, Family Communication) or other main focus (e.g., Parent Psychoeducation) of the CBT session. The Topic Code for any session can be found in the heading for that session in the CBT individual and parent/family manuals. Topic Codes are listed on the CBT Quality Assurance (CBT-QA) Form which is completed by the therapist after each session, and by the supervisor after reviewing the audiotape of a session. The Topic code should also be put on the CBT Session Checklist (CBTA) that is completed after each session.

The Primary Topic of a CBT session usually refers to the main cognitive or behavioral skill introduced in that session. However, if the therapist continues to work on teaching a single skill over more than one session, the same Topic Code may be used for both sessions. In addition, if the therapist handles an event brought into the session by the adolescent or parents, such as an urgent Issue or Incident, by applying primarily one CBT skill taught earlier in treatment, or by teaching and relying primarily upon one new skill, the Topic Code for that skill should be entered as Primary on the CBT-QA Form.

In Stage II of CBT, partial responders to Stage I receive six weekly sessions of treatment. The therapist may continue to introduce new CBT individual or family skills for these partial responders. If the therapist does introduce a new skill, the Topic Code for that skill should be used to designate such a Stage II session. If no new skill is introduced, use codes M1-M5, as indicated on the CBT-QA form.

All Stage III and Stage IV sessions are designated S3 and S4, respectively.

The only Topic Code for which there is no corresponding script in the manuals is ED, which designates an Event-related Deviation. Use this code in instances where the patient or parents present with a major event that can be addressed in a regular (non-ASAP) CBT session, and for which a combination of skills or content areas are applied, with none clearly primary.

As an example, consider the case in which a teenager in Stage I reports engaging in an impulsive, potentially self-damaging behavior since the last session. The therapist must first decide whether this will require an ASAP session, or whether it can be handled in the context of the current regular session. If there is a skill that can be directly applied to this problem, such as Affect Regulation (AR), the therapist may either introduce (teach) or continue to introduce (apply) this skill as the Primary Topic of the session. If the therapist handles the problem by applying several already learned skills, with none clearly primary, the Topic Code would be ED. If the therapist determines that an extra individual or parent/family session is needed; that extra safety precautions are needed; that the adolescent is on the verge of dropping out of treatment; or that the adolescent needs to learn a CBT skill not included in the TADS manuals, an ASAP procedure is required.

ASAP Manual and Procedures for Managing Suicidality

The CBT supervisor and therapist need to be thoroughly familiar with two other TADS manuals, in addition to the CBT manuals. One of these is entitled “Procedures for Managing Suicidality in the NIMH Treatment of Adolescent Depression Study.” This manual describes principles and procedures for the assessment of suicidal ideation or behavior in TADS, and for intervention with suicidal adolescents. The second manual is entitled “Adverse Event Monitoring and Adjunctive Services and Attrition Prevention (ASAP) in the NIMH Treatment of Adolescent Depression Study.” Adjunctive Services are those not included in the protocol. This manual provides definitions and guidelines pertaining to adverse events and to provision of adjunctive services, or referral of family members for adjunctive services. Any treatments recommended or given, which are not included in the TADS CBT manuals, must be reviewed by the TADS ASAP Panel.

Using the CBT-QA Form and Labeling Tapes

All TADS sessions are audiotaped. Certain tapes are reviewed by the site supervisor, and certain tapes are reviewed by the Coordinating Center for Quality Assurance purposes. (See the Quality Assurance Manual for further details.) Tapes must be labeled to include the adolescent's and therapist's ID codes, date of session, type of session as CBT, Stage of CBT, who attended session, and primary Topic Code. **It is critical that tapes be accurately and fully labeled**.

The therapist should complete pages 1-3 of a CBT-QA form after every session. This form includes information on the patient's and therapist's ID codes, date of session, week in treatment, and who attended the session. Next the therapist indicates the primary Topic Code, and if relevant, one or more secondary Topic Codes. The therapist should then complete a self-rating on the CBT-QA form for Session Structure, General Therapist Tasks, Therapeutic Relationship and Orientation, Adherence, Competence, and Flexibility. For all sessions, this provides an opportunity for the therapist to reflect on and to evaluate the session. In addition, therapist ratings will be compared to Coordinating Center reviewer ratings on randomly selected taped sessions. Therapist-completed CBT-QA forms for those tapes that are sent to the Coordinating Center should also be sent to the Coordinating Center.

The CBT supervisor should complete all pages (1-4) of a CBT-QA form for all sessions that the supervisor reviews by audiotape. Regular supervision at the site should include feedback from the supervisor to the therapist regarding Adherence, Competence, and Flexibility, using information derived from these ratings. Coordinating Center CBT reviewers will also complete the CBT-QA for all sessions reviewed at the Coordinating Center. A copy of the CBT-QA form is included in Appendix 1.

Sensitivity to Diversity

TADS therapists must be sensitive to issues of diversity in the adolescents and families who participate in the treatment study. At the October, 1999 investigators' meeting, CBT supervisors reviewed the American Psychological Association Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations. CBT therapists are advised to study these as well. They may be found at http://www.apa.org/pi/oema/guide.html. Sensitivity to the perspective of the patient and family is critical. If, because of cultural differences, the therapist does not understand communications in the context of treatment, he or she should acknowledge this and ask for clarification. If the therapist finds that examples or role-play material in the manual seem irrelevant to the situation facing the adolescent, he or she should adjust the material to make it relevant. If the therapist finds that the model of family involvement does not match the structure and needs of a particular family, he or she may want to adjust accordingly. Consultation with colleagues on the weekly

CBT Conference Call is the primary mechanism in TADS to allow for discussion of such issues and decisions.

The issue of being in some way different can be a difficult one for any adolescent, can lead to feelings of social alienation, and can play a role in the development of adolescent depression. Therapists need to be attentive to any biases they have that could reinforce in the adolescent's mind that the adolescent is different in a negative way.

How TADS CBT Compares to Other Similar Treatments

TADS CBT is a cognitive behavioral treatment. In comparison with Brent and Poling's (1997) cognitive therapy manual, the TADS manual makes more explicit and "required" some of the social and interpersonal skills training components that are included in, but are less emphasized in, Brent and Poling's (1997) manual. This necessitates a somewhat different structure for individual sessions, since skills training is included in specific sessions. Many of the skills training sections are adaptations of the techniques used by Clarke, Lewinsohn, and Hops (1990).

On the other hand, the cognitive aspects of TADS CBT closely follows the Brent and Poling model, based on Beck's work, with an emphasis on moving from identification to challenge of automatic thoughts, and from therapist-assisted to self-initiated cognitive restructuring.

TADS CBT sessions for teens are individual sessions, and in this sense are grounded in the model of Brent and Poling (1997). There is a strong emphasis on the establishment of a working therapeutic relationship. Sessions are less structured than those used in the group intervention of Clarke, Lewinsohn, and Hops (1990), but the inclusion of specific skills training leads the sessions to be more structured than those in Brent and Poling's (1997) model.

TADS CBT uses a "modular" approach to assure adequate adherence and adequate flexibility. Some CBT skills or topic areas are defined as "mandatory," with the expectation that all adolescents at all sites will have these as components of treatment. Others are "optional," with the expectation that therapists will use these modules if the adolescent needs and is likely to benefit from them. The modular approach is intended to maintain a clear CBT rationale and treatment model, to utilize structured, empirically supported treatment components, and to permit individual applications that meet the needs of a wide variety of adolescents and families.

Previous treatment programs for adolescent depression have included parents in various ways as a part of the treatment for depression. For example, Clarke and colleagues (1990) included parent sessions and conjoint parent-adolescent treatment sessions, and Brent and colleagues (1997) used family therapy as a comparative modality for the treatment of teen depression. The most recent

follow-up studies of depressed adolescents treated either with CBT or with medication have emphasized the importance of family functioning with regard to recovery and risk for adolescent relapse. For example, Emslie, Rush, Weinberg, Kowatch, Carmody, and Mayes (1998) found that recovery from a depressive episode treated acutely with fluoxetine followed by open treatment was positively associated with higher levels of family functioning. Brent, Kolko, Birmaher, Baugher, and Bridge (1999) found that seeking open treatment during follow-up after acute psychotherapeutic treatment was associated with more family conflict during follow-up and with less family affective involvement at initial intake.

TADS CBT builds upon these findings and requires the involvement of parents in the treatment. The initial treatment session is a conjoint parent-adolescent Rationale and Goal-Setting Session, and is included in this Adolescent Sessions Manual. Two subsequent parent psychoeducation sessions and additional conjoint parent-adolescent treatment session modules are included in the accompanying Parent Sessions Manual. During Stage II of TADS treatment, parents are also involved in treatment sessions. Clinical judgment determines exactly how many of the allotted Stage II sessions should involve interactive family work, with a minimum set at one and a maximum set at three, unless the therapist requests more than three through consultation with the weekly TADS CBT Conference Call.

The TADS treatment is intended to represent the experience of a variety of CBT clinicians who work with adolescents, whether trained primarily in the cognitive model of Beck and colleagues (Beck, Rush, Shaw, & Emory, 1979), or the more behavioral model of Lewinsohn and colleagues (Clarke, Lewinsohn, & Hops, 1990).
The degree of structure in the TADS manual is intended to be intermediate. Enough structure is included to assure that each adolescent receives essentially the same treatment across numerous sites in the TADS project. Enough flexibility is encouraged to permit the treatment to be individualized.

Treatments Not Compatible with TADS CBT

Adolescents may not be involved in any concurrent psychotherapy during TADS CBT. Although parents may be referred for their own individual or marital therapy during TADS, such referrals must be discussed with the ASAP Panel, and the adolescent may not participate in these treatments. Such participation would confound the results of the TADS treatment. Parental involvement in their own treatment cannot ethically be proscribed, and in fact is encouraged, especially for depressed parents, but occurrence of this treatment will be documented during TADS for subsequent analyses.

TADS is a test of CBT, Prozac and CBT-plus-Prozac, applied to a wide range of depressed adolescents and families. TADS CBT therapists should maintain a clear CBT orientation during treatment, and should not use assumptions, methods or techniques **specific** to other forms of psychotherapy, such as psychodynamic, interpersonal, or client-centered therapy. Of course,

non-specific therapeutic methods and techniques characterize CBT as well as these other approaches to treatment.

Psychodynamic treatment focuses on unconscious conflicts that determine symptoms and behavior, and utilizes the transference as a source of data and a potential mechanism for change. Although there are similarities between psychodynamic treatment and CBT, including the emphasis on the therapeutic relationship, TADS CBT does not include interpretation of unconscious material or use of the transference.

Interpersonal therapy (IPT) is an empirically supported treatment for adolescent depression (Mufson et al., 1999) that focuses upon relationship difficulties in certain common areas (e.g., grief/loss, life transitions). Although there are many common features between IPT and CBT, the two treatments are clearly distinguishable. Interpersonal therapy tends to be more exploratory and less directive than CBT. IPT is based on the assumption that symptoms reflect relationship problems. TADS CBT refers to relationships, but focuses on maladaptive thoughts and skill deficits as these may be reflected in relationship problems.

Client-centered or supportive therapy assumes that the locus of, and potential for, adaptive change is already within the individual. The client-centered therapist identifies necessary conditions for therapy (warmth, empathy, and genuineness) with sufficient conditions for therapeutic efficacy. TADS CBT assumes that depressed adolescents lack certain skills and adaptive ways of thinking in reaction to stress. Therefore, to ameliorate the depression the teen must learn these from an active, more directive therapist.

Medications or herbs outside the TADS protocol are not permitted. TADS compares CBT, Prozac, and their combination to a placebo and to one another. Use of other drugs, herbs, or chemical agents to alter mood poses a major threat to the internal validity of the study.

Phases of Acute Treatment in TADS Stage I CBT

Following recommendations made by Kendall and his colleagues (1998), we organize the TADS acute (Stage I) treatment CBT in terms of a sequence of phases. The overall treatment has goals and each phase has treatment goals. (The adolescent and parents also have their goals, which are distinguished from phase-of-treatment goals.) The therapist's task is to focus the treatment on the attainment of those phase-appropriate goals, and to convey to the teenager and parents the rationale for the overall treatment, and for each phase, so that they understand the role of specific techniques or "Topics" during treatment. Techniques should not be used outside the context of this understanding.

There are four phases of treatment. The first phase focuses on establishing a working relationship with the teen and the parents, and on explaining the treatment rationale. Initial goals are set, and the teen is introduced to the notion of monitoring emotions and associated thoughts, situations, and behaviors.

The second phase begins with a focus on behavioral activation, especially for pleasant activities and, in general, centers on basic cognitive and behavioral skills. Several basic skills are introduced, such as problem-solving, identifying cognitive distortions, and formulating counter-thoughts or more realistic responses to depressive automatic thoughts. Parent sessions have two goals: 1) socializing the parents to the treatment model by explaining depression to them and introducing them to basic skills the teen will be learning; and 2) eliciting parental concerns and family (conjoint) therapy treatment targets.

After the Week Six CBT session, the therapist must review progress toward the adolescent's goals, as well as toward the goals of Phases 1 and 2 of treatment. A case formulation, including anticipated modules that will be used in the next six weeks of treatment must be completed by the therapist and faxed to the Coordinating Center. The CBTP Form, found in the Ancillary Forms Box, is used for this purpose.

In the third phase, more complex and individually tailored skills are a focus of treatment, such as social skills, assertion, communication, negotiation and compromise to resolve interpersonal conflicts. Monitoring of cognitions becomes more self-directed, and the teen is encouraged to self-question and "talk back to" negative automatic thoughts and dysfunctional beliefs. Family sessions are conjoint and interactive, with a focus on the specific issues identified as relevant in the family.

The fourth phase of acute treatment is the transition to Stage II TADS CBT. The adolescent is helped to "Take Stock" of their progress, and to identify which skills covered in Stage I seem to have been helpful. Progress toward goals is reviewed.

Stage II TADS CBT

After acute treatment ends at week 12, the adolescent makes the transition to Stage II, a six-week continuation treatment component of TADS. Adolescents who respond fully after Stage I receive 3 sessions of consolidation CBT, of 50 minutes duration. No new skills are introduced, but continued work is done on applying the skills that have proven most helpful for this teenager to new or more general situations. Adolescents who respond partially, but not fully after Stage I, receive 6 sessions of continuation/consolidation CBT, of 50 minutes duration, in Stage II. New skills may be introduced based on therapist judgment, provided they are included in the TADS manual. The Week 18 session focuses on a Relapse Prevention plan.

Stage III TADS CBT

After Week 18, the adolescent proceeds to a longer term, 18-week maintenance stage. Visits are every 6 weeks for 50 minutes, and focus on relapse prevention. No new skills are introduced. The focus is on Relapse Prevention.

Guidelines for Selecting Modules in Phase 3 of Stage I or in Stage II CBT

In Phase 3 of Acute (Stage I) CBT and in Stage II continuation/consolidation treatment **for partial responders**, the TADS CBT therapist must choose which modules to implement during sessions. The choice should be based on the needs of the adolescent and parents. General guidelines or suggestions generated by the authors are listed below.

For participants with comorbid secondary anxiety disorders involving panic or social phobia, the therapist may want to include breathing re-training or other brief relaxation and to focus cognitive re-structuring on anxious thoughts. For those with generalized anxiety, progressive muscle relaxation (PMR) may be helpful. Basic skills may be applied to anxious symptomatology. For example, increasing pleasant activities, especially of a self-soothing type, may be of help in dealing with phobic reactions, and problem-solving may be helpful in cases of worry associated with generalized anxiety.

Adolescents with labile affective reactions may benefit from a combination of brief relaxation training, to enhance delay and to move away from the source of affective reaction, and affect regulation training. Impulsive adolescents may benefit from these two modules, as well as from emphasis on problem-solving.
Socially isolated adolescents may need assistance in learning social interaction skills. However, if the problem seems to be one of anxiety rather than one of deficient skills, cognitive restructuring combined with role-plays and homework assignments that increase exposure to and mastery of social situations may help.

Passive or dependent adolescents and socially anxious teens may benefit from assertiveness training as well as cognitive restructuring of anxious or fearful thoughts and from family problem-solving in which they take an active role.

In cases of parent-adolescent conflict, modules on family communication, problem-solving and negotiation/compromise may be helpful. Contingency management may be useful. If parents have become detached from or excessively frustrated with their adolescent, the module on family attachment may be of use. If parents are perceived as too critical or demanding, family modules on reducing expressed emotion and on adjusting expectations and increasing positive reinforcement may be helpful.

Treatment Goals and Strategies in the Phases of Stage I (Acute) TADS CBT

Phase I of Acute Treatment (approximately weeks 1 and 2)

Goals:

- ✓ Begin to establish a collaborative, therapeutic relationship
- ✓ Socialize adolescent and parents to the CBT model of depression and treatment
- ✓ Monitor motivation, hopelessness, suicidal ideation
- ✓ Set mutually agreed upon goals
- ✓ Begin to identify thoughts, behaviors, and emotions related to the teenager's depression

General Strategies:

- ✓ Rationale and Goal-Setting Interview with Teen and Parents
- ✓ Explain model of depression, treatment rationale, and role of parents
- ✓ Goal-Setting
- ✓ Mood Monitoring/Emotional Thermometer
- ✓ Socratic questioning about thoughts, beliefs, attributions, and behaviors associated with negative mood

Phase II of Acute Treatment (approximately weeks 3 to 6)

Goals:

- ✓ Increase behavioral activation
- ✓ Increase positively reinforcing activities
- ✓ Enhance interpersonal problem-solving
- ✓ Continue to identify and begin to challenge maladaptive thoughts, beliefs, attributions
- ✓ Continue to monitor motivation, hopelessness, suicidal ideation
- ✓ Assess possible family factors contributing to adolescent's depression
- ✓ Continue to socialize parents to treatment model by explaining skill training

General Strategies:

- ✓ Increasing Pleasant Activities
- ✓ Mastery & Pleasure Ratings with Activity Calendar
- ✓ Problem-solving
- ✓ Identifying cognitive distortions
- ✓ Formulating positive, realistic counter-thoughts
- ✓ Parent psychoeducational sessions

Note: Between the Week Six session and the Week Seven session the therapist must complete and fax to the Coordinating Center, the CBTP form (CBT Formulation and Treatment Plan)

Phase III of Acute Treatment (approximately weeks 7 to 11)

Goals:

- ✓ Enhance social skills
- ✓ Enable adolescent to self-identify and modify maladaptive thoughts, attributions, beliefs
- ✓ Enhance negotiation and compromise skills
- ✓ Improve parent-adolescent interactions related to adolescent's depression
- ✓ Address collateral or comorbid problems contributing to adolescent's depression

General Strategies:

- ✓ Social interaction/assertion/communication training as needed
- ✓ Techniques for challenging automatic thoughts, attributions, beliefs
- ✓ Focused conjoint parent-adolescent sessions
- ✓ Family communication, negotiation, compromise sessions
- ✓ Relaxation/affect regulation/anxiety management/impulse control training as needed

Phase IV of Acute Treatment (Week 12 Session)

Goals:

- ✓ Preparation for and transition to Stage II

General Strategies:

- ✓ Review of progress
- ✓ Review of cognitive and behavioral skills
- ✓ Identification of skills that have proven helpful
- ✓ Plan for Stage I

Recommended Sequence of CBT Topics in TADS Stage I (Acute) CBT

Week	Topic	Participant(s)	Time
1	Rationale & Goal-Setting***	Parents and Adolescent	1 hour
	Mood Monitoring***	Adolescent	1 hour
2	Goal-Setting (continued)***	Adolescent	1 hour
3	Increasing Pleasant Activities***	Adolescent	45’
	Parent Psychoeducation***	Parents	45’
4	Problem-Solving***	Adolescent	1 hour
5	Automatic Thoughts & Cognitive Distortions***	Adolescent	45’
	Parent Psychoeducation***	Parents	45’
6	Realistic Counterthoughts***	Adolescent	1 hour

Between the Week Six session and the Week Seven session, the therapist must complete the CBTP form (CBT Formulation and Treatment plan) and fax it to the Coordinating Center.

7-11*	Social skills/affect regulation/ family session**	Adolescent or conjoint adolescent & parents	1 hour
12	Taking Stock***	Adolescent and parents	1 hour

*At least one and as many as three of these sessions should be conjoint family sessions.

**Social skills modules include social interaction, assertion, and communication skills. Affect regulation modules include relaxation and impulse control skills. Family modules include emotion regulation (expressed emotion), attachment and commitment, expectations and reinforcement, communication, problem-solving, contingency management, and pleasant activities.

***__Required topic__.

Initial Case Formulation

The CBT therapist should review results of the pre-treatment assessment battery, but does not have access to subsequent assessment battery materials. The review of pre-treatment assessment data is to help the therapist make an initial formulation of the case. In particular, the therapist should know the adolescent's major symptoms, comorbid diagnoses, and whether the adolescent experiences high levels of hopelessness or suicidal ideation, prior to the first session. The therapist should review the self-report scales to become aware of overt negative thoughts, perfectionism and areas of parent-adolescent conflict. In general, the therapist should make preliminary hypotheses about what may be contributing to this adolescent's depression, and what in the CBT might be helpful to this teen and family.

In the Rationale and Goal-Setting session, the therapist reviews with the adolescent the symptoms and possible contributing factors, and in this context the therapist should let the adolescent and parent(s) know that he or she has reviewed the assessment battery. The review of symptoms and possible causes that is conducted in the Rationale and Goal-Setting session is intended to be conducted as a dialogue. The therapist may propose possible contributing factors and possible ways this treatment can help**. However, the therapist should not indicate the specific source (instrument, questionnaire, or item) that is the basis for hypothesized symptoms or contributing factors, to avoid biasing future responses to assessment instruments.**

During treatment, the therapist will have access to the Affective Disorders Screen, and thus will be able to monitor depression and suicidal ideation directly.

RATIONALE AND GOAL-SETTING INTERVIEW

TOPIC CODE: RG

This is the first "Psychoeducational" interview of the three allotted in the TADS protocol. (The other two are in the Parent Manual.) This interview includes both the teenager and the parent(s) and is conducted conjointly for the full session, unless clinically contraindicated.

IT IS VERY STRONGLY RECOMMENDED THAT BOTH PARENTS ATTEND THIS SESSION, UNLESS CLINICALLY CONTRAINDICATED.

GOALS OF THE SESSION:

1. To begin to establish a collaborative therapeutic relationship.
2. To review briefly the major findings from assessment and relate these to the model of depression.
3. To explain rationale for CBT; rationale for family involvement; and how this treatment can help this teenager.
4. To elicit adolescent's and parents' initial goals for treatment.
5. To review no-suicide contract and answer questions about treatment.

Materials and Preparation Needed:

Adolescent Workbook with forms for: What is Depression? Three Parts of the Personality; How Thoughts and Behaviors Influence Emotions; What is Cognitive Behavior Therapy? How Parents Can Help; Goals; copy of No Suicide Contract from Gate C interview; Treatment Schedule for Stage One CBT

Therapist writing materials (pen or pencil and paper, or newsprint and marker)

Therapist's case chart for progress notes and therapist checklist

Assessment materials bearing on case formulation need to be reviewed in advance of this session.

The No-Suicide Contract completed at Gate C interview needs to be reviewed prior to this session.

1. STARTING A COLLABORATIVE WORKING ALLIANCE

1.a. Introduction: The therapist begins the first session by introducing himself/herself by name, and as a therapist who works with teenagers and their families. The therapist then asks the teenager to share something about their school, social, or family life, e.g., where they attend school, their grade, their interests and activities, who is in their family. It is often helpful to discuss with the teenager some of the things they like, or particular areas of interest.

The therapist then briefly explains that he/she is aware that the teen has been having some difficulties with how they have been feeling or with their mood. Since the therapist has not conducted the diagnostic interviews, it is necessary to mention that the therapist has reviewed information from those sessions, but also to introduce a brief review of presenting problems.

> *"I realize that you have already spent several hours completing interviews and questionnaires. I will not ask you to repeat all of that, but I would like to spend a few minutes going over what each of you sees as the main concerns or problems."*

1.b. Presenting Problems: Initially the adolescent, the parents, and the therapist should discuss the nature of the presenting problems, in order to reach a shared point of view, or at least a point of departure. There may well be disagreement between the teen and the parents about the nature of the problem, in which case the therapist needs to find some common ground to begin work.

> *"I know from looking over the forms you filled out, and the interviews you completed, some of the concerns that led you to this program. However, I'd like to hear from each of you at this point what you see as the main concerns. Could each of you tell me how you see the problems that we should work on together."*
>
> *"Do you (teenager) see it pretty much the same way as your (parents/mother/father), or do you see it differently?"*

1.c. Emphasize Collaboration: The therapist then explains that she/he and the teenager will be **working together** to understand what is causing the teenager's problems and to help the teen to solve the problems. Today, the therapist will spend some time reviewing what depression is, and explaining how treatment will work.

> *"In this session, I will be explaining more about the treatment program. This means I have to do more talking in this session than I usually will. However, do not hesitate to ask as many questions as you have, so we make sure we all understand the treatment program.*

2. PSYCHOEDUCATION: DEPRESSION

2.a. General Guidelines:

- The psychoeducational interview should be conducted in a way that maximizes involvement of, and **dialogue** with, the teen and parents, individualization of feedback, and some checking with the teen and parents on whether what is discussed seems accurate to them, or "makes sense" to them. This helps to begin the "collaborative empiricism" inherent in the CBT model (Brent & Poling, 1997).

- It is important to be **hopeful** and to keep the feedback focused on things that can be done (such as skills that can be learned) to improve the situation.

> ❑ **Refer to pages a & b in the Workbook, "What is Depression?" and review these pages with the teen and parents.**

2.b. **Depression is more than just feeling bad:** Depression is a **disorder** or **disease** that affects our emotions, our behavior, our thoughts, and our physical condition. The feeling is different from the sadness, irritability, or boredom, which everyone feels sometimes, because it feels much worse, or goes on much longer.

- To parents, the teenager may appear to be "moody" with apparently unexplained shifts in mood. This "moodiness" is part of the disorder, <u>not intentional</u> or under the teen's control.

"What sort of moodiness have you noticed in yourself/your teenager?"

2.c. Symptoms: Depression differs from normal "bad mood", because it is associated with <u>symptoms</u>. These symptoms show up in <u>feelings</u>, <u>thoughts</u>, <u>behavior</u>, and in the way our <u>bodies</u> react (biology).

> ❑ **Ask the teenager and parent to look over the symptom list included in "What is Depression" (p. a) to see which ones have been the major ones for this teenager.**

*"Take a moment to look over the symptoms listed on the handout (**What is Depression?**), so that you can see which ones you/your son or daughter have/has experienced."*

2.d. Causes: There is no single cause for depression. There are many possible causes. Usually, there are several causes for each person who gets depressed, and it is not unusual to be unsure of the causes. Some possible causes are listed on the handout.

- ❑ Ask the teenager and parent to look over the list of possible causes (p. b) to see which ones might have contributed, or be contributing, to this teenager's depression.

"Do you have some ideas about what things might have led to your/your child's depression?"

2.e. A Learned Pattern: Whatever may have caused depression to start, depression becomes a learned pattern of thoughts, emotions, behavior, and biology.

- This pattern has been learned over time, and is not the fault of the adolescent. **It is not something the adolescent can just change by trying harder.**

2.f. Effective Treatment is Available: But the pattern can be changed with special treatment involving learning new skills with a therapist. Cognitive Behavior Therapy can lead to changes in the way we think, behave, and feel, to changes in the physical symptoms of depression and even to changes in brain functioning.

For adolescents receiving medication point out that medication can also change the pattern, and that it can especially help to get the changes started as the adolescent learns new skills. Then, the new skills can take over and the medication will not be so necessary. Analogies can be used, such as having to attach training wheels when starting to ride a bike, but not after learning (March, Foa, Franklin, & Kozak, 1998).

2.g. Time and Practice: It takes time and practice to learn new skills and change patterns, as with any new skill. We will practice skills in sessions and you will be asked to practice them between sessions. The sessions take up only an hour or two of your week, which is not much time to learn new skills. Practice between sessions leads to better results. For this reason, it is important to practice the skills between sessions.

2.h. Two Main Changes: There are **two** main learned patterns we need to change to overcome and prevent depression. We will work together with you in this program to learn how to change these:

- negative, depressing **ways of thinking** about **ourselves**, or **other people**, or our own **future**.
- **ways of behaving** that don't work well when we are stressed.

3. PSYCHOEDUCATION: COGNITIVE BEHAVIOR THERAPY

The "triangle" model of thoughts, emotions, and behavior, as well as the model of "downward spirals" and "upward spirals" are taken from Clark, Lewinsohn, and Hops (1990).

- **Refer to pages c & d in the Workbook entitled "Three Parts of Our Personality" and "How Thoughts and Behaviors Influence Emotions," and review these with the teen and parent while going through this section.**

"Cognitive behavior therapy is an effective treatment for adolescent depression. This is how it works:"

3.a.1. Three Parts of the Personality: There are three important parts of our personalities: **behavior, thoughts, and emotions**. These three parts work together.

Use an example likely to be relevant for this teenager, based on your earlier discussion about interests and activities. Illustrative examples are used below (italicized).

For example, if a teenager is playing basketball (soccer) and making most of their foul shots (passes and shots), the behavior is shooting (passing), the thoughts are something like "I'm doing well at this" and the emotion is happiness or feeling good. If they start missing their shots (passes) they may think, "Uh-oh, I'm doing something wrong in the way I'm shooting," and they may feel discouraged.

3.a.2. Reciprocal Influence: Each of the three parts of our personalities affects the other two parts.

For example, if the teenager who starts missing foul shots starts to think, "I'll ask my coach to give me some help with this," he or she may feel less discouraged and more hopeful. Then their behavior will probably be to ask for help and to practice harder and they can improve.

Or, they may first change their behavior, by trying something different in their body movements. If this works, they may think something like "I've got it. I figured it out." They will feel encouraged and proud.

- Behavior affects our thoughts and emotions.
- Thoughts affect our emotions and our behavior.
- **Positive thoughts or positive behavior lead to good emotions or feelings** like joy, happiness, self-esteem, pride.
- **Negative thoughts or negative behavior lead to negative emotions or feelings**, like depression, low self-esteem, or hopelessness.

3.a.3. What To Change: It is hard to change our emotions just by trying to change the way we feel. It is easier to change our negative thoughts or our negative behavior, which will then change our emotions.

In the example given of the teenager shooting foul shots, the teenager had to think about the problem differently or do something differently before he or she could feel better.

3.b.1. Downward Spiral: When a teenager is depressed, **their thoughts, emotions, and behavior work together in a "downward spiral."**

For example, we may get a poor grade on a test, and feel depressed, think we are stupid, and stop studying (a behavior). Or maybe a girlfriend/boyfriend breaks up with us, and we feel rejected, start to think no one will ever love us, and change our behavior so that we stop going to places where we might meet new friends.

3.b.2. Change is Possible; the "Upward Spiral": However, change is possible. We can turn a "downward spiral" into an "upward spiral" by changing the way we behave or the way we think about something.

To stay with the same examples, we may get a poor grade and feel disappointed at first. However, if we think we could do better next time with some more studying, and then actively prepare for the next test, soon the negative emotion goes away, and the spiral turns around. It becomes an "upward spiral."

We may feel badly about a breakup with a girlfriend or boyfriend; but, after a while we start to think that there are many other people who could love us, and whom we could love. Then, we would make efforts to meet more people and we would feel hopeful and positive.

- ❑ **Refer to page e in the Workbook entitled "What is Cognitive Behavior Therapy?" and review it with the teenager and parent.**

3.c.1. Cognitive Behavior Therapy: Cognitive Behavior Therapy is one of the best treatments for depression. In CBT you learn how your thoughts (Cognition or C) and behavior (B) affect the way you feel (Emotions). Then you learn ways to change your thoughts and behaviors to overcome depression.

3.c.2. Working Together to Understand: First we will work together to understand the way your thoughts and behaviors are connected with negative emotions.

*"You and I will be looking at your emotions, your thoughts, and your activities like **scientists** working together to understand something better."*

3.c.3. Testing Thoughts: Second, we will work together to test those thoughts that may be keeping you depressed, to see if they are really accurate, and to help you to think more positively and realistically.

3.c.4. Learning New Skills: Third, we will work together to help you learn new skills for behaving in positive non-depressing ways when you are dealing with problems or getting stressed.

- Over time, you will build up a set of skills for overcoming depression. You can think of these as **tools** in your **backpack.** You can use these **tools** when dealing with problems or challenges.

When explaining CBT, attempt to link some of the skills in the treatment to problems the teen or parent has already mentioned. It is important to enhance hopefulness to focus on some specific ways the treatment can help with this teenager's particular problems or skill deficits.

"For example, earlier you mentioned that when you are depressed, [you spend more time alone in your room, and stop doing things you enjoy]. A skill that would help you with that is [learning how to increase enjoyable activities]."

3.c.5. Practice: Because you are learning new ways of thinking and new skills in CBT, parts of sessions are spent on learning new skills, and there are "Homework" tasks between sessions. It is important to do the "Homework" in order to learn the most. People who do CBT Homework have better results than those who do not.

3.c.6. Becoming Your Own Therapist (Brent and Poling, 1997):

Explain that in this way, over time, **the teenager learns skills and ways of thinking so that they eventually become their own therapist**.

"Over time you will learn to be your own therapist, and to use the tools in your backpack in the many different situations that come up in their life. You will become a better "Problem-Solver". This will help you to overcome depression and prevent future depression."

3.d. Countering Perfectionism and Taking the Long View: Early termination and perfectionism about achievement can interfere with outcome in treatment for

depression. Therefore, the following points should be addressed at the start of treatment.

3.d.1. Change Takes Time: It is important to stay in the program for the whole time. The adolescent and parent(s) may see improvement during the early part of treatment and think that treatment is over, or no longer necessary. However, depression is a recurring disease. To prevent relapse it is critical to stay in treatment for the whole program, to learn the skills needed to combat depression, and to learn more realistic ways of thinking about stressful events that may come up in the future.

3.d.2. Perfectionism Can Get in the Way: To be successful in CBT, it is not necessary to feel "completely better" by the end of the 3 months of Stage I of Cognitive Behavior Therapy. Of course, this would be the best outcome in such a short period. However, **some improvement is better than no improvement**.

3.d.3. Continued Improvement After Stage I Treatment: The teen will have new skills by the end of Stage I that he or she can continue to use in later Stages of the study and after treatment has ended. In this way, the teenager can better cope with situations that could otherwise lead to depression in the future. These skills can continue to improve the teenager's mood in the time period after treatment has ended.

3.e. How Are Parents Involved in CBT? Explain the model of parental involvement in TADS.

- **Refer the parents and adolescent to the Workbook form on p. f, "How Can Parents Help?" when discussing the parents' involvement in TADS CBT.**

3.e.1. The Team: Depression is the target of this treatment. The teenager, parents, and therapist combine to form a team that fights against depression**. It is not helpful to "blame" anyone for the teenager's depression (teenager, one parent or the other parent). It is better to work together against the common enemy, which is the adolescent's depression.**

3.e.2. The Role of Parents on the TADS CBT Team: The parents are very important team members in CBT for several reasons.

- they need to know how depression works and how this treatment for depression works, so that they can support the teenager in trying out new ways of thinking and behaving;

- parents can receive help on how to respond to their teen's depression

- if negative things going on in the family (such as too much criticism), or a lack of positive things in the family (such as too few fun activities) are contributing to the teenager's depression, they will receive help in making things better in the family;

- if family conflict or communication problems are contributing to the teenager's depression, the teen and parents will work together in some sessions to resolve these problems.

**********Optional, or As-Needed**********

If parents or teenagers have questions about the study, a brief explanation can be given:

- Whatever factors may have caused a person's depression, the depression can be treated in different ways. Studies show that two of the best treatments for depression are cognitive behavior therapy and anti-depressant medication.
- We know that cognitive behavior therapy can lead to improvements in the way people think, behave, and feel, **and** to biological changes, and that medication can, also. So both treatments can work.
- However, we do not know which treatment works best for which teenagers, whether the combination of the two is better than just one alone, or what is the best treatment plan to get over depression and keep from having another depression later. We are trying to answer these questions in this study.

****

4. GOALS FOR TREATMENT

4.a. Introduction to Goals**: Explain that, now that the information about treatment for depression has been discussed, you want to spend some time working with the teen and the parent(s) on their goals for this treatment program.**

> *"Now that we have had a chance to talk about this treatment for depression, let's spend some time talking about your goals in the program."*

4.b. Adolescent's Goals: Ask the teen to think about the goals they have for themselves in this program. The therapist should accept the teenager's goals if they are reasonable. In subsequent sessions, the therapist should help the teen to break down large goals into smaller steps and to "concretize" goals that are too abstract. The goals need to be mutually agreed upon by the teen and the therapist. The therapist should be alert to perfectionistic goals, since perfectionism at the start of treatment is associated with less positive outcome (Blatt et al., 1995).

Examples of questions to use during goal-setting:

- ✓ *"What would you like to get out of this program?"*
- ✓ *"What would you like most to change as we work together in this program?"*
- ✓ *"If things could be different, what would they be like?"*
- ✓ *"What changes do you want to see in yourself as a person?"*
- ✓ *"If someone asked you in three months or six months, how therapy had helped you, how would you like to answer?"*
- ✓ *"Without worrying about how it could happen, what would you like your life to be like 3 months from now (or 6 months from now)?"*

4.c. Parents' Goals: Ask the parents to think about goals they would have for their teenager. Note discrepancies between teen and parent goals as a possible index of discord. Question these discrepancies so as to move toward agreed upon goals. Unrealistic parental goals can in some cases be gently challenged without disrupting the alliance. If there are frankly incompatible goals (parent versus child) identify this as an issue to be worked on in subsequent sessions, but try to find some common ground.

- In particular, try to identify a goal of the teenager that the parent can support.
- Goals that are outside the scope of this program should be so identified. In particular, goals pertaining to mental health problems of family members other than the teenager or to marital conflict are outside the scope of the program.

4.d. Goal-Setting and Treatment: Explain how setting goals can help guide the treatment and also that learning how to set and reach goals is a skill in itself. In later sessions with the adolescent the therapist will work on ways to set and reach goals.

"As you can see, setting goals is a good way to focus the treatment on what is important to you. It allows us to see how well we are doing over time. Setting small goals related to a big goal also helps us not to get discouraged. If we don't get completely better in a hurry, we can see progress along the way. Learning to break a big goal down into smaller goals that we can work on step-by-step is an important skill in itself."

- ❑ **Goals of the teen and of the parents should be written on the forms provided on pp. g & h of the Teen Workbook.**

- ❑ **Ask the parent if there is a goal of their teenager that the parent can help the teen to attain. If so, put this on the space provided on p. h of the Parent Goals Form in the Workbook.**

Explain that you will return to the goals at numerous times during treatment, and will talk more with the teenager about his/her goals in next week's session.

5. REVIEW OF NO-SUICIDE CONTRACT AND TIME FOR QUESTIONS

5.a. No-Suicide contract: *During the last research interview prior to starting CBT, Gate C-2, the teenager and one or both parent(s) will have already completed the No-Suicide Contract. Review that contract with them and make clear to them that you (the CBT therapist) are the person that the teen needs to notify, along with the parent, of any suicidal thoughts, impulses, or behaviors.*

The therapist should check the No-Suicide Contract to assure that a plan to handle any future incidents and the agreement to notify the therapist and parents are included. In addition, check to see if either the adolescent of the parents have any questions about the contract.

The therapist should have available for reference during this section, the script from the Gate C interview. This includes the no-suicide contract, the confidentiality rules, and the treatment schedule.

5.b. Other Questions: Check to see if there are any questions about the confidentiality guidelines, or about the treatment schedule.

- Be sure that the teen and parents understand the **confidentiality** rules.
- Be sure they understand the **schedule**. Stages I and II together, are 18 weeks, Stage I ends at Week 12. Stage I is 12 **weeks.** During those 12 weeks, there are a total of 15 sessions, which take 14 hours. There are two one-hour sessions in Week One. In Week three and in Week 5 there are two back-to-back 45-minute sessions, one for the teen and one for the parent(s). In all other weeks, there is one session. To obtain full benefit, it is important to come to every session.

- ❑ **Refer the adolescent and parent(s) to p. j of the Teen Workbook when discussing the schedule of CBT sessions in Stage I**

- Emphasize the importance of regular attendance. Improvement and continuation of improvement are much more likely with regular weekly attendance at sessions. There are only 12 weeks of treatment in Stage I. Therefore, in order to receive all sessions it is necessary to come each week.
- Ask the parent(s) if they have any questions about the psychoeducational material that was given out at the time of the Gate C-2 interview. This handout includes more material about depression, and about the specific treatment arm to which the adolescent has been assigned.

6. SUMMARY AND CHECK-IN

Check to see if the parents and teenager have any questions. Preview the next session by mentioning that you will be meeting with the teenager for the whole session, starting to work on a new skill and taking steps toward the treatment goals. Remind parents of the parent meeting in Week Three.

INDIVIDUAL SESSION I: MOOD MONITORING

TOPIC CODE: *MM*

GOALS OF THE SESSION:

1. To review key points in rationale, briefly.
2. To introduce routine session format.
3. To assess rationale acceptance and expectations for improvement
4. To teach Mood Monitoring using the Emotions Thermometer.

Materials and Preparation Needed:

Adolescent Workbook with forms for: What are CBT Sessions Like?; Cognitive Behavior Therapy Expectations (Form CBTE); Emotions Thermometer (labeled); Mood Monitor

Envelope (to be provided by site) for Form CBTE: Cognitive Behavior Therapy Expectations

Therapist writing material

Therapist's case chart

This session includes two fairly distinct parts. The first part continues psychoeducation about the treatment, and the second part includes the first training in skills. Try to allot at least 30 minutes, or half of the session time, to the second part. In the first 30 minutes, or less, try to cover review of rationale, explanation of treatment structure, and assessment of rationale acceptance and expectations for improvement.

At the outset of the session, review the adolescent's completed Affective Disorders Screen. If urgent symptoms are indicated, such as suicidal thoughts or behavior, work on those at the start of the session. Otherwise, let the teenager know that you will be working with them to better understand their depression later in this session.

1. REVIEW RATIONALE BRIEFLY

The therapist's task in this portion of the session is to review **briefly** the rationale presented in the feedback interview and to see if the teenager has questions or concerns about the treatment. Use an interactive style to assure the teenager is

actively involved in the review. For example, ask questions rather than simply giving didactic information. Major points to be reviewed include:

- 3 parts of the personality and how they interact
- interrupting downward spirals and turning them around
- it is easier to change our thoughts or our behavior than to change how we feel directly
- cognitive behavior therapy involves paying close attention, as scientists do, to how we think and behave when we feel depressed, and then learning to question, experiment with, and change the way we think and behave
- The parents will be involved in treatment to learn about the cognitive behavior therapy, to help the teenager learn new skills and new ways of thinking, to learn how they can help the teenager and to work on improving things in the family

Ask the teen enough questions to be sure they understand the rationale for cognitive behavior therapy, and ask them for feedback regarding any questions they have about it. If the teen challenges or discounts the rationale, use cognitive behavioral methods to work on this. For example, cognitive distortions ("black and white" thinking), or hopelessness may be involved and could be gently questioned.

At a minimum, the therapist should make sure the teen feels understood with regard to any questions they have or reservations they have about the treatment rationale. An "empirical" approach can then be adopted, in which the teen is encouraged to try out the treatment and test how it is working.

2. INTRODUCE STRUCTURE AND ROUTINE SESSION FORMAT

The therapist's task in this portion of the session is to explain the structure of the treatment, including routine session format.

2.a. Time and Place: Explain that most sessions will last for 60 minutes. There will be one session each week. Meetings will be held in this office (or in other offices in the clinic if necessary). The first part of the program lasts for 12 weeks. It is important to come each week.

2.b. Rule of Respect: *"In therapy, there is one main rule: RESPECT. Each of us needs to respect the other as a person."*

Most of the specific guidelines for therapy come from the main Rule of Respect. These include the confidentiality guidelines, which have already been reviewed. Other guidelines are:

2.b.1. Attend every session:

"If you ever have to miss, be sure to call me to let me know. If I do not hear from you, I will call you to check that everything is O.K.

2.b.2. Speak about things when you are ready to talk about them:

"Sometimes I might encourage you to talk about something, but you do not have to talk about anything you don't feel ready to talk about."

"Also, when we meet together with your parents, I may encourage you to bring up something with them that you and I have discussed, but the final decision will be yours."

2.b.3. Parents are involved in the program so that they can help you:

*"When I meet alone with your parents, I will be **asking them for their ideas on how to help you**. I will be **telling them about the skills you are learning** in our sessions."*

"If I think it would be helpful for me to tell them anything you have said in our sessions I will check this with you first."

2.c. Usual Session Format: Therapist next explains the usual sequence to be followed in sessions. Review the Workbook page, What are CBT Sessions Like?, as you explain the session format.

- ❑ **Refer the teen to page k in the Workbook entitled: "What Are CBT Sessions Like?"**

"Right now I want to talk with you about how we will work in sessions."

2.c.1: Sessions are Individualized: Begin here to socialize the adolescent to take an active role in determining the content and focus of sessions.

"You and I will work together to decide what to talk about in each session. It is important for you to bring in your own ideas about what you want to work on.

2.c.2: First Part of Sessions: First part of session includes Issues and Incidents and Homework Review.

" *At the beginning of each meeting, there will be two things we do. First, we will see what issues or problems you want to bring up, or particular incidents or things that happened, which you want to discuss. We will list these as our agenda, and we will put them in order to be worked on.* ***This part of each session is called "Issues and Incidents."***

"Second, in this first part of each session, we will go over the skill practices you have tried in "Homework" since the last session. We will review these so we can learn from them, ***including learning from mistakes."***

2.c.3. Middle Part of Sessions: The middle part of each session includes learning new skills

"In the middle of many sessions we will then learn and practice new skills for changing behaviors, or thoughts. You will learn to have new ***"Tools" in your "Backpack"*** *so that you can handle problems better and overcome depression. This middle part of each session is called* ***"Skills."***

2.c.4. Last Part of Sessions: The last part of each session includes continued work on the Issues and Incidents, and planning for the next week's Homework.

"In the third part of sessions, we will work on the Issues or Incidents you have brought up. This third part of each session is simply called ***"Working on Issues and Incidents."*** *During this time we will apply the skills you are learning to things you want to work on. We will spend time looking at negative thoughts and checking out more positive ways of thinking."*

"Also in the third part of the session we will work together on planning a ***Homework*** *assignment to do between that session and the next session****. Homework is important to do, so that you get the most benefit out of this program. People who do Homework in CBT get better results than people who do not do it."***

It may be advisable to continue to refer to this Workbook page for the next several sessions, as the teenager learns the routine format.

3. ASSESS RATIONALE ACCEPTANCE AND EXPECTATIONS FOR IMPROVEMENT

"In a few moments we will start working more on understanding your depression, but first I need to ask you to fill out these brief ratings. They are for research purposes only. I will not see them. Just fill them out and put them in this envelope and seal it. We will then give it to (research assistant)."

Provide an envelope in which to place the CBTE.

- **Take out of the Workbook, between pp. k and l, the rating form for rationale acceptance and expectations for improvement (Form CBTE-Cognitive Behavior Therapy Expectations). HAVE ADOLESCENT COMPLETE THIS AND PLACE IT IN A SEALED ENVELOPE, TO BE GIVEN TO RESEARCH ASSISTANT.**

4. TEACH MOOD MONITORING

4.a. Transition to Second Half of Session: Provide a transition statement here, since the teenager will now be asked to become more active in the session.

"Now that we have gone over the way sessions will work, we can get started on working together to understand how you have been feeling."

- Therapist now asks teen to talk about how they have been feeling recently or over the past week. Inquire about some times recently when they have felt bad, and **ask them to describe the situations**. Then inquire about recent times when the teen may have felt good or happy.

  "*Let's get started now on working together to understand your depression. Can you tell me how you have been feeling in the past few days, or the past week?"*

  "What situations have come up recently where you have felt bad?"

  "When you think about your emotions at those times/that time, how bad did you feel compared with other times? Would you say you felt a little bit depressed, pretty badly depressed, more depressed than ever?"

  "How about times when you felt pretty good or very good? Have there been some times like these recently? Tell me about those situations."

Optional: If it seems this teenager is ready to move ahead, socialize the teen further to the treatment model by asking them about the thoughts they were having at these times. However, many teens will need additional time to learn how to identify the way they are feeling, and to understand the link between emotions and situation or behavior before moving on to identifying associated thoughts.

"What was going through your mind at that time?"

"What images or thoughts come to mind when you think back to that situation?"

At this early stage in treatment, empathy with the teenager and acceptance by the therapist are the most critical aspects of this discussion.

4.b. Introduce Mood Monitoring.

4.b.1. Rationale for Mood Monitoring: Introduce Mood Monitoring as a skill that the teen can learn to keep track of how he/she is feeling. **Mood Monitoring means paying attention to how we feel.** Mood Monitoring will help them to see what kinds of **situations** lead to them feeling more or less depressed (angry, guilty, or lonely), and what kinds of negative **thoughts** may be connected to those emotions. Mood Monitoring will also help them to see what situations and thoughts are connected with feeling better or feeling happy.

4.b.2. Mood Monitoring as a Skill, Using Two Tools in the Backpack: Mood Monitoring is, therefore, a skill that will help them to learn what kinds of things help them to feel better. Often people have only a very vague sense of what leads them to feel better or to feel worse. With this skill, the adolescent will understand their depression better, and then be able to do something about it.

- Mood Monitoring involves **two tools** they will then have in their "backpack" to overcome depression: the **Emotions Thermometer** and the **Mood Monitor.**

4.c. Introduce the "Emotions Thermometer:" Explain that the Emotions Thermometer helps to understand how strong our feelings are. By using it the teenager can understand not only what emotion they are feeling but also whether the emotion may be stronger or weaker.

- **Ask the adolescent to take a labeled Emotions Thermometer from the back of the Workbook. At the bottom of the Thermometer is the number "0" and the label "Feeling Bad". At the top is the number "10" and the label "Feeling Good."**

"As we work together, it will be very important for you to rate how strong bad feelings (depression/anger/irritability) are and how strong good feelings are. That way, we can know whether the skills you are learning and the changes you are trying out are helping you to feel better and to reach your goals. Any emotion can be weak or strong, or anywhere in between."

"One good way to do this is to use an "Emotions Thermometer" for rating feelings that range from very bad to very good. It is like the thermometer we use to take our temperature when we are sick, except that this one tells us how 'hot' our emotions are."

- Point out that the Emotions Thermometer goes from 0 (feeling very bad) to 10 (feeling very good*)*

"On this Emotions Thermometer, higher numbers indicate better or happier emotions, and lower numbers indicate worse or more depressed or unhappy feelings."

4.c.1. Fill out parts of the Emotions Thermometer: Therapist then asks teen to recall two or three experiences in which they have felt bad, using the term they use for negative affect (depressed/angry/irritable). Include the worst (or a worse) time, and a time in which the emotion was mild. Therapist then asks teen to recall two or three experiences in which they have felt good or happy. Include the best time (or a very good time), and a time in which the emotion was more mild. Therapist can then help teen to recall intermediate examples, or if necessary, can create contrived or imaginal examples to fill in some intermediate lines on "Emotions Thermometer."

The therapist helps teen to place these examples on appropriate lines on the thermometer, with the worst at "0" and the best at "10."

4.c.2. Discuss the Range of Emotions: Point out that the Emotions Thermometer helps us to realize that our emotions range from good to better and from poor to worse. Even though it might seem that we feel the same way all of the time, by using the Emotions Thermometer we can see how our feelings change.

4.d. Introduce the "Mood Monitor."

- ❑ **Ask the teenager to open the Workbook to the Mood Monitor, pp**. l & m

4.d.1. Rationale for daily ratings: The "Mood Monitor" will help the teenager and the therapist to work together to see what situations, events, and thoughts are connected with feeling bad and with feeling good.

> **"We can use this form or other similar forms during treatment to see how your mood changes, and to see what situations (and thoughts) are connected with feeling bad or feeling good. As you and I work toward your goals and you learn new skills and practice them, you can see on the Daily Mood Monitor how they are affecting the way you feel"**
>
> **"We can use this form to see what kinds of situations lead you to get depressed, what kind lead you to feel good. We will be able to look at the connections between how you feel and what you are thinking. We will be able to see what is working best for you in overcoming depression."**

4.d.2. Explain the Form and Demonstrate How to Complete It: Explain the layout of the Daily Mood Monitor. Show the teenager that the "Daily Mood Monitor" contains places for morning, afternoon and evening for each day of the week.

- Use an example or two from the teenager's earlier discussion to illustrate how to fill out the Mood Monitor.

  "Earlier you had mentioned that during the past week you felt down when….happened. Let's use that example to see how you can record emotions and situations on the Daily Mood Monitor."

4.d.3. Link the Mood Monitor to the Emotions Thermometer: ***After writing in one or two examples, above, ask the teenager to rate how they were feeling at these times, using the Emotions Thermometer.***

> **"How badly did you feel at that time, on the Emotions Thermometer? Put the number in the same space where you write down what was happening."**

5. HOMEWORK

5.a. Daily Recording: Ask the teen to take the "Emotions Thermometer" and the "Mood Monitor" with them, and to notice each day, situations that happen in the morning, afternoon, and evening, that are connected with feeling bad or feeling good. These could include things that they are doing, places where they are, things other people are doing, etc.

Ask them to try to record three situations each day, one in each time block, and to include the rating number from the "Emotions Thermometer." [Teens who quickly catch on to this may be encouraged to record the associated thoughts as well.]

5.b. Trouble Shooting: Anticipate with the adolescent anything that might get in the way of doing the Homework.

Work with them to **set a time of day** to do the Daily Mood Monitor, and **a set place** to leave it at home.

6. SUMMARIES AND CHECK-IN

In all sessions during the program, the therapist should **help the teenager to summarize**, at intermittent points through the session, what has been done in the session.

Toward the end, check with the teen to see if they have felt that they are being understood and that their concerns are being worked on.

Let the teen know that in the next session, you will have more time to work with the Emotions Thermometer, Mood Monitor, and that you will work more on the Goals they set in the Feedback and Goal-Setting session.

INDIVIDUAL SESSION TOPIC II: GOAL-SETTING (Continued)

TOPIC CODE: ***GS***

GOALS OF THE SESSION:

1. To begin routine session format
2. To review Homework using the Emotions Thermometer and Mood Monitor
3. To teach Goal-Setting
4. [Optional] To begin to identify thoughts and behaviors associated with the teen's depression

Materials Needed:

Adolescent Workbook with forms for: Moving Toward Goals; Emotions Thermometer; Daily Mood Monitor

Therapist's writing material

Therapist's case chart

1. ISSUES AND INCIDENTS

Especially since the Homework assignment focused on the daily Mood Monitor, which is likely to evoke Incidents, the therapist may simply integrate Homework Review with Issues and Incidents. If so, also allow the adolescent to add other agenda items.

Also review the Affective Disorders Screen, and integrate this with findings on the Mood Monitor.

1.a. Elicit Issues and Incidents: Therapist reminds teenager of routine session format and asks teenager what events or concerns they would like to work on in this session.

"What things would you like to talk about and work on in this session?"

"What things have come up since we last met that you would like to work on?"

"Are there any things you would like to work on that have to do with your friends, or your family"

1.b. Prioritize: When the teen appears to be finished listing any issues or incidents they want to discuss, spend some time with the teen putting them into an order for discussion.

"*Let's decide which of these Issues or Incidents are most important so we can be sure to get to them."*

- Put priority on suicidal thoughts or behaviors, on any crises that may have occurred, and on therapy-threatening behaviors (verbalized hopelessness, coming late to sessions, missing sessions, wanting to quit). Then rank other topics based on the teenager's priorities.

- Let teen know that you will work with her/him on (non-crisis) issues after reviewing the Homework. Emergency or crisis issues, however, take priority over other aspects of session routine.

2. HOMEWORK REVIEW

It is very important in this session to convey to the teen that you will review Homework with them each time they have an assignment. For this reason, Homework Review early in this session is critical.

2.a. Mood Monitor: Inquire about the teen's experience using the daily Mood Monitor and filling it out on a regular basis. Discuss with them the things that led to negative and to positive mood. It is likely that some of these would be on the list of the teenager's "Issues and Incidents" for more discussion.

2.a.1. Reinforcement and Attributions: If the adolescent was at least partially successful, inquire about what they did to make this positive outcome happen, as well as how they felt about it.

- Look for instances in which they problem-solved, showed flexibility, anticipated barriers and took necessary steps to overcome them, etc. Positively reinforce these efforts, and help the teen make appropriate internal positive attributions.

If the teen was less successful or not at all successful, assure them that one of the reasons for Homework is to help the two of you to understand what gets in the way of the teen being able to reach his/her goals. So we can learn from this as well.

- What were the barriers? Was there an emotion, a thought, a scheduling problem, or a situational problem that got in the way?
- Remind the teen that the two of you are like scientists trying to figure out what contributes to the teenager's depression, so it is important to try to understand any of these factors that are barriers.

Optional: **2.a.2. Identifying Associated "Automatic Thoughts":** Depending on adolescent's readiness, the therapist may decide to go forward and start to identify automatic thoughts. If the teen has been able to record their positive and negative emotions and the situations associated with them, begin to explore with them the associated thoughts.

3. NEW SKILL: SETTING AND BREAKING DOWN GOALS

- ❑ **Refer adolescent to the Workbook page g with the treatment goals set during the Rationale & Goal-Setting Interview.**

"Let's take some time to review what you did in the feedback session we had after your interviews and questionnaires. Look in your Workbook on the Goals pages."

3.a. Review Initial Goals: Ask the teen to review the goals included on the forms he/she completed in the Rationale and Goal-Setting interview. These may be related to family, social, academic, or other areas of their lives.

"You have already set some goals in your feedback interview. Take a few minutes now to review your goals."

- Let the teenager know that you and he/she will keep track of how progress is being made toward these goals during the treatment.

"I want to work with you to reach your goals during this treatment, and we will come back to them at times during sessions."

3.b. Recall Past Attempts: Inquire about the teenager's past experiences trying to reach goals.

"Have you ever worked toward a goal before? What was it?"

- If adolescent has difficulty recalling past goals, suggest possible examples.

"*Some kids try to meet new people, make new friends, get to know the other kids in a new neighborhood. Others try to do better in school or to do better in a sport. All of these things can be thought of as goals."*

- Ask about the way that the adolescent tried to reach the goal(s) recalled.

"How did you go about reaching that goal? What were the steps along the way? How long did it take?

3.c. Small Steps, Concrete Sub-Goals, New Skills: Therapist should point out any instances in which the adolescent has reached an earlier goal by breaking down the goal into smaller or more "concrete" parts and/or by learning new skills.

Examples:

Small steps: Beginning to develop a friendship by starting a conversation.

Concrete Sub-Goals: Getting better as a musician by learning a specific song.

New Skills: Becoming a better student by learning how to study effectively.

"In cognitive-behavior therapy we will be working toward the goals you set. We will do this in the same way you have done it before in your life: by breaking down the goals into parts, by working toward specific, concrete smaller goals, and by learning new skills to reach the goals."

3.c.1. Rationale: Give the rationale for breaking down and concretizing goals.

- Big goals take time to reach.
- It can be discouraging or overwhelming to try to get to them all at once.
- Smaller goals give us an opportunity to see progress along the way, and to stay hopeful as we make progress.
- Working on smaller goals helps us to recognize and work on possible barriers along the way to the big goal.

Give the rationale for making goals concrete.

- Big goals can seem vague and hard to define.
- "Concrete" goals are ones we can see, so we can know when we have reached them.
  "It is important to break big goals down into smaller parts that we can see. That way, we can see progress along the way. We don't get overwhelmed trying to do everything at once. So setting goals and breaking them down into smaller goals is an important life skill. It helps us to stay hopeful and not give up.
- Give the rationale for linking goals to new skills.
  "Sometimes we want to reach a goal but we do not know how to do it. At times like those we need to learn new skills. For example, we might want to meet

people, but we do not know how to get started on that. So we need to learn how to be friendly to others, or how to start a conversation."

3.d. Relate Goal-Setting and Other Skills ("Tools") to this Program. In this program, the teenager will learn several new skills that will help them to reach their goals. The first of these is "Mood Monitoring," which helps a person to know what situations are connected with feeling bad or feeling good. The next skill is how to set goals. Effective goal setting requires "breaking goals down into smaller, concrete parts." Other skills will be included in later sessions, and these will also help the teen to reach their goals.

- Individualize this discussion by relating specific skills in the program to concerns that the teenager has raised, or goals they have set.

3.e. Creating a Concrete Sub-Goal: Therapist then asks the teen to take one of their treatment goals and to identify a part of that goal that they could work on between this and the next session. For example, if the overall goal is to have a better relationship with mother, the teen could do one or two specific, concrete things for mother during the week.

❑ **Refer the adolescent to Workbook p. n, "Moving Toward Goals."**

- Use the Form in the Workbook, "Moving Toward Goals," to record the weekly sub-goal.

- Help the teenager to make the sub-goals small enough to be accomplished, and concrete enough that the teen can tell it has been reached.

4. WORKING ON ISSUES AND INCIDENTS

Following the order decided upon in the Issues and Incidents section of this session, discuss with the teen his or her main concerns at this time. In a collaborative fashion, work with him/her to identify thoughts, situations, or other people connected with their depressed mood or distress. Help them to apply the CBT model as they discuss these concerns, by looking for connections between emotions, thoughts, and behaviors.

- Remind them of the "scientist" analogy, i.e., that the two of you together can work to try to understand how these connections work.
- Use the "triangle" model of behavior, thoughts, and emotions to clarify linkages.
- If goal setting or using a mood monitor can be brought to bear on the issues discussed, show teen how they might be helpful tools to use.

However, the chief point early in treatment is to understand the teen and to maintain and build the working alliance.

Some teens may be ready to start questioning negative automatic thoughts. In this Section of the session or when reviewing the Daily Mood Monitor, they may identify such thoughts, and the therapist can try Socratic questioning to see if the teen is able to get some perspective on the thoughts.

"What do you think now about that negative thought?"

"Is there any other way you could have thought about that situation?"

"How might someone else have thought about that?"

The caution is not to get ahead of the adolescent. At this point in treatment they may still identify their thoughts with "the way things are."

Additional probes can be useful to help the teenager understand that there is a connection between the thought and the emotion, or that a change in the thought is connected with a change in the emotion.

"So when you have the thought: _____, is that when you feel the worst?"

"If you thought about it differently, do you think that would change the way you feel?"

5. HOMEWORK

The Homework this week has two parts.

5.a. Continue Mood Monitoring: First, the teen is asked to continue using the daily Mood Monitor. Mention to them that this Monitor or a different form to monitor mood will be used through much of the program, so that both of you can understand the teenager's depression and look for progress. If the adolescent seems ready, ask them to write down thoughts associated with emotions on the Mood Monitor.

- ***Provide a new daily Mood Monitor for the week. Copies are included in the back of the Workbook. Make additional copies as needed.***

5.b. Working Toward Goals: Second, ask the teenager to work on the Sub-Goal listed on the **Working Toward Goals** form.

- Prepare the teen for these assignments as you did in previous sessions, building upon information that came out in this session about barriers to completion.

6. SUMMARIES AND CHECK-IN

Check to see if the teen feels understood. At points during session and at end of session, help them to summarize the main points.

AT THE END OF THIS AND ALL SUBSEQUENT SESSIONS, COMPLETE THE FORM INDICATING WHETHER THE TEEN COMPLETED NONE, SOME, OR ALL OF THE HOMEWORK SINCE THE PRECEDING SESSION

General Guidelines for Phase 2 of TADS Acute (Stage I) CBT:

The second phase of Stage I CBT involves helping the adolescent to learn basic cognitive behavioral skills, and helping the parents to understand the treatment and to prepare for conjoint adolescent-parent sessions. Generally, this phase occurs during weeks 3, 4, 5, and 6 of Acute (Stage I) CBT.

Scheduling:

Two parent psychoeducational sessions are included, and are typically scheduled in weeks 3 and 5. These are back-to-back with the adolescent's individual session. Total time for both the adolescent and the parent sessions is 90 minutes.

Therefore, the adolescent's individual session on these two weeks is only 45-50 minutes in duration, instead of 60. Parents should not be invited to the first 10 minutes of these sessions for a "check-in" because of these time constraints, and because they will have time to meet with the therapist after the teenager's session. If the parents indicate an urgent need to meet with the therapist at the outset of the 90 minute period, the parent session can be held first.

Session Format and Integration:

Therapists continue to use the routine session format to help structure the treatment. When the adolescent has had Homework that includes use of the Daily Mood Monitor, review of the Mood Monitor should be integrated with the Issues and Incidents part of the session. It is likely that events or situations included on the Mood Monitor will be good topics for discussion in the session. Integration of these two items, along with review of the ADS, also simplifies the session, leaving, at most, only one other Homework practice to be reviewed.

As the therapist elicits the agenda in the Issues and Incidents section of the session, he or she should be alert to possible linkages of this material with skills training. For example, when the adolescent brings up an incident that reflects difficulties with hopelessness or discouragement, the therapist, after appropriately empathizing, can point out that some of the skills in the program, or even in the present session, such as goal-setting and problem-solving, may help with such situations. Optimally, the therapist will find a link between the material the teenager brings to the session and the skills training for that particular session.

Skills training is designed to be included in roughly the middle third of sessions. Time should be allowed for discussion of ("Working on…") Issues and Incidents after skill training. The Homework can be constructed either at the end of "Skills"

or after “Working on Issues and Incidents.” If the former option is chosen, the therapist needs to review the Homework assignment with the adolescent very briefly before ending the session.

Behavioral Work:

In Phase 2 of Stage I Acute CBT, the behavioral focus is first on activation and enjoyment of pleasant activities and then on social problem-solving. Sessions include specific skills training in these areas.

Cognitive Work:

There are some sessions in Phase 2 that focus on cognitive skill training, including recognizing cognitive distortions, and formulating realistic responses or counterthoughts. **However, much of the cognitive work in Phase 2 should be accomplished in the Homework Review and in the discussion, or “Working on Issues and Incidents.”** The therapist can reflect or point out **automatic thoughts** that the adolescent may verbalize during these parts of the sessions (or at any point). The therapist can question the teenager about associated thoughts or images when the teen is talking about a difficult incident or situation. The therapist can look for “here-and-now” events in sessions when the adolescent shows a change in mood or affect. By inquiring about what the teenager may be thinking about at those moments, automatic thoughts can be elicited.

By integrating cognitive work into these sessions, a significant amount of progress can be made in identifying and understanding automatic thoughts before formal monitoring of automatic thoughts is introduced. If the teenager needs specific targeted help in understanding and identifying automatic thoughts, however, an optional section of one session is provided for that purpose.

As the therapist sees patterns or clusters of typical automatic negative thoughts for this particular teenager, underlying **beliefs** may become clear. These may become more evident in Phase 3. Examples of common beliefs are: 1) “To be worthwhile, I must be perfect”; or 2) “I need every person I know to accept and like me.” During the latter phases of Stage I Acute CBT, such underlying beliefs may be identified and labeled for the teenager. Typically in short-term treatment it is difficult for adolescents to modify such beliefs, but identification is a valuable step in that direction (Brent & Poling, 1997).

The therapist also needs to be alert to **attributions** that the teenager makes for success or failure experiences, or for other positive or negative events (Incidents). Homework review may reveal that the teenager does not take credit for positive accomplishments, or blames himself/herself unrealistically when failures occur. The therapist can use Socratic questioning or in other ways point

this out to the teenager and help the teen to develop more realistic attributions. There is no structured skill exercise focused on attributions in TADS Stage I CBT. Instead, the therapist is asked to work with the teenager on attributional style in the context of sessions. A brief description of attributions and some common examples are given below.

Attributions are judgments that individuals make about the causes of events. Attributions vary according to the location of the cause (internal-external), the temporal stability of the cause (stable-unstable), and the breadth of the cause (global-specific). In the reformulated learned helplessness model of depression proposed by Abramson, Seligman, and Teasdale (1978), depressed individuals tend to make internal, stable, global attributions for negative events. There is evidence as well, among teenagers, that depressed adolescents make external, unstable, specific attributions for positive events (Curry & Craighead, 1990b).

Examples of attributions:

Internal: The cause is within me.
External: The cause is outside me. Cause could be fate, powerful others, events.

Stable: The cause is consistent, unchanging, or trait-like.
Unstable: The cause is inconsistent, changing, or state-like.

Global: The cause is broad and widespread.
Specific: The cause is narrow and focused.

Examples:

"I failed that test because I am stupid/a poor student/dumb." (I,S,G)

"My boyfriend broke up with me because I always mess up relationships (I,S,G)

"I got an A on the exam because it was easy." (E,U,S)

"My boyfriend just likes me because he's a really warm and friendly guy." (E,S,S).

Possible Counter-attributions:

"I failed that test because the material was hard." (E,U,S)
"I failed that test because I didn't study very much." (I,U,S)

"My boyfriend broke up with me because he can't handle a relationship right now." (E,U,S).

“My boyfriend broke up with me because I can’t handle a relationship right now.” (I,U,S).

“I got an A on the exam because I am a good student.” (I,S,G)
“I got an A on the exam because I studied hard for it.” (I,U,S)

“My boyfriend like me because I am fun to be around.” (I,S,S)
“My boyfriend likes me because he appreciates my good qualities.” (E/I,S,G)

Family Work:

Parent sessions are held twice during Phase 2. These are intended to permit the parents to express their particular concerns about their child, to identify family factors that may be contributing to the adolescent’s depression, and to socialize the parents to the cognitive behavioral model. Parents are given an explanation of the main skills that their adolescent is learning in the program.

A summary of the goals and strategies for Phase 2 is repeated on the following page.

Therapeutic Relationship:

The therapist must maintain a focus on the relationship with the teen and with the parents. Skills training may have to proceed more slowly than scripted so that the relationship can be maintained and enhanced. Sessions during the second six weeks may be devoted to the basic skills in Phase 2 if necessary.

Goals in Phase 2:

- ✓ Increase behavioral activation
- ✓ Increase positively reinforcing activities
- ✓ Enhance interpersonal problem-solving
- ✓ Continue to identify and begin to challenge maladaptive thoughts, beliefs, attributions
- ✓ Continue to monitor motivation, hopelessness, suicidal ideation
- ✓ Assess possible family factors contributing to adolescent's depression
- ✓ Continue to socialize parents to treatment model by explaining skill training

General Strategies in Phase 2:

- ✓ Increasing Pleasant Activities
- ✓ Mastery & Pleasure Ratings with Activity Calendar
- ✓ Problem-solving
- ✓ Identifying cognitive distortions
- ✓ Formulating positive, realistic counter-thoughts
- ✓ Parent psychoeducational sessions

INDIVIDUAL SESSION TOPIC III: INCREASING PLEASANT ACTIVITIES or ACTIVITY SCHEDULING

TOPIC CODE: ***PA or AC***

GOALS OF THE SESSION:

1. To continue routine session format
2. To review Mood Monitoring in context of Issues and Incidents
3. To review progress in Goal-Setting
4. To teach either Increasing Pleasant Activities or Activity Scheduling

Materials Needed:

Adolescent Workbook with forms for: Mood Monitor; Things I Like to Do; Help with Pleasant Activities; Increasing Pleasant Activities; Activity Schedule

Therapist's writing material

Therapist's case chart

At start of session, remind teenager that you will be meeting with her or his parents after this session. Therefore, this session will be only 45-50 minutes in length. Inquire whether the teenager has any questions about the parent session, and respond to these.

1. ISSUES AND INCIDENTS

1.a. Elicit Issues and Incidents: In this part of the session, therapist continues routine format, starting with Issues and Incidents or Homework Review. Elicit agenda here, with the understanding that topics will be talked about later in this session, after new skill has been practiced.

- Include review of **Mood Monitor and the Affective Disorders Screen (ADS)**, since these are likely to elicit Incidents for discussion.

- In general, the therapist should be thinking of how to relate agenda items to skills already introduced or to be introduced later in this session.

  "We will continue using the outline for sessions that we used last week.
  As you may remember the first part of the session involves setting an agenda of things you want to talk about, and reviewing the Homework"

"What things would you like to talk about and work on today?"

"Have some things come up this week which you would like to discuss and work on today?"

"What problems do you want to work on today?"

"How have you been feeling this week? What kinds of things have gotten you down? Has anything happened to make you feel better?"

1.b. Prioritize Issues and Incidents: Spend enough time on agenda to set priorities collaboratively. Some items, such as suicidal ideation or urges or catastrophic events need to be addressed urgently. Some items may need to be deferred until later sessions, for example, any which fit very well with skills to be covered soon in sequence of sessions.

"Let's decide which of these Issues and Incidents are most important to work on today, so we can be sure to get to them."

2. HOMEWORK REVIEW

2.a. Review Goal-Setting: Therapist inquires about how the teenager fared in his/her effort to attain their weekly goal in the days since the last session.

2.a.1. Reinforcement and Attributions: If the teen was at least partially successful, focus on how they did it, what feelings they had when trying to do it, and how they were able to succeed.

If the teen did not complete the practice, or tried and did not succeed, try to identify what got in the way. Was it a feeling, a thought, a scheduling problem, a situational problem? Work with the teen on how to resolve this problem. Let adolescent know that if the goal proved to be too big to solve, you will work with them to break it down into a smaller goal that can be reached. Continue to work with teen on choosing goals that are **realistic and concrete**.

BE ON THE LOOKOUT FOR A DEPRESSIVE ATTRIBUTIONAL STYLE. IF THE SUCCESSFUL TEEN ATTRIBUTES THE SUCCESS TO EXTERNAL, SPECIFIC, OR UNSTABLE FACTORS, POINT THIS OUT AND QUESTION IT WITH THEM. DO THE SAME IF THE UNSUCCESSFUL TEEN ATTRIBUTES FAILURE TO INTERNAL, STABLE, GLOBAL CAUSES.

3. NEW SKILL: INCREASING PLEASANT ACTIVITIES or ACTIVITY SCHEDULING

- **Provide a transition statement to the Skills Training part of session.**

  "At this point we are going to practice another New Skill. You already are working on two important skills: Goal-Setting and Mood Monitoring using the Emotions Thermometer. The new skill involves becoming more active, especially by doing things that you find enjoyable.

  "The skills you learn in this program will help you to cope with problems and deal with the kinds of Issues and Incidents you just brought up. It will take us some time to learn the skills, but after you have learned them, you will have a "back pack" with the tools you need to cope with problems that come up and to overcome depression. So after we practice the new Skill we will get back to the list of Issues and Incidents we just made up together, and discuss them in the order we agreed on."

Option Point: Therapist needs to decide whether to work on Pleasant Activities or to work on Mastery & Pleasure ratings using an Activity Schedule.

The adolescent's degree of inactivity or anhedonia may be used as a guideline in making this choice. Adolescents with more psychomotor retardation, passive lethargic inactivity, or inability to identify pleasant activities may require use of an Activity Schedule with Mastery and Pleasure ratings. Adolescents who are reasonably active, i.e., attending school, going out of the house on weekends, etc. and able to identify activities they enjoy, may not need that strategy, and may benefit directly from Increasing Pleasant Activities.

In this manual, the session is described first for Increasing Pleasant Activities, with an addendum for Activity Scheduling.

*"So far we have worked on two skills to change behavior that can help us to avoid or overcome depression. These two skills are **Goal-Setting** and **Mood Monitoring** using the Emotional Thermometer. In this session, we are going to work on a third skill, **Increasing Pleasant Activities."***

Increasing Pleasant Activities. This section is adapted from the manual of Clarke, Lewinsohn, and Hops (1990)

3.1. Rationale for Increasing Pleasant Activities: Referring again to the "triangle" of behavior, thoughts, and emotions, explain to the teenager that depression is associated with lack of active, enjoyable behavior. One powerful way to combat

depression is to engage in pleasant activities. Even if we do not feel like doing anything when depressed, by doing things we enjoy, or used to enjoy, we can change our emotions in a positive direction.

- Refer again to the **"downward spiral"** of negative emotions, thoughts, and behavior. Explain how doing Pleasant Activities can turn this into an **"upward spiral."**

  "When we are depressed, not only do we feel bad and think negative thoughts. We also stop doing pleasant activities. Often, we withdraw, lie around, avoid people, stay in our room. If we listen to music, it may be depressing music that just makes us feel even more down."

  "Increasing pleasant activities is a simple but powerful way to change our behavior, which will then have a powerful positive effect on our thoughts and emotions. It is a way to become more active, feel better, and think more positive thoughts, all at once."

  "Even if we try to increase pleasant activities and find we are unable to enjoy them, we may discover that negative, depressing thoughts are getting in the way. Then we can work on identifying and questioning those thoughts."

3.2. Generating Pleasant Activities: Generate a list of Pleasant Activities with the adolescent.

- ❑ **Refer the adolescent to Workbook page o, "Things I Like to Do."**

Using the form in Workbook, therapist and teen together generate a list of potential pleasant activities. To make the task move more quickly, and to be more enjoyable, itself, it often helps for the therapist to write down the activities as the teen "dictates" them.

"Now I want to ask you simply to think of as many things as you can which you like to do. These can include small activities such as making a phone call to a friend; hobbies you enjoy; things you do to stay active or keep from being bored; things you do with your friends; things to do "on a rainy day" or little things you do to make yourself feel better."

- To help the teen generate activities, therapist can inquire using the stems or probes below:

Inquire about: hobbies sports going places with friends
outdoor activities phone calls/conversations
music-related activities writing (poetry/stories)
cooking crafts parties
driving seasonal activities (beach/swim/ski/skate)
mechanical activities games
religious activities shopping
making things art/photography
entertainment/movies/concerts
everyday activities (bath/shower/dressing/shaving)
"stopping to smell the flowers"

- If the teenager has difficulty generating a list because of current depression, ask them to list things that **used to be enjoyable.**

- Continue until **8 or 10** activities have been listed

3.3. Selecting Pleasant Activities to Increase: Work with teen to choose specific activities to try to increase.

3.3.1. Social and Success Activities: Explain that social and success activities are especially helpful in combating depression.

> *"If we look at this list, we may see different kinds of pleasant activities that can help us to feel better. Two kinds are especially important in overcoming depression:*
>
> *"Social activities, enjoyable, fun things we do with other people, such as family members or friends."*
>
> *"Success activities, or things that give us a sense of pride, competence, or accomplishment."*

Therapist should then discuss with teen the importance of increasing social activities and success activities to combat depression. For example, social activities may help to overcome feelings of loneliness or feelings that people do not like us. Success activities help to overcome feeling down on ourselves or self-critical.

> *"What have you noticed, yourself, about the activities that seem to be the most powerful in helping you to feel better?"*

- Ask the teenager to work with you to choose the activities on their list that they would most like to increase, working to assure that they pick at least some social activities.

  - **Refer the adolescent to Workbook page p, "Help with Pleasant Activities."**

- Use the guidelines listed on the handout in the Teen Workbook, **"Help with Pleasant Activities."** Ask the teen to look over these guidelines.

  "To increase pleasant activities we need to be sure to pick some that we can really increase without too much difficulty. It would be hard to increase "playing a complete game of baseball" because that would take 18 people. It would be hard to increase "buying a new car" because that is so expensive. It would be hard to increase "watching a comet go by in the sky" because that happens only rarely."

  "So we need to focus on things that are inexpensive, can be done frequently, do not require a whole lot of other people's cooperation. And we need to pick things that are not harmful to us or to others. We also need to pick things that are truly "activities" so they must be active and not passive (like sleeping)."

3.4. List Target Activities: Demonstrate for the adolescent how to use the form to record and track Pleasant Activities.

- **Refer the teen to page q in Workbook, "Increasing Pleasant Activities."**

- Therapist explains that the activities the teen would like to increase go in the left column, and the dates go along the top row. Ask teen to fill out the left column first.

"Now using the guidelines from 'Help with Pleasant Activities' which we just discussed, please pick some activities you would like to <u>increase</u>, or do more often. Write down the activities on these lines. Remember that they should be active, inexpensive, harmless, and possible to do. "

- Next, explain to the teen how to fill out the top row. The first three dates should be for the previous three days, before the day of this appointment. (The box above the third date is labeled "Yesterday.") Then put in the dates for the next two weeks, beginning with the date for "Today". For example, if today is Tuesday, April 8, put 4/8 in the box under "Today" and the number "1." Day 2 would be 4/9, day 3 would be 4/10, etc.

3.5. Baseline: Then ask the teen to recall about how many of these activities she/he did in the preceding three days, including yesterday.

"Now think back over the past 3 days, and count how many times you did each of these activities on each day. Put this number in the proper box on your paper, even if it is zero. This will be your baseline, or the number you can try to increase."

3.6. Improving on Baseline: Work with the teen to determine what is a realistic number of pleasant activities to set as a goal in the week ahead. This can be related to the goal-setting work done earlier in treatment: pick a target goal that is **realistic and concrete.**

"How many of these activities on the list would you like to try to increase in the next week? Let's try for a number that you think you can probably reach."

3.7. Assigning the Homework: At this point, discuss with the teenager that the homework this week, which will continue for several more weeks, is to use the "Increasing Pleasant Activities" form to record the number of these target activities done each day. The teenager's main homework is to do pleasant activities. Encourage the teenager to pay attention to the way they feel when they are doing the activities.

Additional Points for the Therapist:

These are "trouble-shooting" ideas based on experiences in the Oregon studies (Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999; Lewinsohn, Clarke, Hops, & Andrews, 1990) and experiences during the TADS Feasibility trial.

1. **"Shoulds" getting in the way:** It is important to prepare the adolescent for the possibility that they will not feel as good as they "should" when doing pleasant activities. Some teens are inclined to pick activities that they think they should enjoy, even if they really do not. When this becomes clear here or in reviewing the Homework next time, the thoughts associated with anhedonia or with social desirability can be elicited.

2. **Can't get started:** Some teens will need a reinforcer to motivate them to try increasing pleasant activities. In this case, spend time with the teen to identify the one or two most powerful pleasant activities, and work with the teen to start with these, and later to reward themselves with these contingent upon doing one or two additional activities.

3. Impractical: Some teens will choose activities that are too expensive, contingent on the weather, or contingent on the cooperation of others (being home when the teen makes a phone call). If so, try to identify these categories and their opposites (inexpensive, non-contingent on weather or other people) and to have most of the target activities of the latter type.

4. **Past but not present:** If teens indicate that these activities were pleasant in the past but are not currently enjoyable, work with the teen to take a scientist's approach to this task. Try out the activities and see what thoughts may be associated with trying them, or what seems to get in the way of enjoyment. Encourage the teenager to try them even if they do not feel like doing so at this time. There are two reasons for this: positive behavior leads to positive emotions; and, the thoughts that are getting in the way of enjoyment may become clear when the activities are tried.

5. **Social isolation:** Some teens will need a more general strategy before they can increase social activities. For example, they may need to get themselves in a social situation to have the opportunities for social interaction. Others may try social interaction and not enjoy it, perhaps due to lack of social engagement or interaction skills. For both of these types of teens, the optional session on engagement skills is recommended. Problem-solving can also be brought to bear later in treatment, as the teen is encouraged to explore different clubs, groups, or social settings she or he could join.

4. WORKING ON ISSUES AND INCIDENTS

Continue to implement the CBT model in discussion of agenda items. Use Socratic questioning to help the teen see the **thoughts** they are having that are connected with upsetting emotions in the problem they bring up, and the **behaviors** they are doing or not doing that may be contributing to the problem. Help them to apply the cognitive behavioral model to the problem they raise, by seeing if there are any other ways they could think about the problem or other ways they could behave in the situation.

The therapist may want to use the various methods for eliciting Automatic Thoughts that are reviewed by Brent and Poling (1997, pp. 15-16). These include questioning the adolescent about the images or thoughts that go through their mind when a particular situation occurs or a bad feeling arises. More active methods include role-playing the situation in session, and picking up on mood shifts as they occur spontaneously in the session.

It is important to assess whether the adolescent is ready to challenge any of their Automatic Thoughts, since these are rapid, automatic and perceived as veridical by people when depressed. The therapist will need to determine within the next two weeks whether the adolescent could benefit from a session focused just on identification of automatic thoughts and gaining perspective on them, or whether the teen can move more quickly into challenging such thoughts.

5. HOMEWORK

- Continue to use the Daily Mood Monitor.
- Work to Increase Pleasant Activities
- Anticipate with the teen any potential barriers to completing the Pleasant Activities homework or the Daily Mood Monitor.
- Work to set a time each day to complete the two forms.

6. SUMMARIES AND CHECK-IN

Include as in previous sessions.

Reminder: Complete the form indicating whether the teen completed none, some of all of this week's Homework.

****Alternative Strategy: Activity Scheduling/Mastery & Pleasure Ratings.** This section is based on the manual of Brent and Poling (1997).

This strategy can be used instead of Increasing Pleasant Activities for the teen who is experiencing significant psychomotor retardation or who is unable to identify pleasant activities.

- ❑ **Refer the adolescent to Workbook page r, "Activity Schedule."**

1. Use a weekly schedule form with each hour of the day indicated for the upcoming week. Help the teenager to identify activities they can do <u>at specific times</u> during the week. Include simple and routine activities such as eating breakfast, taking a shower, picking up the mail from the mailbox, as well as potentially pleasant activities similar to those discussed under "Increasing Pleasant Activities."

It is possible to include any activities that the teenager has already indicated would be of some importance, such as talking to a teacher, studying for a test, but be sure to break these down into component parts that can be mastered.

2. Once the schedule is set with a reasonable, but not excessive number of activities, indicate to the teenager that you are asking them to do the activities and to rate each activity on two dimensions: **mastery** and **pleasure**. Using the same 0-10 type of rating scale that is used for the Emotions Thermometer, ask the teen to rate each activity for:

a) the teenager's sense of accomplishment ("I did it!")
b) how much he or she enjoyed it

- Mastery and Pleasure ratings can be used to help the teen to identify activities as pleasurable
- The paired ratings also help the perfectionistic teen to distinguish between mastery and pleasure. In other words they may discover that they can enjoy an activity at which they do not excel.

3. Once pleasurable activities have been identified, they can then be used, along with activities the therapist may suggest, as the basis for "Increasing Pleasant Activities," as discussed above.

4. Dealing with potential barriers to behavioral activation:

Brent and Poling (1997) recommend using Graded Task Assignment and/or Cognitive Rehearsal to deal with potential barriers to enhanced activity. In Graded Task Assignment, the therapist works with the teenager to break down activities into component parts that can serve as intermediate tasks to be accomplished. In Cognitive Rehearsal, the therapist works with the teen to anticipate challenges to completing the activity schedule, and to problem-solve around how to overcome those challenges.

INDIVIDUAL SESSION TOPIC IV: PROBLEM SOLVING

TOPIC CODE: ***PS***

GOALS OF THE SESSION:

1. To review Mood Monitoring in context of Issues and Incidents.
2. To introduce new Mood Monitor form (Three-Column Mood Monitor), if appropriate.
3. To review progress in Increasing Pleasant Activities or Activity Scheduling.
4. To teach Problem-Solving.
5. To decide whether the adolescent requires the optional session on identifying Automatic Thoughts.

Materials Needed:

Adolescent Workbook with forms for: Three-Column Mood Monitor; Increasing Pleasant Activities; 3 letters; Possible Solutions; Ribeye Method; Ribeye Worksheet; What Helps Me to Relax?

Therapist's writing materials

Therapist's case chart

This is probably the session with the most scripted material with the exception of the initial Rationale and Goal-Setting session. It is placed in this week because there is no parent psychoeducation session this week. This session will require a full 60 minutes.

1. ISSUES AND INCIDENTS

1.a. Elicit Issues and Incidents: In this part of the session, therapist continues routine format, starting with Issues and Incidents or Homework Review. Elicit agenda here, with the understanding that topics will be talked about later in this session, after new skill has been practiced.

- Include review of **Mood Monitor** and **ADS**, since these are likely to elicit Incidents for discussion.

- In general, the therapist should be thinking of how to relate agenda items to skills already introduced or to be introduced later in this session.

- Some items may need to be deferred until later sessions, for example, any which fit very well with skills to be covered soon in sequence of sessions.

- Some may need to be "broken down" into smaller parts, which can then be handled through problem-solving

  "What things would you like to talk about and work on today?"

  "Have some things come up this week which you would like to discuss and work on today?"

  "What problems do you want to work on today?"

  "How have you been feeling this week? What kinds of things have gotten you down? Has anything happened to make you feel better?"

1.b. Prioritize Issues and Incidents: Spend enough time on agenda to set priorities collaboratively. Some items, such as suicidal ideation or urges or catastrophic events need to be addressed urgently. Some items may need to be deferred until later sessions, for example, any which fit very well with skills to be covered soon in sequence of sessions.

"Let's decide which of these Issues and Incidents are most important to work on today, so we can be sure to get to them."

2. NEW MOOD MONITOR FORM: THREE-COLUMN MOOD MONITOR

2.a. Introduce New Form: If the adolescent seems ready, introduce a new form for monitoring mood for the coming week and beyond. This form focuses less on day-to-day fluctuations in mood, and more explicitly on the association between thoughts and emotions. If the work done in previous sessions has helped the adolescent to understand that her or his mood varies, and is associated with situations or events, and if the adolescent has some understanding of automatic thoughts, the form can probably be introduced. If not, it will probably be necessary to include the optional material in the next session on Automatic Thoughts.

- **Refer the adolescent to p. s in the Workbook, "Three-Column Mood Monitor."**

"This week I am going to ask you to try out a different form for Mood Monitoring. This one has three columns. When you notice that your mood is "down" write on here what the Situation is, and what your Emotion is. Give your Emotion a rating from the Emotions Thermometer, as you have been doing on the earlier form. Then write in the middle column

what Thought you are having when you feel that Emotion in that Situation."

2.b. Demonstrate Use of Form: Demonstrate how to complete the Three-Column Mood Monitor, using examples as necessary.

3. HOMEWORK REVIEW

3.a. Review Pleasant Activities: Discuss the teen's experience with attempts to Increase Pleasant Activities.

3.b. Reinforcement and Attributions: If the teen was at least partially successful in Increasing Pleasant Activities, focus on how they did it, what feelings they had when trying to do it (Pleasure/Enjoyment ratings), and what they learned about the connection between activities and mood.

3.c. Pleasant Activities and Emotions: Be particularly cognizant of any improvements in mood due to increased activity or social interaction, since this will tie together the impact of pleasant activities on improved mood.

3.d. Trouble Shooting: Refer back to "Additional Points for Therapist" in the preceding session for guidelines in dealing with problems they might have had in increasing pleasant activities. For example, if they completed some of the activities, but did not feel better when doing so, try to help them understand what were the associated thoughts that might have contributed to the lack of enjoyment. If the difficulty is that they tried activities that "should" be fun but actually are not, work with them on the "should" cognition and help them to pick other activities for the coming week.

4. NEW SKILL: PROBLEM-SOLVING

4.a. Rationale for Problem-Solving: Explain how Problem-Solving can be used to deal with Issues or Incidents the teenager has brought up.

By this point in treatment, the teenager will almost invariably have identified some social, interpersonal, familial or academic problem contributing to depression, or some problem getting in the way of completing the treatment homework assignments. The therapist can refer to these as examples of common problems that teenagers face.

"So far in the program, you have been learning new skills, including Mood Monitoring, Goal-Setting, Increasing Pleasant Activities, and identifying thoughts that are connected with depression and thoughts connected with feeling good. As you continue to practice those skills, I will now work with

you on the next skill. This is one you can use whenever you face a problem."

"Since everyone faces problems in their lives, and since problems can lead people to feel discouraged or even depressed, I want to help you to learn a general way of solving problems."

"Since everyone faces problems at times in life, it is very important to have a way of solving them, so that they do not lead to (depression/hopelessness/getting into trouble)."

"The new skill for this session is called 'Problem-Solving'."

- Demonstrate the relevance of Problem-Solving to one or more issues or incidents that the teenager has brought up so far.

- If the adolescent is sometimes impulsive, explain how this method can help them to slow down and think through how to handle problems without getting into difficulties later.

- If they have been suicidal, explain how this method can help them to think through various solutions to problems without getting so discouraged or hopeless.

4.b. Introduction to Problem-Solving: In this part of session, therapist's task is to teach a general method for problem-solving. Teaching should include didactic instruction, modeling, and role-playing.

- In general, the skill should first be presented and discussed with regard to other real or hypothetical people, then applied to one of the teenager's less challenging situations or concerns.

  "One good way to start to learn a new skill is by looking at how it might work for other people. Often this is easier than trying right away to apply it to our own situation. So let's try to learn about problem-solving by beginning with (this letter/these letters) from other teens."

  - *Refer the adolescent to the "Dear Problem-Solver" letter(s), pp. u, v, & w in the Workbook.*

4.b.1. Practice Steps in Problem-Solving: For teens with no major reading problem, one "letter" can be given to them to read. Alternatively, the therapist can read the letter to those with reading difficulties. Therapists can also generate other scenarios to present, or change the names, settings, etc.

"For this part of the session, I will hand out (or read) a letter from a teenager that describes a problem, and asking for help in solving it. For each problem, I want you to ***say what the problem is*** *and to* ***think of as many possible solutions*** *to their problem as you can. Remember to think of as many as possible, and don't worry about whether the solutions are good ones or bad ones. Then we will talk about the possible solutions."*

- Brainstorming

Although it is not the first step in Problem-Solving, Brainstorming is the step to emphasize at this point. The purpose of Brainstorming is to increase mental flexibility. In this sense it is analogous to questioning Automatic Thoughts by asking if there are other ways to think about a situation.

- ❑ Use Workbook page x, "Possible Solutions" to list solutions.

- Not Evaluating

Therapist can either continue to encourage the teenager to generate more possible solutions, or add some himself/herself. Be sure to include some that are outlandish, and to make explicit that it is not yet time to evaluate them.

- Evaluating

After a list of possible solutions has been generated, work with the teenager to look at the positive and negative consequences of each option.

- Choosing

Help the teen to decide which would be the best option, given the pros and cons. Point out that it is probably not a "perfect" solution, but that a good ("good enough") solution is better than being stuck, hopeless, or depressed.

- Encouraging

Reinforce the teenager for having worked through the problem and decided on a solution. Encourage her or him to take credit for this.

4.b.2. Didactic Instruction on Problem-Solving: After completing the exercise with one or two examples, use didactic methods to outline the general problem-solving method. Review with the adolescent the steps listed on the **Ribeye Method** page.

- **Refer adolescent to Workbook page y, "The Ribeye Method."**

"In your treatment program, we will spend a lot of time learning how to solve problems. This exercise we have done shows most of the steps involved in problem-solving. The steps are listed on this page."

"The way to solve problems is easier to remember if we give it a name. In fact, sometimes things can be easier to remember if we give them a silly or ridiculous name. So we call this method the `Ribeye' method. Even though it has nothing to do with ribeye steak, it might be easier to remember this method by using the ribeye name, because the spelling of 'ribeye' contains the first letters of the words that make up the method. Here are the parts of the method:

Additional Points for Therapist:

1. Relax: Almost universally, problem-solving in family conflict situations is blocked because of strong emotional arousal. When working on the "letters," ask the teenager what might be getting in the way of the character's ability to solve their problem. Often it is an anxious or discouraged emotion. Often it is easier for us to suggest solutions to other people's problems than to figure out solutions for our own, and one reason for this is worry or anxiety. Ask the teen what emotions get in the way of problem-solving for them, either at home or with friends. Explore with them any ways they typically can use to help them relax. Material from the optional Relaxation module in this manual may be helpful in this regard.

Refer the adolescent to Workbook p. z, What Helps me to Relax?"

2. Identify the Problem: Some teenagers tend to take excessive personal responsibility for problems, or tend to attribute more control to themselves than is realistic. Help them to see this pattern. One method used to combat this is the pie chart (March, Foa, Franklin, & Kozak, 1998). Using a pie chart, the adolescent is asked to list all the factors that may have contributed to the problem. Proportions of the pie are then assigned to each factor, based on the proportions to which each cause may have contributed. The teen then is asked to realistically assign a proportion of responsibility to herself/himself.

Other teenagers tend too readily to blame others (e.g., parents) for problems. This can lead to hostile, blaming interactions. The pie chart method can be used with this problem also. In general, help such teens to identify a problem without criticizing others.

3. **Brainstorm:** As noted earlier, the key skill here is the ability to generate without evaluating. Many teenagers will need assistance in separating these two actions.

4. The same caution that applies to challenging Automatic Thoughts applies to Problem-Solving. It takes some time for adolescents to gain perspective on central or major problems, so the method has to be applied to such problems at a time when the teen is ready to try it.

5. Often, the therapist must make a clinical judgment whether the teen is ready to "problem-solve" on the issues elicited, or whether he or she first needs an opportunity to express strong emotions or frustrations without moving toward a particular proposed solution.

6. Some adolescents will demonstrate an avoidant coping style, with an apparent lack of motivation to solve problems. The therapist will need to address this motivational problem before training in the steps of problem-solving will be of much benefit. The issue may be hopeless thinking, lack of consequential thinking, anxiety that leads to distraction, or perceived lack of competence.

5. WORKING ON ISSUES AND INCIDENTS

5.a. Consider Applying Ribeye: In this portion of the session, discuss the Issues and Incidents listed on the agenda. Consider applying the RIBEYE method to one item, if possible. **It is important at this point to pick an item that is not highly anxiety provoking, or too difficult, so that the teen is likely to have some success with the method.** It may be helpful to apply the method to problems encountered in the previous week's Homework, Increasing Pleasant Activities**.**

- **The Workbook page aa, "Ribeye Work Sheet," can be used for this.**

5.b. Evaluate Readiness for Further Cognitive Work: In discussing negative thoughts associated with Issues and Incidents items or items from the Mood Monitor, the therapist needs to make a judgment in this session whether the teen needs additional help in identifying Automatic Thoughts and getting some perspective on them. If the teen seems to be moving along well in this area, they are more likely ready to focus their next session on recognizing Cognitive Distortions. If not, the optional section on Automatic Thoughts can be included next week.

6. HOMEWORK

- Continue with Increasing Pleasant Activities, and use the new Three-Column Mood Monitor.
- If the teen had difficulty increasing Pleasant Activities last week, one possible option is to integrate Problem-Solving with Increasing Pleasant Activities, by applying the Problem-Solving steps to solve barriers to Pleasant Activities.

7. SUMMARIES AND CHECK-IN (as in previous sessions)

Complete the form indicating whether the teen completed none, some of all of this week's Homework.

INDIVIDUAL SESSION TOPIC V: AUTOMATIC THOUGHTS & COGNITIVE DISTORTIONS

TOPIC CODE: ***CD***

GOALS OF THE SESSION:

1. To review Mood Monitor, and Increasing Pleasant Activities Homework
2. If adolescent has been having difficulty identifying and getting perspective on Automatic Thoughts, complete optional portion of session on those skills. If necessary move Goal #3 to next session
3. To teach adolescent to recognize and label Cognitive Distortions

Materials needed:

Workbook with forms for: Triple Column (preprinted events); Three-Column Mood Monitor; Letters with cognitive distortions; Cognitive Distortions; Three-Column Mood Monitor with Cognitive Distortions

At start of session, remind teenager that you will be meeting with her or his parents after this session. Therefore, this session will be only 45-50 minutes in length. Inquire whether the teenager has any questions about the parent session, and respond to these.

If the teenager has been able to identify negative Automatic Thoughts using the Daily Mood Monitor, and Three-Column Mood Monitor, and to understand that those thoughts are not the only possible ones a person might have in similar situations, this session can be focused on Cognitive Distortions. If not, i.e., if the teenager has had difficulty identifying Automatic Thoughts, or continues to view them as obviously "the truth," the optional new skill within this session should be covered: Identifying, Defining, and Recording Automatic Thoughts.

1. ISSUES AND INCIDENTS

Proceed as in previous sessions. Both the **Three-Column Mood Monitor** and the **ADS (Affective Disorders Screen)** should be reviewed during this portion of the session, since they will indicate potential Incidents for discussion.

2. HOMEWORK REVIEW

2.a. Review the Homework Assignment: Continue to work with the adolescent on learning to increase Pleasant Activities, and on understanding behaviors and thoughts associated with their mood.

- When reviewing Increasing Pleasant Activities, work with the teen to see the connection between their Mood and the increase in Pleasant Activities.

- When reviewing the Three-Column Mood Monitor, help the teenager to identify Automatic Thoughts

2.b. Reinforcement and Attributions: As in previous sessions, review what the teen did to make the task successful, or what thoughts, behaviors, or emotions got in the way.

- Help the teen to formulate appropriate external, unstable, or specific attributions for failure, such as:

"It turned out to be too much of a job to try to complete in one step." (external)
"I didn't do the task, but I could probably do it next week." (unstable)
"I was not able to get that task done, but if I had planned it a little differently, it would have worked." (specific)

- If the teen succeeded, help them to make internal, stable, global attributions, as reasonable, for their success, such as:

"This experience proves that I can set my mind to solve a problem and succeed." (internal, stable, and global)
"I am pretty good at solving those kinds of problems." (internal, stable, specific)

3. NEW SKILL: RECOGNIZING AUTOMATIC THOUGHTS AND COGNITIVE DISTORTIONS

3.a. Rationale for Recognizing and Challenging Negative Automatic Thoughts: Review rationale, relating Automatic Thoughts to the "triangle" of behavior, emotions, and thoughts, and to overcoming depression.

3.a.1. Three Parts of the Personality, Downward and Upward Spirals: Recall that a "downward spiral" can be turned around by changes in behavior or in thoughts.

3.a.2. Review "Tools" in the Backpack:

> "So far we have worked on several different tools that you will have in your backpack to prevent or overcome depression. The tools we have worked on include: setting goals, monitoring how we feel, problem-solving, and being more active, especially in enjoyable or pleasant activities. All of these are skills to make changes in our own behavior or in situations"

3.a.3. Situations We Cannot Change: Identify examples of situations in which, even though it is not possible to change something that bothers us, it is possible to change the way we think about it. If the teen seems ready for this, the examples given may be directly relevant to their situation.

> "Sometimes the things that get us depressed are situations we can do something about. However, sometimes the things that might get us depressed are situations we really can't control. For example, a teenager could be depressed because their parents argue or fight a lot. Another example is when the teenager gets depressed because of not being as great at school work or some sport as other teenagers. It is not possible to make parents get along, or to suddenly make ourselves into great students or great athletes. However, we can change the way we think about these situations."
>
> *"What are some examples of ways teenagers could think about these examples?*

("It's not my fault my parents argue; I will have a better marriage, myself")

("I may not be as good in math as Marie, but there are other things I do very well, and I can do well enough in math.")

("I am an important and valuable person even if I am not a great athlete.")

3.a.4. Thoughts Lagging Behind Real Change: Point out that, even when we do make positive changes, if our negative thoughts do not change as well, we can still feel badly.

> *"Even in situations where we can make a change, for example by using Problem-Solving or Increasing Pleasant Activities, it is important also to make our thinking more positive. Otherwise, we may not notice that we have actually changed, and we may not feel as good as we could."*

3.a.5. Summary: Relate today's session to the Homework results and other Issues and Incidents discussed so far in the program.

"Along the way, you have been identifying the thoughts that go along with different emotions and different behaviors. Today we will concentrate more on those thoughts."

"When we think in ways that are depressing, we get depressed. When we change those old ways of thinking, we overcome the depression."

**********Optional Section**********

3.b. Recognizing Automatic Thoughts: This section is designed for use with teenagers who have had difficulty to this point either in identifying Automatic Thoughts, or is seeing that such thoughts are not the only possible way to think of given situations.

3.b.1. Is It Possible to Change Your Mind? Ask the teenager whether they think it is possible to change the way they think about things.

"Do you think it is possible for you to change the ways that you think about anything?"

"Have you ever changed your mind about anything?"

- If the teen essentially says "no", work with them to recall actual changes they have made over their lifetime, in opinions or beliefs. Common examples include changes in:

  - preferences for music, clothing, and hairstyle;
  - attitude toward the opposite sex between childhood and adolescence;
  - opinions they have discussed with their parents, i.e., moving from agreeing with to disagreeing with their parents, or vice versa;
  - childlike beliefs, e.g., Santa Claus.

"When we talk about 'changing our mind' in everyday life, we are talking about changing the way we think about things."

3.b.2. How Does This Change Happen? Help the teen to see how earlier changes in the way they thought happened.

"How did that change happen? What did you do that led to the change?"

"Did you get other information that changed the way you thought?"

- Processes such as: 1) questioning the thought; 2) getting other people's opinions; 2) getting more information, may be identified. The therapist can then explain to the teenager that the same kinds of processes can be used to change depressive thinking.

3.b.3. Defining and Recording Automatic Thoughts: Use the session exercises to help the adolescent to understand what is an Automatic Thought.

"Let's take a closer look at how Automatic Thoughts work."

- **Refer the adolescent to Workbook p. bb, with 3 pre-printed events on Triple Column.**

- Therapist gives out a triple column form with pre-printed events, and asks teen to write down (or tell therapist) at least two emotions they might have in reaction to the event, and to rate each emotion on the Emotions Thermometer. The sequence of columns is Event, then Thought, and then Emotion with rating. This is to emphasize that the thought comes between the event and the emotion. The three events listed are:

  Your mother or father tells you that you are lazy.

  You are going through an intersection and another driver runs the stop sign and hits the side of your car. No one is hurt.

  You graduate from high school.

- Ask teen to tell therapist (who writes it on form) the thought that is connected with each emotion in each situation. Here the task is to show the teen that **different ways of thinking about the same event lead to different emotions**. It is very important, therefore, that the teen generate at least two emotions for each event.

- Help teenager to see that the thoughts can be **hard to pinpoint** and that they can **occur so quickly, we don't even notice them**.

  "Sometimes it is hard to realize exactly what the thought is that goes with an emotion. These thoughts often come so quickly we don't even notice that they are there. A name for these thoughts is 'Automatic Thoughts' because they happen so fast. We have learned them so well we don't even notice them."

  "Do you remember learning to drive? (or play a sport or play an instrument or any other motor skill). At first you notice everything, e.g., your hands on the

wheel, where the different pedals are, how wide the car seems, how far you are from the middle of the road line. After some practice, these thoughts become automatic and you don't notice them so much or hardly at all."

"Automatic Thoughts' are like that. Maybe when we first got depressed we noticed them. Or maybe we learned them growing up before we even got depressed. But now they are so fast and automatic that we don't even notice them."

"So first we have to recognize them and get them down on paper."

3.b.4. Challenging Automatic Thoughts: Once automatic thoughts have been recognized and recorded, we can challenge them to see if they are really accurate. Let the teenager know that you will work on this skill more when discussing Issues and Incidents and in the next session.

**********End of Optional Section**********

3.c. Recognizing Cognitive Distortions: Explain that one thing that keeps negative thoughts going, and makes it hard to think positive thoughts, is when we miss or do not pay attention to positive things we might experience. In this next part of the session, we are going to do an exercise to help understand how we might be missing positive information.

3.c.1. Letters with Cognitive Distortions: Use "Dear Problem-Solver Letters" to introduce common cognitive distortions:

- ❑ **Refer teenager to the Workbook pages cc to hh that include Dear Problem-Solver letters keyed to list of cognitive distortions.**

- Ask teen to read the letters, one at a time, and to try to figure out how the writer seems to be thinking about his or her problem. Is the writer missing some important information or twisting information in some way?

- Therapist may adjust the exercise as needed. For instance for teens who are slow readers, read the letters aloud to them. Use as many, or as few, letters as judged useful. The letters can be modified as needed by the therapist. **Note that the letters provided are keyed to the list of cognitive distortions, so if the therapist chooses to change the letters or the list, each should be modified to match the other.**

- Therapist can use paper or board to jot down the problems in the letter writers' thinking identified by the teen.

3.c.2. Identify Common Cognitive Distortions: Therapist may use the list provided or any other suitable list of cognitive distortions. The list provided is a shortened and simplified version of the cognitive distortions described by Beck and colleagues (1979), Burns (1980), and Brent and Poling (1997). Try to use language that is clearly understandable to the teen.

❑ **Refer the adolescent to Workbook page ii, "Cognitive Distortions."**

"Now take a look at this list of common distortions, to see if you, anyone in your family, or any of your friends use these distortions."

- If the teen identifies a distortion in the letters that is on the list of common cognitive distortions, make the connection between the label the teen uses and the label on the list.

- Discuss examples of people using these distortions. Include teens' own use of distortions to maintain negative thoughts, as this has been reflected in earlier sessions or homework assignments.

4. WORKING ON ISSUES AND INCIDENTS

In this portion of session, work with teen on agenda items. Help the teen to apply any of the "tools" so far in the "backpack" to concerns that the teenager raises. Use general guidelines for Phase 2 in discussing material.

5. HOMEWORK

- Continue working on Increasing Pleasant Activities
- Continue using the Mood Monitor. Use either the Three-Column Mood Monitor from the previous week, or a Three-Column Mood Monitor that includes the names of cognitive distortions along the top.

❑ **Optional: Refer the adolescent to p. jj in the Workbook, for the Three Column Mood Monitor with Cognitive Distortions.**

- If therapist opts to use Mood Monitor with the Cognitive distortions listed, show teenager where to record the cognitive distortion connected with a negative automatic thought.

6. SUMMARIES AND CHECK-IN

Include as in previous sessions.

Complete the form indicating whether the teen completed none, some, or all of this week's Homework.

INDIVIDUAL SESSION TOPIC VI: REALISTIC COUNTER-THOUGHTS

TOPIC CODE: ***RC***

GOALS OF THE SESSION:

1. To review Mood Monitor, and Increasing Pleasant Activities Homework
2. To continue identifying negative Automatic Thoughts and Cognitive Distortions
3. To increase adolescent's ability to formulate and use Realistic Counter-thoughts
4. To review progress toward goals and to formulate a plan for second six weeks of Stage I Acute CBT

Materials needed:

Workbook with forms for: Realistic Counter-thoughts; Five Column Mood Monitor with Counter-thoughts and Ratings Columns; Index cards

Let the teenager know that you will spend some time toward the end of this session reviewing progress toward goals, and planning for the next part of the treatment.

1. ISSUES AND INCIDENTS

As in previous sessions, therapist should continue to use the routine session format, beginning with eliciting the agenda and collaborating with the adolescent in prioritizing topics to be covered.

- Elicit agenda items, using **Mood Monitor** and **ADS** to help identify Issues or Incidents

2. HOMEWORK REVIEW

- Review the Homework assignment, which involved continued Mood Monitoring, as well as Increasing Pleasant Activities. Check to see whether the adolescent was able to recognize any negative **Automatic Thoughts** or **Cognitive Distortions** using the Mood Monitor.

- As in previous sessions, review what the teen did to make the task successful, or what thoughts, behaviors, or emotions got in the way.

3. NEW SKILL: QUESTIONING AND TALKING BACK TO NEGATIVE AUTOMATIC THOUGHTS AND COGNITIVE DISTORTIONS

3.a. Continue Cognitive Work: Continue work from last session. This may involve further work on identifying negative Automatic Thoughts, recognizing and labeling Cognitive Distortions, or proceeding to the following material on questioning and talking back to negative thoughts.

3.b. Rationale for Questioning Automatic Thoughts: Explain that negative automatic thoughts are one-sided or exaggerated and depressing. By questioning them and "talking back" to them, we can think more realistically and overcome depression.

> *"Once we recognize negative Automatic Thoughts and Cognitive Distortions, we can question them, challenge them and change them*."

3.b.1 The "contrasting coaches" analogy: The therapist may want to use the analogy of a hypercritical versus a supportive coach to illustrate the difference between excessive self-criticism and self-encouragement. Anne Marie Albano contributed the following text, adapted from the work of Michael Otto. Michael Otto has graciously permitted us to include this "Contrasting Coaches" material in the TADS manual (Otto, 2000).

In order to facilitate the use of cognitive restructuring techniques, the following rationale and narrative are presented directly to the patient.

> *Most people have played a sport or two during their childhood. Have you ever had experience playing T-ball or little league? Let's take a moment to think about a child's first time playing T-ball. Imagine that a little guy (girl) of about 5 years of age has just signed up for his (her) first T-ball team. In the week before the first practice, little Billy is so excited! His mom takes him out for new sneakers. His dad buys him a new glove and helps to break it in with oil, just like his dad once did. Everyone is looking forward to the first practice and Billy's debut as a T-ball player.*
>
> *Now imagine Billy's first day at practice. His coach, Coach A, sends him out to play in the outfield. Billy is out there, watching the batters come to the plate and make their way around the diamond with grounders and singles. Finally, a batter hits a pop fly up and into the outfield. There it is, heading right toward Billy. He's so excited now! He puts his glove up in the air, but oh no! The ball goes flying over his head! Suddenly from the sidelines,* ***Coach A yells out "Oh NO NO NO! What are you doing? I can't believe you missed that! Pay attention, come on kid, what's wrong with you!"***

Wow. Imagine how Billy feels about that. Now imagine that another ball gets popped up, and again it's heading straight for Billy. This time, he holds his glove up and runs towards the ball. It hits his glove but pops right out. ***Immediately, Coach A is screaming again. "What is WRONG with you? That's it, forget it. You can't play the outfield. Come on in here kid. Now what will we do with you?"***

What do you think Billy is telling himself at this point? How does he feel about himself? What do you think he'd do? (Solicit answers such as Billy telling himself he's no good, feeling like a failure, feeling embarrassed and humiliated, behaviors such as crying and giving up).

How do you think Billy will feel about the next practice? Is he likely to want to play ball again? What do you think he'll be feeling and doing before the next practice (e.g., having stomach aches and experiencing tension, feeling depressed, trying to avoid the situation).

Now let's look at this situation again, but with a different Coach. Imagine that it's Billy's first day at practice. His coach, Coach B, sends him out to play in the outfield. Billy is out there, watching the batters come to the plate and make their way around the diamond with grounders and singles. Finally, a batter hits a pop fly up and into the outfield. There it is, heading right toward Billy. He puts his glove up in the air, but oh no! The ball goes flying over his head! Suddenly from the sidelines, ***Coach B yells out "That's okay kid, good try! It's alright. Now, the next time a ball is hit towards you, keep your eye on it, watch for where it's heading, and move towards the ball. Okay? Let's try it again, and do the best you can."*** *Now imagine that another ball gets popped up, and again it's heading straight for Billy. This time, he holds his glove up and runs towards the ball. It hits his glove but pops right out.* ***This time Coach B calls out to him "Way to go! Alright, you're getting there! The next time, close your glove around the ball. Good effort Billy!"***

If you were Billy's parent, which coach would you want for him, A or B? Why?

Billy might not feel 100% great, but there's some big differences in how he's likely to feel, and what he's likely to do about improving his game and staying on the team. Coach B did some very important things that the first Coach missed.

First, he complimented Billy on his effort. *Sure, things weren't perfect, or really going too well at all, but he recognized Billy's attempts and he made sure to reinforce that.*

Second, he gave Billy some very clear instructions *on what to try next time, and how to learn from each attempt. He's helping Billy to build up his skills in playing ball.*

Third, Coach B stayed away from focusing on what Billy did wrong *and he didn't judge him negatively or harshly.*

There are some very clear differences between these coaches, and also between the end result of how Billy will feel about himself and T-ball. It's likely that Billy won't feel totally great about things, but he has good instructions on how to improve. He's probably not very upset, and won't be distracted by feeling incompetent or embarrassed. It's likely that he can develop the skill and have fun at the game.

*We're pretty clear on which Coach did the better job, and which is going to be best for Billy. But let me ask you this****: When you talk to yourself about things, which coach do you sound like?*** *Do you get down on yourself, focus on what went wrong, how miserable things are, and how hopeless you feel? If so, you're not alone****. Most of us coach ourselves like Coach A.*** *We tend to focus on the negative, and replay in our minds the parts of situations that we're least satisfied with, rather than looking at our efforts and accomplishments.* ***But, when we're asked to coach someone else, we tend to be more like Coach B****. We'll give someone else the break, but not ourselves. This is a style of self-coaching that leads to feelings of depression and anxiety.*

I've used the Billy story to get you to start thinking about how you are coaching yourself. I'd like you to start listening to what you say to yourself and see if you're coaching style is harsh, or if it is encouraging. What we will focus on in this program is learning to recognize this coaching style, by identifying our own negative automatic thoughts, and then learning to challenge those thoughts with proactive, realistic coping statements. We'll learn that how we coach ourselves affects how we think about ourselves, how we feel physically and emotionally, and ultimately, it affects what we do.

3.c. Practice Methods of Questioning Negative Thoughts: Referring to any of this teenager's common negative automatic thoughts, use any of the standard

cognitive therapy techniques for questioning thoughts. Have teen practice with you such methods as Socratic questioning, looking for Contradictory Evidence, applying the Double Standard, or role-playing and reverse role-playing. The therapist should be attempting to find a method that seems particularly helpful for this teenager. Further information on the use of these and other techniques can be found in Brent and Poling (1997), Beck, Rush, Shaw and Emery, (1979), and Wilkes, Belsher, Rush, and Frank (1994).

3.c.1. Contradictory Evidence

"Is there any evidence that that thought is not completely correct?"

"What is the evidence in support of that thought? What is the evidence against it"

"If other people took a look at that thought what would they say about it?"

3.c.2. Socratic Questioning

"Is there any other way to look at that situation?"

"Is that the only way someone could look at that situation?"

"How else might someone see that situation?"

3.c.3. Role Playing and Role Reversal with Double Standard

The therapist can role-play the teenager and model self-questioning. In this case, the therapist models thinking of alternative explanations or thoughts. The therapist should model in such a way as to demonstrate the struggle to formulate different thoughts, i.e., use a **coping** model of modeling and not a **mastery** (or 'quick fix' model). The teen then returns to his or her role and practices what the therapist has modeled.

The therapist can also role-play the teenager while the teen role-plays the therapist. Here the therapist (as the teen) remains fixed in the negative automatic thought while the teen (as therapist) suggests alternative thoughts. This illustrates the technique of Double Standard.

3.d. Formulating Realistic Counter-thoughts: Using any of the above techniques, the teen may have generated positive thoughts to "talk back to" their negative automatic thoughts. The therapist should list these on a sheet of paper or blackboard.

3.d.1. Identifying Other Possible Counter-thoughts: A list of realistic, positive thoughts can also be used to help the teen identify thoughts that would help them to "talk back to" negative Automatic Thoughts. A list of this type, a modification of the list in Clarke, Lewinsohn, and Hops (1990), is included in the Workbook.

- ❑ **Refer the adolescent to Workbook page kk, "Realistic Counter-thoughts."**

> *"We can start to talk back to our **Negative Automatic Thoughts** once we recognize them and question them. One way to do this is to use **Realistic Counter-thoughts**. A Realistic Counter-thought is one that is more realistic and less extreme than the negative thought, and which changes the way we feel.*

Work with the teen to identify Realistic Counter-thoughts that make sense to them, and seem to have some effectiveness in influencing their mood.

3.e. Recording Realistic Counter-thoughts: The most effective counter-thoughts should be written on **index card(s)** to be taken home by the adolescent, for Homework practice and subsequently for use in stressful situations.

- Therapist should keep a copy of these for further reference**.**

Additional Points for Therapists:

1. **Distancing the task**. If teen cannot yet endorse realistic counter-thoughts with reference to their own situations, they may be able to do so with reference to

- other teenagers with common teenage problems (getting a bad grade on a test, breaking up with a boyfriend/girlfriend, having an argument with parents).

- well-known people dealing with negative events and potential negative thoughts (politicians who lost a big election, star athletes who did not perform well in a big game, or a person who suffered a major injury with loss of functioning).

2. Using the perspective of others. Teens may be able to identify and gradually accept positive features others would identify or have actually identified in him/her.

4. WORKING ON ISSUES AND INCIDENTS

Proceed as in previous sessions.

5. REVIEWING PROGRESS TOWARD GOALS, AND PLANNING

5.a. Review Progress: After discussing agenda items with highest priority, ask teenager to review the goals that were written down or discussed in earlier sessions. Check progress toward goals. Make adjustments as appropriate. Some adolescents will need help further breaking down goals, if these have proven too difficult. Others will need help choosing the next step(s) to take toward broad treatment goals.

5.b. Plan Collaboratively: When reviewing progress toward goals, attend to the need for training in social skills, since this will help to determine the treatment plan for next 6 weeks. Also consider whether optional modules on Relaxation or on Affect Regulation would be indicated. Engage the adolescent in this discussion of options, in a collaborative manner.

6. HOMEWORK

6.a. Mood Monitor: Continue use of the Three-Column Mood Monitor or introduce the Five-Column Mood Monitor, which has columns for Realistic Counter-thought and subsequent Emotions with ratings. This form is included in the Teen Workbook materials for this session.

- **Optional: Refer to Five-Column Mood Monitor with Counterthoughts, on p. mm of Workbook.**

6.b. Practice Realistic Counter-thoughts: Also, ask the teenager to practice saying the most effective Realistic Counter-thoughts (written on index cards) to themselves each day, **when they are not in a stressful or upsetting situation.** This is to help the thoughts become more "automatic."

7. SUMMARIES AND CHECK-IN

Proceed as in previous sessions

Reminder: Complete the form indicating whether the teen completed none, some, or all of this week's Homework

Week Six Review of Phase II

Phase II of CBT has had several **treatment program goals**. At this point in treatment **(Week Six),** check to assess to what extent you think the goals have been met. If they have been reasonably met, proceed to new material in Phase III. If not, continue to work on Phase II material as clinically indicated. For example, if the adolescent is progressing through Phase II material at a slower pace, but appears to be benefiting from the work, spend additional time in the coming weeks on learning the Phase II skills that seem to be helpful.

It is necessary, however, to include the parents in conjoint sessions during Phase III. Therefore, the groundwork for these sessions must be laid in adolescent individual sessions, and the therapist needs to decide how best to focus the conjoint sessions. Also, if the adolescent needs to develop other skills, such as social skills, communication skills, assertion, relaxation, or affect regulation skills, these should be introduced in Phase III. The therapist must make clinical judgments about which modules to include in Phase III.

At Week Six of treatment, the therapist should review with the adolescent how he or she is progressing toward the **adolescent's goals** outlined at the start of treatment. The therapist also needs to update the working formulation of the case, and to decide, at least in a preliminary way, which modules to include in Phase III.

The formulation of the case, which guides this judgment, should be summarized in written form at this time, and included in the case book. Use the form entitled **CBTP (CBT Formulation and Treatment Plan) found in the Ancillary Forms Box. A copy of this form needs to be faxed to the Coordinating Center between the Week 6 and the Week 7 treatment sessions (attention Dr. John Curry) for Quality Assurance purposes. The fax number is (919) 684-8804.**

Goals for Phase II have included:

1. Increase behavioral activation
2. Increase positively reinforcing activities
3. Enhance interpersonal problem-solving
4. Continue to identify and begin to challenge maladaptive thoughts, beliefs, attributions
5. Continue to monitor motivation, hopelessness, suicidal ideation
6. Assess possible family factors contributing to adolescent's depression
7. Continue to socialize parents to treatment model by explaining skill training

Check to see that the following general strategies have been implemented during Phase II:

1. Pleasant Activity scheduling **or**
2. Mastery and Pleasure ratings
3. Problem-solving
4. Mood monitoring with multiple column monitors
5. Identifying cognitive distortions
6. Formulating realistic counter-thoughts
7. Parent psychoeducational sessions

General Guidelines for Phase 3 of TADS Acute (Stage I) CBT:

The third phase of Stage I CBT involves helping the adolescent to learn more complex cognitive behavioral skills, especially social skills, and working conjointly with parents and adolescent to resolve family problems contributing to the teenager's depression. In addition, time in Phase 3 may be devoted to learning relaxation or affect regulation skills. In some cases, these optional skills will have been introduced earlier in treatment (during weeks 1 to 6) based on clinical judgment that they were needed. Either for this reason, or because the adolescent proceeds more slowly through Phase 2 material, than is scripted in the manual, time in Phase 3 may be devoted to further work on Phase 2 basic cognitive behavioral skills.

Phase 3 generally occurs during weeks 7, 8, 9, 10, and 11 of Acute (Stage I) CBT. Week 12 is devoted to "Taking Stock" of progress to date, and preparing for Stage II.

Scheduling:

One session is held each week during Phase 3. At least one of these must be a conjoint parent-adolescent session, and up to three may be conjoint sessions. If the clinician judges that more than three sessions should be conjoint, a request to this effect must be made during the weekly TADS CBT supervisors' conference call.

If the therapist judges that the minimal number of conjoint sessions is appropriate, then parents should be invited for "check-in" at the beginning of some number of other sessions during Phase 3.

Session Format and Integration:

Therapists continue to use the routine session format to help structure the treatment. The manual includes primarily modular material for Phase 3, but this should be used in the context of a regular session format. In other words, the therapist elicits an agenda ("Issues and Incidents"), reviews the Affective Disorders Screen (ADS), and reviews Homework, then teaches the skill in the module. This is followed by time to discuss Issues and Incidents, and time to prepare for and assign Homework for the next week.

As is true throughout treatment, the therapist should help the teenager to summarize main points during sessions, should check-in with the teen to assure that the teenager feels understood, and should indicate on the appropriate form whether the teen completed all, some, or none of the previous week's Homework.

As was true in Phase 2, the therapist should link the skill to be taught with material the adolescent has brought up in sessions.

Behavioral Work:

There are two clusters of skills included in Phase 3 material in the manual: social skills and tension reduction/affect management skills. Social skills include those that facilitate social interaction and involvement, those that facilitate interpersonal communication, and those that enhance assertiveness. Social interaction skills, such as skills for meeting others, joining a conversation, and leaving a conversation, may be helpful for isolated adolescents, or those who are socially anxious or awkward. Communication skills may be helpful for adolescents who have communication conflicts within the family or the peer group. Assertiveness skills may be helpful for those who are more passive or socially anxious.

The major method recommended in the manual for the teaching of these skills is role-playing, coupled with didactic instruction and modeling.

Tension reduction and affect management skills include a variety of brief relaxation methods, progressive muscle relaxation, and methods to anticipate and prevent escalation of affect. The therapist may choose to use both a relaxation module and an affect management module. Relaxation methods may be particularly applicable to the anxious teenager; affect management to the impulsive or emotionally labile teenager.

Cognitive Work:

During Phase 3, and particularly when reviewing Issues and Incidents, or working on “here-and-now” material in sessions, the major task in the cognitive domain is to help the teenager to become more autonomous in cognitive restructuring. The emphasis is on **helping the teen to become her or his own therapist** (Brent & Poling, 1997). The teen can be encouraged to identify her or his own **negative automatic thoughts, cognitive distortions** and **depressive attributions** as the therapist takes less of a directive role in identifying these. The teenager should also be encouraged to formulate and use **her own or his own realistic counter-thoughts**.

During this phase the underlying **beliefs** may become clearer. The therapist can work with the teen to see the pattern of the underlying belief, which may be in the sociotropic/dependent realm, the autonomous/achievement/perfectionism realm, or other realms.

The therapist should continue to be alert to possible perfectionistic beliefs, since perfectionistic patients may become discouraged with lack of complete progress during this phase of treatment (Blatt et al., 1995). The notions that some

progress is better than no progress, and that progress can continue after Acute treatment should be reinforced.

Family Work:

Family work is extremely important during Phase 3. Conflict or discord that could threaten the adolescent's gains or increase the risk of relapse must be dealt with in this Phase. Again, the therapist must decide which modules from the Family manual to include in conjoint sessions, and must decide how many such sessions are optimal.

A summary of the goals and strategies for Phase 3 is repeated below.

Comorbidity:

As an effectiveness study, TADS includes adolescents with depression who also have comorbid conditions. The depression must be judged to be the primary diagnosis, but it is recognized that many adolescents in TADS are likely to have anxiety disorders, externalizing disorders, or problems in affect regulation or impulse control. The TADS therapist can address these comorbid conditions in Phase 3, or if necessary earlier in treatment, if they are judged to be contributing to the primary problem: depression. Use selected modules from the manual. See the suggested guidelines for choosing modules.

If the comorbid condition rises to the level of requiring additional treatment, beyond those methods included in the TADS CBT manuals, or beyond the allotted number of sessions in the TADS protocol, follow ASAP procedures.

Phase III of Acute Treatment

Goals:

- ✓ Enhance social skills
- ✓ Enable adolescent to **self**-identify and **self**-modify maladaptive thoughts, attributions, beliefs
- ✓ Enhance negotiation and compromise skills
- ✓ Improve parent-adolescent interactions related to adolescent's depression
- ✓ Address collateral or comorbid problems contributing to adolescent's depression

General Strategies:

- ✓ Social interaction/assertion/communication training as needed
- ✓ Techniques for challenging automatic thoughts, attributions, beliefs
- ✓ Focused conjoint parent-adolescent sessions
- ✓ Family communication, negotiation, compromise sessions
- ✓ Relaxation/affect regulation/anxiety management/impulse control training as needed

SOCIAL SKILLS MODULE I: SOCIAL INTERACTION

Topic Code: ***SI***

GOALS OF THE MODULE:

1. To improve the adolescent's basic skills for meeting people, joining, continuing, and leaving a conversation

Materials needed:

Workbook Form: Meeting, Greeting, and Talking with People

Index Cards

Therapist's writing materials

Therapist's case chart

Use this module in the context of a regular session outline. Make sure you have elicited the agenda, and reviewed the previous session's homework. Leave sufficient time after practicing these skills to include discussion of Issues and Incidents and formulation of a homework assignment with the teenager.

1. **ISSUES AND INCIDENTS (including Mood Monitor and ADS)**

2. **HOMEWORK REVIEW**

3. **NEW SKILL: MEETING, GREETING, AND TALKING WITH PEOPLE**

- **Refer to the checklist of social skills included in the Workbook on p. nn, "Meeting, Greeting, and Talking with People."** This list of skills is derived from Clarke, Lewinsohn, & Hops (1990), but it is organized here in checklist format. It is included as a guide to the therapist, with items to be cognizant of as the teen describes or role-plays social situations. It can also be used in Homework assignments after this session.

3.a. Rationale for Practicing Meeting, Greeting and Conversation Skills: Explain rationale for social skills training in the context of the overall CBT. Changing behavior is a way to change emotions. Social behavior, or behavior with other people can be an important type to improve.

- Relate these skills to the earlier skills regarding **Increasing Pleasant Activities.** Improving social skills is one way to combat depression, just as increasing pleasant activities helps to combat depression. In fact, social activities are one of the best types of "pleasant activities" for helping to improve the way we feel.

  "Remember that earlier in the program we practiced Increasing Pleasant Activities, and saw that one important kind of Pleasant Activity is the SOCIAL kind. Since these activities are important in helping us to feel better and overcome depression, that is another good reason to practice social skills."

- Therapist should relate the module to earlier incidents the teen has brought up, or to the therapist's observations about difficulties the teen has shared in "getting started" socially.

3.b. Social Skills can be Improved: Present meeting people, joining conversations, and feeling comfortable leaving conversations as **SKILLS** which people can learn.

"Often we think that people are either very good at meeting people and having conversations, or just not good at these things. However, that is an example of a cognitive distortion. Do you remember which one? (Black & White Thinking)."

"Actually, people vary in how good they are at these things, and they can get better at them if they practice them. Just like anything else, it takes time and practice to get better at them, but we can get a start on it in this session."

3.c. Role-Play Social Situations: Choose role play exercises that seem most relevant for this teenager

3.c.1. Starting a Conversation: Therapist can role-play someone who is starting a conversation with someone they have just met (role-played by the teen).

- Model **poor** basic conversation skills first, and have the teen comment on them. Include both non-verbal (slouching, avoiding eye contact, looking at the floor) and verbal skill deficits (do not use your own or other person's name; go off topic abruptly).

- Teen can then comment on what was positive or negative about the conversation from his/her point of view.

- Follow with therapist role-playing a better example of initiating a conversation.

- Then reverse roles and have teen practice positive skills for meeting people. Use checklist to note the skills used or not used.

3.c.2. Breaking Into a Group Conversation: Proceed using a similar sequence of role-plays, but this time pretend that there is a group of people at a party, one of whom is role-played by the teenager. The therapist's role is to "break into the group conversation."

- Do this first very awkwardly, then repeat it skillfully. Have teen comment on what was positive or negative each time.

- Then reverse roles, as above, and have teen practice positive skills. Use therapist checklist to note the skills used or not used by the teen.

3.c.3. Listening: Use a similar sequence to demonstrate good versus poor listening skills. The therapist should first demonstrate poor listening skills, then have teen comment, then demonstrate good listening skills, have teen comment, then reverse roles, etc. Use checklist to note skills.

- Initially, the teen can pick a topic he/she would like to talk about, and therapist listens. Then, when teen is the designated "listener" therapist picks a topic.

3.c.4. Ending a One-to-One Conversation: Proceed as in earlier role-plays.

3.c.5. Leaving a Group conversation: Proceed as in earlier role-plays.

4. CREATING A TAKE-HOME HANDOUT AND HOMEWORK ASSIGNMENT

4.a. Index Card Reminders: The role-plays should have demonstrated both the skills that the teen readily uses, and those that are in need of more practice. Include **BOTH** types on the handout(s) to be given at the end of this session. For example, strong skills could be listed on one side of an index card, and skills to practice on the other side. Separate index cards can be generated for one-to-one conversations, joining group conversations, leaving conversations, greeting people, etc.

- Tailor the handout to the particular teenager and have them engage with you in the process of creating it.

4.b. Tailored Homework: With the teenager, create a Homework assignment, which will enable her/him to practice the skills reviewed in this session, and thereby to increase **Pleasant Social Activities**.

Examples might include:

- starting conversations 3 times this week with new people

- joining group conversations at school 3 times this week

- going to an organized group and joining it (Youth group at church or synagogue; extracurricular group activity at school; recreational [not highly competitive] sports league)

- practicing listening skills with a parent or friend, and using the checklist to record the skills used

4.c. Practice with Therapist. Before ending the session, the therapist should have the teenager practice any specific new social skills that are included in the homework assignment. These may include any of the specific skills on the form, "Meeting, Greeting and Talking with People," or any other personally relevant skill.

5. DISCUSSION OF ISSUES AND INCIDENTS

When discussing agenda items during Phase 3, use general guidelines for this Phase. The adolescent now needs to be helped to self-question negative automatic thoughts, and cognitive distortions. Therapist can also help the teen to look at the various "Tools" they have learned so far, to see which might be useful for dealing with agenda items.

Negative thoughts associated with social skill deficits or social withdrawal, are likely to be evoked by working on this module. The therapist should be alert to such negative automatic thoughts (e.g., "people don't like me."…"people hate me."..."I'll never be able to make friends."..."Only the popular people have friends.").

It may be necessary, before challenging such thoughts, to ask the teen if it is possible for a person to change his or her mind, or to see things differently more generally, as indicated in the module on recognizing automatic thoughts and cognitive distortions (Individual Session Topic V: Topic Code CD).

6. SUMMARIES AND CHECK-IN

Complete form indicating whether teenager completed none, some, or all of last week's Homework assignment

SOCIAL SKILLS MODULE II: ASSERTION

*TOPIC CODE: **AS***

GOALS OF THE MODULE:

1. To improve the adolescent's understanding of the differences between passive, assertive, and aggressive behavior
2. To identify automatic thoughts, cognitive distortions, or underlying beliefs that inhibit assertion
3. To increase the adolescent's use of assertive behavior

Materials needed:

Workbook with forms for: What is an Assertive Response? Steps in Assertiveness; I Statements; Assertive Guidelines; Assertive Experience Form

Index cards

Therapist's writing materials

Therapist's case chart

Use this module in the context of a regular session outline. Make sure you have elicited the agenda, and reviewed the previous session's homework. Leave sufficient time after practicing assertive skills to include open discussion of agenda and formulation of a homework assignment with the teenager.

1. ISSUES AND INCIDENTS (including Mood Monitor and ADS)

2. HOMEWORK REVIEW

3. NEW SKILL: ASSERTIVENESS

3.A. Rationale For Assertiveness: Therapist should relate the topic of this module to earlier incidents the teen has brought up, or to the therapist's observations about difficulties the teen has had in "standing up for him/herself" in pressure situations or in asking for help. Changing non-assertive behavior to assertive behavior can lead us to feel better, more confident, less depressed.

> *"Earlier in our work together you mentioned some situations that led to you getting (more) depressed. Some of these were situations in which you felt pressured, or blamed, or 'pushed around', or in conflict with someone, but could not figure out a way to handle it. Often, when people get depressed, it is because they cannot figure out how to respond to these situations.*

*Today, we can work on how to handle these types of situations, using what is called "**ASSERTIVENESS**." If a person learns how to be assertive in situations like the ones you have mentioned, that person will feel better, will be better able to get what they need out of the situation, and will be less likely to become depressed.*

3.b. Assertiveness can be Learned or Improved: Present Assertiveness as a **SKILL** that can be learned.

*"Often we think that people are **either able** to handle conflict and pressure **or not able** to handle it. But this is an example of a cognitive distortion. Do you remember which one? (Black and White Thinking)"*

"Actually people vary in how good they are at handling pressure and conflict. Sometimes they can handle it well with teachers or parents, but not so well with friends. Sometimes they can handle it well with friends, but not so well with their boyfriend/girlfriend. However people vary in this skill, they can learn how to do it better if they practice it. Just like all the other skills we have worked on in this program, assertiveness takes time and practice to learn, but we can get a start on it in this session."

3.c. Generating Examples of Assertive and Non-Assertive Responses: Two or three of the following vignettes (or others the therapist may generate) should then be read aloud to the teen, or presented on an index card. **Ask teen to tell you how they would typically react in each situation. Then ask them to think about how a friend of theirs might react differently:**

Situations or Events:

- You are at a college football game. At the end of the first quarter, you go to the concession stand to buy a coca-cola. You give the clerk a $5 bill. The clerk gives you the drink, but no change, and then he starts to wait on the next customer.

- You work at a music store. You have been there for six months as a part-time worker. So far you have not gotten a raise. On Saturday, your co-worker, who has been there for four months, tells you that she just got a raise. Now she is making more than you.

- Your brother is expected to do the dishes each night during the month of February. Your chore during this time is to sweep the kitchen floor and to take out the trash. Because he has been having play practice at school, it's now been four nights since he did the dishes. You have been getting stuck with his chore as well as yours.

- Your girlfriend really wants you to go to her field hockey games. Your parents' car broke down last Friday, so you unexpectedly had to go to the airport to pick up your uncle who came in to visit the family. You did not get back in time for the field hockey game. Now she is mad at you, and won't tell you if she will go out with you on Saturday night or not.

- You are at the grocery store. As you go to enter the check-out line, a woman rushes up and jumps in front of you in the line. You were obviously in the line before she got there. She starts to put her groceries in front of yours.

- You are at a mall with your boyfriend. You mention that you saw a guy you know in the store. Your boyfriend tells you he does not want you talking to any other boys while you are out with him.

- You are flunking math and are completely lost in class. Your teacher seems like a reasonable enough person, but he or she has never asked you to see them for extra help.

3.d. Discuss with Teenager Their Reactions: Relate this exercise to the overall CBT model, including the three parts of the personality.

- Focus some of the discussion on the thoughts and emotions they would experience, as well as on the behavioral response. Relate these to the model of the 3 parts of personality, and to earlier work on automatic thoughts.

- Review the range of possible emotions as well as the different thoughts. Use earlier work on questioning automatic thoughts to help teen see other possible thoughts they could have in the situation. Discuss differences in reactions as related to their likely outcome.

    - ❑ **Refer the adolescent to page oo in the Workbook, "What is an Assertive Response?"**

3.e. Define Passive, Assertive, and Aggressive responses.

"These are all situations involving negative emotions that require standing up for yourself, or ASSERTIVENESS. In these situations, we might be feeling pushed around, boxed in, or taken advantage of.

"There are basically three ways of handling such situations. One is to 'go along with it,' in a way that is passive. This avoids any confrontation or conflict, but leaves us feeling taken advantage of and feeling weak and powerless.

"A second, and opposite way is to be verbally or physically aggressive. We can attack the other person, call them names, yell, curse, or act in offensive ways. This can make us feel powerful, but also foolish. In addition, other people will usually be turned off by this.

"The third way is the middle ground way of being assertive. This means standing up for yourself in a strong way that is effective, but not aggressive or harmful to ourselves or the other person.

- Make sure the teenager can see how the three types of responses would apply in the specific vignettes you discussed together, and if possible, in other situations they have discussed earlier in therapy.

    - ❑ **Refer the teenager to Workbook page pp, "Steps in Assertiveness."**

3.f. Teach the Major Steps in ASSERTIVENESS: Review with the teen the important steps in an assertive response.

"There are 3 main steps in ASSERTIVENESS, and 1 additional step in some situations. These steps are included in your workbook handout.

1. *Recognize your own emotion.*
2 *1-extra. Recognize the other person's emotion and let the other person know that you know how they feel.*
2. *Express your own emotion, using an "I" statement.*
3. *Ask for some course of action."*

- **Refer the adolescent to Workbook page qq, "'I' Statements."**

3.g. Explain "I" Statements: Describe the difference between a statement about how "I" am feeling and a statement about "you." Often people feel criticized or angry if we make "you" statements.

- Contrast "I" statements with "You" statements. For example, point out the difference between "I feel upset when you ask me to do that," with "You have no right to ask me to do that."
- Make sure the teen understands how to use "I" statements to express their own emotions

3.h. Behavioral Rehearsal: Role-play applications of assertiveness, tailored to the needs of this particular teenager.

- **Refer adolescent to Workbook pages rr & ss, "Assertiveness Guidelines" if the guidelines are relevant to his or her situation. Therapist may wish to generate similar guidelines for other types of situations.**

"Other times we get depressed because we don't know how to ask for help. This happens a lot in school. A teenager gets behind in a course or gets lost in a course and feels hopeless or 'stuck.'"

"Let's spend some time practicing how to respond to pressure situations, or situations where we need help. We can use the assertive skills to do this."

- Therapist may use any of the following situations, or other comparable situations, including situations the teen brings up to work on.

- During the role-plays, demonstrate or instruct teen to demonstrate not only an assertive response, but also either a passive or an aggressive response.

- Work with teen to **identify fearful thoughts** related to the social pressure and to practice use of Realistic Counterthoughts.

- Attend to the non-verbal expressions of assertion as well as verbal material (eye contact, firm voice, etc.).

- Anticipate the reactions of significant others.

Spend some time discussing how important other people are likely to react to the adolescent's attempts at assertion. Help the teen to anticipate this, and to anticipate his or her own subsequent reactions. Will this make things better? Will it be too difficult? In what situations, or with what people, is this new skill most likely to be effective?

Situations or Events:

- You just got a new basketball for your birthday, after a friend lost your old one. Another friend asks to borrow your new ball for the weekend, but you don't want to take a chance on losing it.

- You are a teenage girl and your best friend tells you that if you don't have sex with your boyfriend the word will get out and no boy will date you.

- You and a partner you have been dating for several months decide to have sexual intercourse. Your partner does not want to use a condom. Your partner looks perfectly healthy.

- Your brother gets mad at you when he finds out that another boy assaulted you. He tells you that it's your fault because you let yourself get into a situation where that could happen.

- Your parents have a fight and your father leaves the house. Your mother tells you it's your fault that they always fight.

- You are driving through a town you have never visited before and you get lost. There is a gas station on the next corner.

- You have a big paper and an exam due next week in one of your courses. You get very sick with the flu and cannot study or work on the paper. Your teacher has said the work must be done on time.

4. HOMEWORK

4.a. Index Card Reminders: Use Index cards to write down cues or tips that are likely to help the teenager to practice Assertiveness. These could include the basic steps, or Realistic Counter-thoughts to combat negative automatic thoughts.

4.b. Tailored Homework: Tailor a homework assignment collaboratively with the teenager to practice assertiveness.

- ❑ **The Assertive Experience Form on Workbook p. tt may be used for this.**

- Have teenager identify a situation where they can attempt to be assertive. Choose a situation where success is likely.

- It is important to prepare the teenager for possible reactions of significant others to her or his newly assertive behavior. Ask them to anticipate who might react positively and negatively to this change in their behavior. Have them anticipate how they, themselves, will then feel and whether this will make things better or make things worse.

- If the teen wants to try new assertive behavior at home, make sure the way is paved through psychoeducational and preparatory work with the parents.

5. DISCUSSION OF ISSUES AND INCIDENTS

When discussing agenda items during Phase 3, use general guidelines for this Phase. The adolescent now needs to be helped to self-question negative automatic thoughts, and cognitive distortions. Therapist can also help the teen to look at the various "Tools" they have learned so far, to see which might be useful for dealing with agenda items.

6. SUMMARIES AND CHECK-IN

Complete form indicating whether teenager completed none, some, or all of last week's Homework assignment

SOCIAL SKILLS MODULE III: COMMUNICATION AND COMPROMISE

TOPIC CODE: ***CC***

GOALS OF THE MODULE:

1. To improve the adolescent's skills in listening and understanding, even when disagreeing.
2. To practice compromise as a form of mutual problem-solving.

Materials needed

Workbook with form for: Compromising as Problem-Solving or Family Problem-Solving

Therapist's writing material

Therapist's case chart

Use this module in the context of a regular session outline. Make sure you have elicited the agenda, and reviewed the previous session's homework. Leave sufficient time after practicing these skills to include open discussion of agenda and formulation of a homework assignment with the teenager.

1. ISSUES AND INCIDENTS (including Mood Monitor and ADS)

2. HOMEWORK REVIEW

3. NEW SKILL: LISTENING WHEN IT'S NOT EASY

3.a. Rationale For Practicing Listening Skills: Therapist should relate the skills covered in this module to earlier situations, incidents, or patterns brought up by the teenager that suggest that communication breakdowns are connected with her or his depression. Difficulty compromising or resolving conflict within the family, for example, may be costing this teenager support, increasing stress, and making it harder to combat depression. Difficulty communicating with peers or teachers may also be contributing to depression. Changing critical, argumentative communication to positive, constructive communication is one way to change behavior that can lead to positive changes in emotions.

> *"As we have worked together we have talked about some situations in which it was hard for you to communicate with your parents/teachers/friends. Sometimes this led you to feel misunderstood, and 'down.' (or 'mad')." If we work together on communication skills, you can get better at communicating from your end and do your part to resolve these problems more easily."*

3.b. Listening When There is Conflict: The therapist's task in this part of the module is to help the teen practice listening under more difficult circumstances that mirror the situation in his or her life where communication breaks down. Key ideas to convey are: 1) the distinction between listening carefully and agreeing; 2) the distinction between understanding another person's viewpoint and agreeing with it; 3) the connection between negative automatic thoughts or cognitive distortions and inflexibility in communication.

> *"It is especially hard to communicate when we are upset. If someone makes us mad or down, we tend to 'close off' the communication. This can happen when we disagree with the other person. So it is especially important to practice listening to someone who has a different opinion from our own."*

3.c. Listening can be Learned or Improved: Present the ability to listen even when upset, or even when disagreeing, as an important skill that can be learned or improved with practice.

- Listening to someone who disagrees with us is necessary to resolve problems and to compromise.
- Without the ability to listen and the ability to compromise, it is very hard to maintain friendships or to keep up good relationships with parents, teachers, boyfriends, or girlfriends.

> *"Sometimes we may think that people are either very good at, or not good at, communication, but realistically, the ability to communicate is a SKILL that each of us can learn over time. The same thing is true about the ability to compromise. Like any skills, these take concentration and practice. But thinking that you either "Have it" or "Don't have it" is a cognitive distortion. Do you recognize which distortion that is?* (Black and White Thinking)

3.d. Role-play "Debates:" Role-play with the teen one or two "debates" on current controversial issues. Find out first what the teenager's position is on the issue. Then ask the teen to listen closely as you "argue" in favor of the opposite position, so that the teenager can then summarize for you what you said. Next, ask the teen argue his or her position with the therapist summarizing it. Then reverse roles or positions on the debate and repeat the process.

- As the role-play progresses point out two basic distinctions:
    - **Listening carefully to another person's opinion is not the same as agreeing with the other person.**
    - **Recognizing the other person's right to their opinion is not the same as agreeing with it.**
- Individualize the task by using at least one issue in a debate on which adolescent-parent or adolescent-peer disagreements have already come up in treatment, repeating the role-play procedure.

3.e. Recognize negative automatic thoughts or cognitive distortions: Relate difficulties in communication and/or compromise to possible negative automatic thoughts or cognitive distortions.

Using examples the teen has brought up earlier in the treatment, spend some time identifying automatic thoughts or cognitive distortions that may get in the way of listening or of compromising.

Examples of negative automatic thoughts and cognitive distortions that interfere with listening:	
"I am absolutely right and they are absolutely wrong."	Black & White Thinking
"If I 'give in' on this it will prove that I am weak."	Jumping to Conclusions
"If I let this teacher tell me what I have to do, I will feel 'put down.'"	Black & White Thinking
"I can't stand it if someone believes in something I think is wrong."	Catastrophizing

- When these or similar thoughts are identified, use the earlier skills of questioning automatic thoughts, and 'talking back' to those thoughts to help the teen modify their overly rigid automatic thoughts.

These exercises may indicate that the teenager could benefit from the conversation or assertiveness skills included in Social Skills Modules I and II. These include appropriate eye contact, use of "I" statements, avoidance of hostile, aggressive statements, etc. The therapist can then incorporate those skills into this session as needed.

4. NEW SKILL: COMPROMISING

4.a. Rationale For Compromising: Relate the skills covered in this module to earlier situations, incidents, or patterns brought up by the teenager that suggest that inability to compromise is costing this teenager support, increasing family discord, peer conflict, or difficulty with teachers, and thereby contributing to depression.

> *"It seems from some of the issues and incidents we have discussed in earlier sessions, that one thing that contributes to your depression is when you and your parents/boyfriend/girlfriend/teachers cannot agree on a course of action or find yourselves 'dug in' on opposite sides of a choice. For example……(use an example from earlier work together.)….*
>
> *"For that reason, it would help you to overcome or prevent depression, if you could learn more skills for compromising with parents/teachers/friends. In that way you could help to reduce conflict and to improve relationships."*

The therapist's task in this part of the module is to help the teen to practice compromising as an extension of earlier problem-solving skills. Key ideas to convey include: 1) the need for compromise in any relationship; 2) the relationship between compromise and problem-solving; 3) the connection between negative automatic thoughts or cognitive distortions and inability to compromise.

4.b. Compromise as an Essential Social Skill That Can Be Practiced or Improved: Review, with reference to people other than this teenager, the critical importance of compromise. Use examples from broader social groups or from couples or families to illustrate that compromise is necessary in all relationships.

"What would happen if two countries had a disagreement over a border, or over trade, or some other issue and they simply could never agree on a solution?"

"What would happen if a married couple could not agree at all and could not compromise on what they wanted to do or how to live their lives together?"

"Sometimes we may think that people are either very good at, or not good at, compromise, but realistically, the ability to compromise is a SKILL that each of us can learn over time. But thinking that you either "Have it" or "Don't have it" is a cognitive distortion. Do you recognize which distortion that is? (Black and White Thinking)

4.c. Compromise and Problem-Solving: Relate compromising to problem-solving.

"When two people cannot agree on exactly how to do something, that is a problem. Therefore, we need to use problem-solving skills (RIBEYE) to solve the problem. In this case, however, there are two or more people involved, so we have to do problem-solving together. It is like having two or more people do the RIBEYE method together."

- **Refer the teenager to the forms in the Workbook, on pp. uu-vv, "Compromising as Problem-Solving" and/or on pp. ww-xx, "Family Problem-Solving."**

Remind teen of the steps in RIBEYE and apply them to compromising:

1. Each person must first RELAX or calm down.

Sometimes this means taking a break or waiting until later to tackle the problem.

2. Each person must IDENTIFY what the problem is on which they are trying to reach agreement.
3. Each person must BRAINSTORM as many possible solutions to the problem as they can.
4. Each person must EVALUATE the possible solutions. Then they should share their evaluations.
5. When they share their evaluations, they should look for the best OVERALL solution. This is the solution that has the most positive evaluations and fewest negative evaluations from the combined raters.
6. The two or more persons must say YES to one solution and try it out.
7. The two or more persons must ENCOURAGE each other to keep working at the compromise.

4.d. Role-play Compromising: Role-play with the adolescent situations involving the need to compromise. This may be done in preparation for a family session focused on compromise.

Possible vignettes:

Your parents want you to take college prep courses but you want to get out of school after 12th grade and join the military.

You get invited to a party and want to go, but your parents have heard there will be drugs and alcohol at the party and don't want you to go.

Your parents want you to study longer and harder to make better grades, but you already feel exhausted by the amount of work you have, and are not sure you can get better grades.

Your boyfriend wants you to go out with him Saturday night, but you want to go out with a group of your girlfriends.

Your girlfriend wants you to be with her every afternoon after school, but your friends are saying you are never spending any time with them anymore and you want to see them more.

Your friends want you to stay out with them for another two hours, but you told your parents you would be home 30 minutes from now.

4.3.Recognize negative automatic thoughts or cognitive distortions: Relate difficulties in compromising to possible negative automatic thoughts or cognitive distortions. Using examples from the role plays or examples the teen has brought up earlier in the treatment, spend some time identifying automatic thoughts or cognitive distortions that may get in the way of listening or of compromising.

- When these or similar thoughts are identified, use the earlier skills of questioning automatic thoughts, and 'talking back' to those thoughts to help the teen modify their overly rigid automatic thoughts.

5. HOMEWORK

Design with the teen a homework exercise that will require practicing compromise skills. It may be ideal to do this in anticipation of a conjoint family session. For example, the teenager could identify a family conflict, and go through her or his side of the “Compromise as Problem-Solving” form in anticipation of a conjoint session.

An alternative task would be to ask the teenager to use the “Compromise as Problem-Solving” form to work out a compromise with a friend, while imagining how the friend might respond.

6. DISCUSSION OF ISSUES AND INCIDENTS

When discussing agenda items during Phase 3, use general guidelines for this Phase. The adolescent now needs to be helped to self-question negative automatic thoughts, and cognitive distortions. Therapist can also help the teen to look at the various “Tools” they have learned so far, to see which might be useful for dealing with agenda items.

7. SUMMARIES AND CHECK-IN

Complete form indicating whether teenager completed none, some, or all of last week’s Homework assignment

RELAXATION MODULE

TOPIC CODE: ***RL***

GOALS OF THE MODULE:

1. To improve the adolescent's ability to relax.
2. To help the adolescent to identify specific relaxation techniques likely to be effective for her or him.

Materials Needed

Audiotape and tape recorder to use during progressive muscle relaxation

Workbook form: Emotions Thermometer; What Helps Me to Relax?

Index Cards

This module may be used if the therapist judges that the teen needs and would likely benefit from training in specific relaxation techniques. It should be used in the context of a regular session. Prior to training in relaxation, elicit agenda, and review homework. Leave sufficient time toward end of session to discuss agenda items and set a homework assignment.

The therapist needs to decide which relaxation technique(s) to introduce. There is no expectation that every technique mentioned in the module will be included in treatment. It is more likely that one or two will prove helpful. Progressive muscle relaxation (PMR) is contraindicated in adolescents with comorbid Panic attacks and is not likely to help those with comorbid Social Phobia. In addition, brief relaxation methods may be more likely to be practiced and used than progressive muscle relaxation among adolescents in general. Nevertheless, progressive muscle relaxation may be quite helpful to some teenagers, including those with comorbid Generalized Anxiety Disorder or insomnia related to inability to decrease tension.

1. ISSUES AND INCIDENTS (including Mood Monitor and ADS)

2. HOMEWORK REVIEW

3. NEW SKILL: RELAXATION

3.a. Rationale for Relaxation: The therapist should offer a rationale for Relaxation training that is consistent with the overall CBT rationale. Relate this skill to issues or incidents that the teenager has brought up in previous sessions or in this session, and demonstrated where in the sequence of events, relaxation could be used.

“As you have mentioned, there are times when you feel ‘stressed out,’ and this feeling makes it hard to cope with Issues or Incidents that come up. Feeling tense can make it hard to keep calm, to use the skills we have been practicing, and to keep from getting depressed.”

“Learning how to relax is a behavior, just like learning to become more involved in pleasant activities, or learning to problem-solve. It is another way we can change our behavior in order to improve our emotions. Also, relaxing is the first step in the RIBEYE method of problem-solving, so relaxing helps us to be good at solving problems.”

“Also, one of the emotions that can lead to depression or go along with depression is when we feel "tense," "uptight", or "stressed out." Relaxation helps us to reduce this feeling of being "stressed out" and so can prevent depression from starting or getting worse.”

For the impulsive teenager, relaxation can be one method used to "slow down" and give the teen a chance to calm down, before deciding on how to behave.

“We have discussed some times when you lose your temper or do something without taking the time to think about the consequences. At times like those, relaxation can help you to slow down and give yourself time to decide what would be best to do.”

3.b. Questioning about Tension: Use Socratic questioning to help the teen see what kinds of situations get them "stressed out." Use Socratic questioning to help the teen see where in their body they tend to feel the tension.

"Different things or situations make different people feel tense. What things or situations make you feel tense? Have you noticed any times when being tense made it harder for you to solve a problem, or get to sleep, or talk to someone you needed to talk to, or get something done you needed to do?"

"Different people feel the tension in different parts of their body. Some people feel it in their stomach, their arms, their forehead, or wherever. Have you noticed any places where you typically feel tense?"

3.c. Spontaneous Relaxation Methods: Explore with the adolescent what are the ways he or she currently uses to relax. Encourage the teenager to continue using effective methods. Explain that the methods to be introduced in this session can be added to the skills that the teen already uses.

- **Refer back to Workbook page z, "What Helps me to Relax?" Ask the teen to check off which of these methods he or she already uses, and how well they work**

3.d. Brief Relaxation Methods: Teach the adolescent one or several methods of relaxing briefly that can be used in stressful situations.

This section of the module (3.d.1-3.d.5) is adapted with permission from Adolescent Anger Control (Feindler, E., & Ecton, R., 1986). When teaching these methods, therapist should use a general sequence of instruction, modeling, behavioral rehearsal, and feedback. In other words, first explain and describe the technique, then demonstrate it, then ask the teenager to practice it with you, and give appropriate feedback and guidance. Anne Marie Albano contributed sections 3.d.6 and 3.f.

3.d.1. Deep Breathing

- Explain that this may be the simplest and quickest way to relax.
- Model deep diaphragmatic breathing with one hand over your stomach, so that the movement of the hand demonstrates the action of breathing.
- Breathe in through the nose, filling the lungs completely. Then breathe out through the mouth in a steady manner.
- Add a cue word, saying it softly aloud. Examples include "relax," "chill out," "go slow," "keep cool."
- Have the adolescent repeat this process for rehearsal, and give feedback and guidance.

3.d.2. Deep Breathing with a Self-Statement

- Add a brief sentence Explain that the teen can use a brief sentence to enhance the deep breathing method and that this can help to focus attention on the self-statement and away from the anxiety or stress-producing event.
- Work with the teen to generate a self-statement likely to help. Examples include "I am calming down," "I am relaxing," "I am keeping my cool."
- Pair this with the Deep Breathing exercise, above.

3.d.3. Deep Breathing with a Self-Statement, Counting Backward

- In this technique, the adolescent is instructed to count backward one number each time she or he breathes out. Begin with 10, and count backward to 1. Beginning at 9, follow each number with a self-statement stating that "I am more relaxed at (current number) than I was at (previous number)."

  "…as you breathe out, first say the number '10.' On the next outward deep breath, say the number '9,' and say aloud 'I am more relaxed at 9 than I was at 10.' "

- Have the teenager move from making the statements aloud, to making them silently to self.

3.d.4. Deep Breathing with Pleasant Imagery

- Ask the teenager to think of a pleasant outdoor scene, such as a beach or mountain scene. The scene needs to be relaxing or pleasing to this teenager.

- Have the teenager describe the scene in detail, including contents, colors, smells, sounds.

- Pair imagination of the pleasant imagery with Deep Breathing.

3.d.5. Leaving the Scene for a Break

- Explain that one method to keep calm is simply to move away from the stress-producing, tension-producing, or anger-arousing situation. Examples include going out for a walk, taking some time alone in a room in the house, or telling someone that you cannot respond to the problem right now, but will talk with them about it later.

- Relate this to issues/incidents brought up in individual or family sessions.

- **For applications to the family, be sure to lay the groundwork for this with parents, before assigning any "Homework" requiring it. In particular, help parents to agree to a "delay" procedure without seeing it as disrespectful.**

3.d.6. Breathing Retraining.

Ask the teen to assume a comfortable position in the chairs and to close his/her eyes, or to focus on one spot either across the room or on the ceiling. If possible, dim the room lights. Speaking in a calm voice, ask the teen to begin to slow their breathing. Tell him/her to picture a tube running from the back of the throat, all the way down into the stomach. At the end of the tube is a balloon. As they breathe in, the balloon fills up and their stomachs expand. As they exhale, the balloon deflates, and their stomach goes flat again. Ask them to focus on filling the balloon with slow, deep breaths, and then letting the air out in a slow exhale. Putting a hand on the stomach, with the little finger laying right on the belly-button helps. The hand should rise and fall with each breath. First, focus on getting the breath deep, so that the stomach expands. Then, begin to slow the breathing. Have the teen count silently and slowly "1-2-3" with each inhale, then pause and count slowly "relax, 2, 3" with each exhale. (Give individual attention as necessary to assist the teen with pacing their breathing). Counting continues to number 10 (1-2-3; relax-2-3; 2-2-3, relax-2-3; 3-2-3, relax-2-3; 4-2-3, relax-2-3; and so on till 10-2-3; relax-2-3). As the deep breathing continues, ask the teen to notice the relaxed feelings that occur. Suggest that this technique can be helpful if they begin to notice tough feelings starting. Repeat the deep breathing for 10-15 minutes.

3.e. Guided Imagery for Relaxation: Spaceship Ride to the Moon and Back

Ask the teen to close her or his eyes, follow your voice, and listen to what you are saying because together you are going to go on a journey. Let the teen know that it is very important that he or she use *imagination and* picture this as vividly as possible.

We are all in our own little spacecrafts. So picture yourself sitting down in the inside of your space capsule. You're strapped into your seat, and you see the control panels lighting up in front of you. It's a very soft and comfortable seat, and you are reclining back and very comfortable. Every part of your body is supported and feels relaxed. If you look out the window you can see that you are on the lauching pad. You hear mission control starting the countdown--TEN, NINE, EIGHT--you brace yourself in your seat because you are going to blast off--SEVEN, SIX, FIVE--you feel the seat starting to rumble a little as the engines are getting all fired up--FOUR, THREE--you can see smoke rising up outside of the window--TWO, ONE, LIFT-OFF!

Feel yourself in that chair, being pulled against gravity as the rocketship is starting to go up and up and up. All you can see out of the windows now is blue sky as you go rocketing farther and farther up. As you continue, the blue sky outside is turning into dark blue, and darker, and darker, and now outside of your window all you can see is space. It is really dark and there are tons of stars in

front of you. You look around your space capsule and you can see the lights of the control panel all lit up in red and green.

You're going further and further up. You're feeling great and you're very excited. Now notice in your body how you're feeling. You're feeling very excited to be up here. You can't believe that you are an astronaut. You begin to look out of the window because you have stopped blasting off and you're just orbiting now. Looking out the window, you can see the earth. Picture the earth. It's a big blue-green ball outside of your window. You're sitting in your chair and now you reach over and unbuckle the straps. Suddenly, you're floating off of your chair. You feel very weightless, and you're just floating and hovering above your chair in your capsule. You're in the middle of space, and you're safe, and everything's working right. The earth is right out there and it looks really beautiful. You're at peace and very calm. You're just floating, and taking in the scenery.

I want you to go through and picture yourself just hovering there; let your mind go through your body. Let your mind wander through your body and see every bit of tension and tightness that you have inside. Anywhere you come across a bit of tension, I want you to tense that part up and let it go, so you can get more and more relaxed. If there's tension in your neck and in your shoulders, tense them up, and then let them go relaxed. You're just gently floating and hovering. Let your mind wander. If there's any tension in your stomach, make it real hard, and then relax it. You might notice your arms are a little stiff, so you tense them up, and then let them fall and hover next to you. You feel comfortable and relaxed. Stretch your legs out as far as they can go, and then let them relax. You're in space and you're at peace. You feel very tranquil. Your mind is clear, and you're just thinking about how good you feel.

You're thinking about how good it feels to just be floating up in space, and as you look out on that big blue-green earth, you know that you will soon being going home. It looks like a wonderful place to go and you're feeling great as you slowly float around inside the space capsule.

Now pull yourself into your seat. You begin to get settled in and you still feel very comfortable. The lights on the control panel are starting to flash because it's time to turn your capsule toward home. The nose of your spaceship begins to turn towards the planet, and you can see the stars getting smaller and smaller as you move away from them. The earth begins to get bigger and brighter in front of you. Outside your front window, you can see white clouds swirling, and then you can see the continents appearing underneath you. The oceans of the earth are sparkling in front of you as you turn around the earth. You come down across California and you cross over the United States as you get closer and closer to home. You land with a gentle bump and you come back here…..You can slowly open up your eyes now

3.f. Progressive Muscle Relaxation (PMR): If clinically indicated, instruct the adolescent in PMR.

This practice should be audiotaped so the teen can take home the tape.

- Have the teen sit in a comfortable chair with arms, and go through systematic progressive muscle relaxation. The therapist may use any variation of PMR that they have previously used successfully. However, they should cover each of the major muscle groups, successively tensing and relaxing them, and helping the teenager to note the difference between the tension and the relaxation. Also, allow some time at the end of the sequence to allow the teen to try to fully and completely relax the body as the therapist names each muscle group in succession. One excellent model for relaxation training with young people is found in Cautela and Groden (1978), p. 21-33. A second model is found in Feindler and Ecton (1986).

- Muscle groups to be included, with corresponding movements:

Hands and forearms	Make a fist
Biceps	Curl (fist up to shoulder)
Triceps	Stretch arm out forward
Neck	Move head from upright to forward, backward, Side positions
Shoulder	Shrug
Stomach	Tense muscles in stomach
Thighs, buttocks	Stretch legs out forward
Calves, feet	Press heels to floor, raising toes
Forehead	Furrow brow
Eyes	Squint
Jaw	Clench

- Each muscle set should be tensed for at least 5 seconds before being relaxed for 10. For example, the teen should be instructed to make a tight fist with the right hand, hold it for 5 seconds and then relax it for 10 seconds. Next, they should be instructed to bring up their arm to tighten the biceps muscles, hold them tight/tense, then relax them, etc.

- After all muscle groups have been systematically tensed and then relaxed, have the teen sit quietly with eyes closed, direct their attention to any muscles which still feel tense, and "tell" those muscles to relax.

- After the training exercise, ask the teen where they noticed any tension in their body, and help determine if this may be a typical place for the teen to feel the tension.

4. CREATING A TAKE-HOME HANDOUT AND HOMEWORK ASSIGNMENT

4.a. Engage the adolescent in a Decision: Decide together which relaxation method(s) to practice during the coming week. On index cards, write brief reminders or guidelines for how to practice the method(s). The audiotape may be used for PMR. Choose times to practice the relaxation skill at least 3 times during the week.

- ❑ **Refer the adolescent to a blank Emotions Thermometer in back of the Workbook.**

4.b. Use Emotions Thermometer: Complete an **Emotions Thermometer**, for tension or a 'stressed out' feeling. A low score (0) would here represent considerable distress, tension, anxiety, and a high score (10), total relaxation. Demonstrate how to rate tension before and after a relaxation practice. Ask the adolescent to rate their tension before and after the 3 Homework practices to measure how well the method works.

5. DISCUSSION OF ISSUES AND INCIDENTS

6. SUMMARIES AND CHECK-IN

Complete form indicating whether teenager completed none, some, or all of last week's Homework assignment

AFFECT REGULATION MODULE

TOPIC CODE: ***AR***

GOALS OF THE MODULE:

1. To enhance the adolescent's ability to control affective arousal or affective lability.
2. To develop a plan with specific steps for coping with situations that trigger intense emotions and, therefore, have been associated with poor coping.

Materials needed

Workbook Form: Emotions Thermometer

Index Cards

This module may be used if the therapist judges that the teenager needs to improve her or his ability to regulate affective arousal or lability. The module assumes that the teenager has already completed the required CBT sessions on Mood Monitoring using the Emotions Thermometer, and on Problem-Solving. Often teenagers can learn Problem-Solving but completely "forget" how to use it when experiencing intense emotional reactions (Brent & Poling, 1997). Affect Regulation skills are designed to help them maintain affective control at a level sufficient to permit use of other coping skills during stressful situations.

Use this module in the context of a regular session structure. Prior to skill training, review Homework and elicit an agenda (Issues and Incidents) for discussion**.**

In this session, parents are encouraged to attend beyond a 10-minute "check-in," because their involvement in the Affect Regulation plan is essential. They may stay through the New Skill portion of the session.

This module is based on the description of affect regulation included in Brent & Poling's (1997) manual, and on the earlier work of Rotheram (1987).

1. ISSUES AND INCIDENTS (including Mood Monitor and ADS)

2. HOMEWORK REVIEW

3. NEW SKILL: KEEPING FEELINGS UNDER CONTROL

3.a. Rationale for Keeping Feelings Under Control: The therapist should offer a rationale for "Keeping Feelings Under Control" that is consistent with the overall

CBT rationale. The key notion is that the adolescent does have some good skills for coping with stress or is in the process of learning these skills. However, it is always harder to put new skills into action when a person is very upset. Therefore, learning how to keep emotions under control will enable the adolescent to use the other skills they have. These may include Problem-Solving, Assertion, Relaxation, Communication, or other skills.

> *"From what you have told me, it is hard for you to remember how to use the skills we have worked on in this program when you get very upset or stressed out. Being able to keep feelings under enough control to use skills is a skill in itself. Let's take some time in this session to work on a way to do that."*

3.b. Relate Emotions Thermometer to Keeping Feelings Under Control: Apply the Emotions Thermometer to the feeling that the teenager labels as leading to loss of control.

- ❑ **Take an unlabeled Emotions Thermometer from the back of the Workbook.**

Take a blank 0 to 10 Emotions Thermometer and ask the teenager to name the way he or she feels when they are about to lose control. For some it will be "stressed," for others "frustrated," for others "angry." Label one end of the Emotions Thermometer with this term, and then label the opposite end "Feeling In Control," or "Relaxed."

At the intermediate points on the Thermometer, ask the teen to identify both **physiological** cues and **psychological or behavioral** ones indicating escalation toward the "out of control" emotion. Tension noticed in the body, notable increases in speech volume or intensity, agitated behavior, tantrums, or slamming doors are some possible examples.

Parents may be very helpful as collaborators in this part of the session, since they can help the teen to notice the signs of escalation.

3.c. Identify Critical Points: Ask the teenager to indicate at what point (number) things have gotten "too hot to handle" or too escalated to permit backing down. Label this as the "Boil Over Point."

Then ask the teen to pick a point and accompanying cues to serve as signals that they need to "do something" to calm down before they get to the previously identified "point of no return." This is the point where they are still able to use their skills or otherwise to avoid an outburst or explosion. Label this as the "Action Point."

3.d. Plan Specific Actions: Work with the teen to identify specific steps they can take at the point where they are still able to control the escalation. These may include behaviors such as taking a walk, going out of the house with a family member, going to the mall, using a "self-soothing" Pleasant Activity, or using any Relaxation technique that works for them.

3.e. Involve the Parents: The parents must be involved in this part of the session or at least informed at the end of the session of the specific steps that the teen plans to take so that they (parents) can cooperate in the plan.

Parents may also need to be guided to avoid doing anything that is likely to escalate the out of control emotions. One of the most common mistakes parents make is doggedly pursuing an argument with a teenager who is about to "blow up." Both sides need to agree to a "cooling off" period and a procedure for doing this.

3.f. Relate This Skill to Other Skills: Work with the teen to "walk through" in imagery an example in which they might have to Keep Feelings Under Control. Clarify with them the links between this skill and others they can use. Make connections with other skills they have demonstrated, at least partially.

If the teenager has shown an ability to Problem-Solve under conditions of less stress, point out that they can then use this skill after they have "cooled off" enough. If they are able to communicate effectively or assert themselves appropriately, show them how these skills can be used **later** in the situation after they have gained control of their emotions.

Identify negative automatic thoughts associated with escalation toward "out of control" feelings and help the adolescent to formulate realistic counter-thoughts.

Any technique used in the CBT manual may be used as an adjunct to "Keeping Feelings Under Control." For example, relevant self-statements or realistic counter-thoughts may be generated and put on index cards for the teen to take home. These can be tailored to counter negative automatic thoughts associated with loss of emotional control.

3.g. Behavioral Rehearsal: Rehearse with the teenager a scenario similar to one that might trigger intense affect, and walk through each step of the plan with her or him.

Select one or two such scenarios that might occur in the near future. Plan for these specific situations by applying the plan to them. In the next session(s) follow-up on how they turned out.

4. CREATING A TAKE-HOME HANDOUT AND HOMEWORK ASSIGNMENT

4.a. Index Cards/Reminders: Create an index card listing each step the teen is to take when their emotions get close to the "Action Point." Include helpful self-statements, and concrete behavioral actions. Create a second, parallel index card for the parent(s), listing what the teen is to do, and how they can assist.

4.b. Decide on a Practice Plan: Work with the teenager to set several times during the week to practice this plan, under conditions of normal stress, not heightened stress. Rehearse with the teenager as needed.

5. DISCUSSION OF ISSUES AND INCIDENTS

As in previous sessions.

6. SUMMARIES AND CHECK-IN

As in previous sessions.

Complete form indicating whether teenager completed none, some, or all of last week's Homework assignment

WEEK TWELVE SESSION: TAKING STOCK

TOPIC CODE: ***TS***

GOALS OF THE SESSION:

1. To review progress toward treatment goals
2. To review cognitive and behavioral skills covered thus far in treatment
3. To determine which skills have been most helpful to this teenager to date
4. To make a general plan for Stage II of TADS CBT

Materials needed:

Workbook forms: Tools in My Backpack; Moving Toward Goals; Challenges Ahead

Therapist's writing material

Therapist's case chart

Index cards

This is the last session of Stage I TADS Acute Treatment. The session must be tailored to the situation of the adolescent, with sensitivity to their progress or lack thereof. Therefore, the scripting may well have to be adjusted depending on the particular adolescent's situation.

In this session, the therapist reviews progress toward goals, and reviews with the teenager the various cognitive and behavioral skills that have been the focus of sessions in Stage I. The task is to help the teenager to identify which "Tools" in the "Backpack" have proven most helpful, and then to anticipate how continued use of those skills can be applied to continued progress toward goals in Stage II. Anticipated challenges that may arise during Stage II should also be identified.

Parents need to be involved at least toward the end of this session, as future plans are discussed.

The Week 12, Independent Evaluator (I/E) visit must be completed before this session begins. The research measures of the patient's status at the end of Stage I are those of the I/E. These measures must be obtained prior to this session, so that they are not biased by Stage II treatment plan decisions discussed in this session.

However, the determination of the treatment plan for the adolescent in Stage II is based on the CGI-Improvement ratings of the care provider(s). Partial responders (CGI Improvement = 3) receive 6 weekly sessions in stage II. Full responders (CGI Improvement = 1 or 2) receive 3 sessions in 6 weeks. Non-responders (CGI 4 or greater) are referred for clinical care in the community, since they have not benefited from the TADS treatment.

For adolescents in CBT alone, the responder status is determined by the CBT therapist. For those in combined CBT and Medication, the CBT therapist and the Pharmacotherapist make the determination jointly. The determination should be made prior to this session, and then discussed with the teenager and parents during the session.

1. ISSUES AND INCIDENTS (including Mood Monitor and ADS)

2. HOMEWORK REVIEW

3. REVIEW OF GOALS

3.a. Rationale for Reviewing Goals: Explain to the adolescent that today's session will lead up to a plan for the next Stage of treatment. Since Stage I ends today, it is a natural time to review with her or him the progress made toward the original treatment goals.

3.b. Review Goals: Review those goals that were listed near the front of the Workbook at the start of treatment, and/or any other goals that have emerged during treatment.

- Work with the teenager to take credit for efforts toward these goals, and to notice small steps toward the goals, especially if progress has been slower.

3.c. Combat Perfectionism or Hopelessness: The teen may feel that they have not accomplished enough or made enough progress. Refer back to the point in the treatment rationale that some progress is better than no progress, and that progress can now continue in Stage II and beyond. Continued practice using the cognitive and behavioral "tools" in the "backpack" will make further progress possible.

For adolescents who have not responded to this treatment, review alternative treatments. These include different types of psychotherapy and different medications. Help them to understand that they may well get better with another treatment.

3.d. Identify Further Steps: Help the teenager to identify steps toward goals that can now be taken as Stage II begins, or as referral for treatment in the community begins.

- ❑ **Refer the adolescent to a copy of the Workbook form, "Moving Toward Goals," in the back of the Workbook and ask them to fill in steps they can take in the next several weeks to continue progress toward goals.**

- ❑ **Refer to the Workbook form on p. yy, "Tools in My Backpack."**

4.a. List Covered Skills: List on the form, Tools in My Backpack, those skills that have been covered in Stage I with this teenager.

The tools may include:

Mood Monitoring	Recognizing Cognitive Distortions
Goal-Setting	Realistic Thinking
Increasing Pleasant Activities	
Problem-Solving	Meeting, Greeting, and Joining
Assertiveness	Communication and Compromise
Relaxation	Keeping Feelings Under Control
Family Pleasant Activities	Family Problem-Solving

Discussing problems or issues with my family in family sessions
Other specific skills

4.b. Review What Helped: Review each skill and ask the teenager if the skill proved to be helpful for her or him.

- Use Socratic questioning to probe what was most helpful.
- Mark with a check mark or other symbol on the form, Tools in My Backpack, those skills that have proven most helpful.
- Spend some time reviewing the positive changes the teenager has noticed in herself or himself as they have learned how to use these new tools.

5. PREPARE FOR STAGE II

5.a. Discuss Treatment Plan: Discuss the schedule of sessions, and engage the adolescent in preliminary decisions about focus of those sessions. For non-responders, discuss the plan to refer to another provider.

5.b. Anticipate Challenges: Anticipate with the adolescent any challenges or stressors that may be coming up in the next 6 weeks. This serves to foreshadow Week 18 Relapse Prevention at end of Stage II.

"What are the events or situations most likely to get you upset or to trigger off negative emotions over the next 6 weeks?"

"Either big events or little daily problems can upset us, trigger off negative automatic thoughts and negative emotions. Over the next 6 weeks, as we are working in Stage II of the treatment, what big events might happen in your life? What daily problems might get you upset?"

Big events might include those related to health of loved ones, moving, changing schools, changing friends, graduating, changes in family.

Daily problems can be inquired about with reference to home, school, friends.

- ❑ **List anticipated challenges on the form provided in the Workbook on p. zz, "Challenges Ahead."**

5.c. Apply Tools to Challenges: Plan how to use the Tools to cope with these challenges or stressors.

"Let's suppose that that problem does happen. How would you use the Tools in your Backpack to deal with it?"

- Use Index Cards to write down cues or guidelines to help in using the Tools when facing the challenges.

6. DISCUSSION OF ISSUES AND INCIDENTS

7. SUMMARIES AND CHECK-IN

- Let the teenager and parents know you have enjoyed working with them and, for those continuing in TADS, that you look forward to continuing with them.

Complete form indicating whether teenager completed none, some, or all of last week's Homework assignment

General Guidelines for Stage II of TADS CBT (Weeks 13-18):

Purpose of Stage II:

Stage II of TADS focuses on consolidation and/or generalization of treatment gains. However, there are some important differences in how stage II is conceptualized and operationalized, and these differences depend on whether an adolescent is a full responder or a partial responder to Stage I treatment.

For full responders, Stage II focuses on maintenance of gains already realized, on generalization of Stage I learning across time and situations, and on relapse prevention.

For partial responders, Stage II addresses residual symptoms, and is intended to continue new learning as well as maintain gains, foster generalization, and prevent relapse.

Scheduling:

Full responders at the end of Stage I receive 3 sessions of 50 minutes duration during the six weeks of Stage II.

Partial responders at the end of Stage I receive 6 weekly sessions of 50 minutes duration during Stage II.

Content of Sessions:

Sessions in Stage II are minimally scripted to allow maximum individualization of treatment. At Week 18, however, the Relapse Prevention material must be included.

For full responders, no new skill training is introduced during Stage II. Therapist and adolescent continue to work with those skills that have proven most helpful during Stage I.

For partial responders, new skill training may be included. Any skill that is included in the TADS CBT manual for Stage I sessions may be the focus of a Stage II session for partial responders.

Family and Individual Sessions:

There is considerable flexibility during Stage II regarding family versus individual CBT sessions. The guideline is that a minimum of one and a maximum of three

sessions during Stage II are expected to be family sessions. The judgment of the treating clinician and CBT supervisor is the basis for deciding how many sessions to allot to family work.

If the therapist and supervisor wish to allot more than three sessions to family therapy for partial responders, they must request this from the weekly CBT Supervisor's Conference Call. If the therapist and supervisor wish to allot all three sessions to individual therapy for full responders, they must, similarly, request this from the Conference Call.

The Week 18 Session on Relapse Prevention must include parents for at least part of the session, so that the relapse prevention plan can be developed with their cooperation and knowledge.

Therapists who rely heavily on individual sessions and minimize family sessions during Stage II must conduct parent "check-ins" prior to at least half of the individual sessions, so that the parent(s)' perspective and involvement is not lost during this Stage.

Using a Relapse Prevention Framework:

Although one session (Week 18 Session) is specifically devoted to the Relapse Prevention Plan, key concepts in relapse prevention should be woven into sessions during Stage II, where possible. (See sections 4,5,6,7, & 8 of the Week Eighteen Session: Relapse Prevention where these key concepts are discussed). In addition, the Week 12 Session will have laid the groundwork for Relapse Prevention by anticipating sources of stress and planning how to respond. Other key concepts in Relapse Prevention include distinguishing between a lapse or "slip" and a relapse; noticing the first signs of a "slip;" identifying sources of social support; making a Relapse Prevention Plan that includes the role of the parents; and practicing (through role-playing) how to respond to anticipated stressors.

To enable the therapist to prepare the adolescent fully for the transition to Stage III of TADS (Longer Term Maintenance Treatment) these key concepts in Relapse Prevention should be introduced during Stage II and completed or consolidated in a Relapse Prevention Plan completed at the Week 18 Session. Therefore, it is necessary for the therapist to review and become familiar with the Week 18 Session material prior to the start of Stage II (see pp. 138-143).

Completing the ADS

The Affective Disorders Screen (ADS) must be completed by the adolescent prior to all Stage II sessions, and reviewed by the therapist.

FULL RESPONDERS

STAGE II TADS CBT

CONSOLIDATION AND GENERALIZATION SESSIONS 1 AND 2

TOPIC CODE: ***M1 OR M2***

Participants: This can be an individual or a family session.
See General Guidelines for Stage II.

1. ISSUES AND INCIDENTS (including review of ADS)

- Check on symptoms
- Any old symptoms recurring?
- Any new symptoms?
- What (individual or family) skills did you use?
- What (individual or family) skills do you think might have been helpful?
- Reinforce efforts to apply skills to challenges

2. HOMEWORK REVIEW (if applicable)

3. SKILL REVIEW AND GENERALIZATION/WORKING ON ISSUES AND INCIDENTS

- Help the adolescent to see how any new challenges might be met through use of cognitive or behavioral skills he or she learned in Stage I of treatment.
- Continue the process of having the adolescent be her or his own therapist, through self-identification and self-modification of automatic thoughts, beliefs, or attributions
- Do not introduce any new skills

3.a. Anticipation of relapse prevention

- Apply any of the key concepts in Relapse Prevention to the material brought into session by adolescent, as appropriate:

- Distinguish a “Lapse” or “Slip” from a “Relapse”
  A lapse or slip is a brief, perhaps expectable re-appearance of one or a few symptoms; a relapse is a return to a persistent depressive syndrome
- Avoid “catastrophizing” if a “slip” or “lapse” occurs

Don’t assume that, because one or two symptoms briefly flare up, this means nothing has been gained by all the work done in Stage I

- Identify first signs of a “Slip”
  What are the likely initial symptoms for this teenager?
  What were the first symptoms in her or his previous depression?
- Identify the behavioral skills and realistic counter-thoughts that helped before in overcoming depression
  Help the teenager or family to apply these skills and cognitions to counter the “slip.”
- Identify sources of social support
- Identify ways that parents can help
- Plan how to meet anticipated challenges in the weeks ahead
- Enact the plan through role-playing responses to anticipated challenging situations

4. HOMEWORK

Plan for the two weeks ahead, using a tailored Homework assignment.

5. SUMMARIES AND CHECK-IN

Proceed as in previous sessions

Reminder: Complete the form indicating whether the teen completed none, some, or all of this week’s Homework, if Homework was assigned.

PARTIAL RESPONDERS

STAGE II TADS CBT

CONSOLIDATION AND GENERALIZATION SESSIONS 1 THROUGH 5

TOPIC CODE: ***M1, 2, 3, 4, OR 5***

OR USE TOPIC CODE FOR NEW SKILL INTRODUCED

Participants: This can be an individual or a family session. See General Guidelines for Stage II.
If parents are not involved in the session, be sure to have parent check-ins at least biweekly.

1. ISSUES AND INCIDENTS (including review of ADS)

- Check on symptoms
- Any old symptoms recurring?
- Any new symptoms?
- What (individual or family) skills did you use?
- What (individual or family) skills do you think might have been helpful?
- Reinforce efforts to apply skills to challenges

2. HOMEWORK REVIEW

3. SKILL REVIEW AND GENERALIZATION AND/OR NEW SKILL

- Help the adolescent to see how any new challenges might be met through use of cognitive or behavioral skills from Stage I of treatment.
- **Teach a skill from the Stage I section of the manual, which was not completed during Stage I, if in the therapist's judgment, it is likely to be helpful for this adolescent**.
- Continue the process of having the adolescent become her or his own therapist, through self-identification and self-modification of automatic thoughts, beliefs, or attributions

4. WORKING ON ISSUES AND INCIDENTS

Apply cognitive and behavioral skills to material generated in Issues and Incidents section of session.

4.a. Identify the Most Helpful Tools: Continue the process of helping the adolescent to see which of the various skills are most helpful to her or him.

4.b. Anticipation of Relapse Prevention: For partial responders, introduce relapse prevention at suitable points during Stage II. Adjust the relapse prevention material to the adolescent's stage of recovery. For example, when the adolescent is still in a depressive episode, obtaining social support and identifying ways that parents can help may be more relevant than distinguishing between a lapse and a relapse. As recovery continues, the latter distinction is likely to become more relevant.

- Apply any of the key concepts in Relapse Prevention to the material brought into session by adolescent, as appropriate:

    - Distinguish a "Lapse" or "Slip" from a "Relapse"
        A lapse or slip is a brief, perhaps expectable re-appearance of one or a few symptoms; a relapse is a return to a persistent depressive syndrome
    - Avoid "catastrophizing" if a "slip" or "lapse" occurs
        Don't assume that, because one or two symptoms briefly flare up, this means nothing has been gained by all the work done in Stage I
    - Identify first signs of a "Slip"
        What are the likely initial symptoms for this teenager?
        What were the first symptoms in her or his previous depression?
- Identify the behavioral skills and realistic counter-thoughts that helped before in overcoming depression
        Help the teenager or family to apply these skills and cognitions to counter the "slip."
    - Identify sources of social support
    - Identify ways that parents can help
    - Plan how to meet anticipated challenges in the weeks ahead
    - Enact the plan through role-playing responses to anticipated challenging situations

5. HOMEWORK

Plan for the week ahead, using a tailored Homework assignment. Continue Homework assignments during Stage II.

6. SUMMARIES AND CHECK-IN

Proceed as in previous sessions

Reminder: Complete the form indicating whether the teen completed none, some, or all of this week's Homework.

WEEK EIGHTEEN SESSION: RELAPSE PREVENTION
TOPIC CODE: ***RP***

GOALS OF THE SESSION:

1. To review progress toward goals.
2. To complete Relapse Prevention plan, including the parents in the plan.
3. To make a general plan for Stage III of TADS CBT

Materials needed:

Workbook forms: Tools in My Backpack; Challenges Ahead; What is Depression?

Therapist's writing material

Therapist's case chart

Index cards

This is the last session of TADS Stage II Treatment. The session must be tailored to the situation of the adolescent, with sensitivity to their progress or lack thereof. Therefore, the scripting may have to be adjusted depending on the particular adolescent's situation.

Parents need to be involved at least toward the latter half of this session	**so that they can participate in the final Relapse Prevention plan.**

The Week 18 Independent Evaluator (I/E) visit must be completed before this session begins. The research measures of the patient's status at the end of Stage II are those of the I/E. These measures must be obtained prior to this session, so that they are not biased by Stage II treatment or referral planning decisions discussed in this session.

At the end of Stage II, any decision to end TADS treatment (premature termination) or to recommend additional or different treatments, should be handled through an ASAP procedure/ASAP session.

1. **ISSUES AND INCIDENTS (including review of ADS)**
2. **HOMEWORK REVIEW (if applicable)**

3. REVIEW OF GOALS AND PROGRESS

3.a. Rationale for Reviewing Goals and Progress: Explain that this is the last session of Stage II TADS CBT, and that this is a natural time to review how things have been going, whether things are better, and what to plan next.

3.b. Review Goals: Review those goals that were listed near the front of the Workbook at the start of treatment, and/or any other goals that have emerged during treatment.

- Work with the teenager to take credit for efforts toward these goals, and to notice small steps toward the goals, especially if progress has been slower.

3.c. Combat Perfectionism or Hopelessness: The teen may feel that they have not accomplished enough or made enough progress. Refer back to the point in the treatment rationale that some progress is better than no progress, and that progress can now continue in Stage II and beyond. Continued practice using the cognitive and behavioral "tools" in the "backpack" will make further progress possible.

For adolescents who have not responded to this treatment, review alternative treatments. These include different types of psychotherapy and different medications. Help them to understand that they may well get better with another treatment.

3.d. Review Positive Changes in Adolescent and Family: Take some time to help the adolescent and parents to identify any improvements that the teen has made or the family has made during treatment. Have there been improvements in relationships, in attitudes toward school or work, in any targeted treatment area? Help the adolescent and parents take credit for these changes.

3.e. Identify Further Steps: Help the teenager to identify steps toward goals that can now be taken as Stage III begins, or as referral for treatment in the community begins.

4. REVIEW OF COGNITIVE AND BEHAVIORAL SKILLS

- ❑ **Refer adolescent to new copy of Workbook p. yy, "Tools in My Backpack."**

4.a. Briefly Review Skills: As was done in Week 12, list on the form those skills that have been covered with this teenager, either in Stage I or Stage II. Since a similar review was done at Week 12 with reference to Stage I, this review can probably be done relatively quickly.

The tools may include:

Mood Monitoring	Recognizing Cognitive Distortions
Goal-Setting	Realistic Thinking
Increasing Pleasant Activities	
Problem-Solving	Meeting, Greeting, and Joining
Assertiveness	Communication and Compromise
Relaxation	Keeping Feelings Under Control
Family Pleasant Activities	Family Problem-Solving

Discussing problems or issues with my family in family sessions or meetings
Other specific individual or family skills

4.b. Review What Helped: Briefly review each skill and ask the teenager if the skill proved to be helpful.

- Check on the form, Tools in My Backpack, those skills that have proven most helpful.

5.ANTICIPATING STRESSORS DURING NEXT 18 WEEKS:

5.a. Identify Possible Sources of Stress and Ways to Cope: Help the adolescent and parents to anticipate challenges ahead.

> *"As we have gone through this treatment, you and I have noticed what situations are most likely to lead you to get depressed. We have worked to understand how these situations trigger off feelings or thoughts that lead to depression. What we want to do now is plan how to deal with those kinds of situations if they come up."*
>
> *"Let's try to anticipate what situations or events you are likely to face in the next several months which would put you at risk of having a 'relapse' of depression. Then we can plan how you will cope with these situations if they come up."*

- ❑ **Refer adolescent to new copy of Workbook p. zz, "Challenges Ahead."**

- Ask the adolescent to write down anticipated major events or routine problems in the months ahead.

5.b. Identify Ways to Cope: Work with teen and parents to identify how they will cope with stress in coming months.

- Identify helpful "Tools" in the backpack to apply to anticipated sources of stress.

- Identify helpful self-statements or other realistic counter-thoughts.

- Ask teenager to write down the most helpful tools to use in the column on Challenges Ahead.

6. OBTAINING SUPPORT AND HELP

6.a. Identify Helpful People or Groups: Therapist should focus some of the discussion at this point on identifying sources of social support, and on asking for help.

> *"Once you have identified someone who might help you to cope, think about what kind of help you would want, and how to ask for it. For example, you might want someone to talk to, someone to help you to problem-solve, someone to help you with school or other jobs or tasks."*

7. DISTINGUISHING A LAPSE FROM A RELAPSE

7.1.Review Symptoms of Depression: Using the workbook form, **What is Depression**, review with teenager and parents the symptoms of depression. Identify those that tend to be the most likely symptoms for this adolescent, which might signal the beginning of a depression? Which symptoms occurred earliest in the previous depression?

- **Refer adolescent and parents to Workbook pp. a & b, "What is Depression?"**

7.2. Distinguish Between a Lapse or 'Slip' and a Relapse: Discussion should focus on the difference between a lapse and a relapse. A lapse is a one time, brief step backwards. It might be signaled by the start of one or several symptoms. A relapse is a full move back into depression.

- A lapse does not necessarily turn into a relapse.
- If you notice the beginning of one or several symptoms, then is the time to use the tools you have learned in this program to prevent getting back into a "Downward Spiral."
- Don't Catastrophize

"Sometimes a teenager who has overcome depression starts to get depressed again and thinks "Oh, no, I'm going to get just as badly depressed as I was before I ever started the treatment program."

"But this is a cognitive distortion. Do you remember the name of this distortion?" (Catastrophizing)

8. A RELAPSE PREVENTION PLAN

Outline with the parents and the adolescent the steps they will each take to prevent a relapse, or to keep a "lapse" from turning into a relapse.

- Both the teenager and the parent should periodically check on the adolescent's mood. Review how this particular adolescent experiences or demonstrates declining mood. Is it by way of social withdrawal, overt sadness, irritability, or other symptoms? Discuss with the adolescent and parent what would be a comfortable, non-intrusive way of "checking" on the adolescent's mood on some regular basis.
- Help them to review the symptoms that were present before treatment started, and to recall what symptoms were the "first signs," in retrospect, of depression. These may well serve as warning signs of a possible relapse, and should trigger use of the relapse prevention plan.
- Include "tools" for the adolescent to use, "tools" for the parents and adolescent to use together, and other sources of social support, for use in dealing with future stressful situations, and for use in response to initial signs of a "lapse."
- Put key steps and key tools on an index card for future reference.
- Encourage the adolescent who is continuing into Stage III to use continuing treatment sessions, and if necessary, to contact the therapist for help between sessions.
- If, in the future, the teenager seems to be moving from a "lapse" into a "relapse," encourage the parent and teenager to contact the therapist.

9. BEHAVIORAL REHEARSAL

Practice, through role-playing, how to use the Relapse Prevention Plan in the face of an anticipated challenge.

10. ENDING STAGE II AND REVIEWING THE SCHEDULE FOR STAGE III

- Explain to the parent and adolescent that ending treatment is sometimes associated with a temporary return of the initial symptoms. If symptoms do recur, the teenager and parent should try to use the Relapse Prevention Plan. It is likely that this will be an effective way to overcome the symptoms. The teenager or parent should feel free to contact the therapist, however, if the symptoms persist.
- Let teenager and parents know that you have enjoyed working with them, and, for those continuing into Stage III, that you look forward to continued work together.

- Reinforce the notion that the teen has learned skills that will enable her or him to be their own therapist in many situations or circumstances.
- Allow adolescent and parents to share range of emotions about ending this part of treatment. These can include relief at completing this part of the program and having more free time, sadness at leaving regular, frequent contact with the therapist, anxiety about the ability to maintain gains, or other reactions.
- Review schedule for Stage III. Sessions are scheduled once every 6 weeks, for 50 minutes in duration. Clinical judgment determines whether the sessions are to be individual or family sessions.
- Make a preliminary determination of whether the first Stage III visit is likely to be most helpful as an individual or a family session. The therapist may also call the adolescent and/or parent during the week before that scheduled session to finalize that decision.

General Guidelines for Stage III of TADS CBT (Weeks 19-36)

Purpose of Stage III:

Stage III of TADS focuses on maintenance of treatment gains, on continued generalization, and on prevention of relapse.

Scheduling:

All study participants who proceed to Stage III receive three sessions of 50 minutes duration. Sessions are held every 6 weeks.

Content of Sessions:

Sessions in Stage III are minimally scripted to allow maximum individualization of treatment.

No new skill training can be introduced during Stage III. Adolescents and parents should continue, however, to apply the skills learned during Stage I (or for partial responders, during Stages I and II) to problems, issues or incidents that occur during Stage III.

Relapse prevention is a central purpose of Stage III. The Relapse Prevention Plan formulated at the Week 18 session should serve to guide some of the session content. The plan may be updated and revised as indicated.

Family and Individual Sessions:

Both the adolescent and the parents should remain involved in treatment during Stage III. The therapist's clinical judgment guides the decisions about how many individual and how many family sessions to schedule out of the total of three sessions. If individual sessions are held, it is recommended that parents be seen for a "check-in" at the start of sessions, to retain their perspective and to help them to assist in the Relapse Prevention Plan.

Phone Calls:

Since there are 6 weeks between sessions, the therapist may telephone the adolescent and/or parents within the week prior to a scheduled session, to obtain a brief update that might assist in determining whether to have an individual or family session. These calls should not exceed 10 minutes in duration.

Using ASAP Sessions:

As is the case during other Stages of TADS, a limited bank of ASAP sessions may be used during Stage III to deal with crises and to prevent attrition. See the manual entitled “Adverse Event Monitoring and Adjunctive Services and Attrition Prevention (ASAP) in the NIMH Treatment of Adolescent Depression Study” for further details.

Completing the ADS:

The Affective Disorders Screen must be completed by the adolescent prior to all Stage III visits, and reviewed by the therapist.

STAGE III TADS CBT

MAINTENANCE, GENERALIZATION AND RELAPSE PREVENTION SESSIONS 1, 2, 3

TOPIC CODE: **S3**

Participants: This can be an individual or a family session. If it is an individual session, parents should be seen for a "check-in" at the outset. They may also be seen near the end of the session, to assist in applying the Relapse Prevention Plan over the coming 6 weeks. See General Guidelines for Stage III.

1. ISSUES AND INCIDENTS (including review of ADS)

1.a. Symptom Review

- Check on symptoms
- Any old symptoms recurring?
- Any new symptoms?

1.b. Key Incidents. Ask the adolescent to describe any situations that were associated with depressed mood or symptoms. Apply the CBT model to help the teen further understand the relationships between behaviors, thoughts, and emotions in these situations.

1.c. Maintain Perspective. Reassure the adolescent and/or parent(s) that a brief "lapse" or re-emergence of some depressive symptoms is expectable, and that "relapse" can usually be prevented, by applying the skills learned in CBT. A "lapse" does not imply that the gains during Stages I and II are all lost.

2. HOMEWORK REVIEW (Review of Relapse Prevention Plan)

Treatment during Stage III is guided to some extent by the Relapse Prevention Plan. Review the elements of this adolescent's Relapse Prevention Plan, to reinforce the various components or steps in the plan. Inquire about successes in using the plan, and about any barriers that arose to prevent using the plan.

In relation to any incidents that were associated with depressive symptoms, ask the adolescent (and parent(s)):

- What (individual or family) skills did you use?
- What (individual or family) skills do you think might have been helpful?

Reinforce efforts to apply skills to challenges

3. SKILL REVIEW AND GENERALIZATION/WORKING ON ISSUES AND INCIDENTS

- Help the adolescent or family to see how the incidents or challenges brought up in session might be met through use of individual or family cognitive or behavioral skills from Stage I (or Stage II for partial responders) of treatment.
- Take ample time to help the adolescent or family to apply the cognitive and behavioral skills learned in Stage I (and in Stage II for partial responders) to material brought into this session.
- Build upon the adolescent's previous successes or strengths.
- Continue to label the skills to facilitate recall.
- Refer back to the Workbook page yy on "Tools in My Backpack" that was completed in the Week 18 session, to help the adolescent recall what skills were most helpful before.
- **Do not introduce any new skills during Stage III**.

For the adolescent who has been receiving medication as well as CBT, emphasize that the changes in behavior and in thinking that the adolescent has made in CBT have played a major role in reducing depression. Help the teenager to make internal attributions regarding the impact of her or his own effort and new skill development on reducing depression. Challenge attributions that all improvement was due to medication. These can be further examples of a depressive attributional style for positive events.

4. HOMEWORK (Anticipating use of the Relapse Prevention Plan)

Plan for the six weeks ahead, by anticipating any upcoming challenges, and by applying the Relapse Prevention Plan to those anticipated challenges.

- Apply any of the key concepts in Relapse Prevention to the anticipated challenges:
  - Distinguish a "Lapse" or "Slip" from a "Relapse"
    A lapse or slip is a brief, perhaps expectable re-appearance of one or a few symptoms; a relapse is a return to a persistent depressive syndrome
  - Avoid "catastrophizing" if a "slip" or "lapse" occurs
    Don't assume that, because one or two symptoms briefly flare up, this means nothing has been gained by all the work done in Stage I
  - Identify first signs of a "Slip"
    What are the likely initial symptoms for this teenager?
    What were the first symptoms in her or his previous depression?
- Identify the behavioral skills and realistic counter-thoughts that helped before in overcoming depression
    Help the teenager or family to apply these skills and cognitions to counter the "slip."

- Identify sources of social support
- Identify ways that parents can help

Put key steps and key tools from the Relapse Prevention Plan on an index card for reference in the weeks ahead.

5. ROLE-PLAY COPING WITH AN ANTICIPATED CHALLENGE

Role-play enactment of the Relapse Prevention Plan using one anticipated or possible stressor.

6. SUMMARIES AND CHECK-IN

Proceed as in previous sessions

7. ANTICIPATE NEXT SESSION

After the first and second Stage III sessions, make a preliminary determination of whether the next session will be an individual or a family session. Therapist may telephone adolescent and/or parents during the week proceeding that session to make final decision.

References

Alexander, J.F. (1973). Defensive and supportive communications in normal and deviant families. Journal of Consulting and Clinical Psychology, 40, 223-231.

Abramson, L.Y., Seligman, M., & Teasdale, J. (1978). Learned helplessness in humans: Critique and reformulation. Journal of Abnormal Psychology, 87, 49-74.

American Psychological Association. (1990). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. Washington, DC: Author.

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. Psychological Review, 84, 191-215.

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). Cognitive therapy of depression. New York: Guilford.

Beck, A.T., Wright, F.D., Newman, C.F., & Liese, B.S. (1993). Cognitive therapy of substance abuse. New York: Guilford.

Blatt, S., Quinlan, D., Pilkonis, P., Shea, T.(1995). Impact of perfectionism and need for approval on the brief treatment of depression: The NIMH Treatment of Depression Collaborative Research Program revisited. Journal of Consulting and Clinical Psychology, 63, 125-132.

Botvin, G. (1989). Life skills training teacher's manual. New York: Cornell Medical Center.

Brent, D. & Poling, K. (1997). Cognitive therapy treatment manual for depressed and suicidal youth. Pittsburgh, PA: University of Pittsburgh.

Brent, D., Holder, D., Kolko, D., Birmaher, B., Baugher, M., Roth, C., Iyenger, S., & Johnson, B. (1997) A clinical psychotherapy trial for adolescent depression comparing cognitive, family, and supportive treatments. Archives of General Psychiatry, 54, 877-885.

Brent, D., Kolko, D., Birmaher, B., Baugher, M., & Bridge, J. (1999). A clinical trial for adolescent depression: Predictors of additional treatment in the acute and follow-up phases of the trial. Journal of the American Academy of Child and Adolescent Psychiatry, 38, 263-270.

Burns, D. (1980). Feeling Good. New York: Signet.

Carroll, K. (1998). Therapy manuals for drug addiction: A cognitive-behavioral approach: Treating cocaine addiction. Rockville, MD: NIDA.

Carver, C.S., & Scheier, M.F. (1996). Perspectives on personality. Needham Heights, MA: Allyn & Bacon.

Cautela, J., & Groden, J. (1978). Relaxation: A comprehensive manual for adults, children, and children with special needs. Champaign, IL: Research Press Company.

Clarke, G., Lewinsohn, P., Hops, H. (1990) Instructor's manual for the Adolescent Coping with Depression Course. Eugene, OR: Castalia Press.

Clarke, G., Rohde, P., Lewinsohn, P., Hops, H., & Seeley, J (1999). Cognitive-behavioral treatment of adolescent depression: Efficacy of acute group treatment and booster sessions. Journal of the American Academy of Child and Adolescent Psychiatry, 38, 272-279.

Cole, D.A., & Rehm, L.P. (1986). Family interaction patterns and childhood depression. Journal of Abnormal Child Psychology, 14, 297-314.

Curry, J.F., & Craighead, W.E. (1990a). Attributional style and self-reported depression among adolescent inpatients. Child and Family Behavior Therapy, 12, 84-93.

Curry, J.F. & Craighead, W.E. (1990b). Attributional style in clinically depressed and conduct disordered adolescents. Journal of Consulting and Clinical Psychology, 58, 109-115.

Curry, J., Wells, K., Craighead, W.E., Lochman, J., & Nagy, P. (1997). Manual for group treatment of depressed, substance abusing adolescents. Durham, NC: Duke University.

Emslie, G.J., Rush, A.J., Weinberg, W.A., Kowatch, R.A., Hughes, C.W., Carmody, T., & Rintelmann,J. (1997). A double-blind, randomized, placebo-controlled trial of fluoxetine in children and adolescents with depression. Archives of General Psychiatry, 54, 1031-1037.

Emslie, G.J., Rush, A.J., Weinberg, W.A., Kowatch, R.A., Carmody, T., & Mayes, T.L. (1998). Fluoxetine in child and adolescent depression: Acute and maintenance treatment. Depression and Anxiety, 7, 32-39.

Feindler, E., & Ecton, R. (1986). Adolescent anger control. New York: Pergamon.

Forehand, R., McCombs, A., Long, N., Brody, G., & Fauber, R. (1980). Early adolescent adjustment to recent parental divorce. Journal of Consulting and Clinical Psychology, 56, 624-627.

Garber, J., Weiss, B., & Shanley, N. (1993). Cognitions, depressive symptoms, and development in adolescents. Journal of Abnormal Psychology, 102, 47-57.

Haley, G., Fine, S., Marriage, K., Moretti, M., & Freeman, R. (1985). Cognitive bias and depression in psychiatrically disturbed children and adolescents. Journal of Consulting and Clinical Psychology, 53, 535-537.

Kaslow, N, & Thompson, M. (1998). Applying the criteria for empirically supported treatments to studies of psychosocial interventions for child and adolescent depression. Journal of Clinical Child Psychology, 27, 146-155.

Kazdin, A., & Weisz, J. (1998). Identifying and developing empirically supported child and adolescent treatments. Journal of Consulting and Clinical Psychology, 66, 19-36.

Kendall, P., Chu, B., Gifford, A., Hayes, C., & Nauta, M. (1998). Breathing life into a manual: Flexibility and creativity with manual based treatments. Cognitive and Behavioral Practice, 5, 177-198.

Lewinsohn, P., Clarke, G., Hops, H., & Andrews, J. (1990). Cognitive-behavioral group treatment of depression in adolescents. Behavior Therapy, 21, 385-401.

March, J. (2000). Cognitive behavior therapy. In B. Sadock & V. Sadock (Eds.). Comprehensive Textbook of Psychiatry, VII, Vol. 2, 2806-2813.

March, J.S., Foa, E. Franklin, M. & Kozak, M. (1998). Treatment of pediatric obsessive-compulsive disorder: Cognitive behavior therapy treatment manual. Durham, NC: Duke University.

Mufson, L., Weissman, M., Moreau, D., & Garfinkel, R. (1999). Efficacy of interpersonal psychotherapy for depressed adolescents. Archives of General Psychiatry, 57, 573-579.

Otto, M.W. (2000). Stories and metaphors in cognitive-behavior therapy. Cognitive and Behavioral Practice, 7, 166-172.

Reinecke, M., Ryan, N., & DuBois, D. (1998). Cognitive-behavioral therapy of depression and depressive symptoms during adolescence: A review and meta-analysis. Journal of the American Academy of Child and Adolescent Psychiatry, 37, 26-34.

Robin, A.L., & Foster, S.L. (1989). Negotiating parent adolescent conflict. New York: Guilford.

Rogers, C. (1951). Client-centered therapy. Boston: Houghton Mifflin Co.

Rotheram, M. (1987). Evaluation of imminent danger for suicide among youth. American Journal of Orthopsychiatry, 57, 102-110.

Rotter, J. B. (1966). Generalized expectancies for internal versus external control of reinforcement. Psychological Monographs, 80 (1, Whole No. 609).

Schwartz, C.F., Dorer, D.J., Beardslee, W.R., Lavori, P.W., & Keller, M.B. (1990). Maternal expressed emotion and parental affective disorder: Risk for childhood depressive disorder, substance abuse, or conduct disorder. Journal Psychiat. Res., 24, 231-250.

Weisz, J.R., Stevens, J.S., Curry, J.F., Cohen, R., Craighead, W.E., Burlingame, W.V., Smith, A., Weiss, B., & Parmelee, D.X. (1989). Control-related cognitions and depression among inpatient children and adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 28, 358-363.

Wells, K, & Curry, J. (1997). Manual for family therapy with depressed, substance abusing adolescents. Durham, NC: Duke University.

Wilkes, T., & Rush, A. (1988). Adaptations of cognitive therapy for depressed adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 27, 381-386

Wilkes, T., Belsher, G., Rush, A.J., & Frank, E. (1994). Cognitive therapy for depressed adolescents. New York: Guilford.

Youniss, J., & Smollar, J. (1985). Adolescent relations with mothers, fathers, and friends. Chicago: University of Chicago Press.

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Treatment for Adolescents with Depression Study (TADS)

Cognitive Behavior Therapy Manual

Parent and Conjoint Parent-Adolescent Sessions

Karen C. Wells and John F. Curry

March 15, 2000

Introduction to Parent and Conjoint Parent-Adolescent Sessions

The first two sessions in this manual are parent psychoeducational meetings. They are designed to be held during Week 3 and Week 5 of TADS CBT, back-to-back with an individual adolescent session.

The remaining sessions in this manual are conjoint family session modules. These may be the "Topic" or focus of skill training during Phase 3 of Stage I and, for partial responders, during Stage II of TADS CBT. They are not in any recommended order. The therapist chooses which module(s) to use and chooses the order. No new "Topics" or skills may be introduced for full responders during Stage II, or for any participants during Stage III. However, any of these family skills that are introduced and taught in Stage I or, for partial responders, in Stage II, become "Tools in the Backpack" that may be reviewed and applied during Stages II and III.

It is important to note that the therapist needs to review, and in cases of CBT-only treatment, to complete the **Affective Disorders Screen** at the beginning of these conjoint family sessions. The therapist must also complete the form indicating whether the adolescent completed all, part, or none of the Homework assigned in the previous week. In general, the therapist needs to follow the general outline for CBT sessions whether the session is individual or conjoint. The therapist also needs to complete the CBTA checklist and pp. 1-3 of the CBT-QA form after each session.

Guidelines for choosing modules are included in the accompanying **Cognitive Behavior Therapy Manual***: Introduction, Rationale, and Adolescent Sessions*.

Psychoeducation of the parents has been shown to be extremely important in retaining depressed adolescents in treatment (Brent, personal communication). It is important for parents to understand what depression looks like in their adolescent, and that it is a disorder or illness. As an illness, depression is not under the teenager's control, and the teenager cannot overcome it simply by willpower or "pulling him/herself up by the bootstraps."

However, the good news is that treatment for depression is effective. Treatment is also very important. Untreated depression in young people can have a long course, a chronic course, or a course marked by more frequent relapses. It is important to complete the full course of treatment, even if symptoms begin to improve quickly, so as to reduce the risk of relapse.

It is also important for parents to understand that prevention of relapse after acute treatment will be more effective if they can help their teenager to notice the first signs or symptoms of recurrence, to implement the Relapse Prevention Plan, and to contact the therapist if symptoms continue. Parents are key allies on

the team that fights against the teenager's depression and can help by encouraging the teen to attend every session, as well as by their own attendance at sessions.

Be sure that the parents understand the treatment schedule at each Stage of TADS CBT. Stage I is 12 weeks; Stage II is six weeks; Stage III is 18 weeks. In Stage I, there are a total of 15 meetings. In Week One, there are two one-hour sessions. In Weeks Three and Five, there are two back-to-back sessions (one with adolescent, then one with parents) of 45-minutes duration each. In all other weeks of Stage I, there is one meeting of one-hour duration. It is important to attend all sessions in order to obtain the full treatment.

Parent Psychoeducation Meeting 1
*Topic Code: **P1***

GOALS OF THE SESSION:

1. Review parents' views and concerns
2. Answer questions about program structure or about depression
3. Briefly review goals and elicit parents views of family goals related to teen's depression
4. Inform parents about teen Mood Monitoring
5. Introduce parents to skills for behavior change: a) Increasing Family Pleasant Activities ; b) Problem Solving
6. Discuss how parents can support adolescent in use of behavior change skills

This session is scheduled back-to-back with an individual session for the adolescent. Only 45 minutes are allotted. The session has two fairly distinctive parts. In the first, the therapist works to obtain the parents' views of the teenager's problem and what might be helpful in resolving it. In the second part, the therapist teaches the parents about the skills for behavior change. Mood Monitoring is simply explained. Increasing Pleasant Activities and Problem-Solving, however, are likely to be usedon later in conjoint sessions and this necessitates teaching the parents in more detail about these skills.

1. ELICIT PARENTS' VIEW OF THE TEEN AND THE PROBLEM

Begin this session by welcoming the parents to the first parent individual session and acknowledging the long and laborious process that they have already been through to get to this point. Since this is the first time that the parents have been seen by the therapist alone, it is important to provide an opportunity in this session for the parents to voice their concerns about the adolescent in a general way, and give their view of the problem. Begin this session by indicating to the parents that while these first two sessions with them are going to be primarily "educational" in nature (that is, we have a lot of information to tell them about the program and about some skills that the teenager is learning that we want the parents to know about too), we want to begin today by hearing from them how they view their teenager's problem with depression. Is there anything that has not already come out in the pretreatment assessment process that they want to tell us or want to talk about? What are their major concerns about their adolescent? How have they viewed the problem, and what is their reaction to finding out that their adolescent has an illness called depression?

The therapist should listen attentively and empathetically to these concerns and views about the teenager and his/her problem. Use reflective listening skills so that the parents know that they have been heard and understood by you. If the parents raise questions during this discussion that will be addressed in a later section, the therapist can either skip ahead to that section now, or can defer the question until later so that a thorough review of the parents' concerns takes place now.

As the parents voice their concerns, be sure to indicate to the parents that their concerns will be addressed in the various components of the treatment (both individual teen treatment and conjoint parent-teen treatment). Be sure to let them know that if urgent or emergency situation arise during the course of the treatment, they should always report those to the therapist at the beginning of either adolescent individual or conjoint sessions (of course, true emergencies (e.g., suicidal adolescent) should be reported right away).

If parents list concerns that have not been previously identified, make a record of these concerns and incorporate them into subsequent discussions of family goals, family problem solving, etc. as appropriate.

2. ANSWER ANY QUESTIONS ABOUT PROGRAM STRUCTURE OR ABOUT DEPRESSION

Remind parents that CBT overall is designed to help the adolescent to behave differently, especially when faced with stress, and to think differently, so as to overcome and prevent depression. If there is a parent present in this meeting who was not present in the Rationale and Goal Setting session, give that parent the handouts on depression and on the cognitive model. Ask parent(s) if they have any questions about the model of depression and cognitive therapy being used in the project. Answer the questions as succinctly as possible and move on. The caution is not to duplicate the previous session and, therefore, to be unable to cover the material in the present session

GIVE HANDOUTS, "WHAT IS DEPRESSION," AND "WHAT IS COGNITIVE BEHAVIOR THERAPY," pp. a, b, & c of Parent Handouts

Program structure has previously been reviewed with the parents. Ask the parents now if they have any remaining questions about the program structure (how many sessions; meeting times and place, etc.). Answer these questions and then move on.

The parents will have been given a handout at the Gate C-2 interview on depression and their adolescent's treatment arm. Ask if they have any questions about that material.

3. REVIEW TEEN GOALS AND ELICIT FAMILY GOALS

Therapist should review the goals that were identified by the teenager in the feedback session. In addition, the therapist should ask the parents if there were any additional goals for parents to work on that the parents feel would support the teen in his/her coping with depression. Possible questions to ask here would be:

> *"Do you have any ideas about things that you as parents could do that would support your teen in the changes that she/he will be making?"*
>
> *"Are there aspects of the way you interact together (teen-parent interaction) that are unpleasant for everybody and could be contributing to your teen's depression? (such as a lot of yelling or conflict around expectations or rules; having expectations that your teen feels he cannot reach? Poor family communication?). What change goals would help with that?"*
>
> *"Are there any other aspects of family life that you as parents could work on changing that might help your teen's depression?"*

The therapist should write down any new change goals for parents that come out of this discussion.

The handout, "Goal Sheet for Parents," on p. d of Parent Handouts can be used to write down these goals

Therapist should explain that in the remainder of this session, and the next session you will be presenting to them some of the behavior change skills that their teen will be learning and that they (the parents) can also learn to help support their teen's use of these skills and to change the way they interact with their teen. These skills can also help with their change goals identified above. (For example, if one of the change goals is for parents to stop yelling at the teen so much, problem solving is a skill that parents can use with their teen to identify and solve problems calmly and effectively rather than yelling at each other about problems).

Then in conjoint sessions (parents and teen together) they will have a chance to practice some of the most important skills for them, and to address other important issues together.

4. INFORM PARENTS ABOUT TEEN MOOD MONITORING

The first skill that the teen is learning is Mood Monitoring. Briefly let parents know that teen will be monitoring mood, to help understand what situations, activities or thoughts are associated with depression and with feeling better.

> *"The first skill your daughter/son is learning is Mood Monitoring. We will be asking your teen to keep a record every day of situations that happen to her/him and the mood or feeling that is associated with those situations. Later in the treatment, she/he will also be writing down the thoughts that she/he has in the situation that go along with the particular feeling. In this way we will be helping her/him to see that her/his mood is related to his thoughts and that if she/he learns to change her/his thoughts she/he can learn to control her/his mood. We are not asking you to be involved in the Mood Monitoring; this is something that the teen must do himself. However, we did want you to know about it".*

5. INTRODUCE TWO MAJOR SKILLS FOR BEHAVIOR CHANGE

5.a. Pleasant Activities. The therapist should now introduce the skill, **Increasing Pleasant Activities**

5.a.1. Provide Rationale: Why try to increase pleasant events?

> *"People who are depressed often have an unpleasant feeling that is hard to get rid of and act in a depressed way by avoiding the family and other people, avoiding activity, and lying around doing very little. This creates a downward spiral---depression leads to inactivity which leads to more depression which leads to more inactivity, etc. One of the things that we are working on with your teen is helping him to increase his pleasant activities especially when he is beginning to feel depressed. He is working on some plans to do this and it would help if you could encourage this or support these activities when he asks. For example, by agreeing to drive him and his friend to the movie theater if this is something he is doing to get himself out of the house and moving. "*

5.a.2. Relate Skill to Families. Families in which there is one or more depressed person(s) also engage in fewer family pleasant activities than other families.

> *"To help break the pattern of depression, in addition to supporting his independent pleasant activities, families can change their behavior to increase the amount of pleasant events that they engage in as a family. Although your teenager is an adolescent and probably interested in activities with his peer group, teenagers*

still also need to be connected with their families. Families and teenagers can find ways to enjoy each other without taking away from other interests."

5.a.3. Summarize What Teenager will be Learning.

"In the individual sessions, your teenager will be learning how to decide on what activities to try to increase, and will be monitoring the connection between increasing those activities and her/his mood."

5.b. Problem-Solving. The therapist should introduce the second skill, which is **Problem Solving.**

5.b.1. Provide Rationale. Give parents an explanation of the relevance of problem-solving for the prevention of, or recovery from, depression.

"One of the most general skills that your teenager will learn is the skill of Problem Solving. This is a very important first skill, because teenagers have many problems that come up in the different situations in their lives (family, school, peers), and if they can't deal with the problems effectively and the problems pile up, they can make the teenager feel overwhelmed, depressed, helpless, or hopeless (all symptoms of depression). These bad emotions and thoughts, in turn, may spiral into real depression. So learning how to solve problems as soon as they happen, rather than letting them pile up, is very important for depressed teenagers (Incidentally, this is just as true for adults as it is for teenagers, and you may find that using some of these new skills to help your teenager, may have added benefits for you as well)."

5.b.2. Relate Skill to Family. Explain how problem-solving can be especially important for handling family conflict. Therefore, it is important for the parents to learn this skill as well as the teenager

"We would like for you to learn the same method for problem solving that your teen is using because we will be encouraging him to use it with you when conflicts or problems come up in the family and it would be good if you could support his use of these skills by joining with him in this problem solving process. This is especially true when your teen and you are trying to resolve conflicts that currently are causing a lot of tension, anger, or hostility in your interactions with your teen. Let's go through it and then we can talk about how it might work in your family".

5.b.3. A Caution About Implementing Problem-Solving. Indicate to the parents that you are planning on introducing the skill to the teenager on (give date), and that until then, the parents should not use the skill with the adolescent

but should just think about it, try to learn it themselves, and be ready to use it once it has been taught to the teenager.

5.b.4. Teach the Parents the Ribeye Method. Explain the Ribeye Method letting parents know that this method is **general**, i.e., it can be applied to any kind of problem. It can be applied to a problem that one of them is facing individually, and it can be applied to family problems. Note that the following instructions pertain to family problems, since it is likely that later conjoint sessions will involve family problem-solving.

- **Use Parent Handouts, "Ribeye Method," and "Family Problem Solving and Compromise Form," on pp. e, f, & g of handouts.**

1. Give parents the "Ribeye" handout now,

2. Explain the different elements in the "Ribeye". Emphasize the following:

   a. Relaxing first is important. Take a deep breath and calm yourself as the first step in Problem Solving.

   b. When Identifying the problem it is very important to state the problem in very specific terms that avoid using labels or describing attributes of people. Describe the problem, not the people. For example, don't say, "The problem is that she is a lazy teenager". Instead, say, "The problem is that we argue with her every night about doing the dishes". In using the format, every family member should be allowed to say how he or she defines the problem. If family members have different definitions of the problem, they should write them all down on the "Family Problem Solving form".

   c. When brainstorming think of all possible solutions. When the family is doing a problem solving exercise together, somebody should write down the possible solutions on the "Family Problem Solving form". All family members are allowed to contribute possible solutions.

   d. When evaluating solutions, emphasize positive consequences in the family; e.g., people will argue and fight less, and therefore, people will feel less depressed. Also, use the "Family Problem Solving Form" to record everybody's evaluation of each solution with a Plus (+) or a Minus (-).

   e. For the "Yes to One" step, the family should review the form to determine whether a consensus was reached (all plusses) for

any idea. If a consensus was not reached, the family should look for the idea on which they came closest to a consensus and use it as a catalyst for generating additional alternatives and conducting further evaluations. (In subsequent conjoint meetings the therapist may need to help the family analyze factors impeding the family from reaching agreement; for example, cognitive distortions that some family members may be engaging in. For example, the teenager may have the belief that if he adheres to a curfew, he will lose all his friends. Such a belief can begin to be challenged in conjoint meetings.

In saying "Yes" to a particular solution, it is also important to plan the implementation of the solution, and to establish the consequences for compliance versus noncompliance with the agreed upon solution. That is, the family must decide who will do what, when, where and with what monitoring to make the solution work.

It is also important to establish clear-cut consequences for compliance or noncompliance by the adolescent. For example, if the solution to the problem of "family arguments about chores" is that the teenager will do certain chores and the parents will stop all nagging about chores , the specifics of how, and by what deadline chores will be done must be worked out. Also, the positive consequences for doing chores and negative consequences for not doing chores must be worked out. Also, positive consequences for parents adhering to their side of the contract should be discussed (e.g., teen will write his mother a thank you note and leave it on the bulletin board if she does not nag him about chores.).

f. For the "Encouraging" step, talk about how the family members can encourage and praise and support each other as well as encouraging themselves. For example, how can parents praise and encourage the teenager for adhering to the plan?

3. Discuss with parents the different types of family situations in which they could use family problem solving; e.g. establishing a curfew; establishing guidelines about peers; devising a fair plan for distributing chores among siblings.

4. Discuss the importance of setting up a routine for how and when to do family problem solving. This might be done "on the spot" meaning whenever a problem comes up. Or it might be done in a scheduled problem solving session that the parents and teen agree on.

5. Make sure parents have copies of the Family Problem Solving form before they leave the session.

5.b.5. Discussion. Now that the therapist has explained the procedure it would be appropriate to ask them what they think about it, how they think it might work in their family and to name one or two current problems that might be good ones for trying to use this process. (If the parents can identify problems for which they would be willing to use the problem solving format, the therapist can then try to elicit those same problems from the teen in his individual session, and use them as examples with the teen of how to use problem-solving).

However, as noted above, inform parents that we do not wish them to begin using the Problem Solving format with the teen immediately. The teen has not had the Problem Solving session yet, and it may be desirable to do the first joint problem solving interaction in a conjoint session with therapist assistance. Inform parents that we simply want to make them aware of the procedure now. We will be assisting them to use it with their teen later.

Optional: The therapist could now suggest that they use the Problem Solving method together to discuss the problem of infrequent Pleasant Family Activities.

"Let's apply the problem solving method to the problem of "the family not having enough fun together as a family".

a. First, Relax
b. Now, let's define the problem—"Families with depressed teenagers may not be spending enough time having fun with one another"
c. Lets Brainstorm some solutions—Therapist should go to the board and write down suggestions from the parents about pleasant activities that families with teenagers can do together as a family. (If there are any idiosyncratic family problems that come up here, defer them to the individual parent meeting).
d. Have the parents write down the suggestions from the board that they would be willing to try in their family
e. Ask the parents to Choose One solution that they would like implement. Discuss whether and how this could be brought up and discussed with the teen at home.

6. REVIEW AND HOMEWORK IDEAS

Give parents opportunity to ask any questions about the skills introduced in this session. Inquire if they see ways they might support their teenager in the use of these skills. Caution against too early or forced use of skills within family.

"I have presented a lot of material to you tonight. I have presented two new skills that your teenager also has learned or will be learning. I plan on introducing the skills of Problem Solving to your teen on (date) and I will review the importance of increasing Pleasant Activities with him/her on (date). I will talk with him/her about the fact that, in addition to doing both of these things on his own and/or with peers, he can also do both of these things with his parents. In one or more of our conjoint sessions (sessions with the parents and teen together) I will be helping you try to apply some of these skills to the particular goals and problems that you and your teen have identified. I will also be asking you how family pleasant activities are going. Please be thinking about how you can start to do each of these skills in your own family". However, don't start Problem Solving yet because your teen has not heard about this yet. Also, we should do Problem Solving in one of our conjoint session before you start to do it at home.

You may want to talk to your teen about planning at least one Family Pleasant Activity. I will talk to your teen about increasing Pleasant Activities on (date) so you should wait until after that to talk with him about this. Once you have planned a family pleasant activity with your teen, it is important to remember that you may or may not have a lot of fun doing it the first time. Try not to feel too disappointed if the first time doesn't seem like a lot of fun. It sometimes takes awhile to pull out of the doldrums as a family. Be persistent even if the first time doesn't work out extremely well. It may take some time to get going but we think that you will all start to enjoy family pleasant activities eventually".

Parent Psychoeducation Meeting 2
*Topic code: **P2***

GOALS OF THE SESSION:
1. To review progress, goals, and implementation of previously taught skills
2. To introduce concept of reducing "expressed emotion"
3. To introduce parents to cognitive skills for change: a) triple column technique; b) cognitive distortions
4. To discuss how parents can support adolescents in use of behavior change and cognitive strategies skills

This is the second parent meeting for psychoeducation. It is designed to be scheduled back-to-back with an individual adolescent session, typically in Week 5. Allow 45 minutes for this session.

1. REVIEW GOALS, PROGRESS, AND URGENT PROBLEMS

The therapist's task at the beginning of this session is to review with the parents' how they and their teenager may be progressing toward the goals that were identified in earlier sessions, and to ask about any urgent problems that may have come up since the last session. An example of an urgent problem that may have to be dealt with immediately includes suicidal statements or gestures by the adolescent. Other problems should be dealt with, if possible, using the problem solving format.

The therapist should continue to assess what family issues may need to be addressed during the second six weeks of Stage I CBT.

2. REVIEW IMPLEMENTATION OF FAMILY PLEASANT ACTIVITIES (if relevant)

The therapist should inquire if the family did a family pleasant activity together since the last parent meeting. The therapist should be sure to "normalize" it if the parents report that the activity was done, but wasn't much fun or didn't seem to go well because the teen was so withdrawn or surly. It is not unusual for a teen that has been depressed and withdrawn to behave this way the first time there is an attempt at a family activity. The important thing is to get the teenager (and the parents) "moving" as a way of beginning to reverse the "downward spiral of depression". The enjoyment of the activity will come later.

If the parents and teen have not had a chance to do a family Pleasant Activity, the therapist could assist the parents in planning how to set up a family pleasant activity and how to bring it up with their teen at home.

3. INTRODUCE CONCEPT OF REDUCING "EXPRESSED EMOTION"

In this section, the therapist's goal is to introduce concepts about "expressed emotion" in families and their relationship to depression. In some families, the actual term, "expressed emotion" might be used; in others, the technical term might not be useful, but the idea of reducing the amount of negative, critical, interchange in the family is the important concept to convey. In these families the therapist might use the "negative coaching style" metaphor described below.

3.a. Introduce concept of "expressed emotion:" Adjusting the language so that the concept is clearly understandable, explain the major idea that 'expressed emotion' makes it harder to get over depression and more likely that the depression will return.

> *"In families where there is a depressed person, clinical research has shown that the amount of negativity in the interactions of family members can be related to the ongoing depressive symptoms themselves; and, can also be related to relapse later. In families where there is a lot of negative interaction among members, it is more likely that the depression will come back even after it has been successfully treated in the short run. For this reason, clinicians working with depressed people (teens and adults) think that it is important for family members to be aware of this and to look for ways to reduce the amount of negativity in their interactions".*

3.b. Define "negativity," and how it is particularly important in depression. Let the parents know that you understand that negative interactions can occur in any family. However, they are especially important to address in families in which one member is trying to overcome depression and prevent repeated depression.

> *"What we mean by negativity includes interactions that are hostile, blaming, critical or where there is a sarcastic or contemptuous tone to the interactions. Adults and teens are equally likely to be negative in these ways in interactions. To a certain extent this kind of interaction occurs in all families sometimes. However, because depressed people seem to be especially sensitive to these types of interactions, we think that it is important to identify if this is happening in any particular family where there is a depressed person, and to try to help the family change it."*

3.c. Introduce the Contrasting Coaches Analogy. One way to understand this idea is to think about the following scenario:

"Most people have played a sport or two during their childhood. Have you ever had experience playing T-ball or little league? Let's take a moment to think about a child's first time playing T-ball. Imagine that a little guy (girl) of about 5 years of age has just signed up for his (her) first T-ball team. In the week before the first practice, little Billy is so excited! His mom takes him out for new sneakers. His dad buys him a new glove and helps to break it in with oil, just like his dad once did. Everyone is looking forward to the first practice and Billy's debut as a T-ball player."

"Now imagine Billy's first day at practice. His coach, Coach A, sends him out to play in the outfield. Billy is out there, watching the batters come to the plate and make their way around the diamond with grounders and singles. Finally, a batter hits a pop fly up and into the outfield. There it is, heading right toward Billy. He's so excited now! He puts his glove up in the air, but oh no! The ball goes flying over his head! Suddenly from the sidelines, ***Coach A yells out "Oh NO NO NO! What are you doing? I can't believe you missed that! Pay attention, come on kid, what's wrong with you!"***

Wow. Imagine how Billy feels about that. Now imagine that another ball gets popped up, and again it's heading straight for Billy. This time, he holds his glove up and runs towards the ball. It hits his glove but pops right out. Immediately, ***Coach A is screaming again. "What is WRONG with you? That's it, forget it. You can't play the outfield. Come on in here kid. Now what will we do with you?"***

What do you think Billy is telling himself at this point? How does he feel about himself? What do you think he'd do? (Solicit answers such as Billy telling himself he's no good, feeling like a failure, feeling embarrassed and humiliated, behaviors such as crying and giving up).

How do you think Billy will feel about the next practice? Is he likely to want to play ball again? What do you think he'll be feeling and doing before the next practice (e.g., having stomachaches and experiencing tension, feeling depressed, trying to avoid the situation).

Now let's look at this situation again, but with a different Coach. Imagine that it's Billy's first day at practice. His coach, Coach B,

sends him out to play in the outfield. Billy is out there, watching the batters come to the plate and make their way around the diamond with grounders and singles. Finally, a batter hits a pop fly up and into the outfield. There it is, heading right toward Billy. He puts his glove up in the air, but oh no! The ball goes flying over his head! Suddenly from the sidelines, ***Coach B yells out "That's okay kid, good try! It's all right. Now, the next time a ball is hit towards you, keep your eye on it, watch for where it's heading, and move towards the ball. Okay? Let's try it again, and do the best you can."*** *Now imagine that another ball gets popped up, and again it's heading straight for Billy. This time, he holds his glove up and runs towards the ball. It hits his glove but pops right out. This time Coach B calls out to him "Way to go! All right, you're getting there! The next time, close your glove around the ball. Good effort Billy!"*

If you were Billy's parent, which coach would you want for him, A or B? Why?

Billy might not feel 100% great, but there's some big differences in how he's likely to feel, and what he's likely to do about improving his game and staying on the team."

3.d. Articulate Key Differences Between the Contrasting Coaches.

"Coach B did some very important things that the first Coach missed:

First, *he complimented Billy on his effort. Sure, things weren't perfect, or really going too well at all, but he recognized Billy's attempts and he made sure to reinforce that.*

Second, *he gave Billy some very clear instructions on what to try the next time, and how to learn from each attempt. He's helping Billy to build up his skills in playing ball.*

Third, *Coach B stayed away from focusing on what Billy did wrong, and he didn't judge him negatively or harshly.*

There are some very clear differences between these coaches, and also between the end result of how Billy will feel about himself and T-ball. It's likely that Billy won't feel totally great about things, but he has good instructions on how to improve. He's probably not very upset, and won't be distracted by feeling incompetent or

embarrassed. It's likely that he can develop the skill and have fun at the game.

We're pretty clear on which Coach did the better job, and which is going to be best for Billy."

3.e. Relate the Analogy to Families, Without Attributing Blame.

"In many families where there is a depressed person, a negative coaching style can develop between parents and teens. It's nobody's fault that this happens, and its not done on purpose. Rather, it's a result of some complex interactions occurring over time. Often, parents aren't even aware that they've learned to focus on the negative aspects of their child's behavior. The parents' intention may be to try and motivate the child to change a behavior, or do something challenging, but it comes out sounding very punitive and harsh.

I've used the Billy story to get you to start thinking about how you are coaching your son/daughter. I'd like you to start listening to what you say to your son/daughter, and see if you're coaching style is harsh, or is it encouraging. What we will focus on in this effort is interacting with your teenager using a more positive coaching style".

3.f. Inquire about "Expressed Emotion" in This Family. The therapist should now ask the parents if they think negative "expressed emotion" or a negative coaching style is a problem in their family, and if so, who in the family engages in these types of interactions. Ask the parents if they could describe the kinds of interactions that occur in their family. Ask the parents if this is something that they think would be useful to try to reduce while they are in this program and later. Try to elicit the parents' commitment to establishing a goal of "reducing negative interactions in the family."

3.g. Present Change Strategies and Request 'Contract' to Point Out Negative Communications. Indicate to the parents how certain skills the family can practice in this program can help to reduce negativity or "Expressed Emotion."

"In order to help change these types of negative interactions in the family, we will introduce two skill areas that should help with this. One you have already started to learn: Problem Solving. Since a lot of negative interactions in families happen when families are having a problem but

can't solve it effectively, problem solving strategies should over time help reduce the amount of negative interactions.

"A second set of skills is called, "good communication skills". We may be talking about these skills in a subsequent session where your teen is also present. Good communication skills are a substitute for the negative kinds of interactions that can sometimes get going in families"

"Finally, if it is OK with you, if we see any of the kinds of negative interactions that were identified above happening in any of the therapy sessions, we will bring them to your attention by pointing them out when they happen. Sometimes, the first step toward change is becoming aware of when the negative behavior if happening, and an outside observer can help with this. Would that be OK with you?"

By establishing this contract with the parents, the therapist now has explicit "permission" to point out negative interactions when they occur in the family and to prompt them to use good communication strategies and problem solving when they get stuck in negative blaming interactions. From here forward, the therapist should do this as part of his/her attention and intervention in the process of interactions in therapy sessions.

4. INTRODUCE COGNITIVE SKILLS AND STRATEGIES

In this portion of the session, explain to parents that their adolescent will be learning the skill of observing, questioning, and "talking back to" their own negative, depressing thoughts.

4.a. Review rationale for looking at cognitions and cognitive strategies. Relate the cognitive restructuring portion of TADS Stage I CBT to the overall treatment rationale. Remind parents that CBT involves changing behaviors and changing thoughts, so that depression is overcome and prevented.

"We have begun talking with your teen about their thoughts or cognitions, the way that negative thoughts are related to depression, and the way that changing thoughts can help in the process of recovering from depression.

"One reason that looking at thoughts is so important is because episodes of sad mood are frequently preceded by "bad" thoughts. Also, one of the things that your teen is learning is that he can't always change the situations in his life and he can hardly ever change other people, but he can change the way he ***thinks about*** *problematic situations or people.*

"The fact that people can change their thoughts to be more constructive comes as news to a lot of adolescents. They often have the belief that their thoughts are automatic and unchangeable. We challenge that, ask them to think of examples where they might have changed their thoughts in the past and then begin to work with them on identifying and changing negative or "bad" (in the sense that they elicit sad moods or using) thoughts and substituting them with positive, realistic thoughts."

4.b. Present daily mood monitor technique.

"In order to help the your teen learn about changing thoughts we will use a different version of the "Daily Mood Monitor".

- **Therapist should pass out copy of the "Three Column Mood Monitor," pp. h & I of Parent Handouts.**

"We start by giving an example of some situation or having them identify some situation that happened in their life and write it on the form. We then ask them to write down on a zero to 10 scale, ranging from negative mood to positive mood, the emotions associated with that event.

"Later, we ask them to identify the thought that happened just before the emotion. Sometimes the thought is an "Automatic" thought in the sense that it occurs so fast that we almost don't recognize it when it happens. These are usually thoughts that we say to ourselves so frequently that the thought just flashes by our awareness. Examples are things like "I am so stupid".

"In working with negative thoughts using the three-column mood monitor, the kids learn how to identify their thoughts and then how to "talk back" to their negative thoughts. For example if the negative thought is "Nobody likes me" they learn to challenge that negative thought with evidence from their own lives to the contrary.

"Kids also learn how to substitute realistic thoughts for negative thoughts. They do this by planning what a realistic counter-thought might be to the negative thought, writing down the realistic counter-thought, and then identifying how the emotion or the rating of the emotion might change if they use the realistic thought instead of the negative thought.

"Kids are given homework assignment to keep track of their negative thoughts when they are in situations that cause negative emotions or use and then to try to substitute realistic counter-thoughts.

4.c. Inquire about possible negative automatic thoughts of the adolescent.

"Are you parents aware of any negative thoughts that your adolescent may use, that are linked to depression? For example, have you ever heard your teen say things like, "I am stupid", "I am ugly" etc. How have you responded to these statements in the past? Sometimes parents respond out of frustration in ways that aren't very helpful. They may say things like, "Don't be ridiculous!! You are not stupid, you are just lazy". This is related to the negative coaching style that we talked about earlier. Are there ways that you could think of that would help him learn to start substituting realistic counter-thoughts to these negative thoughts?" Are there things that you could do that would support him in his efforts to change his thoughts?

4.c. Present "Cognitive distortions"

"Another aspect of negative thinking that we talk with the kids about is "Cognitive Distortions". Distorted thinking is common in persons with depression (including teenagers and adults). It has to do with the way that we might distort or twist things that we see or hear in ways that keep negative thinking or behavior going.

"For example, if a teenager has an experience walking down a hallway at school in which a person does not acknowledge his presence or say "Hi", the teenager may distort that experience by telling himself that "Nobody likes me".

"Here is a handout that we give to the adolescents with some of the most common "cognitive distortions" that adolescents engage in.

- **Give parents a copy of "Cognitive Distortions" form, p. j of Parent Handouts.**

"We are working with your teen to start identifying and then keeping track of the most common Cognitive distortions that they use by having him keep another triple column form that includes Cognitive Distortions as one of the columns."

4.d. Ask Parents about Cognitive Distortions

Ask parents if they are aware of any Cognitive Distortions that they think their teenager may frequently use. Tell parents that cognitivedistortions, especially those associated with anxiety or depression, can run in families. Sometimes these are things that even get said out loud by family members. Or they may be subtle, but nevertheless, teenagers are aware that other family members believe these things, so they may model them from family members.

4.e. How parents can help with "Cognitive Distortions"

If parents are aware of any times that their teenagers use cognitive distortions, parents can gently prompt the teenager to identify the cognitive distortion and to challenge it with a more positive thought. Parents should merely suggest this however, and not get into a fight or battle with the teenager about it. Teenager thoughts are their own, and parents should not force the issue of teenagers changing their thoughts because the parent wants them to. This has to up to the teenager. Parents' main role can be as prompters and reminders.

Another way for parents to help with teenagers cognitive distortions is to ask yourself is you are somehow modeling cognitive distortions; saying things out loud that the teenager could be picking up on and modeling.

Examples might be something like:

> "You are so lazy, stupid, dumb, ugly, weird", etc. etc. (Usually these are statements that parents don't really mean but say out of frustration. The teen, nevertheless, can pick up on them, and incorporate them as a cognitive distortion.

Other ways that parents can help is to remember to use a positive coaching style rather than a negative coaching style as much as possible when talking to your teenager. When parents change the way that they talk to their teenager, over time it can influence the way the teenager talks to himself.

"Can you think of any other ways that you can be helpful to your teenagers in the arena of "Cognitive distortions"?

5. ASSIGN HOMEWORK

The homework for today is to continue practicing Pleasant Family Activities at home.

Parents can also begin practice on modifying their own modeling of cognitive distortions that might have been identified in the session, and providing gently prompts to the teen to think of a more realistic counter-thought if parents hear the teen engaged in negative thinking habits.

Parents can also begin to focus on using a positive coaching style (or reducing negative expressed emotion) with their teenager at home.

Module on Family Problem Solving and Compromise: In Vivo Practice

(For use in a Parent-Teen Conjoint Session)
Topic Code: ***FP***

GOALS OF THE SESSION

1. Review homework from previous sessions
2. Elicit Issues and Incidents
3. Conduct guided, in vivo practice of Problem solving
4. Assign Homework

1. WELCOME AND INQUIRY ABOUT PROGRESS ON GOALS AND HOMEWORK

Therapist should open each session by welcoming parents and teen to session and inquiring about how the week has gone with regard to progress towards goals and work on homework assignments**. Therapist must review and/or complete the Affective Disorders Screen with adolescent**.

2. ISSUES AND INCIDENTS

In addition, as part of or subsequent to the above inquiry, therapist should raise the question of important issues or incidents that have come up or that the family wishes to discuss that the parents and/or teen believe are related to the teen's depression. This format will be familiar to the teen because it is similar to the Issues and Incidents section of the routine session format in her/his individual sessions. It is a way of eliciting important and immediate issues (and important family processes such as poor communication or poor conflict resolution skills) that may be related to depression.

Questions to ask to elicit important Issues and Incidents are:

"Have some things come up this week that you think are important to discuss today?"

"What goals or problems do you want to work on today?"

Just as in individual sessions, the therapist must prioritize the issues or incidents that are identified in this discussion. Guidelines include prioritizing suicidal behavior or thoughts, therapy threatening behavior or thoughts (e.g., wanting to quit, missing sessions or coming late), and then issues that the therapist assesses will be most helpful to deal with in the session as a first or early experience with new skills, and a model for dealing with problems at home.

It will not be possible to deal with all issues that come up in families in the limited number of conjoint sessions available. This is another reason that issues must be prioritized. The therapist can also tell families that since we have a limited number of family sessions, it is important to really start practicing new skills for dealing with problems, conflicts, issues, and incidents at home. What we do in conjoint meetings can serve as initial practice for how to do this at home.

3. In Vivo Practice using Problem Solving: Parent(s) and Teen together

In a previous Psychoeducational Session the parents learned the RIBEYE technique for Problem-Solving and Compromise. In a previous teen individual session, the teen also learned the RIBEYE method. Parents and teen have also seen copies of the Family Problem Solving and Compromise form.

In this (and possibly subsequent) conjoint session, the goal is to assist the parent and teen to use the RIBEYE method for family problem solving together, in order to solve a current conflict or problem and to gain guided practice in using the technique.

The therapist can introduce the topic by referring to problems or obstacles to the attainment of goals that have been identified in previous sessions. In the remainder of the session today, the Ribeye method can be used to try to reach a compromise or agreed-upon solution to the problem. Alternatively, the therapist can refer to the previously completed Issues Checklists to identify a problem to address in a problem solving practice session today. **In either case, it is probably best to select a relatively minor, or low intensity problem to address in a first practice session.**

Once a problem has been selected, the therapist should hand out copies of the Family Problem Solving and Compromise form, and guide the family through the steps in the Ribeye Method.

- **Use the Parent Handouts, "Ribeye Method," and "Family Problem Solving and Compromise Form," on pp. k, l, & m of handouts**.

Points to remember are that during brainstorming it is very important to direct families not to evaluate the potential solutions generated. The idea in brainstorming is to think of as many different potential solutions as possible (no matter how unlikely, silly, or outlandish some of them may seem initially). The evaluation step comes later. The reason for this is to free up the brainstorming process so that it is not hampered by premature negative evaluations by family members.

Families may also react negatively to the idea of using the form. They may report that it feels unnatural or stilted to use a form in discussing family conflicts. Encourage them to use the form in the exercise today, simply as a mechanism for providing structure to their first problem-solving interaction. As they gain practice and more comfort with the procedure, they will not need to use the form at home.

Be sure to discuss thoroughly the implementation plan once a solution has been selected. Discuss the contribution of every family member to the plan. If consequences are needed to reinforce performance of steps in the plan by any or all family members, be sure to discuss what the consequences will be. For example, if the problem is that the teenager has been breaking curfew; and a new curfew time is selected in the Problem Solving process, be sure to discuss a plan for how the parents will know if the teen has made curfew on time, and what the consequences for breaking the new curfew will be.

4. Homework

1) Family should take home the plan generated in the discussion today with the assignment to implement the plan between now and the next conjoint session.
2) Therapist should decide if the family is ready to conduct a Problem Solving process at home. If so, the therapist could assist the family in selecting one additional problem to discuss at home. Give another blank copy of the Problem solving form to the family to use at home and ask them to bring it back to the next conjoint session.

COMPLETE THE FORM INDICATING WHETHER THE TEEN COMPLETED ALL, SOME, OR NONE OF THE HOMEWORK SINCE THE PRECEDING SESSIONS.

Family Communication Module

(For use in Parent-Teen Conjoint Session)
Topic code: ***FC***

GOALS OF THE SESSION:
1.Review homework from previous sessions
2.Use previously taught skills to problem solve issues that family raises
3.Elicit Issues and Incidents
4.Introduce material on Family Communication (optional)
5.Assign Homework

1. WELCOME PARENTS AND TEEN TO SESSION AND INQUIRE ABOUT PREVIOUS HOMEWORK AND PROGRESS TOWARD GOALS.

Therapist must review and/or complete the Affective Disorders Screen with adolescent.

Welcome the respective family members to the session, and ask about how things are going with respect to goals and skills that teen and parents are working on. As the family discusses progress (or lack thereof) toward goals, problems will probably be identified. As family discusses problems, try to prompt them to use skills they've learned. For example, if they argue nonproductively, try to prompt them into a problem-solving format of defining the problem objectively and then brainstorming solutions. Many families get stuck in an arguing, blaming, or name-calling format. The therapist should try to move them beyond that to a more productive problem-solving format.

2. ELICIT ISSUES AND INCIDENTS

In addition, as part of or subsequent to the above inquiry, therapist should raise the question of important issues or incidents that have come up or that the family wishes to discuss that the parents and/or teen believe are related to the teen's depression. This format will be familiar to the teen because it is similar to the Issues and Incidents section of the routine session format in his individual sessions. It is a way of eliciting important and immediate issues (and important family processes such as poor communication or poor conflict resolution skills) that may be related to depression.

"Have some things come up this week that you think are important to discuss today?"

"What problems do you want to work on today?"

Just as in individual sessions, the therapist, along with the family, must prioritize the issues or incidents that are identified in this discussion. Guidelines include prioritizing suicidal behavior or thoughts; therapy threatening behavior or thoughts (e.g., wanting to quit, missing sessions or coming late); and then issues that the therapist assesses will be most helpful to deal with in the session as a first or early experience with new skills, and as a model for dealing with problems at home.

It will not be possible to deal with all issues that come up in families in the limited number of conjoint sessions available. This is another reason that issues must be prioritized. The therapist can also tell families that since we have a limited number of family sessions, it is important to really start practicing new skills for dealing with problems, conflicts, issues, and incidents at home. What we do in conjoint meetings can serve as initial practice for how to do this at home.

Once an issue has been prioritized for work in the session, the therapist should guide the family members in using skills taught in previous sessions for dealing with the issue or problem. For example, the therapist can assist the parents and teen to use the RIBEYE format as a way of discussing the problem. During this exercise, the therapist should listen carefully for poor communication skills (e.g., on the list of Negative Communication Habits) and should point these out when they happen and try to redirect the family member(s) to use positive communication skills as they go through the Problem Solving exercise.

3. **OPTIONAL COMMUNICATION MODULE—**FOR TEENS AND PARENTS WITH POOR FAMILY COMMUNICATION SKILLS Although this module is presented as "optional" it is anticipated that a majority of families will need this. It should be presented when the therapist and team have observed a high rate of negative communication behaviors and/or irritable or hostile affective tone during family communication. This module would be useful for families in which there is high "Expressed Emotion"; that is, irritable, angry, critical and/or hostile communication.

This module can be used in conjunction with the individual adolescent psychotherapy optional module on Communication and Compromise, as a sequence of sessions.

3.a. Present Rationale for Communication Training.

"So far in this therapy program, we have already started working on goal setting related to depression and problem solving as a way of removing obstacles to goals.

Now we can talk about some basic communication skills for talking to each other in the family so that people can be heard when they speak and don't just get angry and defensive."

3.b. Present Negative Communication Targets

One of the first and most important communication skills is "active listening" This may seem obvious but it is not so easy. A lot of times in families, instead of listening to what other family members may be saying we do other things. These are ways of communicating that are negative

- ✓ Interrupting
- ✓ Lecturing
- ✓ Blaming
- ✓ Name-calling
- ✓ Putting people down for what they said

- ✓ Or on the passive side:
- ✓ Ignoring the person who is talking
- ✓ Walking out of the room
- ✓ Not looking at the person who is talking
- ✓ Looking at the TV instead of looking at the person

These things, which are listed on this page, happen in many, many families with teenagers. Do any of them happen in your family?

- **Give out Parent Handout "Negative Communication Behaviors", p. n of handouts.**

(Other questions to ask):

"(Teenager), when you try to talk to your parent, do you feel like they listen to you or not?"
"What do they do instead of listening?"
"Parents when you try to talk to your teenager, do you feel like she/he listens or not?"
"What does she/he do instead of listening to you?"

3.c. Present Active Listening

Instead of doing some of these other things while people are talking, it will help communication and problem solving if we can listen. What is listening? Listening is an active skill. It has two major parts: Non-verbal and verbal skills.

- **Give out Parent Handout, "Active Listening" on p. o of handouts**

"The first part of listening, nonverbal skills, is the first thing to check. What are nonverbal skills that indicate to the talker that you are listening?"

1. Eye Contact
2. Body Posture that shows attention
3. Head nods
4. Keep quiet while the person is still talking; do not interrupt with any comments until they are finished.

"What are the verbal skills that indicate to the talker that you are listening? Well, listening means that we have really tried to hear and understand what the other person is saying WHETHER WE AGREE WITH IT OR NOT."

3.c.1. We can hear and listen without necessarily agreeing.

"This is an important distinction for parents and teenagers to make because many parents and teenagers believe that if they listen to the other person it necessarily means that they have to agree. So if they don't agree, they stop listening and start blaming, name-calling or interrupting instead. So let's get this straight from the beginning. You can listen to somebody and hear them out without giving up your right to disagree with them."

"So with this cleared up, what does listening mean? It means we are paying careful attention to what they are saying and trying to understand their thoughts and their feelings accurately. What listening skills would let the talker know that you are doing this?"

1. After they are finished, summarize in your own words the other person's thoughts and feelings
2. Ask if you got it right. If they say, "No, that's not what I said", ask them to explain it to you again
3. Summarize it in your own words again, and ask if you got it right this time
4. Keep doing these steps until the talker says that you got it right
5. Reserve judgment on what the talker is saying until all of steps 1-4 have happened. That is, don't state whether you agree or disagree with it until it is clear that you have listened and heard their point of view and feelings clearly.

Why do you think steps 1-5 are so important when parents and teenagers are trying to communicate with each other and solve problems together?

3.d. Therapist Models Listening Skills.

Tell family that you would like to show them what you mean. Ask one of the parents to play the part of teenager while leader plays parent. Ask the parent-playing-teenager to talk with you about some request that they have, such as wanting a later curfew. Ask parent to present it as they think their teenager would present it. Leader-playing-parent should model 'good listening skills'; i.e., modeling verbal and nonverbal aspects of listening, reserving judgment on teenager's request for right now, asking questions to clarify that he understands everything the teenager is asking for and what the teenager's rationale for the request is. Don't get into problem solving the request yet. Just model listening skills.

3.e. Role-play with Teenager and Parents

Ask teenager if he would be willing to try active listening with his parents in the session. Ask teenager to talk with his parents about something he has been wanting to ask them or tell them. Help parent use active listening skills during the exercise. Don't let family get derailed by disagreement among the family members about the request.

3.f. Assess Role-play.

Ask family members what they thought about the role-play. What is hard about listening without judging especially when you strongly disagree with what the talker is saying or you think the request is inappropriate? (E.g., If what the talker is saying makes you really mad, it is hard to remain quiet and control your emotions). Leader acknowledges that this can be hard to do, but controlling your emotions and your urge to interrupt while the talker is still talking is very important in effective communication. How can family members control their emotions and their urge to interrupt? What ideas does the family have about this? (This would be a good place to suggest and use any of the Brief Relaxation methods contained in the Adolescent manual).

3.g. Family Communication: Sending Clear Messages.

*"There are **three rules** to start with about sending clear communications when you are the talker:*

1. Keep non-verbal and verbal messages consistent. This means that words and body language should be consistent. If you are telling someone that you are sad, you should not be laughing. If you are telling someone that you love them, your face should not look hard or angry. If you tell someone that they can trust you, you should not lie to them.

2. Be specific, not vague. Say specifically what you mean or what you want.

3. Use “I” statement instead of “You” statements whenever possible.

   For example, a teenager could say, “I would like to be able to stay out till midnight on Friday night”, instead of, “You are so mean, you never let me stay out late like my friends get to”.

   A parent could say, “I would like for you to make curfew for three weeks in a row before we talk about driving privileges”, instead of, “You are so irresponsible, how can I give you the car?”

   By avoiding “You” statements you will be able to stay away from accusations, blaming and name-calling that just make the other person angry and defensive and don’t get you what you want.

3.h. Review Material with Family. Ask family what they think about “I” vs. “You” statements.

Make sure family understands that subtly changing a “You” statement into an “I” statement is not fair. For example, “I think that you are an irresponsible teenager” is a sneaky “You” statement.

3.i. Role-play

If there is time, role-play the use of clear message sending skills, as you did above with listening skills.

4. ASSIGN HOMEWORK

Homework is to try to use active listening and clear messages when communicating at home around goals, and during problem solving discussions.

Also, homework may include continuation of adolescent or family previous assignments.

COMPLETE THE FORM INDICATING WHETHER THE TEEN COMPLETED ALL, SOME, OR NONE OF THE HOMEWORK SINCE THE PRECEDING SESSIONS.

Module on Family Contingency Management

(For use in a Parent-Teen Conjoint Session)

Topic code: ***FM***

GOALS OF THE SESSION

5. Review homework from previous sessions
6. Elicit Issues and Incidents
7. Set up contingency management plan
8. Assign Homework

1. WELCOME AND INQUIRE ABOUT PROGRESS ON GOALS AND HOMEWORK

Therapist should open each session by welcoming parents and teen to session and inquiring about how the week has gone with regard to progress towards goals and work on homework assignments. **Therapist must review and/or complete the Affective Disorders Screen with adolescent**.

2. ISSUES AND INCIDENTS

In addition, as part of or subsequent to the above inquiry, therapist should raise the question of important issues or incidents that have come up or that the family wishes to discuss that the parents and/or teen believe are related to the teen's depression. This format will be familiar to the teen because it is similar to the Issues and Incidents section of the routine session format in his individual sessions. It is a way of eliciting important and immediate issues (and important family processes such as poor communication or poor conflict resolution skills) that may be related to depression.

"Have some things come up this week that you think are important to discuss today?"

"What goals or problems do you want to work on today?"

Just as in individual sessions, the therapist must prioritize the issues or incidents that are identified in this discussion. Guidelines include prioritizing suicidal behavior or thoughts, therapy threatening behavior or thoughts (e.g., wanting to quit, missing sessions or coming late), and then issues that the therapist assesses will be most helpful to deal with in the session as a first or

early experience with new skills, and as a model for dealing with problems at home.

It will not be possible to deal with all issues that come up in families in the limited number of conjoint sessions available. This is another reason that issues must be prioritized. The therapist can also tell families that since we have a limited number of family sessions, it is important to really start practicing new skills for dealing with problems, conflicts, issues, and incidents at home. What we do in conjoint meetings can serve as initial practice at how to do this at home.

If the Problem Solving format has been introduced to the teen and parents in this family prior to this session, the format can be used to assist the family in dealing with the issue that is selected for discussion.

3. OPTIONAL MODULE: SET UP CONTINGENCY MANAGEMENT PLAN

This module will most likely be used in families where there is a teen who displays oppositional or defiant behaviors; the parents are not successful in their efforts at eliciting cooperative behavior from the teen; **and the teen behaviors and parent-teen interactions resulting from this problem appear to be related to the teens depressive symptoms.** For example, if the parent's efforts to elicit cooperation from the teen result in negative, critical, or hostile family interactions, these may relate to teen depression, as outlined in the earlier section on family expressed emotion.

When this constellation of problems is identified in a family, it may be necessary to assist the parents and teen in setting up a behavioral, contingency management system. The particular plan set up for the individual family will differ depending upon the idiosyncratic problems, capabilities, and resources in the family. Some parents are capable of setting up and administering complex point or token systems, whereas others may prefer a simple contract system (i.e., if you do this, then I will do that). Likewise, functional reinforcers must be identified individually for each family. Therefore, while it is not possible or desirable to create the same system for all families in this project, certain principles can be followed in establishing a contingency management system with each family.

1) Specify in operational terms what the target behaviors will be for the teen and family. These may be social behaviors or they may be chores or other instrumental tasks that the parents would like the teen to perform.

2) Discuss and establish some form of monitoring system for how the target behaviors will be tracked. This may be informal (e.g., each evening after dinner, the parents will check to see if the teen has

washed the dishes); or the system may be more formalized (e.g., a point system where points are given or removed for every instance of a target behavior).

3) Discuss what the rewards and/or punishments in the system will be

4) Discuss what the schedule for reinforcement or punishment will be (e.g., daily rewards; weekend rewards; etc)
5) Discuss how parents will administer the system and how they will react to teen responses to the system. For example, teens may tantrum when rewards are not earned or punishments are administered. How will the parents react to that?

4. HOMEWORK

Parents and teen should leave this session with the details of a contingency management plan worked out well enough that they can go home and implement the system. Assign this as homework and help the parent and teen problem solve any details in implementing the system.

Many teens may protest or express displeasure with the creation of a contingency management system. In that case, the therapist should “normalize” the teen’s reaction. Try to relate improvements in family interactions that will occur when things are running more smoothly in the family, to improvements over time in the teen’s mood and symptoms of depression.

COMPLETE THE FORM INDICATING WHETHER THE TEEN COMPLETED ALL, SOME, OR NONE OF THE HOMEWORK SINCE THE PRECEDING SESSIONS.

Module on High Expectations and Positive Reinforcement

(For use in a Parent-Teen Conjoint Session)

Topic Code: ***FE***

GOALS OF THE SESSION

1. Review homework from previous sessions
2. Use previously taught skills to Problem Solve Issues that Family Raises
3. Elicit Issues and Incidents
4. Introduce material on Excessively High Parental Expectations and Low Reinforcement
5. Assign Homework

1. WELCOME AND INQUIRY ABOUT PROGRESS ON GOALS AND HOMEWORK

Therapist should open each session by welcoming parents and teen to session and inquiring about how the week has gone with regard to progress towards goals and work on homework assignments. **Therapist must review and/or complete the Affective Disorders Screen with adolescent**.

2. ISSUES AND INCIDENTS

In addition, as part of or subsequent to the above inquiry, therapist should raise the question of important issues or incidents that have come up or that the family wishes to discuss that the parents and/or teen believe are related to the teen's depression. This format will be familiar to the teen because it is similar to the Issues and Incidents section of the routine session format in his individual sessions. It is a way of eliciting important and immediate issues (and important family processes such as poor communication or poor conflict resolution skills) that may be related to depression.

> *"Have some things come up this week that you think are important to discuss today?"*
>
> *"What problems do you want to work on today?"*

Just as in individual sessions, the therapist must prioritize the issues or incidents that are identified in this discussion. Guidelines include prioritizing suicidal behavior or thoughts, therapy threatening behavior or thoughts (e.g., wanting to quit, missing sessions or coming late), and then issues that the

therapist assesses will be most helpful to deal with in the session as a first or early experience with new skills, and as a model for dealing with problems at home.

It will not be possible to deal with all issues that come up in families in the limited number of conjoint sessions available. This is another reason that issues must be prioritized. The therapist can also tell families that since we have a limited number of family sessions, it is important to really start practicing new skills for dealing with problems, conflicts, issues, and incidents at home. What we do in conjoint meetings can serve as initial practice for how to do this at home.

Once an issue has been prioritized for work in the session, the therapist should guide the family members in using skills taught in previous sessions for dealing with the issue or problem. For example, the therapist can assist the parents and teen to use the RIBEYE format as a way of discussing the problem. During this exercise, the therapist should listen carefully for poor communication skills (e.g., on the list of Negative Communication Habits) and should point these out when they happen and try to redirect the family member(s) to use positive communication skills as they go through the Problem Solving exercise.

3. **OPTIONAL MODULE-- FOR PARENTS WITH EXCESSIVELY HIGH EXPECTATIONS FOR TEEN AND EXCESSIVELY LOW RATES OF POSITIVE REINFORCENT**

3.a. Present Rationale.

This may be a delicate subject to raise with parents. It is, nevertheless, important to raise it, but in a way that will minimize parents' feeling criticized by the therapist. Strategies for doing this may include:

1) Reminding the parents and teen that they are not in conflict with each other but that they are working together against depression;

2) Presenting the rationale that depression sometimes makes teens feel like they can't accomplish even the simplest goals ` and that nothing they do is right. Parents can help by "lowering the bar a bit" on expectations so that teen feels like she/he has a chance, and by "going out of your way" to notice positive efforts or small positive steps toward goals and commenting on them and praising the teen for them;

3) Using material that the teen may have talked about in his individual sessions (but only if the teen gives prior permission to do this). For example, if the teen has talked about feeling like his parents

expectations for his grades are impossible and
unrealistic, that might be raised for discussion about more realistic expectations.

Some parents of depressed teens resist the idea of lowering their expectations and/or increasing their positive reinforcement for small accomplishments. This may especially be the case if the parents have evidence (e.g., prior I.Q. testing) that the teen is very intelligent and therefore, "should be able to do better", or " shouldn't need my praise for little things". It is important not to argue with parents. Simply present the notion that depression has a negative impact on concentration, cognitive efficiency and other skills needed for academic productivity. Depression can also make it harder to use good problem solving skills. Finally, while the teen is battling depression, it can help if parents will negotiate a set of expectations that feel more realistic to the teen.

3.b. Identify and Negotiate New Expectations in Relevant Functional Domain

1) Ask teen and parents to discuss and identify an area of the teen's functioning where the teen feels his parents' expectations are too high for what he can accomplish right now. Examples of domains that might be identified are academic expectations, expectations about extracurricular activities, or social expectations.

Additional points for therapists:

1. Care is necessary here. We want teens to increase their engagement in "pleasant activities" that can counter depression, but we may need to help teens decrease expectations about burdensome extracurricular activities that the parent is pressuring the teen to do (e.g., practicing the piano two hours a day);
2. Some parental expectations may be counter to the adolescent drive toward independence. For example, some parents may expect their teen to share all aspects of their social lives with their parents and, therefore, see any failure to do so as a breach of trust, resulting in criticism or punishment.

2) Help teen and parents negotiate a new set of expectations.
Use Problem solving format as needed. Write down new set of expectations.

3.c. Discuss ways that parents can reinforce adolescent. Help parents to see how they might be able to reward or praise teen's small steps toward accomplishment of goals and expectations.

1) **Labeled praise**—Praise statement that label exactly what the teen did that the parents notice was a positive step (e.g., "You did a really nice job of working on your homework for a whole hour without stopping last night")
2) **Unlabeled praise**—Praise statements that make a positive evaluative comment but do not state exactly what the behavior was (e.g., "Nice job", "That's great", etc.)
3) Contracting with teen for specific **tangible reward** for accomplishing a goal or newly negotiated expectation (use of the car on the weekend if one hour of homework done every school night).

3.d. Discuss a strategy of reinforcement

Now that parents and teen have agreed to a new set of (lowered) expectations and parents have agreed to increase their praise of small steps toward accomplishment of expectations, discuss more specifically a strategy for doing this. For example, when is the teen's behavior most likely to occur? How can the parent make sure to notice the behavior, since noticing is the precursor to praising?

Ask teen for his input into this discussion. If it makes sense, parents could be asked to set a goal for how many times a day they are going to try to notice their teen's new behavior (small steps toward progress on expectations; goals; etc) and make a specific praise statement. Try to help parents and teen have fun with this idea. It may seem silly at first, but these efforts made by parents can be very important to teen's change efforts.

4. ASSIGN HOMEWORK

If module on Expectations and Reinforcement has been presented, additional homework is to implement new expectations and reinforcement strategy agreed upon in session.

Other Homework may be to continue previous homework assignments (Pleasant Activities, Problem Solving, etc) based on individual or family sessions.

COMPLETE THE FORM INDICATING WHETHER THE TEEN COMPLETED ALL, SOME, OR NONE OF THE HOMEWORK SINCE THE PRECEDING SESSIONS.

Module on Family Attachment and Commitment
(For use in a Parent-Teen Conjoint Session)

Topic Code: ***FA***

GOALS OF THE SESSION

9. Review homework from previous sessions
10. Use previously taught skills to Problem Solve Issues that Family Raises
11. Elicit Issues and Incidents
12. Introduce material on Family Attachment
13. Assign Homework

1. WELCOME AND INQUIRY ABOUT PROGRESS ON GOALS AND HOMEWORK

Therapist should open each session by welcoming parents and teen to session and inquiring about how the week has gone with regard to progress towards goals and work on homework assignments. **Therapist must review and/or complete the Affective Disorders Screen with adolescent**.

ISSUES AND INCIDENTS

In addition, as part of or subsequent to the above inquiry, therapist should raise the question of important issues or incidents that have come up or that the family wishes to discuss that the parents and/or teen believe are related to the teen's depression. This format will be familiar to the teen because it is similar to the Issues and Incidents section of the routine session format in his individual sessions. It is a way of eliciting important and immediate issues (and important family processes such as poor communication or poor conflict resolution skills) that may be related to depression.

"Have some things come up this week that you think are important to discuss today?"

"What goals or problems do you want to work on today?"

Just as in individual sessions, the therapist must prioritize the issues or incidents that are identified in this discussion. Guidelines include prioritizing suicidal behavior or thoughts, therapy threatening behavior or thoughts (e.g., wanting to quit, missing sessions or coming late), and then issues that the therapist assesses will be most helpful to deal with in the session as a first or

early experience with new skills, and as a model for dealing with problems at home.

It will not be possible to deal with all issues that come up in families in the limited number of conjoint sessions available. This is another reason that issues must be prioritized. The therapist can also tell families that since we have a limited number of family sessions, it is important to really start practicing new skills for dealing with problems, conflicts, issues, and incidents at home. What we do in conjoint meetings can serve as initial practice at how to do this at home.

Once an issue has been prioritized for work in the session, the therapist should guide the family members in using skills taught in previous sessions for dealing with the issue or problem. For example, the therapist can assist the parents and teen to use the RIBEYE format as a way of discussing the problem. During this exercise, the therapist should listen carefully for poor communication skills (e.g., on the list of Negative Communication Habits) and should point these out when they happen and try to redirect the family member(s) to use positive communication skills as they go through the Problem Solving exercise.

2. **OPTIONAL MODULE— FAMILY ATTACHMENT AND COMMITMENT--**FOR PARENTS AND TEENS WHO ARE VERY DISENGAGED FROM ONE ANOTHER AND FROM THEIR COMMITMENT TO ONE ANOTHER

The therapist may choose to implement this module when parents and teens are emotionally detached from one another and/or when parents display low commitment to their role as parents. This may be displayed in behavioral ways (e.g., parents who spend no time with their teens; who do not do homework assignments; etc.) or may be stated in verbal ways (e.g., parents who say that they don't know why they should have to be involved in their teen's treatment; parents who state overtly that there are tired of having to be parents; or who state in some way that they are so angry or frustrated with the teen that they don't want to be involved with him, want him out of the house, etc.)

3.a. Develop rationale

Begin by acknowledging to family that while there are many problems and worries in the family now, and family members may be very upset or angry or withdrawn from one another, there were probably times in the family when things were better and everybody was happier. If family members can try to recollect those happier times and the positive feelings attached to them, it will make it easier to do the work needed to help overcome present problems, including the teenager's depression.

3.b. Elicit positive relationship history

Ask about child's birth and early months and years. Try to elicit from the parents positive feelings about and statement of attachment to child. If parents have a hard time getting away from talk about problems, try to refocus them on the time before the problems began.

Likewise, try to elicit from the teenager, statements about/memories of positive times in the family or times when things were better between him and his parents. If necessary, ask family members to describe actual events or scenarios that they remember from the past that illustrate good times or former happy or positive feelings among family members.

The goal is to help family members remember some of their feeling of caring and commitment to each other.

3.c. Ask about the role of parent

Ask parents what their idea of being a parent was back then (i.e., when the child was younger). Assist parents in talking about support, nurturing functions. Underscore any statements of commitment, attachment, and engagement that the parents make. Ask parent what their idea of being a parent is now.

Ask teen if he/she can remember when they were little; before depression and before some of the problems that may be in the family now. Ask teen if he can remember the time when they used to be closer as a family. Ask teen if he would like to have a better/closer relationship with his parents even though he is a teen now and definitely needs more independence too. Reinforce the notion that it is not necessary to give up one for the other; that is, just because a teen may normally want more independence and privacy, he can still have a good relationship with his parents. It is not an either/or proposition. Families that work best are ones where the parents respect the teen developing need for independence and at the same time parents and teen maintain a close relationship with one another.

Underscore that even though their child is a teenager now, and even though the family may be very angry or disengaged from one another, the parents are still very important to the teenager. The teenager does still need his parents. It is not too late to reclaim some of those former positive emotions and experiences in the family. The parents can still be the best medicine for the teenager. And the teenager does still need his parents to help him or guide him.

Use whatever points make the most sense for the particular family. The idea here is to try to rekindle a sense of hope that there can be some positive feelings about and interactions within the family; or at least, a rekindled sense of commitment or responsibility to the child in the parent.

3.d. Reinforce any noticeable rekindling of commitment in session

If parents and/or teen show evidence of a rekindled sense of commitment, reinforce this and suggest that at least for the duration of the treatment program, recommitting to helping the teen in his program of working against depression will be something that they can feel good about later.

4. Assign Homework

Homework is to continue to implement relevant previous assignments, or to develop an assignment stemming from this session. For example, following the rekindling of attachment, family members may be more motivated to try again to engage in pleasant activities as a family.

COMPLETE THE FORM INDICATING WHETHER THE TEEN COMPLETED ALL, SOME, OR NONE OF THE HOMEWORK SINCE THE PRECEDING SESSIONS.

Cognitive Behavior Therapy Program

Parent Handouts

What is Depression?

Everyone experiences times of "bad mood." When we are in a bad mood, we might feel sad, **unhappy**, **irritable** or **cranky, or very bored**. Usually, we bounce back pretty quickly from a bad mood. In fact, the mood often changes in a couple of hours or a couple of days.

However, sometimes we may feel badly for a long time. Or we may feel so badly that the mood is much worse than usual for two weeks or more. At times like this we call the mood problem "depression." When depressed, we cannot quickly "bounce back," or "snap out of it."

Depression is a **mood disorder** or **illness** that affects not just the way we feel, but also the way we think, behave, and relate to other people. We may lose interest in things like school, sports, hobbies, activities, or being with friends. We may think we are never going to feel better, that we are to blame for something bad that happened when we really are not to blame, or that we are not a valuable person.

Parents may notice that their teenager is "moody", has unexplained changes in mood, or gets into a bad mood for no clear reason.

Often in teenagers, depression leads to spending a lot of time alone, or in our room away from other people. Friends may think we are not much fun to be with, and in fact we may have a hard time enjoying anything. When really "down" we may think about hurting or even killing ourselves.

Depression also affects our physical condition. We may have trouble sleeping or sleep too much, lose our appetite or want to eat all the time. Our energy might be very low.

So we know we are depressed when we have some combination of the following symptoms:

Emotions:	Sad or irritable
	Bored or not enjoying things
	Guilty
Thoughts:	Can't concentrate or remember or make decisions
	Self-blame or criticism
	Lose interest in activities
	Thoughts of death or suicide
Behavior:	Crying
	Avoiding people
	Isolating ourselves in our room
	Slow moving or agitated
	Self-harm

Biology: Can't get to sleep or sleep too much
Loss of appetite or weight or eat too much and gain weight
Tired all the time
Loss of sex drive

The **causes** of depression vary from person to person. Usually, there is **some combination** of causes.

1. Perhaps we have parents or close relatives with depression, so maybe we inherited a **biological risk** to become depressed. (This does not mean we will necessarily get or stay depressed.)

2. Some, but not all, people who become depressed have had **very difficult experiences** growing up, such as:

    - the loss of a parent when very young
    - a seriously ill, mentally ill, or substance abusing parent
    - an experience of being neglected or abused.

3. **The way we think about things** contributes to depression.

    - focusing on negative experiences, and not paying attention to positive experiences
    - getting "down" on ourselves
    - having negative beliefs about the world or other people or our own future.

4. Sometimes depression is caused by **recent difficult experiences**, such as:

    - the death of someone we love
    - the failure to do as well as we wish in school or sports
    - difficulty getting along with our friends or parents
    - a recent move or a change of schools
    - being stuck in a relationship that is unhappy or even abusive.
    - breaking up with a boyfriend or girlfriend

Once we become depressed, the depression affects our lives. For example, it may be harder for us to concentrate on schoolwork, be with our friends, talk with our parents. We learn some negative ways to cope with stress, such as withdrawing from people, and dropping fun activities or interests. But treatment that works is available to help us to learn positive ways to cope with stress and overcome depression. You will receive that treatment in this project.

WHAT IS COGNITIVE BEHAVIOR THERAPY?

Cognitive behavior therapy (CBT) is one of the best treatments for depression. CBT is a treatment in which you will learn how your thoughts (cognitions or C) and your behavior (B) influence the way you feel (emotions). You will learn ways to change your thoughts and your behaviors so that you can overcome depression.

Our personalities have three parts: thoughts, behaviors, and emotions. Each part influences the other two parts. For example, negative thoughts lead to negative emotions. Negative behavior leads to negative emotions. Positive thoughts or positive behavior leads to positive emotion.

When we are depressed, our emotions are mostly negative. We feel irritable or cranky, sad, unhappy, or bored. It is hard to change our emotions just by trying to feel differently. However, our emotions can be changed by changing our thoughts or by changing our behavior.

In CBT you first work with a therapist to help understand the ways that your thoughts and behaviors may be connected to negative emotions.

You and the therapist work together to find out what thoughts are connected with being depressed, and then work together to "test out" those thoughts, to see if they are really accurate. More accurate and positive thoughts will help you to feel better. Like a scientist, you can test out different ways of thinking to see how they can improve your emotions.

The therapist will also help you to see what behaviors are connected with feeling bad or depressed, and helps you to learn new skills or new ways of behaving that will lead to feeling better.

In CBT, there is "Homework" but it is much easier and shorter than school homework. You and the therapist decide on brief homework tasks that will help you to learn and practice new skills and new ways of thinking.

By using CBT, you can learn how to cope better with stress and avoid becoming depressed again. Even after CBT is over, you can continue to learn and practice the skills from the program, and continue to feel better.

GOAL SHEET FOR PARENTS

Goals for changes in parents' behavior that might help teenager reach his goals:

1.
2.
3.
4.
5.
6.
7.

Examples:

(Stop nagging; praise teenager for going to school every day).

RIB EYE METHOD

Relax or compose yourselves using the relaxation techniques we will learn later. Don't try to solve a problem while you are real mad or upset

Identify the problem. Be specific. Describe the problem not the people. Write down each family member's definition of the problem

Brainstorm. Think of all possible solutions no matter how ridiculous or crazy they might sound. Don't evaluate solutions at this point. All family members should be asked to contribute possible solutions. Write down all the solutions generated.

Evaluate each possible solution. Emphasize the positive consequences for the family as a whole and for the teenager. (E.g., Parents will nag less and teenager will feel less alienated from family). Put a + or a - for each person for each solution

Yes to one. Choose one solution. Look for the solution that has all +'s. If no solution has all +'s which one comes closest? Choose that one or use that one as a springboard for further discussion.

Encourage each other. Discuss how family members can encourage each other or praise each other.

In addition to the steps of the RIBEYE discussed above, it is also important to discuss an implementation plan (i.e., how, when, where, by whom the solution will be implemented) as well as the positive and negative consequences for adherence or non-adherence.

For example, if the teenager agree to do the dishes four nights a week, she will earn $1.00 for every night. She will pay her parents $1.00 for every night that she is supposed to do the dishes and didn't do them. Parents agree not to nag the teenager to do the dishes but simply to give or ask for money if dishes done or not done by a certain time. Parents must pay teenager $1.00 for every evening that they nag about the dishes.

e

FAMILY PROBLEM SOLVING AND COMPROMISE FORM

Name of Family_____ Date_____

Topic: _____

Definitions of the Problem:

Mother:_____

Father:_____

Teenager:_____

Solutions	Evaluations		
	Mother	Father	Teen
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Agreements on which items?_____

Solution Selected_____

f

Implementation Plan: Describe how the plan will be implemented.

_____
_____
_____
_____
_____
_____

Choose a date on which to review how the compromise worked: _____.
For certain plans there will have to be positive or negative consequences for participants for compliance or noncompliance. State here what those would be for each participant:

Positive Consequences Negative Consequences

Three-Column Mood Monitor

This form has three columns. As you pay attention to situations that lead you to feel worse, or to feel better, during the week, write the situations in the first column. Describe where you were, whether you were with other people, and what was happening.
Then fill out the third column. Describe the emotion you felt and give it a rating from the Emotions Thermometer (0-10).
Then fill out the second column. Describe what you were thinking at that time.

Situation	Thought	Emotion (Rating)
Sunday		
Monday		
Tuesday		

h

Wednesday

Thursday

Friday

Saturday

i

COGNITIVE DISTORTIONS

1. Black and White Thinking

   You see things as **perfect** or **terrible**, or you see people as **all good** or **all bad**. You have "grey color blindness."

2. Catastrophizing

   You react to a disappointment or failure as though it means the end of the world.

3. Jumping to Conclusions

   You assume the worst without checking the evidence. You decide that someone dislikes you, but you don't check it out, or you decide that terrible things will happen even when there is no evidence for this.

4. Missing the Positive

   You don't pay attention to positive experiences, or you reject them or say they somehow "don't count."

5. My Fault

   You take responsibility for things that are not your job, or are not in your power to control.

6. Should's

   You get all over yourself or criticize other people with ideas about what absolutely should or must be done by you or them.

j

RIB EYE METHOD

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Identify the problem. Be specific. Describe the problem not the people. Write down each family member's definition of the problem

Brainstorm. Think of all possible solutions no matter how ridiculous or crazy they might sound. Don't evaluate solutions at this point. All family members should be asked to contribute possible solutions. Write down all the solutions generated.

Evaluate each possible solution. Emphasize the positive consequences for the family as a whole and for the teenager. (E.g., Parents will nag less and teenager will feel less alienated from family). Put a + or a - for each person for each solution

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FAMILY PROBLEM SOLVING AND COMPROMISE FORM

Name of Family_____ Date_____

Topic: _____

Definitions of the Problem:

Mother:_____

Father:_____

Teenager:_____

Solutions	Evaluations		
	Mother	Father	Teen
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Agreements on which items?_____

Solution Selected_____

Implementation Plan: Describe how the plan will be implemented.

_____
_____
_____
_____
_____
_____

Choose a date on which to review how the compromise worked: _____.
For certain plans there will have to be positive or negative consequences for participants for compliance or noncompliance. State here what those would be for each participant:

Positive Consequences Negative Consequences

NEGATIVE COMMUNICATION BEHAVIORS

Problem Communication Habits	Alternatives
1. Accusing blaming, name-calling	Make "I" statements ("I feel ___ when ____ happens")
2. Put downs, zapping, shaming	Accepting responsibility; "I" statements
3. Interrupting	Listening quietly
4. Lecturing, preaching, moralizing	Making brief, explicit problem statements
5. Talking in a sarcastic voice	Using a neutral voice
6. Mind reading (telling others what they think and feel)	Asking person what they think and feel
7. Getting off topic	Catching self and returning to the problem
8. Dwelling on the past	Sticking to the present and future (suggesting changes to correct past problems)
9. Monopolizing the conversation	Taking turns making brief statements
10. Threatening	Suggesting alternative solutions
11. Claming up; not responding	Reflecting; validating; expressing negative or positive feelings

n

ACTIVE LISTENING

Non-verbal listening skills

1. Eye Contact. Look at the person who is talking

2. Body Posture. Show by your posture that you are paying attention

3. Head nods. Nod your head occasionally to show that you are listening

4. Keep quiet while the person is still talking; do not interrupt with any comments until they are finished.

Verbal listening skills

1. After the person is finished talking, summarize in your own words what you have heard the other person say; that is, summarize the other persons thoughts and feelings.

2. Ask if you got it right. If they say, "No, that's not what I said", ask them to explain it to you again.

3. Summarize it in your words again, and ask if you got it right this time.

4. Keep doing these steps until the person says you got it right; that is, that you understood what they said

5. Reserve judgment on what the talker is saying until all of steps 1-4 have happened. That is, don't state whether you agree or disagree with it until it is clear that you have listened and heard their point of view and feelings clearly.

What is Depression?

Everyone experiences times of "bad mood." When we are in a bad mood, we might feel **sad**, **unhappy**, **irritable** or **cranky, or very bored**. Usually, we bounce back pretty quickly from a bad mood. In fact, the mood often changes in a couple of hours or a couple of days.

However, sometimes we may feel badly for a long time. Or we may feel so badly that the mood is much worse than usual for two weeks or more. At times like this we call the mood problem "depression." When depressed, we cannot quickly "bounce back," or "snap out of it."

Depression is a mood disorder or illness that affects not just the way we feel, but also the way we think, behave, and relate to other people. We may lose interest in school, sports, hobbies, activities, or being with friends. We may think we are never going to feel better, that we are to blame for bad things that happened when we really are not to blame, or that we are not a valuable person.

Parents may notice that their teenager is "moody", has unexplained changes in mood, or gets into a bad mood for no clear reason.

Often in teenagers, depression leads to spending a lot of time alone, or in our room away from other people. Friends may think we are not much fun to be with, and in fact we may have a hard time enjoying anything. When really "down" we may think about hurting or even killing ourselves.

Depression also affects our physical condition. We may have trouble sleeping or sleep too much, lose our appetite or want to eat all the time. Our energy might be very low.

So we know we are depressed when we have some combination of the following symptoms:

Emotions:	Sad or irritable Bored or not enjoying things Guilty
Thoughts:	Can't concentrate or remember or make decisions Self-blame or criticism Lose interest in activities Thoughts of death or suicide
Behavior:	Crying Avoiding people Isolating ourselves in our room Slow moving or agitated Self-harm
Biology:	Can't get to sleep or sleep too much Loss of appetite or weight or eat too much and gain weight Tired all the time Loss of sex drive

The **causes** of depression vary from person to person. Usually, there is **some combination** of causes.

3. Perhaps we have parents or close relatives with depression, so maybe we inherited a **biological risk** to become depressed. (This does not mean we will necessarily get or stay depressed.)

4. Some, but not all, people who become depressed have had **very difficult experiences** growing up, such as:

    - the loss of a parent when very young
    - a seriously ill, mentally ill, or substance abusing parent
    - an experience of being neglected or abused.

3. **The way we think about things** contributes to depression.

    - focusing on negative experiences, and not paying attention to positive experiences
    - getting "down" on ourselves
    - having negative beliefs about the world or other people or our own future.

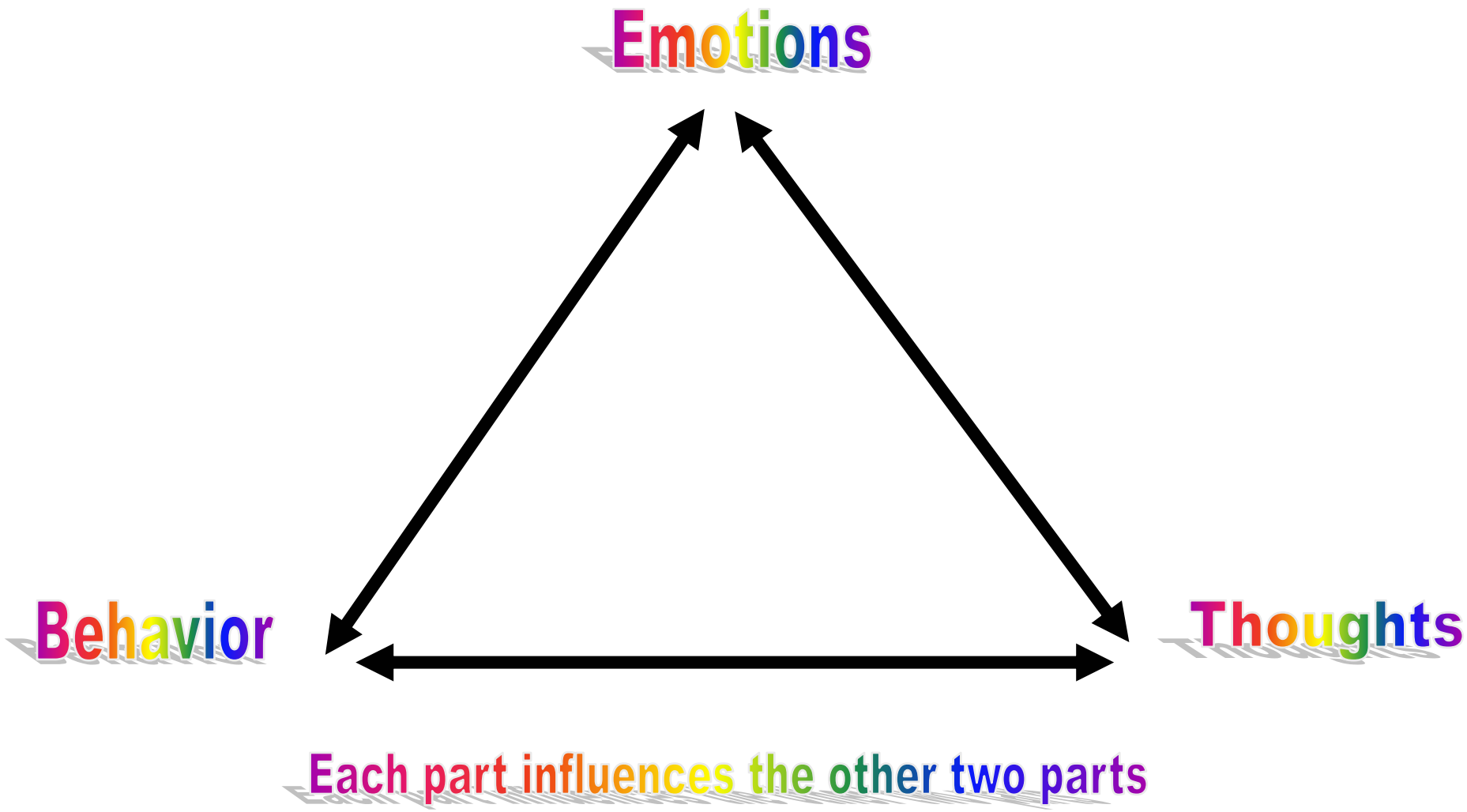
4. Sometimes depression is caused by **recent difficult experiences**, such as:

    - the death of someone we love
    - the failure to do as well as we wish in school or sports
- difficulty getting along with our friends or parents
- a recent move or a change of schools
- being stuck in a relationship that is unhappy or even abusive.
- breaking up with a boyfriend or girlfriend

Once we become depressed, the depression affects our lives. For example, it may be harder for us to concentrate on schoolwork, be with our friends, talk with our parents. We learn some negative ways to cope with stress, such as withdrawing from people, and dropping fun activities or interests. **But treatment that works is available to help us to learn positive ways to cope with stress and overcome depression. You will receive that treatment in this project.**

Depression is a disorder that can come back again. It is important to stay in this treatment program for the whole program, even if the teenager starts to feel better early in the program, so that the adolescent can fully learn the positive ways to cope with stress that will prevent a return of the depression. It is also important for the parents to be involved during the whole program, so they can support the teenager in getting better and staying better.

THREE PARTS OF OUR PERSONALITY



How Thoughts and Behaviors Influence Emotions

Negatives bring us down

Negative Thought	→	Negative Behavior	→	Negative Emotion
"That girl doesn't like me."		*Withdrawing or sulking*		*Sadness*

Negative Behavior	→	Negative Thought	→	Negative Emotion
Not studying for a test		*"I'll never pass that test anyway."*		*Hopelessness*

Positives bring us up

Positive Thought	→	Positive Behavior	→	Positive Emotion
"There are many people who can		Meeting new people and		Happiness

be my friends.” making friends

Positive Behavior	→	**Positive Thought**	→	**Positive Emotion**
Studying for a test		“I can do well on this test if I try.”		Confidence

WHAT IS COGNITIVE BEHAVIOR THERAPY?

Cognitive behavior therapy (CBT) is one of the best treatments for depression. CBT is a treatment in which you will learn how your thoughts (cognitions or C) and your behavior (B) influence the way you feel (emotions). You will learn ways to change your thoughts and your behaviors so that you can overcome depression.

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In CBT you first work with a therapist to help understand the ways that your thoughts and behaviors may be connected to negative emotions.

You and the therapist work together to find out what thoughts are connected with being depressed, and then work together to "test out" those thoughts, to see if they are really accurate. More accurate and positive thoughts will help you to feel better. Like a scientist, you can test out different ways of thinking to see how they can improve your emotions.

The therapist will also help you to see what behaviors are connected with feeling bad or depressed, and helps you to learn new skills or new ways of behaving that will lead to feeling better.

In CBT, there is "Homework" but it is much easier and shorter than school homework. You and the therapist decide on brief homework tasks that will help you to learn and practice new skills and new ways of thinking.

By using CBT, you can learn how to cope better with stress and avoid becoming depressed again. Even after CBT is over, you can continue to learn and practice the skills from the program, and continue to feel better.

HOW CAN PARENTS HELP?

The purpose of this treatment is to help the teenager to overcome depression. The teenager, the therapist, and the parents together form a team that fights against depression.

It is not helpful to "blame" anyone for the teenager's depression. Sometimes teenagers blame their parents and sometimes parents blame teenagers. If parents or the teenager are doing things that might be contributing to the depression, we will work together to change those things, but that is not the same as "blaming" people in the family. It is better to stay united against the common enemy, which is the teenager's depression.

Parents can help a great deal, in these ways:

1. By working with the therapist to understand how depression works and how the treatment works, parents can help the teenager to practice the new skills and new ways of thinking that are part of this program.

2. Often parents are not sure how to react if their teenager is cranky, moody, bored, or unhappy. They can work with the therapist on figuring out the best ways to react so they support the teenager in overcoming depression.

3. Sometimes things going on in the family (such as a lot of mutual criticism), or things that are not going on in the family (such as a lack of pleasant activities), can contribute to the teenager's depression. Parents can take a look at this with the therapist to see if they can make changes that would help the teenager.

4. Almost all teenagers and parents have some communication problems at times. If these are contributing to the teenager's depression, the parents and teen can work together with the therapist to make communication better.

GOALS

In learning new ways to overcome depression, I want to work toward reaching these Goals:

1. Something that would be better for me in my family:

2. Something that would be better for me at school or work:

3. Something that would be better for me with my friends:

4. Other goals:

PARENT GOALS FORM

1. A goal I would like my teenager to work toward in overcoming depression is:

_____

_____

_____

_____

2. A goal **of my teenager** that I can support and help with is:

_____

_____

_____

_____

Cognitive Behavior Therapy Treatment Schedule in TADS

Stage One: 12 weeks

Week:	*Participants:*	*Treatment Time:*
1	Rationale & Goal-Setting (Parents & Adolescent)	1 hour
	Adolescent Session	1 hour
2	Adolescent Session	1 hour
3	Adolescent Session, followed by Parent Session	1 ½ hours
4	Adolescent Session	1 hour
5	Adolescent Session, followed by Parent Session	1 ½ hours
6	Adolescent Session	1 hour
7-12	Adolescent or Family Session	1 hour/week for 6 weeks
		Total Time: 14 hours

Stage Two: 6 Weeks

Session schedule will be determined by what is most helpful to you in Stage One

Total Treatment in TADS, Stages One and Two: 18 Weeks

What Are CBT Sessions Like?

CBT sessions are not all exactly the same, because not all teenagers are alike. The sessions will cover the **things that are important to you** in overcoming depression. CBT sessions will help you to learn new skills or ways of behaving, to discover the thoughts you have that contribute to your depression, and to learn ways of testing those thoughts and changing negative thoughts.

However, there are some common parts in most CBT sessions. Here are the parts to expect during a CBT session.

First Part:

"Issues and Incidents" or "Setting the Agenda"

In this part, you decide, with the help of the therapist, what you want to work on in this session.

Homework Review

In this part, you review with the therapist the "Homework" you did since the last session.

Middle Part:

Skills

In this part, you will practice new skills with the help of the therapist.

Last Part:

Working on the "Issues and Incidents"

In this part, you work on the things you decided to work on in Part I.

Homework

Toward the end of each session, you will get a “Homework” assignment to help you learn new skills or new ways of thinking.

Mood Monitor

We want to help you understand what kinds of things affect how you feel. For the new week, please write down each day some things you are doing and how you feel. Try to write at least one thing for each morning up until lunchtime, one thing for each afternoon up until dinner time, and one thing for each evening. Use the Emotions Thermometer to show how good or bad the feeling is. A 10 would mean the best you have ever felt and a 0 would mean the worst you have ever felt.

	Morning	Afternoon	Evening
Sunday			
Monday			
Tuesday			

	Morning	Afternoon	Evening
Wednesday			
Thursday			
Friday			
Saturday			

MOVING TOWARD GOALS

A goal I would like to work toward first is:

Some steps along the way to this goal could be:

One step I can take this week is:

Things I Like to Do

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

13.

14.

15.

16.

17.

18.

19.

20.

Help with Pleasant Activities

1. **Choose activities that you enjoy**

2. **Choose activities that are <u>ACTIVE</u> not <u>PASSIVE</u>**

3. **Choose activities that are not expensive**

4. **Choose activities that do not harm anyone, get you into trouble, or harm your body.**

5. **Choose activities that you can do often, cooperation of <u>MANY</u> other people.**

INCREASING PLEASANT ACTIVITIES

Activity	Baseline			Days												
	Yesterday			Today												
				1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date																	
1																	
2																	
3																	
4																	
5																	
6																	
7																	
8																	
9																	
10																	
Total Number																	

ACTIVITY SCHEDULE							
Hour	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8 - 9am							
9 - 10am							
10 - 11am							
11 - 12am							
12 - 1pm							
1 - 2pm							
2 - 3pm							
3 - 4pm							
4 - 5pm							
5 - 6pm							
6 - 7pm							
7 - 8pm							
8 - 9pm							
9 - 10pm							

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Three-Column Mood Monitor

This form has three columns. As you pay attention to situations that lead you to feel worse, or to feel better, during the week, write the situations in the first column. Describe where you were, whether you were with other people, and what was happening. Then fill out the third column. Describe the emotion you felt and give it a rating from the Emotions Thermometer (0-10). Then fill out the second column. Describe what you were thinking at that time.

Situation	Thought	Emotion (Rating)
Sunday		
Monday		
Tuesday		

t

Wednesday

Thursday

Friday

Saturday

Letter #1:

Dear Problem-Solver:

Last Saturday, I was driving my father's car to my job at the video rental store. I was close to being late for work, so I was going pretty fast. As I turned a corner on a dirt road after leaving my house, the car slid over to the side of the road. For a minute I lost control of the car. It scraped a tree next to the road, but then I got the steering under control. I was able to get back on to the road, slow down, and stop for a minute. I was pretty shook up.

After I stopped, I got out to look at the car. There is a long scratch mark about 3 inches wide along the passenger side. I could not see any other damage. So I got back in and drove to work. After my usual 6 hour shift, I brought the car home. It was 9 P.M. when I got it home, so it was dark. The next day, my dad went on a trip out of town with some of his friends, in one of their cars.

My dad is coming home in 5 days. So far he doesn't know about the scratch. I'm afraid to tell him, because he might ground me from driving. I need to drive to get to work, and to get to school. Next weekend I'm supposed to take my girlfriend to a big dance. She has been looking forward to it for weeks.

What should I do?

Sincerely,

Worried from Wilson

Letter #2:

Dear Problem-Solver:

This year I started a new school. A lot of the kids are snobs. It's hard to make friends at this school. So far, Maria has been the nicest to me and is my best friend there.
Dear Problem-Solver:

Maria and her friends like to go to the mall on Friday nights and they invited me to go with them last weekend. One of the things they like to do is try to get away with taking little things from some of the stores. Maria stole some cigarettes from the front of the drug store. Her other friend, Clare, took a cassette from a music store where someone had left it out of its case. They kept asking me if I was too chicken to try to take something. Now they have asked me to go to a party with them on Saturday night, and to go shopping with them Sunday afternoon.

I don't know what to do. I don't want to lose my only friends, but I'm pretty scared that I'll get caught and get in big trouble. What should I do?

Sincerely,

Lonely in Louisburg

Letter #3:

Dear Problem-Solver:

My problem is my math teacher. She's a real pain. Last week she was on my case for not getting all my homework in on time. She said she did not care that I had to work extra hours at my job that one night, I still have the responsibility to get the work in. She just doesn't seem to like me. She says I've got an "attitude."

The truth is I just don't like math. I never have. Why do we have to take Algebra anyway? I'll never have to use it in my work. What a waste.

Now I'm behind in the course, and I can't follow what she is teaching on the board. I'm in my senior year, and if I flunk I won't pass for the year or graduate with my class in June.

What should I do?

Sincerely,

Hacked Off in Henderson

Possible Solutions:

THE RIBEYE METHOD

1. **R**elax or calm yourself using some way that helps you to relax (counting to 10, going to another room or going for a walk, waiting until the next day), or using the relaxation methods listed on the next page, **"What Helps me to Relax?"**). Don't try to solve a problem while you are real mad or upset.

2. **I**dentify the problem. Be specific. Decide what part of the problem is yours. Don't take on somebody else's problem as if it were all yours. Think of what you can control and what you can't control.

3. **B**rainstorm. Let yourself think of all possible solutions to the problem. Don't evaluate them yet. Even if they seem ridiculous or silly, consider them. Write down each possible solution. If it helps to do this with someone else, do it that way.

4. **E**valuate each possible solution. Think of the positive and the negative consequences of each possible solution.

5. **Y**es to one. Choose one solution and say "yes" to it in your mind. Use your work on the positive and negative consequences to guide this decision.

6. **E**ncourage yourself. Congratulate yourself for having made a decision. As you put it into practice you will see how it works. If it turns out to have been a mistake, you can learn from it and make a different decision next time. If it turns out well for you, congratulate yourself again and take credit for it.

We will use the RIBEYE method many times during this program. It will help you to solve your problems as they come up, and to get better control over your life right now.

What Helps Me to Relax?

Different people find different things relaxing. Look through this list and put a check mark beside any activity that helps **you** to relax or calm down when you are upset.

_____ Running

_____ Weight lifting

_____ Playing a sport (basketball, soccer, or other sports)

_____ Listening to music

_____ Playing music

_____ Dancing

_____ Working on a hobby

_____ Going out for a walk

_____ Taking a bath or shower

_____ Calling a friend on the phone

_____ Imagining a relaxing scene in my mind

_____ Deep Breathing

_____

_____

RIBEYE WORK SHEET

Name_____ Date_____

Relax. The method I used to relax and calm my feelings was:

_____

Identify. The specific problem I tried to solve was:

_____

Brainstorm. The possible solutions I thought of were:

_____

_____

_____

_____

_____

_____

Evaluate. The consequences I considered were:

_____

_____

_____

_____

_____

_____

Yes to one. The solution I decided to try was: _____

Encourage. To encourage myself for making this decision I: _____
_____

TRIPLE COLUMN

Event (What happened?)	Thought	Emotion (rating 0-10)
Your father or mother tells you that you are lazy. A good friend, who has often helped you, steals your watch. You graduate from high school.		

Dear Problem-Solver:

I seem to be bummed out all the time. People let me down all the time. I've dropped most of my old friends. One after the other, they let me down.

I used to have about 6 good friends. But then I found out that one was going with a girl I didn't like. Another was a poor student. Another tried to play guitar in a band, but he wasn't very good at it. It seems like they all have some kind of problem.

The same thing happened when I started to date girls. The first one I dated talked too much. The next one wore awful clothes. There is one girl who is just perfect, but she already has a boyfriend.

What's wrong with people? They all have something wrong with them. In fact, I'm pretty messed up myself.

Sincerely,

Al R. Nunn
Paradise, PA

Dear Problem-Solver:

I'm scared. It's only been two months since I got to this new school. I'm afraid the principal will throw me out. Then my parents will really be on my case.

What happened is that I was late to class three times this month. The first two times, I had detention after school in the teacher's classroom. But now, after three times, he is writing me up. So now it's in the principal's hands.

Probably, I'll get thrown out. Then I won't be able to get into college. After that, I won't be able to get a good job. My family, if I ever have one, won't have enough money. Man, I am really worried about this. What should I do?

Sincerely,

Freaked Out in
Phoenix, AZ

Dear Problem-Solver:

People don't like me. I was walking down the hall at school yesterday and I did not say "hi" to anyone because I knew they would not respond. I just kept my head down and got to my classroom.

No boy would ever ask me to go out. I'll probably never get a date. Just the other day I was in the music store at the mall, and there was this real cute guy there. But he didn't say anything to me. He probably thought I was ugly.

In school, the teachers don't like me. Why just last week I got a low grade on one of my tests. But even when I get high grades I know they don't like me.

You probably won't bother to answer this letter. If you ever met me, you wouldn't like me either. Should I get plastic surgery to make people like me?

Sincerely,

I.M. Sure
Certitude, CA

Dear Problem-Solver:

Here I am going into my last year of high school, and I've never accomplished anything. When my guidance counselor asked what I wanted to put on my college applications, I could not think of anything.

She said I should talk about my 3.1 grade point average, but grades have always been easy for me to get. Then she said, I should mention that I played on the school baseball team. But my father taught me to play baseball when I was little, so that's really his accomplishment.

Next, she suggested that I write that I was editor of the school newspaper. But my mother is an English teacher, so I'm sure that's how I got to be editor.

After we talked about this college application stuff, my counselor asked me how things were at home. I told her that my job was bringing in some much-needed money for the family. It's such an easy job! My six younger brothers and sisters are doing pretty well. I've been able to help out my mom with taking care of them since my dad has been disabled. They are really easy to take care of!

Anyway, back to my point. What do you put on a college application when you haven't accomplished anything?

Sincerely,

Skip LePlus
Blind Bat Cave, KY

Dear Problem-Solver:

Boy, am I tired! My parents argue all the time. I can't think of any way to stop them. My older brother is a coke-head. No matter what I say to him, he won't stop using. Even when I give him most of my paycheck from my job at McDonald's, he doesn't use the money to pay for his kid's food. He just spends it on drugs.

My teachers want me to stay in school, but how can I do that when my family needs me this much? I think I should drop out and get a full time job that pays $8.00 an hour. That way I could give more money to my brother, and be able to buy nicer gifts for my parents.

Recently, my boyfriend moved in with us. He is looking for a job until he can get it together to go to college next year. We are too young to even think about getting married, and I don't want to be sexually active with him. I gave him my room, and I sleep downstairs in the basement. If I get the $8.00 an hour job, I can buy a bed to use down there. That would be more comfortable than sleeping on that foam rubber mattress on the floor.

What do you think? Should I drop out?

Sincerely,

Glenda Gilt
Giving, GA

Dear Problem-Solver:

What can I do with my girlfriend? She doesn't want to learn how to play a musical instrument. I love music and love to play it. To make matters worse, she doesn't want to be sexually active, and I do.

My teachers are another problem. The best way to teach is to lecture. But some of them use discussion groups all the time.

Then there's the problem with my father. What kind of guy is he if he doesn't want to fish? I never heard of a guy who doesn't fish! And my mother doesn't know how to sew! That's pretty sorry.

The worst part is that I'm fed up with myself. I can't get above a B on my courses this term. My time in the 100 yard dash is still above 11 seconds. I can't talk anybody into doing what they should be doing. I should be able to do that.

What should I do?

Sincerely,

Morris "Musty" Shud
Oughterboro, VA

COGNITIVE DISTORTIONS

1. Black and White Thinking

   You see things as **perfect** or **terrible**, or you see people as **all good** or **all bad**. You have "grey color blindness."

2. Catastrophizing

   You react to a disappointment or failure as though it means the end of the world.

3. Jumping to Conclusions

   You assume the worst without checking the evidence. You decide that someone dislikes you, but you don't check it out, or you decide that terrible things will happen even when there is no evidence for this.

4. Missing the Positive

   You don't pay attention to positive experiences, or you reject them or say they somehow "don't count."

5. My Fault

   You take responsibility for things that are not your job, or are not in your power to control.

6. Should's

   You get all over yourself or criticize other people with ideas about what absolutely should or must be done by you or them.

COGNITIVE DISTORTIONS

Black & White Thinking
Dis'ing the Positive

Catastrophizing
My Fault

Jumping to Conclusions
Should's and Must's

Event (What Happened)	***Negative Thought***	***Cognitive Distortion***

Realistic Counter-thoughts

Read this list of Realistic Thoughts, and check the ones that could help you to "talk back" to Negative Thoughts.

_____ There are some things I am good at, such as _____(a sport, music, a hobby).

_____ I can do well in my schoolwork if I put in the time and effort.

_____ I can do well at my job.

_____ Other people see me as attractive or handsome.

_____ I make friends easily.

_____ I get along with people well.

_____ I am a friendly person.

_____ I have some very good friends.

_____ I can handle problems that come up.

_____ Losing a girlfriend or boyfriend happens to many, many people and they are able to find another boyfriend or girlfriend after some time.

_____ There are some people who love me very much.

_____ I don't get into trouble very often.

_____ My parents love me.

_____ I AM somebody.

_____ I am really interested in: _____

_____ I can solve most problems that come my way.

_____ When I set a personal goal, I go after it.

_____ The future looks good to me.

I am:

_____ a good friend to others.

_____ a good listener when others want to talk.

_____ someone who can be trusted.

_____ fun to be with.

_____ a hard worker.

_____ kind.

_____ someone with a good sense of humor.

_____ able to stand up for myself.

_____ a good problem-solver.

_____ someone with goals for my future.

List any other Realistic Thoughts about yourself that could help you to "talk back" To Negative Thoughts:

u

FIVE COLUMNS

Event	Thought	Emotion (rated 0-10)	Realistic Counterthought	Emotion (rated 0-10)

Meeting, Greeting, and Talking with People

This checklist is included as a guide to the therapist and the adolescent. It is derived from material included in the manual of Clarke, Lewinsohn, and Hops (1990). The list can be used during sessions when practicing skills, and also between sessions as a guide.

Skills that help us to meet other people:
_____Make eye contact
_____Smile
_____Say “Hello” or another greeting
_____Introduce yourself by name
_____Remember the other person’s name and use it in the conversation

Skills that help to start conversations:
_____Look for a good time or situation to start a conversation
_____The other person seems friendly, says “Hello,” makes eye contact?
_____You notice something that you have in common?
_____Same class, same waiting line, same event
_____Shared interests in music, sport, activity

_____Ask a question
_____Tell something about yourself
_____Make a positive comment about the other person

Listening skills:
_____Keep up comfortable eye contact
_____Smile when appropriate
_____Ask questions
_____Talk about your own experiences
_____Look alert (don’t slouch or slump)

Skills for leaving a conversation:
_____Say something polite to end the conversation
_____Mention that you have enjoyed meeting or talking with the other person
_____Mention where you are going or what you are going to do

Skills for group conversations:
_____Stand near the group
_____Listen to the conversation and look for an opportunity to move into the group
_____When the chance comes, say something on the topic of the conversation
_____When leaving excuse yourself and say where you are going

WHAT IS AN ASSERTIVE RESPONSE?

You are in some situation that makes you feel tense, angry, frustrated, or nervous or shy.

...Someone may be pressuring you, or pushing you around, violating your rights, or
blaming you for something that is not your fault.

...You need help with a problem, but you are afraid to ask, or don't know how to ask.

You can respond in one of 3 ways:

- **PASSIVE**: You do nothing, avoid the conflict, or give in to pressure. How does this make you feel?
- **AGGRESSIVE**: You become hostile, sarcastic, nasty, attacking, or manipulative. How does this make you feel?
- **ASSERTIVE**: You stand up for yourself, express your emotions or opinions, speak for yourself, ask for help, or start a conversation with someone without becoming hostile, nasty, or attacking. How does this make you feel?

"I" STATEMENTS ARE ASSERTIVE

"I" STATEMENTS LET PEOPLE KNOW HOW YOU FEEL

STEPS IN ASSERTIVENESS

1. Recognize how you feel.

    1- -Extra. Recognize how the other person feels and let them know you understand how they feel.

2. Use an "I" statement to let the other person know how you feel.

3. Ask for a course of action.

"I" STATEMENTS

When you want to be assertive and to get your point across, try to use one of these phrases in your statement:

I think/don't think.....

I feel/ don't feel.....

I want/don't want.....

I can/cannot.....

I agree/disagree.....

I will/won't.....

I like/don't like.....

ASSERTIVENESS GUIDELINES

For Getting Help with a Problem:

Example: teacher has mistakenly given you a low grade

1. Ask person if you can speak with them

2. State the problem as you see it

3. Ask them to help you with the problem

Example: "Mr. S., can I talk with you about a problem...

"I think my grade on this test is actually higher than what is marked on the paper....Could you help me by looking over the test again?

ASSERTIVENESS GUIDELINES

When you feel unfairly blamed.

Example: your boyfriend yells at you and then blames you for the argument.

1. Recognize how you feel.

2. Tell the other person how you feel.

3. Be clear and firm that this is not "OK."

Example:

1. Get out of the situation, calm down, and start to notice all the different emotions you have.

2. After you have gotten to a safe place and calmed down, and some time has passed, call your boyfriend and tell him: "When we have an argument, I feel angry and hurt. When you yell at me and blame me, I feel furious and then I feel guilty."

3. Tell your boyfriend that you can no longer go with him if arguments continue because this fighting, yelling, and blaming is very bad for you and for him.

ASSERTIVE EXPERIENCE FORM

Briefly describe the situation or problem you are trying to improve through being assertive:

_____

_____

_____

How did you feel as you thought about or prepared to be assertive?

_____

What thoughts were going through your mind?

_____

What exactly did you say and do to be assertive?

_____

_____

_____

_____

How did the other person(s) react? What did they say or do?

_____

How did you feel after this experience?

_____

COMPROMISING AS PROBLEM-SOLVING

Participants:_____
_____

Date:_____

Relax : Is each person calm and relaxed enough to "Problem-Solve" together? If not, wait a while.

Identify the Problem:
_____
_____

Brainstorm: Each person should try to write down 4 to 6 possible solutions to this problem **without evaluating** any of them. Each person can use a separate sheet of paper for this.

Then therapist or leader should take 2 to 3 solutions from each separate list and write them here:

1.

2.

3.

4.

5.

6.

7.

8.

9.

Evaluate: Each person should now rate each possible solution as either a positive or a negative solution

Participants:	**1**	**2**	**3**	**4**
Ratings (+ or -)				
Solution 1				
Solution 2				
Solution 3				
Solution 4				
Solution 5				
Solution 6				
Solution 7				
Solution 8				
Solution 9				

Yes to One: Choose a solution that seems best, given everyone's evaluations, and describe here how it will be implemented.

Encourage one another: Review with each participant how they contributed positively to the compromise.

Choose a date on which to review how the compromise worked:_____ For certain plans there will have to be positive or negative consequences for participants for compliance or noncompliance. State here what those would be for each participant:

Positive Consequences Negative Consequences

FAMILY PROBLEM SOLVING AND COMPROMISE FORM

Name of Family_____ Date_____

Topic: _____

Definitions of the Problem:

Mother:_____

Father:_____

Teenager:_____

Solutions	Evaluations		
	Mother	Father	Teen
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Agreements on which items?_____

Solution Selected_____

Implementation Plan: Describe how the plan will be implemented.

_____
_____
_____
_____
_____
_____
_____

Choose a date on which to review how the compromise worked:
_____.
For certain plans there will have to be positive or negative consequences for participants for compliance or noncompliance. State here what those would be for each participant:

Positive Consequences Negative Consequences

TOOLS IN MY BACKPACK

Tools Helpful?
✓

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

CHALLENGES AHEAD

Possible Big Events in next 6 Weeks: Tools to use:

_____

_____

_____

_____

_____

Daily Home, School, or Friends problems: Tools to use:

_____

_____

_____

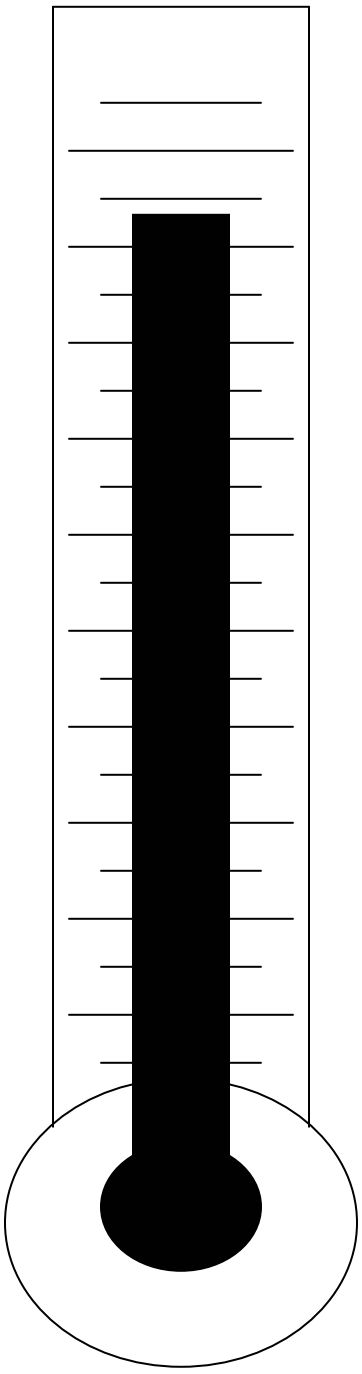
_____

_____

Emotions Thermometer

ff

Feeling Good



Feeling Bad

10 _____

9 _____

8 _____

7 _____

6 _____

5 _____

4 _____

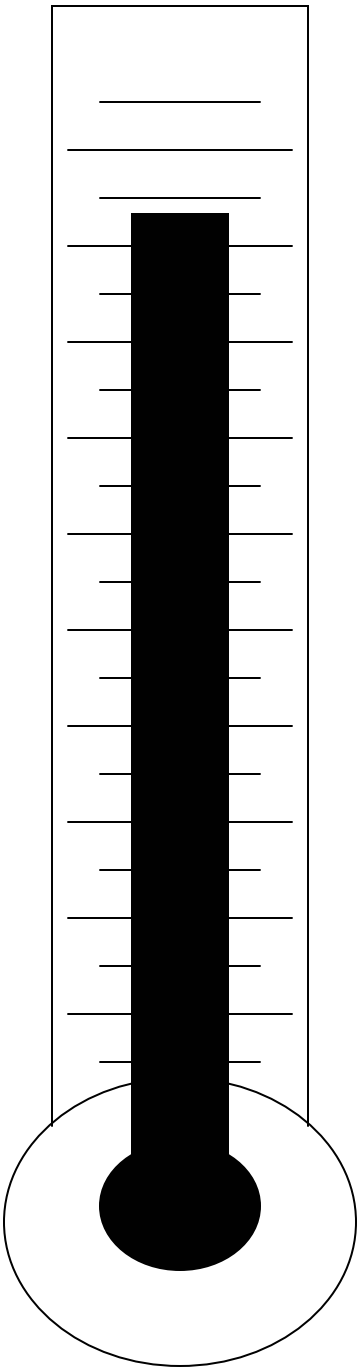
3 _____

2 _____

1 _____

0 _____

Emotions Thermometer gg



10 _____

9 _____

8 _____

7 _____

6 _____

5 _____

4 _____

3 _____

2 _____

1 _____

0 _____