

IMPACT

Improving Mood with
Psychoanalytic And Cognitive Therapies

COGNITIVE BEHAVIOUR THERAPY FOR DEPRESSION IN YOUNG PEOPLE MANUAL FOR THERAPISTS

Date: February 2010

Version: 1.0

Author(s): IMPACT Study CBT Sub-Group

Change summary: Initial (DRAFT) version

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CONTENTS

INTRODUCTION	4
COGNITIVE BEHAVIOURAL THERAPY AND DEPRESSION IN ADOLESCENCE.....	4
What is depression?	5
What is Cognitive Behaviour Therapy?.....	5
Is CBT an effective treatment for young people with depression?	6
The IMPACT Trial.....	7
PART 1 A Cognitive Behavioural Understanding of Depression.....	9
The basis of Cognitive Behavioural Therapy	9
1: The collaborative relationship.....	10
Collaborative empiricism	11
2: Behavioural theories of depression	12
TOM	15
How does a behavioural model of depression apply to Tom?	16
Including parents and carers in behavioural work	19
3: Cognitive behavioural theories of depression.....	20
SOPHIE	21
How does CBT apply to Sophie?	22
Formation of dysfunctional assumptions	26
Critical incidents.....	26
Activation of assumptions	26
4. Using CBT to help Sophie feel less depressed	26
The formulation in CBT.....	26
Formation of (dysfunctional)assumptions	28
Critical incidents.....	28
Activation of assumptions	28
Formulation diagrams.....	28
Using the formulation to guide clinical work	29
Psycho-education with young people	29
Identifying vicious cycles	30
Behavioural experiments.....	30
Monitoring moods and feelings.....	30
Identifying negative automatic thoughts (NATs)	31
Challenging negative automatic thoughts	32
Learning new skills	33
Identifying assumptions.....	34
Cognitive restructuring	35
5. Including parents and carers in CBT	36
Involving parents in the assessment.....	36
Including parents in the formulation	36
Working with parents to support individual CBT.....	37
The parental role during therapy	39
Opportunities to involve parents in therapy	39
6. Adapting CBT for young people.....	40
Key developmental processes	41
7. How to adapt CBT for young people	44



PART 2: THE INTERVENTION	48
1. Basic skills that all CBT therapists need.....	48
2. Core features of CBT	49
3. Characteristics of CBT therapy	50
4. A typical CBT programme for a depressed young person.....	52
PART 3: APPENDICES FOR USE IN CBT FOR DEPRESSION	58
APPENDIX A Psycho-Education	59
APPENDIX B Engagement and goal setting	63
APPENDIX C Emotional recognition	67
APPENDIX D Activity Schedule	73
APPENDIX E Self-monitoring and detection of NATS	79
APPENDIX F Challenging negtive thinking	86
APPENDIX G Communication and interpersonal skills	95
APPENDIX H Social problems	100
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APPENDIX I Symptomatic interventions	106
APPENDIX J Ending: Closure and therapy	115
REFERENCES	120

Acknowledgements:

This manual is developed from those used in the Manchester CBT trials. Thanks are due to workers involved with the original manuals including Alison Wood, the late Richard Harrington and Julia Rogers.



INTRODUCTION

COGNITIVE BEHAVIOURAL THERAPY AND DEPRESSION IN ADOLESCENCE

This manual aims to outline the main principles of Cognitive Behaviour Therapy (CBT) for depression, to describe the key therapeutic techniques of CBT, and to provide specific information about how these may be adapted or developed for use with young people. The manual has been specifically developed for use by therapists who are taking part in the IMPACT Trial; **I**mproving **M**ood with **P**sycho**d**ynamic and **C**ognitive **T**herapy. However, the contents of the manual are intended to be of value to therapists working with young people within a range of contexts.

The manual assumes that CBT therapists have experience of working with young people and their families, have basic knowledge about developmental psychology and mental health, can build and maintain a therapeutic relationship with young people, are sensitive to power issues, boundaries and managing risk, and have a sound grounding of the principles of CBT. We also assume that they receive regular CBT supervision and are working within the context of a multi-disciplinary team.

In this manual we provide background information about the theory behind Cognitive Behavioural Therapy and background information about Depression and how it is experienced by young people. However, most of this manual is about the nuts and bolts of doing CBT with young people. It is this that we expect most therapists to use most often. We would be grateful for your feedback and comments, as this manual is also a work in progress. We hope it will be a useful resource for therapists, a useful source of reassurance when therapy is difficult, and a handy reminder of basic principles.

What is depression?

Depression is a common and potentially serious, even life threatening, disorder. In this manual we are talking about depression as a clinical disorder, distinct from a transient mood state. At any time, around 3% of adolescents will experience a period of depression which would meet the criteria for diagnosis (Angold and Costello 2001). Around 30-40% of adolescents will experience an episode of major depressive disorder at some point. (Target 2002).

To be diagnosed as depressed a young person will have experienced symptoms clustered around three factors namely low mood, tiredness, and lack of interest or enjoyment in things. The core symptoms of depression as defined by ICD-10 are depressed or irritable mood and decreased interest or pleasure. These symptoms must be experienced consistently for a minimum period of two weeks and interfere with normal functioning. Additional symptoms of depression are as follows: fatigue or loss of energy; loss of confidence or self esteem; unreasonable self blame or excessive guilt; decreased concentration or ability to think; indecisiveness or vacillation; psychomotor agitation or retardation (subjective or objectively); insomnia or hypersomnia; marked appetite change with significant weight loss or gain, or failure to gain expected weight; recurrent thoughts of death, recurrent suicidal ideation or suicidal behaviour; marked loss of libido. Mild depression is characterised by 4 of the additional symptoms, moderate depression by 5 or 6 additional symptoms and severe depression by 7 or more additional symptoms.

Depression itself is common and it is also often seen in combination with other mental health problems and with social problems. Thus it is likely that young people with depression may also have another serious mental health problem such as obsessive compulsive disorder (OCD) or conduct disorder. Depression is also more common in people who are economically and socially disadvantaged and amongst those who have experienced adversity. Young people with depression can be difficult to engage in treatment, difficult to motivate, to keep in therapy and to establish an alliance with. It is for those reasons that we assume that therapists using this manual are experienced and knowledgeable.

What is Cognitive Behaviour Therapy?

CBT for depression includes techniques based on a variety of different theoretical models of depression. It incorporates behavioural theories of depression with the cognitive model of

depression, as developed by Aaron Beck (Beck, 1967, 1978). From this initial focus on the understanding and treatment of depression, CBT has been extended to treat a wide range of disorders including anxiety and personality disorder.

Cognitive behaviour therapy progresses from initially developing a collaborative relationship between the therapist and client and a shared understanding of the person's problems and context. This involves the therapist sharing the cognitive model of depression with their client, and linking the individual client's current and past experiences to the model to develop an individual *formulation*. The formulation is a key part of CBT and will be discussed at various points in this manual.

The formulation is used in therapy to help the client and therapist to identify goals and priorities for therapy and to guide change. Early in therapy there is a focus on monitoring moods and behaviours, identifying negative thoughts, increasing behaviours, and symptom management. Behavioural work is likely to occur early in therapy. Subsequently the therapist and client make links between the client's thoughts, feelings and behaviours, and they work on breaking the negative cycles between these. Typically the therapist will use a range of exercises (behavioural experiments) within sessions and homework tasks between sessions to challenge automatic thoughts, generate alternatives, and evaluate the validity of different thoughts. Clients are encouraged to shift their perspective away from negative automatic thoughts and towards alternatives. As therapy progresses clients are encouraged to become more autonomous, to develop new skills and to consider how to solve problems which may arise in the future. With some clients therapy becomes more focused on the central beliefs and philosophy of the individual (their core schema). In recent years research and clinical work have contributed to new therapeutic techniques such as mindfulness, compassionate mind work, schema focused therapy and acceptance and commitment therapy. These are promising avenues but largely un-evaluated in relation to use with young people. In the context of the IMPACT trial we do not anticipate these new techniques forming the core of therapy with any individual but it is likely that some therapists and clients may find them useful additional components.

Is CBT an effective treatment for young people with depression?

CBT was first developed with adults, mostly those with anxiety and/or depression. Evidence collected in the 1980s and 1990s has tended to demonstrate that CBT is an effective treatment for adults with depression, that it has broadly similar effects as medication and

that, compared to medication, it can reduce relapse in the period after treatment ends. New treatment techniques, such as mindfulness, also appear to be helpful in reducing relapse in adults who have depression. Overall, there is a reasonable research literature on the effectiveness of CBT for depression in adults. The current NICE guidelines recommend that 16-20 sessions of CBT is offered to adults with moderate to severe depression.

There are fewer research studies which have examined the effectiveness of different treatments for young people with depression and the results are less clear cut. For example, a recent very large (N=439), multi site study carried out in the United States (TADS Team, 2007) compared CBT, CBT and medication combined, medication alone and a wait list control group after 12 weeks. At the end of 12 weeks, the young people who received CBT only were not significantly improved compared with those on the waiting list, and were significantly less likely to improve than those who received medication or medication combined with CBT. Young people who received CBT and medication had the highest improvement rates. After 36 weeks around 80% of the young people who received CBT, CBT and medication, and medication only had improved. Young people who had CBT only had lower rates of suicidality compared with medication alone. Thus, treatment which included medication brought about more rapid improvement (at 12 weeks) but after 36 weeks there was no difference between CBT and treatment with medication.

In the UK (Goodyer et al., 2008) recently reported the results of a trial in which N young people referred to NHS Child and Adolescent Mental Health services were randomised to receive treatment as usual (typically psychiatric care) or treatment as usual, plus CBT. There was no evidence that adding CBT to usual care was associated with improved outcomes for the young people and there was no evidence that adding CBT was cost effective.

The IMPACT Trial

The IMPACT trial has been designed to compare the effectiveness and cost-effectiveness of 3 treatments for depression in young people – CBT, short term psychodynamic psychotherapy (STPP), and brief psychosocial intervention (BPI). These three treatments are all credible, are available to some degree in the NHS, and have distinctive underlying models and therapeutic techniques. Importantly they differ in the number of sessions offered and therefore in how much they cost. Within the IMPACT trial this natural difference in treatment duration is reflected in order to ensure that treatments are a good reflection of usual clinical practise. Therefore within the IMPACT trial, STPP therapists will offer up to 30 individual

sessions with the young person and up to 6 sessions with their parent(s). In CBT, therapists will offer up to 20 sessions with the young person and may include their parent(s) in those sessions. In BPI up to 12 clinical sessions will be offered by the clinician and these sessions may include the young person alone or with their parent(s).

In the IMPACT trial we will recruit 517 depressed young people who are referred to Child and Adolescent Mental Health Services (CAMHS) clinics around the UK. They will be randomised to one of the 3 treatments (CBT, STPP, BPI) and receive treatment based on manuals developed by specialists in each field and delivered by appropriately trained and supervised clinicians. Treatment will be delivered in the context of normal NHS services and young people will remain under the care of the multi-disciplinary team. All young people entering the trial will be followed up for up to 86 weeks. As a companion to this manual which is specific to the CBT arm of the trial, each of the other treatments have their own manual (i.e. for STPP and for BPI). In addition, for all clinicians and researchers involved in the IMPACT trial there is a complete guide to the trial including the key research questions and associated research assessments.

PART 1

A Cognitive Behavioural Understanding of Depression

As the title implies, Cognitive Behaviour Therapy (CBT) is a blend of two theoretical approaches to understanding depression. There are therefore distinct behavioural and cognitive techniques that therapists and clients can use to interrupt the cycles which maintain the symptoms of depression. This manual consists of 3 main parts. Part 1 provides an overview of CBT and describes the main theoretical background and approach. Part 2 gives an overview of how sessions are likely to unfold over the course of therapy and provides a range of guidance on techniques and methods. Part 3 consists of materials which therapist might find useful in their delivery of CBT. The materials can be used as they are, or can be adapted by therapists and developed further to suit the needs of different young people.

The range of behavioural and cognitive techniques gives CBT a degree of flexibility which suits working with young people and across many different situations. In this section we will briefly describe the behavioural and cognitive models that underlie CBT, describe how they help therapists and clients understand why people get 'stuck' in depression, and show how they can be used to help 'unstick' people from their current experience of depression.

The basis of Cognitive Behavioural Therapy

As CBT has developed there has been great emphasis on the development of new theories of mental health problems, new therapeutic techniques and the continual improvement of treatment outcome for patients. However, behind the theories and techniques, the core of CBT is the relationship between the therapist and their client and in CBT this relationship has a very particular flavour. As it is so central to the practise of CBT, this section begins with an overview of the 'collaborative relationship' and the practise of 'collaborative empiricism' in CBT. These have important implications for the way in which the therapist acts, the style of therapy and the way in which therapy proceeds.

1: The collaborative relationship

All psychological therapists work against the background of a relationship between the therapist and their client. This is known as the 'therapeutic relationship' or 'therapeutic alliance'. The relationship is generally accepted to have two important features; the emotional bond and the task element. Psychological therapists must convey warmth, genuineness and empathy to their clients so that an atmosphere of trust and acceptance is developed. This provides a safe context in which the young person can share private and sometimes very personal and self exposing information, and a safe context in which they can take risks and try out new ways of behaving and thinking. In CBT, this relationship is an essential part of the therapeutic work that is done and allows the development of active collaboration between the therapist and young person. Because the CBT therapists in the IMPACT trial are experienced we have not provided additional materials which support the development of the therapeutic alliance.

The 'task' element of the therapeutic alliance refers to agreement between the therapist and young person on the overall goals of therapy and on any specific targets, a shared understanding of the young person's current situation and the features of their background that are significant, and agreement about the way in which they will move towards the goals. Collaboration is important at every stage of therapy although it can be expected to change as therapy proceeds. There are a number of specific ways of working in CBT that promote collaboration between the therapist and young person.

- First the therapist helps the young person to identify their goals, i.e. what it is that they most want to change. The therapist may help the young person prioritise the goals, or may add to these but it is important to identify the goals which are specific to that young person and their situation and with which the young person can agree.
- Second, the therapist's role is to help the young person understand the basic CBT model – this will enable them to work in partnership and promote active engagement of the young person.
- Third, the therapist and the client begin to develop a shared understanding of the young person's situation and concerns and through linking this with the underlying model, work on a 'formulation'.
- Fourth, each session begins with the therapist and young person setting an agenda – this outlines what will be covered in the session and it is important for both therapist and young person to contribute to this.

- Fifth, the young person will carry out specific exercises, or tasks, within the session. These are likely to be carried over for the young person to carry on with between sessions. This promotes their autonomy, gives them a sense of ownership over the process of therapy, and help therapy generalise to their everyday life.
- Sixth, the structure of CBT in terms the number of session, the end of therapy, progress toward goals and planning for the end of therapy are all explicit and discussed openly in therapy.

For each of these aspects we have provided specific materials and information to help focus on and develop the 'task' element of the relationship.

In order for young people to be able to collaborate with their CBT therapist they need to understand the rationale behind CBT. Thus, 'psycho-education' is an important stage in CBT (See Part 4). Psycho-education needs to be tailored to the developmental level of the young person and to their current emotional state. Because the developmental issues associated with treating young people are an important aspect of therapy there are specific sections about development and on adapting CBT for young people.

Collaborative empiricism

The relationship in CBT provides the context in which therapist and client can develop an approach known as 'collaborative empiricism'. This is a style of working where the aim is to test the client's beliefs and assumptions, to try out alternatives, to collect information, and to evaluate the 'evidence' that supports or refutes beliefs and assumptions. For example, depressed young people can often only remember negative or neutral experiences and emotions. This can be because their experiences are predominantly negative or neutral. It can also be exaggerated because a side effect of depression is that memory becomes biased towards negative aspects of experience. Thus, people who are depressed tend to remember bad things that happen to them and forget any good (or less bad) things in their past. Depression is also linked with other negative biases. Therefore depressed young people may underestimate their successes, attribute good thing to luck or to other people rather than themselves, interpret neutral events as negative, and are likely to remember failures rather than successes. In CBT, collecting evidence day to day, through diaries and other kinds of records, can provide a more neutral source of information and help overcome negative biases.

In this manual and the appendices there are many different approaches to collaborative empiricism. These include materials that can be used to collect information or 'evidence', exercises to learn new skills and behaviours, and 'experiments' to test out beliefs and assumptions. The key is to remember that in CBT the aim of collaborative empiricism is not to 'prove' that thoughts and beliefs or behaviours are good or bad, right or wrong, but to use exercise and experiments to open up the possibility that other ways of thinking, other beliefs and assumptions, and alternative behaviours might also be valid. This is often in direct contrast to how people think and behave when they are depressed and can provide a way of beginning to address low mood.

2: Behavioural theories of depression

Behavioural theories are based on the idea that our behaviours are shaped by our environment and that we learn through the consequences of our behaviours. The core idea is that rewards and punishments influence our behaviour. We are more likely to do things that are rewarded. This is known as 'positive reinforcement' and a 'positive reinforcer' is any event which increases or strengthens the behaviour which precedes it.

Typically, people who are not depressed engage in a range of activities, some of their own choosing (e.g. hobbies) and some which are not discretionary (e.g. their employment) and these will include a range of positive reinforcers. Some reinforcers are very tangible and they include things like money, or food, or tokens of some kind. Some reinforcers are less tangible such as praise, performing a skill (e.g. playing a sport), being part of a social group, having a close confiding relationship with another person, achieving a goal or reaching a target.

When people are depressed their levels of activity and engagement are usually much reduced. This means that they experience a significant reduction in pleasurable and rewarding behaviours. This reduction in positive reinforcement can lead to further depressed mood, is likely to continue withdrawal, and thus maintains the reduced level of positive reinforcement. This cycle of withdrawal, reduced reinforcement, low mood, and further withdrawal contributes to the feeling of being stuck in depression; it leads to feelings of helplessness and this further undermines their ability to change their mood and behaviours. Apathy, lack of motivation, helplessness and social avoidance are all key symptoms of depression that can be explained using a behavioural model. Levels of activity can also be

reduced when we are ill or injured, especially if social contact is limited; thus illness and injury can be triggers for subsequent periods of depression.

We usually think of reinforcement as something positive. However, reinforcement can also refer to something which is taken away. Negative reinforcement refers to the situation where a negative or aversive experience (or the expectation of that experience) is stopped, delayed or avoided. For example, imagine a situation where I am on a train, listening to loud music from someone else's poor quality ear phones. I ask them to turn the music off and they agree pleasantly. I have been negatively reinforced and in future, if I found myself in the same situation, I am more likely to ask someone else to turn off their music. Or, imagine a situation where you are worried about someone being unpleasant or verbally aggressive towards you to you, for example, your boss, a co-worker, or a neighbour. You do your best to avoid that person and by avoiding them you manage not to be exposed to the aversive experience. You are likely to continue trying to avoid them for as long as the strategy works and you have been negatively reinforced in that the thing you feared has not occurred. Thus through negative reinforcement you have learned that avoidance can be a useful strategy.

TOM

Tom is a 16 year old boy in Year 11. He is an average student. Until things went downhill this year, Tom wanted to work in construction. He goes to the local comprehensive and lives with his mum, older sister and younger brother. Most of his friends live on the same housing estate and he has known them since primary school.

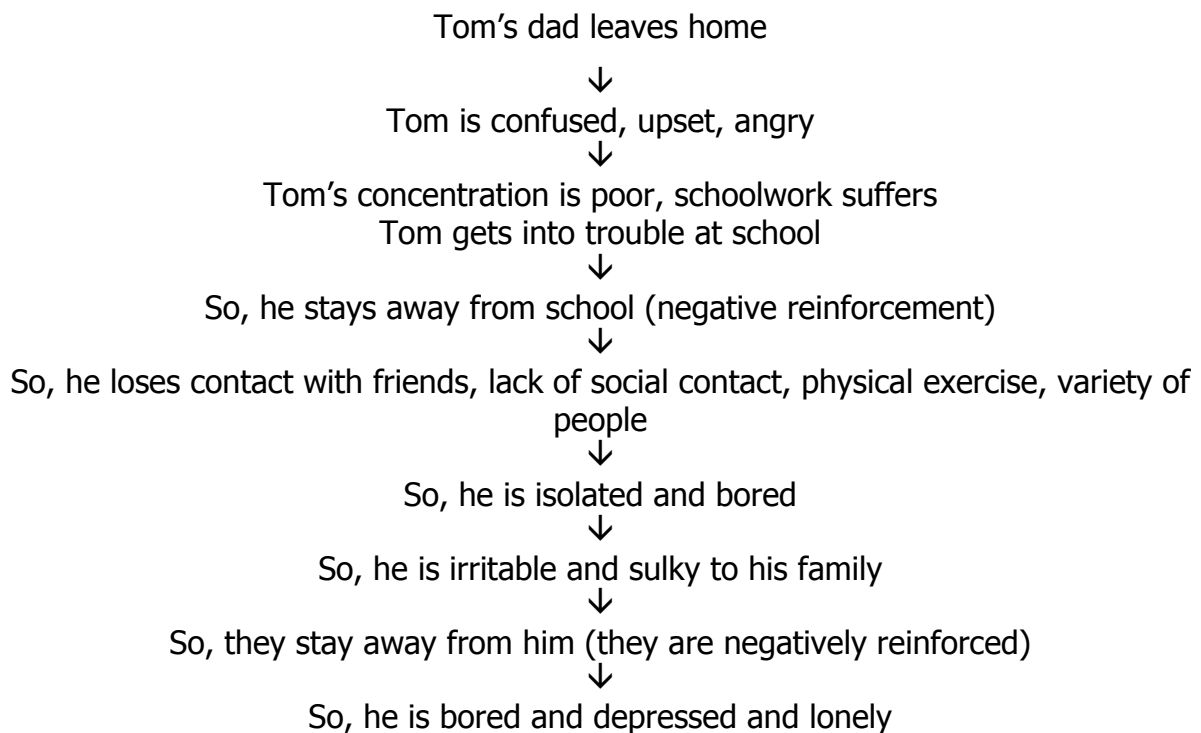
At Christmas, Tom's dad left the family home and moved away to the other side of the city. This was a big shock to the family. Tom has reacted badly. He started messing about at school and began being disruptive in class. The school tried a range of strategies including detentions, time out in the 'Excellence Centre' and brief periods of suspension. Tom started to not attend school. Now, during the day he mainly hangs about at home, playing games on the computer and Play Station. He is going to bed really late every night – at about 2 or 3am and then he doesn't get up until after mid-day. He is always tired and lethargic.

Tom's friends are still at school so he doesn't have any social life during the day and when he sees his friends at the weekend he has less and less to talk to them about. Tom's mum has not been able to get him to go to school and when she tries to persuade him he is either sullen and uncommunicative or rude and verbally aggressive. She is really fed up with him. Also she is still reeling from his dad having left and having to manage the house, her job in the local chemist, and looking after the 3 kids. Tom should be getting ready to sit his GCSEs and then applying for jobs and training courses. But he hasn't done any revision or attended school for 4 months. He hasn't applied for any jobs and he can't see that there is any point.

How does a behavioural model of depression apply to Tom?

Tom is in the middle of a vicious circle – he does less and less and he gets increasingly less fun and enjoyment and ‘positive reinforcement’. He used to have a range of activities that he enjoyed including hanging about with his mates, playing football, and PE lessons at school. He did well enough at school to get encouragement from his teachers and his mum and dad, and he got on pretty well with his brother and sister. There were lots of different ways in which Tom got ‘positive reinforcement’ and lots of different people he could get ‘positive reinforcement’ from. Now, his family and friends don’t enjoy spending time with him and, although they haven’t planned this, they kind of avoid him because he’s no fun to be around. Tom doesn’t have any contact with school at the moment and when he was last there he felt he was being picked on by the teachers anyway. Tom also doesn’t enjoy things like he used to – he uses up time on the computer and Play Station but he’s getting more and more bored and finding it harder and harder to find things he wants to do.

Figure 1: Tom’s vicious cycle



Increasing activity and pleasure

Given that reduced positive reinforcement is seen as a key maintaining factor in depression it follows that a core element of behavioural work with depressed people is to help increase positive reinforcers, or in other words to increase or re-introduce the opportunities for pleasure. For Tom, this means getting him back into doing things he enjoys, widening his range of activities, giving him a sense of achievement and purpose, and providing a structure to his days.

An important early step in working with people who are depressed is to assess, with them, exactly what they do every day. This is usually started in a session and carried on between sessions. With Tom the therapist might ask him to keep a diary of what he does in the week between their appointments. This is known as '*activity scheduling*'. There is more information about activity scheduling and examples of diaries in Appendix D (page 74). The diary has two main elements; first Tom is asked to keep a note of the actual things he does each day. Secondly he is asked to rate how much he enjoyed that activity.

Using activity scheduling diaries

Usually, the diary will show very low levels of activity and low levels of pleasure. It is important to encourage Tom and other clients to write down things that they think are unimportant or trivial, including things like showering or bathing, doing household chores, eating meals, watching TV (specific programmes) or making telephone calls. People who are depressed tend to remember only things that are negative, keeping a diary can help show that even in a bad week, there are sometimes small but pleasurable events. Often diaries show some variation in levels of pleasure; for example, the diary may show that some social interactions were slightly pleasurable, that some TV watching was mildly enjoyable, or that some simple day to day tasks were accomplished. This information can be very useful in therapy; the fact that even some pleasure was experienced is often a great surprise to the client who often remembers only the very negative parts of their recent life. Also any evidence of pleasurable activities provides very useful information about how more positive reinforcement could be introduced into daily life.

Often the initial diaries show almost no activity and no pleasure. This forms the basis on which the therapist and client can build. In behavioural work the aim is to gradually increase the amount of activity experienced by the client each week. Together the client and therapist

identify simple, limited activities which they set as a goal for the subsequent week. This might include solitary activities e.g. walking to the local shops for a paper, listening to a favourite piece of music, taking the dog for a walk, or tackling a small but neglected household chore. Gradually the level, complexity and challenge of the weekly goals are increased but this is approached with caution.

Tom might see this as a pointless waste of time. What good is it to him if he can do a few more things if basically his life is wasted? It will help Tom to see that building up his activities is part of a bigger picture and leads to something which he would value. For Tom, who has always wanted to work in construction, the bigger picture might include getting into a position where he can apply to college or for an apprenticeship. If he can see how the activities which are planned might lead to this far-off goal, it is more likely that he will at least think it worth trying. It can be very difficult early in therapy to motivate someone who is depressed and they may benefit from help with this task from another family member or friend (see Appendix D). Family and friends may also be useful sources of information about preferred activities and possible sources of pleasure. The therapeutic relationship is also a very important source of motivation; having a good relationship with Tom, and showing optimism that change is possible, that he has the capacity to get better and that he deserves to try, can all help give Tom the confidence and motivation to at least have a go at increasing his behaviours. Remember, the point of collecting data is not to 'prove' something to Tom, but to find out. It is important not to cross the line which divides encouragement and support from coaxing and persuasion.

As activity scheduling proceeds it is important to also continue to rate pleasure. The aim is to increase the range and number of activities and, in doing so, to break the vicious cycle of inactivity, low mood, passivity and hopelessness. Typically, as activity increases the client will begin to experience more pleasure and this becomes positively reinforcing. Thus they find it less difficult to repeat the activity in future, experience further positive reinforcement and are more likely to repeat the activity again. In this way the vicious cycle of inactivity becomes transformed into a virtuous cycle of activity and pleasure.

Using reinforcement to tackle depression

Doing more things can often increase feelings of pleasure and achievement through increasing positive reinforcement. This is especially so for young people who have been hopeless about their ability to do anything ever again, and who have begun to think of

themselves as worthless. However, it is also useful to build in explicit rewards for specific activities or acts. Rewards can be tangible (e.g. ice cream) or intangible (e.g. praise) and can be self generated or be given by others (for example parents, teachers, friends, colleagues). Using tangible rewards can help initial motivation; however, it is crucial to use age appropriate rewards and to involve the young person in setting these up. They need to agree to the use of rewards and to the involvement of others, especially their parents. Any whiff of being patronised can be deadly. As therapy proceeds and mood improves, intangible rewards and self generated rewards (e.g. self statements – Well done!) can become powerful reinforcers.

There is a worksheet outlining how to use reinforcement methods with young people in Appendix D.

Including parents and carers in behavioural work

Working with young people who are depressed often means that we need to also work with their parents or carers. Parents and carers will usually find living with the young person who is depressed very difficult, frustrating, upsetting, confusing and worrying. People who are depressed are not good company, they are not fun to be around, they can make us feel inadequate and depressed, they can undermine our own feelings of competence and they can be hostile and abrupt. Therefore being with people who are depressed is itself an aversive experience. As outlined above, typically we try to avoid aversive experiences. Therefore young people who are depressed not only avoid people but they also often become avoided by others. This mutual avoidance forms another kind of vicious cycle. As we avoid someone who is depressed we remove another possible source of positive reinforcement (i.e. ourselves) and add to the sense of isolation and loneliness experienced by the depressed person.

Working with parents and carers gives an opportunity to intervene in this cycle of avoidance and reduced social contact. As described in the section above, parents and carers can become direct providers of positive reinforcement and can receive positive reinforcement from their child. However, involving parents and carers in therapy does need care; some parents and carers are themselves depressed and hopeless and may find becoming actively involved in therapy extremely challenging. They may model passivity and hopelessness and reinforce avoidance in their child.

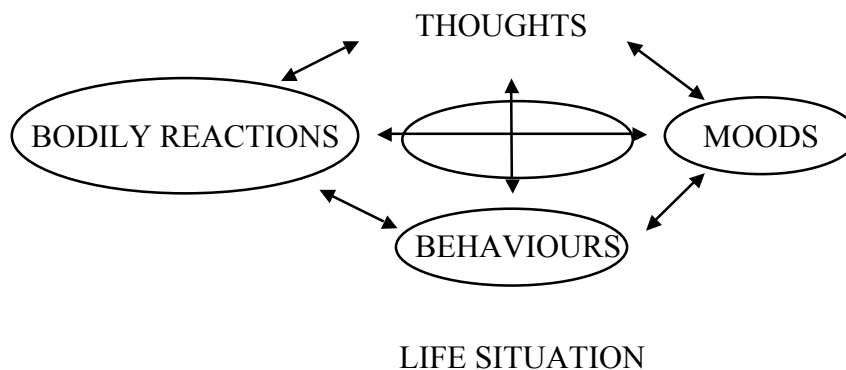
Many of the young people who are referred to CAMHs with depression do not have good relationships with their parents, or have had disrupted experiences of receiving care from parental figures. With these young people it is very important to assess the relationship with their parent and the mental health of their parent before involving parents directly in this role. Decisions about involving parents in therapy with their child should in all cases be based on an assessment of the relationship between parent(s) and child, and on a formulation of the current problems which is shared with the young person. The age and developmental level of the young person is also an important factor when considering how best to involve parents and carers. Generally older teenagers will be more used to behaving autonomously in a range of situations and will have more experiences of developing relationships with adults who are not their parents) (e.g. sports coaches, teachers, youth workers). They may therefore be more comfortable working collaboratively with an adult without their parent present. Developing autonomy and independence is also a key task of adolescence and may even be an explicit goal of therapy.

3: Cognitive behavioural theories of depression

The focus of CBT is on thoughts and beliefs - particularly negative thoughts - and how they link with feelings and behaviour. In the cognitive model of depression, Beck (1976) proposed that people who are depressed have characteristic thoughts and beliefs – cognitions - which maintain their depressed mood and behaviours. He proposed that when people are depressed that their thoughts are characterised by significant errors and biases. These are known as 'information processing errors'. Thus, when they are depressed, people tend to remember the bad things that have happened to them rather than the good things that have happened, they pay attention to negative events rather than positive events in their environment, they make more negative judgements and predictions about the future and they interpret the world and new information in more negative ways.

Figure 2 shows this inter-relationship, in the context of the individual's life situation. Note that a 'vicious circle' can become established whereby the symptoms of depression become self-perpetuating.

Figure 2: The relationship between thoughts, feelings and behaviours



Cognitive Behaviour Therapy brings together the behavioural model, described above using the example of Tom, and the cognitive model to provide a broader understanding of how behaviours feed into moods and thoughts and how these all act to keep young people depressed. Using CBT to understand depression provides a broader explanation of the problems, which is summarised in a 'formulation' and then offers a wider range of techniques and interventions to tackle depression.

SOPHIE

Sophie who is 15, has been experiencing problems at school, related to bullying and perceived criticism from her teachers (*life situation*) She feels very low and down (*moods*) and has stopped going into school and going out with her friends, spending much of her time alone in her room (*behaviour*). In addition, she feels physically unwell - tired and run down, lethargic, with frequent headaches (*bodily reactions*). Her main *thoughts* have been about being a failure and no-one liking her.

Because Sophie is not going out with her friends, or going to school, and is spending a lot of time on her own she is not getting many opportunities to do enjoyable things. This means that she gets much less 'positive reinforcement' than she did previously. This is very much like Tom's experience as described previously.

How does CBT apply to Sophie?**Behaviours:**

Often behavioural work is the first step in CBT, it is useful as a starting point because it is pretty easy to understand and to explain to the young person and their family, and it leads to some simple interventions which aim to increase behaviours and positive reinforcement. CBT builds on this behavioural foundation by looking at how the young person's behaviours are linked to their beliefs and how both beliefs and behaviours are linked to feelings. So for example, Sophie's friends did ring and text her and send her messages on Facebook when she first stopped going to school. But because Sophie feels she has nothing to say to her friends she hasn't replied and they have stopped getting in touch with her.

Thoughts:

This lack of contact and positive reinforcement could be enough to impact on Sophie's mood and make her feel more depressed. However, there is another aspect which also reduces Sophie's mood – her thoughts and beliefs.

Thoughts about her self: Sophie thinks that the fact her friends have stopping texting and emailing her means that they don't like her any more. This makes her think that the bullies might be right – that she is 'rubbish' and that she doesn't have any 'real' friends. This makes her feel lonely and isolated and very sad. She can't see how she can ever go back to school if she has no friends there. Thus, her belief, which may be correct or incorrect, has the power to influence her moods and feelings and behaviours. Because she is depressed and is doing very little, Sophie has a lot more time to think about things. So her lack of activity i.e. her behaviour, gives her more thinking time. This turns into long periods of being self critical, analysing herself and her actions, thinking about nasty things that other girls have said to her, or that her parents have said. This is often referred to as 'rumination'. Rumination is a key feature of depression.

Thoughts about the future: Sophie also remembers a lot of bad things that have happened to her in the past. Sophie also thinks about her future, she can't see a way of going back to school ever. Because she is missing lots of school she is falling behind with her lessons and with her course work. She has been told off before for not doing her homework and falling

behind on her German vocabulary; now she knows that she will do even worse on the next test they have in class. Sophie is making predictions about the future in which the worst happens; her negative expectations about the future are another reason for her to feel sad and depressed.

In the past Sophie has been a fairly good pupil – never top of the class but she worked pretty steadily and usually managed to come somewhere in the middle of the class. Now she 'knows' that if she goes back to school she'll never catch up, that she'll get moved down a class into the lower stream, that she won't be able to get the good GCSE's she needs to stay on at 6th form and that she won't be able to go to college and train as a physiotherapist. Sophie can't see any point in going back to school at all.

Thoughts about the world: Because Sophie has had a bad time with bullies at school she now thinks that she will come across bullies in other places and situations. She's worried about new social situations and thinks that she will be bullied again. Sophie is at home a lot and listening to the news on the radio and TV. She can't stop noticing what an awful place the world is – we seem to be destroying the planet, on the verge of war and so many people are losing their jobs.

Sophie is making a lot of 'cognitive errors'; she is making predictions about what will happen, she is interpreting what the behaviour of others means, she is ruminating about her past and remembering bad things that have happened. She is seeing the world in black and white, 'all or nothing' terms; for example, either she becomes a physiotherapist or she is a failure. Sophie is also making arbitrary inferences; either her friends keep texting and emailing her or they don't really care about her. It's easy to see how Sophie's situation has become 'stuck'. Sophie can see lots of 'proof' that she doesn't have any friends and that no one likes her. Also Sophie can 'see' that she's a failure as she can't go back to school and 'therefore' won't be able to go to college.

Negative automatic thoughts (NATs)

We can see that Sophie has a lot of negative automatic thoughts (NATs) about herself, the world, and the future. These include:

- I'm rubbish
- I don't have any real friends
- I'm unlikeable
- I'll never be able to get my GCSE's now

- I won't be able to go to college
- I'm a failure
- I'll never get a decent job

Sophie is not necessarily aware of these thoughts when they occur and they pop up spontaneously; thus they are 'automatic'. Because of their negative content, which depressed people usually assume to be correct, NATs keep mood low and provide further material for self depreciation and rumination. Because NATs are so central to low mood they are a specific target in CBT.

(Dysfunctional) assumptions

Where do NATs come from? The CBT model hypothesises that they are linked to more general assumptions. These are hypothesised to be generated through the individual's unique set of early experiences, their culture, family history, life events and genetics or biology. Assumptions are learned through experiences and are often implicit 'rules' that provide a basis for our motives and behaviours. For example, growing up in a religious household might contribute to the development of assumptions about the value of clearly differentiating between 'right' and 'wrong' and in upholding a clear (possibly rigid) set of moral principles. Growing up in a chaotic family, with low levels of parental supervision and chronic external stressors, might contribute to the assumption that the world is a harsh place and that to survive it is important to be self-sufficient and independent. Or, growing up with an infirm parent or sibling might lead to beliefs that the individual is most valued and 'needed' if they take a nurturing role and subsume their own needs to those of other family members.

Assumptions can be helpful when the external environment is congruent; therefore if one has learned a strict moral code and can live by it, it need not be problematic and can provide structure and security. Similarly, having assumptions about being self sufficient and independent can work very well for as long as being self sufficient and independent is possible. Being needed, caring for others and being nurturing is of value as long as there is a relationship in which nurturing is valued and one is physically fit enough to fulfil the role.

Sophie comes from a family in which interpersonal relationships, social contact and friendships are highly valued. She has observed the value that her parents place on their friendships, she has seen the value of being a central part of a strong peer group at school,

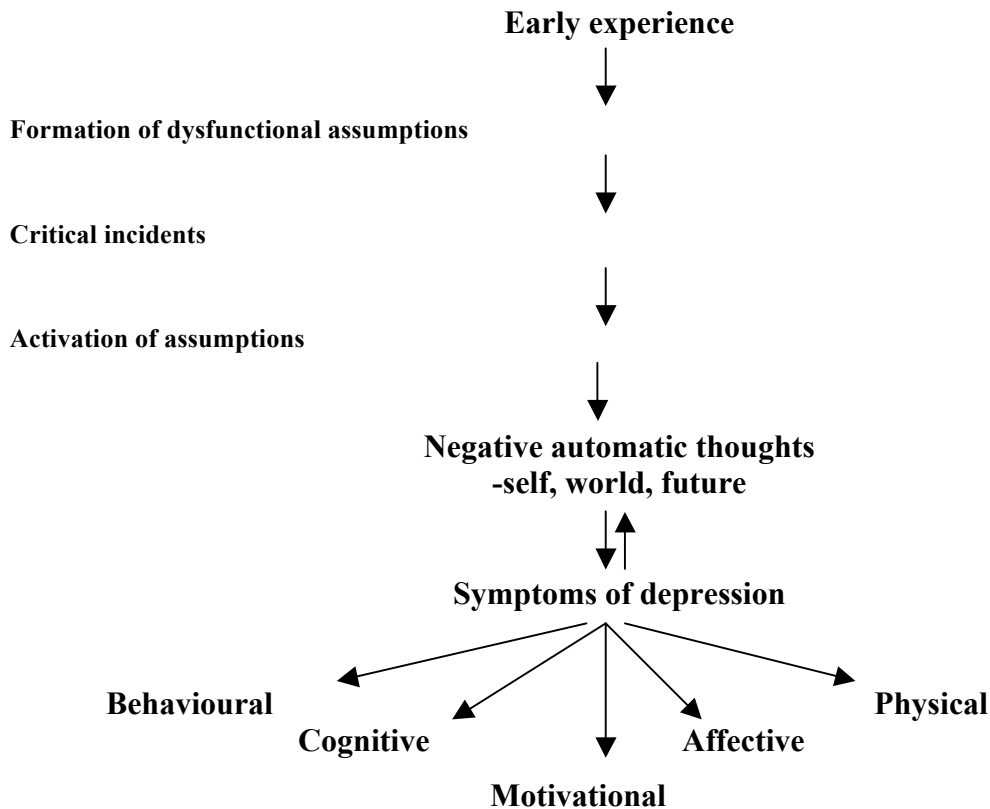
and she has developed the assumption that in order to be happy she must be popular. Developmentally Sophie is at an age when the peer group is very important and she is therefore very sensitive to any perceived rejection from this group. Sophie's preferred career option is linked to this strong social orientation – physiotherapy involves working closely with people as colleagues and in a professional role.

Critical events

Assumptions can become dysfunctional when the environment changes, especially if they are inflexible. The point at which an environment changes or is perceived to change is often a 'critical event' in the development of depression. The morally upright person who makes a morally dubious decision, the autonomous person who can no longer cope alone and must ask for help, and the nurturer who has no one to nurture and needs help themselves are all faced with a dilemma about their own role and their self worth and value.

Since being bullied and then missing school Sophie has lost the regular contact she had with her friends, has had very negative interpersonal contact (with the bullies) and can find a lot of reasons to believe that she has lost her friends, is not popular and is disliked. For Sophie, becoming bullied and then becoming socially isolated were critical events which challenged her assumptions and triggered a range of NATs. This tipped her into the vicious cycle of behavioural avoidance, further isolation, low mood, rumination and further NATs. Figure 3 below illustrates the general sequence as hypothesised in CBT.

Figure 3: The basic CBT model of depression



4. Using CBT to help Sophie feel less depressed

As mentioned above, CBT offers different ways to help young people who are depressed. Because there are a lot of different techniques that can be used it is important to have a clear rationale for choosing them and a clear way of explaining to the young person why they might work. The basis for making decisions about treatment and explaining these to the young person is the *'formulation'* of the young person's difficulties.

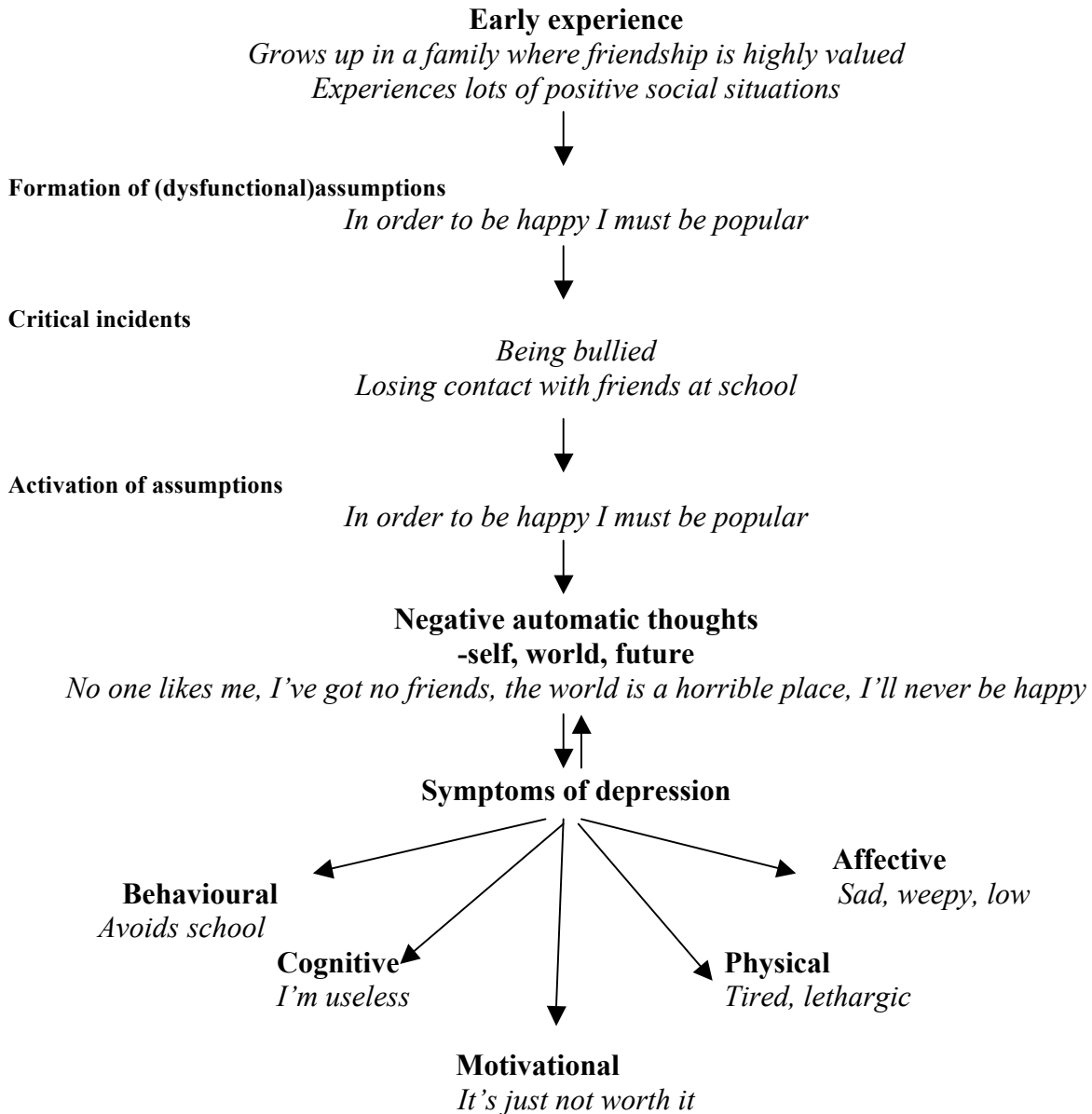
The formulation in CBT

The formulation is an essential part of CBT. The formulation is a way of linking the story elicited from the young person to the theoretical model of depression used in CBT. Thus it is a specific way of linking the theory of CBT to the individual client in front of you. It provides the way to link theory and practice. We can illustrate this by adding specific information about Sophie to the general CBT model shown in Figure 4 below.

The formulation helps provide a way of explaining how the young person (Sophie) has become depressed and why they stay depressed. The formulation should have coherence and be meaningful to both the therapist and the young person. It should capture the key features of the young person's history and provide a rationale for how to proceed in therapy. Working on the formulation is something that can be done together as a way of making psycho-education come to life. For most people, abstract theories and concepts are of no interest – however, if they are obviously related to their own experiences and situation, theories and concepts have a way of coming to life and becoming relevant.

So the formulation can help engage the young person in CBT and show them how it relates to them. The formulation should also help the therapist and young person see how to move forward in therapy. Formulations should be considered provisional – they are not correct or incorrect but represent a set of hypotheses about how problems developed and are maintained. They guide clinical work, but the results of specific interventions and therapeutic techniques will help adapt or confirm parts of the formulation.

Figure 4 The general CBT model as it applies to Sophie



Formulation diagrams

Formulations can be presented in a variety of ways and typically this involves some kind of diagram. Simple diagrams, for example Figure 2 can be helpful to share with young people and their parents; sometimes more complex diagrams can help therapists to work through complex information, prepare for supervision and use as focus of discussion in supervision. Figure 3 shows a more longitudinal formulation which includes background information and hypothesised triggers (critical incidents). Judith Beck suggests using a more complex diagram which highlights background (e.g. early experiences and family factors), core beliefs,

assumptions, critical incidents and current negative thoughts, moods and behaviours. Other clinicians e.g. Kuyken and Padesky also provide outline diagrams which therapists might find useful in thinking about their work. In the IMPACT trial we do not advocate any particular diagrammatic method of recording formulations as they all have merits and suit therapists differently. We appreciate that therapists will have had different influences on their training and development and will naturally find some methods more helpful than others.

At a general level, however, it is essential to remember that the young person and their current circumstances and history should always lead the formulation and that the figure or diagram should follow – it is not good practise for the young person's story to be made to fit the figure!

Using the formulation to guide clinical work

Behavioural work is often used early in therapy. This has already been described in relation to Tom and his family. Mastery and pleasure exercises can help to motivate and energise the young person and can be a useful way of engaging family members in therapy. Often CBT therapists will encourage their clients to test out their beliefs, to challenge them and to look for evidence to support them. This is often done with 'behavioural experiments'.

Psycho-education with young people

In psycho-education the aim is to help the young person understand the background to CBT and to see how it can be used to help them. The therapist explicitly explains the relationship between thoughts, feelings and behaviours. They may also give the young person written information about CBT or guide them to books which might help them understand more about CBT. Obviously the use of written material must be carefully tailored to the young person's interests and abilities. At a starting level, psycho-education can refer to a basic description of the CBT model, and the role of thought, feelings and behaviours. This can be used to develop simple descriptions of how the young person's situation fits the general model of depression.

In Appendix A we have included suggestions for psycho-education and also some handouts that may be useful for parents and for young people themselves.

Identifying vicious cycles

Sophie is altering her own environment in ways that maintain her low mood; for example, her social avoidance mean that she has no opportunity to see if her friends do actually like her, so she does not find if her beliefs about not being liked are correct or not. Not going to school means that she will fall further and further behind with the work and it will certainly get harder to return to school and catch up with her school work. Sophie is in a classical vicious cycle. The formulation and the therapist can help Sophie recognise the vicious cycle and work out different ways of breaking the cycle.

Behavioural experiments

Behavioural experiments are set up by the client and the therapist with the deliberate aim of 'testing' out a 'belief' or checking the 'proof' that a client offers. They are an important tool in breaking existing vicious cycles. The purpose of the behavioural experiment is to collect information. For example, for Sophie thinks that her friends don't really like her because they have stopped texting her. The therapist might think that her friends might have stopped texting Sophie because Sophie hasn't texted them back for weeks and weeks. Sophie and the therapist both have beliefs, or hypotheses about what is going on and their hypotheses are different.

In CBT it can be helpful to identify thoughts as 'hypotheses'. Some young people may quickly catch onto the scientific metaphor whereas others may need a little more explanation. The key idea is that a belief, is simply that, a belief and that beliefs are not necessarily true. Beliefs can be tested out using behavioural experiments. If Sophie sends a text to one of her friends will she get a reply? If she does what does that mean? If she doesn't what does that mean? It could mean that Sophie is right and that her friend is not really her friend; it could also mean that Sophie's friend has lost her phone, has no credit left, has run out of battery or is busy at the moment. The point of the behavioural experiment is not to 'prove' that Sophie is right or wrong, but to use the experiment to generate different ideas and ways of interpreting the world.

Monitoring moods and feelings

Many young people do not have easy access to their moods and feelings and are not used to observing how they feel, identifying what they think or when they think it , and have no experience of discussing their thoughts and feelings with other people, especially adults. Therefore, beginning to recognise, name, and monitor moods and feelings can be a very

good way to begin in CBT. Low mood is nearly always something the young person will report and want to change. Also, starting to monitor moods and feelings helps clarify the difference between moods, feelings and thoughts and is an important element of psycho-education. In Appendix C there are some tried and tested materials to help young people identify and record their moods and feelings. It can be useful to use pictures to illustrate different mood states and there are standard pictures to illustrate common moods.

As well as naming and identifying moods and feelings, a key part of CBT involves rating their intensity. Some young people will take immediately to the use of a rating scale (e.g. On a scale of 1 to 10 how angry were you?). Other young people find the use of visual scales, using the metaphor of thermometers more easy to understand.

An important part of CBT is to get used to the idea of doing exercises between therapy sessions. Monitoring moods and feelings, which usually starts in an early therapy session is a useful exercise to try to complete between sessions. It can be combined with recording activities (Appendix D) or attempted alone. It is important to make sure that the level of the task is not too difficult for the young person to manage – if they fail it does not help their motivation or improve their mood. Ideally, the therapist and young person will also agree that trying this is important but the therapist should check to make sure that the young person is willing to give it a go. If they are initially reluctant it might be useful to identify why they are reluctant and to adapt the task. If writing is a problem then it can be useful to think about using picture and figures instead to record different moods and different intensities.

Identifying negative automatic thoughts (NATs)

Identifying negative automatic thoughts (NATs) and observing how they impact on mood is an important step in CBT for depression. There are standard methods of recording NATs which have been developed from work with adults. You can find examples of these in Appendix E.

However, it can be difficult to distinguish between thoughts and feelings – this is something that adults as well as young people can struggle with and many people do not find it easy to stand back and 'observe' their own internal processes. Sometimes this is because they have not had much experience of doing this and sometimes it is because they are still developing the skills – for young people both of these things are likely.

Research with young children shows that by the age of about 8 years old almost all children can tell the difference between thoughts and feelings and almost all young children understand that having a thought can affect how they feel. So for the young people in the IMPACT study, it is reasonable to assume that they have the potential to understand the basic CBT model. Research also suggests that as children get older this task becomes easier. However, some young people are likely to need considerable help with this element of CBT. It is more difficult for those with lower IQs or poorer verbal abilities and in addition, the young people who are in the IMPACT study are depressed and this will tend to reduce their abilities in all areas. For all of these reasons many young people in the IMPACT study will need additional help to identify their own thoughts and feelings and to distinguish between them. This is an important aspect of psycho-education in CBT.

There are a number of useful tools to help young people discriminate between thoughts and feelings (see Appendix E). It is also important that the young person can link thoughts and feelings and there are materials to help with this in Appendix E.

Challenging negative automatic thoughts

Part of the rationale for recording and 'catching' automatic thoughts is that this helps reduce the extent to which they are 'automatic' and gives the young person more control over them. As there is a link between NATs and low mood, and as this will have been captured by recording the young person's thoughts and feelings, the next step is to challenge the NATs and break the link between them and low mood.

Challenging NATs is often seen as the cornerstone of CBT and it is an important component of the work. This is where the basic ethos of 'collaborative empiricism' is most clearly demonstrated as the way of challenging NATs in CBT is to look for evidence to support and to challenge the NATs. The aim is not to 'prove' that NATs are wrong, incorrect, false, or bad, but to open up the possibility that thoughts can be mistaken and can be changed. Thus it is important for the therapist to adopt an open-minded stance and to accept that evidence for and against NATs can and probably will be found.

Methods of challenging NATS and the rationale behind this can be found in Appendix E.

Learning new skills

As well as challenging negative thoughts and beliefs, CBT also aims to encourage the development of new skills and learning to support more effective coping and resilience. New skills can help overcome areas of relative weakness, for example in problem solving or social skills. New skills can also be useful in helping some young people deal with very adverse environments for example, living in unsupportive family environments, poverty and social deprivation, living in unsafe communities or high exposure to bullying in schools).

Here we identify 3 specific skills which can play an important part in the treatment of depression.

a) Problem solving skills have a direct application to every day life and there are relatively simple techniques which can be used. For many young people the idea of using a structured method of thinking about their day to day problems will itself be novel. In essence problem solving simply involves looking at possible options and consequences around ways of dealing with a specific situation. Thus the young person needs to develop the experience of thinking about alternative solutions. Then, a key aspect of problem solving is developing the skills necessary to evaluate the relative merits of different options. The therapist's role may involve direct explanation, modelling, coaching, and giving feedback to the young person. As part of collaborative practice, problem solving is a key component of much CBT work. In addition, problem solving as part of treatment for depression often involves illiciting assumptions and beliefs about self, others and the world that may be very valuable in aspects of cognitive restructuring (see below).

b) Social skills training may become an important focus when the young person is clearly avoidant of social situation situations. They may have had aversive social experiences, for example bullying which have contributed to their depression, or they may have stopped taking part in regular social activities because of their depression and low mood and subsequently lost confidence. During adolescence the peer group and peer relationships become a key mechanism in determining one's status and value. In addition, for young people, their newly emerging sexual interest, both of others to the self and of the self to others may become a source of confusion and perceived inadequacy. Opportunities to discuss the potential 'agonies' of courtship rituals may sometimes be very helpful as part of general behavioural activation. Role playing situations such as negotiating with a parent about time to be home may be more useful than general discssion of such problems.

c) Mindfulness is a technique of unproven effectiveness with young people. However, the overall approach of CBT is to encourage increased awareness of cognitive states and to reduce high levels of self criticism and self blame. As described above, a key concept is the idea that thoughts and beliefs are not equivalent to truth or reality; thus thoughts are merely that, thoughts. In this way, diary keeping (thought diaries and behavioural diaries), behavioural experiments and thought challenging exercises all encourage a non-judgemental attitude to internal mental states. This concept is entirely congruent with the approach taken in mindfulness. However, in a formal sense, the CBT treatment of depression described in this manual does not require teaching of mindfulness skills as part of the core treatment approach. For those who are interested in using mindfulness techniques as part of relapse prevention there are several sources which may be of interest.

Identifying assumptions

Although CBT does focus on the 'here and now', understanding where beliefs and cognition come from is also important. For young people, their thoughts and beliefs are still in development and will be influenced by the world and social circles in which they live. An obvious place to develop beliefs about the 'self' is at home, from parents and other family members. So, for example, children who experience rejection, loss or other traumas, often believe that they are to blame. Sometimes they are told that they are to blame, sometimes they make the mistake of taking responsibility for things that are not their fault. Parents can and do sometimes, give negative messages to their children about what they are like (e.g. 'You're just like your Dad').. In this context children can quickly begin to believe that they are bad, not worth loving or caring about, and/or worthless.

Parents also can, and do, give their children negative messages about the world, and about other people and about the future. This means that children who have parents who are themselves depressed are exposed to negative thoughts and beliefs on a regular basis. In exactly the same way, young people can be exposed to experiences and contexts in which they are more likely to develop positive beliefs about themselves, even in adverse circumstances. For young people, negative beliefs about the self and the world and about other people can also be developed at school, through sport and other activities, with friends and peers, and in other relationships with people. These relationships at home and outside the home can also provide protection against the development of negative beliefs.

Cognitive restructuring

Cognitive restructuring is not a necessary component of CBT for depression. For many young people, a strong therapeutic relationship, behavioural reactivation, enhanced emotional recognition and the ability to challenge automatic negative thinking either by assessing evidence or by behavioural experiments may result in sufficient improvement. For others, even if such improvement has not occurred, exploration of assumptions and beliefs may not be acceptable or desirable for the young person.

As a process cognitive restructuring shares many of the methods of working that have been described above in respect to working with negative automatic thoughts but focusses more on dysfunctional assumptions (if... then...statements) and core beliefs about the self, others and the world. As with working with NATs, the basic methods are firstly to enable the young person to begin to recognise and articulate such assumptions and beliefs in the therapy and then to begin to explore the validity of these beliefs through a process of socratic questioning.

Socratic questioning is a technique which has the potential to be easily misrepresented as being a subtle (or not so subtle) form of persuasion. This is not correct. Socratic questioning starts from the position that the assumptions and beliefs held by the client are there for good reason and that the task of the therapist is to understand how such beliefs are supported by the young person's experience and current situation. The process of dialogue between the young person and the therapist is to consider whether the conclusions that the young person has drawn are the only conclusions that can be drawn or whether other conclusions are possible. For example, a young person may have come to recognise that he experiences very high levels of guilt and believes that he is 'a bad person'. His mother continuously suggests that his father left the home 'because of the children'. Here the purpose of socratic questioning would be to consider the range of reasons his father may have had to leave home and to examine how much responsibility the young person may legitimately claim about the actions of his father.

Cognitive restructuring should link very closely with the shared formulation. It is often the case that this part of the therapy results in a richer formulation of the young person's difficulties. The new, richer formulation is a concrete way of showing a change in the way in which the young person understands their current difficulties. In cognitive restructuring the aim is to reduce the the impact of highly dysfunctional assumptions (e.g. If I can't do this

properly it proves that I'm useless) and core beliefs (e.g. I am a horrible person; I am unlovable) on the young person's self concept and to allow other processes of change to move forward.

5. Including parents and carers in CBT

Sophie's mum and dad really don't know what to do for the best. They have tried lots of different things to cheer her up and they don't understand why she has started to shut herself away, won't go to school and is irritable and snappy with them and with her younger sister. They are really sympathetic, but also a bit fed up with her. Sophie's mum feels that Sophie shouldn't be left alone for too long and needs to be distracted. But that's difficult because her mum and dad both have full time jobs. Also, whereas Sophie used to enjoy 'girly things' that she and her mum and sister did together, now she doesn't want anything to do with going shopping, buying new clothes, trying on make up or going on family days out and holidays. Sophie's mum and dad both have busy lives and expected to be able to do more things for themselves now that their two kids are older; surely by 15 Sophie should be a bit more independent?

Involving parents in the assessment

Working with the young person within their life context is widely recognised as good practice from assessment through to intervention. Parents are frequently the people who look for help on behalf of their children and will be involved from the outset. However, parental behaviours, beliefs and difficulties can be instrumental in the development or maintenance of their children's depression and this is something that needs to be explicitly assessed early on in therapy. This information will inform the formulation and help decide how, and when, and if, to involve parents in therapy sessions.

Including parents in the formulation

Cognitive theories of depression were developed taking a backwards perspective on development from the view of the adult client and therapist. The CAMHS therapist however, has the opportunity and skills to appraise current parent-child relationships within an attachment framework considering the developmental course of symptoms within the family and potentially intervening on this basis (Crittenden, 2005).

Beck's formulation of depressive schema as developing from early experience implies a role for parents. Thus therapists with young people are faced with working with parents both as part of the problem and part of the solution. Difficult experiences with parents early in a child's life may have compromised the development of a secure attachment. Parental conflict, separation or loss have significant implications in the child's development of self and their understanding of interpersonal relationships. The parents may themselves have experienced losses at crucial stages of the child's development making them less emotionally available to their child. CAMHS practitioners are experienced in applying attachment theory to the understanding of parents' relationships with children. Parents may also have acute or long term mental health problems of their own and there may be both genetic and environmental risks associated with this. Additionally, parents and children often share the same adverse social environment, limited resources (e.g. financial, cultural, educational, social) and chronic external stressors (housing, substance use, lack of employment).

In clinical practice therapists will often work with a depressed young person and their parent(s), regardless of the hypothesised causal factors. It is important that parents do not view their involvement as implying blame of them. Parents usually feel responsible for their children's difficulties regardless of the cause, and developing formulations which are blaming is unhelpful. Parents rarely have direct control over life events and relationship difficulties which may have had an impact on the mental health of all family members directly or indirectly. The therapist may need to support parents to find ways of coping with their own symptoms and to find alternative ways of coping which will also support positive change for their child. Conversely the young person's understanding of the formulation may be assisted by discussing family life experiences for instance bereavement or separation together with a parent.

Working with parents to support individual CBT

When parents are included in CBT therapy sessions they will be able to make a more substantial contribution if they have some basic knowledge and understanding. This includes:

- The nature of the young person's problems as agreed between the young person and the therapist (assuming the young person is happy to share this with their parent)
- The nature of depression
- The aims and methods of CBT in relation to young person and family problems

- How they may assist with specific goals e.g., providing permission and support for particular activities.

Thus, parents who are involved in CBT for their adolescent child should also have the opportunity for psycho-education. This will usually be delivered by the therapist directly but can also be supplemented by other resources including books, information on the internet, computerised CBT programmes and so on.

Everyone involved in CBT therapy sessions also needs to be clear about the boundaries of confidentiality. The therapist should always consider including the young person in any discussion with parents. Such discussions provide opportunities for checking out a young person's understanding, negotiating pitfalls, and establishing clearly what parents hear about the content of sessions. The main danger is of parents being undermining of the young person's progress, but at least this is brought to therapist's awareness. Parents who feel guilty about their child's difficulties can be helped to feel part of the solution by focussing on the hear-and-now and considering ways forward rather than how the young person's depressed situation came about.

Key Issues when working with parents

Education: sharing diagnosis, formulation and treatment approach

Family element in formulation

Differing goals – parent and young person

Confidentiality

Parental role in therapy

Evaluation of progress

Parents with affective disorders

One therapist or two?

Parental mental health issues

Relapse prevention

The parental role during therapy

Parents can play a number of different role in CBT. They can offer support and encouragement from the sidelines, they can be involved in psycho-education to help them understand the cognitive behavioural model of depression and how it affects their child (and possibly themselves too), they can be used more directly as a therapy 'assistant' for example in helping their child to complete homework between sessions, they can also be used as a kind of external 'consultant' by providing information and data and by providing some external corroboration of the young person's progress.

It is important to remember that working to agreed goals with the young person does not automatically mean that these goals will be shared by family members. It is important that some goals are agreed with the young person that do not rely on the compliance of other family members. Also it is important to identify and be explicit about any goals agreed by the therapist and young person which may conflict with those of the parents. Similarly, if conflict between parents and child is a key problem, it is important to identify individual goals and also any shared goals. Care is likely to be needed in recruiting parents where, for instance, their major concern is the young person's behaviour at home or antisocial activities when these are not the major focus of CBT. Parents may struggle to be supportive when they do not share the therapist's formulation of the young person's difficulties.

Opportunities to involve parents in therapy

There are a number of points in therapy when it may be natural to involve parents and these are outlined below.

1. At the assessment

a) as part of the first session in which the goals of treatment as agreed with the young person, also agree a joint meeting with the young person and their parent(s) to discuss treatment and obtain parental views.

b) Meeting the parent(s) should end with agreement about how communication between the therapist and parents will be managed and about the overall role of the parent in therapy. Generally the options are, a) non involved and non supportive, b) non involved but supportive, c) involved in therapy as a facilitator – therapy assistant, d) involved as a patient themselves.

2. During treatment

A joint session with parents approximately half way through therapy is a usual minimum level of parental involvement. In the IMPACT trial we would expect that this would normally be offered to all parents including those who are assessed as being non supportive. Parents in more supportive and/or active roles may have additional meetings or contacts with the therapist according to the plan agreed at the beginning of treatment. For more involved parents there may be a session on formulation, perhaps as part of cognitive work (eg on core beliefs), and joint sessions on problem solving.

3. At the end of treatment

Here there is an opportunity to review treatment and any progress and problems that were encountered. It can be useful to engage the parent in strategies that the young person will use to prevent future relapse and to cope with inevitable life events. Where parents have not been closely involved in therapy throughout it is important to agree with the young person exactly what information can be shared with their parent(s).

6. Adapting CBT for young people

CBT was initially developed for use with adults. Because of this it is important to think carefully about how to adapt CBT when using it with young people. In this section some of the key developmental processes influencing the use of CBT with young people are outlined. All therapists working with young people should be aware of these and developmental issues must be considered in each formulation in CBT. Developmental issues will help shape and adapt the interventions you use, maximise the alliance and collaboration between the therapist and young person, help guide the involvement of parents in therapy, and identify possible problems in the delivery of CBT.

Some young people will easily understand the psychological model behind CBT and others will find it more difficult. Some young people may need help with basic information; for example, they may not have experience in labelling their emotions and they may lack the vocabulary to describe their feelings. The role of psycho-education is particularly important when working with young people as it gives the therapist an opportunity to help the young person develop their own meta-cognitive knowledge as an integral part of the therapy process.

It is also important to be aware that for young people, the experience of taking part in CBT is itself developmentally significant. Young people are developing their assumptions and schema with which they will organise their knowledge of the world; their current experiences of dealing with success and failure, relationships, problem solving and significant life events will all shape and influence the assumptions.

Key developmental processes

Adolescence is recognised as a time of great change and challenge as the young person negotiates the transition between being a child and becoming an adult. The nature of adolescence is biologically determined in that young people develop sexual maturity, and in parallel, develop the mental skills typical of adults. Within adolescents this development proceeds at vastly different rates. In an average classroom of 13 year olds the physical differences between pupils are striking. Therefore chronological age is a poor predictor of sexual development; similarly children are just as varied in their cognitive, social and emotional development.

Cognitive development

Key theories of cognitive development (e.g. Piaget) suggest that by the time children reach their teenage years that they are cognitively equipped to deal with abstract concepts, to understand that these can be manipulated and discussed, and to compare and weight information from different sources in order to make decisions. These are all crucial skills in CBT and when present, would enable a young person to grasp the essential components of the CBT model, engage in discussion about it with their therapist, and adopt the collaborative empirical stance which is the core of CBT. This then suggests that CBT should be an appropriate way of treating young people with depression.

Against this background however, young people who come into mental health services and are in need of CBT may not represent 'average' young people and their development may be less advanced than theory would suggest. There are many reasons for this – for example, being depressed is associated with reduced cognitive abilities so their current performance (e.g. speed of thinking, ability to understand more abstract concepts) may not reflect what they can do when not depressed. Also, young people who are depressed are more likely to have had adverse childhood experiences which may include reduced opportunities to learn and develop. Similarly, cognitive development in children and young people is promoted by good consistent parenting (or equivalent care); therefore children who have had disrupted or poor parenting may also have slower cognitive development. In addition, taking part in CBT involves reflecting about the self, in terms of feelings, thoughts and behaviours. This process of self reflection itself is a skill - something that has to be learned and practised – and for

many young people who are depressed it is not a skill they have yet acquired. For all of these reasons, the CBT therapist who works with depressed young people should be sensitive to their various levels of cognitive development and be prepared to assess this in sessions, contribute to cognitive development through initial and ongoing psycho-education, and adapt CBT to match and ideally extend, their client's current cognitive capacity.

Social development

During adolescence there are marked changes in the social demands placed on young people; typically these increase the degree of autonomy and responsibility given to young people. For example, most young people will take responsibility for getting to and from school, organising their school work and following a timetable, deciding what to wear, with whom to be friends, what subjects they will take at GCSE and A level, and how they spend some of their leisure time. Young people also begin to spend more time with their friends and correspondingly less time with their family – thus the role of friends and school in setting attitudes, beliefs and values is typically increased.

These increased social demands facilitate the development of new social behaviours and skills. Thus young people are required to have more relationships with more adults in a wider range of situations – through experience they learn how to interact with adults and their peers and how to maintain relationships with many different people. This wider social experience promotes the development of 'social cognition'. Social cognition refers to what we learn in a social environment; in a social environment we tend to compare ourselves to other people on important characteristics (e.g. appearance, intelligence, likeability) and we learn how to pick up on social cues and 'read' the reactions of others. This latter skill is closely linked to the emotional skill of empathy to others which is discussed below.

The development of autonomy and independence can be a trigger for conflict between parents and young people. Conflict in families is frequently triggered by parental anxiety about the consequences of risky behaviour such as experimentation with non prescribed drugs, alcohol, cigarette and sex. Conflict can also be exacerbated by specific social or cultural norms if these depart from norms of the wider (dominant) culture. Thus for example, in some families it will be deemed important to make a financial contribution to the family as soon as possible and to become financially independent as quickly as possible. In other families, friendships with the opposite sex are taboo for young people, and there are distinct expectations about how girls and boys should behave and how their lives will differ.

Some families have inflexible expectations about the value of higher education and entering professional careers.

Emotional development

There are three elements of emotional development which are particularly important in CBT. One is knowledge about emotions, including emotion recognition, an ability to distinguish between core emotions (fear, sadness, anger) and more complex emotions (e.g. guilt, shame), and self reflection sufficient to identify 'live' emotions and assess their intensity. Developmental research suggests that children can discriminate between basic emotions, at least on a theoretical level, by the age of about 6 or 7 (Quakley). It is assumed that this ability will translate to the recognition of their own emotions in live situations but this has rarely been tested.

A second aspect of emotional development relates to the ability to recognise emotions in others and, on that basis, to experience empathy. Basic empathy has been observed in very young children interacting with a friend who has been hurt and cries. In observational studies children as young as 3 years old have been observed consoling their friend and seeking help from an adult (Dunn).

Finally, a third element of emotional development, which is crucial in depression, is mood and emotional regulation. Here we distinguish between moods and emotions; moods are typically short lived and more easily changeable; emotions last for longer and are more difficult to shift. Some moods are more or less appropriate for different situations; for example, on entering an examination it is probably more helpful to have a serious, mildly anxious mood than it would be to have a very positive, happy and carefree mood. At a funeral, a sad mood is considered more appropriate than a happy mood and at a wedding the reverse is true. Thus, when we are not depressed, we typically change our moods to suit the situation. When depressed, basic mood regulation skills can be lost, including the ability to self monitor mood and this is therefore an important part of psycho-education, often the focus of early sessions and a key homework task.

7. How to adapt CBT for young people

Young people, like adults, vary in the ease with which they can understand and use the cognitive behavioural model of depression and a key task for the therapist is to be flexible and to adapt their delivery to suit the individual. For younger children exercises to help with psychoeducation can be adapted from Stallard, older adolescents may benefit from exercises in *Mind over Mood* by Padesky and Greenberger.

1. Assess each young person and don't assume that their chronological age, or mature appearance are a good indicator of their psychological developmental stage.
2. Use psychoeducation to assist and accelerate learning. The theoretical work of Vygotsky suggests that the use of an adult to provide 'scaffolding' is a key to helping young people learn new skills, especially those that are just beyond their current capability. In CBT the therapist has the ideal opportunity to act help the young person develop their cognitive, emotional and social skills and to apply those to their daily life.

3. Check things out – be collaborative.

The therapist should not behave as someone who knows best and who routinely *prescribes* solutions to problems. Rather the therapist's role is best viewed as someone who helps the adolescent to find his or her own solutions to problems. A useful model of the relationship can be the 'coach'; many young people will have experience of being coached or trained for a sport and the therapist can use that example.

Collaboration, or encouraging collaboration, should be evident at all stages of therapy and throughout the session. For instance, setting an agenda at the beginning of each therapy session should be routine and should be a joint exercise between the adolescent and the therapist. However, remember that many adolescents are not used to being asked about their point of view, and may find it very hard to deal with questions "What shall we do today?" Therefore in early sessions it may be better to ask the adolescent about his or her current problems, or to summarise the problems from a previous session, and to then help the adolescent to choose one or two for work during that session. Collaboration can also be modelled in the way that home practice is dealt with at the next session. Therapists should avoid taking the home practice and then commenting on it. Rather, they should encourage the adolescent to present the home practice and discuss their experience with it, as this increases the adolescent's sense of ownership of the therapy.

4. Be explicit about things that happen in the room, use what is present to discuss more abstract things.

Many adolescents have difficulties thinking about thinking, and so it is important from an early stage to help them to observe their own thought processes. One commonly used technique is for the therapist to comment on signals of emotion during the therapy session. For example, the statement “ *it looks as if you are thinking about something that made you sad*” introduces the idea that thoughts lead to sadness. Or “*I wonder if your tears mean you were sad about the way your mother treats you?*” may help a young person think about possible links between their experiences and their emotions.

Focusing on ‘live’ emotions helps the young person feel accepted as they are now, is consistent with working primarily in the ‘here and now’, sends a message about the capacity of the therapist to deal with negative emotions and their willingness to do so, allows the young person to share their distress, and provides live examples of moods and feelings, and thus associated beliefs, that can be used therapeutically.

5. Include the family and other key systems (e.g. peers, school) in the formulation – do these reinforce core beliefs and dysfunctional assumptions? Can their influence be changed and if not how can it be countered? Also what strengths and resilience does the family and other systems offer – can these be harnessed in therapy?

6. If necessary use concrete examples.

Diagrams, thought bubbles, examples from popular TV programmes, soap operas, celebrities, sporting analogies etc. all help make the CBT model real and accessible.

Adolescents do not necessarily use words in the same ways as adults. For example, the word “depressed” can mean sad, irritated, hopeless and a range of other things. The therapist will often need to help adolescents to clarify what they mean. For instance, a therapist wanting to know what “getting on better with my mother” means, might ask “when you talk about getting on better, do you mean that she should increase your pocket money, spend more time with you, or do you mean something different?” Similarly, an adolescent complaining that a father does not love them could be asked, “ how would your father behave differently if he loved you?” or “what would you notice if your father loved you more?”

7. Don't get tied into endless 'philosophical' discussions about abstractions e.g. good and bad, but do take advantage of curiosity and engagement in thinking about the 'bigger picture'

8. Do encourage empiricism.

The term empiricism refers to two aspects of CBT. The first is that CBT uses empirical observations of behaviours and cognitions that are the basis for depression. Depression is not viewed as something that comes "out of the blue" or as the result of unconscious processes. Rather, it is a problem that can be understood in terms of adversity, thinking and behaviours. The second empirical aspect of cognitive-behavioural therapy is the use of an "experimental approach to therapy". The therapist does not have all the answers, and will often suggest *experiments* so that the adolescent can test out certain ideas. For example, a phone call to a father to confirm arrangements for a visit could be prescribed as an experiment, just to see if it works.

9. Use yourself as a model

Be authentic and show and reflect on your own emotional reactions and automatic thoughts. Also, model problem solving – acknowledge difficulties in therapy or in your relationship and use explicit strategies to solve them. Many depressed adolescents lead stressful and difficult lives and it is easy to collude with the adolescent's belief that nothing can be changed. The therapist must however adopt an optimistic (and realistic) problem solving approach.

10. Use parents where possible but accept that conflict may make this problematic.

Many adolescents are not yet independent of their family or other parental figures, and are not therefore in a position to make completely independent decisions. Family members play an important role in the development of the adolescent's beliefs about the world. They may also have a very practical role in the therapy, such as bringing the adolescent to the sessions. Family members will usually be involved in some sessions, though the therapist should always bear in mind that in CBT the young person is the primary client in the therapy and that in many cases the majority of sessions will be individual therapy.

Do not take sides. Adolescents often feel things particularly strongly, and it is all too easy for the therapist to become pressured into always agreeing with the adolescent's point of view. There are particular dangers in "taking sides" with the adolescent in a dispute between the adolescent and the parent. Knowing the adolescent's point of view does not mean that the therapist should agree with everything the adolescent says.

Parents/carers are likely to be concerned about the emotional well-being of the young person and may well have been directly involved in the process of seeking help. They may also play an important part in motivating the young person to attend sessions. They may also be depressed themselves. For these and many other reasons, the parents may want to know how the therapy is going etc and may contact the therapist by phone or request a meeting or begin conversations in the waiting room. It is important that, at an early stage of the therapy, clear rules are agreed with the young person as to what the therapist will share with the parent in what circumstance. The exact rules may vary according to the circumstances of the case but they should be explicit and agreed. For example, the therapist may agree with the young person that they will only share information with the parent after checking the content with the young person first. Such agreements would be overridden in circumstances in which the young person's safety was at risk. There is more guidance on how to handle risk in the general trial manual which all therapists will receive.

11. Encourage and support autonomy and use therapy sessions to transfer responsibility towards the young person.

PART 2: THE INTERVENTION

In Part 1 of the manual the theory and principles of CBT were described, illustrated with some case examples. Here in Part 2 the focus is on how to deliver CBT based on that theory and those principals. So in this section we hope to show how CBT will be delivered in the IMPACT trial. There is some repetition between Part 1 and Part 2, especially around the issue of basic therapy skills. However, this repetition reflects the importance of these skills in CBT. It is vital to remember that the delivery of CBT is always based on a formulation and that this should specifically focus on how the theory fits the young person in the room. CBT is flexible and responsive and the formulation is the basis for this.

1. Basic skills that all CBT therapists need

a) Knowledge of features of depression in adolescents and ability to assess suicidal wishes and/or ideas and behaviour through direct questions.

b) General therapeutic skills. These are personal characteristics which are desirable in any therapist

Empathy - requires that the therapist experiences an accurate and empathic understanding of the patient's experience. Seeing the patient's personal world yet remaining objective. It is important the patient perceives the therapist's empathy and acceptance.

Genuineness - The therapist must reflect accurately how they experience the patient's situation.

Warmth - is shown by empathy and positive unconditional regard for the patient.

Understanding - by awareness of each aspect of the patient's experience.

c) Knowledge of the cognitive model.

d) Awareness of boundaries. The therapist is not a friend - therapy requires a formal setting.

2. Core features of CBT

- a) Collaboration. Early on the therapist establishes a collaborative relationship with the patient. This is achieved by being open and explicit, by setting agendas together and both giving feedback.
- b) Gentleness. It is important to avoid being confrontational or persecutory when questioning the patient.
- c) Listening skills. The therapist must be able to be attentive and sensitive in content, mood and deeper meanings of replies.
- d) Professional manner. The therapist must be professional and problem orientated and take responsibility for keeping to the agenda and giving accurate feedback.
- e) Humour. This is useful and effective in building the relationship between the therapist and patient, lifts mood and helps to see a different perspective of the same situation.
- f) Flexibility. Therapists need to be flexible in the choice of techniques used for each patient. One must pitch the therapy at the level of the emotional maturity of the patient, choose the techniques appropriate to the goals that have been set, and sequence therapy in the most appropriate manner.
- g) Work from strengths. Help the young person to build up new skills.

3. Characteristics of CBT therapy

Cognitive behaviour therapy is a short term, structured form of therapy which provides patients with a method for understanding their problems and techniques for dealing with distressing emotions. Cognitive therapy is:

Time limited

At the start of therapy the young person and the therapist are clear about the likely number of therapy sessions and the fact that there will be a clear end to therapy. This provides an important message to the young person, i.e. that you can improve and that you will not need this help for a long time. This message promotes optimism and is consistent with the underlying assumption of CBT.

In the IMPACT trial all young people randomised to CBT will be offered up to 20 therapy sessions. It is not essential that all young people receive 20 sessions but it should be explicit that this number of sessions is on offer. This will promote open discussion of monitoring change and negotiating reviews and discussing the end of therapy.

Structured.

Each session is planned to make the most of the time in focusing on tackling problems. The therapist and young person agree on the agenda at the start of each session and this promotes collaboration. A typical format for a CBT session would be:

- a) review of young person's state, including any recent events. Opportunity to share information about recent events and concerns.
- b) set agenda to review home practice and target areas for this session
- c) review home practice
- d) session targets, ie. defining problems, problem solving, identifying negative thoughts and challenging them
- e) setting home practice
- f) feedback on session

Based in the 'Here and Now'

CBT deals primarily with the 'here and now' and with problems that trouble the young person in their day to day life. The focus of therapy is usually on dealing with current difficulties. Some young people will however be curious about why they have become depressed and their formulation may include historical factors and life events which may have contributed to them becoming vulnerable to depression. This can include family history, critical events and hypotheses about how assumptions have developed. Past experience can also be a good guide to future vulnerability and may be used in relapse prevention.

Problem-oriented

In CBT the therapist and young person focus on defining and solving presenting problems and in developing new skills to tackle possible future difficulties.

Collaborative

The young person and therapist work together to identify goals, develop the formulation and devise an intervention plan. They also review progress and adapt the formulation and intervention in the light of new information and evidence.

Based on practise of new skills

Practicing new skills is central to CBT. The aim is to put into practice, in real life situations, what has been discussed and tried out in sessions. Working between sessions also allows the young person to take more responsibility and shifts the focus towards them behaving in a more autonomous and developmentally appropriate way.

Active and direct

In CBT the therapist takes an active stance. They are direct in their approach (i.e. they do not have a 'hidden agenda') and are clear in their discussions with the young person and their parents.

Scientific

A scientific method is adopted which means asking questions, making a hypothesis, devising behavioural experiments, collecting data and examining the data. In order to be a good scientist the therapist promotes openness to new ideas and models the possibility of there being alternative ways of thinking and behaving.

Open

The therapist and young person share a common understanding of what is happening in the CBT. This is based on psychoeducation and the formulation. The therapist and young person are also open to revising their beliefs in the light of new information.

4. A typical CBT programme for a depressed young person

Following referral for CBT the assessment often involves detailed clarification of symptom status and life problems, using interviews and questionnaires, to establish a baseline for measuring change. Psycho-education includes information about depression and the CBT model.

Goals for therapy are discussed, aiming to be as specific as possible. These are likely to include a goal to “feel less depressed” but may include a range of associated problems identified by the child or young person (for example, being able to go back to school, take part in social events, have fewer rows with parents, or return to a sport). An explanation of the therapeutic process is given and the importance of home practice tasks emphasised.

During the early sessions, work focuses on clarifying the young person’s daily activities by discussion and diary keeping (activity monitoring). Young people have often considerably reduced their activities with the change in the mood state and diaries can be helpful in assessing the extent of this. A check is made on the young person’s vocabulary for describing feelings (emotional recognition) and links are made between activities and feelings. At this stage, home practice tasks may be agreed which increase the range or number of activities from which the young person obtains a sense of achievement or pleasure (activity scheduling). The emphasis is on re-instating previously enjoyed activities which have ceased and increasing normal day to day social routines. These behavioural interventions are aimed to lead to a significant improvement in mood and reduction in social isolation.

A key aspect of cognitive therapy is that of identifying negative automatic thoughts. With children and young people, similarly to adults, this is approached by considering in detail the thoughts that are identified with specific situations. Information gained from the activity monitoring and activity scheduling can be very useful. In explaining to young people, the technique can be likened to video replay – playing back a situation and describing what you are thinking. The therapist may also ask about specific thoughts while the young person is talking about an experience if changes in affect are noticed. Diaries, creative writing or even statements from questionnaire can also be helpful in identifying maladaptive cognitions - the therapist asks if thoughts from these materials connect with everyday experience as a prompt.

Processes of cognitive restructuring then involve working on unhelpful interpretations and identifying recurrent themes such as being unlovable. This may include examining in detail the evidence for particular thoughts and the advantages and disadvantages of this way of thinking. In practice the techniques involve learning to recognise and challenge negative automatic thoughts, identifying general themes which reflect core beliefs, generating more realistic alternative thoughts, and increasing positive statements about oneself. As with adults, therapeutic work with less articulate children can focus on behavioural elements such as activity scheduling, self reward, emotional labelling and goals may include tackling associated problems such as study skills, assertiveness and problems with self control.

Some young people will have clear co-morbid problems including obsessive compulsive disorder, PTSD, conduct problems and anxiety. Sometimes these will improve as depressive symptoms improve but it may be necessary to spend some time dealing with these if they interfere with treatment for depression. In the appendix J there are guidelines for dealing with key co-morbid problems in CBT.

CBT is explicitly time limited and there is a focus on learning new skills, practising them outside therapy and developing autonomy and independence from the therapist. Therefore as therapy progresses it is expected that the collaboration between therapist and young person will continue to develop and that the young person takes a more and more active role. This provides a good basis for thinking about ending therapy and relapse prevention. Towards the end of therapy it is important to plan how the young person will deal with future difficulties. It should be assumed that in life everyone will come up against problems. The aim of relapse prevention is to anticipate future problems and consider how to protect against these.

BASIC FEATURES OF CBT FOR DEPRESSION

STARTING CBT

Assessment

Engagement
Defining goals of therapy
Psychoeducation
Shared formulation and sense making

Mood monitoring
Mastery and pleasure monitoring
Activity scheduling

MIDDLE PHASE

Older/ more psychologically minded adolescents

Activity scheduling
Self-reinforcement
Challenging negative thoughts
Cognitive restructuring

Include social problem-solving
if appropriate

Younger/ less mature adolescents

Activity scheduling,
Social problem solving
Social skills

Cognitive techniques
if appropriate

Management of associated problems/disorders

ENDING PHASE

Summary of sessions
Identification of unresolved difficulties
Future strategies.

5: Additional notes on home practice

a) Home Practice

Doing tasks outside the sessions (home practice) is central to the process of CBT. Many of these tasks are recorded in a diary, which is given to the young person early on in therapy.

The purpose of the home practice is to reinforce the tasks covered in the sessions, and to see them in the context of their everyday lives. It also provides valuable information for the therapist, and helps him/her to assess the young person's motivation and psychological strengths.

(i) Introduction of the diary and home practice

A diary (notebook or loose leaf file) is given to the young person as early in the first session as is practical, in order to emphasise its importance. He/she is encouraged to make it more personal by writing his/her name on it or decorating it.

It is explained that it is important for the young person to keep a record of certain thoughts/feelings/events between the sessions and that this will help both young person and the therapist to think together about what has been happening between the sessions and how things could improve further.

It is explained that the young person would be expected to keep such a record, although if he/she were to forget to do so, the therapist would still review practice in the beginning of that session.

(ii) Setting up the home practice

It is very important that this is done carefully. The young person needs to understand why home practise is important. It might be useful to use comparisons with learning other new skills like music or sport and how practising helps people learn more quickly. The young person also needs to be able to see how the home practise might help them and the therapist and have been involved in setting up the home practise. Often depressed young people may feel that they won't be able to do the task 'well enough' or that they are 'too stupid' to do it properly – the therapist needs to be alert to any clues about the beliefs and predictions, these

can become a useful focus for cognitive work and the home practice can be used as a behavioural experiment.

If in doubt, make the home practice easier rather than more difficult. The complexity of the task can easily be increased and it is very important for the young person to experience success and receive positive reinforcement from the therapist whenever possible.

In addition to explaining what to do, it may be helpful for the therapist to write the instructions in the diary, using clear, simple language (ie pitched at the level appropriate for the young person's literacy skills). Some young people will prefer using pictures to words and the therapist should also consider using other methods of recording such as mobile phones, computers and audio recording.

Before closing the session, the therapist checks that the young person has understood by asking them to explain what they need to do before the next session.

(iii) Home practice Review

The home practice review is an important part of each session as it links the themes of the previous session with those of the current one. It should always occupy a central role in the session.

If the diary/ home practice has been completed

(i) Congratulate him/her. It may also be appropriate, with the young person's permission, to write positive comments in the diary.

By positively reinforcing the young person's cooperation and completion of the diary, the therapist is:

- reinforcing the concept of reward, which is an important theme running through the therapy.
- giving the message that the young person can do something positive to help him/herself and that therapy can only be successful if he/she plays an active part in it.

- (ii) The next part of the review consists of a detailed discussion of the diary material as appropriate for the session.

If the diary /home practice has not been completed:

It is possible that the young person will not have completed the diary or even brought it to the session. If so, it is important to give a clear message that it would have been preferable if he/she had completed the task, as this would have given the therapist a better understanding of how the young person has been feeling recently. It is important to explore with the young person any beliefs or predictions they may have made about the task (see above also). There may need to be a clearer rationale to the young person and opportunity to collaborate on how best to achieve the aims of home practice. The task may also be too difficult, too complex, not clearly linked to getting better, or just wrong and the therapist should remain open to these possibilities.

In these circumstances the therapist will want to find out the reasons the young person did not do the home practice (eg did not understand the task, too depressed to do it etc) and then spend more time in the session practicing tasks and giving positive reinforcement. Positive reinforcement is vital, otherwise home practice may become yet another source of feelings of worthlessness and failure.

NB. Specific points relating to review of a particular home practice tasks are included after the home practice instructions for that session. The therapist will need to remember to check these when preparing for the next session.

See the later section on Troubleshooting for more detailed discussion of home practice problems.

PART 3: APPENDICES FOR USE IN CBT FOR DEPRESSION

This appendix includes a range of resources for CBT therapists to use. They have been developed through routine clinical work with young people and may be adapted for use with specific clients and their parents.

In addition to therapy resources the Appendices also include a list of academic and clinical references for therapists, and books and resources for parents and young people.

APPENDIX A

PSYCHO-EDUCATION

Introduction of therapist and participant:

Acknowledge appreciation for the young person's participation.

Why is he/she there?

Find out the young person's reasons for attendance and objectives for the therapy.

Set meeting days and times, and discuss how long the therapy is likely to take.

Explain that the sessions will be confidential.

Therapist note:

When discussing confidentiality, the therapist may find it useful to explain that the contents of the session are private between the young person and therapist. However, the therapist would need to pass information on if he/she was worried that the young person was going to come to some harm.

2. Explanation of the therapy

The young person is given information about practical matters such as number, duration of frequency of session; use of home practice assignments; arrangements for making contact in case of need; and the like. The core principles of therapy must be simply and clearly conveyed.

Rationale for CBT

The basis for the therapeutic approach needs to be explained during the initial sessions. This may include explanation of the common symptoms of depression, normalising the young person's experience of symptoms and linking the symptoms into a cognitive behavioural explanation. The explanation needs to be targeted to the understanding of the young person. The therapist will need to define cognitions; "thoughts, ideas and beliefs which are circulating inside our heads all the time. They affect our behaviour.". Continue with an explanation of the therapeutic process. "These thoughts affect how we feel. When people feel down and depressed they are often thinking bad thoughts about themselves (I'm hopeless and useless), about the future (nothing's going to change) and the world (everything always goes wrong, everyone hates me). Treatment works towards identifying these negative thoughts, understanding them better and changing

them." "You'll understand this better as we work through the treatment" "Have you ever done anything like this before?"

It is often helpful to establish early on the young person's understanding of certain key terms, particularly recognising symptoms of depression. For example, what does the young person understand by the terms 'hopeless' or 'concentration'? The quality of the description often give useful clues about their ability to describe these symptoms in the context of therapy.

Summary

Introducing the young person to therapy includes clarifying;

How the therapist plans to work with the young person

What is depression and how CBT works for depressive symptoms

Structure of sessions and home practice

Introduction to therapy – Parents and carers

Key points about CBT need to be explained to parents at the outset. The extent of parental involvement will be determined by the age of the young person, the nature of difficulties and the young person's relationship with their parents. For carers who are not parents, similar principles will be involved but these may vary according to the nature of the carers' responsibilities.

Explanation of confidentiality to parents.

Details of when parents will be seen.

Fact Sheets to be given to young person and parents.

Young Person's Fact Sheet

What is depression?

Anyone can get depressed. It is the most common psychological problem. It varies from person to person but often stressful and difficult things can trigger depression. We all feel sad from time to time but usually the feeling passes. With depression these feelings of sadness just seem to go on and on.

Main features of depression in teenagers

Depression can affect how you feel, how you think and things that you do.

- **Negative styles of thinking may include:**
 - low self esteem/confidence
 - feeling things are hopeless and no one can help
 - feeling inadequate or that everyone else is better than you

- **Difficulties with friends may include:**
 - reducing your social activities
 - falling out with people you used to get on with

- **Symptoms of depression may include:**
 - feeling sad and crying easily
 - having trouble sleeping
 - becoming less active
 - loss of interest in things you use to enjoy
 - feeling like harming yourself
 - having no motivation and feeling tired most of the time
 - losing your appetite
 - it is hard to concentrate
 - losing your temper more easily
 - feeling guilty

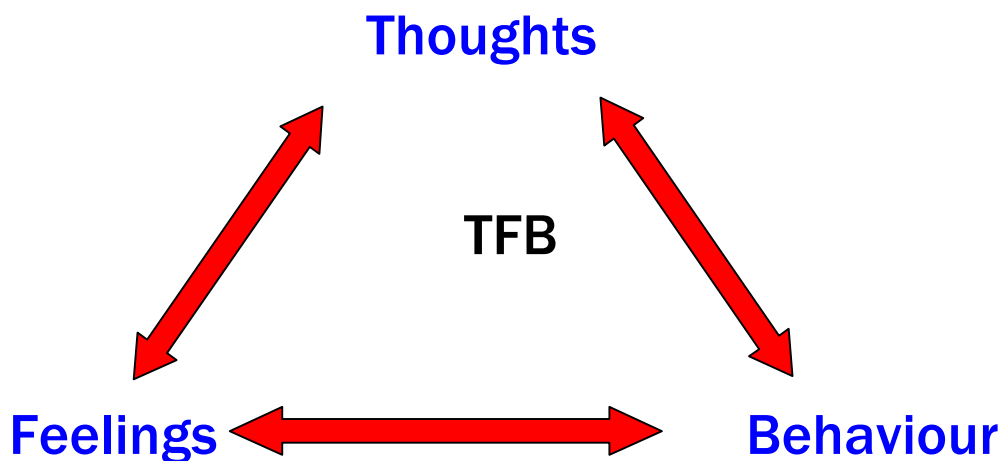
The problem with depression is that the symptoms can make you feel worse and worse. For instance, if you stop going out then you don't see your friends and it gets harder to be sociable. Depression can make you feel like there is no way out but help starts here.

Information sheet for parents

What is CBT?

CBT or Cognitive Behavioural Therapy is a therapy that helps young people get over their depression and the problems related to the depression. There is a great deal of research that shows CBT helps.

A cycle occurs where the depression changes a person's thoughts feelings and behaviour or TFB.



CBT sessions usually last for 6 to 12 weeks. The therapist and the young person work together to understand the problems and set goals. Then the therapist teaches new skills to make things better. When a young person is depressed it changes in how they think and process information. CBT focuses on the links between **THOUGHTS**, **FEELINGS** and **BEHAVIOUR**. The aim of the CBT is to change some of the behaviours and thoughts and reduce the symptoms of depression. An important part of the therapy is the home practice where the new skills are practiced.

CBT looks at identifying and challenging negative thinking styles. When you are depressed it feels that these thoughts are true but it is the depression. CBT will help you to change your thoughts. Negative styles of thinking can relate to childhood experiences, forming the basis of our beliefs about:

self e.g. 'I am bad person'

Others e.g. 'people can not be trusted'

The world e.g. 'the world is not a safe place'

CBT will also help to look at problems in relationships and other areas

APPENDIX B

ENGAGEMENT AND GOAL SETTING

SESSION NAME: ENGAGEMENT AND GOAL SETTING

(i) Definition

Continuing to help the young person to understand the nature of the therapy relationship and to develop a rapport with the therapist.

The identification of clearly attainable targets for the work, against which progress can be evaluated.

(ii) Session aims

1. To obtain an understanding of the young person's current difficulties.
2. To identify areas of strength.
3. To define goals of therapy.

(iii) Rationale for the session

The therapy is collaborative, so right from the start the therapist and young person need to be sharing an understanding of the approach and working in agreement about what needs to change.

SESSION TASKS:

1. Assessment of current difficulties

The goal is to get an overall picture of the present situation as the young person sees it. This involves pin-pointing major problems, and gathering enough information about associated thoughts to make a preliminary formulation of the case.

Use the information already gathered by the research assistant, keeping in mind the following areas:

- symptoms eg panic attacks, sleep problems, worries
- life problems eg contact with parents, educational problems
- interpersonal and social problems eg problems with friends
- associated negative thoughts eg "nothing will change"
- onset/context of depression - "was there a time when you felt OK?"

- hopelessness/suicidal thoughts - "does life feel worth living?"

Therapist note

(i) Assessing current difficulties:

Adolescents will have a different perspective on problems from their parents/carers. It is important that information from either is not treated as strictly factual and hence that conflicting information implies that one source is distorting the truth.

For instance, a mother may report that her daughter is frequently out socialising with a small group of her close friends and that she sees them laughing together in a relaxed manner. Her daughter may describe a sense of failure in relation to her friends' sociability and feeling that she has to struggle to keep in the group. Both views are accurate. Their implications are different. The girl may feel that she does not wish to burden her mother with her social anxiety.

Symptoms of depression such as social withdrawal and loss of concentration can make depressed individuals very difficult to assess. For example, they may have difficulty responding to open questions that invite descriptive answers. It may on occasions be necessary to provide an indication of the type of symptoms that they might be experiencing.

Particular care may need to be taken to establish a vocabulary that the young person uses to describe how they feel. Similarly, clarifying duration and fluctuations in these feelings can require skill. Again, using concrete examples can be helpful. A key task of the first individual interview is to assess the young person's interest and motivation for individual work. Experienced interviewers will be familiar with the need to provide suitable reassurance about the need to seek help and in pacing the interview to the young person's needs.

It is very important that the young person's strengths are also identified to help the therapist understand what they are able to mobilise in support of the intervention and to make clear that the therapist is interested in positive aspects of the young person as well as problems.

The young person's understanding of any difficulties and the purposes of referral must be explored. Problem examples or difficult episodes can be tracked from their own view, again with an emphasis on specific contextual details. The therapist may find it helpful to use hypothetical examples of similar problems and another young person's view to provoke discussion. In the course of discussion levels of distress that the problem causes will be clarified, attitudes to difficulties, motivation for change and attributions about the source of difficulties.

(ii) Assessing suicidal thoughts:

In work with young people with mood disturbance it is always important to consider and evaluate the risk of self-harming behaviour. Suicide can be a difficult area to talk about and many worry that it may not be safe to open up the subject with young people. However all the evidence shows that it does no harm. On the contrary, many suicidal young people experience a real sense of relief when they are given the opportunity to talk about their distressing feelings and it is also important for the therapist to know if they are present.

2. Drawing up a problem list

Draw up a list of problems identified by the young person. Get him/her to rate the severity of each problem, using either the 1 -10 scale, or the thermometer (see appendix)

Example of problem/worry list:

	<u>Problem</u>	<u>Rating</u>
1.	Difficulty getting on with my mum.	9
2.	Feeling bad about myself.	8
3.	Getting depressed.	7
4.	Not being able to say what I think.	5

Therapist note:

It is important for the therapist to help the young person identify their main problems. Drawing up an agreed problem list gives him/her immediate experience of cognitive-behaviour therapy as a collaborative enterprise. It helps the therapist to understand the young person's perspective, and allows clients to feel that a genuine effort is being made to grasp their personal difficulties.

It is crucial when working with depressed adolescents to identify hopelessness and suicidal thoughts.

The problems identified may link in with commonly recognised features (symptoms) of depression, which can be broken down into the following categories:

- i) Low mood eg sadness, apathy*
- ii) Self harm*
- iii) Cognitive eg poor concentration, memory problems*
- iv) Behaviour eg social withdrawal, acting out*
- v) Physical symptoms eg sleep & appetite disturbance*

The therapist with the young person determines which symptom is most distressing and will be most amenable to therapeutic intervention.

The identification of problems helps determine the emphasis of future therapy sessions .

3. Defining the goals of treatment

Goals in relation to each problem area are then identified and recorded. Goals must be realistic and clearly defined so that it is clear when they are achieved - for example "How would you know if you were getting on better with your Mum?"

Getting the young person to write down goals for themselves encourages ownership.

Therapist note:

It is very important to explain to the young person that the therapy is trying to help with just some of his/her difficulties. Some young people feel completely better after the treatment, but most are helped in a few, but not all areas (depressed young people have multiple difficulties). This is a most important message because unless young people have a realistic view of the likely efficacy of therapy they may become disappointed that they are not completely better at the end of treatment and blame themselves for not improving more.

APPENDIX C**EMOTIONAL RECOGNITION****SESSION NAME: EMOTIONAL RECOGNITION****(i) Definition**

Description of the young person's understanding of different emotions.

(ii) Session aims

1. To teach/clarify meaning of different emotions eg anger, sadness
2. To help the young person distinguish between different emotional states
3. To help the young person observe his/her own and other people's emotions
4. To start linking emotions/mood with behaviour and thoughts

(iii) Rationale for session

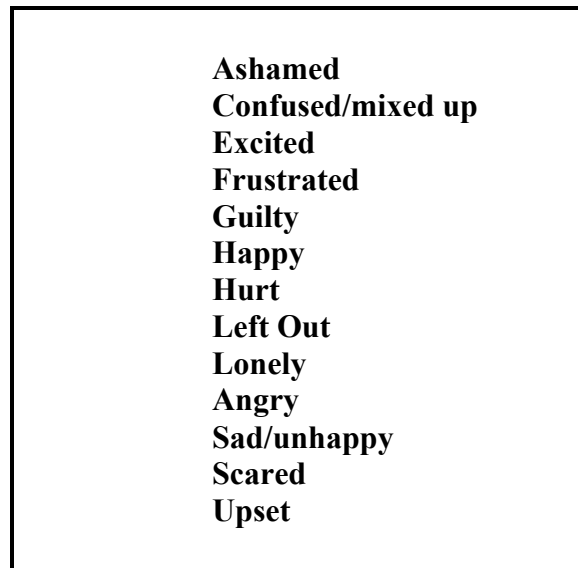
Depressed young people may have difficulties in identifying their own or other people's emotions. They also have difficulty in distinguishing between different types of emotions - for example anger and sadness. They usually tend to perceive thoughts-emotions-activities as part of the same factor which is well beyond their control - for example, being bored. The opportunity to define and identify the way they feel, as well as linking it to their thoughts and activities, often helps them to feel less helpless and more in control of their mood.

SESSION TASKS:**1. Emotional recognition cards**

N.B. Cards are useful for younger adolescents. Older adolescents will prefer to engage in dialogue focused around the identification of feelings as distinct from thoughts.

The rationale for this exercise is explained to the young person with a statement such as: "During the sessions, we will be talking about the way you feel and about ways of helping you feel better in the future; people use different names to describe the way they feel. Therefore, it is important to check with you how you understand different types of feelings. If you find it difficult to give a definition, you can use an example of how one might be experiencing this feeling".

Names of the following emotions are written on separate coloured cards which are covered and put in front of the young person:



(i) He/she is asked to describe/define this emotional state:

The young person is asked to uncover one card at a time, read a name of emotion and define it as much as possible in his/her own words.

If the young person finds it difficult to provide a definition, he/she is prompted to think of a suitable example (particularly for younger adolescents).

If he/she finds it difficult or even impossible to do this, the young person is encouraged to move on to the next card.

Positive verbal reinforcement can be introduced at this stage by comments such as: "That's fine, you can pick up another card now". The young person is asked to define at least six names of emotions.

Therapist note:

A distinction may have to be made between younger and older adolescents in this part of the session: although the aim of the session and the therapy tasks should be identical, the approach and the way the session is introduced to each young person would probably vary according to his/her age. With younger adolescents, the therapist relies more on the use of the cards, attempting to engage them through a game-like approach. In contrast, the therapist should rely more on verbal communication with older adolescents. This does not imply that the aims and content of the session should be different. Although older adolescents have higher intellectual ability in defining emotions (and would therefore be offended if the therapist tries to engage them by putting too much emphasis on the cards), they also present (particularly depressed adolescents) with the same emotional deficits that were mentioned above.

It can be particularly useful to discuss angry feelings particularly in the context of irritability being a very common feature of depression.

(ii) The young person is asked to give an example of recently feeling like this

What was he/she doing and thinking at the time?

(iii) The young person is encouraged to make the link between their feelings and behaviour.

“If you felt like that how would you be acting/behaving?”

2. The young person is asked to uncover at least six more cards

(which could be the same as for the previous task), and to give examples of recently feeling like the emotional state written on the card.

(i) The young person is then asked to recall and describe what was actually happening at the time that he/she was feeling like this.

(ii) He/she is then asked to recall and describe what he/she was thinking at the time.

Therapist note:

This new concept can be difficult for some young people to understand at this stage, i.e., that mood and thought are not the same thing. It is therefore useful to check whether they can make this distinction. If there is some difficulty, the remainder of this session should concentrate on recognition and verbalisation of emotions.

For older, cognitively sophisticated adolescents where emotional recognition is straight forward, the distinction between mood/activity/thoughts can be introduced by a general statement such as "When we feel sad or happy, certain thoughts may be crossing our mind".

It may be useful at this stage to ask the adolescent if he/she can understand this distinction. An appropriate question could be "Can you describe the thoughts that cross your mind when you feel happy or sad?".

In this way, the distinction is gradually introduced without being enforced on the young person. It is not expected that he/she will be able to make the distinction immediately. However, this early introduction of links between mood and cognitions as well as with events/activities begins to operate automatically at this stage.

(iii) The young person is then asked to go through the same emotional states and describe how another young person of his age and sex would behave and what they might be thinking if they appeared to be in this emotional state.

Therapist note:

This gives the opportunity to both young person and therapist to compare his/her own thoughts and behaviour during certain emotional states with what he/she considers as norms for the particular developmental stage. This comparison enables the young person to move on to later

sessions and work on the concepts of self-esteem and negative cognitions of depressed young people.

3. Introduction of the diary and home practice

- (i) As detailed in the “Notes on Home practice”, the diary is given to the young person as early as possible in this session as is practical, and its role and importance emphasised. The young person is encouraged to personalise it by writing his/her name on the front cover and decorating it.
- (ii) The therapist explains how the young person is to be asked to keep a record of mood/events/thoughts for the next session. For this reason, they practice two examples during this session, using the worksheet if desired (see appendix)

If not using the worksheet, the young person is asked to either draw three columns on the first page of the diary. The columns have the following three headings:

What I was feeling	What was happening/what I was doing	What I was thinking

He/she is then asked to practice by recalling two recent emotional states, namely feeling happy and feeling sad. If the young person finds it difficult to complete any of the columns, he/she is encouraged to recall the appropriate mood/event/thought.

Therapist note:

The home practice task is geared to the work completed in the session. If the young person had difficulty identifying cognitions, the home practice task should be geared around the daily identification of feelings and their association with activities. It is anticipated that the young person will be finding it difficult at this stage to distinguish between the three aspects, and therefore revert to answers such as "I don't know", "I don't remember", or repeat an emotional state (such as feeling sad) instead of describing a thought. Continuous prompting reinforces the idea that mood, events and thoughts are different things. Despite the therapist's positive reinforcement, it is still anticipated that the young person might not be able to complete the full task at this stage.

HOME PRACTICE

1. Home practice information for the young person

The same instructions that were explained during the two examples during the session are repeated to the young person.

The young person is asked to recognize when he/she is angry/sad/anxious/happy and write down what was happening, and what he/she was doing and thinking at the time.

He/she is reminded that it will be very important to complete the diary and bring it to the next session.

Before closing the session, the therapist checks that the young person understood what he/she is supposed to do

2. Home practice review

- (i) Explore mood-thought-events links
- (ii) Encourage the young person to distinguish between the three aspects and to start making causal links

It is not anticipated that he/she will have kept a detailed record of his/her mood and accompanying events/thoughts during the previous week. It would therefore be important to discuss representative examples of feeling happy and sad, ie. contrasting types of mood. As most depressed young people also present with anxiety symptoms, and many of them will describe those as the main complaint, it is also important to discuss incidents when the young person felt anxious and/or angry.

The young person is then encouraged to describe the three columns of the diary in more detail, ie. what he/she was feeling, doing and thinking at the time, as well as what was happening. It is possible that he/she will have not completed all three columns for each example, and will have particular difficulty in distinguishing and describing his/her thoughts.

The young person is prompted to expand on brief answers such as "I was thinking of my mother". Facilitating questions include "What were you actually worried about", or "Could you tell me a bit more about your worries at that time?"

Therapist note:

This exercise is an opportunity to help the young person to clarify in his/her own mind that thoughts are different from feelings, although they are often causally linked.

By discussing recent examples of mood/events/thoughts, the therapist also aims at helping the young person to start making causal links between the three. Although the therapist is not expected to give feedback or his/her opinion on such causal relationships, he/she will possibly have a formulation in his/her own mind. If, therefore, the opportunity arises during the discussion of these examples, the young person is encouraged to explore such links as much as possible (without actually asking whether e.g.a certain mood was caused by a certain event).

If the young person has not completed the diary, the therapist could go through the same practice by asking him/her to recall recent examples of the above described emotional states. If the young person gives answers such as "I do not remember" or "I do not know", the therapist should keep prompting (e.g. "Have a good think"). If the young person is still unable to recall recent emotional states, the question could be reversed by asking him/her to recall recent events which could then lead to the discussion of mood and thoughts.

Appendix D

ACTIVITY SCHEDULING

(i) Definition

Activity scheduling involves helping the young person activate themselves by introducing new or previously enjoyed activities in a structured way. The process is in 2 stages. First the young person keeps a diary monitoring their activities. This is reviewed, suitable activities identified and then scheduled in as part of home practice for the following week. The focus is on identifying activities that give either pleasure and/or a sense of achievement. This will take a minimum of 2 sessions and for most will continue through further sessions as well until a "normal" activity level is achieved.

(ii) Session aims

1. To evaluate the level of boredom, social isolation and inactivity and its interaction with depressed mood.
2. To enable the young person to reinforce positive behaviour and gain a sense of control over his/her life. To enable the young person to make a link between a potentially positive effect of self-rewards and sense of achievement on mood.

(iii) Rationale for the session

Depressed young people feel that they have little or no control over their symptoms and their lives. They engage in activities but derive little pleasure from them. Some young people find it difficult to derive pleasure from routine activities and are motivated to seek out novelty in new friends, new music, and new places. For some young people novelty include danger and risk, for example, substance use.

Depressed young people find it difficult to recognise pleasant events; it is even more difficult for them to initiate and maintain pleasant events and activities, which may be related to more positive thoughts and moods.

Depressed young people often have no experience of being rewarded for their acts and their low self-esteem does not allow them to reward themselves.

These tasks have been developed with the understanding that depressed people find it difficult to undertake or participate in tasks and activities which they previously accomplished and enjoyed. They give up easily, "Can't be bothered" and feel it is useless to try.

Introducing activity scheduling

1. Activity Scheduling

- (i)** Therapist elicits from the young person which activities he/she finds pleasurable and whether this has changed. If the young person is no longer engaging in these activities the therapist asks why.
- (ii)** The young person and therapist review his/her activities for a typical weekday and a typical weekend day and complete together an activity diary for the day before the session.
- (iii)** The therapist may determine the amount of time during which the young person feels bored. Many young people report a number of negative cognitions when they are physically and socially inactive.

N.B. If the therapist feels there is an appropriate level of activity, move on to the self reinforcement task

Example of activity scheduling

The activity schedule serves to structure the day and it provides information to assess the young person's daily activities. The therapist and young person can construct a daily activity plan. Ratings can be given for enjoyment of each.

For example:

8.00	Wake up, get up, get washed and dressed
8.30	Breakfast
9.00	Watch TV
10.00	Visit friend
12.00	Eat lunch
1.30 - 4.00	Shopping with friend
5.00	Eat tea
6.00	Watch TV, home practice
8.00	Play on computer
10.00	Bed

SESSION 2

- (i) Young person and therapist review the previous week's activity diary.
- (ii) Therapist reviews the effect of activity on mood using examples from the diary.

Therapist introduces concepts of reward and achievement and effect on mood. A rationale is presented to the young person as follows:

"When you are bored and have nothing to do, the bad thoughts we have talked about are likely to come into your mind. I want you to do an experiment with me to see if you keep yourself busy you find that you have less bad thought and that you feel better"

- (iii) Together, the young person and therapist schedule activities for the forthcoming week. During this process, time is scheduled on an hour by hour basis. Activities over which young person has some control are chosen. If the young person is unable to decide what to plan, the therapist suggests possible activities. Aim to schedule several activities during the week and for each rate pleasure and achievement. The therapist may encourage self reward for achievement of new or difficult tasks.

Therapist note:**Examples of rewards****A Self-rewards:****(i) Material:**

Having a favourite snack.
 Buying an ice-cream/sweet from the nearest shop.
 Watching a favourite video tape.
 Inviting a close friend.

(ii) Thoughts:

Thinking, "Well done!"
 Thinking, "I am proud of myself"
 Thinking, "I am pleased with myself"

B Carer rewards:**(i) Material:**

Joining the young person in a favoured activity at home.
 Taking the young person to a favourite event.
 Giving a token towards the purchase of a small gift.
 Arranging for the young person to visit a close friend.

(ii) Verbal:

Phrases such as, "I am very pleased with you"
 "I am glad to see you happy today". "Well done!".

Rewarding oneself is probably a new and difficult task for the young person, who therefore needs clear and specific examples of self-rewards. If these are too abstract or not realistic enough, it is likely that the young person will gradually give up his/her practice. This could even have an adverse effect on self-esteem and mood as he/she may interpret it as further evidence of failure.

A list of potential rewards, worked in with the therapist during the session, in combination with initial rewards defined by the young person, can help overcome this difficulty.

However, some depressed young people may still be unable to identify anything which gives them actual pleasure. In this situation, the therapist may have to resort to defining rewards which are "less boring" or which result in the young person feeling "not as bad" as usual.

Potential rewards may be material or verbal/cognitive. The latter are more difficult to conceptualise and achieve, particularly for younger adolescents. However, the introduction of positive cognitions as self-rewards is essential as it may lead to subsequent work involving a restructure of negative thoughts and beliefs.

Rewards may also be provided by the carer(s) who can thus play some part in the treatment programme. This is important, as young people do not have enough control in achieving certain rewards (e.g. inviting their closest friend back home).

If self rewards have implications for the young person's normal routine, it is particularly important that the carer is fully involved in planning and implementation. It may therefore be useful to include the carer in part of the session

Self-reinforcement may have two goals:

- *to reinforce participation in pleasant/positive events/activities, which may consequently affect the young person's emotional state*
- *to reinforce the young person's self-esteem, which may then lead to maintenance and further improvement of a desired emotional state.*

Behaviour and standards that may lead to self- or parental rewards should be discussed and decided jointly by young person and therapist, according to the young person's known difficulties.

JOINT SESSION WITH PARENTS

Likely to be useful stage to do this.

May need to be specific about increasing activities, promoting joint activities with parents and general review.

HOME PRACTICE

1. Home practice instructions

The young person is asked to continue to keep an activities diary. They should be encouraged to record at least one new activity completed each day or aim for a minimum of 3 a week. The therapist should discuss this with the young person beforehand. This can be a continuation of the previous weeks' practice i.e. a note of daily activities plus associated feelings and thoughts.

If the emphasis of the session has been on self-reinforcement, the young person is asked to use at least one of the listed rewards every day and to keep a record in the diary. A reward should be given when the young person feels pleased with him/herself, even for a very brief period or for achieving an identified goal.

It is important to introduce this practice in a way which will prevent the young person from perceiving any inability to complete the task as his/her failure. The therapist thus asks him/her to use one of the rewards when (rather than if) he/she feels pleased. The therapist does not collude with the young person's possible belief that he/she may not have reasons for rewards. Inability to complete the task should be perceived as "difficulty in using rewards" rather than as "difficulty in feeling pleased with oneself". The young person is asked to use rewards only after completing a task or feeling certain about being pleased with oneself.

2. Home practice Review

The young person and therapist go through the young person's diary and discuss the activities of the previous week. Degree of inactivity and boredom are reviewed plus enjoyment of and participation in activities. Review of activities schedule if set as a home practice task.

The young person and therapist review "being pleased with myself" and subsequently using one of the agreed rewards. All recorded rewards are discussed in detail, while exploring at the same time the effect of the reward on the young person's mood.

The young person's difficulties are also explored in depth: these could be either related to choosing a specific type of reward (possibly thoughts) or to justify any cause for self-reward.

Therapist note:

It is anticipated that depressed young people will have difficulties with these tasks, particularly if they are not supported by their parents or carers. In such cases, it is important not to collude with the young person's perception that "I am totally incapable of feeling happy or pleased with myself, therefore I do not deserve any rewards".

LIST OF REWARDS

From Parent / Carer

From myself

I am going to reward myself for:

APPENDIX E

SELF MONITORING AND DETECTION OF NATS
--

(i) Definition

Development of the young person's ability to pay attention and observe his/her own thoughts and feelings, and make a judgement about their occurrence or non-occurrence.

(ii) Session aims

To help the young person observe purposefully him/herself and the situations he/she enters:

- (i) Initially, for gathering of relevant information (assessment tool)
- (ii) Progressively, as a re-direction of the young person's attention to more adaptive functioning (therapeutic tool)
- (iii) In order to separate events, thoughts and mood

Continue with monitoring of activity scheduling and introducing new activity targets.

(iii) Rationale for the session

Previous research shows that depressed young people tend to pay greater attention to negative thoughts and feelings than positive ones.

This session is an extension of the emotional recognition session, in which initial links between moods/events/thoughts were explored, although in a less structured way.

In this session, the young person is invited to observe more clearly the way s/he feels and thinks. By being capable of making such observations, it is hoped that he/she will progress to working towards positive thoughts and activities, which could subsequently lead to improved mood.

Session Tasks

1. Identifying thoughts

Young people may have difficulty identifying thoughts. Sometimes it can help to ask what the young person was thinking before coming to the appointment. It has been found, for example, that most people attending the dentist report thoughts about the dentist, the waiting room and the treatment.. The therapist then labels these as 'automatic thoughts' or 'things you say to yourself'.

2. Linking events, thoughts, and feelings.

The therapist gives some representative examples demonstrating a possible link between an event (e.g. "You get invited to your best friends party") and a thought (e.g. I can't go because my mum has grounded me). They ask the young person about how they might feel if they had that specific thought. It might be important to use picture, thought bubbles, emotional faces and so on to help the young person connect the event and the thought to a mood state. There are materials in Quakley et al., (2004) which use a range of hypothetical scenarios.

The therapist can then provide a different thought which could arise from the same event (e.g. I can't wait for the day of the party to come), and ask the young person to think about how they would feel if that had that thought instead of the first one. They can then try to generate different types of positive and negative thoughts and link these to different mood states.

It is preferable (easier for the young person to understand initially) if the examples are general ones (see below) and, therefore, not affected by the therapist's formulation of each individual case. Stress the importance of the difference between feelings and thoughts.

Therapist notes:

Possible pleasant events: Even the introduction of the notion of "pleasant events" can be important for depressed young people, who often only pay attention to unpleasant ones.

It is preferable for the therapist to give examples of pleasant events that are well within the young person's control. It is also important that they are realistic and achievable, as these may be given as practice at future sessions.

NB. The aim here is not to get the young person to "look on the bright side."The point of the exercise is to help young person to identify and focus on potentially pleasurable events, not to find the good in unpleasant ones.

Unpleasant events: It is preferable to give one unpleasant event that is beyond the young person's control (e.g. feelings, death of a relative or a friend), and an unpleasant event that is within his/her control.

In both cases, the concurrent mood and thoughts are described in a way that demonstrates that thoughts and mood can be within the young person's control. .

Examples of pleasant events and concurrent mood/thoughts :

**Last weekend, I decided to invite two friends. We spent a few hours chatting and listening to music:
I was feeling excited and happy.
I was thinking that perhaps I should try to see my friends more often in the future.**

**On Monday I had my school report:
I felt very pleased with myself.
I thought that, although many of my friends had an even better report, I had tried really hard.**

Examples of unpleasant events and concurrent mood/thoughts:

**Yesterday, I asked about my grandmother's serious illness. I was told that she is still very poorly:
I felt sad and was tearful for the rest of the day.
I thought that I was missing her very much.**

**On Wednesday, I was bullied by some young people in the playground.
I felt really miserable.
I thought that perhaps I should stand up for myself if that happens again.**

3. Linking thoughts and feelings in the 'real' world:

The therapist initially checks if the young person has understood the notion of pleasant/unpleasant events.

The therapist then asks the young person to imagine one of these pleasant or unpleasant scenes. If the young person indicates a positive or negative emotional response, the therapist can then enquire about his/her thoughts.

He/she is then asked to provide his/her own examples. It is anticipated that a depressed young person will find it much easier to provide examples of unpleasant events and that he/she will be having difficulties in describing the concurrent mood and, particularly, thoughts.

Facilitating questions such as "How were you feeling in yourself when this happened?", or "What was going through your mind at the time?", may help the young person to describe his/her mood and thoughts.

4. Introducing the idea of self-monitoring

The notion of self-monitoring is introduced with a remark such as "sad young people usually only pay attention to negative things that happen and negative thoughts and feelings about themselves". The words negative/positive were selected for the introduction of self-monitoring as their concept will be important for the subsequent description of cognitions. This in contrast with the pleasant/unpleasant dichotomy, which rather tends to describe mood and events.

During this part of the session, the therapist should identify:

- Negative thoughts about self and the future.
- Positive thoughts about self and the future.
- Only paying attention to the negative.

It is important to check with a young person that he/she understands what the therapist means by the words "negative" and "positive". By asking the young person to record both pleasant and unpleasant events, the therapist immediately challenges his/her existing belief that most events and most aspects of him/herself are negative.

5. **Detecting automatic thoughts**

Once the young person understands the definition of a thought and the presence of positive and negative cognitions the idea of the "thought detective" is introduced by such comments as "our minds are rarely completely blank, thoughts both positive and negative are crossing them all of the time. We are going to work on catching these thoughts and putting them down in writing. You are going to become a sort of detective catching all of the thoughts going through your mind - a thought detective".

Therapist note:

Identifying negative thoughts: Beck categorised the content of depressive thinking in terms of a "cognitive triad". This comprises distorted, negative views of the self (eg. "I am useless"); current experience (eg. "nothing I do turns out right"); and the future (eg. "I will never get better"). He considered that depressed patients had "automatic thoughts". These are habitual, involuntary, plausible and they occur in response to an extensive range of stimuli, including therapy itself. So, talk of ending treatment would be interpreted as rejection (eg. "he just wants to get rid of me") and home practice assignments will be abandoned because the patient predicts failure. Negative automatic thoughts can therefore prevent engagement of therapy, and should be identified at an early stage.

6. **Techniques for identifying negative thoughts**

Projective techniques

Cartoons –"the thought detective" " I want to imagine you as a detective, trying to catch thoughts,..."

Therapist observations

" Tell me all about what happened with your friend in the playground. Describe it to me, what was going through your head?"

Using 'thought bubbles' and stick figures

Use a stick figure to illustrate the young person and indicate what is going on around them and indicate their feelings by drawing a face on the stick figure – then draw a thought bubble, as in a cartoon, and ask them what should go in here – it can be words, or pictures (images) - try out different thoughts in the bubble – how do different thoughts change their feelings?

Discussing a recent emotional experience

Adolescents are asked to remember a recent event that was associated with depression. The adolescent is asked to describe the event in detail, the therapist then elicits thoughts using questions such as "what went through your mind just then"?

Using imagery or 'replay' to relive an emotional experience

If questioning fails to elicit thoughts, it can be useful to ask young patients to relive an event by using imagery. We usually mean visual imagery, i.e. pictures they can 'see', but imagery can also include sounds and smells.

For example "*It looks as if it is difficult for you to remember what happened*". *When this problem occurs, we sometimes find it is helpful for young people to produce a picture in their minds of what has happened. To help you to do this, lets practise with other clear images. For example, I would like you to try and imagine a flower. Can you see its petals? What colour are they? Can you smell it? Is there a breeze?*

Good. I'd now like to imagine yourself back in the situation that we discussed (give example of stressful event). Try and produce a picture of it. Can you see it? Can you tell me a bit of what you are seeing? What else can you hear or feel? Now, run the image forward like a video, noticing all the time what is happening? How are you feeling? What is going through your mind? What are you thinking?"

Shifts in mood during a session

Mood shifts during a session are common among depressed adolescents and can be particularly useful sources of automatic thoughts. The therapist might comment "*You looked sad just then. What went through your mind?"*

Role-Play

If the adolescent cannot imagine a situation then it is sometimes possible to role-play interpersonal situations. The adolescent is asked to remember what the other person said, and then the therapist can role-play this.

HOME PRACTICE

1. Home practice Instructions

Keep a diary of pleasant and unpleasant events and thoughts/feelings, either in the diary, or using the sheets below. The concept of the "thought detective" can be stressed here to encourage the young person to identify and record concurrent thoughts.

2. Home practice Review

This will depend on how successful the young person has been in completing their home practice

The young person is asked to go through the diary/sheets and to describe two pleasant and two unpleasant events that occurred during the previous week. They are then asked to describe his/her concurrent mood and, finally, his/her concurrent thoughts.

If he/she has not completed the home practice, the young person is prompted to recall such events in the beginning of the session.

Thought diary for home practice

Pleasant event	Feelings	Thoughts
1.		
2.		

Unpleasant event	Feelings	Thoughts
1.		
2.		

APPENDIX F

CHALLENGING NEGATIVE THINKING

Sessions on emotional recognition and self-monitoring have differentiated between feelings and thoughts and introduced ideas of thought monitoring. The notion of negative automatic thoughts has been introduced and linked with depressed mood. These sessions will build on this work and constitute the main cognitive therapy of the programme. As we have emphasised, some young people will spend all the sessions covering cognitive behavioural techniques whilst younger and less mature adolescents may not have the cognitive sophistication to complete all tasks and apply all techniques. For them, the social skills learning sessions will be most appropriate and will be expanded to fill the programme. This session is based on cognitive behavioural therapy as practised with adults.

This is likely to span several sessions with the young person generating NATS in relation to a range of events and discussing and working on them over a period of time.

It may be useful to continue activity scheduling as part of this.

(i) Definition

Challenging negative thinking (cognitive re-structuring) involves learning ways of observing/monitoring one's thoughts, evaluating them and seeking evidence about whether they are appropriate.

Specific techniques covered in these sessions:

- detection of automatic thoughts (continuation of previous work)
- examination and reality testing
- re-attribution techniques
- the search for alternative solutions

(ii) Aims

1. To achieve an understanding of the young person's depressive symptoms using the cognitive model of depression
2. To change negative cognitions and thus improve mood.
3. To work further on the cognitive formulation and where appropriate involve parents in work with the young person.

(iii) Rationale for the session

These sessions build on earlier work during which the young person has learnt to monitor his/her thoughts. The techniques above are introduced, encouraging the young person to evaluate his/her thoughts by looking for evidence whether these are related to objective causes or to his/her own experiences and perceptions.

The young person begins to generate alternative thoughts and ideas, and to gain understanding which will hopefully lead to improvement in mood and adjustment.

SESSION TASKS:**1. Explaining the rationale to the young person**

The young person and therapist will act together as "scientific collaborators" who will "investigate" the young person's thinking. The therapist elicits the young person's ideas about the nature of his/her problems and uses an introduction such as: "The ways in which we think about things affects our mood. Young people who are depressed often have ways of thinking which mean that they tend to look on the bad side of things. We are going to work together to identify these thoughts and challenge them. This is similar to the work we did at the beginning. Do you remember?"

2. Detecting automatic thoughts

(i) Remind the young person of previous work about difference between feelings and thoughts.

(ii) Look back through the diary to home practice tasks, highlighting "The thought detective". Check understanding.

If the young person is unclear the therapist can define a cognition as "either a thought or a visual image that you may not be aware of unless you focus your attention on it".

(iii) A vignette can be used to demonstrate the relationship between thinking, feeling and behaving.

Demonstrating the relationship between thinking, feeling and behaviour:

Therapist: "The way young people think and understand things affects how they feel and behave. For example, say a boy was in bed at home and he heard a crash in another bedroom. If he thinks "there is a burglar in the room. How do you think he would feel?"

Young person: "Very scared"

Therapist "How might he behave?"

Young person: "Lie very still in bed. Or try to shout to his mum and dad"

Therapist: "Okay, so the boy thought that a burglar made the noise and he felt anxious and scared. Now lets say he heard the same noise and thought "the window's open and something has blown down" How would he feel?"

Young person: "Still a bit scared but mainly worried that something was broken or annoyed that it had woken him up or sad that he might have lost something precious."

Therapist: "And would his behaviour be different following these thoughts?"

Young person: "He would go and see what had happened."

Therapist: "So, this example shows us that there are a number of ways in which you can interpret situations. The way you interpret situations, affects your feelings and behaviour"

Demonstrating the relationship between thinking, feeling and behaviour in an interpersonal situation

Many young people will struggle with negative thoughts and feelings about interpersonal situations and this is understandable given the key role that friends and peers play during adolescences.

Therapist: Sometimes what we think other people believe can also lead us to feel upset. Imagine how you might feel if your friend promised to text you to see if you wanted to go to see a film with her. If she didn't text you and you thought "That just shows that she doesn't really like me" how do you think you would feel?

Young person: Really fed up and lonely. Like she didn't want to be my friend.

Therapist: And how do you think you would behave?

Young person: I might not want to see her again, I'd try to avoid her, maybe stay at home for a while.

Therapist: OK so if you thought that she didn't want to be your friend you would feel fed up and lonely. Now suppose you thought that she had forgotten to text you because she had had to spend a lot of time doing her homework that evening. Now how would you feel?

Young person: Well I might be a bit fed up about not seeing the film.

Therapist: Would you feel fed up and lonely at all? Do you think you would want to avoid her for a while?

Young person: No, I'd probably go and see her the next day to fix up another time.

Therapist: So do you see how differently you feel in yourself because of the different thoughts that you have about your friend and why she didn't text you?

(iv) Remind the young person of the pleasant/unpleasant events exercise.

Ask the young person about recent experiences:

- pleasant event
- unpleasant event
- thoughts prior to the appointment

Promote discussion of associated thoughts. If the young person has difficulty with the terminology, the therapist may use other terms to describe cognitive phenomena such as "the things you say to yourself" or "self statements".

Therapist note:**Some problems that arise in identifying negative thoughts**

1. *Young person avoids recording thoughts. This can be helped by limiting the time spent focusing on distressing thoughts and providing other means of controlling them (eg. a programme of absorbing activities).*
2. *No negative automatic thoughts. If no negative thoughts can be identified in a particular upsetting situation, it may be helpful to ask; "what else was happening in that situation?"*

3. Examining and reality testing automatic thoughts and images

- (i) The therapist engages the young person in reality testing of his/her ideas. While depressed people characteristically view their world in a negative light, the therapist should not fall into a trap of assuming that all of the young person's negative thoughts or statements are invalid. The therapist and young person examine a sample of the young person's thoughts in collaboration. The basis or evidence for each thought should be subjected to the scrutiny of reality testing.

Example of reality testing

A fifteen year old girl expresses the belief that no-one would like her:

Therapist: "Why do you feel that no-one would like you?"

Young person: "Because I'm ugly"

Therapist: "Didn't you tell me that a boy came up to you at the weekend to talk to you and said you were pretty and he fancied you?"

Young person: "Yes, but he didn't mean it"

Therapist: "Why do you think he didn't mean it?"

Young person: "I don't know...because I'm ugly"

Therapist: "It is possible that he said it because he meant it?"

Young person: "I guess...I don't know"

Therapist: "Can you think of any other reason for him to say it?"

Young person: "No "

Therapist: "So perhaps he was telling the truth?"

Young person: "I guess "

Therapist: "So, isn't it likely that he did like you and did think you were pretty?"

Young person: "I guess"

Therapist: "Isn't it interesting that it's possible to see the same thing in different ways?"

Client: "I guess so".

Therapist note:

The essence of reality testing is to enable the person to question their firmly held beliefs and to recognise that beliefs are not always accurate or 'true'. The therapist gently shows the young person that perhaps there are other possible explanations or reasons – however it is very important not to use reality testing as a way of proving that the therapist is 'right' – the whole point is that we don't know what is 'right' but that there are other alternatives.

Once the young person has acquired the relevant self-monitoring skills they will recognise that certain cognitions are particularly frequent at times when he/she feels depressed. Cognitions often reflect a person's belief in his/her lack of competency, unattractiveness, or social isolation. These are their 'core beliefs'. The therapist helps the young person to recognise these negative biases in his/her choice of interpretations and how he/she tends to make negative inferences even in the face of contradictory evidence.

The therapist should not expect the young people to change their views simply because they become aware of their biased interpretations - the accuracy of each interpretation requires a careful examination so that the young person can improve both his/her observational, self monitoring skills and his/her ability to form realistic and logical inferences.

- (ii) When stereotyped negative responses have been elicited work can begin on altering these. The following cognitive techniques can be helpful.

1. Reattribution

A common cognitive pattern in depression involves incorrectly assigning the blame or responsibility for adverse events to oneself. Depressed young people are particularly prone to blaming themselves for the negative consequences of events beyond their control as well as those which are a consequence of their actions and judgements. "Reattribution" can be used when a young person unrealistically blames him/herself for occurrences.

The therapist and young person review the relevant events and make an appropriate assignment of responsibility. The point is not to absolve the young person of all responsibility but to look at all the factors contributing to an adverse experience. Thus the way may be opened for applying objective problem-solving techniques and a search for solutions.

Example of reattribution

A 14 year old girl who had developed a depressive illness had been sexually abused by her stepfather. She came to her 5th session of therapy saying that she felt that all the family's difficulties were her fault.

Client: "My mum is unhappy, my dad is in prison, all because of what I did"

Therapist: "What have you done wrong?"

Client: "I told about what my dad did"

Therapist: "Can you remember that decision?"

Client: "Yes, I was very very scared and unhappy and I couldn't bear it any longer"

Therapist: "It sounds to me that you didn't have much of a choice. How about if we agreed to talk about how you are now and how that decision to tell people about what your Dad did to you affects you now"

When the therapist and young person talked about her feelings and thoughts this girl was helped by the method of re-attribution ie. identifying the cause of the difficulty as residing outside of herself. The therapist and young person went on to talk about the changes which had occurred following disclosure and her stepfather's responsibility. Cognitions of the self-blaming client may be countered by reviewing the facts of the events which resulted in self-criticism and challenging the belief that the patient is 100% responsible for any negative consequences. Using a responsibility pie can be helpful here.

3. The search for alternative solutions/explanations

Depressed young people may perceive their problems as insoluble. If appropriate, work on social problem-solving can be introduced and the concepts developed to involve other interpretations or solutions to the young person's problems.

The therapist should not be diverted by the young persons' claims that he/she has "tried everything". While depressed people sincerely believe that they have explored every possible option, it is more likely that they will have automatically rejected several options and stopped the search for others because they have made a prejudgment that the problem is insoluble. Searching for alternative explanations provides another approach to insoluble problems.

Example of search for alternatives

A depressed 15 year old was convinced that she was unlikeable and would never have any friends. As evidence she told the therapist about having overheard two classmates talking about her, and saying that she was boring and miserable. The therapist elicited 2 points. First, the girl had been depressed at the time this conversation took place, and so it is likely that she was not behaving as normal. Secondly, she did not like these particular classmates, whom she knew to be spiteful, and so their opinion did not really matter. The therapist encouraged the girl to examine her beliefs in the light of these two points.

Beliefs can be listed and rated and then empirically tested.

- i) I'm someone who finds it difficult to make friends (90% believable)
- ii) These girls always tell the truth and are good judges of character (25% believable).
- iii) Nobody likes me (80% believable).

This could be a good opportunity to think about setting up a behavioural experiment (but with caution!)

3. Socratic questioning

Socratic questioning is the use of a series of questions that should lead the adolescent to challenge his or her beliefs or behaviours. In Socratic questioning questions are used not only to obtain information but also to raise issues and to offer suggestions. The therapist must be careful not to persecute or cross-examine the adolescent.

A depressed sixteen-year-old girl was convinced that she was nearly worthless at her schoolwork. Rather than stating that her thinking was wrong, the therapist asked her

“Can you help me to understand how your teachers can tell you that you are a very good pupil, you get high grades in your recent examination, but somehow you think that you are nearly useless at school work?”

Socratic questioning sometimes evokes responses such as “I don’t know”. In such circumstances the question may be either repeated using different words, or if there is an obvious misunderstanding the therapist can repeat the question with statements such as “I don’t seem to have asked that question very well. I’ll try and put it differently...”

4. Challenging black and white thinking

The term “black and white thinking” or “binary thinking” refers to the tendency to think in all or nothing terms. Black and white thinking is common in depressed adults, and is often evident in the thinking of normal adolescents. Thus, normal adolescents may be “completely down” one week and “really happy” the next.

The key principle in dealing “black and white thinking” is to encourage the adolescent to work with the therapist to develop more graded emotional and cognitive responses to the world.

Key strategies for dealing with “black and white thinking”

Rating thoughts or emotions on a scale:

for example, an adolescent might be asked to rate on a 0 – 10 scale of depression “what was the rating when your father failed to visit you that weekend?”

Adopting a proportional standpoint: alternatively, the adolescent could be asked, “how much of your depression today is due to your father not coming at the weekend?” Alternatively, if the adolescent is blaming him or herself for fathers non-attendance (e.g., “it is all my fault that he didn’t come because I was horrible to him last time”), the therapist can challenge this assumption with questions such as “what proportion of responsibility for your dad not coming was yours?”

The client can then re-rate her beliefs after they have been tested.

Summary of general tasks for the sessions

- 1. Recalling dysfunctional thoughts - recording them.**
- 2. Examining evidence supporting or refuting these (session worksheet)**
- 3. Other techniques for challenging negative thoughts - reattribution; search for alternative explanations**

JOINT SESSIONS WITH PARENTS

Involve parents again here. Likely to be around mid-treatment. Review progress, use cognitive work to pick up any specific issues in family relationships which have a direct bearing on formulation

Needs example.

HOME PRACTICE

1. Home practice instruction

The young person is asked to act as a "thought detective" for the next week. Each day, negative thoughts should be recorded in the diary. The young person is encouraged to weigh up the evidence which supports or rejects them.

2. Home practice review

Young person and therapist review entry to diary.

Negative thoughts are explored with evidence for and against. If he/she claims not to have detected any negative thoughts then the week's events are reviewed and the therapist enquires about mood, arguments etc and attempts to elicit negative cognitions.

Thought records:

There are several model thought records available. The record will need tailoring according to the ability of the young person to take on board the ideas and work independently as part of home practice. Alternatively the therapist may suggest partial completion of the Thought record in home practice, with the therapist assisting in completion.

Example 1: ADD IN ALTERNATIVES

EVENT	FEELINGS	THOUGHTS

APPENDIX G

COMMUNICATION AND INTERPERSONAL SKILLS

SESSION NAME: COMMUNICATION AND INTERPERSONAL SKILLS

(i) Definition

Helping the young person to improve basic communication skills:

- listening to others
- following instructions
- starting a conversation
- continuing a conversation
- introducing him/herself

Working on interpersonal skills:

- joining in
- sharing
- complimenting
- helping others

Continue activity scheduling; new skills may link directly with key goals.

(ii) Aims

1. To elicit and work on communication difficulties.
2. To improve interpersonal skills
3. To elicit and work further on social withdrawal and social isolation in continuation with work on activity scheduling.
4. To give the young person the message that the above skills can be learnt.
5. To link improvement in social relationships with improved mood.

(iii) Rationale for the session

It is well established that depressive symptoms in adolescents are strongly associated with impairment of interpersonal relationships (with peers, parents, teachers).

There is also evidence that poor peer relationships predict poor outcome in adolescent depressive disorders.

Many depressed people report an overwhelming number of self-debasing and negative cognitions at times when they are socially and physically inactive.

They criticise themselves for being inactive and avoiding other people. This can cause increasing passivity and social isolation.

This session covers basic social skills. The young person is given the opportunity to explore more adaptive ways of thinking and relating to others. Together with the session on social problem-solving, this part of the intervention offers a variety of social skills strategies which should be adapted to the needs of the individual adolescent in therapy.

Social tasks are likely to have featured in goal setting and activity scheduling. This may be an opportunity to explore difficulties further and address them.

3. SESSION TASKS:

1. The therapist starts with a general statement such as "Young people who feel the same way as you, often have difficulties in getting on with other people or finding different ways of dealing with everyday problems with others; these difficulties have an effect on their mood by making them feel even more sad".

The rationale of the session is also given to the young person with a statement such as "Today we are going to look at how you get on with other kids, your parents and teachers and how we can work to make it better"

2. Communication skills

(i) "Getting on well with people involves communication. Do you know what that means? Communication consists of listening to others as well as talking to others. To have a conversation you need to start one and be able to continue one. Before all of this you need to get to know new people. These are the skills which we are going to practice today"

(ii) The young person is asked to offer two recent examples of difficulties with communication e.g. lots of arguments, scared to talk to people, difficulty making new friends.

(iii) Using the "skills" handout as a basis, go through the main features of listening and conversation skills:

LISTENING SKILLS

**Stop and look at the person who is talking
Wait until it is your turn
Then answer.**

CONVERSATION SKILLS

**Find someone you want to talk to
Stop and think of something to say
Go over to the person
Say "hello"& start talking in a friendly way
Take turns talking
Finish the conversation or say "Goodbye"**

INTRODUCING MYSELF

**Think
Go over
Say your name
Ask their name
Start a conversation**

(iv) Ask young person whether he/she is a good listener and to give examples. Ask for examples of recent conversations with problems. Break these down into the skills above and using role play, if appropriate, practice listening and conversation skills.

Therapist note:

It is important to practice role plays before trying to use them in sessions, so that they can be introduced informally. The aim is to set it up without the young person noticing - almost in the normal flow of conversation. For example "So, imagine that I'm a friend of yours and I say...."

Remember:

- keep them brief and to the point*
- make sure that the young person understands the purpose*
- make sure that the young person succeeds*
- always reflect back on the positives and practice the weaker points again*

(v) As above, share the information about skills of "introducing myself"
Ask young person when they last met somebody new, talk about difficulties with making new friends, meeting new people. As with listening and conversation skills, use role play where appropriate.

3. Interpersonal skills

"The next set of exercises involve working on talking to people and on thinking more about getting on with friends, parents, teachers better."

Share the information in the handout and explore difficulties in each area. Use role play as you see fit.

JOINING IN

Think
Go over
Ask to join in

SHARING

Think whether you want to share (advantages/disadvantages)
Ask if he/she/they want to share
Share fairly

GIVING A COMPLIMENT

Think about something nice to say that is truthful
Look at the person
Say something nice.

RECEIVING A COMPLIMENT

Look at the person speaking
Say "Thank you"
Tell more about it if you want to

HELPING OTHERS

Think about whether help is needed
Ask if help is needed
Help if needed

Joining in: explore current difficulties - feeling left out, excluded, lonely

Sharing: explore difficulties - siblings, peers, jealousy, rivalry.

Complimenting: explore understanding, experiences of complimenting others and being understood.

HOME PRACTICE

1. Home practice instructions

The home practice task will depend on the work/skills covered in the session and on the young person's individual difficulties. The young person is asked to initiate one conversation per day over the coming week and record these in his/her diary. In addition, the therapist explores the potential for the young person to meet new people, introduce him/herself and use other interpersonal skills practised in the session. The young person is asked to pay attention to arguments over the week with parents, peers, teachers and to record these in the diary. The aim is to encourage the young person to monitor and record difficulties with social relationships.

2. Home practice review

As in previous sessions, the young person's degree of participation will determine the exact nature of this part of the session. If he/she has not completed the diary, the therapist should ask him/her to recall problems with communication over the past week eg arguments, avoidance. In reviewing problems over the past week, it is important to reinforce the positive elements and practice/model areas of difficulty.

APPENDIX H

SOCIAL PROBLEM SOLVING

Social problems are very commonly experienced by young people with depression and can be exacerbated by their tendency to avoid difficult situations as well as by relatively poor social problem solving skills.

(i) **Definition**

Further development of interpersonal skills, helping the young person find ways of dealing with everyday difficulties in getting on with others.

Problem solving

- identifying problems
- thinking of various solutions (brainstorming)
- examining the pros and cons of each solution

(ii) **Aims**

1. To help the young person clarify specific ways of approaching social/interpersonal problems. It is important to highlight the notion of "small everyday problems" rather than major crises or life events since these are within the young person's ability to change.
2. To link improvement in social relationships with mood.
3. To combine work on basic social skills with interpersonal problem solving and with activity scheduling tasks.

(iii) **Rationale for the session**

This session may follow or precede the session on communication and interpersonal skills. Although the majority of depressed young people are expected to have impaired psychosocial functioning, its causes and characteristics are anticipated to vary. However, usually it will be related to a degree of poor self-esteem, negative thinking and depressed mood. It is therefore important for the therapist to keep working on these links.

Sessions on social skills are focused on "here and now" difficult situations. By being successful in certain tasks it is hoped that the young person may generalise and create a new pattern in his/her interpersonal relationships. It is hoped that he/she will notice the link between successful completion of social tasks and improved mood.

SESSION TASKS:**1. Problem solving**

- (i) Share the handout "7 steps to problem solving"

7 Steps to Solving Problems

- 1. Define the problem**
What exactly is the problem? Make it fit into "...the problem is how to..."
- 2. Brainstorm to generate possible solutions**
Think of as many ways you can of solving this problem.
- 3. Focus energy and attention on the task**
*Be determined to solve this problem - don't let it beat you.
Be sure of why it is important to solve the problem*
- 4. Project the outcome of each of the possible solutions.**
What would be the advantages & disadvantages of doing each of the things you outlined in Step 2?
- 5. Weigh the consequences and choose a solution**
Step 4 can take some time! Weigh up the pros and cons and choose a solution to try for starters.
- 6. Evaluate the outcome of the chosen action**
See what happens!
- 7. Give yourself a reward for success or try one of the other possible solutions**
If you got it right the first time, well done! Give yourself a treat. If not, don't be too disappointed - work your way through your list and try another solution or go back to the start and re-define the problem

(ii) Using the previous weeks' diary if appropriate, the therapist chooses a problem situation. The young person is asked to clarify which particular aspect of this situation/ interaction is most difficult and uses it to brainstorm options.

(iii) The young person is asked to choose a social situation in which he/she encounters the most difficulties. The young person and therapist then work through the 7 steps. Repeat with another problem if felt necessary. The examples below may be useful if the young person is unable to think of one.

Role play is very helpful. The therapist may take the role of the young person in an attempt to change his/her cognitive set from self-critical to sympathetic.

Examples of difficulties:

Initiating or keeping a conversation going with another young person

Joining in activities with other young people - breaktimes at school

Asking for something in class or home

Arguments with parents or peers

Handling an argument

Standing up for oneself at school or home or school

Therapist note:

Many young people are overwhelmed by the scale of most of their problems. It is therefore important to choose a problem which is small and practical enough to be solvable, and for which the goal is realistic and specific.

Depressed adolescents often find it difficult to generate solutions. Suggesting "silly" solutions as well as sensible ones can often help to free them up.

Remember that young people with low mood are likely to disqualify any of their successes. It is therefore important that the therapist is very positive about any attainment of goals and problem solving processes.

This task may provide a useful context within which to identify and challenge a young person's negative attitudes - about both him/herself and his/her ability to sort out problems.

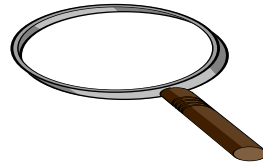
PROBLEM-SOLVING MODEL HANDOUT

We all have choices of how we behave towards other people. The responses we choose can produce different outcomes. We can therefore think of ourselves as Detectives trying to solve social problems – just as police detectives try to solve crimes.

Step 1: DETECT

Stop and think!

What is the problem?



Step 2: INVESTIGATE

What could you do? (Think of three different things. Don't worry whether they are the right choices or not.)

What would happen next? (Think of good things and bad.)

Which of these would be best?



Step 3: SOLVE

What are you going to say or do?

What do you have to remember?



PROBLEM-SOLVING WORKSHEET

What is the problem?

.....
.....
.....

What could you do? (think of three different things. Don't worry whether they are the right choices or not.)

1.
.....
2.
.....
3.
.....

What would happen next?

1.
.....
2.
.....
3.
.....

Which of these would be best?

.....
.....

Make a plan

What are you going to say or do?

.....
.....

What do you have to remember?

.....
.....

Why not have a go? How did you get on?

.....
.....

HOME PRACTICE:

1. Home practice instructions

The young person is asked to continue to monitor problem situations. For every problem he/she should be encouraged to think of possible solutions, using the 7 steps model.

2. Home practice review

The diary is reviewed, and examples of how the young person has put his/her new skills into practice highlighted. Problems encountered with solutions are discussed.

If he/she has not completed the practice, the week is reviewed and the work of previous sessions summarised.

APPENDIX I

SYMPTOMATIC INTERVENTIONS

MANAGEMENT OF ANXIETY AND PANIC

Symptoms of anxiety and/or panic are common in depression. They can often be successfully treated using the following techniques which can be incorporated into the social skills or problem solving sessions. Common anxieties are social anxiety (often involves worries about what others think) and agoraphobia (fear of going out) will need to be considered as a factor in activity scheduling sessions.

1. Assessment

All aspects of situations where the problem arises, what does the young person avoid going as a result. Establish if a panic attack has ever been experienced – it is usually necessary to describe one or two physical symptoms e.g., pounding heart, sweaty palms etc. Prompt the young person to describe others.

Diary sheets can be very helpful in gathering formation and to prompt discussion e.g., "I went to the shops with my mum and had a panic so when I got home I stayed in" panic = 5.

2. Cognitive Behavioural Model

The cognitive model of panic disorder proposes that panic results from the misinterpretation of physical sensations that are perceived as abnormal. During a panic attack the ability to stop attacks or minimise the symptoms is lost. The person sees this as disastrous which leads to greater physical arousal. Thus a vicious circle develops. The therapist therefore needs to help the person take control of their direct thinking and evaluate their sensations objectively.

A common response is for the person to develop avoidance behaviour which they see as reducing anxiety. This becomes a permanent disability.

Anxious people report thoughts and images that they see as a personal danger. Thus they react to situations as if they were dangerous or threatening when in fact there is little or no danger. These involve thoughts and images of vulnerability, inadequacy, lack of self control, social rejection, failure, disease, physical harm and death. Where a person experiences high levels of anxiety they are likely to have thoughts relating to immediately impending physical injury or harm. They see the world as threatening and the future as unpredictable and dangerous. They will misinterpret events.

3. Make goals ones the young person wishes to achieve.

4. Treat symptoms by teaching coping strategies.

Behaviourally: e.g., Relaxation (physical, tapes)
Graded exposure to anxiety provoking situations
incorporated into activity scheduling or problem solving.

Cognitively: Challenge beliefs about the real threat of
Consequences

Self monitoring

Problem Solving

Self Reward

4. Support from carers in homework tasks is essential. Need to offer rewards for doing diary, relaxation and exposure programmes.

STRATEGIES IN ANGER CONTROL

Control of anger, temper and other negative, aggressive responses is a frequent problem for young people with behaviour and depressive disorders . Young people are often aware that the problem exists because of sanctions from adults as a result – convictions for violence being at one extreme, more commonly changes of placement or school suspensions. A young person may feel that they want to work on anger control – the sanctions make life difficult or unpleasant. The therapist is aware of the risk that the young person faces and hence also wishes to help with the behaviour.

Development into child and adolescent field from the work of Ray Novaco with adults. Feindler has evaluated school-based programmes in U.S.A. but limited outcome research to date.

Objectives:

1. Assess the context of anger – past and current.
2. Develop strategies to inhibit angry or aggressive responses.
3. Promote alternative ways of coping with provoking situations.
4. Establish self reward for control.

1. Assessment

Through detailed discussion in session and information from diary establish the parameters that provoke an angry/aggressive response. Behaviour records can be very useful.

For instance:

<u>What started it</u>	<u>What I did</u>	<u>Consequences</u>
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A final column can be added in due course, for instance "Possible alternative action" or similar challenge to the response or thought.

Consider as many different problem situations as possible to identify provoking or risk factors. Assess the beliefs that the young person has about each situation "It was his fault", "She would have hit me if I hadn't hit her first." "He was staring at me". "I lost control" – frequently they will involve blaming someone else and minimising the impact "H had it coming" etc. List the beliefs about the situations.

Consider the vocabulary that the child or young person uses to describe intense feelings, both negative and positive.

2. Goal Setting

Identifying realistic, relevant and meaningful goals is crucial to successful engagement. Formulating angry behaviour will form part of this process.

3. Intervention Techniques

i) Social problem solving

These approaches are very useful in challenging angry responses and in generating alternative responses to the situation. Role play should be used within sessions to maximise the impact.

ii) Impulse control

Techniques such as counting to 10, walking away, positive talk to oneself (silent) can be enacted as soon as the young person is aware of feeling aroused. Often these can be very difficult for the young person to implement because loss of control is very rapid or because at the time the action seems justified or escalates from very little.

iii) Challenging negative thinking/inappropriate attributions

Persistently aggressive children and adults have been shown to view neutral events as hostile in intent, believe that aggression and retaliation can be a legitimate or a necessary response and underestimate or discount the consequences. These beliefs, if identified, can be challenged using cognitive restructuring techniques.

It may be possible to substitute causal beliefs such as "He can't help himself", "She didn't mean to do it", "He must be as fed up with this as I am".

Self statements should be directed at identifying nonhostile cues, thinking of alternative explanations, accepting responsibility for the event and focussing on negative consequences. One of the commonest problems in working with anger control is that the young person persistently refuses to accept any responsibility and externalises the problem. It is important for the therapist to consider how their self esteem may be sustained by "being hard" and work on alternatives.

iv) Self rewards

Learning to recognise successful management of interpersonal problems and reward oneself.

v) Support/rewards from others

It is essential that carers :

- i) reward examples of handling situations nonaggressively, and
- ii) notice examples of temper control and cue the young person if possible.

Responses to Trauma

A high degree of co-morbidity between post traumatic stress disorder (PTSD) and depression has been reported both in adults and children (Bolton, O’Ryan, Udwin, Boyle and Yule, 2000; Thabet, Abed and Vostanis, 2004). Trauma may be associated with bereavement, for instance sudden death of a relative, or with the young person’s direct or indirect experience for instance being assaulted or witnessing violence to a friend. For some, experiences over a period of time may be involved, for instance those who have been sexually abused.

Mechanisms for the relationship between trauma and depression are unclear and may vary between cases. There are likely to be complex processes involving interaction between the effects of direct exposure to trauma, child-related factors such as age and previous emotional problems, and environmental factors such as loss of a family member in the same traumatic incident. The presence of both disorders may result from overlapping symptoms, or from the development of distinct conditions in response to the same event or one disorder precipitating the other through the effect of mediating variables. For instance the persistence of PTSD symptoms coupled with an accumulation of adversities resulting from the trauma could lead to development of depression. The experience of displacement and the additional stressors of immigration have been found to have an independent impact on child psychopathology in refugee children (Tousignant, Habimana, Biron, Malo, Sidoli-LeBlanc and Bendris,1999).

Significant numbers of children will develop PTSD following traumatic events such as natural disasters such as earthquakes, transportation disasters or war (Perrin, Smith and Yule,2000). Stallard, Velleman and Baldwin (1998) reported that one in three children involved in everyday road traffic accidents had symptoms sufficient to warrant a diagnosis of PTSD. Diagnostic criteria require symptoms indicating the persistent re-experiencing of the trauma, the avoidance of stimuli associated with the trauma and increased arousal following a traumatic event that is outside normal experience. Symptoms may include flashbacks, nightmares, sleep disturbance, poor concentration, hyper-vigilance to threat, avoidance and distress. These may be associated with separation anxiety, psychosomatic complaints such as stomach aches and head aches and with reckless behaviour and accidents.

As for adults, the risk of PTSD in children increases with physical proximity to the trauma, previous trauma exposure and may be greater for girls than boys (Pfefferbaum,1997). Additionally trauma-related distress in parents increases the risk of children developing PTSD (Smith, Perrin, Yule and Rabe-Hesketh, 2001).

Symptoms if untreated may persist for many years (Yule, Bolton, Udwin, Boyle, O’Ryan and Nurrish,2000). When symptoms are not sufficiently extensive to warrant a diagnosis of PTSD the impact of the trauma may still warrant direct intervention with symptoms (Kamine, Seedat & Stein,2005).

PTSD symptoms involve:

- the persistent re-experiencing of the trauma,
- the avoidance of stimuli associated with the trauma and
- increased arousal
- onset following a traumatic event that is outside normal experience.

These may include flashbacks, nightmares, sleep disturbance, poor concentration, hyper-vigilance to threat and distress.

Cognitive behavioural models of the development and persistence of PTSD have been discussed in detail by Meiser-Stedman (2002). There are a small number of outcome studies for treatment of PTSD in children including group and individual CBT interventions (March, Amaya-Jackson, Murray and Schulte, 1998). In the UK, the National Institute of Clinical Excellence recommended trauma-focused CBT as the treatment of choice (NICE, 2005). Programmes involve anxiety management, coping with anger, cognitive restructuring, exposure and response prevention (March et al, 1998).

Assessment

When young people present with depressive symptoms the impact of past trauma may not be immediately apparent. Routine interviews should ask for information about difficult events in the young person's life including any experienced by other family members. The possibility of the young person having witnessed domestic violence or violence within the community should be considered.

Enquiry about sleep disturbance should include questions about the content of nightmares and any daytime experiences such as flashbacks or disturbing visual images. Particularly if trauma occurred many years earlier it is not unusual for the young person or parent to assert that the consequences have been overcome.

In the absence of symptoms involving re-experiencing the trauma the young person may still have cognitions which are directly related. These may include anxiety-related cognitions which lead to avoidance, cognitions about blame or about themselves in relation to the experience ("it happened to me because I deserved it"). Survivor guilt can contribute to reckless behaviour.

For some young people treatment of post traumatic symptoms such as cognitions of self blame which emerge during treatment may be included within the framework of cognitive restructuring. Sometimes the young person will avoid discussion of traumatic events which can be an indicator of residual difficulties. The therapist will need to use judgement in deciding whether or not to pursue this.

The influence of trauma on the presentation of depression can include:-

- Experience of PTSD symptoms
- Low self esteem and sequelae as a result of the traumatic episode, particularly if sexual assault is involved
- Avoidance behaviour contributing to social withdrawal
- Anger
- Impulsive behaviour and risk-taking

Conduct disorder and depression: linking with the school and family.

For some young people, improvements in mood during the early stages of therapy can result in increased conflicts and relationship difficulties either with peers, school teachers or with other family members. This may be experienced by the young person as increased feelings of anger and loss of control (see previous section for helping young person to manage anger).

Although CBT is present and future focussed, the individual formulation of the young person's depression may include the identification of long standing conflicts which the young person has been unable to address particularly either around his/her relationship to adult authority. As mood improves and the young person increases general activity, problems may re-emerge either in school or home. In relation to school difficulties, it may be appropriate for the therapist to discuss with the young person whether liaison with the school either jointly with the young person or by the therapist may be helpful in trying to problem solve around such difficulties. This direct work with the wider network is fully consistent with the overall CBT approach.

Improved mood and increased activity may lead to reactivation of conflicts with parents particularly around boundary setting and other common parent-adolescent conflicts. Such problems may lead to the young person and the family concluding that the therapy is making things worse. In such circumstances it may be appropriate to discuss with the young person the option of meeting with the whole family (or the young person's parents without the siblings) to talk over the current family difficulties. The method of working for such family sessions would be consistent with the overall CBT approach in that it would encourage the family to recognise the thoughts and feelings around the current conflicts and to do some joint problem solving around these problems. Although no exact prescription is made

about the number of such sessions, in general this would usually be a single family meeting but for some cases it may be appropriate to meet for two-three family sessions to address such difficulties.

Overall, it is important that the therapist does not become overly distracted by conduct problems. For both the therapist and the young person, the purpose of having a goal focussed approach is to ensure that the therapy does not simply become reactive to the immediate events and conflicts which readily appear each week. Conduct problems easily have the appearance of 'seriousness' and high emotion but may be a long standing aspect of the young person's interactions with others. Although it is important not to be disrespectful or minimising of such problems, it is also important for the therapist to help the young person to stay focussed on the agreed focus of treatment around improving mood and reducing depression. Evidence from outcome research generally suggests that improved effectiveness is likely to be associated with less reactive treatments and with the therapist persisting with agreed goals and plans.

APPENDIX J**ENDING: CLOSURE OF THERAPY****SESSION NAME: ENDING: CLOSURE OF THERAPY****(i) Definition**

A review of the main themes/concepts discussed so far in therapy. Encouragement for further use of the principles, arrangement for follow-up.

(ii) Aims

1. To help the young person summarise what he/she has been discussing in treatment so far
2. To help him/her realise that there were specific links between the initial symptoms and the different sessions, which implies that the themes of the therapy could be of further help in the future.
3. To compare the way he/she currently feels with his/her mood at the beginning of therapy, and thus realise even more that he/she may have significant control over these symptoms.
4. To focus on particular aspects of the therapy which he/she found helpful.
5. To think of specific areas of remaining difficulties, which are yet to be resolved.
6. To help the young person realise that he/she should continue to work on these ideas after the end of therapy.
7. To reinforce the young person's belief in self-control and ability to overcome depressive symptoms.

(iii) Rationale for the session

As therapist and young person approach the end of the therapy, it is important that the young person is given some time to reflect on the different stages and the possible impact that these had on him/her.

This gives the therapist the opportunity to underline that this intervention was aimed at showing him/her ways of dealing with feelings of sadness, and that the young person was not expected to resolve all his/her previous difficulties in the space of a few months. However, he/she should be able to maintain the improvement and deal with similar feelings in the future if necessary, by working on the ideas introduced during the therapy.

Young people often forget how things have changed. Therefore, it is important to ask them to think back and to compare their moods, thoughts, behaviour and any other symptoms or difficulties.

By doing so, the young person realises that there can be effective ways to deal with problems. On the other hand, symptoms do not improve overnight and they would thus need to work on them continuously if the improvement is to be maintained.

This review enables the young person to feel in even more control of the symptoms and some of the difficulties, by realising that there has been improvement.

Reviewing basic themes of the therapy reinforces the belief that the improvement was not coincidental - aims of the individual sessions were linked, while the overall aim of the therapy was to help him/her find ways of dealing with feelings of sadness and unhappiness.

By focusing on specific helpful aspects, the young person gains further insight into reasons for improvement, feels in control, and hopefully realises that, by using these ideas in the future, he/she may remain well or improve again without the therapists help.

Reflecting on unresolved difficulties is linked with the message that therapy is not the answer to all problems. By identifying unresolved areas, the young person has the opportunity to discuss some of them during this final session. If the young person has already achieved a certain degree of improvement in these areas, the therapist suggests that he/she only needs to work on the same lines in the future.

If the unresolved difficulties are still major and there are no signs of improvement, particularly if related to the young person's environment, the therapist starts thinking of alternatives eg referral to young person psychology/psychiatry services.

It is also important to stress that, although the young person and key worker will continue to work together, the therapy is now formally coming to an end. While the key worker may continue to refer to the skills the young person has learned during the therapy, and may remind him/her of them when new situations arise, this will be done in the context of the key worker's general role. However, if the young person would benefit from a "top-up", it may be possible for the key worker to do more sessions.

SESSION TASKS:

1. General review

- (i)** The therapist starts by acknowledging that this course of therapy is coming to an end, as he/she has already discussed and agreed with the young person.
- (ii)** The young person is then asked to think back to the beginning and of the initial reasons related to it. Particular importance is paid to the young person's depressed mood at the time.

If the young person has difficulty in remembering or comparing his /her current and previous states, the therapist counts and uses some of the information already available to him/her from previous sessions.

If the young person describes an improvement even in few areas, the therapist agrees and reinforces the idea of success and congratulates the young person. He/she then also repeats the overall aim of these sessions which was to "help you think of different ways to get rid of the feelings of sadness and unhappiness".

2. Review of the therapy - what was helpful

- (i)** The therapist then acknowledges that these ideas usually prove helpful to young people who feel sad in themselves, although sad kids may obviously have different difficulties, and are thus helped in different ways by the different parts of the programme.
- (ii)** The therapist then introduces this session by stating that it would be useful to think of "what has proved helpful so far and to discuss whether there are still difficulties which should be tackled either in a similar way or by arranging a different kind of help after the end of this course of therapy".

The therapist also underlines that the young person is expected to use the ideas which proved helpful, without having to meet with the therapist in the future.

- (iii)** The therapist defines and repeats the main themes of the treatment to the young person.

These are:

- a) Recognition of emotions
- b) Links of events with feelings and thoughts
- c) Rewarding yourself for being able to change
- d) Solving problems in social situations
- e) Checking on your thoughts and looking for evidence that these are correct

It is preferable that each of these themes is discussed separately.

After each definition, the young person is asked to give his/her opinion on whether this theme was helpful for him/her and, if so, in which way.

He/she is then asked to think whether he/she still has difficulties in this particular area.

Therapist note:

It is anticipated that most young people will identify certain areas rather than have a balanced interest in all six themes.

Throughout this discussion, the therapist attempts to enable the young person to focus as specifically as possible on the process of improvement and to reinforce his/her idea of self-control.

At the same time, he/she continuously repeats the message that he/she will have to persevere on his/her own in order to maintain the improvement (e.g. by keeping a diary).

3. The remaining time of this and the next session if appropriate, may be used to discuss in more detail the remaining difficulties. It is at the therapist's discretion to repeat any previous tasks which may be relevant at this stage.

The following key messages are given to the young person:

1) Once the therapy sessions have come to an end, we will go back to our previous pattern of working together. However, it is likely that from time to time we will continue to discuss the skills you have learnt and look at how they are working in new situations.

2) It is important that you continue to keep your diary and to use the ideas which we discussed during the therapy: you have proved that you can overcome your difficulties - therefore, I believe that you could overcome them again.

3) If any problems arise, or the feelings of sadness return and you are finding it difficult to cope with them, do not hesitate to tell someone. It may be possible to arrange some "top-up" sessions, or, if necessary, refer you for some other help.

FINAL SESSION

**Treatment goals
helped?**

What

The treatment: an overview

- * Recognising emotions
- * Linking events with feelings and thoughts
- * Rewarding yourself for being able to change
- * Solving problems in social situations
- * Checking on thoughts, looking for evidence
- * Looking for positive causes, consequences, effects on feelings

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