The Society for Clinical Child and Adolescent Psychology (SCCAP): Initiative for Dissemination of Evidence-based Treatments for Childhood and Adolescent Mental Health Problems

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SOCIETY OF CLINICAL CHILD & ADOLESCENT PSYCHOLOGY

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DIVISION 53

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Workshop

Evidence-Based Treatment for Depression in Adolescence: Cognitive Behavioral Strategies

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Part 1 of 9

Depression in Adolescents I: Diagnosis and Assessment

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What do we mean by "depression"?

- Symptom

  Feeling sad or blue

- Syndrome

  A set of co-occurring symptoms, such as a sad feeling, loss of interest, fatigue

What do we mean by ‘depression’?

- Disorder
  1. A set of symptoms
  2. A certain severity and duration of symptoms
  3. An expectable course
  4. A significant and persistent change in the child’s functioning

Major Depression: one of the Mood Disorders in DSM-IV

- Depressive Disorders
  1. Major Depressive Disorder
  2. Dysthymic Disorder
  3. Depressive Disorder NOS
- Bipolar disorders
  1. Bipolar I Disorder (Manic-Depression)
  2. Bipolar II Disorder (Hypomanic-Major Depression)
  3. Cyclothymic Disorder (Hypomanic-Minor Depression)

Symptoms of MDD

- Five or more of the following, most of the day, most days, for at least 2 weeks:
- Depressed or irritable mood*
- Loss of interest or pleasure*
- Appetite or weight gain or loss
- Insomnia or hypersomnia
- Psychomotor agitation or retardation

[* one of these must be present]

Symptoms of MDD (continued)

- Fatigue or loss of energy
- Excessive guilt or worthlessness
- Diminished ability to think, concentrate, decide
- Recurrent thoughts of death, recurrent suicidal ideation, or a suicide attempt or plan

Additional Qualifiers

- Mild, Moderate, Severe
- With Psychotic Features
  - Hallucinations or Delusions
- With Melancholic Features
  - Pervasive anhedonia, distinct quality of mood, terminal insomnia, mood worse in morning, agitation or retardation, anorexia or weight loss, guilt
- With Atypical Features
  - Weight gain, hypersomnia, leaden feelings, rejection sensitivity

Dysthymic Disorder: a milder but prolonged depression

- Depressed or irritable mood, most days, for 1 year
- 2 of the following when depressed:
- Poor appetite or overeating
- Insomnia or hypersomnia
- Low energy or fatigue
- Low self-esteem
- Poor concentration or difficulty making decisions
- Feelings of hopelessness

Prevalence of MDD and DD

- Oregon Adolescent Depression Project (Lewinsohn et al., 1993)
  - High School Students

    Point prevalence of adolescent MDD: 2.57%

    Lifetime prevalence: 18.48%

    Point prevalence of adolescent DD: .53%

    Lifetime prevalence: 3.22%

Costello, Erkanli, & Angold (2006)

- MDD, or “Any Depression”
- Meta-analysis of 26 studies

- Prevalence under age 13: 2.8%
- Prevalence for girls, ages 13-18: 5.9%
- Prevalence for boys, ages 13-18: 4.6%

Age Differences

- Much higher rates of depression in adolescents than in children
- Adolescents with MDD are more likely than children with MDD to have anhedonia, hypersomnia, weight change, lethal suicide attempts

Gender Differences

- In children, approximately equal gender distribution
- In adolescents, from age 14, as in adults, depressed females outnumber depressed males as much as 2:1

Course of MDD and DD

- Kovacs (1996) [clinical sample]:
  - Children with MDD had median duration of 9 months
  - Children with DD had median duration of 4 years
  - Both groups had high risk of second depressive episode (MDD) during 9-year follow-up, with risk higher in original DD children

Course of MDD and DD (continued)

- Lewinsohn et al. (1993) [community sample]
  1. Adolescent MDD had mean duration of 26 weeks (6 ½ months), but median duration was only 8 weeks (2 months)
  2. Range of duration was from 2 to 520 weeks
  3. About 33% of those who recovered from first episode had a second episode within 4 years
  4. Those with onset before 15 ½ years of age had longer episodes and shorter times between recovery and relapse

Duration of MDD: TADS

- TADS (2004; 2007) was a 13-site clinical treatment study
- N = 439
- At TADS baseline, mean duration of MDD was 70 weeks
- Median duration of MDD was 40 weeks

Risk for Adult Depression

- Harrington et al. (1990)

  Depressed young people were compared to non-depressed young people within a child psychiatry clinic sample, and were followed up an average of 18 years later

  Fourfold increased risk of adult depression in those who had been depressed as children, compared to these psychiatric controls

Risk for Bipolar Disorder

- In outpatient treatment samples, about 6-8% of MDD youths have bipolar outcome
- Among inpatient samples, rate can go as high as 20%
- Childhood onset; psychotic depression; hypomanic response to anti-depressant medication; and family history of bipolar disorder are risk factors for bipolar outcome

Common Co-morbid Disorders

Angold and Costello review (1993)

- Conduct or Oppositional Disorder
  - From 20% to 80% across studies and time frames
- **Anxiety Disorders**
  - From 30% to 50% across studies and time frames

Co-morbid Disorders (cont.)

- Oregon Adolescent Depression Project

  Lifetime comorbidity for any Anxiety Disorder in adolescents with current MDD was 21%

  For Substance Use Disorder, 20%

  For Disruptive Behavior Disorder, 12.4%

Patterns of Co-morbid Disorders

- Anxiety most often precedes depression
- Conduct disorder usually precedes depression, but in some cases follows depression
- MDD and DD may be co-morbid ("double depression"): this predicts longer episodes, more suicidality, and worse social adjustment

Patterns of Co-morbid Disorders

- Co-morbid MDD and CD or SUD raise risk of suicide attempts or completions during late adolescence or adulthood
- Most adolescents coming to clinical care for MDD have additional disorders
- Therefore, it is important to assess both depression and possible co-morbid disorders, and to rule out bipolar disorder at start of treatment

Diagnostic Process: Interviews, Questionnaires, and Rating Scales

- Unstructured clinical interview
- Semi-structured diagnostic interview, e.g., K-SADS-P/L (Kaufman et al., 1996); available on-line for not-for-profit clinical settings
- Questionnaires: BDI, RADS, CDI; CTI; BHS; DAS; ATQ; CNCE; FAM
- Rating scale for depression severity, e.g., Children's Depression Rating Scale-Revised (Poznanski & Mokros); published

Unstructured clinical interview

- Allows adolescent and parents to present their concerns, and to tell their stories
- Permits patients to make linkages between depressed mood and precipitants
- Builds rapport
- Structure it enough that you cover core elements of any intake or initial interview, e.g., strengths, interests, family, peers, school, activities

Developmental History Forms

- Conners-March Developmental History
- Child Neuropsychological History Form
- Yields information on early temperament, developmental milestones, school adjustment
- Include current and past medications, psychological treatments
- Include family history of psychiatric disorders

K-SADS-PL is semi-structured

- Clinical interviewer decides if a symptom meets criteria (threshold)
- Interviewee is asked to describe experience of symptom so interviewer can make the rating
- Use as many probes or as few probes as necessary to make the rating

Probes for depressed mood

Have you ever felt sad, blue, down, empty?

Did you feel like crying?

Did you have any other bad feelings?

Did you have a bad feeling all of the time that you could not get rid of?

Did you cry or were you tearful?

Did you feel _____ all of the time or some of the time? Did it come and go? How often?

What do you think brought it on?

Anchors for depressed mood

0 No information

1 Not at all or less than once a week

2 Sub-threshold: Often experiences dysphoric mood at least 3 times a week for more than 3 hours each time

3 Threshold: Feels ‘depressed’ most of the days, more days than not

Semi-structured (continued)

- No need to read probes verbatim
- Adjust language for child, parent, or for cultural considerations
- Use the language of the child or parent
- Do not read the anchors to the child or parent as if they were probes

Time Line

- During the initial open-ended portion of the interview [to be discussed], try to construct a time line of episodes, including onset estimates
- Edit this time line as you go through the more detailed semi-structured portion with parent and child

Sequence of Parent and Child K-SADS-PL Interviews

- For adolescents, recommendation is to interview adolescent first, and then interview parent
- For children, recommendation is to interview parent first, and then interview child
- My preference is to conduct the initial unstructured portion with adolescent & parent

Components of K-SADS-PL

- Initial Unstructured Clinical Interview
- Screen Interview
- Diagnostic Supplements [Mood; Anxiety; Psychosis; Eating; Disruptive Behavior; Tics
- Summary Diagnostic Checklist
- Children's Global Assessment Scale
- [Children's Depression Rating Scale-Revised]

Screen for Depression

- Depressed Mood
- Irritable Mood
- Anhedonia
- Thoughts of death
- Suicidal ideation
- Suicidal actions
- Non-suicidal self-harm

Questionnaires can assess…

- Self-reported symptoms (BDI, RADS, CDI)
- Depressive thoughts abut self, world, future [hopelessness] (CTI, BHS)
- Dysfunctional attitudes (DAS)
- Automatic thoughts (ATQ)
- Cognitive distortions (CNCEQ)
- Family functioning (FAM)

CDRS-R General Characteristics

- Semi-structured
- Suitable for ages 6-12 and for adolescents
- 17 symptom areas:14 queried,3 observed
- Rating of ‘3’ is in clinical range
- Uses a short time-frame (1 or 2 weeks)
- Symptom questions arranged from easiest to hardest for children
- Total scores range from 17 to 113

Items 1-2

- Difficulties concentrating
- Diminished performance
- Problems usually due to internal preoccupations rather than to distractibility, as in ADHD
- Key dimensions for #2 are interest, enjoyment, enthusiasm, and frequency of involvement in activities

Items 3-4

- Social Withdrawal: pertains to a change of functioning, not to a schizoid style
- Friendships, initiative, and responsiveness
- For internal reliability, you may want to create a threshold for sleep disturbance
- For example, is 30 minutes enough to warrant a ‘3’?
- Check whether initial, middle, or terminal

Items 5-14 and 15-17

- Appetite increase or decrease; fatigue
- Physical complaints; irritability
- Excessive guilt; low self-esteem
- Depressed feelings; morbid ideation
- Suicidal ideation; Excessive weeping

- Observed items: Depressed facial affect; Listless speech; Hypoactivity

A Medical Model of Depression

- Criteria for a ‘Disease:’ symptoms (phenomenology), course, laboratory markers, genetic or biological basis, response to specific treatment
- Is MDD a disease?
- Symptoms by now well-established (since about 1980)
- Genetic basis, reflected in family history, is probable, but less robust than for bipolar disorder
- Course is highly variable

Medical Model (Continued)

- Laboratory markers controversial, not well established
- Serotonin hypothesis
- Selective serotonin reuptake inhibitors (SSRI's) maintain a higher level of serotonin in the central nervous system
- Recommended treatment: medication to inhibit reuptake of serotonin (and for some medicines, norepinephrine)

Cognitive Behavioral Models of Depression

- Two models have guided treatment for adolescent depression:
  - Beck's cognitive theory
  - Lewinsohn's multifactorial theory

Beck's Cognitive Theory

- Depression is a "Disorder in thinking"
- The cognitive triad:
  1. Negative views of self: defective, inadequate
  2. Negative views of world: too demanding, too many obstacles, others as unreliable, hostile, unsupportive
  3. Negative view of future: expectations of failure; things will never get better; hopelessness

Automatic thoughts, dysfunctional attitudes, core beliefs

- Automatic Thoughts: superficial, rapid, linguistic or image-based, tied to affect
  - She ignored me
- Dysfunctional Attitudes: If-then beliefs
  - Unless she likes me, I am unlovable
- Core Beliefs in Depression:
  - I am unlovable
  - I am helpless/incompetent
  - I am worthless

What Maintains Negative Core Beliefs?

- Faulty information processing
  - Underdeveloped self-schemas
- Cognitive Distortions
  - All or none thinking
  - Discounting the positive
  - Making the relative absolute (should/must)
  - Overgeneralization

Role of Early Experiences

- Early experiences in the family or with other significant persons provide the basis for forming negative concepts about self, world, and future
- These may remain latent
- They are then activated by a current life experience

Lewinsohn's Multifactorial or Behavioral Model

- Depression is a function of lack of positive reinforcement, especially social reinforcement
- Poor social skills or lack of involvement in pleasant, reinforcing activities, leads to this deficit in experiences of positive reinforcement

Reciprocal Influence

- Unlike Beck's model, Lewinsohn's model does not give priority to cognition

- Personality has three, reciprocally influencing parts:

  Thoughts
  Behaviors
  Emotions

Influence Processes and Treatment

- Downward and Upward Spirals

- Behavior affects thoughts and emotions
- Thoughts affect behavior and emotions
- It is easier to change behavior or thoughts than to change emotions directly
- Depressed patient needs to learn new skills

The CBT model of treatment

- Learn to monitor mood
- Learn the connections between activities and mood
- Develop activity-related skills to influence mood
- Learn coping skills for problem-solving
- Learn the connections between thoughts and mood
- Challenge and modify depressive thoughts

What additional elements can be part of CBT for adolescent depression?

- Factors that influence the depression in this particular case
- Social skills/deficits
- Emotion regulation skills/deficits
- Family processes

Part 2 of 9

Depression in Adolescents II: Starting Treatment

Case Formulation

Psychoeducation

Goals and Safety Plan

Biology and Learning in CBT Case Formulation

- Biological vulnerability through genetics, family history, temperament and personality
- Behavior is learned over time through operant and classical conditioning, modeling, social influence
- Operant: based on reinforcement
- Classical: based on association
- Modeling: parents, peers, siblings, others
- Social influence: family, school, peers, culture
- Cognition: scripts, expectancies, attributions, biases, beliefs

We can’t change genes, but…

- CBT can target those learned patterns of behavior and thinking that maintain depression or create risk for further episodes

Learning and Depression

- Operant: Depressed adolescents avoid potential sources of pleasure or positive reinforcement.
- Classical: They over-generalize from one negative event or situation.
- Modeling: Parents or siblings may model depressive behavior or thinking

(continued)

- Social: Peer or relationship rejection/disruption or parent-adolescent conflict can lead to depression
- Cognitive processes: Expectations; automatic thoughts; dysfunctional attitudes; attributions; schemas

Cognitive Processes and Depression

- Expectation: Girls will not like me
- Automatic thought: She ignored me
- Dysfunctional attitude: Unless she pays attention to me, I cannot be happy
- Attribution: She ignored me because I am boring
- Schema: I am unlovable

Treatment for Adolescents with Depression Study (TADS) CBT

- TADS CBT manual is available on-line for downloading at:

https://trialweb.dcri.duke.edu/tads/tad/manuals/TADS_CBT.pdf

TADS CBT uses a modular approach, with required and optional modules

We will review required modules first

Treatment Targets in CBT

- TADS CBT addresses those individual and family factors that are relevant for **most** depressed adolescents and those that are relevant for **this** depressed adolescent
- **Core** treatment modules address the most common factors
- **Optional** treatment modules address additional individualized factors

Individual Factors in Adolescent Depression

- Behavioral withdrawal
- Lack of involvement in reinforcing activities
- Lack of social interactions
- Passivity (non-assertion)
- Poor problem-solving
- Depressive cognitions

Individual Factors (continued)

- Affective dysregulation
- Anxiety

Family Factors in Adolescent Depression

- Excessively high parental expectations
- Low rates of parental positive reinforcement/reward to teen
- Poor family problem solving
- High EE (Expressed Emotion, including criticism)
- Parents more hostile and rejecting
- Parents less warm

Family Factors (continued)

- Ineffective parenting practices
- Parent-teen conflict predicts lack of recovery from depression after treatment, chronicity of depression and recurrence of depression
- Parent-teen conflict predicts need for additional treatment during follow-up

Case Formulation in CBT

- Why is this adolescent depressed?
- What factors in the adolescent or the family are contributing to her/his depression?
- What skills does the adolescent or family need to learn in order to cope better with stress?
- What strengths do the adolescent and family have to build on in treatment?

Ongoing Case Formulation

- Baseline Formulation from Assessment
- Week 6 Revision
  - Based on therapist's impressions after 6 weeks of treatment
- Week 12: Taking Stock
  - What skills have proven most helpful?
- Week 18: Relapse Prevention
  - What stressors are anticipated?
  - What skills can be used to cope?

Example Case Formulation

- Mary is the oldest of 5 children; her father is alcohol dependent and there is much parental conflict at home
- Mary was a rather shy, inhibited child, who frequently avoided competitive games, focusing more and more energy on her school work
- When she failed math in high school, she became very depressed

Case (continued)

- Mary withdrew from her friends, spent more time alone in her room, and started to have trouble sleeping and eating.
- Her parents worried about her and urged her to go out; when she refused they got angry at her

Formulation

- Temperament: shy, introverted, avoidant
- Lack of parental nurturance, due to parental conflict
- Narrowing of child's interests
- Self-schema overly focused on academic achievement
- Stressful event triggers depression, due to dysfunctional attitude: 'If I do not do well in school, I am incompetent.'

Formulation (continued)

- Belief ?: “I cannot burden my parents with my distress, because they have too many problems.”
- Behavior change: social withdrawal, perhaps due to loss of self-esteem
- Increasing parent-adolescent conflict

Mary: Skills to learn

- Increase pleasant activities, even when you don't feel like it!
- Increase social interaction
- Reality-test beliefs, attitudes, schema
- Cope with failure: problem-solving
- Reduce parent-adolescent conflict

Strengths

- Intelligence
- Supportive parents, despite their own problems
- Social skills appear intact, even though she withdraws

Case #2

- Charles is the younger of two brothers, whose mother suffers from intermittent depression, which was severe when he was a child
- He seems emotionally closer to father than mother
- He has a learning disability that makes school work very difficult

(continued)

- Poor verbal communication skills
- Depression followed a break-up with his girlfriend, which took him completely by surprise
- Charles made an impulsive suicide attempt
- Parents frightened, anxious

Case Formulation

- Temperament: emotionally ‘independent’
- Nurturance mixed: better from father than from mother; parents not critical but not ‘rewarding’
- Pleasure typically from social interaction and not from academics
- Verbal communication deficits lead to lack of awareness of how girlfriend is feeling
- Dysfunctional attitude: ‘If she rejects me, I am worthless/unlovable.’

Case Formulation (Continued)

- Impulsivity
- Parental withdrawal due to anxiety

Skills to Learn

- Affect regulation
- Problem-solving
- Reality-test the belief that this is the only possible girlfriend
- Reality-test the schema of unlovability
- Increase peer interactions
- Increase parents' understanding

Strengths

- Interests that are shared with peers (music, sports)
- Committed parents
- School has reasonable IEP

Downward Spiral

- Mary fails a test, starts to criticize herself, feels sad, withdraws, incurs parental worry and criticism, and starts to lie around and sleep a lot during the day.

Disrupt the Spiral

- Cognition: Change the way I think about failing the test
- Emotion: Change the way I react to sadness and disappointment [e.g., exercise; relaxation; verbal expression]
- Behavior: Instead of withdrawing, call a friend on the phone

Phases of Acute CBT Treatment

- Phase 1: Establish relationship; explain model of depression and of treatment; goal-setting; mood monitoring
- Phase 2: Continue to build relationship; Behavioral activation; Problem-solving; Psycho-education for parents

Phases of Acute CBT Treatment

- Phase 3: Cognitive restructuring; conjoint family sessions, as needed
- Phase 4: Optional individual or family modules; Taking Stock at approximately 12 weeks

Part 3 of 9

First TADS CBT Session

- Rationale & Goal-Setting
- Psycho-education and planning session
- Distinct in some ways from all subsequent sessions
- Future psycho-education sessions are only for parents

Rationale & Goal-Setting

- Adolescent and parent/s, unless contraindicated
- Introduction of therapist & review of presenting problem
- Collaborative model of treatment
- Model of depression & of CBT
- The “Triangle”

Session I (continued)

- Focus on behavior and on ways of thinking
- Skills, time, practice
- Tools in Your Backpack
- Becoming Your Own Therapist

Role of the Parents

- The "Team:" Adolescent, parents, and therapist
- The "Target:" The adolescent's depression
- Work with parents might include help in responding to their adolescent's depression…
- Increasing positive things in the family…
- Decreasing negative communication or family conflict

Goals for Treatment

- What would you like to get out of this treatment?
- If things could be different (better), what would they be like?
- What would you like your life to be like 3 or 6 months from now?
- Are there ways you would like things to be better at home, with friends, at school?

Rules of the Road

- Confidentiality
- Contacts between sessions
- Attendance
- Schedule

Safety Plan

- History of suicidal thoughts, urges, actions
- Review what helped
- Emphasize the importance of time, and ‘surfing the urge’
- What if it happens again
- Actions
- People to contact; contact numbers

Second Session: Mood Monitoring

- "How have you been feeling in the past few days, or past week?"
- "What situations have come up where you felt bad?"
- "How about times when you felt better or felt good?"
- MM = paying attention to how we feel
- MM= 1 tool for the backpack

MM using Emotions Thermometer

- Use visual thermometer
- Fill out points along the thermometer from “feeling really bad” to feeling really good” (0 to 10)
- Link the Daily Mood Monitor to the Emotions Thermometer
- First ‘Homework:’ the Daily MM

Third Session: Revisiting Goals

- Review initial goals
- Review past attempts to reach goals—what worked; what did not work?
- Breaking down goals
- Making goals ‘concrete’ or observable
- Creating new sub-goals

Part 4 of 9

Depression in Adolescents. III Session Structure

Consistent Session Structure

Parent Psycho-education

Positive Parent Focus

Importance of Consistent Structure

- In modular therapy, the specific skill training changes from week to week
- Potential for drift
- Skill training is partly didactic
- Potential for only psycho-education
- Structure permits active collaboration and tailoring of treatment

Structure of a TADS CBT Session

- Agenda-setting or Issues and Incidents
- Review of Homework
- Skills Training
- Work on Agenda Items
- Formulate New Homework
- Use Summaries and Linkages

Agenda

- Patient and therapist collaboratively set the agenda
- May want to write this down on paper or on a blackboard/newsprint
- Therapist has an agenda (skill training)
- Patient is expected to be active contributor to agenda each session

Agenda (continued)

- Of all sections of a CBT session, the agenda was the one most likely to be omitted by TADS therapists
- Therapists can be too anxious to get to the skills training
- Agenda is critical to creating a problem-solving focus and a collaboration

Linkages; Goals; Safety

- Briefly review together what was discussed last time or in previous sessions
- Goal-check: from time to time check on adolescent's attainment of goals
- Mood check: use questionnaire for depression
- Safety check: in cases where indicated, check on suicidal ideation or behavior

Homework Review

- Check to see if teen completed all of part of homework
- What was learned from this?
- If not completed, what got in the way?
- Problem-solve to increase chances of better completion next time
- Complete in the here-and-now

Skill Training

- Selected methods that therapist and patient think may help the patient to overcome depression
- Skill training and related homework also help to uncover maladaptive thoughts
- About 1/3 of session
- Ideally integrated with patient's current concerns

Skills and Modules

- In TADS CBT, each skill is represented in a module that can be selected for use in one or more sessions
- A module does not = a session
- A module is part of a session
- A module can be ‘covered’ across several sessions

Individual Skills (Modules)

- Mood Monitoring
- Goal-Setting
- Increasing Pleasant Activities
- Problem-Solving
- Cognitive Restructuring

Optional Individual Skills (Modules)

- Communication
- Assertion
- Social Interaction
- Relaxation
- Emotion Regulation

Optional Family Skills (Modules)

- Family Attachment and Commitment
- Family Communication
- Family Problem Solving and Compromise
- Family Contingency Management
- High Expectations and Positive Reinforcement

Back to Session Structure: Working on the Agenda

- Prioritize agenda items: safety, treatment engagement, crises, skills
- Make clear that you may not get to all items today, and that others can be carried over
- Apply skills learned already to new agenda items

Summaries & Linkages

- Throughout sessions and at end of each session, take time to assist patient to review main points covered in session
- Make linkages to previous sessions
- Check how patient feels about session, if anything happened that seemed particularly helpful or distressing

New Homework

- Choose a task collaboratively, that is based on the skill being learned
- Give rationale (as always)
- Explain that HW increases benefits
- Work to problem-solve possible barriers to completion
- Take time; don’t rush this part

Homework Tips

- Bargain to a high probability level
- Determine place and time
- Consider mid-week call or email
- Emphasize learning
- Anticipate possible barriers
- Individualize
- ALWAYS ASK ABOUT LAST WEEK'S ASSIGNMENT!

Role Playing in CBT

- **Every** session should involve a role play
- Sequence of skill-teaching:
  - Rationale, tied to this patient's case conceptualization
  - Explain, teach the skill
  - Role-play the skill, first modeling and then asking patient to enact the skill
  - Build homework practice on the skill

Parent Psycho-Education Sessions

- After the initial Rationale and Goal-Setting session, these are the only ‘required’ sessions involving parents
- They are for parents only
- Half of the session is for listening
- Half is for informing parents about the treatment
- Parents can also be seen before or after individual sessions for ‘check-ins’

Parent Psycho-education Sessions

- These are intended to be done back-to-back with an individual adolescent session
- Therapist meets with adolescent first for individual session
- Then meets with parents for psycho-education session
- One in week 2 or 3; one in week 4 or 5

Parent Psycho-Ed Meeting 1

- Goals of this session:
  - To obtain the parents' views of the teenager's problems and their ideas about what might be helpful
  - To teach the parents about the behavioral skills the adolescent is learning
    - Mood Monitoring
    - Increasing Pleasant Activities
    - Problem-Solving

Parent Psycho-Ed Meeting 2

- Goals of this session:
  - To obtain the parents' further views of the teenager's problems and progress
  - To address Expressed Emotion through psych-education
  - To teach the parents about the cognitive skills the adolescent will be learning
    - Catching automatic thoughts and distortions
    - Challenging and restructuring negative thoughts

Contrasting Coaches Metaphor

- Ask about how much negative or critical interchange there is in the family
- Relate to a “negative coaching” metaphor (M. Otto)
- Critical interchange or “negative coaching” makes it harder to get over depression
- Negative coaching=catching teens being “bad”, blaming and criticizing, using a sarcastic or contemptuous tone of voice

Contrasting Coaches (cont.)

- “Negative coaching” happens in all families sometimes
- But when it takes over as dominant style or overwhelms “positive coaching” it can contribute to depression or inability to recover from depression

Contrasting Coaches (Cont.)

- Present examples of contrasting coaches:
  - Negative Coach-Yelling, criticizing, pointing out all errors
  - Positive Coach-Points out the positive; instructs for improvement, encourages, praises
  - Ask parents to articulate differences
  - Ask parents to discuss feelings associated with being the recipient of both styles

Contrasting Coaches (Cont.)

- Inquire about “coaching style” in the family
- Ask family if they would work to change
- Skills that help reduce negative coaching style:
  - Problem solving for conflict
  - Good communication skills
  - Focus on “catching teen being good”

Parent Psycho-Ed 2 Cognitive Distortions

- Present “cognitive distortions”
  - Distortions of events
  - Parents get handout on cognitive distortions
  - Distortions can “run in families”
  - Parents may say things “out loud” that teens pick up as cognitive distortions
  - E.g., “you are so lazy; stupid”; etc.

Revising the Case Formulation

- Around week 6, revise the formulation based on all information now available
- What cognitions has the adolescent demonstrated during sessions that likely contribute to depression?
- What family factors have become evident that likely contribute to depression?

Revising Case Formulation (Cont.)

- What strengths have become evident in the adolescent or family?
- Are other co-morbid disorders now evident?
- Based on the above considerations, what, if any, modules will be used after completing the required ones?

Examples

- Isolated adolescent??
- Angry adolescent??
- Oppositional, acting-out adolescent??
- Substance abusing adolescent??
- Passive-dependent adolescent??
- Impulsive, borderline adolescent??

Example Options to Choose From

- Family contingency management
- Social interaction training
- Assertion
- Affect regulation
- Refer for additional treatment

Part 5 of 9

Depression in Adolescents. IV: Core Behavioral Modules

Behavioral Activation/Increasing Pleasant Activities
Problem Solving

Behavioral Activation

- Increasing pleasant, non-harmful activities
- Rekindling hedonic capacity
- Challenging the belief that activities cannot be enjoyable
- Pleasant Activity Scheduling
- The third tool in the backpack

Increasing Pleasant Activities

- Generate list of activities the adolescent likes or would like to do
- Obtain a baseline
- Select 2-3 target activities to increase
- Rate mood daily
- Note connection between activities and mood

Generating Activities

- Stems: hobbies outdoor activities
  sports music
  cooking poetry/writing
  mechanical/automotive
  religious phone calls/IM
  going places with friends
  entertainment
  art/photography games

Generating Activities

- Brainstorming
- Using a list of activities
- Referring to activities that you know some teens enjoy

Guidelines to Select Targets

- Inexpensive
- Can be done frequently
- Do not require a lot of other people
- Not harmful
- Active, not passive

Choose Weekly Targets

- From the overall list generated, choose 2-3
- Take a baseline of last several days or last week
- Select number of times the adolescent would like to do the 2-3 targets
- Make one target social
- Use weekly chart (see figure)
- Rate mood daily

Challenges in Behavioral Activation

- Should's: I 'should' enjoy this but I don't
- Can't get started
- Impractical
- Social isolation

- Decide if there is a need for basic activity scheduling, using a weekly grid and mastery and pleasure ratings

Problem-Solving

- A general life skill that may be applicable in situations that would otherwise lead to use
- The fourth tool in the backpack
- RIBEYE acronym

Relax	**E**valuate
Identify problem	'**Y**es' to one
Brainstorm	**E**ncourage self

Teaching Problem-Solving

- Use an example that is based on someone else
- Anne Landers letters
- People in the news
- Practice each step separately and slowly
- Then apply the method to a small problem of the adolescent

Challenges in Problem-Solving

- Sometimes emotional expression is needed before problem solving
- Having a positive attitude toward problem-solving is important
- Relaxation or calming almost always needed as first step
- Identifying the problem can be challenging, and tends to intersect with values

Challenges (Cont.)

- Brainstorming: take it to an extreme to make the point, by mentioning some ridiculous options
- Evaluating: go slowly though all pro's and con's, both short-term and long-term
- Choosing: Reinforce the choice and then plan to follow-up to see how it works

Different aspects of PS are key for different disorders

- CD and substance abuse adolescents fail to think of consequences, especially long-term consequences
- Anxious adolescents can be paralyzed by fear of consequences
- Depressed adolescents can be hopeless about arriving at a solution
- Perfectionistic adolescents want the ONE perfect answer
- Suicidal adolescents have great difficulty brainstorming

Part 6 of 9

Optional Family Module: Attachment & Commitment

- Parents and adolescent
- For families in which the parents are ‘burned out’ with regard to this child
- Parents spend little or not time with adolescent
- Parents who avoid or don’t want to be involved in the treatment
- Parents are so angry they want the child out of home

Steps in the Module

- Acknowledge problems
- Refer to likelihood that there were happier times in family's history
- Explain that if family can re-connect with those happier memories, it will make the work of treatment easier to do

Steps (Cont.)

- Elicit positive relationship history
- Recall birth and early years
- Similarly ask adolescent to recall some happier memories of events
- Try to focus on actual events or scenarios
- With parents, talk about nurturing role, what it was like to be a ‘parent’ back when child was young
- With adolescent, talk about better times from past and what was good about them

Ending the exercise

- Ask if adolescent would like to have better relationship with parents, even though he/she may also want more independence
- Ask if parents want to have a better relationship with adolescent now and in the future

Ending the Exercise

- Emphasize the lasting importance of parents over the lifespan, despite changes in role
- Try to rekindle emotional connection and have all members re-commit to working together during treatment

Optional Family Module: Communication

- May be helpful prior to family problem-solving
- For families with high conflict
- For families with confusing or distorted communication
- For families with irritable or hostile communication (high EE)

Steps in the Module

- Describe negative communication behaviors
- Provide handout to family members
  - Interrupting
  - Lecturing
  - Blaming
  - Name-calling
  - Put-downs
  - Ignoring
  - Leaving room
  - Looking at TV or newspaper instead of person talking

Steps (Cont.)

- Describe positive communication behaviors
- Active listening
  - Eye contact
  - Attentive posture
  - Head nods
  - Short summaries

Listening is not = Agreeing

- Summarizing and disagreeing exercise
- Pick a topic other than one the family argues about
- Have one member take a position on it and explain the position to another person
- Have the second person take an opposite position, but NOT express it, as he/she listens
- Have second person summarize first person's position, and check out summaries
- Then reverse direction

Rules for Communication

- Keep verbal and non-verbal communication consistent
- Be specific, not vague
- Use “I” statements, not “you’ statements

- Demonstrate poor communication so everyone can see it
- Then demonstrate good communication
- Have family members role play the latter

Part 7 of 9

Depression in Adolescents. V. Cognitive Restructuring

Depressive Cognitions

Attributions

Methods of Restructuring

Cognitive Restructuring

- CR is the third and final core skill in CBT for adolescent depression
- CR can address automatic thoughts, dysfunctional attitudes, and core beliefs
- Once CR is learned, the adolescent can apply it broadly

Beck's model of cognition

- Automatic Thoughts: Rapid, on-the-surface, ideas, images, comments
- AT's reflect underlying beliefs
- Dysfunctional Attitudes: Conditional beliefs; if-then, or unless-then beliefs
- Core beliefs: Not in conscious awareness; based on early experience

Example

- Event: Mary fails a test
- AT: “I am no good at math.”
- DA: “Unless I excel in all areas, I am stupid.”
- CB: “I am incompetent.”

Core Beliefs in Depression

- I am unlovable
- I am worthless
- I am helpless/incompetent
- These beliefs are latent until triggered by an event
- Two major classes of events triggering depression: **failure or loss**

How Do Cognitive Distortions Fit In?

- Cognitive Distortions serve to maintain negative core beliefs by twisting, ignoring, or over-emphasizing perceptions
- This forces the perception to “fit” the belief.

Examples

- Event: Mary fails one test
- Possible interpretations: 1)That was a hard test; 2) I am not very good at that section of the course; 3)That test was unfair; 4) I did not study well for that test
- Cognitive Distortion of Overgeneralization: “I am no good at math.”
- CD serves to activate Core Belief: “I am incompetent.”

How to Discover the Adolescent's Depressive Thoughts?

- What precipitated the depression?
- Might it suggest a core belief of helplessness, worthlessness or being unlovable?
- What does adolescent endorse on self-report questionnaires, such as the CTI, BHS, DAS

How to Discover… (Cont.)

- What themes emerge during therapy sessions?
- When adolescent experiences an affective shift or expression of affect during sessions---therapist should focus on that [just as in other types of psychotherapy]

Affective shifts or expressions

- Adolescent demonstrates a shift during session, expressed non-verbally or by change of focus, avoidance, discomfort, or by facial expression
- Therapist reflects emotion; then asks what thoughts or images are linked to it

Questions to Uncover Thoughts

- What was going through your mind when that happened?
- What are your thoughts about that?
- I noticed your mood just seemed to shift. Can you tell me what was going through your mind?
- What does that mean to you?

Adolescent report during session [There-and-then]

- Adolescent reports having felt particularly bad one evening since last session
- “What was happening” or “What were you thinking about when you felt badly?”

Cognitions and Homework

- Mood, Event, and Thought Monitor: the Triple Column Method
- Behavioral Experiments: Try a particular behavior during the week and notice how you feel and what thoughts you have. For example, plan to call a friend or to ask a teacher for help.

Daily Thought Record

- Event
- Thought
- Emotion

Adolescent is asked to fill this out each day between sessions.

Here-and-Now

- Notice events that happen in the therapy hour or between the therapist and the adolescent, and what thoughts they might trigger
- E.g., therapist or patient arrive late; patient comments or asks about therapist's family

There is More Than 1 Way to Think About Events

- The traffic accident exercise
- ‘Historical’ review: Have you ever changed your mind about anything?
- Examples, Santa Claus; attitudes toward opposite sex; preferred kind of music

Cognitive Restructuring: Key Questions

- Is that thought absolutely, completely true?
- What's the evidence?
- Is there any other way to look at it?

What's the Evidence?

- This method is designed to counter the cognitive distortions of selective attention or ignoring the positive
- In collaboration, the adolescent and therapist agree to act 'like scientists' to see if a thought is accurate or not.
- Identify one thought to test
- Decide what would be acceptable evidence one way or the other
- Then collect and assess the evidence

Example: “Nobody likes me.”

- Therapist and adolescent agree that this is a recurring automatic thought
- What peer behaviors would support this? Range of possibilities include talking with, texting or calling, inviting, smiling, sharing, asking, ignoring, etc.
- Select a group of people, e.g., classroom, to test this out

How would you test: “All of my teachers are jerks”?

- What evidence?
- What teachers?
- What is ‘jerk’ behavior?

Thought: “All of my teachers are jerks.” Belief: 1-100% __

- Evidence for the thought
- Evidence against the thought
- New Thought: “_____”
- Belief: 1-100% _____

Is there any other way to look at it?

- This method is designed to increase cognitive flexibility
- Therapist and adolescent work together to come up with as many alternative interpretations as possible, which are realistic

What Happened? Thought? Belief: 1-100% __

- What are other ways to look at it?

_____

_____

_____

_____

_____

New Thought: _____

Belief: 1-100%: _____

Additional Cognitive Methods

- Pro-Con Analysis
- Downward Arrow
- Responsibility Re-attribution

- Identification of key control beliefs
- Index cards

Pro- Con- Analysis

- Can be a ‘jarring’ intervention
- Undercuts the adolescent’s absolute belief in a thought
- Designed for those situations in which you suspect the thought is serving a defensive purpose

“What are the Advantages & Disadvantages of Believing That?”

- “No girl will ever go out with me.”
- “I’ll never get a job.”
- “Everybody does drugs.”
- “I’ll always feel depressed.”

Downward Arrow

- This method is designed to counter such cognitive distortions as catastrophizing and other forms of exaggerated beliefs
- Therapist accepts the basic facts of a situation as presented by adolescent
- Therapist then proceeds to ask repeatedly, “What if that were true?”

Alternative phrasings

- “So What?”
- “And then?”
- “And what would that mean?”
- “What’s the worst thing that could happen”

- Goal: Note the ridiculous!

Responsibility Re-attribution

- Designed to counter cognitive distortion of excessive personal responsibility “My fault” (100%).
- Pie Chart
- Take the whole ‘pie’ of responsibility and cut it into portions, assigning each to a different cause.

Part 8 of 9

Teaching Adolescents to Identify Their Distortions

- Use a distancing technique
- Ann Landers letters
- Someone I know…
- Add the list of CD's to the weekly triple column, and ask adolescent to catch it when they use a CD

Identification of Cognitive Distortions

- All-or-None Thinking
- Catastrophizing
- Emotional Reasoning
- Overgeneralization
- Discounting the Positive
- Should’s & Must’s
- My Fault

Realistic Counterthoughts

- For adolescents who are not able to use the methods just described to develop more realistic thinking, provide them
- Use a short list and ask them to indicate which ones are true of them
- In group therapy have peers give positive, and realistic feedback

Constructive Beliefs

- Once constructive beliefs are identified, write them on index cards, and practice them at home
- Practice when not upset so they can be used when depression is worse
- Carry them in wallet or backpack

Attributions

- Explanations of the causes of an event

- Internal-External [I-E]
- Stable-Unstable [S-U]
- Global-Specific [G-Sp]

Attributions: How to intervene

- These will come up in many sessions as you are working on agenda items
- “Jump on them”
- Pay attention to attributions for positive events as well as for negative events
- Depressed adolescents do not ‘take credit’ when credit is due

Why did I get dumped?

- I am unattractive
- I am a loser
- He is an idiot
- He found someone else
- What a break!

Why did our team win?

- The other team was weak
- My teammates are talented
- We are a good team
- We got lucky

Part 9 of 9

Depression in Adolescents VI. Additional Modules

Emotion Regulation

Individual Skills

Family Skills

The Modular Approach

- Characteristics
- Advantages
- Risks

Flexibility between Sessions

- The therapist can choose a module that is most directly relevant to the needs of the adolescent
- Example: Affect regulation can be “moved up” in sequence for those teens who engage in self-cutting or other impulsive behavior

Individualized Pace of Treatment

- More than one session can be devoted to a given module or topic
- Treatment can thus be adjusted to the learning pace and style of the adolescent
- Motivation, trust, cooperativeness, general intellectual functioning contribute to differences in pace

Individualized Sequence of Treatment

- Order of modules can be rearranged to meet needs of adolescent or of parents
- Example: Some, but not all, adolescents who may benefit from Family Problem-Solving will need skills training first in Communication

Flexible Involvement of Family Members

- Psycho-education to reduce parental criticism of teen or attributions of blame for depression
- Psycho-education can enhance parental investment by providing clear rationale and purpose of treatment
- If family factors are assessed as contributing to teen's depression, interactive family modules can be used

Modifications for Families

- Family Attachment module used in cases of parent "burn-out"
- Contingency Management used for oppositional, depressed teens

Potential Benefits of Modular Treatment

Improved Retention

Therapist Satisfaction

Utility of a case formulation

Capacity to address co-morbidity

There is no, as yet identified, single key therapeutic process to overcome MDD (as there is to overcome anxiety disorders: exposure)

Potential Disadvantages of Modular Treatment

- Potential for drift
- Core process may be missed
- Lack of coherence; shotgun approach
- Overly complex treatment
- Trying to do too much/'cover' everything
- 'Replacing' adolescent treatment with family treatment

What holds ‘modular’ CBT together?

- A good case conceptualization
- Psycho-education
- Transparency (genuineness)
- Collaboration
- Session-to-session links and summaries
- Building from basic skills to more complex skills

Taking Stock and Relapse Prevention

- At Week 12, therapist, adolescent and parents review progress made to date, what skills have seemed to help most
- This guides focus of Weeks 12-18 sessions
- Relapse Prevention occurs at Week 18: anticipating potential stressors and choosing most effective coping skills

Ongoing Case Formulation

- Initial assessment
- Update at Week 6
- Taking Stock at Week 12
- Relapse Prevention at Week 18

Adjustments for Co-morbidity

- Oppositional→ Family Contingency Management module
- Impulsive, self-harming→ Affect Regulation module
- Anxious→ Relaxation Module and creation of exposures using Pleasant Activities

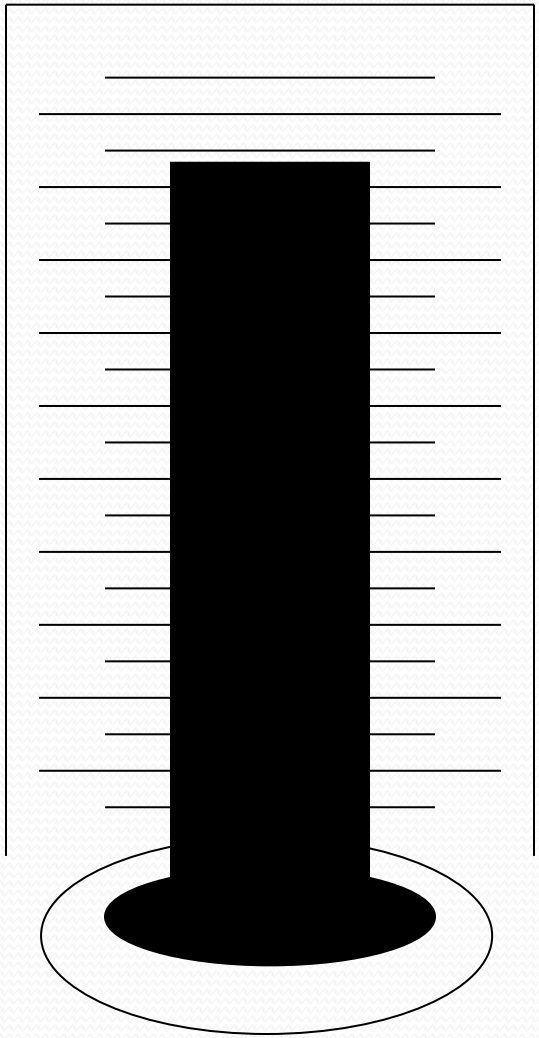
Self-harming or Impulsive Teens

- Affect Regulation
- Use Emotions Thermometer to rate severity of impulse-related affect
- Identify ‘boiling over’ point
- Identify ‘action point’
- Define specific actions to take
- Involve parents in plan

Example

- Adolescent girl cuts self when anxious/irritated/angry
- What are some possible distractors?
  - Walk outside, preferably with family member
  - Pray
  - Self-soothe (bath; art; poetry)
- Feasibility?

Emotions Thermometer



10 _____

9 _____

8 _____

7 _____

6 _____

5 _____

4 _____

3 _____

2 _____

1 _____

0 _____

Using the ‘unlabeled’ Emotions Thermometer

- This thermometer rates the intensity of whatever bad feeling leads to impulsive actions or self-harm
- Fill out steps within the thermometer using examples of situations that have led to various intensities of affect
- Identify the point at which the affect is out of control (boiling point)
- Identify a lower point where action can and must be taken (action point)

Family Module: High Expectations & Low Reinforcement

- Explain the relevance of this skill to this family
- May want to meet with parents separately to lay groundwork for this module
- Discuss how high expectations can be a positive factor, but can also become a burden if they are too high or unrealistic
- Acknowledge that some depressed adolescents impose such expectations on themselves without parental input

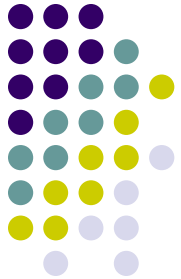
(Continued)

- The importance of positive reinforcement
- Affects mood in the whole family
- Increases attachment and connection between people
- Improves mood of the adolescent
- OK to give praise even for ‘expected’ actions

(Cont.)

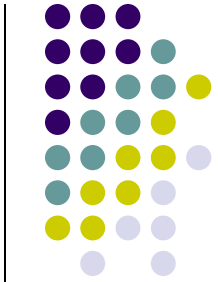
- Work with parents and adolescent together to identify positive things that the adolescent does, or positive aspects of his/her behavior and personality
- Work to adjust unrealistically high expectations
- Give a ‘homework’ assignment to attempt to increase positive reinforcement

Integrating Medication and CBT



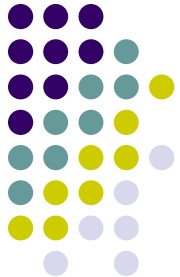
- TADS used fluoxetine (Prozac)
- In 2 therapist model, regular discussions between therapists, e.g., every 4-6 weeks
- Rate of progress in CBT can assist PT in deciding whether to increase dosage
- In TADS, dosage was 20 or 40 mg, and could go as high as 60mg after Week 12
- COMB teens had lower doses that FLX teens

Initial PT Session



- 50-60 minutes in duration
- Establish relationship with adolescent and parents
- Discuss past history and current problems as related to symptoms of MDD
- Establish target symptoms
- Provide rationale for medication
- Discuss dosage, time line, side effects

Second and Subsequent Sessions

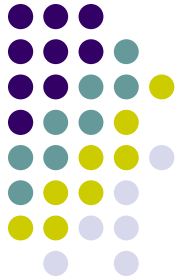


- 20-30 minutes in duration
- Systematic review of symptoms and side effects
- Support hope and optimism
- Further education about the “hows” and “whys” of medication
- Phone visits may be converted to office visits or may be omitted, depending on response

Dosage

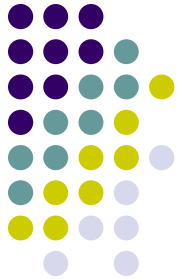
- Week One: 10 mg/day
- Week Two: 20 mg/day
- Increase at Weeks 4, 6, 9, and 12, as follows:
  - If mildly ill (CGI-S = 3), optional
  - If moderately ill, but improved (CGI-S = 4, from 6 or 7), optional
  - Otherwise, if CGI-S = 4, increase by 10 or 20 mg/day, assuming limiting side effects
  - Partial responders at Week 12 may increase to 50 or 60 mg/day

Summary of Visits and Dosing



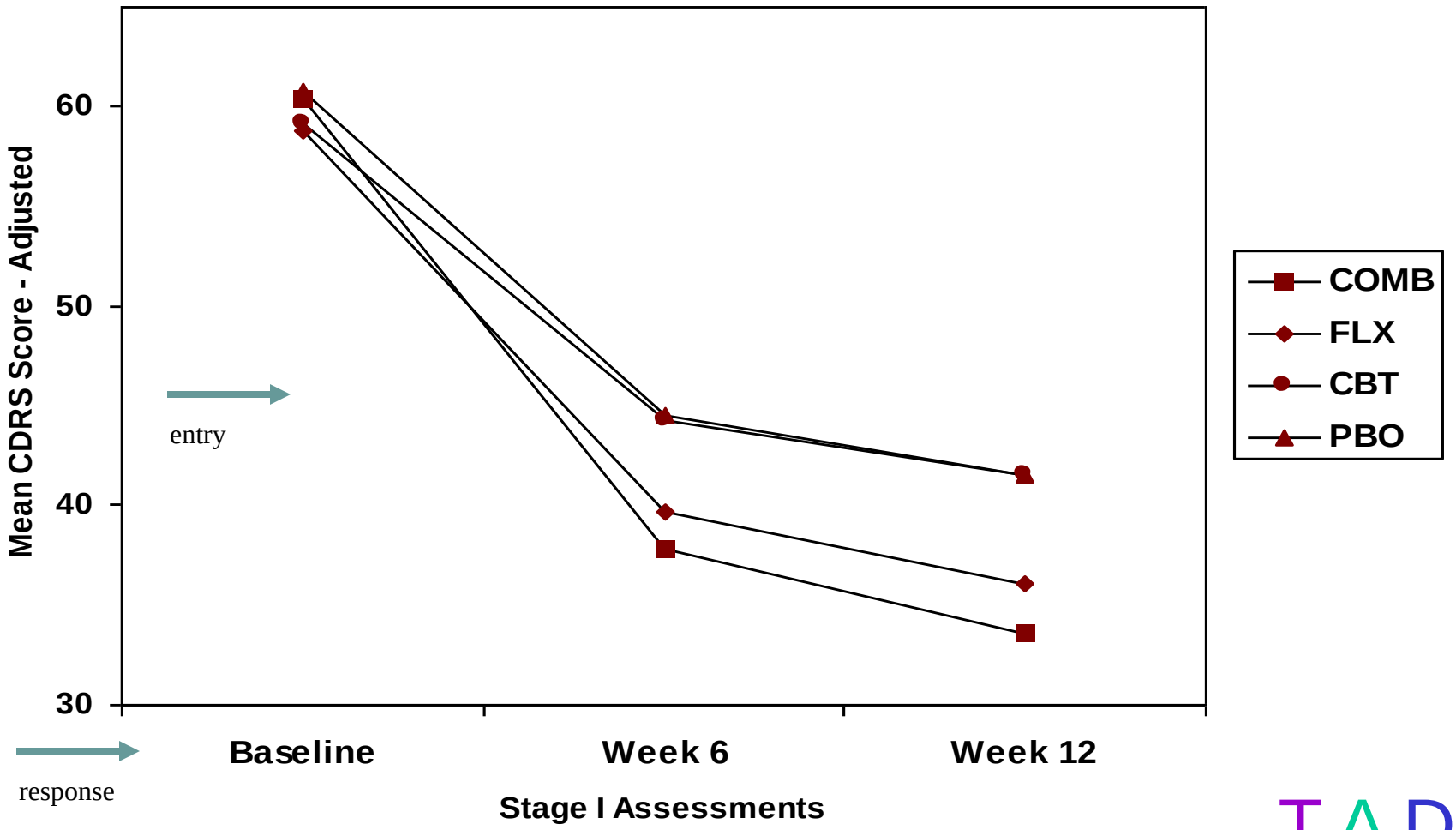
• 1st Week	Office Visit	10mg
• 2nd Week	Office Visit	20mg
• 3rd Week	Phone	20mg
• 4th Week	Office Visit	20-30mg
• 5th Week	Phone	20-30mg
• 6th Week	Office	20-40mg
• 7th and 8th Week	Phone	20-40mg
• 9th Week	Office Visit	20-40mg
• 10th and 11th Week	Phone	20-40mg
• 12th Week	Office Visit	20-60mg

Week 12 Results in TADS



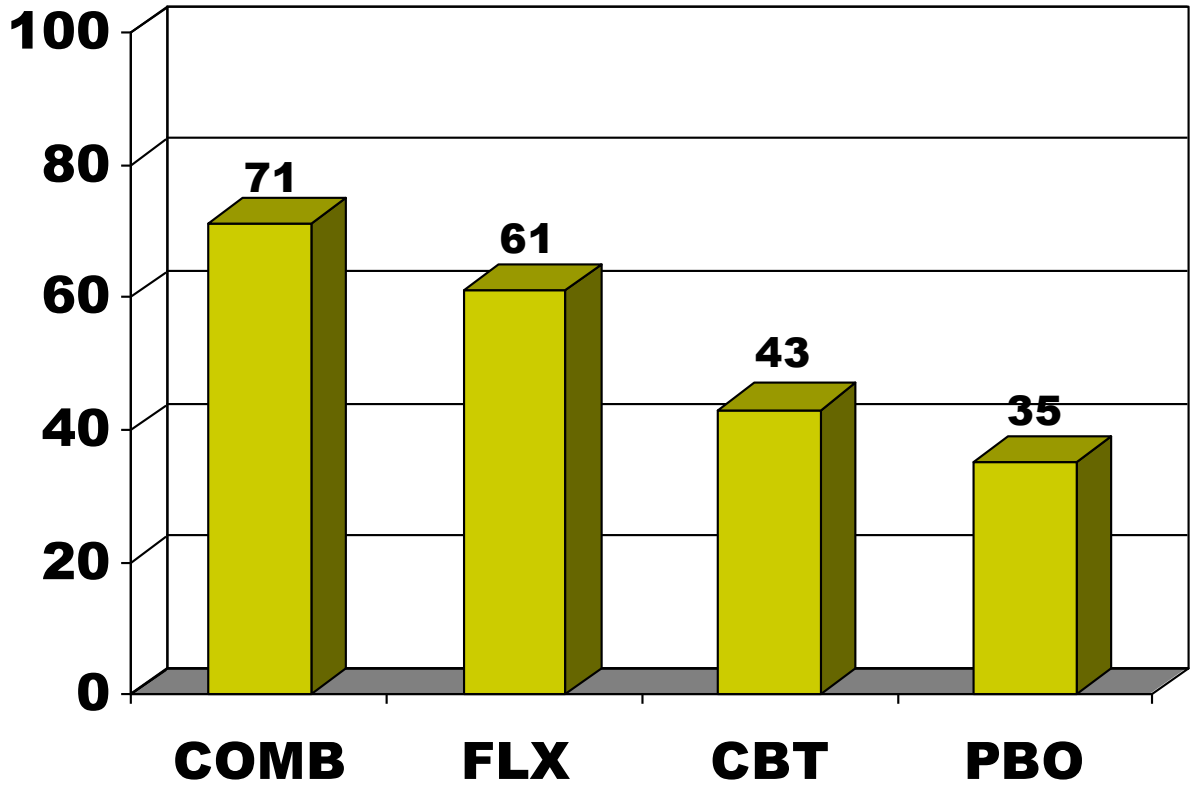
- COMB was the most efficacious treatment
- FLX was next most efficacious
- CBT was third and did not separate from med management with a PBO
- CBT had major impact on suicidal ideation

CDRS: Adjusted Means (ITT)

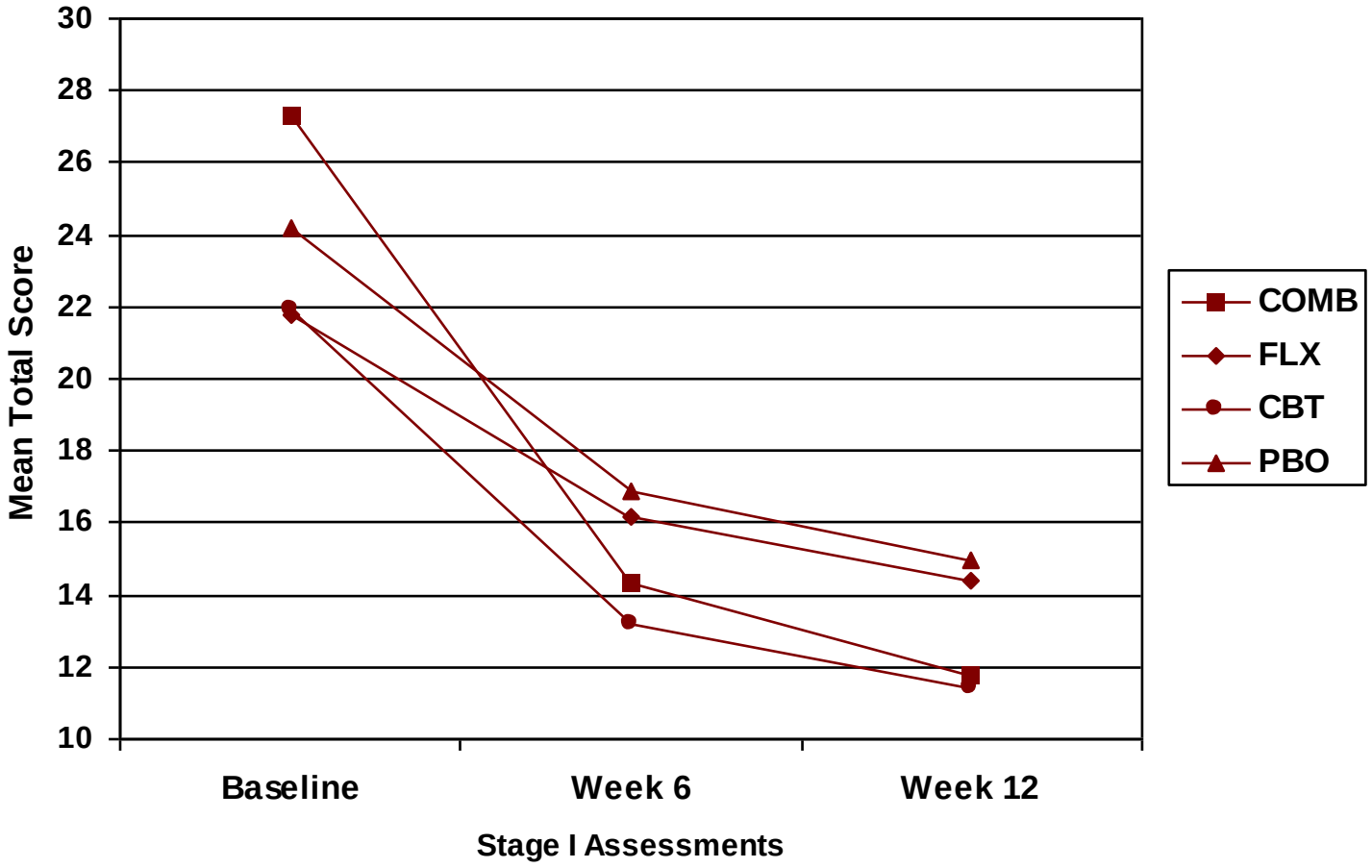


TADS

Treatment Response: Week 12

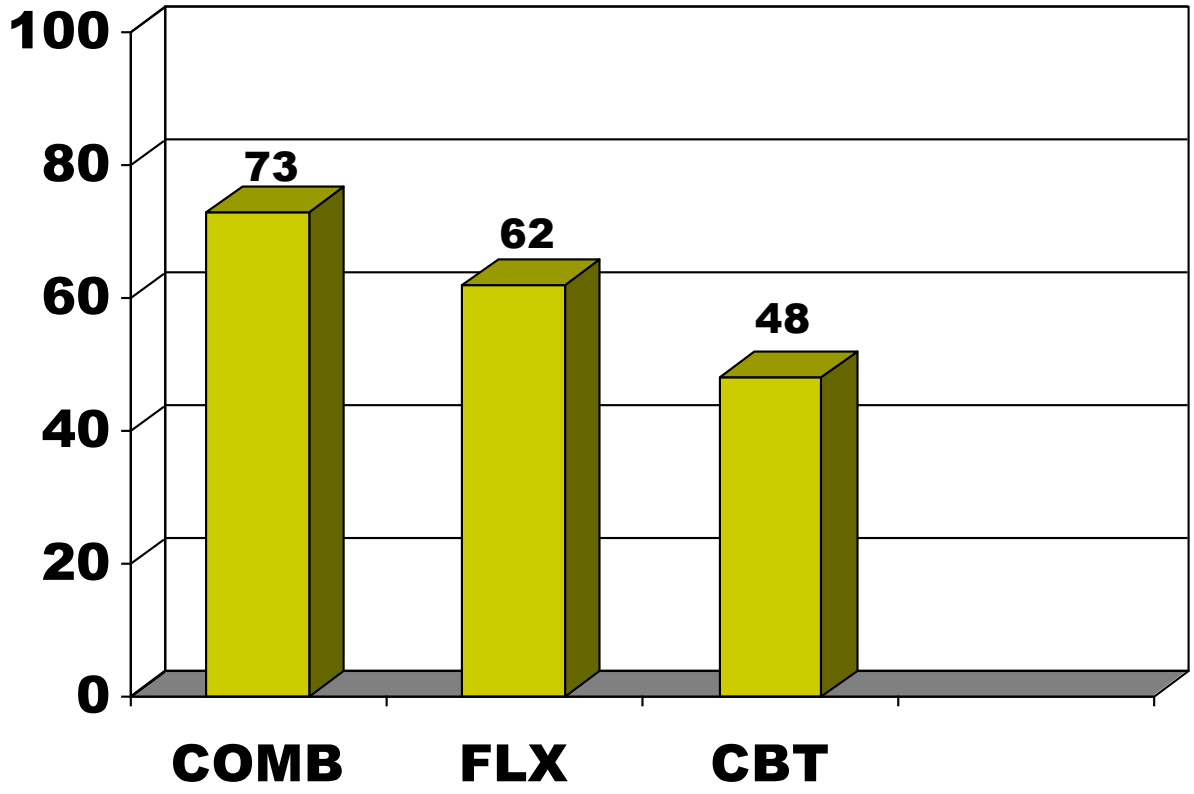


SIQ : ITT Adjusted Means

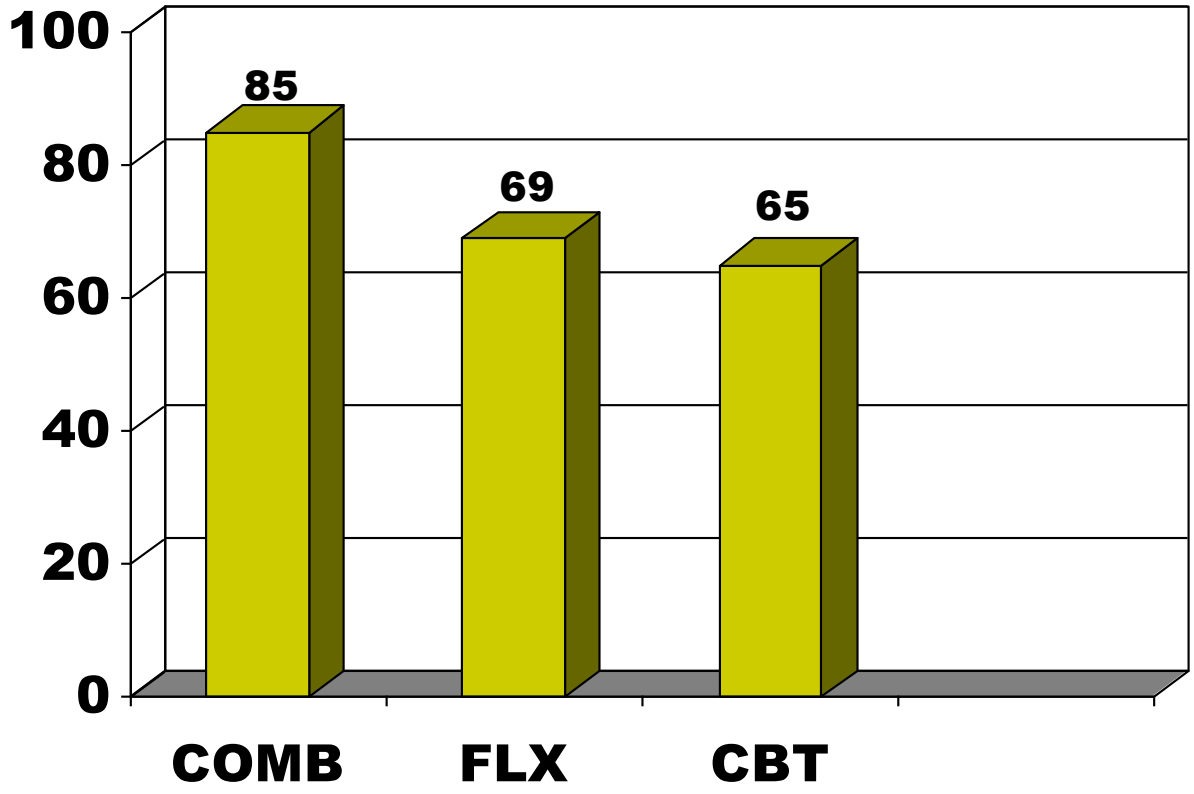


TADS

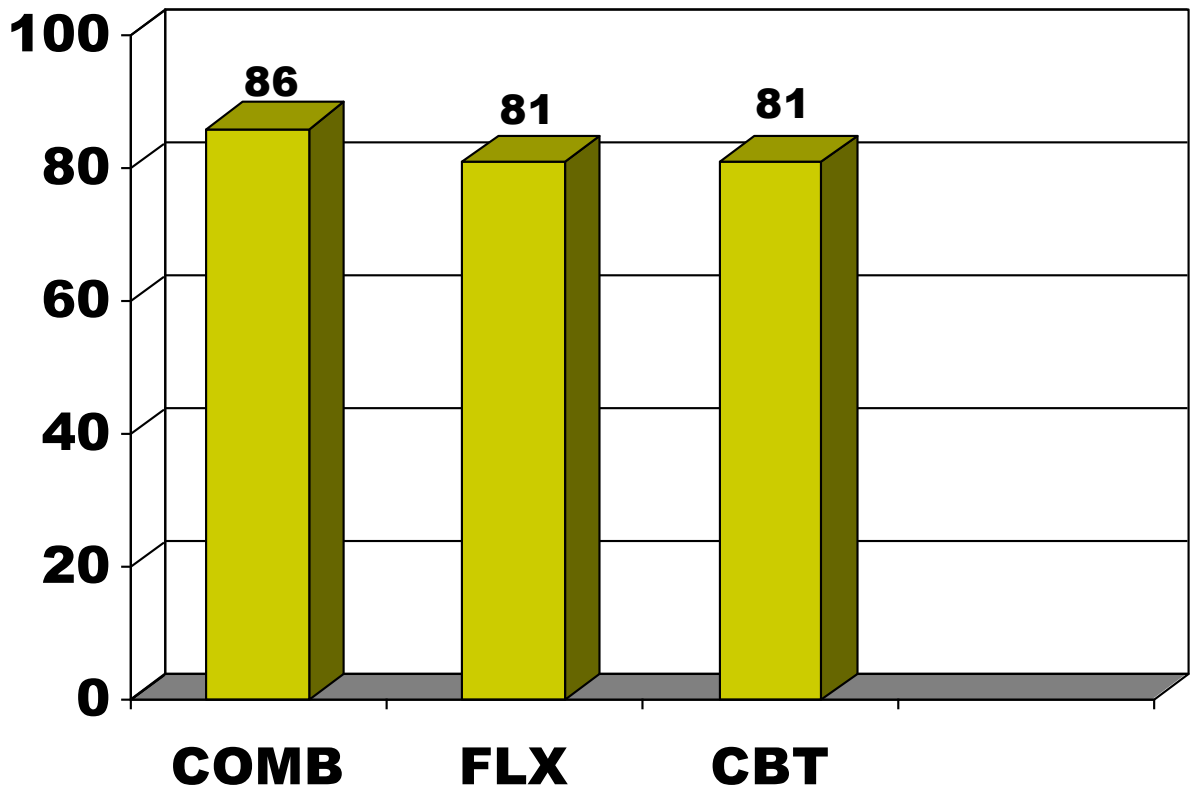
Treatment Response: Week 12



Treatment Response: Week 18



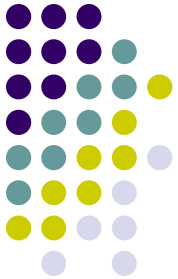
Treatment Response: Week 36



Response by Treatment Arm (ITT) Adjusted for Site

	Week 12	Week 18	Week 36
COMB	73	85	86
FLX	62	69	81
CBT	48	65	81

Clinically significant Suicidal Ideation



- Baseline:

  COMB (40%) FLX (26%) CBT (25%)

- Week 12:

  COMB (9%) FLX (19%) CBT (6%)

- Week 36:

  COMB (3%) FLX (14%) CBT (4%)

Suicidal Events

- Week 12:

  COMB (5%) FLX (11%) CBT (5%)

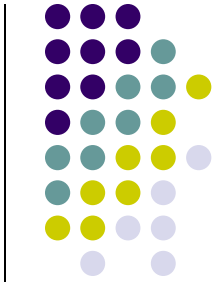
- Week 36:

  COMB (8%) FLX (15%) CBT (6%)

Coded by Columbia system as an attempt, preparatory action, or ideation, plus functional impairment of seeking medical attention

Does NOT include self-harm without suicidal intent

Continuation and Maintenance Treatment



- The gap between CBT and FLX closes by Week 18 on CGI-I Response.
- On the CDRS-R, FLX remains superior to CBT until Week 24, when FLX and CBT are no longer different;
- COMB remains superior to CBT at Week 24
- All 3 treatments converge at Week 30

Family Module: High Expectations & Low Reinforcement

- Explain the relevance of this skill to this family
- May want to meet with parents separately to lay groundwork for this module
- Discuss how high expectations can be a positive factor, but can also become a burden if they are too high or unrealistic
- Acknowledge that some depressed adolescents impose such expectations on themselves without parental input

(Continued)

- The importance of positive reinforcement
- Affects mood in the whole family
- Increases attachment and connection between people
- Improves mood of the adolescent
- OK to give praise even for ‘expected’ actions

(Cont.)

- Work with parents and adolescent together to identify positive things that the adolescent does, or positive aspects of his/her behavior and personality
- Work to adjust unrealistically high expectations
- Give a ‘homework’ assignment to attempt to increase positive reinforcement

TADS Acknowledgement

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- For additional training, please contact

Dr. John Curry- john.curry@duke.edu

For more information, please go to the main website and browse for more videos on this topic or check out our additional resources.

Additional Resources

Online resources:

1. Society of Clinical Child and Adolescent Psychology website: http://effectivechildtherapy.com
2. Treatment for Adolescents with Depression Study website: https://trialweb.dcri.duke.edu/tads/manuals.html

Books:

Curry, J.F., & Reinecke, M.A. (2003). Modular cognitive behavior therapy for adolescents with major depression. In M.A. Reinecke, F.M. Dattilio, & A. Freeman (Eds.) *Cognitive Therapy with Children and Adolescents* (2nd Ed.), pp. 95-127. New York: Guilford.

Peer-reviewed Journal Articles:

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