Cognitive Therapy Treatment Manual for Depressed and Suicidal Youth

David A. Brent, M.D.
Kim Poling, L.S.W.
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University of Pittsburgh Health Systems

Services for Teens at Risk

David A. Brent, M. D.
Kim Poling, L.S.W.

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Foreword

STAR-Center is a treatment, training, outreach and research program of the Division of Child Psychiatry, University of Pittsburgh School of Medicine. We acknowledge with gratitude the funding of the Pennsylvania General Assembly, which makes our services possible.
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Assessment of the Depressed and Suicidal Adolescent

The first step in the treatment of suicidal adolescents is a careful assessment of the patient and the family (Brent, 1996). In this way, an appropriate treatment plan can be formulated that takes into account all of the critical issues with which suicidal patients present. When this information is available at the outset, decisions can be made as to: (a) the need for hospitalization; (b) the appropriateness of cognitive therapy; and (c) the need for alternative or additional modalities such as pharmacotherapy. The assessment has several important components:

Suicidality

Perhaps the most critical feature of the initial interview is the establishment of the degree of suicidal intent (Appendix 1). Suicidal intent, or the extent to which the suicide attempter wished to die, is a construct first described by Beck, Schuyler & Herman (1974). This can be inferred from the intent (using the Beck Intent Scale) and lethality of a recent suicide attempt (using the Risk Rescue Rating, Weisman & Worden, 1972), subsequent persistence of suicidal ideation with a concrete plan, and an active wish to die and pervasive hopelessness. Patients who have these features and cannot promise to keep themselves safe (no-suicide contract, see Table 1) should be considered for hospitalization, even if they must be committed involuntarily.

It is important to note that suicidal intent is probably not a unitary concept, but instead consists of four orthogonal factors: (1) belief about intent; (2) preparation before attempt; (3) prevention of discovery; and (4) communication (Kingsbury, 1993). Items indicating high suicidal intent that discriminate between completers and attempters, include evidence of planning, timing the attempt so as to avoid detection, confiding suicidal plans ahead of time, and expressing a wish to die. High suicidal intent is associated with repetition of suicide attempts, and completion of suicide (Brent et al., 1988; Hawton, Osborn, O'Grady & Cole, 1982a).

Other aspects of suicidal behavior that are important to ascertain are: (a) onset; (b) chronicity; and (c) relationship to other psychiatric symptoms and syndromes: For example, a chronically depressed patient may have had an exacerbation of suicidality following abuse of marijuana. Therefore, it is not the depression alone, but the comorbidity with substance abuse that must be addressed acutely.

Additionally, it is critical to ascertain the nature of the precipitant, that is, the event most closely associated with the suicidality. Most frequently, these precipitants are interpersonal discord, loss, or personal humiliation. Reconstructing the external chain of events and internal (i.e., chain of cognitions and emotions) sequences linking the precipitant to the suicidal event can provide helpful clues as to the type of thinking that led the patient to consider suicide. Understanding the nature of the precipitant, and how it is perceived by the adolescent and family are critical to
successful treatment, and often provide a beginning basis for therapeutic intervention. Gaining an understanding of the cognitive distortions is critical to the formulation of a treatment plan in cognitive therapy, because the basis of cognitive therapy is that the identification and modification of distortions will result in an improvement in depressive symptomatology. For example, a patient may make a suicide attempt after a break-up with a girlfriend, and he may say, "without her, I'm nothing." This can provide the theme for focal cognitive therapy that explores the erroneous assumption that one's self-esteem and happiness are entirely dependent on another person. A fight with a parent may also serve as a precipitant for an attempt, with the person reporting, "we always fight, so I must be a bad person and unlovable." This statement can help the therapist to formulate a reasonable plan of action, including an exploration of the meaning of fighting, and to question whether it is possible to have arguments and still be a decent and loveable person.

Motivation is also a crucial aspect of the suicidal episode. The motivations for the attempt are the reason or reasons given for the suicidal act. For those of highest suicidal intent, the motivation for the suicide attempt is a wish to die. For about two-thirds of adolescents attempters, the motivations are distinct from this, and include a desire to escape (either psychological pain or an unbearable situation), to gain attention, express hostility or induce guilt (Hawton, Cole, O'Grady & Osborn, 1982b; Kienhorst et al., 1995). Those with a persistent wish to die are at highest risk for repetition of suicidal behavior. However, those with a strong desire to escape may also be at increased risk to repeat their suicidal behavior. It is important to identify the affect associated with the suicidality. Frequently, the adolescent suicide attempter is angry rather than depressed at the time of the attempt, so that the management of anger and the accompanying impulsivity should be important components of treatment.

For all patients, the motivation for the attempt can be an important guide to the treatment plan, since, even for those who do not wish to die, there are preferable and safer methods of regulating affect, expressing hostility, or gaining attention than attempting suicide.

No-suicide Contract

The negotiation of the no-suicide contract is one of the most critical parts of the assessment of suicidality. With the no-suicide contract, the patient promises not to engage in further self-harm, and to notify the therapist, parent or responsible adult if suicidal urges resurface (Drye, Goulding & Goulding, 1973). In the formulation of a no-suicide contract, it is helpful to review what steps the patient and family would take if the same difficulties that led to the suicidal crisis would resurface, and to develop alternative methods of coping with these stressors. These steps can be written down on a business card for the patient to refer to in time of stress. The parents are a party to this contract as well, and the procedure for involuntary commitment should be reviewed with them. Ongoing monitoring of suicidality should
be a part of every subsequent treatment session, in essence, recontracting with the patient. When making the no-suicide contract, it is helpful to go beyond a simple assertion on the part of the patient, and test his/her resolve by asking what the patient would do if the precipitant (e.g., family discord) for the initial suicidal episode should recur. The no-suicide contract is not fool-proof, but is an initial measure of the therapeutic alliance and should be viewed within the context of other clinical risk factors. If the patient and family can agree to the contract, and there are no clinical contraindications (e.g., psychosis, active substance abuse, unstable bipolar disorder) then treatment can proceed on an outpatient basis.

**Referral for Hospitalization**

While there are wide national variations with respect to the availability and acceptability of inpatient hospitalization, it can be agreed that the higher the judged suicidal risk, the more intensive the recommended treatment. Psychiatric hospitalization is indicated for patients who, unless monitored in a structured and protective environment, are judged to be in imminent danger of suicide or suicidal behavior. Patients who are preoccupied with death, who show evidence of a suicidal plan and have intent to carry it out, and who have made suicide attempts of high intent or of extremely high lethality are best treated on an inpatient unit. Where psychiatric hospitalization is unavailable, more intensive treatment might correspond to day hospitalization, vigilant monitoring at home by relatives, or intensive outpatient treatment. Table 2 lists some common indicators for more intensive monitoring and treatment, and is a natural extension of our knowledge of risk factors for repeated suicidal behavior and completed suicide.

One helpful clinical tool in the decision to seek more intensive treatment for the patient rests on the clinician's judgment of the patient's ability to keep a no-suicide contract. This contract is an agreement between the patient, family, and therapist that the patient will not attempt suicide, and that if the patient does feel suicidal, he/she will notify a significant other, as well as the therapist.

Psychiatric hospitalization may be opposed by the patient, and if a no-suicide contract cannot be obtained, and/or the patient has a dangerous constellation of risk factors, then an involuntary commitment should be sought. One exception to this general guideline is when both the patient and the family are adamantly opposed to hospitalization. In this case, the clinician must weigh the need of the patient for immediate protection against the possibility that commitment may alienate both the patient and family against subsequent psychiatric care. Unless the patient is at immediate suicidal risk, the clinician may be better off trying to arrange for frequent outpatient monitoring of the patient, while maintaining a strong alliance with the family.

Hospitalization is at best a temporary respite from suicidality. The risk of suicide and suicidal behavior is greatest in the time immediately after discharge from the hospital, according to studies of adolescents and adults. Therefore, linkages...
between inpatient and outpatient programs are essential, as is a clear discharge follow-up plan, so that treatment and monitoring of suicidal risk can continue uninterrupted after discharge from the hospital.

**Psychiatric Symptomatology**

In over 80% of community and referred cases of suicide attempts, there are associated psychopathological conditions, most often affective, anxiety, conduct, or substance abuse disorders (Andrews & Lewinsohn, 1992; Fergusson & Lynskey, 1995; Kerfoot et al., 1996, Reinherz et al., 1995). The diagnostic category most closely associated with attempted suicide has been depression, and the general observation has been made that as the number of comorbid conditions (either affective or non-affective) increases, so does the risk of suicide attempts (Fergusson & Lynskey, 1995; Kerfoot et al., 1996; Lewinsohn, et al., 1995; Reinherz et al., 1995).

Comorbidity with personality conditions, particularly cluster B disorders (borderline, antisocial, histrionic) also appears to increase the risk of suicide attempts and completions (Brent et al., 1993d. 1994b). Chronicity of disorder has been associated with increased suicidal risk (Brent et al., 1988; Ryan et al., 1987). There is also a suggestion from one psychological autopsy study that early in the first episode of a major depressive episode, youth are at high risk for completed suicide (Brent et al., 1993b. Psychiatric conditions that are labile, not easily managed, or likely to be refractory to early intervention, namely bipolar disorder, chronic mood disturbance comorbid with substance abuse, and psychotic conditions are associated with increased suicide risk.

Psychiatric symptomatology is best gleaned from the parent and child by use of a semi-structured interview such as the K-SADS (see Appendix 2). This type of interview establishes the presence, the severity, and chronology of different psychiatric disorders. Particularly critical to establish are the presence or history of mania or psychosis, since these features are best treated with pharmacotherapy, rather than with cognitive therapy, if impairment is severe, then hospitalization may be required. Patients with substance abuse may need to be detoxified before they will respond to any other form of treatment. Patients with externalizing problems complicating depression tend to be more impulsive, and this needs to be taken into account in the treatment (e.g., greater emphasis on problem solving and affect regulation). Patients whose primary problems relate to anxiety rather than depression will also require a slightly different approach, as their negative cognitions may relate to catastrophic rather than pessimistic themes. When treating depressed adolescents who present with co-existing anxiety, it is essential to treat the anxiety as well as the depression. In a recent study of depressed adolescents, untreated co-existing anxiety was found to be one major predictor of poor treatment outcome. For guidelines regarding treatment of anxiety disorders, please refer to "Cognitive Therapy Supplemental Treatment Manual for Anxiety Disorders".
Cognitive Style

This can be ascertained by discussion or by pencil and paper assessments such as the Automatic Thoughts Questionnaire (ATQ), Beck Hopelessness Scale (BHS), or the Beck Depression Inventory (BDI). From these sources of information, one can learn if the patient persistently engages in cognitive distortions, such as overgeneralization, dichotomous thinking, or personalization, and whether the person experiences pervasive hopelessness.

Family Environment

An understanding of the family environment is critical to the treatment of suicidal patients. Dysfunctional family processes, particularly parent-child discord, are among the most common precipitants for suicidal behavior (Brent et al., 1988; Hawton et al., 1982b; Kerfoot et al., 1996; Kosky et al., 1990; Taylor & Stansfeld, 1984a), and may also be related to increased risk for dropout from treatment (Taylor & Stansfeld, 1984b). It is important to assess the meaning of such discord to the patient. For example, the adolescent may think that if his/her parents fight, that this means he/she is a bad, unlovable person and that if only he/she could have been a better son/daughter, the parents would not be fighting. A family approach might directly deal with the marital relationship, but in a cognitive approach, the patient will learn to assess the accuracy of the conclusions they make about themselves and others as well as learning strategies for staying out of parental conflict. The cognitive approach, would also encourage the parents to keep the child/teen out of their own disagreements.

The components of family assessment include: a history of any disruptions of relationship with either parent, the presence of discord or abuse (parent-child or inter-parentally), and the degree of support and warmth in family relationships. Significant disruption in the relationship (e.g., divorce or death) may lead a patient to be consumed with anger, to conclude that he/she is unworthy, or may have even contributed to the disruption.

Discord, particularly violent discord, is a frequent precipitant for suicidal behavior and may need to be addressed in family sessions. Often, it is possible to get a "truce" while one helps the adolescent patient not to be so reactive to every "potential argument." In addition, sessions with the family that aim at teaching conflict resolution and communication skills may attenuate the level of conflict.

Given the high proportion of youthful suicidal behavior attributable to physical or sexual abuse (Fergusson et al, 1996), the assessment of abuse is critical. Active physical or sexual abuse usually precludes cognitive treatment and always requires legal action through children and youth services and more of a family systems and case-management approach. When parental abuse surfaces, often the other parent is disbelieving or unsupportive of the adolescent, heightening his or her sense of
isolation. Another related family problem stems from parents' inability or unwillingness to provide the kind of support and warmth that a child may want. In these cases, it is important to help the patient adjust his/her expectations and learn other appropriate ways of gaining the support and affection that he/she may require.

Finally, one should try to obtain diagnostic information about each parent, and if either has untreated psychopathology, they should be referred for treatment. If the parent is depressed, he/she may be irritable, which in turn, may contribute to discord within the home. Untreated parental depression and or anxiety have been shown to predict poor treatment outcome for the depressed adolescent. Also, parental depression was found to be a risk factor for adolescent suicide, even after controlling for the presence of depression in the suicide victim (Brent et al., 1994). Therefore, treatment of these parental conditions should be part of the treatment plan for the depressed or suicidal adolescent. Also, if the parent is suicidal, he/she may function as a model for the suicidal adolescent. Steps should be taken to estimate the degree to which modeling has taken place, such as if this appears to be significant assessing the degree to which the parent makes suicidal threats in the presence of the patient, and the family's reinforcement of this parent. Parents are instructed not to discuss suicidal feelings in front of the child and not to visibly reinforce this behavior.

Social Competency

The ultimate harbinger of the success of any psychiatric intervention is the level of social competency attained by the patient. There are three arenas of social competency for most adolescents: school (academic and behavioral), peers, and family. Frequently, difficulties in one of these areas may initiate suicidality, and sometimes the psychiatric problems that predispose to suicidality may also have an impact on social competency. With regard to school, it is important to establish whether expectations are appropriate, e.g., whether the patient and family expect too much academically relative to the patient’s ability. On the other hand, due to depression or other conditions the patient may have difficulty concentrating, resulting in a decline in her grades. In this case, ameliorating the concentration difficulties is likely to result in improvements in performance.

Problems with peers may relate to discord which may stem from poor negotiating skills. Also, many patients harbor feelings of rejection which may have their origin in poor self-esteem, unrealistic expectations, and a tendency to overpersonalize situations and view them as "rejection." Patients may also report isolation, which may stem from actual difficulties in initiating and sustaining friendships, or from a distortion (e.g., they may actually have friends, but while depressed, may feel they do not). All of these types of interpersonal problems are potential targets for treatment. In general, it is important to differentiate distortions about ability (e.g., a popular student who feels unpopular from actual skill deficits (a socially unskilled person who actually has few friends).
Physical Health

Chronic medical illness may be an important part of the presentation of the suicidal patient. First, depression is more frequent in chronically ill patients such as diabetics, epileptics, or those with inflammatory bowel disease. Second, the treatment of some chronic illnesses involves the use of medication that may destabilize affect, such as Phenobarbital for epilepsy, or steroids for inflammatory bowel disease. Third, these patients may have cognitive distortions relating to their illness. For example, a patient may feel that, because his/her life span may be foreshortened, or because he/she is limited in certain ways (e.g., inability to drive with epilepsy, special diet for diabetes) that his/her life is ruined. Fourth, the experience of chronic illness may give patients a sense of hopelessness and a lack of control that may be generalized to other spheres outside of the illness itself. Of course, the view that a chronic illness such as diabetes is "completely" out of a patient's control is also a distortion. Finally, the illness may provide an arena for the patient to manifest his/her self-destructive impulses (insulin overdose, non-compliance with diet or treatment).

Psychoeducation with the Family

The process of educating and socializing the patient and family to treatment begins with the initial feedback session to the family. This feedback should include: (1) a discussion of the factors that seem to have contributed to suicidality; (2) discussion of the no-suicide contract; and (3) a summary of the diagnostic findings.

At a minimum, the parents should be seen at the outset, at midpoint, and towards the end of treatment to provide feedback and give them a chance to raise any concerns. Issues of discord and subsequent family contracting can also be addressed in these meetings (see section, "Role of the Family," page 22).

Assuming the patient is appropriate for cognitive therapy, the basic principles of cognitive therapy should be explained. The parent and patient should be given a copy of "Feeling Better" (see Appendix 4). The patient should be asked to read it, and check off the parts that seem to apply especially to him/her.

In order to teach family members about the related psychiatric illnesses and suicidality, we embark on a didactic intervention with parents referred to family psychoeducation (Brent, Poling, McKain & Baughner, 1993). In our clinic, we had the experience that parents often felt that the adolescent patients were "faking" their symptoms or were simply being manipulative. We developed a psychoeducational program that has helped parents to better understand the problems of their adolescent. The goals of such education are to increase compliance with treatment, promote a partnership with the parents so that they can monitor the patient with regard to recurrences, and to help the family learn how to cope with a child with a psychiatric illness. The parent should be given a copy of "Depression: A Survival
Manual for Families," (Poling, 1997) and invited to come back and discuss it when they return for the first visit as well as subsequent visits. If the patient is experiencing a co-existing anxiety disorder, the adolescent and family should be given a copy of "Child & Adolescent Anxiety: A Handbook for Families."

It is equally important to assess for the availability of lethal agents for suicide in the household, particularly firearms. It has been conclusively shown in several American case-control studies that firearms are more likely to be found in the homes of suicide victims than psychiatric or community controls (Brent et al., 1988, 1993; Kellerman et al., 1992). Loaded guns in the home are associated with suicide even in the absence of clear psychiatric risk factors. Because guns convey an increased risk of suicide even if they are securely locked, they should be removed from homes of suicide attempters as part of the initial intervention.

Contraindications to Cognitive Therapy

Patients with Bipolar Disorder or psychotic depression are best treated somatically, although cognitive techniques may be a useful adjunct. Similarly, patients with severe eating disorders, accompanied by nutritional problems require refeeding before psychosocial issues can be addressed. Patients with substance abuse must be detoxified before treatment with cognitive therapy can be successful, and one must continue the recovering substance abuser in some supportive group work such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) in order to maintain abstinence. Also, if the patient is cognitively limited, either developmentally, or due to depression, it may be difficult to make progress with cognitive treatment alone. Finally, families in crisis, particularly with inter-parental or parent-child physical or sexual abuse, will probably require a family-oriented approach, because the issue of the abuse tends to override other psychotherapeutic issues. However, a past history of abuse is not incompatible with such an approach, and in fact, the distortions accompanying such traumatic events ("I deserved it, I'm dirty, I'm unworthy") are quite compatible with a cognitive approach (Cohen and Mannarino, 1996).

Indications for Pharmacotherapy

Although there are no evaluations of the efficacy of combined treatment approaches, cognitive and pharmacotherapeutic approaches are not incompatible and clinically are frequently used together. However, as in most clinical interventions, it is best to add one intervention at a time, so that it will be possible to ascertain the efficacy of each separate intervention. Pharmacotherapy is absolutely indicated for patients with psychotic depression or mania. Patients with a history of hypomania, but who present without the classic hypersomnic, hyperphagic depression may be treated cognitively, but those with major depression and a past history of mania should receive pharmacotherapy. We have avoided tricyclic antidepressants (TCA’s) in adolescent depression because their efficacy has not
been demonstrated and they posed a serious risk for fatal overdose (Kapur and Mann, 1992). A recent study demonstrated the efficacy of fluoxetine for child and adolescent depression (Emslie et al., in press). In contrast, several studies have failed to find differences between tricyclics and placebo in child and adolescent depression. Our general approach has been to start with cognitive therapy, and to add an SSRI such as fluoxetine, if the patient makes no progress symptomatically after 4-6 weeks, or if fatigue, sleep, and concentration difficulties interfere with the patient's ability to grasp and apply the cognitive model from the outset.
Structure of the Therapeutic Session

Establishing/Rapport

Rapport can be achieved through the use of basic psychotherapeutic skills, and involves active listening, genuineness, a non-judgmental attitude, warmth, and accurate empathy. It may be helpful to elicit from the patient his/her interests and invite discussion about these. Since the foundation of cognitive therapy is that of collaborative empiricism, rapport-building will also be facilitated by soliciting the patient’s feedback and ideas about each aspect of therapy. For example, any interventions that the therapist undertakes should be explained to the patient. If homework is assigned, then the therapist should explain why it is being assigned, and how it is expected that the patient will benefit from this. Furthermore, the patient’s thoughts about this intervention should be solicited. Another example of how rapport can be facilitated is through the agenda, or list of topics to be covered in the session (see section, “Setting An Agenda,” page 10). In essence, the therapist and patient mutually establish the priorities for a particular session. In this way, the patient has input into every aspect of his or her treatment.

Setting an Agenda

The purpose of the agenda is to use the time in therapy most efficiently. The setting of the agenda should be a collaborative effort, between patient and therapist. The agenda should include a summary of the patient’s experiences since the last session, including discussion and feedback about the last session, homework, and current mood. Furthermore, the therapist and patient should develop a problem list, and from there, set priorities on which of these problems to focus. In general, in the initial stages of treatment, the main concerns are behavioral goals, whereas after the patient is less depressed and amotivational, the focus shifts to more cognitive interventions.

The purpose of the agenda are several. First, setting an agenda helps to protect the therapeutic process against “depressive inertia.” Secondly, the mutual effort of patient and therapist in setting an agenda reinforces the sense of collaborative empiricism that is the foundation of cognitive therapy. Moreover, the use of the agenda enables the patient to target specific areas of concern, allows the treatment session to stay consistent with the overall goals of therapy, and to be able to evaluate critically the efficacy of specific interventions.

Sample opening gambits: "Is there anything that you want to take care of today"? "Is there anything you’d like to focus on this session"? Aside from the patient’s problems, the following are also fair game for the agenda: administrative issues, such as scheduling, fees, etc., explanation of the cognitive therapy model, feedback about previous session, and homework. It is best to list out the agenda first, and then get into discussion about specific agenda items only after the complete list is
fleshed out. This allows the patient and therapist to prioritize the most important agendas.

If the patient doesn't come up with any agenda items, then it may be useful to assign homework to the patient to do so for the next session. The therapist should also be active in generating agenda items, and the assessment and discussion of hopelessness and suicidality should be on the agenda for any session with a moderately or severely depressed patient. The therapist has responsibility for pacing the session and making sure that peripheral items don't occupy the bulk of the session. However, even in the enforcement of therapeutic efficiency, the therapist should explain to the patient why he/she may want to shift the focus back to a more pressing agenda item, and if the patient can make a cogent argument for not doing so, then the therapist has learned that an ostensibly peripheral issue was really more central than it initially appeared.

In summary, the therapist should work with the patient to establish an appropriate agenda that is suitable for the available time. Moreover, the therapist and patient should establish priorities that are then reflected in the conduct of the session.

**Review of Presenting Problems and Therapeutic Goals**

This is naturally the heart of the agenda. There is a tendency on the part of patients who are not yet socialized to cognitive therapy to generate very vague and non-specific problems, such as "I want to feel better." One therapeutic response to this fuzzy goal is, "If you were not depressed or anxious, what would you be doing differently?" Once the patient has operationalized the problem, then the patient and therapist can mutually assess whether or not this problem stems from a skill deficit or is related to a cognitive distortion. For example, a patient may say that if he/she was not depressed, he/she would be doing better in school. It is important to assess whether his/her poor performance is truly a consequence of his/her depression, or whether the patient's expectations are unrealistic compared with his/her true abilities.

In the formulation of a treatment plan for suicidal adolescents, it is important to include knowledge of the precipitant and motivation for the suicidal episode, the affect at that time of the episode, and the degree of suicidal intent. For example, if a patient became suicidal in response to interpersonal rejection, it will be important to assess the meaning of rejection and the affects and behaviors usually triggered by such an event. Often the motivation for engaging in suicidal behavior is to gain attention or induce guilt in another person. For such patients, one goal for treatment should be the acquisition and consistent utilization of direct communication skills.

At the time of the suicidal episode, the patient may have been overwhelmed by strong affect, typically dysphoria or anger. If this is a typical pattern, then treatment must focus on ways to help the patient to prevent strong affect from subverting appropriate problem-solving, generally by teaching methods of affect regulation (e.g., relaxation techniques) and problem-solving (see section, "Impulsivity and Problem-
Solving," page 20). Finally, knowledge of the suicidal intent, or the degree to which the patient wants to die, contributes to the formulation of the treatment plan. A patient with high suicidal intent is likely to feel hopeless, and hopelessness must always take a high priority on the agenda and problem-list, because of the hopeless patient's potential lethality, as well as their likelihood to terminate treatment prematurely.

Once the problem has been operationalized, it becomes possible to elicit cognitions about the problem in order to learn what role cognitive distortions play. The operationalization of the problem also allows for interventions, such as reality testing within the session with regard to negative cognitions and/or unrealistic expectations, and the assignment of homework or "experiments", to empirically test the validity of certain cognitions. For example, a patient may say that he lacks the self-confidence to call a girl for a date. He might be invited to do that, even in the office, and go through the negative cognitions that occur in anticipation, and during a call. He also might be invited to make a prediction about how he might do and compare this with his actual performance. Also, at this point, it will be important to determine to what extent the patient's lack of dates is due to cognitive distortions or social skill deficits that need amelioration.

With regard to deciding which problems should take priority, the following can be offered as a guide. Hopelessness and suicidal ideation always need to take priority over other concerns. Hopelessness about the possibility that treatment could help must be dealt with incisively in order to prevent premature termination. In general, behavioral goals, such as self-care, getting out of bed, etc., need to take priority over cognitive problems, such as poor self-esteem. For example, a person may complain of social isolation, yet if he/she doesn't groom him/herself or even get out of bed, then all the work on cognitive distortions in the world won't help because his/her life is devoid of the opportunity to meet people.

**Behavioral Techniques**

Behavioral techniques must take priority over cognitive interventions in severely depressed patients. In these types of patients, the first goal of the therapist is getting them moving and motivated enough to begin to try to change their thinking patterns. Parents may be able to help implement these behavioral techniques in very depressed adolescents. In such patients, it may be helpful to find out what their weekly schedule actually consists of. The patient should simply fill out a weekly schedule and rate each activity as to the degree to which, on a (1 to 10 scale), the individual experienced mastery and pleasure from participating in that activity. For some patients who claim to "do and enjoy nothing", and examination of this schedule may reveal significant cognitive distortion (e.g., they actually may be engaged in a lot of activities). Alternatively, the patient may truly be inert, in which case the therapist can help the patient set behavioral goals for the week. For example, activities such as shopping, having lunch with friends, and cleaning the house are much more
incompatible with depressive rumination than would be lying in bed and watching television.

In order to help the more inert patient, one may resort to the following techniques: graded task assignment (the patient wants to have a dinner party, but can’t get out to shop or plan a menu—the first step might be shopping for supper for the family, or just picking menus that appeal to the patient), cognitive rehearsal (identifying the roadblocks that may interfere with task performance and preparing in advance how to overcome them), and role-playing with self or the therapist. Another useful variant of role-playing is role-reversal. For example, in the case of the reluctant shopper, the patient may perceive the checkout person as disapproving, yet in fact, when the patient reverses roles, he/she may discover that the checkout person is too detached to really care about any given customer. Positive self-instruction (self-talk or self-coping statements) are useful techniques as the patient focuses on what he/she can say to her/himself or “do” to combat feelings of depression or hopelessness. "Rehearsing" positive self-talk during therapy sessions, may help prepare the patient for coping with difficult situations in which he/she may otherwise engage in negative self-talk.

**Mood Check**

The mood check should always be part of the agenda. The mood check consists of objective (e.g., score on a given instrument) and subjective (patient’s sense of severity) portions. Mood can be evaluated by use of the Hamilton Depression Rating Scale, K-SADS, or Beck Depression Inventory (BDI). Additional measures include the Beck Anxiety Inventory (BAI), Self-Report for Childhood Anxiety Related Disorders (SCAReD) (see Appendix 3) and Beck Hopelessness Scale (BHS) for anxiety and hopelessness, respectively. In addition to having the patient fill out a BDI and score it, it is helpful to have the patient verify the interpretation of the score: "According to the BDI today, you must be feeling better. Do you agree?" As noted, hopelessness and suicidality are extremely important to check out. If the patient is hopeless, it is difficult to get him/her to engage in any other aspects of treatment until this overwhelming distortion is dealt with. Also, sometimes the items on the BDI may generate issues for the agenda. For example, if a patient endorses worthlessness or excessive guilt, this may lead back to some important negative cognitions and assumptions.

If the patient is suicidal, then part of the session should be spent re-establishing a "no-suicide contract" (See section, "No-Suicide Contract", page 2). Within this contract, the patient promises to abstain from hurting him/herself (see Table 1). Other precautions include notifying the patient's parents about the suicidality and reviewing procedures for calling the number of the emergency room and initiating procedures for involuntary commitment. Also, lethal agents such as firearms should be removed if this has not occurred at the stage of the initial assessment.
Socialization to Cognitive Therapy

As in any type of treatment, it is important to educate and explain to the patient the rationale for therapeutic interventions. Because of the collaborative empirical approach of cognitive therapy, the socialization phases is particularly important. The sooner the patient is adequately socialized, the sooner he or she can function as an equal partner to the therapist in therapy.

Socialization is largely a psychoeducational process. Aside from orienting the patient to the typical parameters of treatment (e.g., weekly sessions of about an hour, how to get in touch for emergencies, etc.), the most critical aspect of socialization is to get the patient thinking in terms of the cognitive model. Often, reading materials will be helpful, with a didactic presentation of the cognitive model by the therapist for emphasis (see Appendix 4, "Feeling Better"). It is useful to ask patients to check off portions of this pamphlet that seem to pertain particularly to their own situation.

The foundation of cognitive therapy is the concept of the cognitive triad: a negative view of the self, the world, and the future. After presenting this information, it is helpful to ask the patient if he/she has evidence to test the extent to which his/her view of self, the world or the future are consistent with this. In order to demonstrate how this theoretical concept relates to the patient’s depression, it is helpful to illustrate the interrelationship between thoughts, affects and behaviors. For example, following an argument with a friend, the patient may report having thoughts such as, "we always fight," "my friend doesn’t care about me," "I will never talk to her again." Subsequently, the patient may experience feelings of depressed or angry mood which may lead to avoidant behaviors. This then allows for the introduction of the concept of automatic thoughts, and the errors in cognition that depressed patients frequently make: selective abstraction, personalization, overgeneralization and dichotomous thinking, discounting the positive and overvaluing the negative. To motivate the patient to monitor his/her cognitions, it is important to explain to the patient that by identifying and recording these automatic thoughts, it will be possible to alter them by examining the evidence for and against holding such beliefs as true.

One should look for every opportunity to reinforce the concept of the cognitive model. For example, if the patient notes that his/her teacher yelled at him/her, and he/she was down the rest of the week because he/she felt that he/she was a dummy, then this is an opportunity to emphasize the relationship between thought and affect. Moreover, if there is any cognitive distortion involved in this interchange, then it would be important to show how some of the errors in thinking on the part of the patient were related to his/her subsequent low mood, anxious mood, and that this is precisely what the cognitive model would predict. Even better are affective shifts that occur during a session, which provide an opportunity to illustrate the links between thought and affect in the "here and now."
While the therapist is trying to engage and socialize, and perhaps even "convert" the patient to the point of the view of the cognitive model, he/she should also be eliciting any negative thoughts about the model, treatment, etc. For example, patients may feel that this model is too simplistic, and may add that they have tried such approaches in the past without symptomatic relief. This in itself may be an example of dichotomous thinking (e.g., something either works or it doesn't). Other patients may be partially socialized to alternative models such as psychodynamic treatment, the biological view of depression, or family treatment. Again, it may be helpful to point out that it is possible to hold more than one view simultaneously about as complicated and heterogeneous a disorder as depression.

Identification of Automatic Thoughts and Beliefs

One of the key aspects of cognitive therapy is the identification and remediation of automatic thoughts and beliefs. Automatic thoughts are defined as follows: (1) they are rapid and reflexive; (2) they are accepted as valid; (3) they may be triggered by internal or external events; and (4) in content they relate to the cognitive triad.

An example of an automatic thought is, "I'm not going to have a date for the dance." Automatic thoughts are based on assumptions, that in turn are derived from early schema or beliefs. Assumptions are so termed because they are conditional, and tied to a specific situation, whereas schema or beliefs are more global and unconditional. For example, a person who was raised by an alcoholic parent may believe him/herself to be worthless (schema). As a result, he/she may assume that in order to be liked, he/she has to be perfect (assumption). Finally, this assumption may manifest itself in automatic thoughts such as "no one will want to go out with me," "I just don't have the style to ask anyone out," etc. In treatment, one begins with automatic thoughts and follows the trail back to assumptions and beliefs. If one can identify these underlying assumptions and beliefs, and alter them, then one can better cope with stressors and will not be as plagued by negative cognitions. However, it is important to build up trust, rapport, and understanding about the cognitive model before trying to attack the core beliefs. In practice, in brief treatment, the target is on how to cope with core beliefs, rather than on their modification or elimination.

In eliciting automatic thoughts, it is helpful to ask the patient, "what images, thoughts, feelings go through your mind when 'X' occurs." Ellis' (Ellis, A., 1962) paradigm of antecedent, belief, and consequence is a useful framework with which to understand the context in which automatic thoughts occur. An understanding of this context, particularly if the thoughts occur under particular circumstances (e.g., loss, perceived failure) may enable the therapist to hypothesize and hone in on the underlying assumptions and basic beliefs. In order to provide more ready access to important, "hot" cognitions, the therapist may have the patient reconstruct the events surrounding these cognitions, and heighten the sense of immediacy on the part of the patient by encouraging him/her to recall the weather, the clothes he/she was
wearing, etc. "Hot" (i.e., current) cognitions may be accessed by engaging in role play with the patient. Another means for gaining access to "hot" cognitions is to ask the patient during session at a point when he/she appears to be experiencing some intense affect (affective shift) to clarify his/her feelings and thoughts at that moment. Finally, for those patients who have endured critical stressors such as loss, divorce, or abuse, reconstructing those events and the associated affects and cognitions may be helpful in understanding the current status of the patient’s distorted thinking.

In summary, techniques for eliciting automatic thoughts include:

- inductive questioning
- asking the patient what goes through their mind
- using imagery to heighten the situation
- role-playing
- targeting mood shifts that occur during the session to identify "hot" cognitions
- as noted below, the daily record of dysfunctional thoughts
- ascertaining the meaning of a particular event (current or past)

One helpful intervention with regard to automatic thoughts is simply to ask the patient to record them on the dysfunctional thoughts record, which is set up in four columns: situation, emotion, automatic thought, evidence for and against the automatic thought. It is also helpful to have the patient perform an "experiment" by testing the degree to which he/she believes a given automatic thought before and after examining the evidence. In general, the following are useful questions to have the patient ask him/herself

- what is the evidence?
- what are the errors in my thinking?
- what is the best/worst that could happen?
- what is the most realistic concern?
- what are the effects of my thinking this way?
- what are some alternative viewpoints?
About automatic thoughts:

It is also helpful to teach the patient to identify the different kinds of cognitive errors or distortions that lead to automatic thoughts:

- dichotomous thinking
- overgeneralization
- selective abstraction
- disqualifying the positive
- arbitrary inference (e.g., mind reading, negative prediction)
- magnification/minimization
- emotional reasoning (since I feel bad, everything will turn out badly)
- personalization
- should/must/ought reasoning
- catastrophization (dwelling on the worst possible outcome)
- overemphasizing the possibility of that outcome.

There are multiple techniques that the therapist can resort to in order to illustrate the dysfunctional nature of automatic thoughts. The following are a list of some of the more commonly used techniques in cognitive therapy:

- explore the idiosyncratic meaning to the patient of the distortions
- label the distortion (e.g., dichotomous thinking (all or nothing), overgeneralization, etc.)
- guided association (unpacking the fantasy or "what if")
- decatastrophizing (an extension of guided association in which the fantasied concerns are deflated"
- use of exaggeration (useful to accomplish
- scaling (to combat dichotomous thinking)
• rating the advantages and disadvantages of an action or viewpoint (also rating relative importance and probability that an advantage/disadvantage is true)

• retribution (useful for personalizing)

• turning adversity to advantage (taking a negative situation and attempting to see something good about it)

• development of replacement imagery to combat "negative" images

• cognitive rehearsal

• development of coping imagery/self-statements

• thought-stopping/distraction

• development of cognitive dissonance direct disputation

One of the goals of treatment is to identify the underlying assumptions, or unspoken rules by which the patient may live. By identifying clusters of automatic thoughts, it is possible to help the patient identify these assumptions. The patient should be invited to learn what is the general rule that connects a set of automatic thoughts. One shortcut in identifying automatic thoughts and underlying assumptions is that certain affects are usually associated with certain assumptions: (1) depression and guilt are usually related to thoughts about not meeting one's or another's expectations; (2) anger is usually related to thoughts that others are not meeting the patient's expectations; and (3) anxiety relates to thoughts about dangerous (catastrophic) consequences of a given situation. The use of this cognitive "map" may be helpful in getting a stalled therapeutic session "jump-started."

Experiments and Homework

Guided experiments are one useful way to test the validity of automatic thoughts and assumptions. It is important that the therapist help the patient chose experiments that the patient is likely to regard as meaningful, and in which he/she will experience some success. However, even if "failure" occurs, this can be reframed as positive because of the potential for learning. It is helpful to rehearse any experiments or homework assignment in the session in order to go over any potential misconceptions or roadblocks. The rationale for homework or experiments should be clear to the patient. It is also important to let the patient know that if they are having trouble completing the task, they should call the therapist as soon as possible in order to help overcome "roadblocks" to completion.
For example, a patient who is having trouble generating agenda items in session may be asked to bring in one item for the next week. Even if he/she comes in without an item, the therapist can explore with the patient the thoughts he/she might have had as he/she was trying to complete the assignment. A patient who might be having trouble getting up in the morning and "getting anything done" may be asked to wake up at a certain time and make his/her bed, so as to preclude getting back into bed. Also, having made the bed, the patient could then not say he/she hadn't done "anything."

A patient who felt that no girl wanted to go out with him might be invited to call up a girl for a date. If that was too difficult, he could be asked to generate a list of girls he was interested in, and then try to figure out steps he would need to take to decide how to get to his ultimate goal, a date.

Homework is also helpful for issues where the patient seems stuck in the session. For example, a patient who felt that being from a working class neighborhood was a stigma which he could never overcome was invited to make a list of successful people who had their origins in that neighborhood.

**Summarizing**

At certain points in the session, it is useful to summarize what has transpired. At the beginning of a session, summarization may be useful in formulation of an agenda by connecting the previous session with the goals of the present one. After the patient is socialized to the model, it may be helpful to have the patient do the closing summary. Part of the point of the summary is to connect the content of the session to the long-term goals of treatment. During the summary, it is helpful to get feedback about the session. Also, summarization is useful after any important points have been made by having the patient do the summarizing. One can test the extent to which the issues have been assimilated by the patient. When a patient is very depressed, and concentration is impaired, it is helpful to use summarization at frequent intervals.

**Feedback**

At the beginning and end of each session, it is important for the therapist to ask the patient for feedback about what they thought was helpful/unhelpful about the session. As therapy progresses, it is important for the therapist to provide feedback to the patient. Exchanging feedback is an effective method of creating the collaborative framework of the cognitive therapy model. It is helpful for "checking in" with the patient about their thoughts and feelings about the progress of their treatment and extremely important for "quality control".
Process Issues: Specific Issues In The Treatment of Adolescents

Cognitive Development

The variability in the cognitive development of adolescents is an important consideration in the use of cognitive therapy for this age group. Some adolescents may have much greater ease with the cognitive model, whereas other, more concrete patients may find this approach overly abstract unless the therapist draws on many examples to illustrate the utility of this approach. It is important to solicit feedback from the patient during the session, and encourage him/her to summarize frequently, so as to monitor the degree to which the concepts of cognitive therapy are being assimilated.

Autonomy and Trust

Adolescents rarely initiate the request for treatment. Therefore, they often see treatment as something forced upon them by adults. In light of this, rapport-building is a critical first step in the cognitive treatment of adolescents. The issue of trust is an important one, as many clinically referred adolescents tend not to be trustful of adults. Therefore, concerns of the adolescent patient about the therapeutic "contract" are likely to relate to the issue of trust in some measure. The concept of collaborative empiricism is particularly helpful to invoke for the treatment of adolescents because of the high degree of autonomy and control that this principle affords patients. The framework of collaborative empiricism may also serve to motivate adolescents to engage in positive practice or homework (referred to as "experiments") in between sessions, since the main goal of such practice is to teach the patient to become his/her own therapist. It is also critical to elicit any negative distortions about treatment that the adolescent may have, in order to dispel them and continue subsequent rapport-building and progress unencumbered.

Impulsivity and Problem-Solving

Another issue is the impulsivity that characterizes many clinically referred adolescents, particularly those who engage in suicidal behavior. Impulsivity is a common characteristic of adolescent attempters. Consequently, most adolescent attempts occur with little planning, and are, by definition difficult to predict. Under stress, impulsive adolescents may engage in suicidal behavior despite considerable therapeutic effort and apparent progress, unless the impulsivity and associated difficulties with affect regulation, problem-solving, and social skills are addressed (Linehan, Armstrong, Suarez, Allmon & Heard, 1991; Linehan, Heard & Armstrong, 1993; McLeavey, Daly, Murray, O'Riordan & Taylor, 1987; McLeavey, Daly, Ludgate & Murray, 1994). Therefore, impulsivity, particularly in the face of recurrent or chronic stress, represents a source of increased risk for suicidal behavior in a suicide attempting adolescent.
The cognitive model of depression often presupposes a psychomotorically retarded, emotionally blunted adult who, if nothing else, will not engage in any risky behavior or make any major life decisions within the course of the first few sessions. A broader array of cognitive-behavioral techniques, while certainly consistent with the overall cognitive framework, are required to work with more impulsive patients. The main indication for invoking interventions which target impulsivity are when this problem, or the problems stemming from impulsivity appear to be clinically paramount. For example, a depressed adolescent girl got into verbal battles with teachers and pupils at school and was continually getting suspended. A three-step approach was useful for difficulties of this sort. First, she was encouraged to subject these events to behavioral analyses: antecedents, behavior, consequences. Second, she was encouraged to look more carefully at the process by which she lost control. Third, she was taught to ask the five problem-solving questions:

- What is the problem?
- What are the alternative solutions?
- What are the consequences of each alternative?
- What is the best solution?
- How did I do?

In our experience, the teaching of affect regulation is another important component for helping impulsive adolescent suicide attempters. We had treated many impulsive patients who seemed to be responding favorably to a combination of cognitive therapy and problem-solving skills training, only to be confronted with them in the emergency room in crisis, having made another attempt and having "forgotten" everything they learned in treatment. Kienhorst et al. (1995) have noted that an escalation in tension and frustration is reported to be associated with "crossing the bridge" between thinking about and actually attempting suicide. What seemed to be happening for many of these adolescents is that they felt increasingly under stress, they became more effectively labile, and much less dispassionate and rational. Therefore, to help them avoid these situations we recommend the use of a feeling thermometer, as described by Rotheram (1987). With this technique, which often is initially taught as part of the no-suicide contract, the adolescent creates a scale from 0 to 100, where 0 is totally in control and calm, and 100 is totally out of control, agitated and upset. The psychological and physiological markers are mapped for each 10-point increment. The adolescent is asked to identify where on his or her scale is the point of no-return (e.g., "60"), that is, where things will be likely to escalate to an explosion or outburst. Then the adolescent is asked to back down the scale to where he or she can recognize that things are likely to get out of control, but can still be dealt with effectively (e.g., "40"). The adolescent and parents are taught to
recognize the psychological, physiological, and behavioral markers of this critical inflection point, and to develop agreed-upon tactics on how to de-escalate.

Relaxation techniques, self-statements, and written reminders may be helpful in slowing the impulsive adolescent down enough to re-evaluate the consequences of a potentially self-damaging impulsive act.

Role of the Family

Another critical issue in the treatment of adolescents is the role of the family members, since adolescents are still dependent to a large degree upon their parents. It is important to help the adolescent feel a sense of trust and privacy without promising an unrealistic and unhelpful amount of confidentiality. Parents are often the referring agents for treatment, usually provide transportation, and bear the financial responsibility for treatment. Therefore, parents have a right to be kept informed about the goals and progress of treatment. In fact, if the parents are unmotivated or uninterested in treatment, a successful outcome for the adolescent is much less likely.

Ground rules should be set about the structure of the sessions, setting (or cancelling) appointment times, contacting the therapist between sessions and confidentiality. Confidentiality in an absolute sense should not be promised to the adolescent. Instead, the patient must understand that serious issues (e.g., suicidality) that necessitate an abrupt change in treatment plan must be shared with the parents. Also, parents have a right to know, in a general sense, the goals and progress towards those goals in treatment. However, parents should not expect a "blow-by-blow" discussion of therapy sessions by the therapist. Both the patient and parents should be encouraged to call between sessions for any concerns about suicidality or other serious psychopathology (e.g., possibility of psychosis, substance abuse, homicidal thoughts or behavior). A back-up number (e.g psychiatric emergency room) should be available in case the patient or family need consultation when the therapist is unavailable. It is recommended that if the parents call during the week between sessions, the general nature of the call will be shared with the patient.

Conflict with parents is one of the most common precipitants for suicidality, depression, and clinical referral for adolescents. Therefore, it is important to determine areas of conflict as well as the nature of supportive interactions. Understanding how behavioral communication patterns are reinforced in the family is important since social reinforcers are powerful in maintaining the patient's dysfunctional cognitions and subsequent behaviors. Parents and other family members may have distorted perceptions of the patient. They may reinforce the depressed patient's negative view of self, the world, and the future. A "pure" cognitive approach would involve the patient changing his/her point of view about the centrality of this conflict to his/her sense of well-being, as well as coming up with appropriate interpersonal strategies for ameliorating the conflict. However, sometimes the amount of discord at home is so great that it is difficult for the patient
to benefit from any amount of cognitive treatment. In this case, parents are invited in, and a list of expectations from both parent and child are solicited, with the aim being the negotiation of a viable behavioral contract. It is important to stress that what is being sought is not a solution to all interpersonal problems, but simply agreements on the key problem(s), and a "truce" to abstain from discord in other potentially conflictual areas. It is helpful to rehearse with both parent and child how such a contract can be maintained.

Our work indicates that in general, depressed adolescents will benefit from individual treatment. However, sometimes family difficulties interfere with individual cognitive therapy, or are so overriding that family assessment and intervention is indicated. During the initial session with the teen and family, it is important to identify if significant family problems are present and set the stage for their discussion initially or at later points in treatment. It is an essential first step in treatment to elicit what each family member sees as the main difficulties related to the presenting problem that brought them in for treatment. At the beginning of the family session, the therapist may "go around the room", asking each family member a variety of questions such as, "in your opinion what is the main problem you and your family are currently experiencing?" It is crucial to focus on what the family sees as the main problem toward identification of problem areas that relate to the presenting problem that brought the family to treatment. It is important to involve each family member in the process of identifying the central problem list and determining realistic treatment goals. The family may bring up problem areas that have little relation to what brought them to treatment; therefore the therapist will want to guide the family to explore the central concerns related to the initial presenting problem (or modify the presenting issues accordingly). The therapist may ask questions such as, "how do you see these concerns relating to what brought you here?" The therapist may inform the family that the areas of focus may change throughout the treatment. The establishment of goals is a critical part of the treatment contract. These goals should be as empirically defined as possible. The goals of treatment and the rationale should be reviewed with the family.

Once the main problems are "on the table", the therapist is to assist the family with operationalizing the problem by setting realistic, concrete goals. After this is accomplished, the therapist may focus on defusing conflict and further formulation of the problem. Another important step will be for the therapist to provide the family his/her formulation of the problem (i.e., "it seems like I hear..."). After the therapist "hears" the central theme, it is important to give the family feedback. Asking questions such as "how do you see these things relating to your teen's depression", "are there any other problems in the family that could be impacting on your teen?", will help clarify the treatment goals. The therapist should then focus on helping the family identifying their priority for treatment ("which area do you want to focus on?"). Assembling a sequence of how the treatment will be delivered will be negotiated with the family. The therapist must also focus on the question, "how will we know if the treatment is/is not working?" It is important for the therapist to look for every
opportunity to focus on positive interactions noted in the sessions. The therapist may assist the family with acknowledging to each other what currently "works well" for the family, in addition to "what's not working well". Helping the family to identify "anchor points" for how they will know "when it's better", will enhance collaboration around whether treatment goals have been met. The therapist must establish a treatment contract and review the rules related to confidentiality (see page 22).

As mentioned before, socialization to the cognitive-behavioral therapy is also an essential component of treatment. Socializing the parents to the core principles of the cognitive therapy model will be helpful in assuring that the entire family understands the basic rationale for therapeutic interventions. Parents may be able to reinforce treatment and assist in "experiments". It is important to discover any concerns the family may have about this model of treatment.

Another very critical element of treatment is to continue providing the family with psychoeducational information about the patients specific psychiatric condition (depression, anxiety, etc.). Through socialization and psychoeducation, parents may also function as auxiliary therapists by providing a support net to the patient, e.g., monitoring medication compliance, noting a recurrence in symptoms of depression, or even aiding the patient in practicing assertiveness or monitoring cognitive distortions. However, it is best to avoid involving parents as auxiliary therapists when they are also involved in a highly conflictual relationship with the patient.

Parental Psychopathology

Because of the familial nature of depression, it is often the case that at least one parent of the depressed adolescent will have a lifetime history of depression or anxiety. In fact, it is not uncommon that at least one parent will be depressed at the time of clinical presentation of the adolescent. A depressed parent may be significantly more irritable than usual, thereby contributing to familial conflict. Also, he/she may be much less effective and supportive in the parental role. In a recent study of depressed adolescents, we discovered that untreated parental depression and/or anxiety impedes the ability for the depressed adolescent to recover fully. Therefore, one of the critical tasks of the clinician working with the parents of depressed adolescents is the referral of psychiatrically ill parents for clinical evaluation and treatment. Therefore, parents of depressed and suicidal adolescents should be assessed at intake. Parents should be informed that treatment of these conditions is a necessary component of the treatment of their child, with reinforcement from psychoeducation sessions.

Predictors of Poor Treatment Outcome

It is essential for clinicians treating depressed adolescents to be aware of the factors making the depressed adolescent less likely to respond to psychosocial treatment:
• Long duration of depressive episode.
• High levels of depressive symptomatology or functional impairment.
• History of dysthymia (chronic depression).
• Co-existing condition of anxiety disorders.
• Increased family disorganization/discord.
• Depression or anxiety in parent.
Process Issues: Developmental Phases of Treatment

Although the above noted framework is useful for a generic therapeutic session, certain elements will need to be emphasized to de-emphasized, depending on the stage of treatment.

Socialization

In the socialization phase the therapist is much more active and didactic. The main goals for this phase of treatment are to establish rapport, set ground rules of treatment, identify problem areas and goals for treatment, socialize the patient to the cognitive model, and prescribe behavioral interventions if required to help the patient become more functional. During this initial phase, it is critical to deal with roadblocks to treatment, such as hopelessness, anergia, etc. Specifically, if the patient is plagued by thoughts such as "no one can help me" and "this can't possibly work," then these distortions must be dealt with before the patient can be socialized to the model. Also, it is more important to use examples to illustrate the type of interventions that will be employed than to rush ahead and employ them. As part of the socialization to the model, the patient will receive written material about cognitive therapy and be taught how to monitor and record his/her automatic thoughts. By the end of the socialization phase of treatment, the patient and therapist agree not only on the problems to be targeted, but also the general method of how these problems will be solved.

Distortions, Assumptions and Beliefs

Once the patient has begun to identify automatic thoughts, the therapist should guide the patient to begin to examine these thoughts for systematic distortions. What is more, the therapist can now aid the patient in learning to empirically assess the veracity of their automatic thoughts, and to challenge their veracity through experiments and homework. Finally, the patient will learn specific techniques for substituting more adaptive thoughts after "debunking" his/her initial distortions. It is also during this phase that the therapist will try to help the patient to draw together the themes, or assumptions underlying the most commonly occurring distortions. These faulty assumptions can be challenged, and in fact followed further back to the level of beliefs, or unspoken rules for thinking, feeling, and behaving.

Generalization, Self-monitoring, Boosters and Maintenance

During the final phase, the patient should take the lead in monitoring his/her thoughts, noting areas in his/her life that seem to be governed by dysfunctional assumptions and beliefs, and recommending appropriate courses of action. Also, this is an excellent time to plan for methods of coping with anticipated stressors. As the patient becomes more autonomous and less symptomatic, the frequency of the
sessions can be diminished to once every two weeks, to once a month, or even less frequently (booster sessions). Booster sessions are designed to reinforce the model, monitor the patient for reoccurrence of depression, and help him/her prepare for future stressors. In general, booster sessions should be offered over the average length of a depressive episode (6-9 months) since the risk for relapse is highest at this time. The patient and parents should be educated to monitor for subsyndromal depressive symptoms and to call should they recur. This is important since subsyndromal symptoms are associated with a higher risk of subsequent depressive episodes and earlier cognitive treatment forestalls the development of full-blown depression.
References


Tables

1) No-Suicide Contract

2) Indicators of a Need for a More Intensive Level of Care
TABLE 1

STEPS IN A "NO-SUICIDE" CONTRACT

1. Child/Adolescent agrees not to hurt him/herself.

2. Child/Adolescent, parents, and therapist rehearse strategies to cope with suicidal thoughts should similar precipitants recur.

3. Child/Adolescent will tell parents or counselor if they are having suicidal thoughts.

4. Child/Adolescent will present themselves at an Emergency Room if there is no one available to help.

5. Child/Adolescent will structure his activities in a way that will reduce suicidal potential.
TABLE 2

INDICATORS OF A NEED FOR A MORE INTENSIVE LEVEL OF CARE

Characteristics of the attempt/current suicidality

- Active suicidal ideation (with plan and intent)
- High intent or lethal suicide attempt
- Motivation to die or to escape a painful situation or affect
- Inability to maintain a no-suicide contract

Psychopathology

- Depression - severe or comorbid
- Bipolar illness
- Substance abuse
- Psychosis
- Multiple diagnoses

Past History

- Previous non-compliance or failure with outpatient treatment
- Past attempt

Psychological characteristics

Hopelessness

Aggression/hostility

Family Problems

- Abuse
- Severe parental psychiatric illness
- Parents unable/unwilling to protect or monitor patient
Appendices

1) Suicide Circumstance Schedule (SCS)

2) Mini KSADS

3) Instruments: SCAReD

4) Feeling Better
SUICIDAL CIRCUMSTANCES SCHEDULE

Patient Name: ________________________________

- Use SCS only for patients with past and/or present suicidality.
- Use p. 1-4 of SCS to assess most serious suicidal episode in past 3 months.
- Use p. 5 to assess suicidality for the past 48 hours.
- If no suicidality in past 3 months and/or 48 hours, but suicidality in the past, skip to p. 6.

1. Date of most serious suicidal episode within past 3 months:

   __/__/  (Parent)  __/__/  (Child)  __/__/  (Summary)

   P  C  S

2. Type of suicidal episode (most serious within 3 months):

   00 ideation without method and/or plan
   01 ideation with method and/or plan
   02 threat (verbal or written)
   03 gesture (ideation plus method in hand)
   04 attempt (actual behavior)

3. Method of suicidal episode:

   01 firearms
   02 hanging
   03 jumping
   04 drowning
   05 stabbing
   06 carbon monoxide
   07 overdose
   08 cutting
   09 other: ____________________________

4. Toxicology at the time of the episode:

   a. Alcohol

      01 No
      02 Yes

   b. Drugs

      01 No
      02 Yes  If 02, what? ____________________________
PRECIPITANTS

By this point in the assessment, the child has likely already named possible precipitants for suicidality. For this section, first confirm the status of these events as precipitants for the suicidal episode identified on the preceding page.

Next, ask the following: On ______ (date of previously identified most serious suicidal episode), what other events or experiences were on your mind that you believe contributed to/influenced your ______ (ideation, threat, gesture, attempt)? (If most serious episode is ideation, complete only if it was a discrete episode)

On a separate page, informally list the precipitants described by the child and parent; if you are aware of any other stressors that are not spontaneously endorsed as precipitants, review these with the adolescent or parent. However, only list those stressors that are considered a definite factor in influencing suicidality (the most common categories for precipitants are interpersonal conflict and interpersonal loss)

After eliciting precipitants, have the child and parents rank order them from the most important factor to the least important factor, and list them below:

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<th>Parent</th>
<th>Child</th>
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</table>
MOTIVATION

Open ended question: When you ___________ (specify most serious recent suicidal episode), what did you hope would happen after you did what you did?

After the child has given a spontaneous answer to this question, ask the following more specific questions if they have not yet been addressed:

1. Did you want to die?

2. Did you want to escape?

3. Did you want to communicate/express a feeling—such as anger, desperation, love, sadness, shame etc.?

4. Did you want to influence people in any way, such as to:
   a) Make them feel sorry?
   b) Make them change their mind about something?
   c) Get help for you?
   d) Get attention?

5. After assessing motivation, repeat the areas endorsed and ask the child to rank order them from the most important to the least important motive.
   1.  
   2.  
   3.  
   4.  
ASSESSMENT OF SUICIDAL INTENT
(COMplete ONLY IF MOST SERIOUS EPISODE IN PAST 3 MONTHS WAS AN ATTEMPT)

1. Where were you when you made your attempt? Was anyone present or nearby, or were you all alone?

2. What time of the day did you make your attempt? Did you make your attempt at a time when you knew someone would be around to help you?

3. Did you take any precautions against being discovered (can range from passive precautions such as avoiding others to active precautions such as locking oneself in a room)?

4. Did you try to notify someone to help you after you made your suicide attempt? How long did you wait?

5. Did you write a suicide note or do anything else because you believed you might die? (e.g. make out a will, give away possessions, say goodbye to friends or family)?

6. For how long had you been planning to make this suicide attempt?

7. Did you communicate, either directly or indirectly, your plan to attempt suicide?

8. Did you think there was a chance that you would actually die? What physical consequences were there after your suicide attempt (e.g. bleeding, nausea, loss of consciousness)? Did you require any medical attention?
**ASSESSMENT OF CURRENT SUICIDAL IDEATION**

Even if the child has denied suicidality for the past 3 months; you should still double-check for suicidality during the past 48 hours, up through the current interview.

1. Over the past day or two have you had any thoughts about wanting to die or kill yourself? If yes, how long have these thoughts lasted, how many times a day have you had them, and how intense have they been (i.e. could you distract yourself from them?)

[If child answers No to question #1, skip to the next section on page 6]

2. Can you name anything that would prevent you from making a suicide attempt? (i.e. deterrents) What are your reasons for living, and do you feel these are stronger than your reasons for wanting to die?

3. What methods have you considered for attempting suicide? How available are these methods, and when would you have the opportunity to use any of them? (here is where it is especially important to begin assessing the availability of firearms)

4. Over the past day or two have you spoken or written about death, or thought about writing a suicide note?

5. Right now, what are the chances that you would try to kill yourself if you had the opportunity? Would you say the chances are less than 50%, about equal, or more than 50%?
HISTORY OF SUICIDALITY

1. When was the first time you ever thought about attempting suicide? How old were you?

2. When was the first time you ever made a suicidal threat, gesture, or attempt?

3. Have the child chronologically list the incidents of suicidal ideation and behavior from the past to the present (you may already have some of this information from previous sections).

EXPOSURE

1. Have you ever known anybody who has thought about, threatened, gestured, attempted, or completed suicide? Was this person an acquaintance, friend, or family member?

2. If yes, when did this happened and how did you find out about it? (e.g. Did you witness it or hear about it from someone?)
FIREARMS

1. Are there any firearms in your house?

2. What kind of firearms and how many of each kind?

3. Are they stored loaded? If not, is ammunition available?

4. Are the firearms locked? Is the ammunition stored and locked separately?

5. Are there any firearms available in any of the other homes that you visit regularly? (e.g. If parents are separated and child lives with mother but visits father, you must assess the availability of firearms at the father's residence)

* If there are any firearms present in any of the child's familial environments, you must meet with the child's guardian(s) and recommend that the firearms be removed as a standard safety precaution. You must also inform the consulting psychiatrist that firearms are available, and the psychiatrist should reinforce your recommendation regarding the removal of firearms from the child's familial environment. Finally, you must document all firearms information and recommendations in the P.E.F.
NEGOTIATING THE NO-SUICIDE/NO-HARM CONTRACT

If the child has endorsed any past or present suicidality whatsoever, a No-suicide contract must be negotiated. This is an essential aspect of assessing suicidal risk and safety. If the child has endorsed aggressive or homicidal ideation, this contract should be modified to focus on this behavior. The child must be able to agree 100% to the following:

1. That he/she will not attempt suicide/harm another between now and the next inpatient appointment.

2. The child will inform an adult should he/she feel in danger of acting upon suicidal/aggressive thoughts.

3. Should there not be an adult available when the child feels in danger of acting upon suicidal/aggressive thoughts, the child will phone or present himself/herself to the nearest emergency room.

4. The child will try to avoid activities and situations which he/she believes may increase the chance of feeling suicidal/aggressive.

If the child has endorsed significant suicidal or homicidal ideation and is hesitant to agree to the no-suicide/no-harm contract, the assessment may need to be abbreviated so that you can consult as soon as possible with the psychiatrist and evaluate the necessity of inpatient hospitalization.
Appendix II
DEPRESSION CHECKLIST

NAME ___________________________ DATE ___________________________

DEPRESSED MOOD

0 No Information
1 Not at all or less than once a week.
2 Slight: Occasionally has dysphoric mood at least once a week for more than one hour.
3 Mild: Often experiences dysphoric mood at least 3 times a week for more than 3 hours each.
4 Moderate: Most days feels "depressed" (including weekends) or over 50% of awake time.
5 Severe: Most of the time feels depressed and is almost painful. Feels wracked.
6 Extreme: Most of the time feels extreme depression which I can't stand.*
7 Very extreme: Constant unrelied extremely painful feelings of depression.

IRRITABILITY AND ANGER

0 No Information.
1 Not at all, clearly of no clinical significance.
2 Slight and doubtful clinical significance.
3 Mild: Often at least 3 times/3 hours each week) feels definitely more angry, irritable than called for by the situation, relatively frequent but never very intense. Or often argumentative, quick to express annoyance. No homicidal thoughts.
4 Moderate: Most days feels irritable/angry or over 50% of awake time. Or often shouts, loses temper.
5 Severe: At least most of the time child is aware of feeling very irritable or quite angry or has frequent homicidal thoughts (no plan) or thought of hurting others. Or throws and breaks things around the house.
6 Extreme: Most of the time feels extremely irritable or angry, to the point he "can't stand it." Or frequent uncontrollable tantrums.
7 No. 6 Plus homicidal plea.

NEGATIVE SELF IMAGE

0 No Information.
1 Not at all.
2 Slight: Occasional feelings of inadequacy.
3 Mild: Often feels somewhat inadequate, or would like to change his looks or his brain or his personality.
4 Moderate: Often feels like a failure, or would like to change 8 of the above.
5 Severe: Frequent feelings of worthlessness or would like to change all 8. Occasionally says he hates himself.
6 Extreme: Pervasive feelings of being worthless or a failure. Says he hates himself.

HOPELESSNESS AND HELPLESSNESS DISCOURAGEMENT, PESSIMISM

0 No Information.
1 Not at all discouraged about the future.
2 Slight: Occasional feelings of mild discouragement about future.
3 Mild: Often discouraged. Doubts he will get better.
4 Moderate: Often feels quite pessimistic about the future. Doubts he will make it to being a grown up.
5 Severe: Pervasive feelings of intense pessimism. Has given up. Helpless.
6 Extreme: Delusions or hallucinations that he is doomed, or that the world is coming to an end.

ANEHODONIA, LACK OF INTEREST, APATHY, LOW MOTIVATION, OR BOREDOM

0 No Information.
1 All activities as pleasurable and interesting, or more so.
2 Slight: 1 or 2 activities less pleasurable or interesting than before or than his/her friends.
3 Mild: Several activities less pleasurable or interesting, Bored or apathetic over 50% of the time during activities.
4 Moderate: Most activities much less pleasurable or interesting, Bored or apathetic over 75% of the time during activities.
5 Severe: Almost all activities much less pleasurable or interesting, Bored or apathetic 90% of the time during activities.
6 Extreme: Total inability to experience or interest pleasure (I don't enjoy anything).

FATIGUE, LACK OF ENERGY AND TIREDNESS

0 No Information.
1 Not at all or more energy than usual.
2 Slight: Possible less energy than usual.
3 Mild: At times definitely more tired or less energy than usual.
4 Moderate: Often feels tired without energy. Has to rest (not sleep) during the day.
5 Severe: Almost all the time feels very tired or without energy or spends a great deal of time resting, (not sleeping). Limbs may feel heavy and hard to move.
6 Extreme: Constant feeling of extreme fatigue or lack of energy or spend most of the time resting. Limbs feel heavy and hard to move.

EXCESSIVE OR INAPPROPRIATE GUILT

0 No Information.
1 Not at all.
2 Slight: Occasional feeling of mild self-blame, but no persistent ruminations beyond reasonable time.
3 Mild: Often feels guilty about past actions, the significance of which he exaggerates, and which most children would have forgotten about.
4 Moderate: Feelings of guilt which he cannot explain or about things which objectively are not his fault. (Except feeling guilty about parent's separation: and/or divorce which is normal and should not last by and of itself to a positive guilt rating in this score, except if it persists after repeated appropriate discussions with the parents).
5 Severe: Pervasive feelings of intense guilt, or generalized feelings of self-blame for most situations. Feels he should be punished more than he has been.
6 Extreme: Delusions of guilt, hallucinations in which he is accused of having done something terrible, or agonizing constant feelings of guilt.

ACHES AND PAINS

0 No Information.
1 Not at all.
2 Slight: Occasionally, at least once every two weeks.
3 Mild: One or more physical symptoms to mild degree, at least once a week.
4 Moderate: One or several symptoms to a considerable degree, at least every other day.
5 Severe: Frequent onsets, almost daily.
6 Extreme: Constantly bothered, for several hours every day.

DIFFICULTY, CONCENTRATING, INATTENTION, OR SLOWED THINKING

0 Not enough information.
1 Not at all.
2 Slight: Slight and of doubtful clinical significance.
3 Mild: Definitely aware of limited attention span but causes no difficulties other than substantially increased effort in schoolwork.
4 Moderate: Interferes with school marks. Forgetful.
5 Severe: Interferes with school work and most other activities. Can't concentrate even when he wants to. Very forgetful.
6 Extreme: Unable to do the simplest task e.g., watch T.V. or engage in a conversation.
DEPRESSION CHECKLIST

PSYCHOMOTOR AGITATION

0 No Information.
1 Not at all, retarded, or associated with manic syndrome.
2 (3) Increase which is of doubtful significance.
3 Mark: Unable to sit quietly in a chair, fidgeting or pulling and/or rocking.
4 Moderate: Frequent temper tantrums, or marked inability to sit still in class, always distractible.
5 Marked: Pacing, hand wringing, or very frequent temper tantrums. Increased activity both at home and school.
6 Extreme: Almost constantly moving or pacing about or nonstop talking. Hyperactive in all settings.

PSYCHOMOTOR RETARDATION

0 No Information.
1 Not at all.
2 Slight, and of doubtful clinical significance.
3 Mild: Conversation is noticeably retarded but no strained, and/or slowed body movement.
4 Moderate: Conversation is difficult to maintain, and/or moves very slowly.
5 Marked: Conversation is difficult to maintain, and/or moves very slowly.
6 Extreme: Conversation is almost impossible, mute and immobile most of the time (depressive stupor).

SOCIAL WITHDRAWAL

0 No Information.
1 Not at all, no change from usual or increased contact.
2 Less contact or slight avoidance, but of doubtful clinical significance.
3 Mild: Somewhat less involved or sometimes avoids social contact that he ordinarily participates in.
4 Moderate: Definitely less involved when with people or often avoids social contact that he ordinarily participates in. Has lost friends.
5 Severe: Goes out of his way to avoid many social situations that he ordinarily participates in.
6 Extreme: Actively avoids all social contact that he ordinarily participates in.

INSOMNIA

0 No Information.
1 Not at all, or feels no need for any sleep.
2 Slight: Occasional difficulty.
3 Mild: Often (at least 2 times a week) has some significant difficulty. (At least 1 hour to fall asleep, or bedtime delayed for one hour. No middle or terminal insomnia.)
4 Moderate: Usually has considerable difficulty. Either at least 3 hours initial insomnia, or any middle or terminal insomnia unrelated to urination, lasting up to half an hour. Feeling of unrestorable sleep.
5 Severe: Almost always has great difficulty. Either at least 3 hours initial insomnia or any middle or terminal insomnia lasting over one hour total. Considerable circadian reversals.
6 Extreme: Claims he almost never sleeps and feels exhausted the next day or complete circadian inversion.

ANOREXIA

0 No Information.
1 Not at all - normal or increased.
2 Slight decrease of questionable clinical significance.
3 Mild decrease.
4 Moderate decrease.
5 Rarely feels hungry.
6 Never feels hungry.

ANOREXIA

0 No Information.
1 Not at all - normal or increased.
2 Slight increase of questionable clinical significance.
3 Mild increase.
4 Moderate increase.
5 Rarely feels hungry.
6 Never feels hungry.

WEIGHT LOSS

0 No Information.
1 No weight loss (stays in same percentile grouping).
2 Weight loss of failure to gain under 1.5 kg. (3.3 lb) or doubtful.
3 Weight loss plus failure to gain between 1.5 kg - 3 kg (3.3 - 6.6 lb.).
4 Weight loss plus failure to gain 3 kg - 4.5 kg. (6.6 - 9.9 lb.)
5 Weight loss plus failure to gain between 10-24% of ideal body weight.
6 Weight loss of 25% or more of ideal body weight.

INCREASED APPETITE

0 No Information.
1 Not at all - normal or decreased.
2 Slight increase of questionable clinical significance.
3 Mild increase.
4 Moderate increase.
5 Hungry most of the time, but restrains self.
6 Hungry most of the time and eats without restraint.

SUICIDAL IDEATION

0 No Information.
1 Not at all.
2 Slight: Thoughts of his death (without suicidal thought). "I wish I were dead" or "I wish I were dead" or only in the context of anger.
3 Mild: Occasional thought of suicide but has not thought of a specific method.
4 Moderate: Often thinks of suicide and has thought of a specific method.
5 Severe: Often thinks of suicide and has thought of a specific method.
6 Extreme: Has made preparations for a potentially serious suicidal attempt.

HYPERSONMIA

0 No Information.
1 Not at all, or needs less sleep than usual.
2 Occasionally sleeps more than usual.
3 Frequently sleeps at least 1 hour more than usual, or regularly sleeps much longer if not forced out of bed by parent or other authority.
4 Frequently sleeps at least 2 hours more than usual.
5 Frequently sleeps at least 3 hours more than usual.
6 Frequently sleeps at least 4 hours more than usual.
MANIA CHECKLIST

ELATION, EXPANSIVE MOOD

0 No information.
1 Not at all, normal, or depressed.
2 Slight: Good spirits, more cheerful than most people in his circumstances, but of only possible clinical significance.
3 Mild: Definitely elevated mood and optimistic outlook that is somewhat out of proportion to his circumstances.
4 Moderate: Mood and outlook are clearly out of proportion to circumstances. Noticeable to others.
5 Severe: Quality of euphoric mood, way out of proportion to circumstances.
6 Extreme: Clearly excited, almost constantly excited expression, overexcitement.

DECREASED NEED FOR SLEEP

0 No information.
1 No change or more sleep needed.
2 Up to 1 hour less than usual.
3 Up to 2 hour less than usual.
4 Up to 3 hour less than usual.
5 Up to 4 hour less than usual.
6 4 or more hours less than usual.

INCREASE IN GOAL-DIRECTED ACTIVITY

0 No information.
1 No change or decrease.
2 Slightly more interest or activity but of questionable significance.
3 Mild but definite increase in general activity level involving several areas.
4 Moderate generalized increase in activity level involving several areas.
5 Marked increase and almost constantly involved in numerous activities in many areas.
6 Extreme, e.g., constantly active in a variety of activities from awakening till he goes to sleep.

UNUSUALLY ENERGETIC

0 No information.
1 No different than usual or less energetic.
2 Slightly more energetic but of questionable significance.
3 Little change in activity level but less fatigue than usual.
4 Somewhat more active than usual with little or no fatigue.
5 Much more active than usual with little or no fatigue.
6 Usually active all day long with little or no fatigue.

GRANDIOSITY

0 No information.
1 Not at all, or decreased self-esteem.
2 Slight, e.g., is more confident about himself than most people in his circumstances but of only possible clinical significance.
3 Mild, e.g., definitely inflated self-esteem or exaggerated his talents somewhat out of proportion to circumstances.
4 Moderate, e.g., inflated self-esteem clearly out of proportion to circumstances.
MANIA CHECKLIST

ACCELERATED, PRESSURED OR INCREASED AMOUNT OF SPEECH

0 No information.
1 Not at all or retarded speech.
2 Slight increase which is of doubtful clinical significance.
3 Mild: Noticeably more verbose than normal but conversation is not strained.
4 Moderate: So verbose that conversation is strained.
5 Marked: So rapid that conversation is difficult to maintain.
6 Extreme: Talks rapidly or continuously and cannot be interrupted. Conversation extremely difficult or impossible.

POOR JUDGEMENT

0 No information.
1 Not at all.
2 Slight: Of doubtful clinical significance.
3 Mild: e.g., Calls friends at odd hours.
4 Moderate: e.g., Purchases many things he doesn't need and can't afford or gives money away.
5 Severe: e.g., On impulse, goes to places without plans or money and takes too many chances.
6 Very Severe: Attempts activities with potentially very dangerous consequences.

DISTRACTIBILITY (Observational or reported by informant)

0 No information.
1 Not at all.
2 Slight: Of doubtful clinical significance.
3 Mild: Present but responds to structuring and repetition.
4 Moderate: Difficult to complete interview because of child's inattention which doesn't respond to structure.
5 Severe: Impossible to complete interview because of child's inattention.

FLIGHT OF IDEAS (Observational or reported by informant)

0 No information.
1 Not at all or some other form of disturbance of thought or speech.
2 Slight: Occasional instances, which are of doubtful clinical significance.
3 Mild: Occasional instances of abrupt change in the topic with some impairment in understandability, >5% of sentence to sentence transitions are abrupt.
4 Moderate: Frequent instances with moderate impairment in understandability, >10%.
5 Severe: Very frequent instances with definite impairment in understandability, >25%.
6 Extreme: Most of speech consists of such rapid changes of topic that it is impossible to follow, >50%.

RACING THOUGHTS

0 No information.
1 Not at all.
2 Doubtful.
3 Mild: Occasional racing thoughts at least 3 times per week.
4 Moderate: Racing thoughts at least 50% of awake time.
5 Severe: Racing thoughts most of the time.
6 Extreme: Almost constant racing thoughts.

MOTOR HYPERACTIVITY

0 No information.
1 Not at all or retarded.
2 Slight increase which is of doubtful clinical significance.
3 Mild: Unable to sit quietly in a chair.
4 Moderate: Passes about a great deal.
5 Extreme: So hyperactive that he would exhaust himself if not restrained.
HALLUCINATIONS - general
Perceptions in the absence of identifiable external stimulation occurring in the wake state, in the absence of fever or drug influence. Do not include hypnagogic or hypnopompic hallucinations, eidetic imagery, elaborated fantasies such as imaginary companions, religiosity or a single voice calling one's name.

2. present but not influencing behavior because the child can distinguish them from reality.
3. present but interfering with daily functioning because the child is distressed by or acts upon the content of the hallucinations.

SUBTYPES OF AUDITORY HALLUCINATIONS - (not mutually exclusive)

Commanding auditory hallucinations
Voice(s) tell child to do something.

Commenting auditory hallucinations
Voice(s) offering judgment on the child's actions, thoughts, or feelings as they occur.

Conversing auditory hallucinations
Two or more distinct voices carrying on a conversation.

Other Auditory hallucinations
Any other auditory hallucinations not included above.

OTHER TYPES OF HALLUCINATIONS (Other sensory modalities through which hallucinations are perceived. Note all that apply.)

Visual hallucinations

Tactile hallucinations

Olfactory hallucinations

RELIGIOSITY
Conviction that there are supernatural powers which impact on the child's life either malevolently or benevolently, mysticism, or hearing the voice of God may be expected. These should be consistent with the child's religious or ethnic community.

DELUSIONS - general
Fixed false beliefs of variable duration which may or may not influence behavior, occurring in the absence of fever or drug influence. Fixed beliefs shared by family members, religious community or cultural groups are not considered to be delusions.

1. considers his/her "explanation" only a possibility. Other explanations are possible.
2. child cannot be dissuaded from his/her belief(s) by any other plausible explanation. Does not affect his/her behavior in a major way.
3. cannot be dissuaded from belief and significantly affects behavior.

SUBTYPES OF DELUSIONS

Persecutory delusions
Unrealistic belief in a conspiracy, attack or harassment.

Somatic delusions
Unrealistic belief in a distorted appearance, incurable disease or altered organ system.

Nihilistic delusions
Unrealistic belief that a catastrophic event will occur in the near future.

Grandiose delusions
Incredible claims of power, wealth, greatness, knowledge or identity.

Delusions of guilt or sin
Unrealistic belief that the child has performed or is responsible for a disastrous event.

Other
DIURNAL MOOD VARIATION
Worse in Afternoon and/or Evening

0 No Information.
1 Not worse in evening or variable.
2 Minimally or questionably worse or for less than 2 hours.
3 Mildly worse for at least 2 hours.
4 Considerably worse for at least 2 hours.

HYPOCHONDRIASIS

0 No information.
1 Not at all or concern is appropriate to real physical illness.
2 Slight: Occasional excessive concern about body, symptoms, or physical illness.
3 Mild: At times is preoccupied with thinking about illness, without actually feeling sick in any way.
4 Moderate: Frequent preoccupation. >25% of awake time.
5 Severe: Often absorbed. >50% of awake time.
6 Extreme: Delusional hypochondriasis (somatic delusions).

OBSESSIONS OR COMPULSIONS

0 No Information.
1 Not at all.
2 Slight: Occasional obsessive thoughts or ritualistic act, but unclear if clinically significant. “Games” which child can start and stop at will.
3 Mild: Definite obsessions or compulsions but not very frequent and little significant effect on functioning.
4 Moderate: Frequent obsessions or compulsions with some impairment in social or occupational functioning or daily routine. (e.g., comes late or can’t get appointments or some sleep delay with some significant consequences).
5 Severe: Frequent obsessions or compulsions with considerable impairment in social or occupational functioning or daily routine (e.g., grades are adversely affected because of lateness or tasks are severely delayed or interrupted by rituals or bedtime is delayed several hours or social life is partially disrupted).
6 Extreme: Very frequent obsessions (at least 1 per hour) or compulsions with marked impairment in social or occupational functioning or daily routine e.g., attends school sporadically or not at all, social activities are (almost totally disrupted, spends at least 50% of time in ritualistic behavior and or thoughts.

GENERALIZED ANXIETY
Subjective feelings

0 No information.
1 Not at all or less than one a week.
2 Slight: Occasionally feel somewhat anxious (at least once a week for more than one hour).
3 Mild: Frequently feels anxious (at least 3 times a week for more than hours each).
4 Moderate: Most of the time feels anxious. (over 50% awake time).
5 Severe: Most of the time feels very anxious. Never anxiety free, even when no stressful circumstances are apparent.
6 Extreme: Pervasive feeling of intense anxiety, constant and unrelied.

Autonomic hyperactivity (outside pani attacks). (Cold clammy hands, frequent urination, nausea, diarrhea, abdominal pains, sweating, heart racing or pounding, lump in throat, palor, dizziness, lightheadedness, dry mouth).

CURRENT EPISODE 1 2 3 4
CLINICAL GLOBAL IMPRESSIONS CHECKLIST

Row No. 1. Clinical Global Impressions
Considering your total clinical experience with the particular population, how mentally ill is the patient at this time?

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not assessed</td>
</tr>
<tr>
<td>1</td>
<td>Normal, not at all ill</td>
</tr>
<tr>
<td>2</td>
<td>Borderline mentally ill</td>
</tr>
<tr>
<td>3</td>
<td>Mildly ill</td>
</tr>
<tr>
<td>4</td>
<td>Moderately ill</td>
</tr>
<tr>
<td>5</td>
<td>Markedly ill</td>
</tr>
<tr>
<td>6</td>
<td>Severely ill</td>
</tr>
<tr>
<td>7</td>
<td>Among the most extremely ill patients</td>
</tr>
</tbody>
</table>

THE NEXT TWO ITEMS MAY BE OMITTED AT THE INITIAL ASSESSMENT BY MARKING “NOT ASSESSED” FOR BOTH ITEMS

2. GLOBAL IMPROVEMENT - Rate total improvement whether or not, in your judgment, it is due entirely to drug treatment. Compared to his condition at admission to the project, how much has he changed?

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not assessed</td>
</tr>
<tr>
<td>1</td>
<td>Very much improved</td>
</tr>
<tr>
<td>2</td>
<td>Much improved</td>
</tr>
<tr>
<td>3</td>
<td>Minimally improved</td>
</tr>
<tr>
<td>4</td>
<td>No change</td>
</tr>
<tr>
<td>5</td>
<td>Minimally worse</td>
</tr>
<tr>
<td>6</td>
<td>Much worse</td>
</tr>
<tr>
<td>7</td>
<td>Very much worse</td>
</tr>
</tbody>
</table>

3. EFFICACY INDEX - Rate this item on DRUG EFFECT ONLY.
Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items interact.
EXAMPLE: Therapeutic effect is rated as ‘Moderate’ and side effects are judged “Do not significantly interfere with patient’s functioning”. Record 06 in rows 40 and 41.

<table>
<thead>
<tr>
<th>THERAPEUTIC EFFECT</th>
<th>SIDE EFFECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Do not significantly interfere with patient’s functioning</td>
</tr>
<tr>
<td>MARKED - Vast improvement</td>
<td>01 02 03 04</td>
</tr>
<tr>
<td>Complete or nearly complete remission of all symptoms.</td>
<td></td>
</tr>
<tr>
<td>MODERATE - Decided improvement</td>
<td>05 06 07 08</td>
</tr>
<tr>
<td>Partial remission of symptoms.</td>
<td></td>
</tr>
<tr>
<td>MINIMAL - Slight improvement</td>
<td>09 10 11 12</td>
</tr>
<tr>
<td>which doesn’t alter status of care of patient</td>
<td></td>
</tr>
<tr>
<td>UNCHANGED OR WORSE</td>
<td>13 14 15 16</td>
</tr>
</tbody>
</table>

Not Assessed = 00
Appendix III
SELF-REPORT FOR CHILDHOOD ANXIETY RELATED DISORDERS
(SCARED)

CHILD FORM (8 years and older)

Name: ___________________________ Date: ______________

Identification #: __________________

Below is a list of items that describe how people feel. For each item that describes you, please circle the 2 if the item is very true or often true of you. Circle the 1 if the item is somewhat or sometimes true of you. If the item is not true of you, please circle the 0. Please answer all items as well as you can, even if some do not seem to concern you.

0 = Not true or hardly ever true
1 = Somewhat true or sometimes true
2 = Very true or often true

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>When I feel frightened, it is hard to breathe.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I get headaches when I am at school.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I don’t like to be with people I don’t know well.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I get scared if I sleep away from home.</td>
<td></td>
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<td>I am nervous.</td>
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<td>8</td>
<td>I follow my mother or father wherever they go.</td>
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<tr>
<td>17</td>
<td>I worry about going to school.</td>
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<tr>
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<td>When I get frightened, I sweat a lot.</td>
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<tr>
<td>23</td>
<td>I am a worrier.</td>
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<td>24</td>
<td>I get really frightened for no reason at all.</td>
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*For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.*

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlene Cully, M.Ed., David A. Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95).

Email: birmaher@msx.upmc.edu

2
SELF-REPORT FOR CHILDHOOD ANXIETY RELATED DISORDERS
(SCARED)

PARENT FORM

Child's Name: ___________________________ Date ___________________________

Parent's Name: ___________________________ Identification #: ___________________________

Below is a list of items that describe how people feel. For each item that describes your child, please circle the 2 if the item is very true or often true of your child. Circle the 1 if the item is somewhat or sometimes true of your child. If the item is not true of your child, please circle the 0. Please answer all items as well as you can, even if some do not seem to concern your child.

0 = Not true or hardly ever true
1 = Somewhat true or sometimes true
2 = Very true or often true

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<td>1</td>
<td>When my child feels frightened, it is hard for him/her to breathe.</td>
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<td>2</td>
<td>My child gets headaches when he/she is at school.</td>
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<td>3</td>
<td>My child doesn't like to be with people he/she doesn't know well.</td>
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<td>4</td>
<td>My child gets scared if he/she sleeps away from home.</td>
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<td>5</td>
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<td>My child follows me wherever I go (he/she is like my &quot;shadow&quot;).</td>
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Email: birmaherb@msx.upmc.edu
Appendix IV
FEELING BETTER

This manual was prepared by Mary Beth Boylan, M.A., Clinic Coordinator, Services for Teens at Risk, University of Pittsburgh, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213.

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FEELING BETTER

The purpose of treatment is to feel better - to get enjoyment out of life and gain a sense of control over your moods. In treatment, you will have the opportunity to learn about depression. Your therapist will work with you in helping you understand the powerful role your thoughts and beliefs play in depression and what you can do to help yourself feel better.

If you have never been in treatment before, you may be wondering what to expect. Thoughts such as "Nothing is going to make any difference," "It’s my parent’s problem, not mine," or, "Coming here means I’m weak and unstable" are not uncommon. What you think and how you feel about treatment are important and we encourage you to share your concerns with your therapist. This will provide a starting point for you and your therapist to begin identifying problems that are causing the most difficulty for you.

The type of treatment you will be participating in is called Cognitive Therapy. It is an approach that many people have found helpful in eliminating symptoms of depression. Learning about depression is a good place to start in understanding how Cognitive Therapy works.

What is depression?

Depression can be thought of as an illness. It is more than the everyday ups and downs. When the "down" mood along with other symptoms lasts more than a couple of weeks, the condition may be clinical depression. No one person is the cause; not yourself, family members, or friends are responsible for depression. While stress may be associated with the start of depression, we know that it is not the sole cause. Only some people who experience a given stressor will become depressed.

There are many things we do not know about depression. What we do know is that it tends to run in families and can reoccur. It involves biochemical changes and changes in thinking.

The American Psychiatric Association has identified the following as symptoms of depression.

- sad mood
- increased irritability
- loss of energy or feeling tired the time
- thoughts of suicide or being "better off dead"
- difficulty concentrating, remembering, or making decisions
- crying spells, feelings of hopelessness or guilt
- unusual loss or increase in appetite or weight
- trouble falling asleep, waking up at night, or waking up too early
- sleeping too much
- loss of interest in people or usual activities

**Treatment for Depression**

An important thing to remember is that depression can be treated successfully. Major approaches used in treatment include medication, psychotherapy, and sometimes a combination of both.

**What about medication?**

There are several different types of medication used to treat depression that collectively are known as antidepressants. Because there are biochemical changes in the brain, antidepressants act on altering the action and distribution of brain chemicals. They tend to bring mood, appetite, energy level, sleep patterns and concentration back to normal. They are more often used when depressive symptoms are severe.

In attempting to relieve some of the uncomfortable symptoms of depression, people sometimes resort to the use of pills, caffeine, alcohol or street drugs. These drugs do not work in alleviating depression and may even make depression worse. We urge you not to use them.

**What about psychotherapy?**

Many people have found psychotherapy or talking therapy to be very helpful in the treatment of depression. Cognitive Therapy, the type of psychotherapy in which you will be involved, is an approach that has been studied and found to be especially effective.

Studies have shown that the depressed person interprets many situations incorrectly. What he thinks about what is happening around him affects how he feels. In other words, he may feel sad and lonely because he "thinks" he is unworthy and deserted.

As a result of these studies, we are now concerned with the kind of statements that people make to themselves - that is, what they think. We have found that depressed people have continuous unpleasant thoughts, and with each negative thought the depressed feeling increases. These thoughts, generally not based on facts, make a person feel sad when there is no objective reason to feel that way. The negative thoughts may keep the depressed person from doing things that will make him feel better.
Examples of mistakes in thinking:

In order to understand this faulty thinking, consider the following examples:

1. You reject positive experiences by insisting that "don't count" for some reason or other. Example: When a friend compliments you, you tell yourself, "I've fooled him" or "He's just saying that to be nice."

2. You see a single negative event as a never-ending pattern of defeat by using words such as "always" or "never" when you think about it. Example: You're late for an appointment or you make a mistake and you tell yourself, "I'm always doing that."

3. Suppose you are walking down the street and you see a friend who appears to completely ignore you. Naturally, you feel sad. You may wonder why your friend has turned against you. If you were feeling like your usual self, you might mention the incident to your friend, who tells you he was too preoccupied at the time and didn't even see you. At this point you will probably feel better and put the incident out of your mind. If you were depressed, you may not ask your friend about it, and will probably believe your friend has really rejected you.

If you are depressed, many of your bad feelings are based on mistakes in thinking. These mistakes relate to the way you think about yourself and the way you judge things that happen to you.

Still, you have many skills and may be good at solving problems in other areas. In fact, you have solved problems all your life. Like a scientist, you can learn to use your reasoning powers and your thinking and see what is realistic. In this way, you can keep yourself from becoming upset at every experience that seems at first glance to be unpleasant.

How to become your own therapist:

In treatment, you can learn to help yourself by recognizing your negative thoughts, correcting them, and substituting more realistic thoughts. Your therapist can also help you to devise ways to deal more effectively with real day-to-day problems. You may do things to help yourself between therapy sessions to test out beliefs you hold that increase depressed feelings. With your therapist's guidance and your own effort, you can learn to respond with far less depression and misery when you encounter difficulties in the future.
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<td>$10.00</td>
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<tr>
<td>Living with Depression: A Survival Manual for Families, Revised 1/98</td>
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<tr>
<td>Survivors of Suicide: A Support Group Leaders Handbook</td>
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<td>Cognitive Therapy Treatment Manual: For Depressed and Suicidal Youth</td>
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<td>Child and Adolescent Anxiety: A Handbook for Families</td>
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<td>Understanding and Coping with Bipolar Illness: A Survival Manual for Families</td>
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Address __________________________________________

City, State, Zipcode: __________________________________________

County __________________________________________

PAYMENT MUST ACCOMPANY ORDER – NO PURCHASE ORDERS, PLEASE. MAKE CHECKS PAYABLE TO STAR-CENTER OUTREACH.

3/04