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Characteristics and Components of the TADS CBT Approach

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Abstract

In this paper, we describe the Acute phase of a cognitive-behavioral therapy (CBT) developed for and utilized in the Treatment for Adolescents with Depression Study (TADS). The Acute phase of TADS CBT consists of eight skills that were considered essential to any CBT intervention for adolescent depression (e.g., mood monitoring, increasing pleasant activities, identifying cognitive distortions and developing realistic counter-thoughts). In addition, five optional individual CBT skills (e.g., relaxation, affect regulation) can be incorporated into treatment, depending on the needs of the adolescent. We describe each of these individual skills by reviewing the rationale for their inclusion in the treatment protocol and describing the format that is used to teach the skill area. Recommendations are provided for dealing with common challenges that can occur in the teaching of each skill module. It is our hope that clinicians will find this a useful introduction to this particular form of treatment and a practical guide to dealing with clinical problems common to the delivery of any cognitive behavioral intervention with depressed teens.

Characteristics and Components of the TADS CBT Approach

Introduction

Based on our review of available research on the treatment of adolescent depression (summarized in Curry, Wells, & March, 2005), we chose a cognitive-behavioral treatment (CBT) approach for TADS. The primary goal of cognitive therapy is to help the depressed individual become aware of pessimistic and negative thoughts, depressotypic beliefs, and causal attributions in which the person blames him/herself for failures but does not take credit for successes. Once these depressotypic patterns are recognized, the client is taught how to substitute more realistic constructive cognitions for these counter-productive ones. The primary goal of behavior therapy for depression is to increase engagement in behaviors that either elicit positive reinforcement or avoid negative reinforcement from the environment. The TADS CBT intervention for adolescent depression (Curry et al., 2000) combines cognitive and behavioral strategies aimed at ameliorating the types of problems that commonly characterize depressed adolescents (e.g., pessimism; internal, global, and stable attributions for failure; low self-esteem; low engagement in pleasant activities; social withdrawal; anxiety and tension; low social support and increased interpersonal conflict). The treatment incorporates other elements common to cognitive-behavioral treatments, such as the focus on specific and current actions

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and cognitions as targets for change, structured intervention sessions, repeated practice of skills, use of rewards and contracts, and a relatively small number of therapy sessions. To encourage greater generalization of the therapy skills to everyday situations, adolescents are given homework assignments to be completed outside of the session, which are reviewed at the beginning of the subsequent session.

Stages of CBT in TADS

In TADS, CBT occurs in three stages: Acute treatment, Continuation, and Maintenance. Acute treatment consists of 12 weekly sessions and is focused on alliance building, goal setting, and skill building. In the early sessions of Acute treatment, basic behavioral and cognitive skills (e.g., mood monitoring and pleasant activities) are introduced. In the later sessions of Acute treatment, more complex and individually tailored skills (e.g., social skills, negotiation and compromise) are the focus of treatment. During Acute treatment, there are two parent-only sessions devoted to psychoeducation and at least one conjoint family session. The Continuation stage of CBT is six weeks in duration, with weekly sessions for partial responders and biweekly sessions for full responders. For adolescents who fully respond to treatment, these sessions are aimed at consolidation of gains and relapse prevention, with no new skills introduced. For teens who only partially responded during the first 12 weeks, new skills from the TADS manual can be introduced as needed to further enhance treatment gains. The last session in the Continuation stage is devoted to developing a relapse prevention plan. The Maintenance stage of CBT is 18 weeks long with visits scheduled every six weeks. In this phase, sessions are oriented around skill consolidation, maintenance of gains, and relapse prevention. Homework is regularly assigned across all three stages of treatment. In this paper, we will focus on the Acute treatment stage; Continuation and Maintenance phases of treatment will be addressed in Simons et al. (2005) in this volume.

Modular Approach

When delivering a manual based intervention, it is important to balance therapist flexibility and adherence to the manual. TADS CBT utilizes a modular approach to assure such a balance. This approach is intended to maintain a clear CBT rationale and treatment model, to utilize structured, empirically supported treatment components, and to permit individual applications that meet the needs of a wide variety of teens and their parents. Thus, CBT in the Acute stage consists of teaching a set of skills modules (all to be discussed below) some of which are required, others of which are optional. One of the major ways in which treatment is individually tailored within TADS is the use of collaborative (i.e., the teen and the therapist together) agenda setting at the beginning of each session. In addition, while certain skills are required, additional skill modules are available depending on the needs of the specific adolescent. TADS CBT also incorporates the flexibility to addressed crises that arise (e.g., school refusal, suicidality) within regularly scheduled sessions or by using additional crisis sessions (i.e., Adjunctive Services and Attrition Prevention; ASAP), a certain number of which are allotted to each stage of treatment.

General Structure of TADS CBT Sessions

TADS CBT sessions are moderately structured, with the goal of balancing skill training and supportive, empathic listening (Carroll, 1998). Although the focus of each session varies depending on the specific skills being addressed and the needs of the individual client, TADS CBT sessions have a fairly consistent format, which is described to the adolescent in the first individual session. The hourly session is divided into three sections, each lasting approximately 20 minutes.

In the first third of the hour, the therapist checks in with the adolescent regarding depression symptoms since the last session, reviews the homework assignment from the previous session,

and sets the agenda in collaboration with the client. If the homework has not been done, the therapist brainstorms solutions with the client to increase the likelihood of future success, and attempts to complete the homework in the session. When homework has been completed, the adolescent should be strongly reinforced and encouraged to make an internal attribution for that accomplishment.

The middle third of the session is typically devoted to learning a new CBT skill or continuing to work on a skill that was introduced in an earlier session. CBT skills are most relevant to a client when they are linked to the adolescent's personal concerns and life experiences. Skills can be taught using a variety of techniques, including didactic teaching, modeling, role-playing, and Socratic questioning. Adolescents are encouraged to learn a variety of skills, with the expectation that not all skills will be useful to them, but that we do not know a priori which skills will be most powerful in improving their mood.

The final third of the session is devoted to addressing additional issues raised by the adolescent and planning a homework assignment for the upcoming week. Often, non-CBT therapists (and many beginning CBT therapists) do not devote enough time to planning the homework assignment. To maximize the therapeutic effectiveness of homework assignments, the therapist needs to make sure of several things: that the adolescent understands and accepts the rationale for homework, knows how to complete the assigned homework, has a plan for how they will remember to do the assignment outside of session, anticipates problems to completing the assignment, and brainstorms solutions to address these potential problems. Homework assignments need to be developed in consideration of the unique needs and abilities of the adolescent.

Parental Involvement in TADS CBT Sessions

Parents are typically the ones who have sought treatment for their teen, and they are often instrumental in ensuring treatment attendance. In addition, several factors involving the parents (e.g., marital discord, high parental expectations, poor problem solving skills, low rates of pleasant activities involving the family) often contribute to maintaining the adolescent's depression. For these reasons, parents are viewed as important members of the treatment team that is joined together against a common enemy – the adolescent's depression. Parents participate in treatment both by attending individual psychoeducation sessions and conjoint teen-parent sessions. In the Acute phase of treatment, there are two parent psychoeducation sessions and at least one conjoint session. In the psychoeducation sessions, the therapist reviews the skill-based modules with the parents, apprises them of the treatment and progress toward goals, and helps them understand ways in which they can reinforce the skills at home. In conjoint family sessions, family members can work together to identify and improve problem areas. In addition, during individual sessions with the adolescents, the TADS CBT therapist may "check in" with the parents for up to 10 – 15 minutes at the start of the session. The purpose and components of the parent sessions are described in more detail in Wells and Albano (2005).

The Therapeutic Relationship

As is true of any psychotherapeutic intervention, TADS CBT needs to be conducted within the context of a strong working alliance and therapeutic relationship between the adolescent, parents, and the therapist. Essential therapist characteristics include the capacity for accurate empathy, warmth, genuineness, and an ability to establish rapport with a diverse range of adolescents and parents. At times the therapist who works with the adolescent must maintain an alliance both with the teenager and the parents in the face of conflict between the adolescent and the parents.

The essential characteristics of the therapeutic relationship with the adolescent and parent include rapport and collaborative empiricism. Rapport refers to the therapist's ability to establish a connection with clients so that they feel accepted and able to express thoughts and feelings without fear of reproach. Collaborative empiricism refers to the therapist's ability to "work with" with the teen in looking for evidence regarding the accuracy of thoughts, establishing the session agenda, and choosing and planning homework. For example, one of the challenges is to question the client in a way that feels supportive and nonjudgmental. Therefore, the therapist who discovers that the adolescent is not completing the homework assignments may use the collaborative spirit so that therapist and teen think together as scientists about the obstacles that may be interfering with homework completion and then generate solutions to ensure more success in future homework completion.

Description of Required Individual CBT skills

The Acute phase of TADS CBT consists of eight required skills. Based on our review of the CBT literature, these skills were considered core concepts essential in any CBT treatment of adolescent depression. Five optional individual CBT skills can also be incorporated into the treatment, depending on the specific needs of the adolescent. In addition to these individual CBT skills, there are communication and problem-solving skills for clients learn in collaboration with their parents (described in Wells & Albano, 2005). Below, we review the individual skills by describing the rationale for their inclusion in the treatment protocol, the format we use to teach the skill module, and clinical applications, or common challenges that can occur for each skill area.

Treatment Rationale and Goal-Setting

Rationale—The first CBT session is conducted with both the adolescent and his or her parent (s). Based on the CBT premise that treatment should start with a model of change that is shared with the client, TADS CBT educates the family about the cognitive-behavioral model of depression and the treatment which is derived from that model. Additional aims of the first session are to elicit a list of the initial treatment goals from the family and begin to establish a collaborative therapeutic alliance with both the adolescent and parents.

Our model of depression includes the following components: (a) Depression is more than "feeling bad." It is a disorder that affects a person's mood, thinking, behavior, and biology. (b) Depression has many possible origins; there is no single cause that applies to everyone. (c) Effective treatment is available. Studies have shown that two of the best treatments of depression are CBT and the selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine.

Our model of CBT has the following components: (a) Personality can be thought of as a three-part system consisting of actions, thoughts, and emotions. (b) Each part of our personality affects the other two parts. If one component changes, the other two parts will be impacted. (c) A series of negative feelings, thoughts, or actions can cascade into a "downward spiral." Conversely, positive actions, thoughts, and feelings can build on each other to improve a person's outlook. (d) It is difficult to change emotions directly. Instead, it is easier to change negative thoughts or negative actions, which in turn will change emotions. (e) Recovering from depression requires that people do several things both in and between sessions. Clients need to become aware of their actions, thoughts, and feelings; evaluate how positive and helpful these actions, thoughts, and feelings are; and, if they are not helpful, they need to learn new skills for behaving and thinking in ways that more positive and helpful. (f) Change takes time and effort. It is important to learn all of the skills to see which ones will be most beneficial to the individual. (g) Once these skills are learned and used outside of the session, adolescents can become their own therapist.

Format—After a brief introduction, the therapist obtains a description from the adolescent and parents of the presenting problem. This information is helpful in personalizing the subsequent presentation of the CBT model of depression and treatment. It is also important to build hopefulness that the treatment approach will be of benefit to the specific problems your client is experiencing.

Once the therapist has reviewed the CBT conceptualization, the family is asked what their goals are for treatment. Goals are defined as guides to treatment. In addition, the ability to articulate and achieve one's goals is presented as a valuable skill in its own right. Begin your discussion with the adolescent, then ask the parents whether they can support their child's goals before asking for their own treatment goals for the adolescent. The session ends with a review of any questions the family may have and a discussion of practical matters regarding scheduling.

Clinical applications—The first session is obviously extremely important in terms of setting the stage for the rest of treatment. At least three issues can interfere with its effectiveness. The first problem is that the therapist does not create an adequate therapeutic alliance with the adolescent, most often because the parents are present and receive the majority of the therapist's attention. If this is a concern, attempt to conduct your first individual session with the adolescent as quickly as possible (aim for less than one week). If you know before the first session that there is a high degree of conflict between the adolescent and parent(s), it is possible to hold two sessions, one with only the adolescent and the second with just the parents.

Second, this session contains a large amount of material and therapists can overwhelm the family/adolescent if they cover everything too quickly. Emphasize with family that the remaining sessions will be much less didactic. Personalizing the material regarding the model of depression and CBT wherever possible also greatly helps to maintain the family's attention. Repeatedly check in with the family to ensure that the descriptions you are providing make sense to them and are relevant.

The third issue is that the adolescent and/or parents do not accept the CBT model of depression. When this occurs, it is most often because the individual sees depression as a problem in "brain chemistry" which requires medication. If this occurs, the therapist needs to note that it is not well-established who responds best to medication and who responds best to CBT. Also, the combination of treatment (if that is being provided) appears to be particularly helpful in impacting depression on two complimentary fronts.

Mood Monitoring

Rationale—Mood Monitoring is a basic skill that is taught to adolescents as a way to track how they are feeling. This kind of monitoring facilitates learning what situations lead to feeling more or less depressed (or irritable, lonely, etc.) and what kinds of thoughts may be connected to those emotions. Then, instead of having a vague sense of what contributes to feeling better or worse, teens will understand their depression better and feel more empowered to do something about it. Once situations have been identified that are associated with feeling better, the goal will be to increase such activities. Thus, Mood Monitoring leads naturally into the Pleasant Activities module. In addition, Mood Monitoring often sets the stage for later cognitive work by allowing teens to realize that they are not "always" feeling bad.

Format—TheMood Monitoring module is comprise d of two tools: the Emotions Thermometer and the mood monitoring form. The session begins by teaching teenagers that emotions vary in strength, and that by using an Emotions Thermometer, they can understand not only what they are feeling, but also how strong that emotion is. Adolescents are taught to rate emotions on an 11-point scale, ranging from 0 (very bad) to 10 (very good). To provide

concrete anchor points for the thermometer, the therapist asks the teen to recall two or three experiences in which they felt bad, and two or three in which they felt good, and to rate these experiences. Teens are encouraged to generate experiences that vary in intensity so that the whole thermometer range can be used. This exercise provides an opportunity to highlight to the adolescent that feelings range from good to better, and bad to worse, and concomitantly, that even though it might seem like they feel bad all the time, by using the Emotions Thermometer they can see how their emotions change over time.

Next, the mood monitoring form is introduced as a way to track daily what situations, events and thoughts are connected with feeling good or bad. Using several examples, teens are taught to rate their mood using the Emotions Thermometer. It is helpful to use examples that the teenager has brought up in the session to illustrate how to use the mood monitor. For homework, the teen is instructed to notice and record situations that happen in the morning, afternoon, and evening each day of the week that are associated with feeling good or feeling bad.

Clinical applications—Mood monitoring can present several challenges to the CBT therapist. One of the most common challenges with mood monitoring is that teens fail to record any situations in which their mood is good. If this occurs, empathize with the client and then briefly review the week to capture any missed positive emotions or experiences. Use the lack of variation in mood to bolster the rationale for doing more things that the teen enjoys (i.e., pleasant activities). Other common obstacles with mood monitoring are that the teen forgets to complete the form or finds it overwhelming. In either of these cases, attempt to reconstruct the form as completely as possible in the session and help the teen decide on one time in the evening to look back over their day and record their mood, as well as a particular place where the form will be kept (e.g., on a bedside table, in her or his backpack with other “homework”).

Goal Setting

Rationale—Goal setting is used to provide a therapeutic “map” to help identify a clearly defined set of reasons why the adolescent and family are seeking treatment. During the initial assessment, the parent(s) and teen identified how the teen’s symptoms of depression are manifested on a day-to-day basis. These symptoms or areas of concern are then translated into a list of goals to be addressed during treatment. With a list of clearly defined goals, the therapist can focus the treatment on specific areas and over time, better assess the degree of progress which has been made.

Format—During the first CBT session, the adolescent and parents discussed their goals for treatment. During the goal setting session, the teen meets individually with the therapist to review and refine goals. The teen is told that the therapist will keep track of how progress is being made toward these goals during the treatment.

The therapist reinforces the concept of goal setting as a familiar idea or technique that the adolescent has previously used in their lives. For example, the therapist can help the teen recall examples of how previous goals, such as trying to improve in a sport or learn a new instrument, were achieved. The therapist then asks the client to take one of the treatment goals and to identify the necessary smaller steps along the way to that larger goal. It is important to help the teen break down large goals into smaller steps and concretize goals that are too abstract so that progress can be seen along the way. One or two specific steps toward a larger goal that the teen identifies then becomes the homework assignment for the next session. For example, if the overall goal is to have a better relationship with peers, the teen may e-mail one or two friends or acquaintances during the week.

Clinical applications—One common challenge is that the adolescent's goals appear unreasonable. In this case, the therapist can take a stance of an inquisitive listener and accept the teen's goals as a reasonable starting point, but then help to break the goals down into manageable chunks. You may want to let the teen know that they may not be able to achieve their long-term goal during the course of therapy but that they can make meaningful progress towards it.

Another common problem is trying to tackle goals that are not clearly defined such as, "I want to do better in school." To be useful, goals must be broken down into manageable units and defined in concrete, measurable terms such as, "I want to get a B in math." Ideally, steps toward a clearly defined goal are articulated and roles are clearly defined. For example, "I will ask my teacher for additional assistance in math after school and my parent will check my homework and meet with the school personnel to discuss additional resources in the school."

With regard to parent involvement, discrepancies between teen and parent goals can be a significant area of discord. It is essential to question and discuss these discrepancies. Unrealistic parental goals can in some cases be gently challenged without disrupting the therapeutic alliance. If there are incompatible goals between parent and teen, the issue can be addressed in subsequent sessions. In general, goals pertaining to mental health problems of family members other than the teenager, or to marital conflict, are outside the scope of the program.

Increasing Pleasant Activities

Rationale—Like depressed adults, depressed adolescents often stop engaging in activities that once were enjoyable. Their repertoire of fun activities frequently is reduced to a small number of solitary, relatively passive activities (e.g., computer videogames, watching television, listening to potentially depressing music).

Format—The therapist begins by explaining the rationale for this skill module, which is to increase the level of pleasant activities. Once the rationale is established, generate a personalized list of pleasant activities, having the adolescent think of as many fun activities as possible. Be as specific as possible and include easy-to-accomplish activities, such as making a phone call or doing little things around the house. Given that you have already had a few sessions with the adolescent, you can remind the teen of previously mentioned enjoyable activities if they are unable to remember them. Continue until the adolescent has generated a list of at least 10 activities.

Next, review the list to select specific activities to increase. The following criteria should be used to select the most potent list of mood-enhancing activities: (a) personally enjoyable to the adolescent, (b) active rather than passive, (c) inexpensive, (d) not harmful to oneself or others, (e) can be done at least weekly, and (f) do not require the cooperation of many other people. Including one or two forms of physical activities (e.g., exercise, walking, sports) also is helpful.

Once the list of approximately 10 activities is generated, assess the rate of activity engagement for the previous three days to obtain baseline data. The homework assignment is to track activities (and mood), aiming to increase the teen's activity level slightly over baseline.

If the adolescent is experiencing significant psychomotor retardation or is unable to identify pleasant activities, the therapist may need to begin with Activity Scheduling (Brent & Poling, 1997). If Activity Scheduling is indicated, a weekly schedule is created in which the adolescent identifies activities to do at specific times each day. Include simple, routine activities (e.g., eating breakfast, taking a shower). The teen does the activities and then rates each activity on two dimensions: mastery (sense of accomplishment) and pleasure (enjoyment level), using the

0–10 point scale similar to the Emotions Thermometer. Once pleasurable activities are identified in subsequent sessions, they can become the focus for behavioral activation.

Clinical applications—Several factors can interfere with behavioral activation. Sometimes, depressed adolescents select activities that they believe should be enjoyable but in reality are not pleasant for them. If you suspect this given your knowledge of the adolescent, gently question whether other activities might be more enjoyable. Second, some depressed adolescents are overwhelmed with the assignment of tracking all of the activities on their list. If the list is too much, focus on one or two activities that appear to be particularly reinforcing for the adolescent and work on engaging in that specific activity as the homework. Other adolescents may state that they don't "feel" like doing the activities. Gently remind the adolescent of the personality triangle (increasing their activity level has to occur prior to the improvement in mood) and encourage them to try this as an experiment. Third, the list of activities may be impractical (e.g., too expensive or contingent on factors out of the adolescent's control). If this occurs, augment the list with additional activities that are more likely to occur.

Some adolescents have a high level of required activities, either related to school, work, or home chores. It may be necessary to work with the parents to free up the adolescent's schedule to accommodate more fun activities. Other depressed adolescents are already engaging in a lot of activities which theoretically could be enjoyable, but they are sabotaging these activities with negative self-talk. If this appears to be the case, gather information on the adolescent's negative cognitions during homework review, making notes for the upcoming sessions on cognitive distortions. Other adolescents may be engaging in potentially enjoyable social activities but failing to enjoy the events because of their social skill deficits. If this appears to be the case, the optional social skill modules described below may be helpful.

Occasionally, adolescents increase their activity level but report no corresponding improvement in mood. There are several possible explanations: (a) they are not tracking the activities that have the strongest effect on their mood, (b) it may take more time for the behavioral activation to have a noticeable effect, or (c) they may not benefit from behavioral activation. Fortunately, increasing Pleasant Activities is only one of a number of potential skills that can help them feel better.

Problem Solving

Rationale—Depressed teens often have impaired problem solving skills or experience psychosocial stressors that contribute to the maintenance of their depression. Many times, because of concentration difficulties, pessimism, passivity, or slowed thinking, depressed adolescents find it difficult to generate options and to think through these options systematically. Teaching a structured method to solve problems can combat such obstacles and help teens to adaptively cope with problems that would otherwise lead to feeling down, hopeless, or powerless.

Format—The therapist's first task is to lay the groundwork for problem solving as a skill by explaining to the teenager that everyone faces problems in their lives, and it is very important to have a way to solve them so that they do not lead to pessimism or depression. Next, the therapist can introduce a general method for problem solving with practice situations. In general, problem solving should first be taught using examples of other people's problems. In TADS CBT, for example, problem solving is first demonstrated using "Dear Problem Solver" letters that contain elements of common problems for teenagers (e.g., curfew, grades, conflicts with friends and parents). After reading these letters, teens are asked to define the problem and to generate as many possible solutions as they can without worrying whether the solutions are

good or bad. After brainstorming solutions, the therapist helps the client look at the potential negative and positive consequences of each option, and then to make a hypothetical choice.

Once the adolescent has practiced the basic steps of problem solving with several such examples, the therapist can review the components of problem solving more formally. In TADS, our problem solving method was named "RIBEYE" to facilitate teens remembering all the important components of solving problems. This acronym stands for: **R**elax, **I**dentify the problem, **B**rainstorm, **E**valuate the solutions, say **Y**es to one, and **E**ncourage yourself. After Problem Solving is practiced in the session, selected solutions are assigned as homework for the upcoming week.

Clinical applications—Problem solving can be a very useful tool for most depressed teens. However, several difficulties may occur when teaching this skill. First, teens may try to use the skill to tackle complex, difficult problems without sufficient practice, and become frustrated or hopeless when they do not immediately succeed. This is especially the case with perfectionistic teens who have unrealistically high standards for themselves. Therapists should take care to guide teens to use RIBEYE first with moderately difficult problems so that they can experience some success with the method and gain practice with all of the steps.

Another common challenge is that teens find it difficult to generate options without evaluating them at the same time. Particularly for teens with pronounced negative thinking styles, repeated brainstorming practice with gentle reminders ("Let's brainstorm first; we'll evaluate later.") will be essential to allow them to entertain a variety of solutions instead of quickly dismissing the problem as hopeless. A third common challenge is that some adolescents think this kind of a problem solving process is unrealistic, saying things like, "if I have a real problem, I won't have time to whip out my RIBEYE sheet." To address this criticism, encourage the teen to find parts of problem solving process that can be employed regardless of the situation. For example, some teens report that the only step that they reliably use is brainstorming, and that that allows them to slow down enough to think more clearly about their options. In general, the more RIBEYE steps that they use, the greater the likelihood of finding a positive solution to the problem.

Automatic Thoughts and Cognitive Distortions

Rationale—Patterns of maladaptive thinking (e.g., automatic negative thoughts) negatively influence emotions and behaviors (Beck, 1995). In CBT, a fundamental intervention focus is teaching teens to identify and challenge errors in thinking (i.e., cognitive distortions). Certain cognitive styles or maladaptive patterns of thinking (e.g., overlooking the positive aspects of a situation) can halt treatment progress or lead to depression relapse. Therefore, it is necessary to teach the depressed client how to identify and then to counteract negative irrational thinking patterns.

Format—This session builds upon the adolescent's understanding of the daily mood monitoring log and launches into the next step of examining the role of thoughts in mood disturbance. By this time, your client will have completed several weeks of a mood monitoring log linking feeling states to specific situations, and may have already begun to identify thoughts associated with these situations. In this session, a three-column mood monitor is introduced on which the adolescent records upsetting events, negative thoughts associated with the situation, and resulting emotions.

In this session, the teen is provided with a simplified list of commonly described cognitive distortions (e.g., Beck et al., 1979; Burns, 1980). After reviewing this list, the teen is asked to read a series of hypothetical scenarios entitled "Dear Problem Solver" letters which are designed to illustrate cognitive distortions (e.g., catastrophizing, black and white thinking,

missing the positive, jumping to conclusions). This provides the teen with an opportunity to identify unhelpful thinking in other people. Once the adolescent can accurately identify these distortions in the letters, the therapist has an opportunity to help the adolescent apply the list of distortions directly to their own experiences.

Clinical applications—Some teens have difficulty identifying their negative automatic thoughts. In this case, you can start with identifying thoughts in more familiar neutral arenas, such as thoughts related to preferences in music, or friends, and identify the ways that the thoughts have changed over time in order for the adolescent to become acquainted with the notion that thoughts can change. Alternatively, the therapist can give clients hypothetical events and ask them to record at least two emotions they might have in reaction to the event and to rate these emotions on the Emotions Thermometer. Such hypothetical scenarios are “your mother or father tells you that you are lazy” or “you graduate from high school.” The therapist helps the teen to understand that different ways of thinking about the same event lead to different emotions.

Realistic Counter-Thoughts

Rationale—Once the adolescent understands the concept of cognitive distortions and has begun to identify common automatic negative thoughts, the therapist moves on to the next skill, which is to “talk back” to negative automatic negative thoughts and cognitive distortions by formulating and using realistic counter-thoughts.

Format—The module starts with an analogy of “contrasting coaches” to illustrate the differences between excessive self-criticism and self-encouragement. Most depressed people talk to themselves like a critical, punitive coach, whereas they tend to treat other people in a positive coaching style (e.g., complimenting the other person on her or his effort, ignoring past mistakes, giving clear instructions for future efforts). The goal is for the adolescent to “coach” him/herself in a more positive manner.

Using examples of automatic negative thoughts, the therapist begins teaching the adolescent a variety of methods to question negative thinking. Techniques can include (a) looking for contradictory evidence (e.g., “Is there any evidence that this thought is not completely correct?”), (b) Socratic questioning (e.g., “Is there any other way to look at the situation?”), and (c) role playing and role reversal (e.g., the therapist and adolescent switch roles with the therapist modeling “stuck” negative automatic thinking and having the adolescent suggest alternative thoughts, acting as the therapist). The goal is to develop a realistic counter-thought, which is defined as a more realistic, positive thought about the same topic.

The homework assignment for this skill is to develop, write down, and review potentially helpful counter-thoughts, with the goal of practicing them in real-life stressful situations. Also, the five-column form from cognitive therapy with adults (i.e., describing the event, automatic negative thoughts, initial emotions, realistic counter-thoughts, and subsequent emotions) can be extremely powerful.

Clinical applications—Probably the most common challenge is that some adolescents cannot grasp the underlying concepts of this skill module. These skills are the most demanding cognitively. When the client is young or immature, it may be more effective to focus on using positive statements or affirmations instead of attempting to have the adolescent develop realistic counter-thoughts on their own. If you attempt to teach this concept and are unsuccessful, be sure to assure the client that they are not at fault, otherwise they may generate additional negative attributions (“I’m so stupid that I can’t even understand therapy.”)

Occasionally adolescents get preoccupied with finding the one “right” counter-thought. The therapist needs to clearly note that there is no single correct response to a negative automatic thought. The value of a counter-thought depends on whether it is believable and whether it helps the client feel more positive and accepting of the event.

A common dilemma is that, although exaggerated, a depressed person’s negative thoughts sometimes are fairly accurate. As cognitive therapists, are we attempting to encourage our clients to look at the world through rose-colored glasses? If you try and push an overly-optimistic thought, it will not be believable to the adolescent and will be rejected. A more helpful approach is to aim toward thoughts that are just slightly more positive than the client’s view of reality. The therapist needs to validate accurate negative thoughts and acknowledge that it is perfectly realistic to think negatively when negative things happen. If the person remains stuck in that negative thinking, however, it may no longer be as helpful.

When working on this skill, sometimes therapists can become argumentative with their clients. You can’t force this skill on the adolescent. A helpful stance to take is that we teach our clients these skills with the clear understanding that it is up to them to decide if and when they will use these skills.

Taking Stock

Rationale—The final session in the Acute stage of treatment, Taking Stock, is aimed at reviewing progress in treatment, determining which skills have been most helpful, and making a plan for the next stage of treatment. This is an opportunity for the therapist to highlight gains that the teen has made and to reinforce the connection between use of the CBT skills and achieving these gains. For all adolescents, but in particular those who are hopeless or perfectionistic, therapists should clearly convey that continued practice with the cognitive and behavioral skills taught in the first stage of treatment will make additional progress possible.

Format—The Taking Stock session needs to be individually tailored with regard to the particular adolescent’s progress or lack thereof. It is important that parents are involved in this session at least at the end when plans for the next stage of treatment are being discussed. The format of this session is slightly different than previous sessions because the emphasis is on reviewing skills, as opposed to learning new ones. After reviewing homework, the therapist reviews the progress that has been made towards goals set at the beginning of therapy and the steps that were remain to be taken toward these goals. Next, the therapist and the teen review skills taught so far in treatment and discuss which particular skills were most helpful. It is useful to emphasize to the teen the positive changes achieved over the course of treatment as a result of using these skills. Next, discuss the schedule for the upcoming Continuation phase of treatment, as well as the focus of the remaining sessions. For clients who have not benefited significantly from treatment, this is an opportunity to discuss other treatment options and to provide referrals, if appropriate. For teens who will continue in treatment, spend time anticipating any upcoming challenges and plan with them how to utilize the tools that they have already identified as helpful to cope with these stressors.

Clinical applications—For many teens, the Taking Stock session is an opportunity to celebrate treatment progress. However, for adolescents who have made very little progress or who belittle the progress they have made, the challenge of this session is to remain optimistic. Encourage clients to notice the small steps that they have taken toward their goals and highlight that some progress is substantially better than none at all. Also, talk about that fact that the next stage of treatment will provide additional opportunities for steps towards goals and skills practice. If other treatments will replace or augment CBT in the future, the main goals of this

session will be to educate the teen and parents that several different treatment options exist and that lack of success in CBT does not mean that other treatments will not help.

Description of Optional Individual CBT Skills

In addition to the eight CBT skills that are provided to all clients during the first 12 weeks of TADS CBT, five additional skills can be added to treatment, based on the specific needs of the adolescents. These optional modules are reviewed next.

Social Interaction

Rationale—This module is for teens who are having difficulty making and keeping friends. Underlying personality characteristics such as shyness may contribute to a longstanding history of difficulty initiating friendships. Diminished competency regarding social interactions may lead to further isolation from peers, and negative thoughts that they will never make friends. These negative cognitions, in turn contribute to feelings of depression. Social skill instruction may be introduced to halt this downward spiral.

Format—The adolescent is given practical social skills derived from Clarke, Lewinsohn, and Hops (1990). These skills include basic components of social interactions, such as meeting, greeting, and talking with people. Specifically, through role-playing and discussion, clients learn skills to help meet other people (e.g., making eye contact) and helpful ways to start a conversation (e.g., asking open-ended questions). Additional practical skills covered include listening skills, skills for ending a conversation, and skills for group conversations.

As an example, the therapist can model poor conversation skills at first and have the teen comment on observable conversation errors such as slouching, looking at the floor, changing topics abruptly, etc. The therapist can then model more effective conversation skills with the adolescent playing the role of a peer. To help solidify learning the new skill, the adolescent then reverses roles with the therapist and practices employing effective conversation skills.

Clinical applications—Negative thoughts associated with social skill deficits or social withdrawal are likely to occur when working on this module. The therapist should be alert to such negative automatic thoughts (e.g., “people don’t like me,” “I’ll never be able to make friends”), as it is important to help the teen identify and challenge those thoughts.

Initially, shy adolescents may feel awkward about the role plays, particularly if they are uncomfortable talking about and placing themselves in unfamiliar social situations. Therefore, it may be necessary for the therapist to reassure the teen that feeling somewhat uncomfortable in a new group is a universal phenomenon. Additionally, it is important for the teen to know that social skills can be learned just like any other skill. Although these techniques may feel difficult or awkward initially, with practice, the results can be rewarding.

Assertion

Rationale—As part of their social skill deficits, many depressed adolescents have difficulties standing up for themselves. The majority of depressed individuals are overly passive, but a subset of depressed adolescents fail to express their frustrations until they blow up at someone (often a parent) in an aggressive manner. Some depressed adolescents experience pressure from deviant peers or coercion from a boyfriend or girlfriend. Others could benefit from improved assertiveness with their parents. The therapist needs to convey that assertiveness is not a personality trait that you either do or do not have; it is a skill that can be learned. Clients who learn how to be assertive in difficult interpersonal situations feel better and have a greater likelihood of getting what they want or need out of a situation.

Format—The terms "passive," "aggressive," and "assertive," are defined, along with examples of each type of response in common interpersonal situations. When these concepts are understood, the therapist moves into personal situations in which the client has responded either passively or aggressively. In addition to understanding the teen's behavior, it is useful to identify the cognitive distortions which inhibit assertiveness.

Three main steps are taught in generating an assertive response. First, clients need to recognize how they feel about the situation. Second, they express that emotion, using an "I statement." Third, they ask for a different course of action. The session can be especially productive if it includes as much behavioral rehearsal as possible, including role-playing the potential responses of the other person.

Homework for this skill consists of writing the steps for being assertive on index cards, and practicing the assertive response to a real-life interpersonal situation. This practice is recorded for review at the following session.

Clinical applications—Perhaps the most common challenge to learning this skill is that it requires a troublesome interpersonal situation to occur in close proximity to the session. Often, the adolescent is unable to practice this skill after the session because the most relevant situation requiring an assertive response does not happen or is not under the adolescent's control (e.g., the challenging person does not interact with your client that week). This makes it difficult to practice the skills in a real-life situation. A second challenge to teaching this skill is that the adolescent inadvertently goes from acting passively to acting in an aggressive manner. If this happens with the adolescent's parents, it may be necessary to carefully review this skill with the parent to forewarn them of what to expect and what to reinforce.

Communication and Compromise

Rationale—Depressed adolescents may have other social skill deficits that contribute to their depression, including difficulties with communication, negotiation, and compromise. For example, difficulty negotiating family conflicts may lead to decreased social support and higher levels of hostility, both of which increase stress and exacerbate depression. Difficulty communicating with peers and teachers may also contribute to depression. Changing ineffective or hostile communication patterns is one way to change behavior that can lead to positive changes in relationships and emotions.

Format—This module is comprised of two separate but interrelated skills: listening and compromising. Listening is taught first, and is related to incidents that the adolescent may have brought up previously where communication breakdowns were connected to feeling depressed. For the therapist to effectively teach listening, two important concepts need to be conveyed to the adolescent: (a) one can listen even when one disagrees, and (b) one can learn or improve listening and other communication skills with effort and practice. In order to provide practice in listening skills, role-playing is very useful. One way to do this is for the teen and the therapist to role-play debates on current controversial topics. First the therapist should find out the teen's stance on a particular topic. Then, while the therapist argues the opposite position, the teen is instructed to listen closely and summarize what was said. After correctly summarizing the therapist's stance, the teen presents his or her position on the topic, which the therapist listens closely to and summarizes. This practice provides an opportunity to highlight the difference between listening and agreeing, and to target any negative thoughts or cognitive distortions that may be contributing to ineffective communication.

Listening as a skill lays an essential foundation for teaching compromise. Convey the importance of compromise by using earlier incidents from the client's life to illustrate the connection between an inability to compromise and reduced social support or increased

interpersonal conflict, which contributes to the adolescent's depression. Your task is to help the client practice compromise as an extension of the problem solving skills taught earlier. Central points that need to be conveyed include: the need for compromise in all relationships, the relationship between compromise and other problem solving skills, and the connection between negative thinking and being inflexible. Role-play situations that require compromising using the RIBEYE steps from previous sessions. For example, present the teen with one of the following scenarios: "Your friends want you to stay out till 2 AM, but your mom told you to be home by 12 – and it's 11:30"; "Your parents want you to study harder so that you'll get better grades, but you already feel burned out and aren't sure that you are capable of better grades." Work through each of the RIBEYE steps with one of these problems and help the teen to generate solutions that involve compromise. For homework, design an exercise that requires practicing compromise skills.

Clinical applications—One of the difficulties in teaching teens listening and compromise skills is that other members of their families have similar communication styles or deficits. Families of depressed adolescents may develop maladaptive or hostile communication patterns that contribute to the teen's continuing depression or to their risk for relapse. When you have observed high rates of negative communication behaviors or hostility during conjoint parent-teen sessions, it is essential to build on what the teen has been taught by also teaching parents these listening and communication skills.

Another common challenge is that the teen finds it very difficult to stay calm enough to either listen or compromise. For these adolescents, additional work on relaxation or affect regulation (both described below) may be necessary before they are able to successfully employ their newly learned compromise skills.

Relaxation

Rationale—The relaxation module may be employed by therapists who are working with adolescents who appear tense when problem solving or in social situations. Difficulty relaxing and feeling stressed can contribute to depression and can interfere with being able to employ skills that were introduced in the other modules.

Format—The therapist introduces the relaxation module by indicating that the adolescent has mentioned times when they feel "stressed out." The therapist explains that feeling stressed makes it difficult to cope with issues that arise and that feeling tense breeds additional problems to implementing the first step of the RIBEYE method of problem solving.

Through a series of questions, the therapist helps the teen identify different situations that increase tension and speaks with the adolescent about how their tension is manifested physically. The teen is then taught brief relaxation methods that have been adapted from Adolescent Anger Control (Feindler & Ecton, 1986). The therapist describes the technique, demonstrates the skill, invites the teen to practice the skill, and then gives appropriate feedback and guidance regarding how the skill is used. The following list of relaxation skills may be covered: Deep Breathing, Deep Breathing with a self statement such as "I'm relaxing" and "I'm keeping my cool," Deep Breathing with a self statements and counting backwards, or Deep Breathing with pleasant imagery such as asking the teenager to think of an appealing outdoor scene. Tension reducing options such as leaving the negative situation for a period of time and going out for a walk are also introduced.

Should the teen need additional training in Progressive Muscle Relaxation, the therapist may utilize techniques outlined by Cautela and Groden (1978), which involve going through progressive muscle groups with corresponding movements such as making a tight fist for five seconds and then relaxing the hand for ten seconds. It is important to elicit feedback from the

teen as to how they feel after the relaxation exercises by having them rate their feelings on the Emotions Thermometer.

The techniques may be audiotaped so the teen can take the tape home and listen to the techniques for review. Additionally, the therapist may write brief guidelines or reminders about how to practice the methods on index cards for the teen to follow at home. With regard to the homework assignments, the teen may rate their level of tension before and after the relaxation technique along with the associated automatic thoughts.

Clinical applications—The therapist needs to tailor the relaxation techniques to the needs of the adolescent. For example, progressive muscle relaxation may be helpful to teens with generalized anxiety disorder or insomnia, but is contraindicated for adolescents with panic attacks, and it is not likely to be helpful for adolescents with social phobia. In general, briefer relaxation methods are more likely to be used by teens than the more time-consuming technique of progressive muscle relaxation.

With teens prone to impulsivity or losing their temper, the therapist should help them to understand that the relaxation techniques are a way for them to regain their composure so that they have an opportunity to actively decide the right thing to do.

Parents may be instrumental in the use of relaxation techniques, such as allowing the teen to leave a room for a brief "cooling off period" without being reprimanded for avoiding parent/teen interactions.

Affect Regulation

Rationale—Affect Regulation is introduced if the therapist has noticed that the teen has difficulty coping with emotionally arousing situations. The module is used to enhance a teen's ability to control sudden changes in mood and to develop a plan with specific steps for coping with situations that trigger intense emotions (Rotheram, 1987). If the teen becomes too emotionally aroused (e.g., becomes angry or tense), it is difficult for them to employ the coping strategies that they have learned throughout TADS CBT.

Format—The therapist introduces this module to the teen as a way of "keeping feelings under control." In an empathetic manner, the therapist explains to the teen that it is difficult to remember how to use the skills they have worked on in treatment because the teen becomes very upset or "stressed out."

The therapist then asks the teen to look at a blank Emotions Thermometer and to name the way he or she feels when they are about to lose control. The emotions will likely vary between feeling "stressed," "frustrated," or "angry." The teen is asked to label the higher end of the Emotions Thermometer with a term that connotes feeling out of control (e.g., "about to explode"), and to label the opposite end "feeling in control" or "relaxed." At the intermediate points on the Emotions Thermometer, the teen is asked to identify physiological, psychological, and behavioral cues indicating escalation toward the "out of control" emotion. Examples include tension in the body, increases in speech volume or intensity, agitated behavior, tantrums, or slamming doors.

Once behavioral anchors have been developed for the various points on the Emotions Thermometer, the teen is asked to indicate on the Thermometer the point at which the situation becomes "too hot to handle." We label that point on the scale the "Boil Over Point." The adolescent is then asked to choose a point and accompanying cues to serve as signals that they need to "do something" to calm down before they arrive at the "Boil Over Point." This point is labeled the "Action Point," or the point where the teen is still able to use their skills or

otherwise avoid an explosive outburst. The therapist then works with the teen to identify specific steps that they can take at the Action Point (e.g., taking a walk, leaving the house with a family member, choosing an activity from the Pleasant Activity list).

Parental collaboration during a portion of the session is helpful so that they can add their observations regarding these occurrences. Parents should also be involved so that they can cooperate in the plan. Parents may need to be encouraged to avoid engaging in behaviors that are likely to escalate the situation, such as continuing to pursue an argument with the teen who is about to flare up. Both parents and teen need to develop a plan for a "cooling off" period with each party going to a different location in the house should the need arise.

As a way to reinforce the newly learned skill, an index card listing each step the adolescent may take when their emotions approach the "Action Point" is made along with helpful self statements or realistic counter-thoughts and concrete actions. The teen is encouraged to use the affect regulation as a prerequisite to problem solving once they have "cooled off." A second, parallel index card is given to the parent, listing what the teen may do and how the parent may assist.

Clinical applications—The most common clinical problem is that adolescents learn affect regulation strategies during the therapy session but "forget" to employ these coping skills when experiencing intense emotional reactions. It is important to rehearse a scenario similar to the one that might trigger an intense emotion and walk the teen through each step of the plan. As a way of troubleshooting, the therapist with the help of the teen, selects one or two such scenarios that may occur in the near future and discusses a specific action plan. The teen is encouraged to imagine and "walk through" an example in which they might have to "Keep Feelings Under Control." The automatic thoughts are identified along with realistic counter-thoughts that may reduce feelings of stress.

Conclusions

The Acute phase of TADS CBT covers a wide array of behavioral and cognitive techniques known to be effective in reducing depression (e.g., Curry et al., 2005). Our aim in developing this intervention was to create a comprehensive, yet practical, treatment approach for working with depressed adolescents. We have attempted to develop an intervention that effectively includes parents in treatment and provides an optimal blend of structure and flexibility for the therapist. Clinicians interested in adopting this treatment approach may need to adapt the intervention to fit the demands of their setting and client population. Our goal in this paper was to introduce the intervention to clinicians and to provide practical advice related to providing these specific skills to their depressed adolescent clients. While results from the TADS project suggest that the combination of CBT and SSRI medication is superior to CBT monotherapy by the end of 12 weeks (TADS Team, 2004), future research examining the moderators and mediators of treatment response and the long-term effectiveness of TADS CBT will provide a more complete understanding of the factors therapists need to consider when selecting the treatment approach that has the greatest likelihood of being successful for the specific depressed adolescent clients in their practice.

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