



The National Centre of Excellence
in Youth Mental Health

Cognitive-behavioural therapy for depression in young people

A modular treatment manual



Acknowledgments

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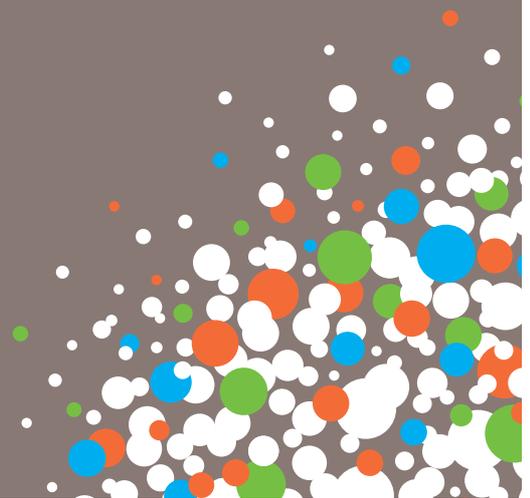
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INTRODUCTION



About this manual

This manual reflects the work undertaken in the Youth Mood Clinic at Orygen Youth Health in Melbourne. The clinic works with young people aged from 15 to 25 years, most of whom have depressive illnesses that are severe, complex, and associated with high risk. Many have recently attempted suicide, or had thoughts of doing so.

Although this manual describes a structured course of cognitive-behavioural therapy (CBT) that has been developed in a specialist youth mental health clinic, the principles and practices can be applied more broadly. Inflexible progression through the modules of the program is rarely appropriate; instead, the delivery of therapy must be guided by the needs of the young person, the available resources and the particular skills and expertise of the therapist.

The comprehensive care of young people with depression requires coordination and integration of disciplines and services. While this manual focuses on the implementation of CBT, clinicians providing the therapy must remain alert for difficulties that require the attention of others in the treating team, and should seek assistance when needed. Continuous assessment of risk is essential in this group of young people, and clinicians should not attempt to deal with such risks in isolation.

Many young people will be from a culture other than the dominant English-speaking culture of Australia. Such issues need to be considered at every stage of the program, from engagement, assessment and formulation to the delivery of therapy. Resources are available to assist in responding to the challenges of cultural and linguistic diversity; for example, from Victorian Transcultural Mental Health (www.vtmh.org.au).

The treatment of young people with depression should be delivered with hope and realistic optimism. There are great opportunities to reduce the lifelong burden of depressive illness, for individuals and the community, through early recognition of depressive disorders and the early delivery of effective therapy.

The benefits of early intervention

About one in five young people will experience an episode of depression before the age of 25.¹ The peak age for the onset of depression is adolescence and young adulthood, and most adults who suffer from recurrent depression will have first experienced it during this period.² The longer depressive symptoms remain untreated in a young person, the longer they will take to respond to treatment. In addition, delays in treatment increase the risk of chronic or recurrent symptoms. Because depression tends to first occur early in life and is then recurrent, it places a bigger burden on the community than any other illness.³ Effectively treating depression when it begins in youth is, therefore, of the utmost importance: intervening early in the course of the illness can reduce the likelihood of relapse and reduce the burden of depression in the community.

Young people complete a number of key developmental tasks during adolescence and early adulthood, include individuating from their parents, developing new interests and skills, forming and maintaining relationships (especially intimate sexual relationships), completing further study and finding a job. If these tasks are disrupted by illness, young people can "fall out of step" with their peers who are continuing to develop at the usual rate. The consequences of this can include social isolation, demoralisation and reduced potential for achievements in the future.^{4,5}

For these reasons, early intervention for depression also focuses on restoring the young person's developmental trajectory. This has the potential to reduce disruption to relationships within the family, difficulties with employment and education, the need for inpatient care, the risk of suicide and the likelihood of social isolation.⁶

Cognitive-behavioural therapy (CBT)

CBT is the most thoroughly researched psychotherapy for young people with depression⁷, and one of the most effective treatments.⁸ CBT was first developed in the 1960s when Aaron Beck described his cognitive model of depression and later incorporated ideas from behavioural therapy.⁹ In the CBT framework, distress is viewed as being derived largely from irrational beliefs and cognitive distortions. People and events may influence behaviours and emotions, but it is irrational beliefs and core schemas that influence the way they are interpreted and cause distress.¹⁰

The overall goal of CBT for depression is to help young people identify, explore and modify patterns of negative thinking associated with depression. CBT also involves behavioural activation, which focuses on changing behaviours in order to trigger changes in thoughts and emotions.^{4,11} CBT is a time-limited, evidence-based approach that focuses on the present and de-emphasises the past. It is a collaborative process and relies on the young person completing "homework" tasks between sessions.

Treatment of depression aims to alleviate the symptoms, which in turn reduces risk, restores function and improves quality of life. Within the CBT model, treatment aims to:

- increase participation in pleasant activities
- increase and improve social interactions
- improve conflict resolution and problem-solving skills
- reduce physiological tension and excessive affective arousal
- identify and modify depressive thoughts, attributions and beliefs.

How to use this manual

This manual is designed to be used by qualified mental health clinicians who have completed some training in CBT, but who may be new to working with young people.

The first part of the manual describes the initial elements of treatment, including engagement, assessment, formulation and goal-setting. Assessment informs the formulation of the young person's difficulties, which in turn is the basis for the collaborative process of goal-setting and the development of a treatment plan.

Treatment modules are described in the second part of the manual. The modules should be used in a flexible and formulation-driven approach to therapy, rather than in an inflexible linear fashion. The "core" modules are applicable to all young people and represent the central components of CBT. The "targeted" modules should be used as needed, according to the initial and ongoing formulation of each young person's difficulties. Thus, not every targeted module will be relevant to every young person.

Each treatment session should last about 50 minutes. Typically, a session has three components:

- The first third of the session is devoted to reviewing the take-home practice activities and setting an agenda for the current session by reviewing mood, events, incidents or issues that have arisen during the previous week.
- The middle third of the session is devoted to the skill to be taught that week, linking it with any issues or incidents raised in the first third of the session.
- The final third of the session addresses issues that have been generated in the first third of the session, and plans the next take-home practice activity.

The development of the manual has been influenced by the following books and manuals, which provide excellent resources for clinicians who are keen to read further:

Brent, D. A., Poling, K. D., & Goldstein, T. R. (2011). *Treating Depressed and Suicidal Adolescents: A Clinician's Guide*. New York: The Guilford Press.

Clarke, G. N., Lewinsohn, P. L., & Hops, H. (1990). *Leaders Manual for Adolescent Groups: Adolescent Coping with Depression Course*. Portland: Kaiser Permanente Centre for Health Research.

Curry, J. F., Wells, K. C., Brent, D. A., Clarke, G. N., Rohde, P., Albano, A. M., ... March, J. S. (2005). *Treatment for Adolescents with Depression Study (TADS): Cognitive Behavioural Manual: Introduction, Rationale and Adolescent Sessions*. Duke University Medical Centre.

Verduyn, C., Rogers, J., & Wood, A. (2009). *Depression: Cognitive Behaviour Therapy with Children and Young People*. New York: Routledge.



Phases of therapy

The manual is designed to be used for the acute treatment of depression over a period of 12 weeks. The course of therapy may be slightly shorter or longer, depending on the clinical setting and local factors, but would generally last from 10 to 16 weeks.

There are four phases of treatment during the standard 12-week period:

- Phase 1 (weeks 1–3) includes engagement, assessment, formulation, goal-setting and the first two core modules on psychoeducation and understanding and monitoring emotions.
- Phase 2 (weeks 4–6) emphasises behavioural activation and includes an introduction to the core cognitive modules (chain analysis, identifying automatic thoughts, and cognitive restructuring).
- Phase 3 (weeks 7–9) continues this work, and targeted modules may also receive more focus.
- Phase 4 (weeks 10–12), the final phase of treatment, consolidates the preceding work, with a focus on relapse prevention.

This time line is intended as a guide, and it is important to remain flexible in delivering therapy. For example, if a young person is distressed and suicidal, the early sessions should focus on distress tolerance and risk management, while for a young person who is unable to participate in social activities, the early focus may be on social and communication skills.

After 12 weeks of therapy some young people will have only a partial response. This will usually become apparent by the end of phase 3, and the need for further sessions of CBT may be negotiated at this time. If the therapy is extended, then it will probably be necessary to review the core modules and identify the problem areas that need further attention. Additional targeted modules may be introduced. The relapse prevention module should be delayed until 2 or 3 weeks before the anticipated discharge date.

THE INITIAL ELEMENTS
OF TREATMENT



Introduction

For each young person referred for CBT, as for any other psychological therapy, there are a number of crucial elements of treatment that take place before engaging in structured sessions. This section covers six elements that should begin within phase 1, but which are all ongoing processes that should be revised according to need. These are: engagement, assessment, case formulation, goal-setting and treatment planning, involving the family and case management.

Engagement and assessment are both ongoing processes that occur in parallel. Assessment informs the formulation of the young person's difficulties, which in turn is the basis for the collaborative process of goal-setting and the development of a treatment plan.

Engagement and the therapeutic alliance

Engagement and the development of a therapeutic alliance are particularly important components of treatment when working with young people: the strength of the therapeutic alliance is a strong predictor of outcome, irrespective of the treatment approach.

The interpersonal skills of the clinician are an essential building block of a good therapeutic relationship. Desirable characteristics include flexibility, warmth, empathy, active listening, a non-judgmental attitude, collaboration, emotional attunement and a strong knowledge of developmental and life-cycle issues.

Clinicians and young people can develop a mutual understanding of the young person's difficulties by discussing their shared expectations of engaging in treatment, identifying problems from the young person's point of view (being sensitive to their vocabulary), setting goals collaboratively and developing a shared formulation.

The degree of input from, and involvement of, family members should be discussed with the

young person early in treatment. Relevant ethical and confidentiality issues, including limits to confidentiality, should be considered in the context of the "mature minor" principle; that is, most adolescents are competent to consent to their treatment. See "Involving families" on page 20.

Engagement is facilitated by avoiding the use of jargon, using humour where appropriate and validating the young person's efforts in attending and seeking help.

Flexible hours for appointments, youth-friendly reading material in the waiting room, and appointment reminders by text message can encourage attendance. Non-attendance among this age group is common and should be assertively addressed without becoming overbearing or controlling.

Barriers to engagement

Clinicians should try to determine the reason for any underlying resistance to engagement and address it before treatment progresses.

Stigma, stoicism and poor mental health literacy can interfere with engagement, especially for young males. Such barriers can be addressed by taking time to establish rapport, normalising depression as a common illness that has both biological and social components, emphasising the high likelihood of a good treatment outcome with regular attendance, and linking young people with online peer and professional support communities.

Many young people entering treatment are not doing so of their own volition – for example, they might be brought to treatment by their parents. This may mean they deny there is a problem, have no personal investment in the process of problem solving, and therefore have poor motivation to make any changes. Clinicians should respond to such young people in an empathic and genuine way. It can be useful to first join them in their individual world view, even if this is the belief that nothing is wrong. Then ask about the minimum amount of change that would allow whoever sent them for treatment to relax and stop sending them:

- "Parents tend to worry a lot, don't they?"
 - "It must be really annoying having to come here each week when you don't even think there is anything wrong."
 - "What is the smallest change that [parent, referrer, etc.] would have to see for them to stop forcing you to come here?"
-

Other common barriers to engagement include drug and alcohol use, having no experience of talking about difficulties and emotions, lack of family engagement, avoidant personality traits, feelings of hopelessness about the possibility of recovery, unhelpful past experiences with therapy, a fear of confronting the need to change, stigma and stressful life events. Practical problems like a lack of transport to attend appointments or concerns about money can also make engagement difficult.

CASE EXAMPLE: CARA

 Cara, 16 years old, was referred to a youth mental health service to address her symptoms of depression, suicidal thinking, and her tendency to superficially cut her arms when distressed. She thought the problem was her parents' and teachers' being overly-concerned about her cutting, which she considered normal, and "driving me crazy checking on me all the time" when she was moody or withdrawn.

Cara's therapist initially empathised with her, agreeing that having people check up on her must be really annoying, especially when she doesn't see her behaviour as a big deal. After acknowledging Cara's world view in this way, her therapist gently and off-handedly put it to her that any good parent would be concerned if their child was engaging in this behaviour. She then asked Cara what she thought the minimum change in her behaviour might be for her parents and teachers to "get off her back".

Cara decided that if she were to agree to stop cutting and to at least tell her parents when she was upset, rather than just retreating to her room, they might be able to trust her more, relax, and leave her alone. The therapist negotiated these terms with Cara's parents, and after Cara fulfilled her end of the bargain, they withdrew. A similar approach was subsequently used to address Cara's remaining depressive symptoms so that her parents would stop "sending her for treatment".

Another group who can be difficult to engage in treatment are young people who recognise and complain about the suffering produced by their problems, but regard the solutions as being outside the self: as being the responsibility of others.

Joining with the world view of the young person can again be a useful strategy. Clinicians can accompany this with a compliment:

- "Given what you have told me, it makes sense that you are feeling depressed right now."
- "Actually, I'm surprised at how well you are doing."
- "I'm not sure I could have handled it that well."

and then subtly encourage increased ownership of the problem:

- "What have you tried?"
- "What could you do to make things a bit easier for yourself while you go through this?"
- "How could you change [the other person's] behaviour to take some pressure off yourself?"

CASE EXAMPLE: TEO

 Teo, 20 years old, presented with severe depression and dissociation in the context of major stressors, including family conflict and pending criminal charges. He felt he had been unfairly treated by the courts, and was worried that he could be sentenced to jail.

When he had finished relating his story, the therapist could say, with absolute integrity, "Given everything that's going on for you right now, it really makes sense that you are feeling depressed and hopeless, and at times dissociate when it all just gets too much [joining]... In fact, I'm surprised you are doing as well as you are [complimenting]".

Teo visibly relaxed, glad to have someone really understand what he was going through, and his symptoms started to make more sense to him. The therapist asked, "How could you make it just a little easier on yourself, while all of this is still hanging over you?" Teo thought that he could exercise a little more (walk the family dog), and that it might be useful to tell his mother more about the charges laid against him (that he had previously kept secret out of shame). He was behaviourally activated, able to release some guilt and shame and able to engage trusted family members more fully in his treatment. This in turn relieved his symptoms.

Assessment

Assessment is an ongoing process, so an initial assessment will require revision during treatment. Information for assessment should be obtained mainly from the young person, but collateral information from family members and other significant people such as school teachers and welfare coordinators should also be sought, where possible. This approach should be established from the first session by interviewing the young person alone, and then with family members later in the session or at a subsequent session if appropriate.

The clinician should explain the rationale for assessment questions and give an overview of the topics to be covered, so that the young person knows what to expect. One strategy is to ask the young person's permission to discuss a certain topic, explaining why it is important and whether it is okay to talk about it. This is particularly the case for potentially sensitive issues such as past trauma, drug use or sexual orientation. If the young person appears concerned or reluctant to elaborate on an answer, explore this issue immediately rather than pushing ahead.

Use open-ended questions whenever possible, as they are likely to provide more information. Closed questions may be needed to clarify some points.

Continuously monitor the non-verbal behaviour of the young person, particularly for any changes in behaviour that may indicate frustration or anxiety. If this occurs, it can be helpful to acknowledge the change in behaviour and ask what may have contributed to it.

The assessment should obtain the following information, ideally in the first session.

Demographic information

Gathering information such as the young person's age, where they live, who they live with, and their educational and vocational status provides a non-threatening way of beginning an assessment. Then discuss how the young person came to be referred to the service: who referred them and why? If the reason is perceived risk, this needs to be addressed before the session concludes (see page 14).

History of presenting problem

Explore the young person's core depressive symptoms. Ask when the deterioration in their mood occurred, and explore the context in which it happened. Young people might need to be prompted so they can relate changes in their mood to events occurring at the time, as they might not have previously made any connection between them. Remember that depression can be accompanied by many symptoms other than change in mood, so get as much information about these symptoms as possible. Box 1, over the page, lists some typical symptoms of depression.

Determine the perceived severity of the young person's symptoms. A score between 0 and 10 can help to rate their mood and provide a baseline for assessing subsequent changes.

Determine the onset, time course and fluctuations in mood.

It can be helpful to use the above information to draw a timeline with the young person to help them visualise the course of their mood problems (see Figure 1 on page 13). The timeline can also help identify important life events and experiences that may have contributed to mood fluctuations. Check for any periods of elevated mood: if these have the characteristics of a hypomanic or manic episode, it suggests a diagnosis of bipolar disorder.

BOX 1

Typical symptoms of depression

Emotional changes:

- Feelings of unhappiness, moodiness and irritability, and sometimes emptiness or numbness
- Tearfulness or frequent crying
- Feelings of worthlessness, guilt, sadness and/or hopelessness
- Loss of interest and pleasure in activities that were once enjoyable
- Tiredness, lack of energy and motivation
- Feeling worried or tense

Cognitive changes:

- Difficulty concentrating and making decisions
- Being self-critical and self-blaming
- Having negative thoughts about the self (e.g. negative body image and low self-esteem), others, the future and the world
- Thoughts of death or suicide

Behavioural changes:

- Poor attention to personal hygiene and appearance
- Decreased participation with peers and normal activities
- Self-harm
- Avoidance of family interactions and activities
- Being withdrawn, spending more time alone
- Easily upset or quick to get angry

Physical changes:

- Low energy
 - Changes in appetite and weight (either a decrease or an increase)
 - Changes in sleep pattern, including difficulty sleeping or over-sleeping
 - Lowered libido
 - Restlessness and agitation
 - Unexplained aches and pains
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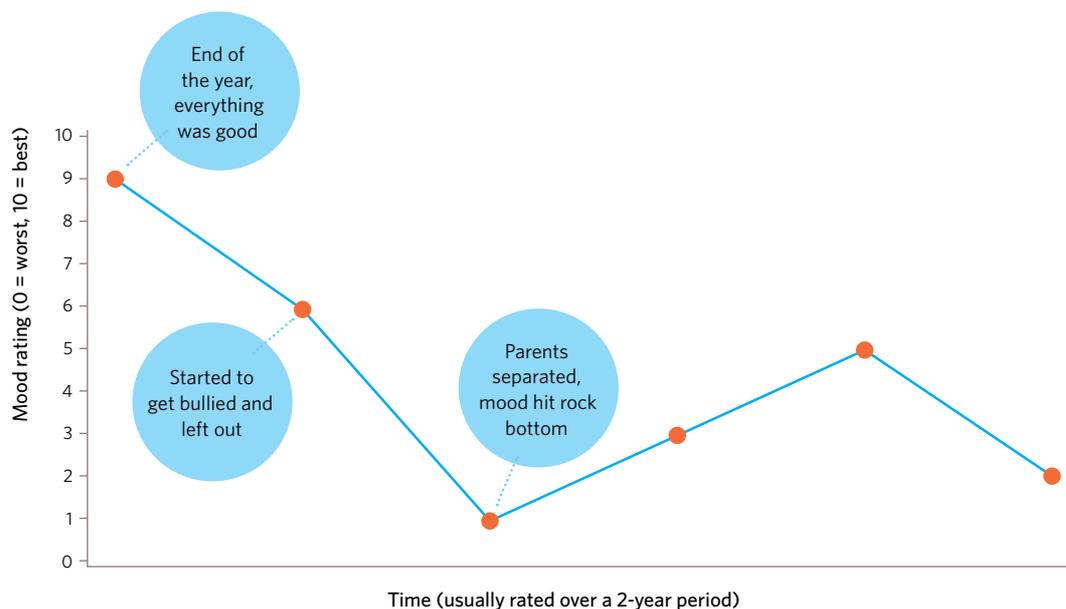


FIGURE 1 Example of a mood timeline

Comorbidities

Depression often occurs with other conditions such as anxiety disorders, drug and alcohol misuse, eating disorders and personality disorders. Be alert for the presence of such problems, and follow up any indications that they might be present.

Past psychiatric history

Assess whether the young person has experienced mental health difficulties in the past and whether they received treatment for these difficulties (including medications). If they have participated in therapy in the past, find out about their experience, focusing on what was helpful or unhelpful.

Family psychiatric history

Ask the young person and family members about any family history of mental illness, which is common in young people with depression. This may also be a good time to discuss the family's structure and family attitudes, and complete a genogram. Genograms are a useful way of collecting and organising family information and can involve discussion of family characteristics and relationships within the family. Completing a genogram with a young person during the initial session/s is a useful engagement tool and will assist in understanding the young person's family background.

Developmental and personal history

It will often be necessary to collect information about the young person's early development from their parents or other family members, rather than the young person. Relevant information includes the young person's achievement of developmental milestones, childhood temperament and early peer relationships. Discussion of personal history can be usefully divided into discrete time periods: for example primary school years, high school years and post-school years. Emphasise social relationships during these years, and the young person's ability to adapt to changes and problems. Their relationships with parents and siblings should also be assessed, for example by asking the young person to describe each of their family members and their relationship with them. Finally, ask about current social relationships, interests and hobbies, and how these have been affected by their depression.

Risk assessment

Risk assessment is an essential component of all interactions with young people. Suicide and deliberate self-harm are the major concerns, but other risks such as poor self-care, neglect of physical health and vulnerability to exploitation must also be considered.

Suicidal thoughts often fluctuate in frequency and intensity and therefore need constant monitoring. Thoughts of suicide, and a history of suicide attempts, are the best predictors of a subsequent suicide attempt.

Strategies for undertaking a risk assessment include open-ended questions, ensuring that you put the young person at ease, taking an interested, curious and non-judgmental stance, and creating an atmosphere in which the young person feels comfortable to disclose their thoughts. Normalising suicidal or self-harm cognitions as a common consequence of depression may assist in open discussion, assessment and safety planning.

Some factors to consider when assessing suicide risk are listed in Box 2, and some examples of questions to ask to assess this risk are listed in Box 3.

BOX 2

Factors to consider when assessing suicide risk

Mental state

Assess whether there has been a recent deterioration in mental state, the degree of subjective distress and level of hopelessness, severity of depression or anxiety, alcohol or drug abuse and psychological traits, such as impulsivity, lack of ability to access and sustain positive feelings and emotional dysregulation.

Withdrawal and isolation

Consider whether the young person has recently been withdrawing themselves from previous close relationships.

Recent significant stressors

Check for recent multiple or repeated stressors, including recent discharge from an inpatient unit.

Suicidal thoughts, suicidal behaviours or exposure to others' suicide

Check whether there has been a recent or previous death or suicide of a relative or close friend, a recent history of suicidal behaviour, any suicide-related cognitions (including their frequency, intensity and severity), the detail and lethality of any plans to self-harm, preparations and access to lethal means, impulsivity, and whether the young person regards suicide as "the only option".

Coping skills

Consider the young person's adaptive coping skills and resilience level. Document these factors and encourage the young person to utilise their adaptive coping repertoire wherever possible.

Supports and help-seeking capacity

Determine the availability of supervision and support to the young person, their adherence with medications and protective management plans, the degree of openness the young person has with supports and clinicians about their current mental state, and the young person's capacity to self-manage impulsive behaviour.

Factors to consider when assessing suicide risk (continued)

Reasons for living and barriers to self-harm

Assess the young person's future goals, current successes, ongoing responsibilities to others (e.g. children, parents, pets), cultural or religious factors that may reduce the likelihood of acting on suicidal thoughts, meaningful employment or study, and things that have previously helped the young person manage difficult times.

Risk level

Document the young person's risk as either "low", "medium", or "high", considering background features and current factors. The assessment of risk is dynamic: it can change from session to session. "Low risk" generally indicates no history of suicide attempts, and either no thoughts of suicide or fleeting thoughts of suicide that they have no wish to act on. "Moderate risk" suggests, for example, a history of suicide attempts (of low-medium lethality) and thoughts of suicide with some specific plans. "High risk" might indicate a history of suicide attempts of medium-high lethality and a well thought-out suicide plan. See section C2.3 of *Clinical Practice Guidelines: depression in adolescents and young adults* for further information.¹²

Examples of questions to assess suicide risk

BOX 3

What has happened that makes life not worth living?

When you have felt this way, have you ever had thoughts of killing yourself?

When have you had these thoughts? How often? How long do they last?

Have you ever acted on these thoughts? How? Did you plan it?

What specifically have you thought about doing to yourself?

Have you taken any steps toward doing this?

Have you thought about when and where you would do this?

Have you thought about the effect your death would have on your family and friends?

What has stopped you from acting on your thoughts so far?

What are your thoughts about staying alive?

How does talking about this make you feel?

What increases the likelihood that you will act on suicidal thoughts?

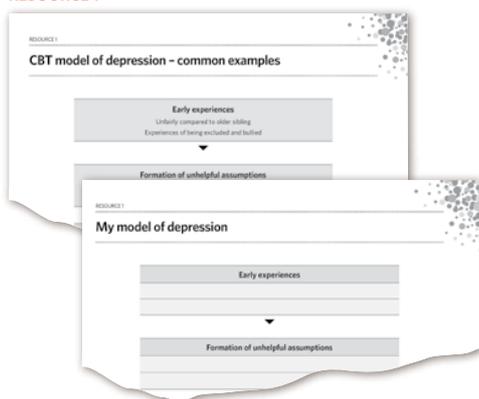
Case formulation

The clinician begins the collaborative process of developing a formulation with the young person based on the information gathered during the assessment. The aim is to achieve a joint understanding of why the young person is unwell at this particular time and with these particular symptoms. The formulation guides treatment and planning.

Formulations are often structured in a way that reflects the predisposing, precipitating, perpetuating and protective factors that have influenced the onset and course of the illness. The strengths of the young person should also be considered in developing a formulation: when a person is unwell and vulnerable, it is important to emphasise that they have strengths, talents and skills that can be accessed during the path to recovery.

Some young people may benefit from a depicting a shared formulation visually, using arrows or a flowchart to highlight the contribution of predisposing, precipitating, and perpetuating factors to the current diagnosis (see Resource 1, “CBT model of depression – common examples”). Attention should also be given to the young person’s strengths as protective factors that buffer against more severe illness and functional impairment.

RESOURCE 1



The following questions outline an approach to developing a formulation and case conceptualisation.

What is the diagnosis?

This course of CBT is designed for young people with major depressive disorders. Important additional diagnoses not to be missed include anxiety disorders, personality disorders and substance use disorders. Evidence of psychotic or manic symptoms may change treatment priorities or selection of therapeutic interventions.

What are the main problems/symptoms?

Depressive symptoms could include lack of motivation, poor sleep, hopelessness or suicidal ideation. Related problems that are not necessarily primary depressive symptoms should be included in the formulation. For example, distress arising from relationships with peers and family might indicate that communication skills are a problem area.

What are the predisposing factors?

Consider how the person came to develop this disorder. Predisposing factors can include biological factors such as genetic disposition, psychological factors, such as early attachment problems or losses, and underlying personality characteristics, such as borderline, dependant or avoidant traits. If personality traits are identified early, it can help the therapist avoid, or at least better manage, some of the pitfalls associated with these disorders. For example, difficulties in maintaining boundaries in a young person with borderline traits can be managed by an increased emphasis during psychoeducation on the role of the therapist and the nature of the therapeutic relationship.

What are the precipitating factors?

There is sometimes a clear precipitant to an episode of depression, but in other cases the young person may struggle to identify any discrete precipitants. Precipitants may become apparent later in therapy as the young person’s understanding of the illness improves, as rapport develops, and as recurrent themes becomes clearer.

What perpetuates or maintains the disorder?

Underlying thoughts, beliefs, behaviours, coping strategies and rumination may perpetuate the young person’s episode of depression. Underlying thoughts, beliefs and attributions may become more apparent as therapy progresses through the core cognitive modules, particularly “A-B-C and Chain Analysis”, and “Identifying Automatic Thoughts”. Some perpetuating cognitive structures such as black-and-white thinking or a tendency to catastrophise might

become apparent relatively early. Coping strategies, including self-harm and substance use, can also maintain the disorder.

What are some of the young person's strengths?

Identifying a young person's strengths is vital. It helps promote a sense of optimism for both the therapist and the young person. It can also help guide treatment by highlighting abilities that can be used in the therapy.

What is the young person's understanding of the conceptualisation and does it need to be modified?

A summary of the conceptualisation should be shared with the young person in weeks 2-3. By this stage, it should be clear whether they are able to think in a psychological way, so the formulation can be tailored to a level that they will be able to comprehend. Keep this summary brief, and consider providing a written copy of the key points. Check the young person's understanding, and seek their input on whether they have any changes to suggest. A collaborative process will provide a sense of ownership for the young person. The conceptualisation may be refined during the course of therapy as more information is obtained and as hypotheses relating to thinking patterns are tested.

CASE EXAMPLE: MEGAN



Megan is an 18-year-old female of Pacific Islander descent, currently living independently and studying a design course. She was referred to the clinic by emergency department clinicians after being taken to the emergency department by a concerned housemate. She presented with suicidal ideation, including a suicide plan, and fluctuating intent – she disclosed thoughts of wanting to throw herself in front of a train near her local station. At initial assessment her symptoms reflected low mood, anhedonia, fatigue, concentration difficulties, feelings of worthlessness, guilt and irritability. She also reported several instances of deliberate self-harm within the previous fortnight by superficial cutting (approximately 15 cuts per episode) to her forearms, upper thighs and, one occasion, her abdomen. The precipitants of Megan's deterioration in mental state were not initially clear.

Megan grew up interstate in a regional area, where her immediate, intact family continue to live, including her mother (a professional-level sports coach), her father (a high-level executive at a local multinational food producer) and two younger brothers in middle- and senior-secondary school. Megan disclosed being adopted by her current family at 3 years of age. Her history prior to this is unknown. She recalled being told of her adoption by her adoptive parents when she was around 5 years of age. Though her adoptive parents always made her feel accepted, Megan was conscious of not fitting in with her family – especially given the differences in her physical appearance from other family members.

Megan reported a strong family expectation that she would achieve excellence in all domains, and for the most part lived up to these expectations. However, despite being attractive, intelligent, and a proficient basketballer, she reported a long history of self-criticism and self-loathing.

During her teenage years her relationship with her adoptive parents became increasingly distant and hostile. She believed her parents favoured her younger brothers, who were their biological children. Megan became increasingly irritable at home. Her mother reported that Megan would “shut down” and refuse to talk about her emotions when distressed. Her parents made several unsuccessful attempts to engage Megan with a private psychologist.

Three years ago, Megan was awarded an undergraduate scholarship for industrial design at a university in Melbourne. Since relocating to Melbourne she has become increasingly emotionally distant from her family. Despite this, Megan's adoptive mother and father spent the week following her referral to the clinic in Melbourne providing her with emotional support.

After several therapy sessions, Megan reported that she had been sexually assaulted. She reported being raped by an unknown male about 12 months ago as she walked along the train tracks towards her home. She did not reveal this to anyone, including family members or police. While Megan was initially unable to catch trains alone and experienced vivid nightmares, flashbacks and hyper-arousal in response to the sexual assault, she stated that these symptoms soon remitted and no longer troubled her.

Megan said that since this time she had managed, more or less, up until 3 weeks ago, when a female friend from university disclosed to her one night that she herself had been sexually assaulted several years ago. Megan stated to her therapist that she just wanted help to forget about the rape and get on with her life, but that her friend's revelation had brought everything back again. Prior to the deterioration in her mood, Megan was in the process of applying for an internship in design in Europe.

Formulation for Megan

Megan, an 18-year-old Industrial Design student, is experiencing mood symptoms consistent with a diagnosis of major depressive disorder. She was referred to the clinic after presenting at her local emergency department with suicidal ideation. Predisposing factors for Megan's current difficulties include a complicated family history, feelings of abandonment, separation from her birth family and culture, attachment problems and chronic low self-esteem. Her current mental state was precipitated by recent vivid reminder of a sexual assault she had experienced approximately 12 months ago.

Perpetuating factors include avoidant and maladaptive coping style (including deliberate self-harm, intolerance of painful emotions, difficulty discussing feelings and insistence on stoicism and independence). Further perpetuating factors include perfectionistic tendencies, parental expectations about success and achievement, corresponding self-criticism and lack of knowledge about her birth family and culture.

Protectively, Megan is intelligent, is motivated to achieve, is in good physical health and does not abuse alcohol or drugs. Furthermore, her family are supportive of her recovery. Should she engage in treatment, gain greater control over managing distressing feelings related to abandonment, and come to accept emotional support from close others, her prognosis for functional recovery in the short-medium term is good.

Developing and sharing the formulation with Megan

Megan's therapist was aware of the importance of providing Megan with an explanatory model of her current difficulties through a shared formulation. The process of sharing the formulation was undertaken in a flexible manner (e.g., differing in detail according to the level of engagement, and developmental and cognitive factors relevant to Megan). With Megan's agreement, the next therapy session focused on integration of previously presented psychoeducation material and her difficult life experiences leading to her current symptom presentation. Megan's therapist was careful to deliver this content in a non-blaming, non-judgemental manner, checking for agreement or otherwise with Megan throughout the process.

Initially the therapist outlined early risk factors that may have led to Megan's depression (i.e., precipitating factors), including her feelings of sadness or loss related to not knowing her birth family, her feeling different to her other siblings, and her tendency for self-criticism and independence. The therapist pointed out that Megan had become an expert at managing her difficult feelings by avoiding them and distracting herself (i.e., perpetuating factors), and that this type of coping sometimes led to her bottling up emotional pain.

The therapist emphasised that Megan was very resilient and strong, and had tried her hardest to manage things as best she could (i.e., protective factors), but that her belief that she had to manage without help from others might make life difficult for her at times, leaving her isolated and without support (i.e., perpetuating factors).

Megan agreed with this summary and said it helped make things clearer to her. She then said that she blamed herself for the sexual assault, and that she just wished that she could forget the whole thing had ever happened. Megan's avoidant tendency was clear to her therapist, and the remainder of the session was spent exploring the pros and cons of avoiding painful emotions.

Goal setting and treatment planning

The goals for treatment, and a plan for achieving them, can be developed once a psychological formulation about the presenting problems has been developed and discussed with the young person. Multiple goals and priorities (e.g. crisis planning) will need to be weighed against each other and prioritised accordingly.

Distinguish between short-term and long-term goals. Although it is possible to focus on both during therapy, the young person and the clinician need to have realistic expectations about what can be achieved in 12 weeks. Agree on a time to review each goal.

Some young people find it difficult to identify specific goals, and others may have unrealistic goals. The therapist can gently explore the goals, and guide the young person towards goals that are likely to be both achievable and beneficial.

The implications of developmental stage for therapy

Late adolescence and early adulthood can be times when new themes emerge in a young person's life – themes such as separating, challenging, rejection, rebellion, secrecy and “acting out”, or antisocial behaviours. Young people may also develop a new capacity for closeness and connecting.

There are many ways in which these themes can be enacted. For example, behaviour associated with themes of separating and challenging can create significant conflict in both family and peer relationships. Acting-out behaviour by young people can generate increased risks of harm to themselves and others. Angry outbursts can occur when the adolescent's emerging sense of self feels threatened and can become a method of feeling, even if temporarily, more solid in their own identity. Such threats can be triggered by behaviour from others that is perceived as controlling.

The experience of depression for young people not only triggers feelings of disengagement from others, but also from themselves and their own lives. Fear of relapse and the limitations this can impose can be perceived as a threat to the young person's sense of self and autonomy. Similarly, keeping secrets from parents and other adults can become a powerful way of separating themselves from the parental world and protecting the private space of an individuating self and of “forbidden” action. In addition, young people need to learn from their own experience, rather than being told or informed about what to do or how to live. The experience of adolescence needs to be seen as part of the therapeutic process.

The power imbalance between the adult therapist and the young person can potentially mirror that of the family or school. This can lead to a therapeutic relationship marked by ambivalence and conflict where the therapist and the young person grapple with issues of control, projection and freedom. Adolescent ambivalence means young people can frequently be caught between rejecting adult advice and seeking that same advice. Parents of a depressed young person can find themselves wanting to take a more prominent and potentially controlling role in their child's life. Similarly, clinicians might need to take a more controlling role if a young person is at significant risk of suicide and requiring hospital admission. This can present challenges of autonomy for the young person, and potentially trigger feelings of shame, failure, anger and rejection. The therapeutic process and how the treatment is delivered and negotiated are crucial to engaging young people in treatment.

Working therapeutically with young people therefore involves a range of skills and approaches that include: respecting ambivalence, conflict and the importance of secrets; negotiating the pace and direction of the therapy; and working with families. It also requires therapists to be aware of the power imbalance and how each young person responds to this (i.e., being aware of repeating any existing patterns of control). If the therapist needs to take more control then there needs to be a high degree of transparency regarding why this needs to occur.

Involving families

The positive involvement of families, including parents, partners, friends, siblings and other significant supports, in the treatment of young people is likely to help their recovery. The level of involvement of families will vary according to the presentation and the desires of the young person. Adolescents and young adults are in the process of individuating from their family, and so are sometimes reluctant to have them involved in their treatment. However, they should be encouraged to allow their families at least to be provided with psychoeducation about their depression and how it will be treated. Where indicated, more intensive family therapy may sometimes be useful. Detailed discussion of family therapy is outside the scope of this manual.

Confidentiality is a key issue if family members are to be involved. It is helpful to clarify with the young person exactly what information may be shared with their family, and to negotiate an agreement that limits what is passed on to family members: for example, information about drug use, sexuality or other sensitive issues might be withheld. A young person's unwillingness to share information is often partial rather than complete, and can change over time. Families can find it difficult to accept that they do not have an automatic right to information, and confidentiality can be a challenge for clinicians as they balance the needs of their patients with the understandable needs of the family.

Mental health legislation defines a number of circumstances relevant to the release of information without the young person's consent. For example, information can be released if it is essential to prevent harm to the young person or to others. However, if a situation requires breaching the young person's confidentiality, involving the young person as much as possible in the decision-making and information-sharing process can assist in maintaining engagement and limiting the impact on the therapeutic alliance.

CASE EXAMPLE: DAVID



David, aged 15, was referred for treatment of depression, suicidal ideation, and comorbid generalised anxiety. During the first session with David's family the therapist realised that his parents appeared to be responding defensively to many questions. The therapist decided to change course and instead suggested that they discuss the different causes of depression and anxiety. During this discussion, the therapist made it clear that parents often blame themselves for the onset of the disorder and think that others blame them too, but in fact depression develops from a combination of factors which are not the fault of the parents.

David's parents were obviously relieved by this comment. They acknowledged that they did have a strict parenting style and had assumed they would be told that it had caused David's symptoms. They spoke much more openly for the remainder of the session.

Case management

Young people often present with a range of practical issues that need to be addressed in addition to their depressive symptoms. Examples include unstable accommodation, drug and alcohol issues, unemployment or disengagement from education, and physical health problems. Assistance with these issues is commonly referred to as "case management", and may involve linking the young person with appropriate support services and advocating for their needs. Addressing these issues early will improve the chances of treatment being successful, and also help engage young people if they identify the clinician as someone who can help produce positive changes in their lives.

CASE EXAMPLE: REBECCA

Rebecca, aged 24 and unemployed, had been in treatment for severe depression for about 8 weeks. Therapy had been progressing well and the agenda for the day's session was to review her homework on thought monitoring. When Rebecca arrived she was clearly upset and agitated. She broke down in tears and said she had a massive fight with her mother and had been kicked out of home. Last night she slept on the couch of an old school friend, but did not know how much longer this would be possible.

Instead of going ahead with the planned session, the therapist explored accommodation options with Rebecca, explaining the available services and organising appointments with housing workers. Rebecca was provided with a range of options, resources and corresponding contacts. Rebecca was grateful for this assistance and left the session markedly less upset and anxious. Her therapist offered phone support over the next couple of days. While these phone calls were only brief, they provided Rebecca with important emotional support and containment. Several days later Rebecca had arranged medium-term accommodation and therapy was able to recommence.

Ending therapy

Ending therapy can be a difficult process for young people and requires careful planning and preparation.

The end of therapy may result in an increase in emotional distress for a young person. As with other issues that arise during treatment, this should be explored openly in therapy. The aim of these discussions should be to allow the young person to process their feelings and focus on having a "good" or "good enough" ending. It is important to acknowledge that the problems in their life may not have resolved completely, but that there will be a number of skills and insights that they can take with them from therapy. In essence, the young person is encouraged to become their own therapist, and transfer the skills they have learnt into their daily life.

It is the role of the clinician to notice the young person's reaction and explore it with them. Young people can present with a range of responses to the end of therapy, including feeling lost, abandoned or angry, feeling as though they are unable to cope on their own, reporting an increase in their symptoms, or avoiding the final stages of therapy by not attending. The clinician should assist the young person to understand that the process of termination will evoke normal feelings of loss and that helping them cope with these feelings is a part of therapy. Some strategies to help with the end of therapy are presented in Box 4, over the page.



BOX 4

Strategies to help with ending therapy

From session 1, discuss the likely duration of therapy.

Discuss discharge early in treatment so that the young person is aware of the planned length of treatment and is prepared for it to end. Discharge should then be discussed regularly throughout the course of therapy.

Discuss the fact that the impending end of therapy often causes distress, and openly explore the emotions the young person is experiencing in response.

Review the gains that the young person has made in order to increase their confidence in being able to cope on their own.

Involve families in conversations about the ending of treatment and explore any concerns or anxieties that they may have. Also inform families of other services and supply them with their contact details.

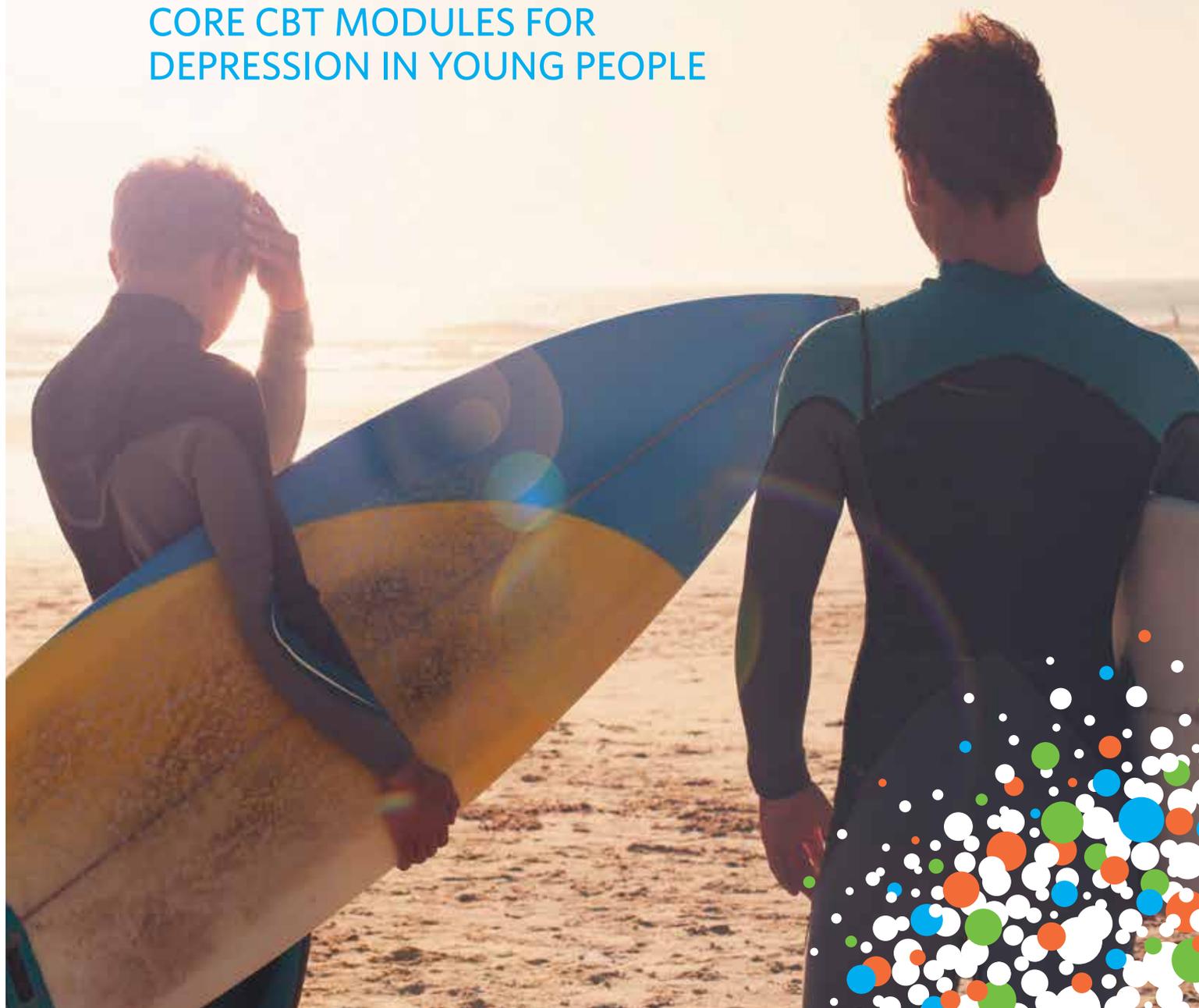
If possible, consider the scheduling of booster or maintenance sessions.

Referral to other services

Young people regularly require ongoing support after they leave treatment at a specialised service. This may include referral to a private psychologist or psychiatrist, a youth worker, school or university counsellor, drug and alcohol counsellor, housing workers, employment services or group programs. Most importantly, the young person's general practitioner should be informed that they are going to be discharged from the service.

It is ideal to communicate with any referral destinations both verbally and with a written discharge summary. The discharge summary should highlight the formulation, diagnosis, treatment received, progress and recommendations for further care. If possible, have a formal hand-over session with the young person and the new clinician/service.

CORE CBT MODULES FOR DEPRESSION IN YOUNG PEOPLE



CORE MODULE 1

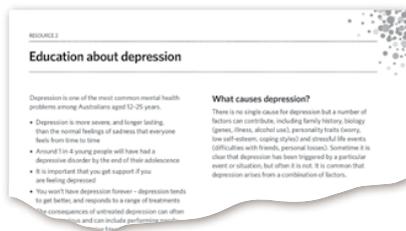
Psychoeducation

Many young people have a limited understanding of mental illness, its treatment and the likely outcomes, often leading to confusion and anxiety. It is essential to provide this information as early as possible in treatment, ideally to both young people and their parents. Psychoeducation should be pitched at the correct level for each young person, and repeated and reinforced throughout treatment.

Psychoeducation helps young people understand their difficulties and is an important tool for engagement. It is the foundation for treatment, and essential when considering the prevention of relapses. Psychoeducation also has an important role in addressing stigma, informing the young person that depression is an illness and is not a product of having a weak character or other personal “failings”. Psychoeducation can instil hope by providing realistic optimism about a full recovery.

It may be helpful to provide the young person with a copy of Resource 2, “Education about depression”.

RESOURCE 2



Psychoeducation topics

Symptoms and causes of depression

Once the presence of major depressive disorder is confirmed, it is important to communicate the diagnosis clearly to the young person. Young people readily associate having a low, sad or irritable mood with “being depressed”, but they are often unaware of the full consequences of clinical depression, the range of symptoms that can be experienced, or the effect it can have on their function and quality of life.

One way of presenting this information is to ask the young person to identify which emotional, cognitive, behavioural and physical changes (listed in Box 1, on page 12) they have been experiencing.

Factors that might be contributing to their depression should also be discussed, including genetic and biological factors, personality traits and stressful life events. Sometime it is clear that depression has been precipitated by particular events or situations, but often it is not. Explain that it is not possible to be certain about the causes, and that it is likely to have resulted from a combination of factors. However, treatment can be effective in alleviating their symptoms despite not knowing the exact cause.

Therapy

Psychoeducation should explain to the young person the processes of therapy and answer any questions they have. Their understanding of CBT can be helped by providing them with a CBT model of depression (see Resource 1, “CBT model of depression”). Some important factors to discuss about the CBT program are listed in Box 5.

Medication

The treating team may have concluded that medication is likely to be helpful for the young person. Medication will be explained by the treating doctor, but the clinician providing CBT is well-placed to encourage and monitor adherence, support the benefits of medication, strongly recommend that the young person speak to the doctor about any concerns and liaise with the prescribing doctor about any apparent difficulties.

Psychoeducation for families

Parents and other family members can have a range of responses to their family member’s depressive illness, and their attitudes and behaviours may be either helpful or detrimental. Psychoeducation should offer family members accurate information about depression, its “causes”, the treatments that are available and the likely outcomes.

Common but unhelpful reactions that might need to be addressed include:

- blaming themselves for their child’s illness – clinicians should emphasise that depression does not develop from a single event and parents can play an important role in the recovery of their son or daughter

- viewing the young person as lazy, as not trying hard enough, or as having conscious control over their symptoms – the clinician can help parents understand that depression is an illness, and that the symptoms and dysfunction are not under the young person’s control
- believing that depression is entirely a biological disorder and that only biological treatment is effective – clinicians should emphasise that biological, psychological and social factors are all likely to have played a part in the onset of the illness, and will be a target of effective treatment.

Online resources

The Internet is an ideal source of educational material for young people with depression, provided that they are guided to accurate and credible information. Useful websites include:

- Centre for Clinical Interventions – www.cci.health.wa.gov.au
- headspace (the National Youth Mental Health Foundation) – www.headspace.org.au
- Orygen Youth Health – oyh.org.au
- Youth beyondblue (the National Depression Initiative) – www.youthbeyondblue.com

CASE EXAMPLE: BRAD



Brad, aged 22, was referred by the emergency department after an overdose of medication. During the first session with his therapist, Brad said he had felt helpless and unable to enjoy life for at least 5 years, and he had lost hope that things would ever improve.

The therapist slowly guided Brad through the symptoms and causes of depression, focusing on how treatment could be helpful and what it would involve. The therapist told Brad that the experiences he had described were consistent with a diagnosis of depression, which was a treatable illness with good prospects for recovery. Brad was relieved to discover that depression was a common and treatable problem. He was also provided with written information to read at home, and between sessions he accessed some of the online resources listed in these handouts (e.g. the headspace website). He came to his next therapy session with a series of questions about his diagnosis and treatment, which his therapist was happy to answer. This was the beginning of Brad becoming actively engaged and informed in his treatment for depression.

Explaining the CBT program

BOX 5

This program is based on 12 weekly sessions.

Therapy may involve talking about difficult experiences and emotions, but the young person can control the intensity of these discussions.

Therapy will be most effective if the young person attends sessions regularly.

CBT involves exploring how a person’s thoughts and behaviours influence the “causes” and symptoms of depression, and how these might be changed for the better.

Therapy is a collaborative process and will require effort from both the clinician and the young person.

Homework tasks are part of therapy. (It may be necessary to come to a shared understanding of the meaning and importance of homework tasks within CBT. Collaborative development of homework tasks may assist with homework compliance.)

Young people are encouraged to be open with the clinician about any parts of therapy they are not finding helpful or feel uncomfortable with.

CORE MODULE 2

Understanding and monitoring emotions

Understanding feelings and emotions is the first step toward being able to manage one's emotions. By monitoring their emotions, young people can start to understand how they respond to different circumstances and events, the types of thoughts that might contribute to their emotions, how they might achieve more control over their emotions, and how this might improve their overall mood. Mood monitoring aims to help the young person to identify and label emotions and rate their intensity over time.

Naming emotions

The clinician aims to increase the young person's "emotional vocabulary" through the following process.

Enquire about emotions

Ask the young person to talk about how they have been feeling by exploring times when they have felt bad and getting them to describe the situation in detail. Repeat the process for times they have felt good.

Provide a rationale

Explain why it is important to be able to identify and label emotions and moods. Discuss how this will help the young person to develop skills in managing their emotions.

Develop a vocabulary for emotions

Prompt the young person to name the emotions they have recently experienced: "brainstorm" different labels that can be used for that emotion, ask them to describe similar emotions, and discuss the fact that different emotions can be experienced at the same time. Perhaps use a personal experience the young person has shared in the session, for example when describing their week, or provide some simple scenarios (personalised as far as possible) and ask

the young person to describe how they would feel. For example:

- "Your friend didn't message you about getting together."
- "You tripped over a shoe that your brother (or flatmate) left on the floor and hurt yourself."
- "You went to meet some friends in the city and they didn't turn up."
- "You won free concert tickets to see your favourite band."

If the young person is struggling to describe their emotions, acknowledge that recognising and naming feelings can initially be very difficult and many young people find it hard. There might be some obvious reasons for the individual's difficulties, for example living in a family in which emotional expression was "not allowed", or learning over the years to suppress emotions as a "survival strategy".

Techniques to help the young person begin to recognise their emotions include:

- using the emotion faces chart to help recognise emotions (see Resource 3, "Emotions")
- allowing the young person to provide their own words for different emotions
- pointing out the difference between thoughts and feelings
- asking the young person to recognise physical sensations (e.g. tightness, heaviness all over, butterflies in their stomach, feeling shaky) as a way of recognising emotions
- drawing a picture of the body as a prompt to recognise these physical sensations.

RESOURCE 3



Rating the strength of emotion

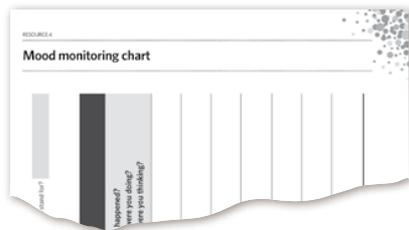
Provide a rationale

If people can understand the intensity of their emotions and recognise when that intensity is growing, they are more able to take action to improve their emotional state before they reach a “tipping point”, when their emotions seem too much to handle.

Introduce a rating scale

Introduce the concept of a rating scale for the young person to estimate the strength of their feelings, from 0, being the worst they have ever felt, to 10, being the best they have ever felt (see Resource 4, “Mood monitoring chart”).

RESOURCE 4



Use scale in practice

Use the mood monitoring chart to facilitate a discussion about the previous week. Ask the young person about their mood today (using the 0-10 scale), when it was the worst during the previous week (rating it from 0 to 10), and when it was the best (rating it from 0 to 10). Explore the situation at each of these times, and highlight the connections between their emotions and what was happening at the time.

CASE EXAMPLE: EMILY



Emily, aged 17, was referred following a brief hospital admission after taking 38 paracetamol tablets at school in response to chronic low mood and suicidal ideation.

At assessment Emily was found to have a 3-month history of major depressive disorder on a background of a 4-5 year history of dysthymia. She also presented with chronic self-harm (punching things and cutting), dissociative episodes, emotional dysregulation and no memory of primary school. She denied any past trauma or abuse. There were no clear precipitants to Emily's recent onset of depression, but factors that may have contributed included her impression of always feeling “different”, “more emotional” and “sadder” than her peers. She saw any emotional experience as being “out of control” or “weak”, and tried to cut herself off from her feelings by self-harming and either binge eating or not eating at all.

She often presented in sessions trembling and shaking but unable to answer questions about how she was feeling or what might have triggered it, often responding with, “I don't know”, or simply shrugging her shoulders. The sessions focused on the difficult work of Emily's becoming more aware of her emotions and the physical sensations that accompanied them. They were used to model how to be aware of, and accept, emotions. Prompt cards were used to help generalise the emotion regulation skills learnt in other parts of her therapy.

CORE MODULE 3

Behavioural activation

Depression is associated with a lack of active, enjoyable activity, and improvements in mood have been associated with increased engagement in such activity. Behavioural activation involves encouraging a young person to engage in behaviour that is reinforcing and enjoyable, and will enhance senses of mastery, accomplishment and self-esteem.

The loss of pleasure, energy or motivation that occurs from depression can cause a young person to cease previously enjoyable activities, such as getting together with friends, participating in sports, or enjoying hobbies. This in turn can worsen the symptoms of depression. For example, if a young person continues to turn down invitations to go out, friends may stop calling and the young person may then feel abandoned, and have more time to ruminate and feel sad. Lack of activity can worsen problems with loss of energy, leading to increased fatigue and over-sleeping. Loss of normal activities can also undermine a person's sense of achievement.

Re-engaging in such activities, even if the young person finds it difficult, provides at least a *possibility* of experiencing positive emotions. It is a powerful way to interrupt the "downward spiral" in mood and function and change emotions in a positive direction.

A specific aim of behavioural activation is to help young people structure their time to engage in meaningful activities. Even small activities can provide some distraction, a renewed sense of control and a sense of moving forward. Activities can provide a sense of achievement even if the activity itself was not pleasurable, for example washing the dishes.

Increasing pleasant activities

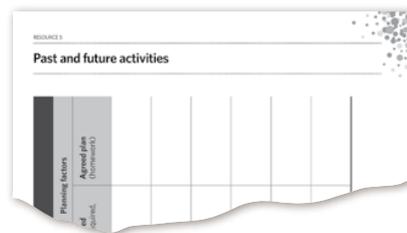
Provide a rationale

Discuss with the young person the benefits of activity: becoming more active and re-engaging with the world is an important step in recovering from depression.

Assess current activities

Use an informal approach and simply ask about the person's activities, for example over the last week. Resource 5, "Past and future activities", can be used if needed; it includes a rating scale for the pleasure and achievement associated with each activity. This process can not only help to identify pleasurable activities, but also help a person with perfectionistic traits to distinguish between achievement and pleasure: you can enjoy an activity without being good at it.

RESOURCE 5



Establish previously enjoyed activities

Ask about activities that the young person used to enjoy before they became unwell (see Resource 6). Identified activities can be rated on a scale from 1 to 5 with respect to pleasure and achievement.

RESOURCE 6



Generate a list of possible activities

The clinician and the young person can work together to generate a list of activities that might be enjoyable. Some previously enjoyed activities might need to be deferred or modified in some way until the young person is further advanced in their recovery.

Ideal activities:

- can be done easily and frequently
- include activities done alone and with others
- do not cost a lot of money
- have a social aspect
- are likely to increase wellbeing and a sense of accomplishment.

Select the pleasant activities to be targeted

Highlight the importance of activities that increase social interaction as well as a sense of accomplishment, pride and competence.

Help the young person to set realistic goals about how many times they will do the activities in the coming week. Avoid setting unrealistic goals, as they are likely to lead to failure rather than success.

Provide reminders (perhaps a prompt card or prompts in their phone) about the activities, ensure they have the resources needed, and spend some time planning each step needed to successfully undertake the activities.

It may be helpful to integrate self-care strategies when planning behavioural activation (see Targeted Module 3 and associated resources).

Activity schedule

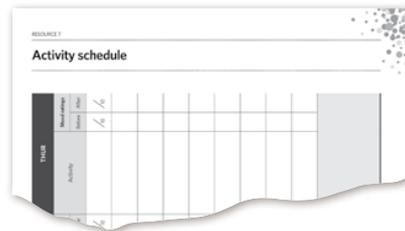
Provide a rationale

Activity scheduling will help the young person become more active, with benefits as described above.

Develop a weekly schedule

Use a weekly schedule form (see Resource 7) to help the young person plan activities during the week. Include simple and routine activities, such as eating breakfast, taking a shower or shopping for food or preparing meals, as well as potentially pleasurable activities. Start with small steps and avoid an excessive number of activities or unrealistic goals.

RESOURCE 7



It is reasonable to include important but potentially challenging activities, such as talking to a teacher or employer or studying for an exam, but break them down into achievable components. Include the concept of “rewards” for completing difficult or challenging activities: this is usually some type of pleasant event.

As described previously, provide reminders to the young person about the scheduled activities, ensure they have the necessary resources and plan each step they need to take.

Mood ratings

Remind young people to monitor their mood each day on the mood monitoring chart (Resource 4). Use the results to discuss connections between their activities and their mood.

Remember:

- Even simple tasks might seem unachievable for people with depression who have little motivation to start the task. Thoughts such as “I won’t enjoy this”, “it’s too hard”, or “I’ll probably fail” can be substantial barriers to activity. The clinician can normalise such thoughts, and frame the intervention as an “experiment” to increase motivation.
- Young people may try to do too much too soon. Emphasise that small goals will be built on in the future. For example, they might initially try going for a walk once this week rather than every second day.
- If a young person’s goals are too ambitious, they may not achieve them and become disappointed, confirming their negative beliefs about themselves.
- It may be better to aim to do a task for a set period rather than a set level: for example, reading for 10 minutes a day rather than reading a book every week.

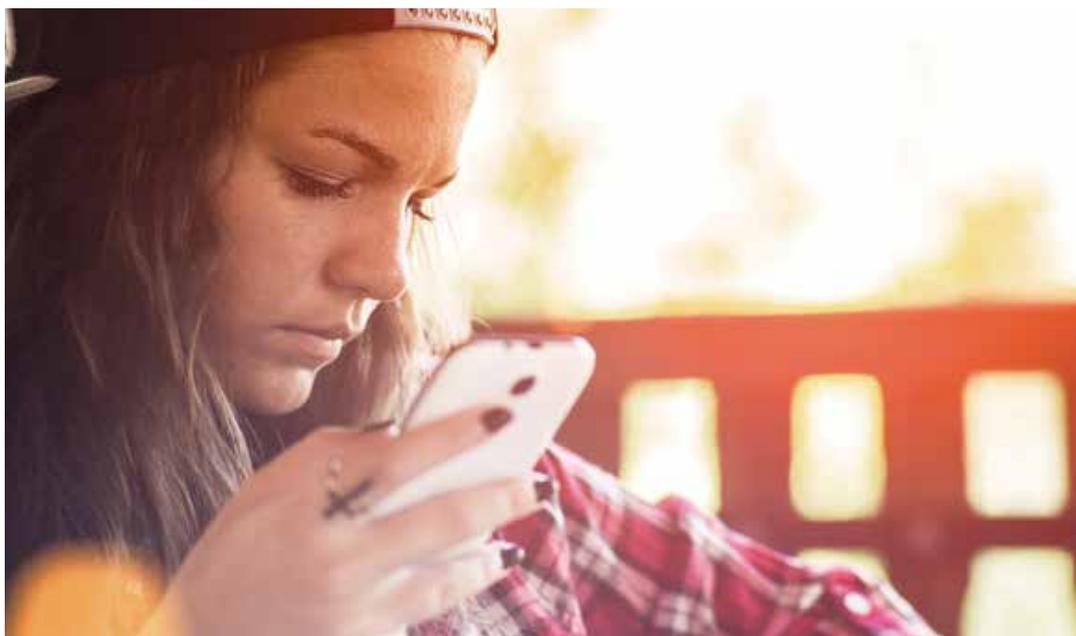
CASE EXAMPLE: SHOBANA



Shobana, 15, was experiencing a range of depressive symptoms associated with long-standing low self-worth and anxiety. She had reduced social contact and engagement in enjoyable activities, and struggled to find motivation to complete basic daily tasks. Her symptoms worsened when she was not occupied, as she became absorbed in rumination and self-critical thinking patterns.

Behavioural activation was introduced to address symptoms, such as tiredness, lethargy and loss of interest and pleasure, that were maintaining Shobana’s depression, and to provide distraction from rumination. Shobana and her therapist identified a series of activities that would provide a sense of enjoyment or achievement, including hobbies that she used to find rewarding, as well as some household chores.

For Shobana, negative thinking patterns were a significant barrier to increasing activity (e.g. “I won’t enjoy doing this”, “My friends don’t want to spend time with me”), so time was spent in therapy to help her to identify and challenge these thoughts. Addressing these barriers helped motivate Shobana to follow through with the activity schedule.



CORE MODULE 4

The A-B-C model and chain analysis

The A-B-C model

CBT aims to identify and challenge the negative or unrealistic thoughts and beliefs that underlie and maintain problematic behaviours and to replace them with more positive or adaptive ones, thus alleviating distress and improving mood. The A-B-C model describes the relationship between thoughts, feelings and behaviours.

- Situations, or **A**ctivating events, trigger certain thoughts, or **B**eliefs, which cause emotional or behavioural **C**onsequences.
- Activating events have little to do with feelings. Instead, it is our beliefs (thoughts and interpretations) about the situation that control the consequences (how we feel and behave).



Table 1 uses the A-B-C model to describe how three different people reacted to the same situation.

TABLE 1 The A-B-C model

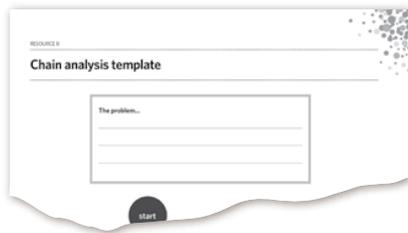
Situation (the 'A')		
Mark, Susan and Alex each experienced a friend forgetting to message them about a night out		
Person	Thoughts/beliefs (the 'B')	Emotions/behaviours (the 'C')
 <p>Mark</p>	<p>"That's typical, I am such a loser, no-one would want me to come."</p>	<p>Feels upset, humiliated, self-conscious, distressed</p> <p>He avoids contact with others and hangs out in his room</p>
 <p>Susan</p>	<p>"How could she forget me, she is so useless, she always does stuff like this."</p>	<p>Feels flustered, angry, stressed</p> <p>She snaps at everyone at work and is stressed all day</p>
 <p>Alex</p>	<p>"Oh, my mate must have just forgotten, he can be forgetful sometimes."</p>	<p>He decides he might bring it up with his friend the next time he sees him, but it has no effect on his day</p>

Chain analysis

Chain analysis provides a detailed functional analysis of a behaviour by reconstructing the chain of events that contributed to the onset and maintenance of the behaviour. The chain analysis is incorporated within the A-B-C model, as the chain of events leading to a particular behaviour can be described in terms of activating events or situations (As), the thoughts or beliefs (Bs) that are triggered and the behaviours or emotions (Cs) that follow.

Reconstructing the chain of events allows the clinician and young person to identify and understand the sequence of factors (A-B-Cs) that contributed to the problematic or maladaptive behaviour and identify therapeutic interventions that target these factors. By targeting these factors, or “links”, the chain can be broken and the problematic behaviour prevented. See Resource 8, “Chain analysis template”.

RESOURCE 8



Provide a rationale

Provide the young person with a rationale for conducting the chain analysis, within the context of the A-B-C model, using Mark, Susan and Alex (Table 1) as an example. When young people complete a chain analysis for their own behaviours, it can:

- help them to better understand their behaviour in the context of particular situations
- help develop an increased sense of control over their behaviour
- enhance their belief that change is possible
- help the young person feel validated and understood: “Someone else knows why I did this”
- help the young person understand that they may have difficulty with the complex tasks of planning, prioritising, organising thoughts, suppressing impulses and weighing consequences, but that practice using A-B-C analysis will help to develop these skills.

Identify vulnerability factors

It can be helpful to begin the chain analysis by identifying factors that increase the risk of engaging in the behaviour of interest, such as alcohol and other drug use, sleep disturbance, lack of exercise or poor diet. Targeted modules 3 and 4 on self-care strategies and alcohol and other drug use can address these issues if needed.

Consider asking the young person directly about these factors, or perhaps asking:

- “What was different about that day when you had the problem?”
- “What made it more likely that you would do X on that day, rather than the day before or the day after?”

Reconstruct the chain of events

Ask the young person to reconstruct the chain of events leading to the situation or behaviour of interest, for example by describing:

- the situation or behaviour, and then reconstructing the events in reverse order, or
- the events leading up to the situation or behaviour, in the order they occurred, or
- a clearly identifiable stressful event that may have triggered the situation or behaviour.

The young person’s memory can be jogged by asking practical questions such as, “What were you wearing?”, “What was the weather like?”, “Where were you?”, “Who were you with?”

The “freeze frame” is another technique, which uses the metaphor of watching a movie of the day’s events. The clinician can say, “Imagine that the day’s events are a movie, and we can pause at critical frames and discuss them in detail”. In the context of the A-B-C model, stop the young person at each link in the chain and ask about thoughts and beliefs that were triggered and the emotions and behaviours that followed.

Plan therapeutic interventions from the chain analysis

Once the chain has been reconstructed, the clinician and young person can examine each link and identify how the chain might be broken. This may be as simple as generating one or two alternative ways of acting or responding, or may involve implementing a therapeutic intervention around a specific link.

The analysis can help guide subsequent therapy, such as the following.

- Difficulty with problem solving is addressed in Targeted Module 6: Problem Solving Skills.
- Negative automatic thoughts are addressed in Core Module 6: Working with Unhelpful Thinking.
- Negative or strong emotions are addressed in Targeted Module 1: Distress Tolerance.
- Vulnerability factors are addressed in Targeted Module 3: Self-Care Strategies and Targeted Module 4: Alcohol and Other Drug Use.

Involve others

In some cases, especially with very young people, it may be useful to conduct a separate chain analysis with a parent or caregiver in order to gain a different perspective on the chain of events.

Further reading

Brent, D. A., Poling, K. D., & Goldstein, T. R. (2011). *Treating Depressed and Suicidal Adolescents: A Clinician's Guide*. New York: The Guilford Press.



CORE MODULE 5

Identifying automatic thoughts

This module helps young people to identify and understand the automatic thoughts that contribute to how they feel, and how they subsequently behave, to give them greater control over their mood. Once these thoughts are identified, they will be targeted with relevant therapeutic interventions (Core Module 6: Working with Unhelpful Thinking).

Explain to the young person that to change one's thinking it is necessary to first identify any unhelpful thinking patterns. This process starts with monitoring thought patterns. The next step is to identify what tends to happen as a consequence of these thoughts - that is, how the young person responds to these thoughts.

Provide a rationale

Remind the young person about the A-B-C model and the relationship between thoughts, feelings and behaviours. Highlight that we are able to change some situations, but other situations are outside our control, for example, acrimony between parents,

a relationship break-up, not being successful in a job application or a test at school, or having a pet die.

Introduce the concept that the situation itself does not make us feel a certain way, but rather how we perceive the situation: our beliefs and thoughts about the situation influence how we feel and respond to it. Explain that these thoughts are often not conscious and that we are not aware of them because they happen so quickly; however, these "automatic thoughts" have an enormous impact on our feelings and actions. By attending to these thoughts we can begin to recognise them.

Explain that there is an opportunity to change the way we think about situations, even if we cannot change the situation itself. Emphasise that some automatic thoughts are relatively easy to identify and challenge, while others, especially those related to core beliefs, may be more resistant to change.

Discuss the relationship between thoughts, feelings and behaviours

Take time to ensure that the young person understands the difference between feelings and thoughts, and how feelings, thoughts and experiences are connected. One technique is to review the young person's mood monitor chart, which includes a column for recording "What happened? What were you doing? What were you thinking?" It can be used as a prompt to explore the links between feelings and situations (see Box 6).

BOX 6

Exploring links between feelings and behaviours

Ask young people to describe:

- some of their positive/negative memories or recent events, and how these affected their feelings.
- times when they are most likely to experience pleasant feelings.
- times when they are most likely to experience their least pleasant feelings.
- what they do to avoid or cope with experiences that evoke unpleasant feelings.
- anything they do to help experience pleasant feelings.

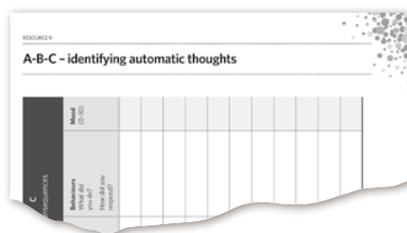
Challenge them to think about how much of a problem it is for them to experience feelings they don't like.

Challenge them to think about whether they can always make feelings they do not like go away.

Challenge them to think about how they can manage feelings they do not like.

Another technique is to use Resource 9, “A-B-C – identifying automatic thoughts”, to analyse a commonly encountered pleasant scenario. Ask the young person to describe at least two thoughts that come to mind in the scenario and the corresponding emotions they might experience. Ask them to identify how these emotions may contribute to subsequent behaviour and to rate their likely mood at this time. Repeat this process, but instead use examples of negative or troubling events that the young person has discussed. Focus on eliciting the automatic thoughts that are activated, so the young person becomes practised in identifying them – the ‘B’ in the A-B-C model.

RESOURCE 9



If young people have difficulty identifying emotions corresponding to a given automatic thought, focus instead on the behavioural component (the ‘C’ column) and then link this to how the young person may have been feeling.

Overcome resistance

If a young person is resistant to the idea of changing their thoughts, then sensitively highlight that the approach is not just about “being positive” and ignoring the situations and thoughts that arise; instead, the rationale is to decide whether the thoughts are helpful or not. The next module, “Working with Unhelpful Thinking”, provides some strategies young people can use to create some distance between their thoughts and themselves so that negative thinking has less impact “in the moment”.

It should be possible to initiate discussion about times in the past when young people have changed their minds or opinions about something, even something as simple as fashions they have liked.

Discuss automatic thoughts

Highlight that automatic thoughts:

- can arise without prior reflection or reasoning
- can include images, daydreams or a train of thoughts
- can be neutral (“I think I will watch a DVD today”), positive (“Wow, I did that well”) or negative (“I am going to fail again”)
- can be useful in allowing us to act quickly without needing to think “too much”
- can be negative or unhelpful if we are unaware of them (they are out of our conscious control). They may be distortions of reality and they may cause unpleasant or distressing emotions
- tend to reflect long-held underlying beliefs (or rules) about ourselves. Because they can become so familiar, we forget that they are beliefs rather than facts.

Identify common cognitive distortions

Use Resource 10, “Common unhelpful thinking styles” to explore the various types of cognitive distortions or thinking errors that can cause difficulties and, if possible, elicit examples from the young person’s experience.

RESOURCE 10



Introduce a practice activity for the week

Remind the young person that negative or unhelpful thoughts are automatic, so it takes practice to be able to identify them. Use Resource 9 to set up a homework activity of identifying and analysing an automatic thought within the A-B-C model. If appropriate, practise the technique in the session, before asking the young person to complete another example during the week.

At first, the thoughts identified as unhelpful may simply be negative rather than truly unhelpful, such as “I don’t want to be at this party”. Young people may not admit to the true negative automatic thought if it is embarrassing, such as “People at the party don’t want to talk to me because I am ugly”. If this is the case, reinforce the principle that *it doesn’t matter how silly something sounds – if it is causing some distress then it is important to talk about it*.

Careful questioning can help to dissect the unhelpful automatic thought from the one which is reported, for example: What is bad about that? What do you see happening in this situation? What are you concluding about yourself or others in this situation? And that is bad because...? What does this say about you...?



CASE EXAMPLE: JANE

 Jane, 19, was experiencing fluctuating depressive symptoms. During therapy a link was made between these symptoms and her experiences of problematic social interactions. On reflection, Jane stated that she had a tendency to make bad choices about her peer group, often finding that her friends would treat her poorly.

On exploring the issue, it became clear that Jane was resistant to making new friends. When asked about the pros and cons of establishing new friendships, she declared that “friends never really stick around long”. Her therapist asked about the origins of this belief, and Jane tearfully recounted significant experiences of bullying throughout childhood and early adolescence, when her friends would physically run away from her, or fail to meet her at designated places or times.

Through eliciting these painful memories of abandonment and subsequent internalisation, Jane and her therapist were able to identify and name the relevant automatic thought: “There’s no point in getting close, everyone just leaves”. Because of a fear of loneliness, Jane had remained in unsatisfying and sometimes destructive friendships.

Jane and her therapist were able to work towards challenging and restructuring this thought with a view to her initiating and maintaining satisfying and supportive friendships.

CASE EXAMPLE: JACK

 Jack, 21, struggled with symptoms of anxiety, which he found overwhelming and caused him to feel hopeless about himself and the future. Jack told his therapist that this anxiety often came over him “out of the blue” with no identifiable triggers.

The relationship between thoughts and feelings was introduced as a way of understanding negative emotional responses to situations and experiences. Jack appeared to grasp this concept well, but said he wasn’t aware of the thoughts that preceded his anxiety, telling his therapist “I just feel anxious”.

Common unhelpful thinking styles were discussed and Jack was able to recognise several traps that he often fell into, including catastrophising and black-and-white thinking. His therapist encouraged Jack to ask himself key questions that could help him to identify his automatic thoughts, such as “What bad thing am I expecting to happen?”, “And that is bad because...?”, “And what does that mean about me?”

Jack learned to analyse his thinking and identify the negative automatic thoughts that contributed to his anxiety and low mood. Once he was able to clearly see how his thoughts affected his mood, he was able to work with his therapist on challenging and restructuring his thinking patterns.

CORE MODULE 6

Working with unhelpful thinking

This module aims to give young people skills in changing unhelpful thinking that contributes to their depressed mood. It highlights the process of negative thinking as one-sided or exaggerated, and seeks to question such thinking and promote more realistic and less negative thinking patterns. By learning to notice and recognise their thoughts, young people can gain a greater sense of control over them.

Provide a rationale and encouragement

Once again, commence by revising the A-B-C model and the relationship between thoughts, feelings and behaviours, as explained in Core Module 4. Highlight the “thinking” part of this model – the point where it is possible to intervene to address low mood.



Discuss in more detail the opportunity to challenge and change their thinking or, as a first step, to create some distance between their thoughts and themselves. Emphasise that the process will allow a greater sense of control over internal experiences and help stop the downward spiral that leads into low mood and negative emotions.

Point out that the earlier thoughts are noticed and changed, the more likely it is the cascade of emotions can be interrupted.

Highlight that changing unhelpful thinking is a *process*, and that it may take some time for one’s emotions to “catch up”. A useful analogy is training for a sport, where skill acquisition is a process of practice, patience and dedication. Emphasise that it may be necessary to repeatedly challenge old styles of thinking with new ways of thinking, in order to break long-held habits of automatic negative thinking.

Consolidate the work on identifying unhelpful automatic thoughts

Revise the previous work, described in Core Module 5, on identifying the young person’s most common unhelpful automatic thoughts (or “frequent flyers”).

Identify common thinking errors

Revise, or complete, the previous work on identifying common unhelpful thinking styles, using Resource 10, “Common unhelpful thinking styles”. This should identify the “traps” that young people fall into with their thinking.

Challenge negative and unhelpful thinking

This step is a key component of the CBT program. Some of the strategies that can be used to challenge negative and unhelpful thinking are summarised in Box 7.

BOX 7

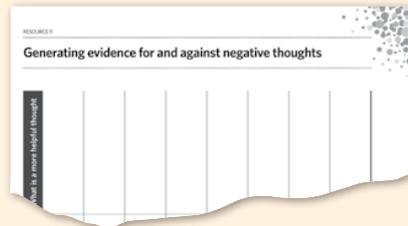
Strategies to challenge or modify negative and unhelpful thinking

Evaluate the evidence for and against a thought

See Resource 11, “Generating evidence for and against negative thoughts”. Start with the young person’s view or idea and get them to ask themselves:

- Is there any evidence that does not support this idea?
- Are there facts that I am ignoring or overlooking?
- What is the evidence in support of that thought? What is the evidence against it?
- If other people looked at that thought, what would they say about it?
- How do I know my thoughts and beliefs are true?
- What other explanations are there?
- Are there other ways of viewing the situation?
- How realistic are my thoughts, beliefs and expectations?
- Am I thinking like this because my mood is so low? Would I be thinking this way if I felt better?
- Do these thoughts always come up when I feel this way?
- How helpful is it to focus on this thought or idea?

RESOURCE 11



Generate alternative explanations for an event through Socratic questioning

Encourage young people to ask:

- What is bad about that event or situation?
- What do I see happening in this situation?
- What am I concluding about myself or others in this situation?
- And that is bad because...?
- And what does this say about...?
- Is there any other way to look at the situation?
- How else might someone see the situation?

Identify the advantages and disadvantages of keeping, compared with changing, a thought

Encourage young people to ask:

- Is it helpful for me to think this way?
- Is thinking this way helping me to achieve the things I want to achieve, do the things I want to do, enjoy the things I usually enjoy?
- How is this way of thinking working for me?
- Are there other ways of thinking that may not be as painful for me?

Challenge “all or nothing” thinking

Use the types of challenges outlined above to address “absolute” thinking, in which the young person judges events and actions as either a success or a total failure.

Reattribute the emotions

Review the evidence for and against the young person’s assigning all the responsibility to themselves for things that go wrong. Assist them to assign responsibility more appropriately by examining all the factors that contributed to the adverse experience.

Use a pie chart to allocate responsibility to each person, event or circumstance involved in the adverse experience.

Develop “thought control” techniques

There are a number of techniques young people can use to “control” unhelpful thinking.

“Thought stopping” involves stopping a train of thought once the young person detects an automatic thought. A distraction, such as focusing on breathing, can be helpful.

- Use imagery linked to thought stopping. For example, young people can be encouraged to imagine a fork in the road, where they can choose to continue ruminating over the negative thoughts or to do something else. Another method is to imagine a stop sign or a hand held up to signal them to stop.

Development of distraction and self-soothing skills can assist in managing automatic negative thoughts. This strategy is considered in more detail in Targeted Module 1: Distress Tolerance.

Use positive self-statements. This involves building up positive beliefs about the self that the young person is able to agree with.

Reframe the experience by exploring the meaning of a particular thought or belief, and then identifying a positive rather than negative approach (for example, anxiety symptoms can be reframed as excitement in some situations).

Set an amount of time (say 10 minutes) to wait before they react; or suggest they delay reacting until they have checked their thinking with someone they trust to see if it is logical and realistic.

Alternative ways of relating to unhelpful thoughts

With practice, young people will be able to choose not to accept negative thoughts that do not reflect actual events or facts. However this can take time and can be a challenging concept to communicate.

For example, a young person might think "I am not good at anything". If accepted as fact, it would not be surprising to feel quite low as a result. However, this thought is likely to occur more often when the person feels down. By looking at the evidence for and against this concept, it is possible to recognise it simply as a thought and not a reality.

Some young people may find that when they focus attention on their thinking patterns during CBT, this increased engagement with thoughts becomes overwhelming.

It might be helpful to suggest that the young person try the following:

- A deep breathing exercise. Focusing their attention on the breath may not only assist with relaxation, but also be a helpful distraction by focusing their attention on this task instead of thoughts.

- Focusing on bodily sensations. A progressive muscle relaxation exercise may have a similar distracting effect to deep breathing.
- Recognising thoughts as "just thoughts" rather than responding to them and engaging with them. Simply notice that the thoughts are occurring, rather than engaging with the content.

Create distance from thoughts (e.g. reducing rumination)

This can take time and be a challenging concept to communicate.

With practice, young people will be able to choose not to accept negative thoughts that do not reflect actual events or facts.

Metaphors can facilitate the process of distancing oneself from one's thoughts and reducing rumination. For example:

- The sky: It might be helpful to imagine the mind as the sky, where thoughts are like passing clouds that come and go.
- Leaves: Visualise leaves floating down the stream and put each thought on a leaf.
- Cars driving past the window: Imagine your thoughts are the cars, you can tune into the noise or let it be background noise.
- A train going through the station: Imagine that you can get on that train with thoughts and end up at the station of distress, or stay at the current station and watch the train of thoughts pass by.
- Noise on the radio: We can turn the volume down and let the noise just be in the background.
- People passing in the street: You can nod your head at them but don't have to stop and have a conversation.
- "Pop-ups" on the internet: You can choose to ignore them, you don't have to open them.

Set behavioural tasks

The clinician can role-play the young person while the young person role-plays the clinician. The clinician (as the young person) remains fixed in the negative automatic thought while the young person (as the clinician) suggests alternative thoughts.

Behavioural experiments can also be used to “reality test” the young person’s thinking. For example, set a homework task to test if the actual outcomes of a particular situation or challenge match the anticipated/predicted outcome.

Formulate realistic counter-thoughts or alternative ideas

Using any of the above techniques, the young person may have generated positive thoughts to “talk back to” their negative automatic thoughts. Some examples are listed in Resource 12, “Common negative automatic thoughts and alternative responses”. The clinician can help develop “coping cards” on which the most effective counter-thoughts are written down, or they can be entered on the young person’s phone.

RESOURCE 12

Negative thoughts	Alternative responses
I must not admit that I'm depressed.	Being honest about my situation might help - if I can recognise my depression and acknowledge how I feel, I can do something about it.
Others are getting me down.	It might be my negative thinking that is getting me down. I'll try to take a bit more responsibility for how I feel.
My life was perfect, why can't things go back to how they were?	Maybe I'm focusing too much on the past. I should try to focus on the present.

Practice

Resource 13, “A-B-C - identifying thoughts and alternative responses”, and Resource 14, “Thought disputation strategies”, can be used to help the young person to apply some of the techniques described above. Appropriate responses can be developed for each of the individual’s automatic negative thoughts.

RESOURCE 13

Situation	Beliefs	Consequences	Alternatives
Homework Task	Thought: I can't do this	Feeling: Frustrated	Alternative: I can try to do it in small steps
Meeting	Thought: I will be late	Feeling: Nervous	Alternative: I can leave 10 minutes early
Friend's problem	Thought: They are a mess	Feeling: Annoyed	Alternative: I can offer them support

RESOURCE 14

Evaluate the evidence for and against a thought	Identify the advantages and disadvantages of keeping, compared to changing, a thought
<p>Consider the negative thought or idea:</p> <ul style="list-style-type: none"> Is there any evidence that does not support this idea? Are there facts that I am ignoring or overlooking? What is the evidence in support of that thought? What is the evidence against it? 	<ul style="list-style-type: none"> Is it helpful for me to think this way? Is thinking this way helping me to achieve the things I want to achieve, do the things I want to do, enjoy the things I usually enjoy?

CASE EXAMPLE: HASSIM

24-year-old Hassim and his therapist had identified that Hassim held a fixed belief that he was unable to solve problems encountered in life. Consequently, Hassim would manage his problems by ignoring or avoiding them. When Hassim's therapist attempted to generate evidence for and against this belief, Hassim was unable to respond with any counter-examples.

Changing tack, Hassim's therapist encouraged discussion of the advantages and disadvantages of ignoring his problems. Though resistant at first, Hassim was able to identify that avoiding his problems left him feeling stuck, frustrated and unhappy. The therapist used this information to increase Hassim's motivation to utilise the problem solving skills they had begun discussing, while encouraging him to reappraise his problems as opportunities.

During subsequent sessions Hassim became angry, saying he had so many problems he didn't know where to begin. The therapist normalised Hassim's frustration, and together they developed comprehensive lists of his problems, workshoping possible solutions and choices he could make to improve his situation.

Core beliefs and unhelpful thinking

Core beliefs are rigid, strongly held and inflexible beliefs that influence how a person views themselves, the world and others. Core beliefs are developed throughout childhood and adolescence, and are based on a person's experiences, life events and circumstances. These beliefs are generally unquestioned and are perpetuated by a person's tendency to focus on information that supports a belief and ignore the evidence that contradicts it.

If the young person is convinced of the validity of a negative automatic thought, despite significant evidence to the contrary, the thought might reflect a core belief that will require more extensive intervention to change.

Identifying core beliefs

Sometimes core beliefs will emerge naturally through the thought monitoring process and particular themes will become apparent. It is important that the clinician looks out for patterns in the young person's thinking in the following areas:

- I am...(for example, I am worthless)
- Others are...(for example, people will abandon me)
- The world is...(for example, the world is a dangerous place)
- The future is...(for example, the future is hopeless)

At other times the clinician may need to take a more assertive approach to access the core beliefs of a young person. The "downward arrow technique" can be helpful. The first step is to identify one of the young person's automatic thoughts that likely stems from underlying negative core beliefs. The clinician then uses a process of questioning to get to the underlying core belief by asking questions such as "If that thought was true, what would be so upsetting to you? What would it mean about you?" This questioning continues until the core belief is discovered. For example:

Clinician: When reviewing your thought monitoring we can see that you had the thought "I'm ugly" and became distressed.

Young person: That's right.

Clinician: Let's explore together what it was about that thought that made you feel so bad. Let's assume that you are right, and you are ugly. What is so bad about that?

Young person: No one would want to hang around me.

Clinician: What does that mean for you?

Young person: I will never have any friends.

Clinician: And what does that mean for you?

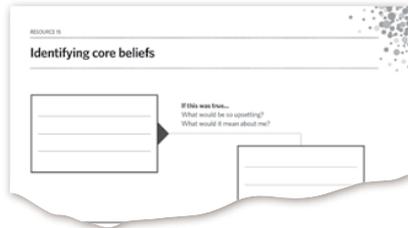
Young person: I'll be lonely and miserable for the rest of the rest of my life.

Clinician: And what does that say about you?

Young person: I am unlovable [core belief].

See also Resource 15, “Identifying core beliefs”.

RESOURCE 15



Modifying core beliefs

Once the negative core beliefs have been identified, it is best to prioritise and focus on the most problematic core beliefs. The clinician will help the young person to challenge and replace this negative core belief with something more positive and balanced. The alternative view exercise is one method that can be used to modify core beliefs.

The alternative view exercise

Provide a rationale for developing and using the alternative view to the young person’s problematic core beliefs:

As you have become aware over the last few sessions, when we are depressed, we tend to only focus on thoughts and activities or behaviours that confirm our depressed view of the world and ourselves (i.e. that fits in with our problematic beliefs). We don’t see that there are other ways of looking at the situation and of coping. This biased view will still be there even when we are not feeling depressed – it will be ready to bring us undone. So, when learning to manage depression we need to learn how to pay attention to all those other thoughts, activities and behaviours that are outside our problematic beliefs. We have just worked together to help you develop a more balanced view of yourself, one based on evidence rather than your negative bias. Now, we need to get you used to paying attention to this new belief.

Demonstrate how to use the “alternative view” during the session using the following ideas:

Over the next week, I would like you to write down the date and time when you observe evidence that supports your more balanced, alternative belief, and what you have observed. Make sure you are specific about the evidence you write down on this form. So, instead of writing down “someone was nice to me”, write down “so-and-so said ...” Try to fill in the “Alternative View” as soon as you observe the evidence – while it is fresh in your mind.

Warn the young person that there may be times when they play down the evidence or ignore it. Explain that this could be a function of their old belief trying to exert its power. Remind them that they are trying to break out of these unhelpful automatic thought patterns and their negative biases about the world. This breakthrough is facilitated by writing everything down, even if they think it is unimportant.

Discuss how they might practically complete the form during the day, so as to limit the attention others might direct towards them.

Further reading

Beck, J. (2005). *Cognitive Therapy for Challenging Problems: What to Do When the Basics Don't Work*. New York: The Guilford Press.

Stallard, P. (2005). *A Clinician's Guide To Think Good - Feel Good. Using CBT with Children and Young People*. West Sussex: John Wiley and Sons.

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CORE MODULE 7

Relapse prevention

Towards the end of the therapy, young people need to develop a plan to help them maintain the gains they have made in treatment. Anticipating the difficulties that might be encountered in everyday life is one step. The therapist should focus on the specific areas that the young person has struggled with in the past and on the problems or skills deficits that have been the focus of the therapy. Emphasise the skills and strengths that the young person has brought to therapy, or has developed over the course of treatment, that will assist them to overcome future difficulties.

Provide a rationale

Depression often recurs. The therapist and young person need to work together on strategies to prevent its recurrence, and to recognise symptoms of depression early so that the young person seeks help when needed.

Highlight the inevitability of “down days”

It is part of normal human experience to have challenging and difficult days, and sometimes feel “down”. To prepare for this inevitable experience, help the young person to anticipate possible negative automatic thoughts that might arise when they have a period of low mood (for example, “I’m back to square one”). It is useful to develop strategies in advance for responding to such situations and developing alternative thoughts, using some of the techniques in Core Module 6.

Recognise the early warning signs of depression

It is important for the young person to be alert to signs that their depression may be recurring, especially at high-risk times, such as major life events or periods of significant transitions. The early signs of depression will vary from person to person, but may include:

- signs of a lowering mood, such as poor sleep patterns, social withdrawal, less exercise, poor appetite and excessive use of alcohol and other drugs
- lack of participation in pleasurable, rewarding or meaningful events
- a perception of increased stress and conflict at home, school or work
- re-emergence of common negative automatic thoughts.

Highlight the skills and strengths to be used in dealing with early warning signs

Encourage the young person to recall the skills they have learnt during therapy. For example, identify the pleasurable events that improve their mood, and use the cognitive challenges that have proved to be helpful. Spelling out such strategies in a wellness plan can be helpful (see Resource 16).

RESOURCE 16

RESOURCE 16

Relapse prevention and wellness plan

This plan should highlight the things you identify as helpful to manage your depression.

What have I achieved (or done well at) during treatment?

Are there any areas for improvement?

Provide information on future services and treatment if required

Provide the young person with details about who they should contact if they feel that they are experiencing depression again. This might include the therapist’s own service, the young person’s GP or other services in the community.

CASE EXAMPLE: NIK



Nik, 17, had become increasingly worried and depressed during Year 12. He did not understand what he was experiencing, but thought he should talk to his family's GP, who referred him to the clinic.

With the help of a mood timeline (see page 13), Nik was able to identify his emotional experiences and plot them against events that had occurred in the past year. This helped him to understand the development and causes of his depression. Using this information, Nik and his therapist developed a relapse prevention plan to help him recognise the early, middle and late warning signs of depression.

Early warning signs included feelings of tension and stress, poor sleep and poor dietary behaviours. Middle warning signs included decreased sleep and decreased appetite, poor concentration, increased fatigue, withdrawing from friends, and noticing a reduction in enjoyment from usual activities. Late warning signs included persistent low and irritable mood, social withdrawal, weight loss, suicidal thoughts, indecisiveness, and feelings of hopelessness and worthlessness.

Nik and his therapist recorded specific strategies he had used before and could try to match to his early, middle and late warning signs. For example, strategies for early warning signs included mindfulness meditation, breathing exercises and monitoring his sleep quality. Strategies for middle warning signs included eating well, scheduling time to see his friends, and maintaining a regular sleep/wake cycle. Finally, strategies for late warning signs focused on challenging negative thoughts and re-engaging with professional support.

At the end of this process, Nik had a written plan of what strategies to use and who to contact if he needed support in the future.



TARGETED MODULES



TARGETED MODULE 1

Distress tolerance

Some young people with depression experience very intense emotional states that they find overwhelming and distressing. Such states are common in people with borderline personality disorder, and specific techniques have been developed for managing these experiences using dialectical behaviour therapy (DBT) by Marsha Linehan. Similar techniques can be used in young people with depression who are experiencing high levels of distress that is associated with intense or difficult emotions.

Factors that make it hard for young people to deal with difficult emotional experiences might include a limited understanding of their emotions, or responding to these experiences in ways that increase rather than reduce their distress. A detailed understanding of the young person's experience is necessary to help them change how they manage overwhelming emotions.

Discussing this issue with a young person might itself bring on difficult emotions, so it is important to plan how to deal with this situation if it arises. Ask young people to state if they feel themselves becoming distressed, and then either move to a different topic or take a break. The young person might already have found some helpful techniques to deal with difficult emotions, such as controlled breathing.

Assessment

A recent experience of difficult emotions can be used as the basis for assessment. Ask the young person to recall a typical experience and map it in diagrammatic form. Resource 7, "Chain analysis template", can be used, or you may prefer to create your own structure.

In the assessment, try to establish:

- the trigger – what was the situation?
- the emotions experienced
- the young person's appraisal of the emotions – for example, did it make them afraid, and why? What did the emotion mean to them?
- what behaviours were used to help deal with the emotional experience
- whether these behaviours had any effect on their emotions
- whether there were other effects of their behaviour, including on other people.

Discussing emotions

Ask the young person for their ideas about the issues below, and reflect on how they relate to the experiences identified in the assessment.

- Emotions have a purpose. They signal us to act in a particular way. For example a feeling of fear is a signal to protect oneself in some way. Emotions also give a signal to other people about how they should act towards us. For example, if a person appears sad then other people know that it would be helpful to provide some sort of care.
- The way a person judges emotions can make the emotions more intense. If an emotion causes a person to feel very upset or angry at themselves, the risk is that the person will become even more upset. This type of response is called a "secondary emotion".
- Emotions are often temporary. In the midst of an intense emotional experience it can be easy to assume that it will simply get worse, and that it cannot be stopped. In fact, it is likely to lessen and then stop, and be part of the past rather than the present or future.

Treatment planning

Emphasise that as treatment continues, the young person can expect to have overwhelming emotional experiences less often. Making them less intense and difficult is a starting point.

Strategies need to be individualised, and guided by the intensity of the distress.

Specific strategies

Reducing exposure to trigger situations

Encourage the young person to try to avoid trigger situations. This may not always be possible, but can be helpful when first starting to deal with overwhelming emotions.

Identifying and not judging the emotion

Have the young person try to name the emotion when it occurs, and not judge themselves negatively for having had it.

This is an emotion your young person probably would like to feel less, and being able to name it is an important starting point for working on it in therapy.

Seeking support

The young person should try to seek support from someone who can help, at least a little.

It is important for the young person to check with someone whether they would feel OK about supporting them at times like this. Something that is likely to make this possible is for the young person to let them know the best way in which they can be helpful.

Ways that other people might be able to help include:

- just listening to what the young person is saying
- distracting them from what is distressing by talking about other general stuff
- trying to help them sort out the problem that made them feel so upset.

People who young people can talk to include their case managers and crisis teams.

Challenging unhelpful thinking

If the young person's thoughts are falling into a negative spiral, it may help to try to challenge these thoughts.

The skills learnt from Core Module 6 can be used in this situation.

A specific thought the young person can use to combat feelings of helplessness is to remind themselves that, as awful as things may be, they have managed to get through situations like this before, and their emotions will slowly settle down.

Changing focus

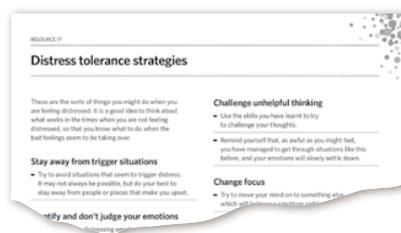
Another potential strategy to help settle emotions is for the young person to try to move their minds on to something else. The range of strategies for changing focus include:

- self-soothing: doing something nice for oneself (e.g. listening to music)
- physical exercise
- relaxation (e.g. controlled breathing, progressive muscle relaxation)
- grounding exercises: these direct focus to the external, rather than internal, world.

It may be that a significant other can support the young person with these strategies.

As with all the skills discussed in this manual, it is essential to review and consolidate the work carried out over the course of treatment. Resource 17, "Distress tolerance strategies", provides the young person with an outline of these strategies that they, and their family or other supports, can refer to when distress becomes evident.

RESOURCE 17



CASE EXAMPLE: MELINDA



Melinda, 22, presented with major depressive disorder and post-traumatic stress disorder on the background of sexual abuse between the ages of 8 and 12 years. She experienced panic attacks when she encountered situations that triggered memories of the sexual abuse and sometimes cut her thighs to numb her emotions.

When Melinda and her therapist explored her reaction to the panic attacks, they discovered that Melinda spent a lot of time struggling with the emotion. She would berate herself for still experiencing anxiety after this period of time, and so would feel increasingly angry. She would desperately try to distract herself to avoid feeling distressed, but this regularly failed and she would again experience frustration that she could not control the emotion.

Melinda and her therapist identified this anger as a secondary emotion that seemed to prolong the distress she was experiencing. Instead of fighting with the emotion and trying to push it away, Melinda's therapist taught her mindfulness strategies that involved "opening up" to the emotion instead of judging it, and learning to accept it. Although Melinda continued to experience panic symptoms, she noted that the period of anxiety did not last as long when she used this strategy, and it did not feel as distressing.

CASE EXAMPLE: JASMINE



Jasmine, aged 19, had severe major depressive disorder with a wide range of symptoms, including extreme emotions of sadness, anger and frustration. Early in her therapy, Jasmine disclosed that she had been cutting herself on her lower arms. The therapist and Jasmine used a CBT approach to help her identify these emotions and the situations that triggered them.

The therapist helped Jasmine explore the functions of deliberate self-harm: she said she was much calmer after cutting, as it distracted her from the difficult emotions she was feeling. The therapist supported Jasmine in trialling other strategies that helped her to manage difficult emotions, including earlier identification of their onset and activities to prevent them from escalating.

Further reading

Linehan, M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: The Guilford Press.

McKay, M., Wood J.C., & Brantley, J. (2007). *The Dialectical Behaviour Therapy Skills Workbook*. Oakland: New Harbinger Publications.

Miller, A. L., Rathus, J. H., & Linehan, M. (2007). *Dialectical Behavior Therapy with Suicidal Adolescents*. New York: The Guilford Press.

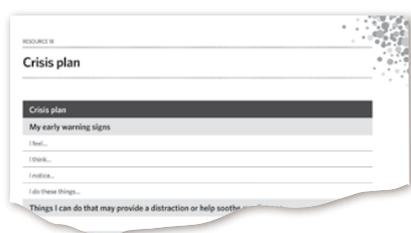
TARGETED MODULE 2

Safety planning

Creating a safety plan

A safety plan aims to help a young person manage distressing and painful emotions earlier rather than later, and prevent an escalation in their thoughts of suicide and self-harm. Developing an effective safety plan depends on the clinician collaborating with the young person to identify warning signs of suicidal or self-harming behaviour and develop a hierarchy of coping strategies and supports that can be used when a crisis arises. See Resource 18, “Crisis Plan”.

RESOURCE 18



Young people with depression who present with some suicidal ideation, but without any particular plan or intent, may still benefit from self-soothing strategies. Those who present with higher suicidal risk, identified in their risk assessment, will need a more detailed plan that may include restricting access to likely means of suicide and providing after-hours support.

Provide a rationale

Explain that a safety or crisis plan:

- aims to prevent the escalation of very distressing and painful emotions
- is designed to ensure the young person’s safety in a time of crisis
- can explain how to prevent a future suicidal crisis
- illustrates the seriousness of suicidal behaviour, and that it is worthy of attention
- may help the young person develop an increased sense of control over their emotions and resulting behaviour
- highlights that suicidal behaviour is manageable.

If a safety plan cannot be negotiated, it is likely that a higher level of care will be needed and consultation with senior clinicians is essential. The young person’s family or other responsible carers should be consulted if possible.

Identify warning signs and vulnerability factors

Ask the young person to identify potential early warning signs, such as thoughts, behaviours and emotions, for suicidal behaviours. Factors that may increase their vulnerability to developing suicidal thoughts and behaviours include sleep difficulties, substance use and specific social situations. The clinician can elicit this information by using a chain analysis of a specific situation, as explained in Core Module 4. This may be particularly helpful if the young person feels that the intense distress or suicidal behaviours “just happened”, and has trouble identifying warning signs and vulnerability factors that preceded the crisis.

Develop coping strategies

Coping strategies can help prevent emotions from escalating and encourage an appropriate response when a suicidal crisis arises. Coping strategies should be used in a stepwise, hierarchical fashion, beginning with lower-intensity strategies and progressing to higher-intensity strategies as risks and needs dictate. Reinforce to the young person that coping strategies are best employed early in a chain of events, maintaining a focus on the A-B-C model and chain analysis.

The clinician and young person should firstly identify “internal” strategies, ones that do not need assistance from others. These are generally of lower intensity and include distraction or techniques to improve mood, for example, engaging in pleasant events (as explained in Core Module 3) or using tools to manage intense and difficult emotions (see Targeted Module 1).

If internal strategies are ineffective, external strategies can be used. External strategies require assistance from other people. Planning usually commences with identifying people and places that can provide distractions or improve mood, for example, talking to a friend. The next step may be to contact people from the young person’s support system, such as family members, who can provide help with the current crisis. Finally, provide contact details for professionals who can provide more directive, higher-intensity support, such as the young person’s clinician, after-hours support services, suicide helplines and local emergency services.

Identify potential obstacles

Discuss potential barriers that may be encountered when trying to employ each coping strategy – for example, if friends or members of the young person’s support network are unavailable – and how to respond.

Involve others in the safety plan

Young people should be encouraged to allow people in their immediate family or social network to be involved in their safety plan. While it is important to respect confidentiality, a significant concern about high suicide risk is usually sufficient grounds for breaching it. Ideally, a family member or other responsible adult should be included in developing the safety plan, or otherwise provided with the safety plan once it has been formulated.

Make the environment safe (for those with clear intent and a plan)

If the young person has well-developed suicidal intent (a clear plan and the means) then a means-restriction exercise can be carried out during the session. This involves a discussion about the availability of potentially lethal means (such as paracetamol, other medications, sharp objects or rope), and asking the young person to remove these items from their environment.

Respond to high risk

If the risk is thought to be very high, the therapist should consult senior members of the clinical team. They may need to consider inpatient admission or intensive after-hours follow-up. Ideally, parents or other responsible adults should be involved in the process.

Integrate the safety plan into ongoing therapy

Once a safety plan has been developed, it should be reviewed during subsequent therapy, particularly if it has been necessary to use the plan. Reviewing the plan provides an opportunity to identify coping strategies that might be ineffective, or to discuss barriers to their use. Strategies in the plan can be updated as the young person learns and develops new coping skills, such as relaxation techniques and problem-solving skills.

CASE EXAMPLE: LEILANI



Leilani, 23, disclosed to her therapist that her thoughts about suicide had intensified over the past week, and she was having strong thoughts of taking an overdose of all of the medication she could find in the house. After working through a safety plan with Leilani, the therapist suggested that together they should inform Leilani’s mother about her recent thoughts. Although reluctant at first, Leilani eventually agreed, and her mother was brought into the session.

Topics covered with her mother included the warning signs of a deterioration in Leilani’s mood, how her mother could support her, an agreement from her mother to hide the medication in the house and an agreement to avoid topics that would typically lead to conflict within the family. Leilani’s mother was also given a copy of Leilani’s safety plan, which included the crisis numbers that she could contact if she was concerned.

Further reading

Brent, D. A., Poling, K. D., & Goldstein, T. R. (2011). *Treating Depressed and Suicidal Adolescents: A Clinician’s Guide*. New York: The Guilford Press.

TARGETED MODULE 3

Self-care strategies

There is a well-described link between risky health behaviours, such as poor diet and low physical activity, and depression. The impact of risky behaviours on physical health tends to be overlooked during psychological interventions with young people. Basic steps such as getting enough sleep, eating the right food, and getting some exercise can have a significant impact on cognitive and emotional functioning.

Sleep, diet and exercise are often addressed early in treatment, but should be revisited during discussions about relapse prevention.

Sleep

Poor sleep is itself a symptom of depression, but also exacerbates many of the other symptoms: for example, it can lead to fatigue, irritability, poor concentration, physical aches and pains and a further lowering of mood (see Clark and Harvey¹³ for a comprehensive review).

“Poor sleep” may involve difficulty getting to sleep, poor quality of sleep, regular waking during the night, waking early and being unable to fall back to sleep, or sleeping too much. Young people with depression often have a “reverse” sleep cycle, in which they are awake all night but then sleep during the day.

The first task of the clinician is to explore a young person’s sleep habits and identify any problem areas, before providing information about the importance of sleep and the causes of poor sleep (see Box 8, over the page).



BOX 8

Discussing sleep and mood with young people

Role and function of sleep

Sleep is essential to humans, just like air, water and food. Sleep has a restorative purpose, both psychologically and physiologically. It is important for general physical health, restoring energy, repairing injuries and illness, growth, psychological wellbeing, mood, concentration, memory, work performance and getting along with others.

Effects of lack of sleep

A lack of sleep or poor quality sleep can cause multiple problems, including: poor attention, concentration and memory; irritability and other mood disturbances; impaired judgement and reaction time; and poor physical coordination.

What is normal?

People vary in their need for sleep. On average, adults need 7-8.5 hours per night, but some people function well with 4-5 hours and others require 9-10 hours. Good sleepers typically take less than 30 minutes to fall asleep and will wake up once or twice during the night. It is unrealistic to expect to fall asleep immediately after getting into bed or to never wake up during the night. Also, *everyone* has an occasional night when it takes them a long time to get to sleep, perhaps triggered by a stressful event, but this will usually pass after a night or two.

Possible contributors to poor sleep

Alcohol, caffeine, nicotine, pain, stressful life events, habits such as daytime napping, and dependence on sleeping medications can interfere with sleep.

Management of insomnia

Many medications are available to treat insomnia, but these are usually only effective in the short-term. For long-term sleep management, young people should be educated about strategies such as sleep hygiene, cognitive therapy and reducing stress levels.

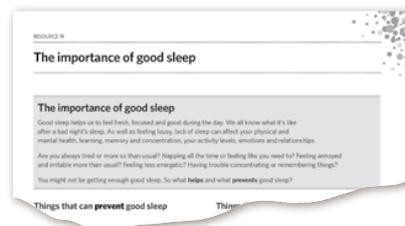
Insomnia and the role of thinking

Many factors can initiate problems with sleep, but quite different factors are often implicated in sustaining the difficulties. For example, negative thoughts about getting to sleep, the quality of sleep and the consequences of poor sleep can worsen the risk of having poor sleep. The negative thoughts become self-fulfilling prophecies and interfere with returning to regular sleep patterns. A sleep diary to monitor sleep and highlight any negative thoughts while trying to get to sleep, or when waking in the night, can be helpful. Once identified, these issues can be addressed through thought-challenging strategies.

If the young person seems ambivalent about addressing their sleep problems after receiving the information in Box 8, then it is possible to use motivational interviewing strategies to encourage change.

Resource 19, "The importance of good sleep", provides information and suggestions about sleep. Remember that the young person may have been struggling with a disrupted sleep pattern for a long time, so changes should be made in small, achievable steps.

RESOURCE 19



Diet

Poor diet is a risk factor for the development of depression and anxiety in adolescents and adults.¹⁴ Young people should be encouraged to establish regular eating habits and to pay more attention to the quality of their diet.¹⁵ They should be able to recognise times when they are eating too much or too little, or eating poor quality foods, and realise that this can have a negative impact on health, self-esteem and mood. Resource 20, “The importance of healthy eating”, provides useful information.

RESOURCE 20



Exercise

Increased physical activity can help to alleviate depressed mood.¹⁶ Many depressed young people become sedentary, perhaps spending much of their time in front of computer screens, which tends to further lower their mood.¹⁷ Interventions to increase levels of physical activity can improve mood by interrupting or distracting the person from dysfunctional or negative thoughts. The physiological effects of strenuous exercise can also have an effect on mood.

Weekly monitoring of physical activity within psychotherapy sessions is effective in reducing depressive symptoms. A key component for success appears to be encouragement and assistance in engaging in regular physical activity, accompanied by assessment and routine monitoring of daily levels of exercise.

Young people who have been very inactive should start with small amounts of exercise and increase them gradually towards realistic individual goals: remember that any activity is better than none.

Resource 21, “The importance of being active”, provides useful supportive information and ideas about how to increase activity levels. Resource 6,

“List of enjoyable activities”, may be helpful in generating some other ideas. Resource 7, “Activity schedule”, can assist in planning activity and monitoring the beneficial effects on thoughts and feelings.

RESOURCE 21



Further reading

Biddle, S. J., & Asare, M. (2011). Physical activity and mental health in children and adolescents: a review of reviews. *British Journal of Sports Medicine*, 45(11), 886-895.

Jacka, F. N., Kremer, P. J., Leslie, E. R., Berk, M., Patton, G. C., Toumbourou, J. W., & Williams, J. W. (2010). Associations between diet quality and depressed mood in adolescents: results from the Australian Healthy Neighbourhoods Study. *Australian and New Zealand Journal of Psychiatry*, 44(5), 435-442.

TARGETED MODULE 4

Alcohol and other drug use

Many young people with depression also have difficulties with the use of alcohol and other drugs, and these issues should be addressed in treatment.

One hypothesis is that depression leads to the development of substance use disorders, and substance use can be viewed as an attempt to alleviate psychological distress (“self-medication”). Alternatively, it is possible that repeated intoxication and withdrawal from a drug may lead to the development of depression. Mental health problems and substance use may co-occur because they have common underlying biological, psychological, social and environmental risk factors.¹⁸ Some young people will be able to clearly identify one problem as preceding the other, but many cannot.

This module describes some basic strategies to use with young people who have depression and accompanying problems with alcohol and other drug use. If there is a significant substance use problem, such as a long history of dependence, then more intensive treatments will be needed, perhaps from a specialist drug and alcohol service.

Assessment and formulation

The initial assessment should have included a discussion of substance use, including the type, frequency, duration and intensity of use. This information contributes to the formulation, and also provides a baseline against which progress can be monitored. An assessment of a young person’s readiness to change their substance use should also be performed, to determine the appropriate focus of treatment.

Psychoeducation

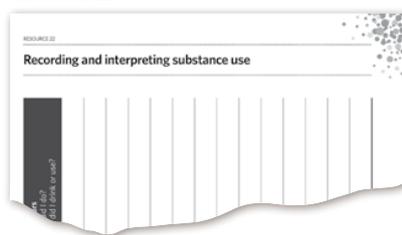
Psychoeducation should cover the short- and long-term effects of substance use on the young person’s physical and psychological health. Information about the population “norms” of usage provide a benchmark for assessing the young person’s use. Resources such as the Australian Drug Foundation website (www.druginfo.adf.org.au) can assist the discussion. Psychoeducation should emphasise the impact of substance use on depression.

Monitoring

Work with young people on keeping a written record of their substance use. It should include the situational trigger for substance use, the emotional state and thought content at the time and details of the substance use itself. A written record helps to accurately identify patterns of use and provides baseline data for later comparison and treatment evaluation.

Evident triggers for substance use should be discussed, including a review of links with their symptoms of depression. Resource 22, “Recording and interpreting substance use”, can assist.

RESOURCE 22



Motivational interviewing

Young people may be ambivalent about change and not ready to work on reducing their substance use. Motivational interviewing techniques are specifically tailored to the person’s stage of readiness for change, and are designed to increase their readiness to change.¹⁹ The “stages of change” model describes five stages of readiness: pre-contemplation, contemplation, preparation, action and maintenance.

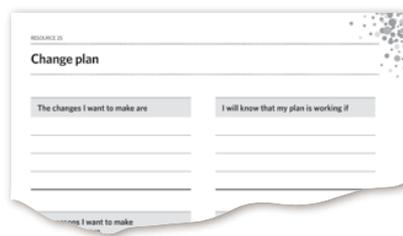
In the earlier stages of pre-contemplation and contemplation, phase 1 of motivational interviewing aims to elicit indications that the young person is willing and able to change. Techniques include asking open questions, listening reflectively, affirming and summarising. Eliciting “change talk” is a key component, using the strategies summarised in Box 9.

Phase 2 of motivational interviewing consolidates the issues raised in phase 1 and develops a plan for change. The key components of phase 2 are as follows.

- *Recapitulation* involves summarising the gains made during phase 1.
- *Asking key questions* involves posing open-ended questions about what the young person sees as the next step, now that they feel willing and able to change their substance use.

- *Information and advice* should be provided only when the young person invites it, such as by asking the therapist or by agreeing that it would be helpful. It may include describing the drug and alcohol services that are available.
- *Negotiating a plan and eliciting commitment* usually involves goal-setting, brainstorming possible options for obtaining these goals, deciding on a plan, and exploring commitment to enacting this plan. Encourage realistic goals and explore the advantages and disadvantages of reducing substance use rather than aiming for abstinence. Encourage young people to realistically consider potential obstacles to achieving their goal, and plan for how these might be managed throughout treatment. Resource 25, "Change plan" provides a template.

RESOURCE 25



Eliciting "change talk" in motivational interviewing

BOX 9

Ask evocative questions. Use Resource 23, "Decisional balance worksheet", to explore the person's views about the pros and cons of change, compared to the pros and cons of maintaining the status quo.

Use an "importance ruler". Resource 24, "Importance and confidence rulers" can be used to gauge the importance of change and the confidence to change. It can be used to generate questions such as, "What would need to happen for your importance score to move up from X to Y? What stops you moving up from X to Y?"

Elaboration. Ask the person to clarify or further describe their views on how they might change.

Present extremes of possible consequences. This can be helpful if the person has little apparent desire to change, as it challenges them to think of a worst-case scenario. For example, "What concerns you the most? What are your fears about what might happen if you don't make a change?"

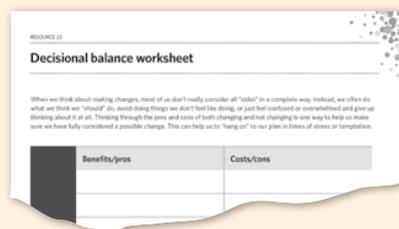
Look back. Encourage the person to consider life before their problematic substance use, to create a contrast. "What was life like before you started using? When was life last enjoyable/not out of control?"

Look forward. This strategy elicits goals, hopes and dreams and helps develop disparity between the current situation and what they foresee. "In 3/6/12 months, what do you hope life will be like? What would you like to be doing? What is in the way of these hopes?"

Explore goals. Similar to looking forward, this step explores what goals or values the person holds most dear, looking for inconsistencies with substance use.

High scores on the importance and confidence rulers are good indications that a person may be ready to move to the next phase.

RESOURCE 23



RESOURCE 24



Harm minimisation: practical strategies

Harm minimisation is a practical approach to drug-related harm that accepts the reality that drug use does occur in our community. The priority is to keep people alive and reduce the harm while involved in substance use. Abstinence is one of the best harm minimisation strategies, but additional strategies are needed for people who are not yet ready, willing or able to cease their use.

It is important to try to find strategies that are relevant, achievable and beneficial from the young person's point of view. Success in using one harm minimisation strategy may also build the young person's confidence and motivation to attempt further change.

Strategies should be raised as suggestions (e.g. "Some people find it helps to..."), encouraging

the young person to discuss the pros and cons of each option. Be curious about their perception of barriers or benefits, and try to assess their level of confidence in attempting a strategy.

Harm can be reduced in terms of:

- acquisition – how the person obtains the drug or the money to purchase it
- administration – how the person puts the drug into their body
- intoxication – the effect of the drug on the body
- intoxicated behaviours – what the person does while using the drug
- crash/withdrawal – what the person does while recovering from the drug use.

Some harm minimisation strategies are listed in Box 10.

BOX 10

Substance use harm minimisation strategies

Avoid using substances alone. Have a "minder" present in case of overdose, allergic reactions or "bad trips".

Use in environments where emergency support can be easily accessed if required, and learn first aid (especially CPR) in order to assist others if necessary.

Avoid combining substances. The effects of mixing substances are unpredictable and potentially dangerous.

Use safer methods for administering the substance, for example orally instead of IV.

Buy from a known source and be aware of the purity of the substance and the cutting agents used.

Have a "taste test" first, especially if the drugs have been obtained from new sources or tolerance has dropped.

Be cautious of taking drugs when you are angry, anxious, depressed or vulnerable: alcohol and other drugs can negatively affect the way you feel, think and behave.

Avoid using substances when you are driving a vehicle or involved in any other potentially dangerous activities. Substance use reduces concentration, slows reflexes and impairs judgement and perception.

TARGETED MODULE 5

Interpersonal skills

Depression can have a significant impact on social relationships. Friends and peers becoming increasingly important as young people individuate from parents, so the social withdrawal that often accompanies depression can have a marked effect on important aspects of development. Re-engaging the young person with social activities is an important component of treatment (see Core Module 3), but some young people may not have the interpersonal skills to successfully engage with this part of the therapy.

The first part of this module highlights how young people can improve their general communication skills. The second part details “micro-skills” for young people with more pronounced social difficulties. Such skills include maintaining appropriate eye contact, using the right tone and volume of voice and knowing how to greet someone.

The third part is for young people who have social anxiety that inhibits their social interactions. Social anxiety is a common comorbid problem for depressed youth, often exacerbating their depression and further entrenching their social isolation.

Communication skills

Provide a rationale

Good communication skills are important for improving and maintaining relationships. Stating one’s feelings to other people can encourage other people to change their behaviour. This feedback enables others to increase the behaviours that make the young person feel good, and reduce the behaviours that cause them distress.

Explore barriers to good communication

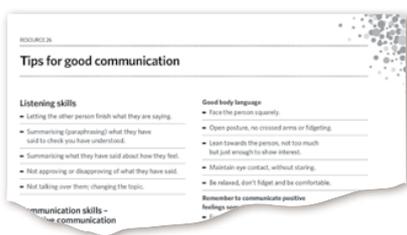
Discuss the issues that commonly interfere with good communication, for example:

- **Cognitive distortions:** For example, “I am absolutely right and they are absolutely wrong” (black-and-white thinking); “If I give in, it will show I am weak” (jumping to conclusions); “I can’t stand it if someone believes in something I think is wrong” (catastrophising). Use skills from Core Module 6 to challenge these distortions.
- **Mind reading:** Explain that other people cannot necessarily know what one is thinking or feeling, unless it is clearly stated. For example, the young person may expect someone to know that they are doing something annoying, even though they have not told them.
- **Labelling:** Using a label (“you are a liar”, “you are a spoilt brat”) can make people feel under attack, and provoke them into retaliating. Such labels alienate people because they criticise the person rather than their behaviour.
- **Criticism, put-downs and aggressive communication:** This type of communication makes the other person feel threatened or under attack, often provoking an attack in return and perhaps an angry confrontation.
- **Avoiding communication:** Communication problems often arise because people do not say how they feel, what they think or what they want. This leads to tension in relationships, and sometimes to angry outbursts. Emphasise that the young person has a right to present a point of view, while at the same time recognising that other viewpoints exist.

Tips for good (assertive) communication

For a summary of this section to use with young people, see Resource 26, “Tips for good communication”.

RESOURCE 26



Use whole messages

These allow people to express how they *think* and *feel*, while at the same time stating what they want. The process has four parts, incorporating the A-B-C module described in Core Module 4.

- State the situation (A - activating event) or describe what happened (e.g. "The other day when I realised I didn't get a text message about everyone getting together at the park").
- State your beliefs (B) or opinion, thoughts or interpretation of what happened (e.g. "I thought it was because you didn't want me to come").
- State the way it made you feel (C - the consequences) (e.g. "This made me feel upset").
- State what you want to happen in this situation should it arise again (e.g. "Can you put me in your group text message list so you don't forget again?").

Use "I" statements

While "you" statements blame or accuse the other person and can put them on the defensive, "I" statements have the opposite effect: for example, "I felt upset that you didn't text message me", rather than "You have let me down again".

Do it now

If people avoid communicating their thoughts, feelings and wants, then it increases the likelihood that they will feel angry, resentful and frustrated. In most cases it is better to communicate one's concerns sooner rather than later.

Learn how to compromise

An inability to compromise can cause difficulties in relationships. It may be useful to role-play situations relevant to the young person in which compromise appears to be necessary.

CASE EXAMPLE: NEENA

Neena, aged 23, referred herself to the clinic as she had a long-standing difficulty making friends and felt anxious in company and when talking to her colleagues at work. Over the past year she felt increasingly isolated, frustrated and depressed. In therapy she struggled to initiate conversation, spoke softly and had poor eye contact. Over time it emerged that Neena was afraid to express herself for fear of "sounding stupid".

With support, Neena was able to identify the physical sensations that accompanied this difficulty and practise some simple relaxation strategies. She also engaged in role-plays in sessions, which allowed her to receive supportive feedback and learn to express herself with greater ease.

CASE EXAMPLE: AIMEE

After five therapy sessions Aimee, 18, reported little improvement in her low mood and anger outbursts. After repeated encouragement from her therapist, in week 6 she attended with a completed mood monitoring sheet, which she had previously been reluctant to complete. The monitoring made it clear that her periods of low mood and anger closely corresponded to bitter arguments with her mother.

A subsequent session with Aimee and her mother uncovered a range of unhelpful patterns of communication including frequent sarcastic, critical and negative comments, and failures to resolve issues at hand. At the next session the therapist reflected this back to Aimee. Whilst defensive at first, Aimee agreed that she would try to reduce her use of sarcasm when communicating with her mother.

The therapist was pleasantly surprised when Aimee attended the following week to report a reduction in her affective instability, and that things with her mother had slightly improved. On reflection, Aimee attributed this change to fewer arguments at home, mostly as a result of her reducing her use of sarcasm. Subsequent sessions addressed further improvements in her communication skills such as the use of "I" statements and active listening.

Develop assertiveness

Assertiveness is a skill that not everyone has, but it can be learnt. It can be developed in young people who tend to be passive in their communication style to help them get their needs met, improve relationships and build confidence. Assertiveness is also important when working with young people with anger issues or aggressive communication. For these young people, assertiveness will make it more likely that their feelings are being listened to and, again, will greatly improve relationships.

Assertiveness skills take time to master, but they can provide an alternative to acting aggressively or passively. From an anger management perspective, the best way to react to a situation or a person who may have violated one's rights is to respond assertively. Just as anger is a learned behaviour, so too can assertiveness be learned as an alternative response. Some examples of the differences between aggressive and assertive statements are listed in Box 11.

Consider working through some role-plays in session, for example dealing with a rude or unhelpful sales assistant, dealing with a friend who does not respect the young person's privacy, or dealing with parents when they are trying to set rules or boundaries that the young person does not agree with.

Provide a rationale

Assertiveness is an important communication skill that involves the ability to express your thoughts and feelings without violating the rights of others. Assertiveness can reduce feelings of depression and anxiety by improving your ability to speak openly about your feelings in a way that others will listen. Assertiveness is also an important skill in dealing with anger and aggression and can significantly improve relationships.

Develop communication styles

Explain the following communication styles to the young person. Get them to identify which style most fits them.

Assertive

Assertiveness is the ability to communicate opinions, thoughts, needs and feelings in a direct, honest and appropriate way. It is standing up for your rights in a way that respects the rights of others.

The advantage of being assertive is that you can have control over your own life and it is less likely people will take advantage of you. Assertiveness can help improve confidence and can assist us in achieving our goals.

Aggressive versus assertive statements

BOX 11

Aggressive statements

You're an idiot
 Don't f***** shout at me
 You don't care about me
 You never listen to me

Assertive statements

I don't agree with what you're saying
 I don't like it when you shout
 I would really like it if you could spend more time with me
 Please listen to what I'm saying

Aggression

Loud and bossy
 Only care for self
 Feel threatened
 Lack communication skills
 React instantly
 Won't accept 'no'
 Hurts others

Assertion

Clear and direct
 Care for self and others
 Confident about self
 Skilled communicator
 Thoughtful
 Can say 'no' and accept 'no'
 Does not hurt self or others

Aggressive

Aggression is standing up for your rights in a way that is pushy and inappropriate. It offends the rights or feelings of others, because it is a “win at all costs” attitude. Aggression can help achieve goals but at a cost: after being aggressive a person often feels upset, angry or guilty. Aggression also affects our relationships: people we are aggressive toward often feel threatened, frustrated, disrespected or humiliated by our behaviour.

Passive

Passive communication involves putting the needs of others before your own at an unreasonable cost to you. It involves not standing up for your rights, not expressing your thoughts and feelings, and going with other people’s decisions even when they do not meet your needs. Passive communication can leave you feeling hurt, resentful, angry and disempowered.

Indirect

Indirect communication is attempting to express your thoughts and feelings (usually negative) in a variety of indirect ways, for example by not talking about the problem and using body language, silence, avoidance, sarcasm or “back-stabbing” instead. It is a common but not very constructive way to try to deal with strong negative emotions. Indirect aggression can be refusing to look at or speak to someone you are upset with, or running out and slamming a door in the middle of a conversation. “Gossip” is a form of indirect aggression because you tell others about your annoyance rather than sort it out with the person concerned.

Indirect communication tries to achieve goals by influencing, pressuring or manipulating people’s responses, but it does little to resolve problems and you can be left feeling frustrated, misunderstood or guilty. The people with whom we use it often feel angry, manipulated, confused or frustrated by our behaviour.

Exercise

Provide the young person with an opportunity to role-play passive, assertive and aggressive responses to particular situations. Examples of situations are presented below.

- Your mum asks you to help with the housework but you have a big assignment due tomorrow.
- You are trying to sleep but there is a loud party going on next door.
- You have recently broken up with your girlfriend/boyfriend after they cheated on you. You notice that your best friend continues to have contact with your girlfriend/boyfriend on Facebook and they have organised to catch-up.
- Your new housemate is not contributing to the housework.

Goal-setting

It is useful to review real-world examples in sessions and to set goals with the young person around assertive behaviour. Ask the young person to recall situations where they reacted in a passive or aggressive way. Help the young person explore ways in which they could have responded more assertively. Where appropriate, set clear goals between sessions for the young person to practise assertive behaviour.

Micro-skills training

Some young people have pronounced, long-standing deficits in social skills. Learning the micro-skills such as those described in Box 12 might not make the young person immediately feel more natural or comfortable, but, like learning any new skill, they should feel more confident over time.

Developing micro-skills

BOX 12

Make appropriate eye contact

Good eye contact lets the other person know that you are listening and interested in what they are saying. It is best not to stare, but to have “micro-breaks” in eye contact. If direct eye contact is difficult, suggest choosing a spot directly between or slightly above the eyes of the other person.

Greetings

Smile when greeting someone, and respond to their greeting by returning it. Shaking hands is sometimes, but not always, appropriate. Ask the other person, “How are you?”

Right tone and volume of voice

Do not speak too quietly or too loudly, and ensure that the tone of voice communicates interest and a lack of criticism. It can be useful to role-play different volumes and tones of voice with the young person, so they can experience what it feels like.

Personal space

Do not stand too close or too far away from the person with whom you are talking. The space will depend on the nature of the relationship and interaction.

Boundaries

The boundaries in relationships can be difficult to comprehend. Emphasise the need to set limits to the closeness of relationships with other people. However, boundaries may change over time, others may have their own boundaries, and different kinds of behaviours are appropriate for different types of relationships.

Starting conversation

Help to prepare the young person for starting conversations by suggesting that they think about the things that they know well or are interested in (e.g. movies they have seen, music they like). Discuss how joining with a group or person may require that they hover briefly on the edges until they know what is being talked about, and then make eye contact with a person to show their interest in what is being said. They should wait for a natural break in the conversation before they speak.

Continuing conversations

Suggest that the young person practise having conversations while doing an activity with someone, such as walking, playing sport or shopping. This provides a common topic of conversation and a focus in addition to the conversation itself.

Open-ended questions

Point out the usefulness of open-ended questions that have beginning words like “how”, “what”, “where”, “who”. When young people are asked an open-ended question, they could give a specific answer and then ask an open-ended question in response.

Active listening

Emphasise that the young person should not interrupt others when they are talking and engage in active listening, by taking turns in a conversation, ensuring that their answers are not too long, but that they are responsive enough so the other person knows that they are interested.

Ending a conversation

It can be difficult to politely end a conversation. Explain that it is fine to listen for a while, and then to find or create a pause in the conversation and make an excuse to move on (e.g. “Anyway, I need to get back to studying”). Once they leave a group, do not look back and do not feel bad.

Social anxiety

Social anxiety can be a significant problem for young people with depression, so techniques and skills to manage the problem may be an important component of treatment. Skills include managing the physical symptoms of anxiety, for example through breathing techniques, progressive muscle relaxation and pleasant imagery. Targeted Module 1: Distress Tolerance may be helpful in the presence of anxiety. Treatment may also include cognitive strategies such as challenging negative automatic thoughts (see Core Module 6).

The key component in addressing social anxiety is encouraging the young person to face anxiety-provoking situations that have been previously avoided. This involves graded exposure to such situations, in which young people repeatedly make contact with the things that they fear, and remain in contact with them until the fear starts to subside. Treatment is designed to extinguish, or at least reduce, anxiety and avoidance by exposing young people systematically to feared situations. Graded exposure can be conducted using imaginal desensitisation, but this is less effective than exposure to real-life situations.

Provide a rationale for the exposure by explaining that avoidance helps maintain, rather than diminish, anxiety. Although avoidance might appear attractive, it can increase the fear of the anxiety-provoking stimulus, make it impossible to enjoy potentially positive experiences, and require lying or deception to explain to others why it is impossible to participate in a particular activity.

Graded exposure can be analysed in terms of a hierarchy, in which the anxiety of specific situations is graded on a "distress" scale from 0, reflecting no distress, to 100, reflecting the highest level of anxiety. Starting with a situation that is only moderately anxiety-provoking, encourage the young person to stay exposed to it until they have

a reduction in the score of at least 50%: this might take 30 to 90 minutes. Confronting the situation just once will not be enough. Many repetitions are usually necessary, and the more often the exposure is repeated the better. Once the situation being confronted provokes less anxiety, progress to the next item on the list. It might be necessary to provide support for young people outside of the clinic, for example on a train or in a supermarket, while learning these techniques.

CASE EXAMPLE: JAMAL



Jamal, aged 18, had a severe major depressive episode. When he started therapy he also described symptoms of social anxiety, including nervousness when needing to make conversation and worries about being judged for the way he spoke and looked. He was sometimes so overwhelmed by these experiences that he would use alcohol or drugs to cope in social situations, or avoid them altogether.

During the assessment period, Jamal also disclosed a history of being bullied during primary school. CBT focused on how the bullying experiences may have led to the development of the negative automatic thoughts Jamal experienced in social situations. Jamal was supported to recognise these thoughts when they occurred and to learn to challenge them by searching for evidence against them. He was also referred to a group program which provided positive social experiences with his peers that allowed him to build his social confidence.

TARGETED MODULE 6

Problem-solving skills

Improving a young person's problem-solving skills helps them cope more effectively with their current difficulties, as well as perform better in other areas of their lives.²⁰ It assists young people to systematically generate solutions to problems and implement structured plans to resolve their difficulties. The therapy focuses on implementing changes in the "here and now", rather than working through the meaning and impact of past experiences.

The clinician aims to help the young person to:

- correctly identify and recognise problems when they occur
- adopt a more rational view towards problems (that is, that they are a normal part of life)
- increase their expectations that they will be able to resolve problems successfully
- reduce the tendency to act impulsively when attempting to deal with emotional difficulties or to avoid problems when they occur.

There are seven steps in the problem-solving approach, described in Resource 27, "Problem-solving", and outlined below.

RESOURCE 27



1. Identify the problems

Generate a list of the main problems identified by the young person. Try to separate facts from assumptions or cognitive distortions. Resource 27 lists some useful questions for this step.

2. Choose one, or possibly two, clear problems to work on

Again, Resource 26 lists useful questions. Practical problems may be easier to address than, for example, relationship problems. More recent problems are likely to be easier to solve than long-standing problems, and an urgent problem might deserve priority before other issues can be tackled. Making progress with easier problems will provide confidence to try harder problems.

The chosen problem needs to be clearly defined and written down as clearly as possible. If it cannot be clearly defined, the following questions might help:

- Is the problem too vague?
- Is the person blaming others for the problem?
- Is the problem unsolvable? For example, "All my problems are caused by what happened to me in the past".

3. Identify a goal

Resource 27 lists questions that help define the goal of the problem-solving exercise. State the goals in terms of observable behaviours that are within the young person's control.

4. Generate solutions

It is common for people to propose just one solution to a problem and keep on trying it, even when it is obvious that it is not effective. Examples include: avoiding the problem and hoping it will go away; using alcohol, other drugs or self-harm to obtain some temporary relief; and waiting for other people to change. Brainstorming can be used to generate as many alternative solutions as possible, ignoring, for the time being, their likely usefulness.

5. Decision-making

Once a number of potential solutions have been identified, it is necessary to evaluate them and select one or more to implement. This decision-making stage can be difficult: the clinician can guide the young person in systematically evaluating the potential solutions, for example by drawing up a list of the pros and cons for each one.

6. Make and implement a plan: be “SMART”

A good plan breaks complex solutions into small achievable steps, uses the person's strengths and supports, is specific about who does what and when, has a good chance of succeeding, and identifies if the solution is realistic (if not, return to 4).

The “SMART” acronym can be used to check whether the plan is workable.

- **S**pecific: Can I identify my goals? What do I want to achieve?
- **M**easurable: How will I know when I have got there?
- **A**chievable: Can I achieve this? What do I need? What are the likely problems?
- **R**ealistic: Am I being realistic? Do I believe this is possible? Am I willing and able to work for this?
- **T**ime-bound: Can I do this in a reasonable time?

7. Review progress

Hopefully there will be successes to celebrate, but this is not always the case. If the young person did not get started on the plan or things did not work out as expected, it is important not to dwell on the negatives. Instead, ask whether the plan was too hard to achieve (in which case it might be better to break it into smaller steps), or whether there were new obstacles, and then develop a new SMART plan.

Emphasise that the skills learnt during this process can provide a new technique for life, and the skills will improve with practice.

CASE EXAMPLE: CAROLINE



Caroline, aged 17, regularly arrived at her session wanting to discuss conflicts with her boyfriend during the week. She said she often felt threatened by his friendships with other females. She would react either by withdrawing from him and refusing to answer his phone calls, or by yelling at him and accusing him of cheating on her. Caroline found it difficult to see that her responses to the situation contributed to the conflict and would often ask the therapist, “But what else could I have done?”

The therapist spent some time explaining the problem-solving method and asked if she would like to try it for this situation. Caroline agreed and together they evaluated the pros and cons of different approaches.

Working together, Caroline and her therapist decided on a potential solution that Caroline could try between sessions. Caroline decided to speak to her boyfriend, using assertive communication skills, about his friendships with other females. Together, she and her therapist broke this down into several parts: thinking about what she would say and writing several short points down as reminders; choosing a good time to have the conversation; and using relaxation and deep breathing techniques to remain calm and in control prior to and during the conversation.

Further reading

Mynors-Wallis, L. (2005). *Problem-Solving Treatment for Anxiety and Depression: A Practical Guide*. New York: Oxford University Press.

TARGETED MODULE 7

Anger management

Intense anger causes physical stress and can lead to aggression and violence. Verbal abuse or intimidating behaviour can damage relationships and isolate a person from family members, friends and co-workers, even in the absence of violence.

Anger management aims to help a person develop skills in managing their anger, increasing their ability to control their thoughts and behaviours and their capacity to engage with, and receive support from, others.

Provide a rationale

Anger becomes a problem if it is intense and frequent, or if it leads to inappropriate expressions of anger. The expression of anger is a learned behaviour which can become a routine response to a variety of situations or activating events. People with problems managing their anger often use aggressive behaviours to solve their problems, leading to negative consequences for themselves and for the people around them.

Break the anger habit

To break the habit of inappropriate expression of anger, the young person needs to become more aware of the events, circumstances and the behaviours of others that “trigger” the anger. The A-B-C model can be applied to analysing some episodes of anger and its consequences, looking for common underlying features.

Events that can trigger anger may be everyday occurrences, for example a train running late or difficulties in traffic. They might also be events that the person is particularly sensitive to: for example, someone with a history of being teased when younger might be sensitive to comments about their appearance.

It is helpful for the person to learn to recognise signs that their anger is escalating.

- Physical cues include feeling hot or flushed, an increased heart rate or tightness in the chest.
- Behavioural cues can include clenching the fists, pacing back and forth, slamming doors, or shouting.
- Emotional cues include the core feeling that underlies the episode of anger, such as feeling rejected, abandoned, afraid, guilty, humiliated, insecure or jealous.
- Cognitive cues include thoughts that occur in response to the triggering event, such as negative self-talk, interpreting a friend’s comments as critical, or experiencing aggressive images.

Explore the young person’s behaviours when angry – for example, becoming verbally abusive or being physically intimidating – and the context in which these behaviours occur. Once these have been established, encourage the young person to explore the consequences of expressing anger in this way, particularly its effects on their interpersonal relationships. Some people focus on the rewards of expressing their anger, such as peer approval or feeling it is a part of their identity. It can be useful to work through the costs and benefits of an inappropriate expression of anger, to highlight its negative consequences. Resource 28, “The hassle log” can be used to help the young person monitor and interpret episodes of anger.

RESOURCE 28

The screenshot shows a form titled "The hassle log" with the following fields and options:

- Date:** A text input field.
- Time:** Radio buttons for Morning, Afternoon, and Evening.
- Where were you?:** A text input field.
- What happened?:** A large text area for describing the incident.
- How did you feel?:** A text input field.
- What did you do?:** A text input field.
- How do you feel now?:** A text input field.

Change the anger cycle

There are three phases to anger: *escalation*, *explosion* and *post-explosion*. Escalation is evidenced by the physical, behavioural, emotional or cognitive cues discussed above, indicating that anger is building. If the escalation continues, it will lead to the explosion of anger, which is characterised by uncontrollable expression of anger as verbal or physical aggression. The final stage, post-explosion, is characterised by the negative consequences of anger such as suspension from school, losing a job, losing family or friends, or feelings of guilt, shame and regret.

Encourage the young person to think about preventing anger, and also about immediate strategies for controlling anger early in the escalation phase before the emotions are too intense to manage. This can be achieved by monitoring their anger, for example, using a 0–10 scale and encouraging action when anger is still at a level of 3–4. This technique can increase the young person's awareness of anger cues and allow them to practise the strategies they have developed.

Develop strategies for controlling anger

Work with the young person to develop strategies to effectively manage anger. The young person should aim to target both immediate situations (e.g. avoiding the expression of intense anger) and preventive strategies (e.g. slowing or stopping the escalation of anger).

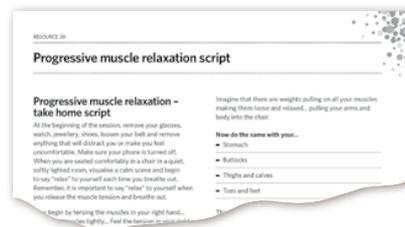
Immediate strategies include:

- taking time out, removing themselves from the situation if their anger is escalating out of control
- doing something active like going for a run, punching a punching bag, or doing some push-ups
- deep breathing exercises
- if progressive muscle relaxation exercises have been practised, using a cue word to help calm down (most often "relax")
- thought-stopping, for example, saying, "I need to stop these thoughts. I will get in trouble if I keep thinking this way", or "Don't buy into it. Don't go there"
- self-talk, such as, "I can choose my own response to this situation".

Preventive strategies include:

- engaging in regular physical activity
- challenging irrational beliefs (e.g. "Everybody should follow the rules", or "I must always be in control")
- talking to a trusted friend
- practising progressive muscle relaxation exercises, as described in Resource 29, "Progressive muscle relaxation script"
- practising mindfulness and other distress tolerance skills, as described in Resource 17, "Distress tolerance strategies".

RESOURCE 29



CASE EXAMPLE: ROBERT



17-year-old Robert presented with affective instability and a history of severe anger outbursts. He reported a long history of becoming involved in physical fights, throwing things and slamming doors when feeling angry. Although he acknowledged that it was a problem, he was adamant that he could not change his anger as it came on so quickly he was unable to control it. He found it difficult to identify any internal warning signs that he was getting angry.

Through slow exploration with his therapist, Robert devised a list of common external triggers to his anger. One example was his father speaking to him using a sarcastic tone. Robert devised the strategy of recognising this as a trigger, and immediately leaving the house for a long walk or run.

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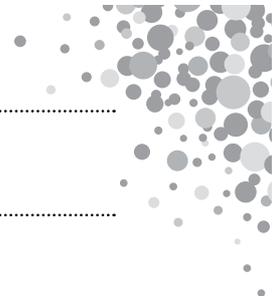
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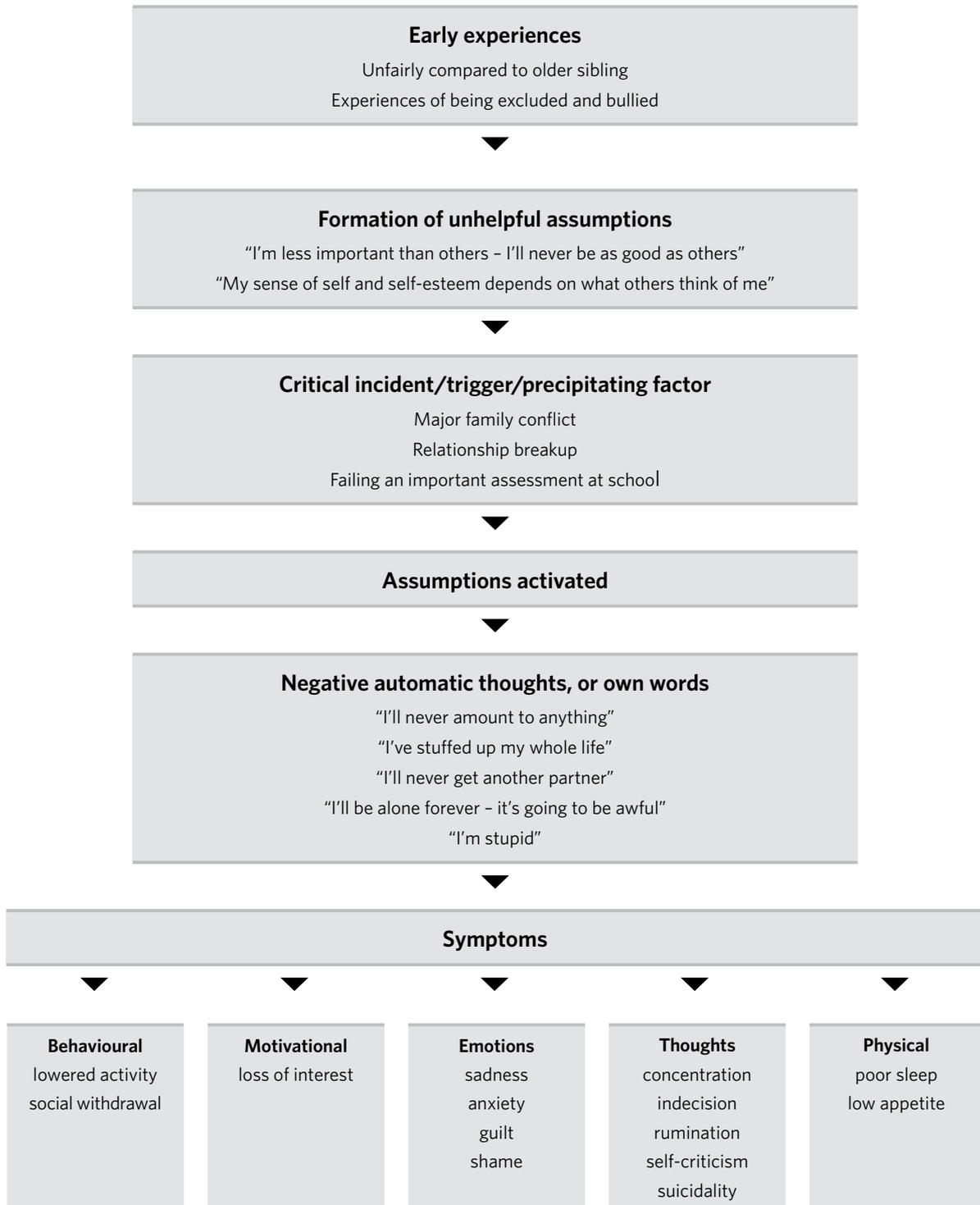
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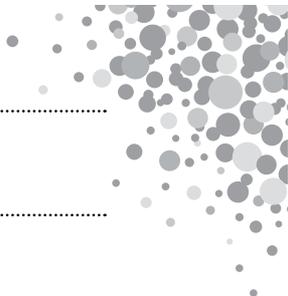
RESOURCES





CBT model of depression – common examples





My model of depression

Early experiences				
▼				
Formation of unhelpful assumptions				
▼				
Critical incident/trigger/precipitating factor				
▼				
Assumptions activated				
▼				
Negative automatic thoughts, or own words				
▼				
Symptoms				
▼	▼	▼	▼	▼
Behavioural	Motivational	Emotions	Thoughts	Physical

Education about depression

Depression is one of the most common mental health problems among Australians aged 12–25 years.

- Depression is more severe, and longer lasting, than the normal feelings of sadness that everyone feels from time to time
- Around 1 in 4 young people will have had a depressive disorder by the end of their adolescence
- It is important that you get support if you are feeling depressed
- You won't have depression forever – depression tends to get better, and responds to a range of treatments
- The consequences of untreated depression can often be quite serious and can include performing poorly at school or work, losing friends and family supports, substance abuse, and risk of self-harm or suicide

What causes depression?

There is no single cause for depression but a number of factors can contribute, including family history, biology (genes, illness, alcohol use), personality traits (worry, low self-esteem, coping styles) and stressful life events (difficulties with friends, personal losses). Sometime it is clear that depression has been triggered by a particular event or situation, but often it is not. It is common that depression arises from a combination of factors.

Typical symptoms of depression

Emotional changes

- Feelings of unhappiness, moodiness and irritability, sometimes emptiness or numbness
- Loss of interest and pleasure in activities that were once enjoyable
- Tearfulness or frequent crying
- Feelings of worthlessness, guilt or hopelessness
- Feelings of being worried or tense

Cognitive changes

- Difficulty concentrating and making decisions
- Being self-critical and self-blaming
- Having negative thoughts about yourself, others, the future and the world
- Thinking about death or suicide

Behavioural changes

- Tiredness, lack of energy and motivation
- Poor attention to personal hygiene and appearance
- Decreased participation with peers and normal activities
- Self-harm
- Avoidance of family interactions and activities
- Being withdrawn, spending more time alone

Physical changes

- Changes in appetite and weight (usually decreased but can be increased)
- Changes in sleep patterns, including difficulty sleeping or over-sleeping
- Lowered libido
- Restlessness and agitation
- Unexplained aches and pains

Education about depression (continued)

Treatment for depression

Cognitive behavioural therapy, or CBT for short, is a “talking” therapy that helps people understand and change unhelpful thoughts and behaviours. CBT is well researched, and there is good evidence that it is helpful in young people with depression. Other talking therapies may also be used to help treat depression.

A CBT program for depression in young people

An effective depression treatment program usually includes the following components:

- Weekly sessions, usually lasting around 12 weeks.
- Regular attendance — therapy will be most effective if you attend each week.
- Willingness to talk about difficult experiences and emotions. You can control the intensity of these discussions.
- Exploration of how your thoughts and behaviours influence the ‘causes’ and symptoms of depression, and how these might be changed for the better.
- Collaboration — getting better will require effort from both you and your clinicians.
- Homework tasks — these are an important part of therapy.
- Being open with your clinicians about any parts of therapy that you are not finding helpful, or which you feel uncomfortable with.

Some young people will also take antidepressant medication in addition to CBT. This is a decision that is made by you in collaboration with your treating doctor. Medication takes between 3 to 6 weeks to work, and may help some symptoms more than others. If you do decide to take medication, it is important to talk to your doctor about any concerns you have or any side effects you experience.

What if things get worse?

It is possible that there will be ups and downs during your treatment. Your treating team will discuss a crisis plan with you, but you should make immediate contact with a mental health professional if you feel at serious risk of suicide or hurting yourself in any way.

For **24-hour support**, you can also call:

Lifeline **13 11 14**
Kids Help Line **1800 55 1800**
beyondblue **1300 22 4636**

Reliable information is also available from the following websites:

www.orygen.org.au
www.headspace.org.au
www.youthbeyondblue.com
www.reachout.com

Make sure you have phone numbers for your treating clinicians and your GP handy. If you don't have a GP, you can talk to your treating team about local youth-friendly practices.

Emotions



Mood monitoring chart

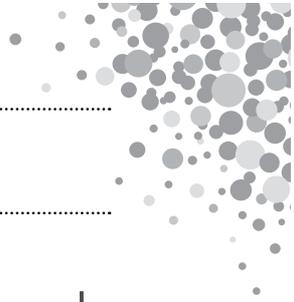
Create your own 0-10 mood scale

What does 0 stand for?

What does 5 stand for?

What does 10 stand for?

Mood Monitor			Rate your mood (0-10)	What were you feeling? (draw a face or use words)	What happened? What were you doing? What were you thinking?
Day					
Monday	AM				
	PM				
Tuesday	AM				
	PM				
Wednesday	AM				
	PM				
Thursday	AM				
	PM				
Friday	AM				
	PM				
Saturday	AM				
	PM				
Sunday	AM				
	PM				





Past and future activities

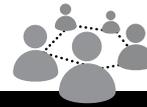
		Future			
Activity	Past or anticipated enjoyment ratings (1 = low, 5 = high)	Motivational factors		Planning factors	
		Reasons against engaging in activity	Reasons for engaging in activity	Steps involved (planning required, barriers)	Agreed plan (homework)
	Pleasure				
	Achievement				
	Pleasure				
	Achievement				
	Pleasure				
	Achievement				

List of enjoyable activities



Solo activities

- Plan a holiday
- Go for a walk or a jog
- Listen to music
- Lie in the sun
- Read a magazines or a good book
- Write a poem or short story
- Go to the gym
- Cook from a new recipe
- Practice karate, judo or yoga
- Do some gardening
- Go swimming
- Draw or paint something
- Make a list of tasks and tick them off
- Play a musical instrument
- Make a gift for someone
- Practice meditation
- Do a jigsaw puzzle
- Start collecting something
- Sew something
- Buy some clothes
- Prepare your resume
- Read the newspaper
- Daydream
- Watch a movie
- Go bike riding
- Chat on the internet
- Take some photographs
- Write a letter
- Spring clean
- Join the local library
- Look at some old photos
- Do a crossword puzzles
- Dress up in something smart
- Learn a new language
- Get a massage
- Taking a sauna or steam bath
- Reorganise my cupboards
- Light some candles
- Listen to the radio
- Work on my finances
- Play a computer game
- Rearrange the furniture in my room



Activities with others

- Go to a movie
- Spend an evening with good friends
- Play a card or board games
- Join a book club
- Go to a party
- Talk to friends
- Sing in a choir
- Go to the beach
- Go ice skating or roller-blading
- Go for a drive
- Go hiking or bush walking
- Go out to dinner
- Play tennis
- Go to a play or concert
- Go to a footy game
- Go fishing
- Join a sporting team
- Go on a picnic
- Have lunch with a friend
- Play pool or billiards
- Go to a museum or art gallery
- Go surfing
- Go bowling
- Go horse-riding
- Go rock climbing
- Go window shopping

Adapted from resources from the Centre for Clinical Interventions (<http://www.cci.health.wa.gov.au>) and the National Cannabis Prevention and Intervention Centre (<https://ncpic.org.au>).

Common unhelpful thinking styles

Mental filter

This refers to a tendency to focus on the negative aspects of a situation and ignore the positive. For example, maybe you are out with a friend. You disagree on which movie you should see, and you end up seeing the film your friend prefers. You stew on this for the next few days, feeling that your friend is selfish, and that you are weak for not having stood up for yourself.

All or nothing thinking

This is the tendency to see things in extremes, and is also called 'black-and-white' thinking. Things are either all good or all bad, you either love or you hate, you are either brilliant or you are useless.

Over-generalising

This is the tendency to use one specific incident from which to draw general and sweeping conclusions. Perhaps you have found yourself saying something like, "Everyone is always having a go at me".

Hopelessness

This is a pessimistic view of the future that colours the way you see everything. The future is predicted in a negative way, without evidence for it. You might have had a thought like "I will *never* be happy". 'Mind-reading' is a related thinking error, and is another way of jumping to conclusions. In this you have the mistaken assumption that you can predict what someone is thinking, again usually in a negative way. An example might be if you are speaking to someone and they look at their watch and you think, "They don't want to talk to me, they think I am boring".

Discounting the positive

This is the tendency to turn something positive into something negative: for example, turning a compliment into an insult. A friend might say, "You laugh so much", and you think that they are criticising you for being annoying. In this way a person both misses out on a positive experience, and creates another negative experience.

Magnification and minimisation

This involves blowing things completely out of proportion, or shrinking their importance. Magnification might happen if someone thinks that they are going to embarrass themselves while making a presentation. They think of times when this has happened, which has a snowball effect because the thoughts become a huge obstacle. Minimisation happens when someone is paid a compliment but they think, "They didn't mean it, they were just being polite".

Emotional reasoning

This is the tendency to make a judgment about ourselves, the world or the future based on our current emotional experience. For example, if we feel hopeless we are more likely to judge our future negatively. Or if we felt guilty (an emotion that is also common in depression), we are more likely to judge that we have done something wrong.

"Should" statements

"Should" statements show unhappiness with a certain situation, but do not help in solving the situation. Someone might say, "My life would be much better if my parents hadn't divorced", or, "People should be kind". This is unhelpful because there is nothing you can do about that.

Labelling

This is where one particular characteristic or event then becomes the definition of a person. For example, you failed one test so you are a loser.

Taking things personally

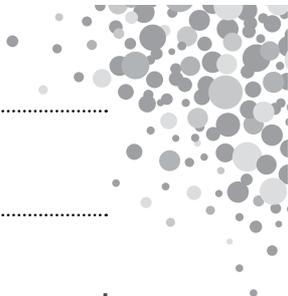
This is where a person interprets an event as indicating something negative about themselves. For example, if a social situation goes badly on one occasion then the person assumes they are unlikeable and will never be able to make friends.

Adapted from

Resources at the Centre for Clinical Interventions (<http://www.cci.health.wa.gov.au>)

Brent D, Polling K, & Goldstein T (2011). *Treating depressed and suicidal adolescents: A clinician's guide*. New York, Guilford Press.

Wood, A., Verduyn, C. & Roger, J. (2009) *Depression: Cognitive behaviour therapy with children and young people*. Taylor & Francis: London, UK.



Generating evidence for and against negative thoughts

Thought or belief	Evidence for...	Evidence against...	What is a more helpful thought



Common negative automatic thoughts and alternative responses

Negative thoughts	Alternative responses
I must not admit that I'm depressed.	Being honest about my situation might help - if I can recognise my depression and acknowledge how I feel, I can do something about it.
Others are getting me down.	It might be my negative thinking that is getting me down, I'll try to take a bit more responsibility for how I feel.
My life was perfect, why can't things go back to how they were?	Maybe I'm focusing too much on the past and making it sound better than it was. I'll try to make the most out of the future.
Everyone is happier and more confident than I am.	There's no way I can really know this so I'll try and think about what I can do to help myself feel better and not worry about everyone else.
I need someone stronger than I am. I can't cope alone.	I will learn about what I can and can't deal with by taking on as much as I can without depending on others.
I'm worried that being depressed might cause me permanent damage - mentally and physically.	This situation won't last forever, with a bit of work I will start to feel better and my abilities will return
There is no point. I can't change the situation.	I will make an effort to change what I don't like and I'll try to accept what I can't change. At least I can change my attitudes.
I can't feel any better because I have too many problems.	I will try to take it just one day at a time and set some small goals for myself. It might take a while, but I'll give myself enough time to work through this.
My future doesn't look good.	I will try to find some things I can do to make things better in the future.
Why me? It's not fair that I should be down.	I might be doing it pretty tough at the moment, but everyone goes through rough patches from time to time.
No one can help me.	There is no reason to think that others won't be able to help me. It doesn't hurt to ask for help when I need it.
It's up to others to make me feel better.	Other people can be really good sources of support but at the end of the day it is up to me to get better.
Someone, somewhere knows all the answers and will tell me the solution.	There is no solution or magic wand that can make all my problems go away. Getting better will involve a bit of work, but it will be worth it in the end.
There is no point in trying. I've tried things before and they didn't help.	The only way I can know whether this particular technique will work is to give it a try.



Thought disputation strategies

Strategies to challenge or modify negative and unhelpful thinking

Evaluate the evidence for and against a thought

Consider the negative thought or idea:

- Is there any evidence that does not support this idea?

- Are there facts that I am ignoring or overlooking?

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

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

- How do I know my thoughts and beliefs are true?

- What other explanations are there?

- Are there other ways of viewing the situation?

- How realistic are my thoughts, beliefs and expectations?

- Am I thinking like this because my mood is so low?
Would I be thinking this way if I felt better?

- Do these thoughts always come up when I feel this way?

- How helpful is it to focus on this thought or idea?

Generate alternative explanations for an event

- What is bad about that event or situation?

- What do I see happening in this situation?

- What am I concluding about myself or others in this situation?

- And that is bad because...?

- And what does this say about...?

- Is there any other way to look at the situation?

- How else might someone see the situation?

Identify the advantages and disadvantages of keeping, compared to changing, a thought

- Is it helpful for me to think this way?

- Is thinking this way helping me to achieve the things I want to achieve, do the things I want to do, enjoy the things I usually enjoy?

- How is this way of thinking working for me?

- Are there other ways of thinking that may not be as painful for me?

Develop 'thought control' techniques

- 'Thought stopping' involves stopping a train of thought once an automatic thought is detected. A distraction, such as focusing on breathing, can be helpful.

- Use imagery to help with thought stopping. For example, imagine a 'fork in the road' in which you can choose to continue worrying about the negative thoughts or to do something else; or imagine a stop sign or a hand held up to signal you to stop thinking in this way.

- Development of distraction and self-soothing skills can help you manage automatic negative thoughts.

- Use positive self-statements. This involves building up positive beliefs about yourself that you agree with.

- Reframe the experience by exploring the meaning of a particular thought or belief, and then identifying a positive rather than negative approach (for example, anxiety symptoms can be reframed as excitement in some situations).

- Set an amount of time (say 10 minutes) to wait before they react; or suggest they delay reacting until they have checked their thinking with someone they trust to see if it is logical and realistic.

Thought disputation strategies (continued)

Alternative ways of relating to unhelpful thoughts:

- With practice, you will be able to choose not to accept negative thoughts that do not reflect actual events or facts. However this can take time and can be a challenging concept to communicate.

 - For example, you may think “I am no good at anything”. If accepted as fact, it would not be surprising to feel quite low as a result. However, this thought is likely to occur more often when the person feels down. By looking at the evidence for and against this concept, it is possible to recognize it simply as a thought and not a reality.

 - Some young people may find that when they focus attention on their thinking patterns during CBT that this increased engagement with thoughts can become overwhelming. It might be helpful to try the following:
 - A deep breathing exercise. By focusing their attention on the breath may not only assist with relaxation, but can also be a helpful distraction by focusing their attention on this task instead of thoughts.
 - Focus on bodily sensations. A progressive muscle relaxation exercise may also have a similar distracting effect to deep breathing.
 - Recognise thoughts as “just thoughts” rather than responding to them and engaging with them. Simply notice that the thoughts are occurring, rather than engaging with the content.
-

Create distance from thoughts (e.g. reducing rumination)

Metaphors can facilitate the process of distancing oneself from one’s thoughts and reducing rumination. For example:

- The sky: It might be helpful to imagine the mind as the sky, where thoughts are like passing clouds that come and go.

 - Leaves: Visualise leaves floating down the stream and put each thought on a leaf.

 - Cars driving past the window, imagine your thoughts are the cars, you can tune into the noise or let it be background noise.

 - A train going through the station imagine that you can get on that train with thoughts and end up at the station of distress, or stay at the current station and watch the train of thoughts pass by.

 - Noise on the radio, we can turn the volume down and let the noise just be in the background.

 - People passing in the street, you can nod your head at them but don’t have to stop and have a conversation.

 - “Pop ups” on the internet, you can chose to ignore them you don’t have to open them.
-



Identifying core beliefs

If this was true...
What would be so upsetting?
What would it mean about me?

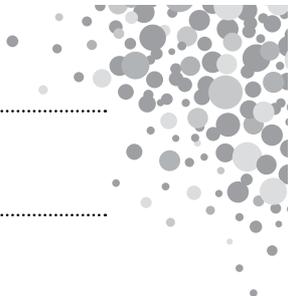
If this was true...
What would be so upsetting?
What would it mean about me?

If this was true...
What would be so upsetting?
What would it mean about me?

My Core Belief

If this was true...
What would be so upsetting?
What would it mean about me?

My alternative, balanced belief:



Relapse prevention and wellness plan

This plan should highlight the things you identify as helpful to manage your depression.

What have I achieved (or done well at) during treatment?	
Are there any areas for improvement?	
My goals for the next 3 to 6 months (these should be specific and realistic)	
Signs and symptoms to watch out for	
Potential triggers of depression	
Things that I have found useful that I can keep doing in order to stay well	

Distress tolerance strategies

These are the sorts of things you might do when you are feeling distressed. It is a good idea to think about what works in the times when you are not feeling distressed, so that you know what to do when the bad feelings seem to be taking over.

Stay away from trigger situations

- Try to avoid situations that seem to trigger distress. It may not always be possible, but do your best to stay away from people or places that make you upset.

Identify and don't judge your emotions

- Try to name the distressing emotion when you feel it, and don't judge yourself for having it.

Seek support

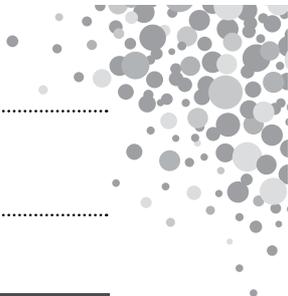
- Seek support from someone who can help, even if they can only help a little bit.
- Ask the person if they feel OK about supporting you when you are distressed. Let them know the best way in which they can be helpful.
- The kind of ways that they might be able to help include:
 - just listening to what you are saying
 - distracting you from what is distressing by talking about other stuff
 - trying to help you sort out the problem that made you feel so upset
- People who you can talk to include your case manager and crisis team.

Challenge unhelpful thinking

- Use the skills you have learnt to try to challenge your thoughts.
- Remind yourself that, as awful as you might feel, you have managed to get through situations like this before, and your emotions will slowly settle down.

Change focus

- Try to move your mind on to something else, which will help your emotions settle down.
- Strategies include:
 - self-soothing: doing something nice for yourself (e.g., listening to music, or having a bath)
 - physical exercise
 - relaxation (e.g., controlled breathing, progressive muscle relaxation)
 - grounding exercises: focus your mind on the external, rather than your internal world (e.g., the clouds in the sky rather, or the sounds of the birds, rather than how terrible you are feeling).
- Other people might help you with these strategies, and remind you to use them.



Crisis plan

Crisis plan

My early warning signs

I feel...

I think...

I notice...

I do these things...

Things I can do that may provide a distraction or help soothe my distress

Things my friends and/or family do to support me

Things that will make my environment safer

People and social settings that provide a distraction

Name	Place	Phone
Name	Place	Phone

Name	Place	Phone
------	-------	-------

People I know I can rely on who I can call for help

Name	Phone
------	-------

Name	Phone
------	-------

Professionals or agencies I can call during a crisis

Clinician Name	Phone
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Clinician Name	Phone
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GP	Phone
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Local Mental Health Services	Phone
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Local Emergency Services Phone	000
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Lifeline	13 11 14
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Kids Help Line	1800 55 1800
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beyondblue support service	1300 22 4636
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The importance of good sleep

The importance of good sleep

Good sleep helps us to feel fresh, focused and good during the day. We all know what it's like after a bad night's sleep. As well as feeling lousy, lack of sleep can affect your physical and mental health, learning, memory and concentration, your activity levels, emotions and relationships.

Are you always tired or more so than usual? Napping all the time or feeling like you need to? Feeling annoyed and irritable more than usual? Feeling less energetic? Having trouble concentrating or remembering things?

You might not be getting enough good sleep. So what **helps** and what **prevents** good sleep?

Things that can prevent good sleep

Caffeine

Try to stay off caffeine (coffee, cola, strong tea) in the afternoon or evening. It's a stimulant and hangs around in your system for a while and can make it difficult to get to sleep.

Exercise or strenuous activity right before bed

Things like exercise increase your attention and arousal and if done too close to bedtime, will make it difficult to fall asleep. Exercise is excellent and good for your physical and mental health but do it earlier in the day.

Nicotine and alcohol

Tobacco is a stimulant and may make it difficult to get to asleep. Alcohol is a depressant and can make you drowsy but it won't help you sleep, the sleep you do get will be disrupted and you will likely wake feeling lousy.

Napping during the day

This can mess up your body clock and make it harder to sleep at night. If you do nap, only do it if you're tired and keep it short.

Weekend sleep-ins

This sounds outrageous - but sleeping in to catch up on sleep can throw your body clock out and the effects may last for days, making it harder to return to your normal sleep cycle when the school or work week resumes.

Thinking and worrying about falling sleep

This will actually make it harder to sleep. If you find you haven't fallen asleep after being in bed for 20 minutes or so, don't stress about it, get up and try something relaxing like reading or progressive muscle relaxation. Get back into bed only when you feel more relaxed. Don't worry if you have to repeat this a couple of times. This can also help if you find yourself waking during the night and have difficulty getting back to sleep.

Too much stress

Too much stress can make sleeping difficult. There are some things you can do to help clear your mind before trying to sleep - write things down, talk things over with someone you trust, do something you find relaxing or ask your clinician about progressive muscle relaxation or even problem solving skills.

Things that can help with getting good sleep

A warm bath or shower before bed

This can help you relax and feel sleepy but allow a little bit of time between your bath/shower and bed, as it's harder to fall asleep when your body temperature is high.

Physical activity during the day

Being active (e.g. exercising) during the day can help you feel good and sets you up for a good night's sleep.

A warm drink like milk or chamomile tea

Milk contains amino acids and these can make you drowsy; the tea will help you relax and feel ready for sleep.

Associating your bed with sleep

Only use your bed for sleeping. Try not to do other activities like reading, homework or watching TV in bed. Train yourself to associate your bed only with sleep.

Having consistent 'sleep' and 'wake' times

Try to keep the time you go to bed and the time you get up each morning consistent throughout the week. Avoid sleeping in on days when you don't feel like getting out of bed. Getting up at a good time (even when you still feel tired) will make it easier to fall asleep at night. This also helps get your body clock into rhythm and sleep will feel more natural.

A room that is quiet, dark and cool

Make sure your room is quite, dark and cool. This gives you the best chance of falling asleep and might stop you waking during the night.

Trying some relaxing activities to wind down before bed

Try reading a book, listening to some relaxing music or ask someone for a massage. Ask your clinician about some relaxation techniques that can be practised before bed - like progressive muscle relaxation.

The importance of healthy eating

The importance of healthy eating

Staying healthy is important for everyone but can be hard if someone has a mental health problem. Older children and adolescents need sufficient nutritious foods to grow and develop normally. Australian dietary guidelines encourage a wide variety of nutritious foods and drinking plenty of water.

Depending on body size and activity level, teenagers 12-18 years old should eat on average each day 5-11 servings of cereals (bread, rice, pasta, noodles), 4 servings of vegetables, 3 servings of fruit, 3 servings of milk, yogurt or cheese and 1 serving of lean meat, fish, poultry, nuts or legumes. They should have no more than 1-3 extra foods (cake, biscuits, chocolate, soft drink, ice-cream, jam, honey, pizza, potato chips).

A serving size is, for example: 2 slices of bread, 1 cup cooked rice or pasta, 1 cup breakfast cereal, 1 medium potato, ½ cup broccoli, 1 medium sized apple, 20 grapes, 4 dried apricots, ½ cup fruit juice, 2 slices of cheese, 200 g (small carton) of yogurt, 1 cup of almonds, a piece of chicken or meat the size of the palm of your hand, 2 small eggs, 1/3 cup of lentils, 1 medium piece of cake, 3-4 sweet biscuits, half a chocolate bar, 1 tablespoon jam or honey, 30 g potato chips, 1 slice of pizza, 1 can of soft drink.

Food safety is also important. You can keep your food safe from bacteria by washing your hands well before preparing food, making sure kitchen equipment is clean and returning food to the refrigerator as soon as you have finished rather than leaving it out on the bench.

While healthy eating can be tricky, it is worth it. It reduces the risk of other physical health problems and can help with improving energy levels, getting a good night's sleep and feeling good about yourself. Your brain will work better if you feed it right.

Tips for healthy eating

- Breakfast is important; if you are rushed or don't feel like something substantial, try having a glass of milk or a piece of fruit.
- Keep your snacks healthy and plan what and when you eat.
- If you can't avoid fast food, try to make healthy choices, such as felafel wraps, rice paper rolls, stir fried vegies and salad sandwiches. Have salad instead of chips, avoid extras like garlic bread or soft drink and say no to upsizing.
- Eat slowly and wait 10 minutes before having a second helping to be sure you are still hungry.
- Eat home cooked meals. You can make your own healthy pizza using pita bread as a base and topping it with veggies and lean meat - and go easy on the cheese.
- Be aware of what you are drinking. Soft drinks can add a lot of sugar to your diet. Always have a water bottle with you (try adding lemon or lime) that you can refill, and reduce sugar in your tea and coffee.
- Alcohol and some drugs can stimulate your appetite and lead you to eat more than you need to. Alcohol also contains lots of kilojoules, which can lead to weight gain.
- Try not to shop at the supermarket when you are hungry; take a list with you to avoid impulse purchases.
- Read the labels on food and check the number of servings, kilojoules, fats and sugar. Be aware that some low-fat foods have high levels of sugar in them.



The importance of being active

The importance of being active

Being physically active is important for staying healthy, not only physically but mentally too. It can be difficult to stay active at the best of times, but when you're depressed, it's even harder. It can be difficult to find the energy or motivation to do things, but it's usually the case that the less you do, the worse you feel. Even though it's difficult, physical activity (even in small doses) can have a big impact on how you think and feel, and is a really good way of combating depression.

Being physically active can...

- ...give your mood a boost

- ...increase your energy levels

- ...help with getting a good night's sleep

- ...provide a distraction from your thoughts and worries

- ...help increase your concentration

- ...help with getting out and socialising when done with others

- ...help with maintaining your physical health

- ...help you feel and look great (increases your self-esteem)

- ...give you a sense of achievement, especially if you would like to increase your fitness or just feel better

- ...change levels of chemicals in your brain (e.g. serotonin, endorphins and stress hormones), making you feel better

- ...help reduce your stress levels and help you feel less irritable or frustrated

Tips to help increase physical activity

Everyday things...

Take the stairs instead.
Ride or walk instead of taking public transport or driving.

Enjoy what you do

Think about the sort of physical activities you might find enjoyable or did so in the past (e.g. running, playing sport, walking, swimming etc.) and try to get back into them. Doing things that are enjoyable may increase your chances of actually doing them, and they will give your mood a boost. Steer away from things you don't like (e.g. don't go to the gym if you've never liked going).

Don't fly solo

Involve someone else like a friend or family member. This can make being active more enjoyable and is an easy excuse to socialise. If lack of motivation gets in the way sometimes, involving someone else can help you stick at it. Doing exercise classes or joining a casual sporting team can provide social environments for your physical activity.

Start small

Some is always better than none. If you aren't used to very much physical activity, start with small, low intensity activities. While it might be difficult at first, it's important to stick with it - you'll be amazed at how much easier it gets and how good you feel. It might be helpful to aim to do something for a set amount of time rather than aiming for an amount of something (i.e. try walking for 30 minutes rather than trying to run a total of 5 km).

Set achievable goals

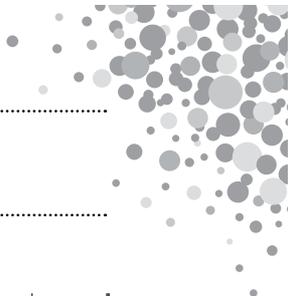
If you are beginning to get back into being active or thinking of doing so, setting goals can be a good starting point. This gives you something to work towards and can help motivate you. Try to be realistic and make your goals achievable (aiming to run a marathon in your first week of exercise might not be a good idea: start small). Getting a sense of achievement from reaching your physical activity goals can make you feel good and help motivate you to keep going.

Make a plan

Plan what you would like to do and when you can do it. Take into account the things you need to do during the day (school, work etc.) and plan your physical activity around them. It can be good to involve a friend or family member when planning as they can help motivate you (it's always better doing things with someone else!). Try writing your plan down, this may help you stick with it.

Building up

Start small but always look to build up the amount of activity you do, try increasing the amount of time you exercise during the day (aim for 30-60mins) or increase the number of days in the week you exercise.



Recording and interpreting substance use

	What was the best/worst I felt today? Rating (1-10)	Activating situation or trigger What time of day was it? Where was I? Who was I with?	Behaviours What did I do? What did I drink or use?
Monday	Best		
	Worst		
Tuesday	Best		
	Worst		
Wednesday	Best		
	Worst		
Thursday	Best		
	Worst		
Friday	Best		
	Worst		
Saturday	Best		
	Worst		
Sunday	Best		
	Worst		

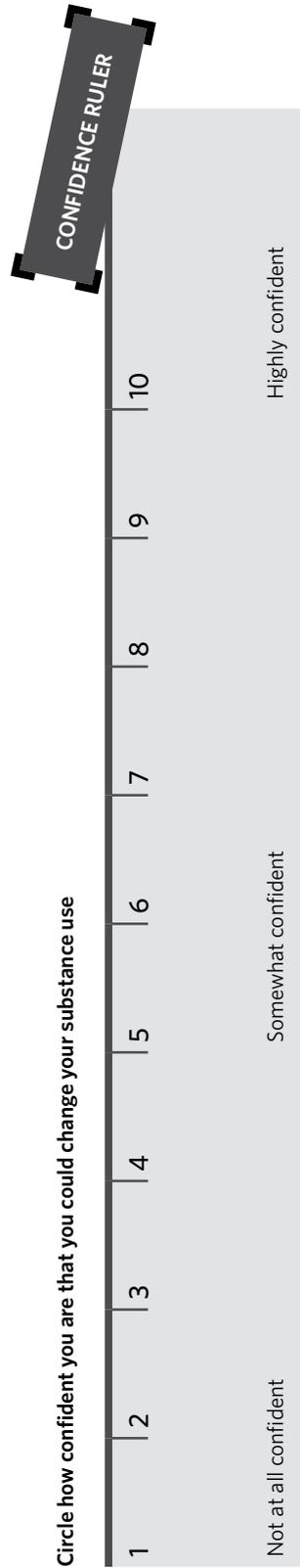
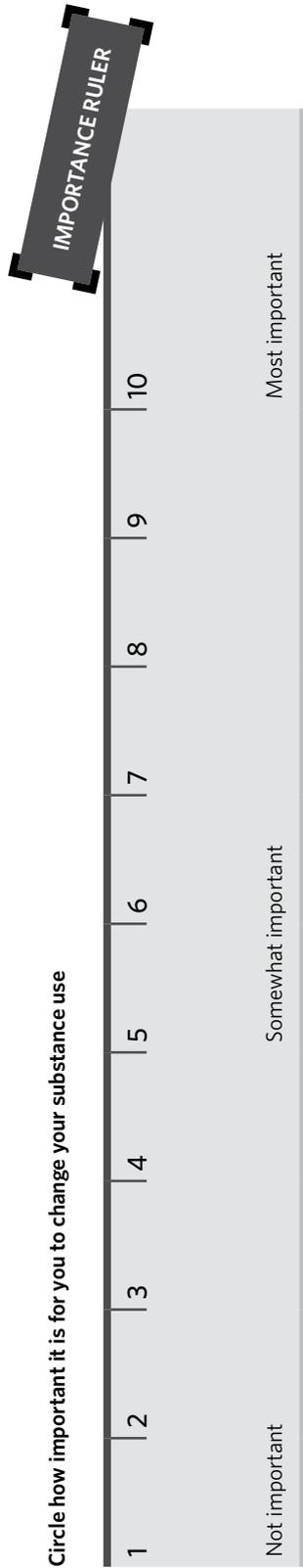


Decisional balance worksheet

When we think about making changes, most of us don't really consider all "sides" in a complete way. Instead, we often do what we think we "should" do, avoid doing things we don't feel like doing, or just feel confused or overwhelmed and give up thinking about it at all. Thinking through the pros and cons of both changing and not changing is one way to help us make sure we have fully considered a possible change. This can help us to "hang on" to our plan in times of stress or temptation.

	Benefits/pros	Costs/cons
Making a change		
Not changing		

Importance and confidence rulers





Change plan

The changes I want to make are

I will know that my plan is working if

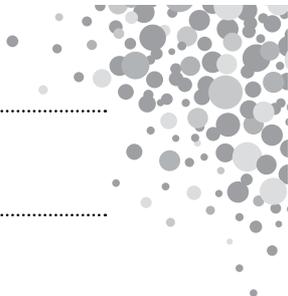
The reasons I want to make these changes are

Some things that could interfere with my plan are

The steps I plan to take to make these changes are

What will I do if the plan isn't working?

The ways other people can help me are



Tips for good communication

Listening skills

- Letting the other person finish what they are saying.

- Summarising (paraphrasing) what they have said to check you have understood.

- Summarising what they have said about how they feel.

- Not approving or disapproving of what they have said.

- Not talking over them; changing the topic.

Communication skills - assertive communication

Use whole messages

- Communicate the situation:
 - What happened
 - What you think or believe
 - How it made you feel and what you would like to happen next time.

Use 'I' statements

- 'You' statements blame or accuse the other person and can make them defensive.

Express yourself clearly

- State what you want, what you think and how you feel clearly.

- Don't just assume that others know.

Do it now

- Don't let things fester (exception: don't do it now if you're too angry).

Ask for clarification

- It can be difficult to know what others are thinking and feeling.

- It's better to ask and avoid misunderstanding, rather than trying to mind read.

Acknowledge your discomfort

- Some issues can be uncomfortable to raise - be upfront with the other person.

Good body language

- Face the person squarely.

- Open posture, no crossed arms or fidgeting.

- Lean towards the person, not too much but just enough to show interest.

- Maintain eye contact, without staring.

- Be relaxed, don't fidget and be comfortable.

Remember to communicate positive feelings sometimes

- Everyone appreciates being told that they are valued, loved and liked.

Things to avoid

Mind-reading

- Try not to assume what others are thinking or feeling - ask them instead.

- Try not to assume that others can read your mind - express yourself clearly.

Labelling

- Try not to label the other person. This can create bad feelings and heated arguments.

Criticism, putdowns and aggressive communication

- These often make people feel threatened and usually lead to angry confrontations.

Avoiding communication

- This increases the likelihood of feeling angry, resentful and frustrated.

- Confidently present your point of view while recognising that other viewpoints exist.

Adapted from

The TADS manual: Curry, J. F., Wells, K. C., Brent, D. A., Clarke, G. N., Rohde, P., Albano, A. M., ... March, J. S. (2005). *Treatment for Adolescents with Depression Study (TADS): Cognitive Behavioural Manual: Introduction, Rationale and Adolescent Sessions*. Duke University Medical Centre.

The CWD-A manual: Lewinsohn PM, Clarke GN, Hops H, Andrews JA. Cognitive-behavioral treatment for depressed adolescents. *Behavior Therapy*. 1990;21:385-401.



Problem-solving

STEP 1 Identify the problem as early as possible.

STEP 2 Be specific about the problem.

What is the problem?

STEP 3 Consider as many solutions as possible.
Try to list all the potential ways that you could respond to this problem.

- a.

- b.

- c.

- d.

- e.

STEP 4 List the advantages and disadvantages of each solution

Advantages	Disadvantages
a. <hr/>	a. <hr/>
b. <hr/>	b. <hr/>
c. <hr/>	c. <hr/>
d. <hr/>	d. <hr/>
e. <hr/>	e. <hr/>

STEP 5 Choose the best solution based on the above evaluation.

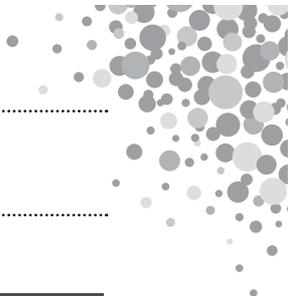
STEP 6 Create an action plan. This involves breaking the solution down to smaller steps.

- Step 1

- Step 2

- Step 3

STEP 7 Evaluate the outcome. If you didn't achieve your desired outcome, consider returning to Step 4 and choose another potential solution. Create another action plan based on the new solution.



The hassle log

The hassle log

Date

- Morning
 Afternoon
 Evening

Where were you?

What happened?

- Somebody put me down
 Somebody yelled at me
 Somebody told me to do something
 Somebody was doing something I didn't like
 Somebody starting fighting with me
 I did something wrong
 Other (describe)

Who was that somebody?

What were your feelings?

- Angry
 Frustrated
 Scared
 Jealous
 Put down
 Sad
 Rejected
 Other (describe)

What did you do?

- Hit someone
 Breathed deeply
 Ignored
 Broke something
 Walked away calmly
 Ran away
 Count backwards
 Talked to friend
 Cried
 Talked to adult
 Took time out
 Yelled
 Was assertive
 Changed thinking
 Visualised
 Other (describe)

What happened next?

How intense were your feelings?

- Not at all
 Slightly
 Quite a bit
 Very
 Extremely

How did you handle yourself?

- Poorly
 Not so well
 Okay
 Good
 Great

Reproduced from

French, R. (2001). *Getting along and keeping cool: A group program for aggression control*. Centre for Clinical Interventions, Western Australia.

Progressive muscle relaxation script

Progressive muscle relaxation – take home script

At the beginning of the session, remove your glasses, watch, jewellery, shoes, loosen your belt and remove anything that will distract you or make you feel uncomfortable. Make sure your phone is turned off. When you are seated comfortably in a chair in a quiet, softly lighted room, visualise a calm scene and begin to say “relax” to yourself each time you breathe out. Remember, it is important to say “relax” to yourself when you release the muscle tension and breathe out.

Now begin by tensing the muscles in your right hand... Tense the muscles tightly... Feel the tension in your right hand... Hold the tension... Now breathe out, and say “relax” and let the tension go. Relax... Now, once again, tense the muscles in your right hand... Hold the muscles tighter and tighter... Feel how tight and tense the muscles are... Now slowly breathe out, say the word “relax” and release the tension in your hand. Relax... Feel the tension dissolve... Feel the difference now that your right hand is relaxed.

Now do the same with your...

- Right upper arm
- Right shoulder
- Left hand
- Left upper arm
- Left shoulder
- Head (turn right, then left)
- Mouth (open wide, then press lips closed)
- Tongue (press up to roof, then press down)
- Now just sit there and relax. Try not to think of anything...
- Eyes (squeeze tightly closed, then hold open wide)

Now take a deep breath and hold it... Relax... Now exhale. Breathe all the air out... all of it... Say the word “relax” to yourself..

Imagine that there are weights pulling on all your muscles making them loose and relaxed... pulling your arms and body into the chair.

Now do the same with your...

- Stomach
- Buttocks
- Thighs and calves
- Toes and feet

This completes the relaxation procedure. Now explore your body from your feet up. Make sure that every muscle is relaxed. First your toes, your feet, your legs, buttocks, stomach, hands, arms, shoulders, neck, eyes, and your forehead. All should be relaxed now. Just sit there and feel very relaxed, noticing the warmth of relaxation.

You can now finish the session with a few minutes of visualising a calm and relaxing scene.

Adapted from

Bourne, E. J. (2011). *The Anxiety and Phobia Workbook*. 5th Ed. New Harbinger Publications; Oakland, CA.

Relaxation audio

Orygen Youth Health has created a CD of relaxation exercises to help young people chill out during difficult times. You can go to <http://oyh.org.au/training-resources/free-downloads/pause> and follow the instructions to download the audio files and use them for free.

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