24 Major Depression

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24.1 Overview

For many years, depression was considered a condition that affected only adults. Over the past 30 years, however, there has been a recognition that the major affective disorders occur during childhood and adolescence, are persistent, and are associated with a wide range of negative outcomes. Experiencing a major depressive episode (MDE) during childhood or adolescence places an individual at risk of depression as an adult (Kessler & Walters, 1998). Developmental continuities or trajectories appear to exist in those individuals who experience an episode of major depression as a child and are more likely to experience further episodes as an adolescent (Kovacs & Gatsonis, 1994). Clinically depressed adolescents, in turn, are more likely to experience depressive episodes as an adult (Fombonne, Wostear, Cooper, Harrington, & Rutter, 2001). Major depression among youth can have a severe impact on social relationships and academic functioning, and can place youth at risk of other psychiatric conditions, alcohol and substance abuse, and suicide (Angold, Costello, & Erkanli, 1999; Brent, 1995). Major depression among youth, then, is a significant clinical and public health concern, and it is important for clinical psychologists who work with adolescents to develop the necessary competencies to provide high quality care.

24.2 Recognition of Symptoms and Their Assessment

Major Depressive Disorder (MDD) is marked by one or more MDEs in the absence of manic or hypomanic episodes. MDEs during childhood and adolescence are phenomenologically similar to those experienced by adults. DSM-IV-TR criteria for major depression during childhood and adolescence are very similar to those for adults (American Psychiatric Association, 2000), with the few exceptions noted below in italics. To meet criteria for MDE, a child or adolescent must manifest five or more of the following symptoms for most of the day, nearly every day, for at least a 2-week period: (1) depressed or irritable mood, (2) markedly diminished interest or pleasure in activities, (3) significant weight loss or gain, or a change in appetite or failure to make expected weight gains, (4) sleep disturbance, (5) psychomotor agitation or retardation, (6) fatigue or loss of energy, (7) feelings of guilt or worthlessness, (8) indecisiveness or inability to concentrate, or (9) recurrent thoughts of death or suicide, or a suicide attempt. Either the depressed or irritable mood, or anhedonia, must be present. Moreover, these symptoms must cause significant impairment in academic or psychosocial functioning and cannot be due to the direct effects of substance abuse or a general medical condition. As with adults, then, major depression during childhood is characterized by affective, cognitive, and somatic changes.

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Epidemiological research indicates that the first onset of MDD frequently occurs during adolescence, and that the condition is not uncommon among prepubertal youth. Across a number of studies, approximately 5–8% of adolescents (Essau & Dobson, 1999; Kessler, Avenevoli, & Merikangas, 2001) meet diagnostic criteria for MDD. A recent meta-analysis generated estimated point prevalence rates of 2.8% for childhood MDD, and 5.9% for girls and 4.6% for boys for adolescent MDD (Costello, Erkanli, & Angold, 2006).

Major depression frequently co-occurs with other psychiatric illnesses (Angold et al., 1999), which can complicate diagnosis, case formulation, and treatment planning. Both internalizing and externalizing behavior problems can co-occur with depression among youth. Of these, anxiety disorders are the most common, with over 50% of clinically depressed adolescents reporting a current or past history of anxiety (Pine, Cohen, Gurley, Brook, & Ma, 1998). In the Treatment for Adolescents with Depression Study, 27% of the participants also met DSM-IV-TR criteria for a current anxiety disorder (TADS Team, 2005). Twenty-four percent of the sample met diagnostic criteria for a current externalizing disorder. Given these complexities, a principal competency of the clinician is that of accurate diagnosis, including differential diagnosis and comprehensive assessment of comorbid disorders.

As noted, rates of MDD among prepubertal youth are relatively low. Childhood MDD tends to occur equally in boys and girls. Rates of depression among males and females diverge during adolescence, with females meeting the criteria for major depression about twice as frequently as males. Depression among youth has a highly variable course (Lewinsohn, Clarke, Seeley, & Rohde, 1994), but both chronicity and recurrence are frequent (Reinecke & Curry, 2008). In Lewinsohn's study of a high school sample, duration of MDE ranged from 2 to 520 weeks! Clinical samples, not surprisingly, demonstrate considerable duration. The median duration of depressive episodes among youth entering the Treatment for Adolescents with Depression Study (TADS) was 40 weeks, and the mean was 71 weeks (TADS Team, 2005).

Depression among adolescents also tends to be recurrent. Rao et al. (1995) reported a 7-year recurrence rate (i.e., emergence of depressive symptoms after a period of sustained recovery from a depressive episode) of approximately 70% in their clinical sample of depressed youth.

### 24.3 Maintenance Factors of the Disorder

MDD among adolescents, like other psychiatric disorders, appears to be multiply determined. A range of biological, social, environmental, developmental, and cognitive factors appear to interact in placing individuals at risk (Gotlib & Hammen, 1992; Kendler, Gardner, & Prescott, 2002). Contemporary models of psychopathology, including interpersonal and cognitive behavioral models discussed below, typically take the form of diathesis-stress formulations in which vulnerabilities interact with the occurrence of social or environmental stressors in contributing to the onset of a depressive episode. From this perspective, it is unlikely that any single factor (biological, social, etc.) will account for a very large portion of the variance in predicting the onset of MDD. Rather, these factors appear to influence one another in a transactional manner over the course of development in placing youth at risk. These models are consistent, as well, with recent models of gene–environment interaction in developmental psychopathology (Moffitt, Caspi, & Rutter, 2006).

Some vulnerability factors, such as biological vulnerability and past developmental history, are beyond the scope of psychotherapeutic intervention, i.e., they cannot be changed by
psychotherapeutic treatment. Others, however, can be identified as targets of treatment. Those vulnerability factors that are currently serving to maintain a depressive episode, and that are modifiable by psychological intervention serve as targets for evidence-based psychotherapies.

In the psychotherapeutic treatment of adolescent depression, clinicians must recognize that both individual and family factors might contribute to or maintain the disorder. The specific focus of treatment will be driven both by the clinician's theoretical orientation (e.g., cognitive behavioral or interpersonal) and the salient maintaining factors in a given case. Psychological maintenance factors can be categorized as cognitive, behavioral, and interpersonal/family factors, any of which can interfere with the adolescent's ability to cope effectively with stress, and thus maintain the depressive condition.

Cognitive Factors. A variety of cognitive correlates of adolescent depression has been identified in psychopathology research guided by social cognitive learning theory or cognitive processing theory. In the classic cognitive theory of depression (Beck, Rush, Shaw, & Emery, 1979), cognitive processes at different levels of awareness are proposed as contributing to depression. At the most superficial level of cognition, automatic thoughts are proposed as rapid ideas, reactions, or images triggered by certain situations. For example, an adolescent boy who fails a math test may experience the thought "I am dumb." Automatic thoughts are related to underlying dysfunctional attitudes or conditional beliefs, such as "Unless I am an excellent student, I am incompetent." At the most fundamental level of cognition are the adolescent's core beliefs, such as "I am worthless." Negative beliefs may pertain to the self, the world, or the future (Kaslow, Stark, Printz, Livingston, & Tsai, 1992). Cognitive therapy proceeds from the identification of automatic thoughts to that of their underlying attitudes and core beliefs, with the therapist assisting the patient to restructure cognitions at each level. As treatment proceeds along this path, the adolescent's typically used cognitive distortions will be identified, such as failure to process positive feedback, dichotomous (all/none, good/bad) thinking, or overgeneralization. By collaboratively identifying and challenging these information processing distortions, the therapist and adolescent increase the adolescent's openness to information that serves to disconfirm depressive beliefs, thus alleviating depression.

Additional cognitive maintenance factors have been identified by other models of depression, and shown to be associated with depression. For example, Abramson, Seligman, and Teasdale (1978) demonstrated that depressed individuals attribute negative outcomes to internal, stable, global causes ("It is my fault that we lost"; "I will never be any good at this game"; "I am not good at anything."). A feature that is characterized as a depressive explanatory style. On the other hand, they tend to attribute positive outcomes to external, unstable, and specific causes ("I aced the test because it was easy"; "I had a good day"; "I can do long division, but not other math."). Whereas attributions pertain to judgments about events that have already occurred, expectancies pertain to future events. Studies have demonstrated that hopelessness, or negative expectancies about the future, characterize depressed adolescents (e.g., Garber, Weiss, & Shanley, 1993).

A recent review article summarized the evidence in support of the association of these cognitive variables and youth depression (Ingram, Nelson, Steidtmann, & Bistricky, 2007). Measures exist for the assessment of each variable, facilitating the clinician's ability to target relevant processes in specific cases.

Behavioral Factors. Research based on operant or multifactorial models of depression has emphasized the importance of social withdrawal or general inactivity to the maintenance of depression (Clarke, DeBar, & Lewinsohn, 2003). By avoiding potentially gratifying mastery
activities and social interaction, depressed adolescents deprive themselves of pleasure, or positive reinforcement that can counter depressed mood or anhedonia. In addition, depressed adolescents tend to engage in more unpleasant activities than do nondepressed adolescents (Carey, Kelley, Buss, & Scott, 1986).

Interpersonal and Family Factors. Interpersonal problem-solving deficits have been identified in some studies of depressed adolescents, particularly suicidal depressed adolescents (Speckens & Hawton, 2005). Such deficits can prevent resolution of interpersonal conflicts that are, themselves, quite normal for adolescents. Interpersonal loss can be another factor contributing to or maintaining adolescent depression. Bereavement following parental death has been found to be associated with increased psychiatric symptomatology in the first 2 years following death, with complex bereavement (parental death and additional stressors) more likely to be associated with depression (Cerel, Fristad, Verducci, Weller, & Weller, 2006). Loss of relatives or close friends has been associated with elevated depressive symptoms (Harrington & Harrington, 2001). Adolescents can experience traumatic grief reactions to the death of a peer by suicide, which in turn predicts subsequent depression (Melhem et al., 2004).

Additional family factors that can maintain adolescent depression include excessively high parental expectations of the adolescent, coupled with low levels of praise or positive reinforcement (Cole & Rehm, 1986), poor family problem-solving, negative parent–adolescent affect, or high parent–adolescent conflict and mutual criticism (Asarnow, Tompson, Hamilton, Goldstein, & Guthrie, 1994; Ge, Best, Conger, & Simons, 1996; Sheeber, Davis, Leve, Hops, & Tildesley, 2007).

24.4 Evidence-Based Treatment Approaches

Several approaches have been piloted as treatments for adolescent depression (e.g., attachment-based family therapy; Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002). To date, two approaches to the psychotherapeutic treatment of adolescent depression have garnered a substantial evidence base: cognitive behavior therapy (CBT) and interpersonal psychotherapy (IPT). The evidence base in support of CBT is more extensive than that in support of IPT, and CBT is the only psychotherapy that has been tested in multisite adolescent depression trials. We review IPT first, and then CBT.

Mufson and her colleagues adapted IPT for depressed adolescents and completed the initial efficacy trial of this treatment with 48 mostly Hispanic female subjects (Mufson, Weissman, Moreau, & Garfinkel, 1999). Compared to a clinical monitoring condition, 12 weeks of IPT led to greater reductions in interviewer-rated depression, self-reported depression, and remission from the episode of MDD. A larger school-based study was subsequently completed (Mufson et al., 2004), in which IPT was compared to usual treatment in school-based clinics. Sixty-three adolescents with MDD, or other depressive diagnoses, across five schools, were randomized to one of the two conditions. IPT surpassed usual treatment on interview-based and self-reported depression, and on global functioning at outcome.

Rossello and Bernal (1999) applied a somewhat different version of IPT with 71 Puerto Rican adolescents with MDD. Adolescents were randomized to IPT, CBT, or a Wait List (WL). After 12 weeks of treatment, those receiving either IPT or CBT reported significantly less depression than those in the WL condition. IPT, but not CBT, surpassed WL on measures of self-esteem and social adaptation.
In summary, IPT has been demonstrated to be more effective acutely for adolescent depression than WL, clinical monitoring, or standard school-based counseling. It has not yet been compared to pill placebo, or compared to, or combined with, medication in controlled trials. Based on Beck's cognitive processing model of depression, Brent et al. (1997) at the University of Pittsburgh conducted a single-site comparison of CBT, nondirective supportive therapy (NST), and systems behavioral family therapy (SBFT) for adolescents with MDD (Brent et al.). All treatments included psychoeducation for parents regarding the nature of depression and available treatments. CBT was adapted for adolescents by increasing the emphasis on interpersonal problem-solving and social skills training, and including a component to enhance adolescent affect regulation. Treatment sessions were held weekly for 12–16 weeks across conditions. Positive response to treatment was defined as absence of significant MDD symptoms on a diagnostic interview along with at least 3 consecutive weeks of normal scores on self-reported depression. CBT was more effective than either of the comparison conditions, led to faster time to response, and was rated as a more credible intervention by parents.

During treatment, CBT had a significantly greater impact on reducing cognitive distortions than did either of the other psychotherapies, a finding maintained at the 2-year follow-up. SBFT had more impact on the measure of family functioning. By contrast, there was no difference among treatments in their impact on hopelessness (Kolko, Brent, Baugher, Bridge, & Birmaher, 2000). At the 2-year follow-up, the great majority of adolescents (80%) had responded and there were no longer differences in outcome across treatment groups (Birmaher et al., 2000). This finding is likely related to the nature of depression as an episodic disorder, and suggests that the advantage of CBT lies in its facilitation of a more rapid response than is attained by less depression-specific psychotherapies. Conversely, 30% experienced a recurrence of MDD during the 2-year period, pointing to the importance of relapse prevention as a treatment target.

A second approach to CBT for adolescent depression has been based upon Lewinsohn's multifactorial model of MDD, which identifies multiple biological, cognitive, and behavioral factors contributing to MDD (Clarke, Lewinsohn, & Hops, 1990). In this model, the same priority is not accorded to cognition as in the Beck model. Instead, the underlying assumption is that cognition, behavior, and emotion are mutually influencing factors, so that change in either behavior or cognition can lead to modifications in emotion and reduction in depression. Treatment stemming from this model is psychoeducational in nature, administered in highly structured groups, and focused on the learning of a wide variety of skills. These include mood monitoring, goal-setting, problem-solving, relaxation, increasing involvement in pleasant activities, and cognitive restructuring. The intervention is presented as a course, with sessions usually held in nond clinic sites, and the program is entitled the Adolescent Coping with Depression Course (CWD-A).

Two randomized trials have assessed the effectiveness of CWD-A, the second of which was a two-site study. In each study, three conditions were contrasted. One third of adolescents were randomized to CWD-A alone; one third to CWD-A plus a parallel psychoeducation group for their parents; and one third to a WL. Treatment response was defined as no longer meeting the criteria for a depression diagnosis. In both studies, response was greater in the two CBT conditions than in the WL group. Of note is the fact that the absolute response rates varied greatly between studies. In the initial study of 59 subjects (Lewinsohn, Clarke, Hops, & Andrews, 1990), response to CWD-A was 43% without concurrent parent group and 48% with concurrent parent group, as opposed to only 5% in the WL condition. Parallel rates in the second
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study (Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999), with 123 subjects, were 65%, 69%, and 48%. Follow-up of the initial study cohort showed that 82% had responded by 6 months, indicating, as in Brent's (1997) study that improvement continues following acute treatment. Also, similar to Brent's findings, after the second CWD-A study, follow-up indicated a 25% recurrence rate over a 2-year period.

A recent application of the CWD-A compared it to a life skill (LS) condition for adolescents with comorbid MDD and conduct disorder (Rohde, Clarke, Mace, Jorgensen, & Seeley, 2004). Adolescents treated with CWD-A had higher recovery rates than those treated with LS (39% versus 19%), but, as would be expected with this significant comorbid condition, absolute response rates were lower than in the initial CWD-A studies.

Two major multisite studies of CBT for adolescent MDD have now been conducted in the USA. In the 13-site TADS, 439 adolescents with moderate to severe MDD were randomized to receive CBT, fluoxetine, their combination, or clinical management with pill placebo for 12 weeks of acute treatment. After week 12, the placebo arm was discontinued and placebo nonresponders received their treatment of choice. Partial or full responders to the active treatments continued to receive for 6 weeks in continuation and then 18 weeks of maintenance therapy in their assigned arms. CBT in TADS combined elements of the Brent and Lewinsohn/Clark models: Behavioral and cognitive skills training was embedded within the individual therapy sessions (Curry et al., 2000; Wells & Curry, 2000). Parents were included in some treatment sessions. Core elements of the CBT included mood monitoring, goal-setting, behavioral activation, problem-solving, and cognitive restructuring. The TADS CBT model has been described extensively in a special issue of *Cognitive & Behavioral Practice* (Vol. 12, No. 2, 2005). The primary hypotheses of the TADS study were that the combination of CBT and fluoxetine would be more effective than either monotherapy, and that each of the latter would surpass placebo acutely.

Acute treatment results supported combined CBT + fluoxetine as the most effective intervention, as measured by the rate of change (slope) of scores on a standardized interview-based rating scale completed by Independent Evaluators uninformed of treatment assignment (TADS Team, 2004). Combined treatment surpassed placebo, CBT alone, and fluoxetine alone on this primary measure. Response rates at week 12 were 71% for combined treatment, 61% for fluoxetine, 43% for CBT, and 34% for placebo. Fluoxetine, but not CBT, was superior to PBO at the end of 12 weeks of treatment. By week 18, response rates for CBT and placebo were equivalent (69% and 65%, respectively), and at the week 36 treatment endpoint, all three active treatments converged with rates of 86%, 81%, and 81% for combination, fluoxetine, and CBT, respectively (TADS Team, 2007).

In the six-site Treatment of Resistant Depression in Adolescents (TORDIA) study, 334 adolescents who had not responded to an adequate trial of a selective serotonin reuptake inhibitor (SSRI; antidepressant medication) were randomized to one of four conditions. They were switched either to another SSRI or venlafaxine, with or without concurrent CBT. CBT with a medication switch proved more effective than a medication switch alone, with 55% responding in the CBT-containing conditions versus 40% without CBT (Brent et al., 2008). In summary, CBT has been shown to be more effective acutely than WL, and alternative psychotherapies, but not to pill placebo acutely. The combination of CBT and fluoxetine has attained a higher absolute response rate than either of these single interventions for acute treatment of MDD, and surpassed medication alone as a second stage treatment following nonresponse to initial medication. However, a British study found that CBT did not add to the efficacy of
antidepressant medication for adolescents not responding to initial psychosocial intervention (Goodyer et al., 2007).

### 24.5 Mechanisms of Change Underlying the Interventions

Only a limited amount of empirical evidence exists regarding the mechanisms of change associated with the efficacy of CBT or IPT for adolescent depression. We review that evidence below, following a discussion of theoretically proposed mechanisms of change. IPT is based on the assumptions that clinical depression is a psychiatric disorder manifested in specific symptoms, and that it may be either a cause of an effect of disturbances in current interpersonal relationships (Klerman, Weissman, Rounsaville, & Chevron, 1984). Treatment proceeds in three phases. Initially the therapist reviews the patient's symptoms, identifies the depressive syndrome as a disorder, explains the interpersonal model of depression and treatment, and assesses the need for antidepressant medication. An inventory of past and current interpersonal relationships is conducted, and the current depression is linked to a major interpersonal problem area. Patient and therapist work together to formulate goals, with a focus of work primarily on one interpersonal problem area.

The second phase of treatment constitutes the majority of sessions. One of the four possible major problem areas is the focus of these sessions: grief, interpersonal disputes, role transitions, or interpersonal deficits. The final phase of treatment is termination, which is discussed openly and viewed as a type of grieving, in itself. During IPT sessions, the therapist encourages the patient to explore and express emotions, especially in the context of the problem area that is the focus of treatment. There are emphases on clarification of communication and the IPT therapist may also incorporate social skills or interpersonal problem-solving skills into sessions. To this extent, there is a clear overlap between IPT and CBT. In the course of the treatment, the patient is assisted to resolve the key interpersonal problem that appears to be most clearly associated with the onset and/or maintenance of the current depressive episode.

For example, an adolescent girl may experience the onset of depression following the death of her father. This would clearly determine the focus of IPT on the major problem area of grief. During the initial treatment phase, the onset of depressive disorder would be linked to the loss of the adolescent's father. In the middle phase sessions, the girl would be assisted to review her relationship with her father, both in its positive and negative aspects, exploring all associated emotions. As the mourning process proceeds, the adolescent is encouraged to become interested in other relationships and activities or social interactions that can, to some extent, substitute for the loss of the parent.

A different example would be that of an adolescent who experiences the onset of depression after making a transition from middle to high school. This is an instance or "role transition." It is analogous to a grief reaction, however, in that the focus of treatment would be on mourning the loss of the old role, partly by reviewing both its positive and negative aspects, and then moving toward adoption of a new role. Inherent in the latter may be the need to develop more advanced social or academic skills required for mastery in the new situation.

These examples illustrate the centrality of the interpersonal context of depression that characterizes IPT. It appears that the proposed core mechanism of change underlying IPT is the resolution of the most salient interpersonal problem associated with the onset or maintenance of the current depressive episode. IPT is a short-term treatment and does not seek to restructure
personality or rework relationships from the past as these may be internalized in object relations or schemas.

As noted above, American CBT for adolescent depression has stemmed from two different schools of thought: the cognitive model of psychopathology and the multifactorial model. As such, there are some differences in proposed mechanisms of change. The cognitive model hypothesizes that depression is a cognitive disorder (Beck et al., 1979). Negative life events trigger underlying cognitive diatheses or vulnerabilities that may stem from early life experiences, such as a core belief that the self is unlovable or helpless. Cognitive therapy for adolescent depression, like IPT, begins with an assessment of symptoms and the description of the depressive syndrome as a disorder (Brent & Poling, 1997). The adolescent and family receive psychoeducation about depression and about the treatment. In the early phase of treatment, the adolescent is asked to attend to events or situations that affect his or her mood (mood monitoring), and may be helped to engage in an increased level of activities, not only to counter depressive passivity, but also to create more opportunities to monitor mood and associated cognitions. Within sessions, here-and-now focusing on subtle shifts in mood is facilitated by the therapist to help the adolescent identify what thoughts or images are going through his or her mind as mood shifts occur. In general, cognitive therapy proceeds from identification of automatic thoughts associated with depressive affect to the identification of underlying conditional beliefs (dysfunctional attitudes) and to that of depressive core beliefs. Themes in the automatic thoughts tend to disclose the nature of the relevant underlying attitudes and beliefs.

For example, an adolescent boy may become depressed after breaking up with his girlfriend. Associated automatic thoughts may be: "She thinks I am unattractive"; or "She likes my best friend better than me." By rigidly focusing on the breakup, the boy may be demonstrating an underlying dysfunctional attitude such as, "Unless every girl finds me attractive, I am a loser." The associated core belief may be, "I am unlovable." To maintain such a belief, the adolescent relies on cognitive distortions, such as ignoring the fact that another girl seems to like him, or overgeneralizing from this one negative experience to form an expectation that all romantic relationships will end in painful separation. The proposed key mechanism of change in cognitive therapy is modification of depressive automatic thoughts, dysfunctional attitudes, and core beliefs, and ultimately the latter. Thus, cognitive restructuring is the major therapeutic mechanism of change.

Multifactorial CBT (Clarke et al., 2003) is less linear in its assumptions and uses a reciprocal influence model of depression, according to which deficits in behaviors, cognitions, or emotional coping responses can be associated with the onset and maintenance of depression in any given case. Treatment proceeds, therefore, by presenting to adolescents an array of skills to learn for coping with stress. Since treatment is psychoeducational and often done in a group format, the assumption appears to be that some skills will be relevant for a given adolescent, while other skills will be relevant for another adolescent. There is a greater emphasis in multifactorial CBT on behavioral activation as an end in itself, and not only as a means to generate depressive cognitions for subsequent restructuring. Thus, the CWD-A program puts considerable emphasis on monitoring mood while increasing weekly pleasant activities, in order to show the link between pleasant activities of a social or achievement nature with elevations in mood.

To our knowledge, there have not been any empirical studies of the mechanisms of change associated with effective IPT for adolescents. There have been only a few relevant studies of CBT. In a small study of 22 adolescents with depressive symptoms (not diagnosed MDD), Ackerson, Scogin, McKendra-Smith, & Lyman (1998) found that reductions in dysfunctional
attitudes mediated response to a bibliotherapeutic intervention based on cognitive theory. Kaufman, Rhode, Seeley, Clarke, & Stice (2005) conducted a mediation analysis of the sample included in Rohde’s (2004) study of CBT or life skills training for depressed, conduct-disordered adolescents. They found that changes in negative automatic thoughts mediated the outcome of CBT on depression. Thus, there is some evidence that a key mechanism of change in CBT for adolescent depression is the restructuring of depressive cognitions.

24.6 Basic Competencies of the Clinician

Clinical psychologists who propose to work with depressed adolescents must have relevant competencies in knowledge, assessment, and treatment. A framework for conceptualizing these professional psychology competencies, in general and not with specific reference to adolescent depression, was generated by a large conference work group in 2002, and we will rely to some extent on that framework in the discussion of this topic (Collins, Kaslow, & Illfelder-Kaye, 2004). In addition, the most fundamental competencies for psychological practice with children, adolescents, or adults involve aspects of personal character and psychological fitness that are essential for clinical effectiveness (Johnson & Campbell, 2004).

Johnson and Campbell (2004) argue that character and fitness are necessary but not sufficient personal characteristics for competence in professional psychology. Under the rubric of character, they include honesty and integrity in one’s dealings with other persons. More specifically, clinicians must have the personal qualities of integrity (honesty and consistency across contexts), prudence (capacity for planning and good judgment), and caring (concern for the welfare and needs of others) (p. 406). Under psychological fitness, they refer to emotional stability, absence of serious psychological disorder, benign personality adjustment, and absence of substance abuse. In a survey of the Directors of Clinical/Counseling Training (DCT’s), they found that such character and fitness markers were ranked as quite important, both for admission to graduate school, and even more so for graduation from doctoral training.

How do these character and fitness requirements pertain to clinical work with depressed adolescents? First, honesty and consistency across contexts are necessary in order to establish good working alliances both with the adolescent and with the parent(s). Research by Hawley and Weisz (2005) has shown that a positive therapeutic alliance with the adolescent or child is associated with better treatment outcome, and that a positive alliance with the parent is associated with retention in treatment and regular attendance at sessions. In adolescent depression work, it is critical that the adolescent and parents be aware of the parameters of treatment, including confidentiality limits, child abuse reporting requirements, and steps that will be taken in the event of worsening suicidal ideation or a suicide attempt. There is a risk of the therapist identifying either with the adolescent or the parents, instead of forming a clear working alliance with both. Identification with the adolescent can lead therapists to offer excessive guarantees of confidentiality, which then serve to trap them when dangerous information is disclosed by the adolescent. Identification with the parents can lead therapists to transform treatment into socialization, by trying to obtain the outcome parents wish for, rather than the outcome most appropriate for the adolescent. For example, depression may be associated with excessive parental expectations for academic achievement. Therapists who identify with parents will be inhibited from confronting this parental pressure, a step essential to the recovery of the adolescent.
Honesty and consistency across contexts require that the therapist begins treatment with a clear contract about whether and when parents will be expected to attend sessions or parts of the sessions, how parents will be informed of the adolescent's progress, or lack thereof, what level of detail from adolescent sessions will be shared by the therapist with the parents, and how out-of-session contacts (e.g., phone calls or e-mails) from the parents will be shared with the adolescent. Limits of confidentiality must be clarified at the outset of treatment. In general, the adolescent needs to know that increased suicidal risk, any homicidal ideation or threats, incidents of possible physical or sexual abuse, and medical emergencies will be disclosed to relevant authorities and/or parents. As for adolescent substance use, it is important for the therapist to have a clear position on disclosure to parents that is consistent with state law and acceptable both to the adolescent and the parents. The key principle in all of these matters is that the therapist must be clear and consistent with all parties so that trust is created and maintained.

Prudence, or capacity for planning and good judgment, will inevitably be required in working with depressed adolescents. One element of prudence is the capacity to develop, monitor, and modify the initial treatment plan, about which more will be said, below. Prior to the start of treatment, the clinician must use prudence to address these key questions:

1. Is this adolescent a suitable candidate for outpatient psychotherapy? Adolescents who are either experiencing merely a normal mood variation of mild severity or brief duration might benefit more from reassurance and "watchful waiting" than from the immediate implementation of a course of treatment. On the other hand, those with severe and/or persistent depression need to be evaluated for possible medication treatment. Those with complex comorbid conditions, such as substance abuse or serious conduct disorder, will likely need more than simple weekly outpatient psychotherapy.

2. Is this adolescent's family likely to be able to support outpatient psychotherapy for the adolescent? "Family" here is broadly construed to mean the adolescent's immediate support system, including the adolescent's living situation, and is not restricted to nuclear or biological family. Some adolescents living in group homes, for example, will be fully supported in the practical matters of attending psychotherapy sessions, whereas others in chaotic, disorganized nuclear families or those who are homeless may lack such support. Given that evidence-based forms of psychotherapy for adolescent depression are intended to last for 3–4 months, an adolescent who is unlikely to be able to attend even a significant proportion of the sessions may not be suitable for such intervention. Alternative interventions, such as as-needed crisis management, school-based counseling, or involvement in other school-based activities may be of more benefit to such adolescents.

3. If the adolescent does appear to be a reasonable candidate for outpatient psychotherapy, which psychotherapy should be initiated? To date there are two forms of psychotherapy with empirical support in the treatment of adolescent depression: IPT and CBT. The choice of which to implement will depend primarily on the expertise of the therapist.

Caring, or concern for the well-being of the other, is clearly essential for working with depressed adolescents. The therapist must be willing to tolerate the pessimism and even hopelessness that some depressed adolescents express without becoming immobilized by them. Beck et al. (1979) wrote eloquently of the risk that the therapist will "buy into" the depressed patient's negative views of self, world, or future by abandoning the role of a scientific observer and the task of
collaborative empiricism (p. 59). Again, this points to the difference between caring for the well-being of the depressed patient and identifying with the patient's depressive world view. Some depressed adolescents have experienced exceptionally negative life experiences or are currently living in extremely negative situations. For example, one of us worked with a boy who had lost both parents to AIDS and was now living with a rejecting stepmother. In the face of such adversity, the therapist needs to maintain a caring and hopeful stance, seeking to apply the treatment model, augmented if necessary by environmental modifications, to help the adolescent reduce depression and establish sources of hope.

Therapists who work with depressed adolescents must also be emotionally healthy, themselves. If the therapist is in significant distress due to current life circumstances, longer-standing personality disturbances, psychopathology or substance abuse, such work is seriously contraindicated. As is the case in all types of psychotherapy, the therapist needs to have his or her own emotional needs met elsewhere, and not seek to meet them through the treatment.

24.6.1 Basic Knowledge Competencies

Clinical psychology is grounded in psychological science, and the "scientifically minded" practitioner is an intended outcome of all accredited doctoral training programs, whatever the specific training model of the program might be (scientist-practitioner, practitioner-scientist, clinical scientist, local clinical scientist) (Belar & Perry, 1992; Bieschke, Fouad, Collins, & Halonen, 2004). Bieschke et al. delineated five components of scientifically minded practice in professional psychology, the first of which is the ability to access and apply current scientific knowledge habitually and appropriately. What does this competence imply with regard to clinical work with depressed adolescents?

First, a basic knowledge competence is to be cognizant of the contemporary theories and their evidence regarding the psychopathology of depression in adolescents. This includes the kind of material that would be included in the doctoral-level courses in psychopathology, especially developmental psychopathology. Familiarity with biological, cognitive, behavioral, social learning, and interpersonal (including family) models of depressive psychopathology would constitute required knowledge.

Second, a basic knowledge competence includes awareness of current evidence-based interventions for adolescent MDD, as reviewed above. It is incumbent on psychologists to know the essential outcome of major treatment studies, the limitations of those studies, and also to be aware of the lack of evidence supporting non-scientific interventions.

Third, a basic knowledge competence is the facility in the process of reviewing emerging knowledge on adolescent depression. It is extremely unlikely that the practitioner's graduate school knowledge will remain current after more than 5 or 7 years. As new knowledge develops, the practitioner needs to have the skills to locate and obtain updated sources of knowledge. Bieschke et al. (2004) argue that clinicians need to adopt an evidence-based practice approach and make use of systematic review papers, meta-analyses of treatment outcome studies, and reviews of randomized controlled trials, as sources of continuing education. Training in the requisite computer and data searching skills should be obtained during graduate school, although these, too, will need to be revised as methods of data reporting, collection, and dissemination are modified over time.
As Mash and Hunsley (2005, p. 362) noted, "[i]t would be difficult to imagine providing any form of psychological services to children and families without using some type of informal or formal assessment." Assessment is central to our work as clinicians – it guides the selection of problems to be addressed, provides a foundation for case formulations and treatment planning, and allows us to determine if what we are doing is doing any good. In a very real sense, the development and application of tests and measures is central to the identity of clinical psychology. It is a defining characteristic of the profession. With this in mind, care must be taken to insure the utility and integrity of our assessments, and to demonstrate that they contribute to improved care and enhanced outcomes. There is a number of essential tasks which must be accomplished when working with depressed adolescents. These include: (1) making the right diagnosis, (2) attending to comorbid psychiatric and medical illnesses, (3) assessing symptom severity and monitoring treatment gains, (4) understanding the home and school environments in which the teen is functioning, and the ways these may be exacerbating or maintaining their distress, and (5) monitoring suicidal risk. Each of these tasks requires a specific set of skills, and can be facilitated by the use of psychometrically strong assessment instruments. At a minimum, the clinician must have competencies in the administration of clinical interviews, semi-structured diagnostic interviews, and self-report rating scales.

The clinical interview (Beutler & Groth-Marnat, 2005) is necessary in order to establish rapport, obtain a broad picture of the adolescent's interests, functioning, and problems, and to gain information about the home and school environments. The clinical interview can lead directly into a semi-structured diagnostic inquiry, and in fact the latter should not be attempted without at least some less structured interview time.

Determining whether an adolescent manifests a MDD, and ruling out alternative diagnoses and conditions, can be a challenging endeavor. One impetus for the development of criterion-based psychiatric diagnosis was the unreliability of diagnoses based on unstructured clinical interviews. With this in mind, it is important for clinicians to receive training in the administration of semi-structured diagnostic instruments, such as the K-SADS-PL (Schedule for Affective Disorders and Schizophrenia for School-Age Children) (Kaufman et al., 1997), and to use them in a systematic manner. The K-SADS-PL addresses both current and past episodes of each psychiatric disorder. The instrument includes a screening interview incorporating key symptoms from each diagnostic domain to determine if further, more detailed, assessment is necessary. In addition to each of the affective disorders, the K-SADS-PL allows for the assessment of the full range of anxiety, disruptive behavior, and substance use disorders. The clinician interviews the adolescents and their parents separately, insuring that both behavioral observations and the adolescent's subjective emotional state are taken into account. The clinician integrates information from each of the respondents in making the diagnosis. As might be expected, differences between parents and teenagers about the occurrence of specific symptoms, their severity, and their meaning often occur. As a consequence, clinical judgment and sensitivity play an important role in the diagnostic process. It is usually too time-consuming and not necessary to administer an entire semi-structured diagnostic interview in clinical practice. However, practicing clinicians should administer those components of an interview that are indicated by the referral question and/or screening question responses.

When treating depressed youth, it is very helpful to assess the severity and the key concomitants of depression, especially hopelessness and suicidal ideation, and monitor these
regularly over the course of the therapy. Objective self-report scales, such as the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), the Suicide Ideation Questionnaire-Junior High School Version (Reynolds, 1987), and the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, & Trexler, 1974), can be very helpful in this regard. These scales are quick, efficient, and psychometrically sound. Responses on these measures can be used as a stimulus for discussing the teen's concerns, and compliment a clinical discussion of their recent feelings and experiences. Some adolescents are more comfortable acknowledging their feelings on a rating scale, rather than in an interview. With this in mind, the "numbers" of an objective rating scale may or may not mesh with what a teenager (or his or her parent) reports in the session. The art of clinical practice, then, is in integrating information garnered through objective assessment with the subjective reports of the adolescent.

24.6.3 Basic Treatment Competencies

Psychologists who treat depressed adolescents must have the basic competencies required for any psychotherapy, as well as competencies in evidence-based interventions for this particular disorder. We first delineate the basic competencies required for any psychotherapy, relying significantly on the work of the competencies conference (Spruill et al., 2004). Subsequently, we outline basic competencies required to conduct CBT or IPT.

Dovetailing with scientific knowledge competence is the basic treatment competence of knowledge about current evidence-based interventions for the problem of adolescent depression. This can be expected to constitute a moving target over the course of a psychologist's career, but at present the evidence-based treatments in the psychotherapeutic domain are cognitive behavior therapy and interpersonal psychotherapy. Knowledge of these treatments entails knowledge of the relevant model (theory) of depression and the model of treatment. Such knowledge implies that the psychologist can explain to the adolescent and parents how depression develops or is maintained, and how the treatment at hand proposes to alleviate it. Moreover, the psychologist needs to conduct such psychoeducation in a manner that is accessible to the adolescent and parents, so that the proposed treatment "makes sense" to them and their motivation to engage in psychotherapy is increased.

Basic competence also entails knowledge of the alternative treatments, specifically antidepressant medication. It is beyond basic psychological competence to have detailed knowledge of the pharmacotherapy literature, but at a basic level, the psychologist should be aware of the evidence in support of medication, as this is reflected in review papers and psychiatry practice guidelines (e.g., Hughes et al., 2007). Finally, the psychologist should be aware of the major studies that have compared evidence-based psychotherapy, medication, and their combination, as interventions for adolescent depression (Brent et al., 2008; Goodyer et al., 2007; TADS Team, 2004, 2007). Such knowledge enables the psychologist to have a dialogue with the adolescent and parents in which consideration is given to the selection of an initial single or combined treatment.

Another domain of knowledge required for competent practice is the relevant state laws, and the psychologists' ethical principles and code of conduct. In work related to depressed adolescents, psychologists need to be aware of state laws pertaining to age of legal consent, voluntary and involuntary commitment for inpatient care, confidentiality, and privileged communication. Regarding adolescents of divorced parents, the psychologist must know the
custody arrangement, which parent(s) may seek professional care for the adolescent, and what are the rights of the noncustodial parent to be involved in treatment and have access to records. Psychologists who work with adolescents must have the requisite training and supervision for such work and practice within the bounds of their competence. Any professional working with young people must know the requirements for reporting suspected physical or sexual abuse or neglect.

Beyond knowledge, the psychologist needs to demonstrate competence in the establishment of a therapeutic alliance with the adolescent and parents. Spruill et al. (2004) consider here three relevant sets of more specific competencies: relationship skills, communication skills, and sensitivity to individual and cultural differences. Included under relationship skills are the essential components of warmth, genuineness, and empathy (Rogers, 1992). Explanations of evidence-based treatments sometimes tend to omit discussion of these fundamental skills, instead focusing on intervention techniques, but in fact all evidenced-based psychotherapies require fundamental relationship skills. Beginning therapists sometimes err in the direction of emphasizing change techniques too rapidly, such as introducing cognitive restructuring too early in the process of CBT, before allowing the adolescent time to develop trust and feel that her or his concerns have been heard and understood (Wilkes & Rush, 1988). Other beginning therapists rely too rigidly on treatment manuals, almost “reading” the treatment to the adolescent. This is a distortion of evidence-based treatment that actively precludes establishing a therapeutic alliance. Indeed, it is incumbent on therapists who used manual-based interventions to learn how to “breathe life into the manual” (Kendall, Chu, Gifford, Hayes, & Nauta, 1998).

Communication skills are the second elementary competence upon which an alliance depends (Spruill et al., 2004). Verbal communication with adolescents must be honest, open, and clear. The therapist needs to listen to what the adolescent expresses and check to be sure that understanding is accurate. Listening also involves attending to omissions, distortions, repetitions, emphases, and the other markers of the personal salience of interview material that have been identified by Alexander (1990). Nonverbal communication conveys respect for the adolescent and parents, and includes the therapist's dress, posture, eye contact, and time management. Therapists should begin sessions at the scheduled time, alert patients when the end of a session is approaching, and stop the session on time. If urgent matters appear to require additional time, the therapist should renegotiate the end point of the session or schedule an additional meeting within a short period of time.

Sue and Sue (1999) noted relevance of understanding the patient's culture for establishing a therapeutic alliance. If we consider culture to refer primarily to national, ethnic, or racial heritage, it becomes part of a broader context required for understanding the diversity represented by the given patient. Such a context would also include religion, gender, sexual orientation, family composition, geographic location, and socioeconomic status among other possible sources of diversity. Certainly therapists need to understand frequent commonalities in the cultural groups that come to their attention at given clinical sites, always with the caveat that individual differences can override frequent commonalities. This points again to the need to listen attentively to the adolescent's and the parent's narrative at the outset of treatment, so as to avoid erroneous overgeneralizations based on frequent cultural features.

Given requirements for establishing a working therapeutic alliance, the psychologist treating depressed adolescents needs to be able to use information gathered in the assessment to develop a provisional case formulation and treatment plan (Spruill et al., 2004). The case
formulation goes beyond diagnosis to include the factors proposed as contributing to the presenting problem (in this case, depression) and the factors representing personal assets upon which treatment can be based. As an example of a case formulation, recent loss of a friend may have precipitated a depression in a young female with a primarily introverted, conscientious personality, and a family history of mood disorders. The impact of loss may be mediated through maladaptive cognitions such as: "I will never again have a good friend like Sarah, who moved away." This depressed young woman may be noted to have supportive parents, good verbal skills, and the capacity for self-reflection, all of which will facilitate psychotherapy. Stemming from the case formulation, the therapist develops a treatment plan. If opting to use IPT, the therapist will help the adolescent to see the link between the loss of her friend and her own depression, and will then focus on moving through the associated grief reaction. If opting to use CBT, the therapist may focus more on the maladaptive thinking that has changed normal sadness into a hopeless kind of depressive reaction. In either case, it is likely that the therapist will want to engage one or both parents in initial psychoeducation about depression and treatment, and perhaps in auxiliary sessions to support the adolescent over the course of treatment.

24.6.4 Basic Competencies in Delivery of IPT or CBT

Evidence-based treatments have by definition been used in clinical trials. As an element of these trials, it is incumbent on investigators to assess and monitor the extent to which therapists adhere to and competently enact the type of psychotherapy that is being tested in the trial. Thus, a number of scales have been developed for this purpose. In addition, several instruments have been developed to measure psychotherapeutic processes across treatment models. Ablon and Jones (2002) used a rating method to develop prototypes of ideal sessions of IPT and ideal sessions of CBT so that these ideal models could then be applied in a study of actual sessions from the NIMH Treatment of Depression Collaborative Study (Elkin et al., 1989). In Ablon and Jones' study, a panel of ten experts in CBT and a panel of 11 experts in IPT rated each of the 100 items of the psychotherapy process measure on the extent to which the item was characteristic of an ideally conducted session of CBT or IPT, respectively, using a 1–9 rating of each item. Based on their findings about the 20 highest-rated items in each treatment model, we propose that the most basic competencies of the IPT and the CBT therapist, respectively, enact the following characteristics.

In the IPT sessions, the therapist focuses on the patient's interpersonal relationships, puts an emphasis on the patient's emotions, makes interpretations that refer to actual people in the patient's current life, and adopts a supportive stance. Feelings of love, being close to someone, or romantic relationships are a topic of discussion. Attention is drawn to the patient's nonverbal behavior or to the changes in the patient's mood or affect. The therapist facilitates the patient's expression, and clarifies or rephrases the patient's communications. The structure of the session is such that the current or recent life situations, rather than past situations, are the focus of attention, dialogue is focused, and the patient's goals are discussed, as are practical issues such as termination or scheduling.

In the CBT sessions, the discussion centers on cognitive themes, such as ideas or beliefs. There is a focus on activities or tasks for the patient to complete before the next session. The therapist encourages the patient to try out new behaviors, and presents to the patient a different
perspective for interpretation of an experience or event. Therapists explain the rationale behind any technique introduced into the session, and tend to be active in structuring the session. CBT therapists may be didactic in manner and give explicit advice or guidance. As in IPT, the patient's goals are discussed, the focus is on the patient's current or recent life situation, and the therapist adopts a supportive stance.

In short, the IPT therapist has the competence to facilitate the patient's emotional expression, to focus on emotions and interpersonal relationships, in the service of resolving one of the four foci of IPT (grief, role transitions, role conflict, interpersonal skill deficits). The CBT therapist has the competence to identify and target relevant cognitions, explain and introduce therapeutic techniques, encourage exploration of new behavior and new perspectives, and assign between-session tasks. Both the IPT and the CBT therapist are competent in providing support, focusing on the present, rather than the past, structuring the session, and structuring the treatment sequence.

24.6.5 Basic Competence with Families

As noted above, basic competence in the treatment of adolescent depression includes formulating a treatment plan that designates how parents will be involved in treatment. Unfortunately, there is very little empirical evidence to guide clinicians in making this decision. As a general rule, the therapist must establish a working treatment alliance with the parents, and must provide parents with at least psychoeducation about depression and about the treatment to be delivered. Parents should be involved in developing a safety plan in the event that a depressed adolescent experiences worsening suicidal ideation or urges, and most certainly, if there has ever been a suicide attempt. Parents should be kept informed about the progress of the adolescent and about the types of skills that the adolescent is learning in treatment. The therapist must rely on clinical judgment on the question of whether and when to include conjoint parent-adolescent sessions in the course of treatment.

The therapist will, in some cases, note that the parent also has a psychiatric or substance use disorder. In such cases, the related competence is the ability to make a treatment referral at a time and in such a way as to increase likelihood that the referral will be followed.

24.6.6 Advanced Knowledge Competencies

Along with advanced competencies in assessment and intervention considered below, there are advanced competencies in knowledge, case formulation, and case management. We consider these together because they are likely to be relevant to cases marked by greater severity or complexity. Psychologists with advanced competence in the treatment of adolescent depression will be knowledgeable regarding the following aspects of adolescent mood disorders:

1. Psychotic depression: its symptom pattern, and how to differentiate this from schizophrenic disorders, substance-induced psychosis, and bipolar disorder with psychosis
2. Bipolar disorder: prevalence of bipolar outcome in the early-onset mood disorders; its symptoms; and how to differentiate this from nonbipolar depression, schizophrenic disorders, and substance-induced disorders
3. Anxiety disorders: comorbidity of anxiety and depressive disorders; prevalence and patterns of the relative first onset of anxiety and depression in young people; establishing a primary diagnosis for initial treatment

4. Disruptive behavior disorders: comorbidity of disruptive behavior and depressive disorders; prevalence and patterns of the relative first onset of disruptive behavior and depressive disorders in young people; establishing a primary diagnosis for initial treatment

5. Substance use disorders: comorbidity of substance use and depressive disorders; establishing an integrated treatment plan to address both disorders in comorbid cases

6. Medication guidelines: the array of first-line and second-line medications and evidence supporting these; augmenting medications; and principles to follow in the process of medication modification (Hughes et al., 2007)

7. More intensive, lengthy, or invasive treatments for refractory cases: extended IPT or CBT; continuation and maintenance phases of outpatient treatment; hospitalization for suicidal risk; aftercare following inpatient care; evidence pertaining to consideration of electroconvulsive therapy in rare or extremely refractory cases

24.6.7 Advanced Expert Competencies of the Clinician

As noted, adolescent depression is multiply determined. The ways in which biological, social, environmental, and cognitive variables interact in contributing to the development of depression, however, is not well understood. Basic competence requires the ability to construct a case formulation, but this skill should advance as the clinician's knowledge base advances in concert with scientific advances in the field. By targeting factors implicated in risk for depression, we may be able to offer treatments that yield a positive outcome. This task requires an understanding of research on moderators and predictors of treatment response, and of mediators of depression among youth, as well as competence in their assessment.

Studies indicate that a number of factors predict and moderate response to treatment among depressed adolescents (Brent et al., 1998; Curry et al., 2006). These include: age, family income, verbal IQ, duration and severity of the depressive episode, number of comorbid diagnoses, level of anxiety, hopelessness, parental depression, cognitive distortions, parent–child conflict, and treatment expectancies. Systematically assessing factors that predict outcome can be helpful in selecting the most effective program of treatment, addressing factors that may impede progress, and assisting adolescents and parents to set realistic expectations for rate of progress and likely duration of treatment. Findings from the TADS project indicate, for example, that treatment with a combination of CBT and medication management with fluoxetine may be more helpful for depressed adolescents who manifest high levels of cognitive distortions than treatment with medication alone (Curry et al., 2006). In the same study, adolescents from affluent families (family income over $70,000) were found to respond well to CBT alone. Treatment strategies may be tailored, then, based upon the specific needs and strengths of the patient and an understanding of moderators of outcome. In a similar manner, parental depression, parent–child conflict, and parent and teen expectations about the effectiveness of treatment all have been found to predict treatment response. All can be assessed during an initial diagnostic evaluation and addressed clinically, if appropriate.
Given new developments in research on cognitive factors in depression and the importance of these factors in contemporary cognitive theories of depression (Jacobs, Reinecke, Gollan, & Kane, 2008; Spence & Reinecke, 2003), they can serve as targets of clinical intervention. Assessment that directly addresses a number of recently identified cognitive factors can thus be used to provide a more advanced case assessment.

In addition to the class cognitive targets of negative automatic thoughts, dysfunctional attitudes and core beliefs, and depressive explanatory style, recent research has identified depressive schemata (including perfectionistic standards), deficient problem-solving motivation, and rumination as potentially relevant cognitive factors maintaining depression. Rating scales have been developed to use in the assessment of each of these variables, and adolescents can be asked to complete them as part of an initial assessment. Both cognitive vulnerabilities and cognitive strengths or abilities can be identified and harnessed. CBT, from this perspective, employs both deficit and competency-based strategies. A teenager may, for example, manifest deficits in problem-solving motivation (they may approach day-to-day problems in an impulsive or careless manner, or attempt to avoid them altogether) and strongly believe that others will reject or abandon him or her, if they get to know him or her. Once identified, these difficulties could be addressed through problem-solving training, social activity scheduling, and schema-focused CBT strategies. Another teenager, in contrast, may demonstrate relatively strong problem-solving skills, yet be troubled by rigid, perfectionistic standards. For her, it would make little sense to introduce problem-solving training. Rather, traditional CBT techniques, such as rational responding and behavioral experiments, might be used to address her perfectionistic beliefs. The use of evidence-based assessment strategies facilitates the development of individually tailored treatment programs, and so can accelerate clinical improvement. These approaches can also be used to identify cognitive factors that are hindering progress.

A promising new area of research with clear treatment implications centers on rumination. Rumination, the tendency to focus repetitively on problems or symptoms of emotional distress, and on their meanings, causes, and consequences, has been found to predict recurrent depression among adults (Papageorgiou & Wells, 2004). Moreover, recent studies suggest that relations also may exist between ruminative style and depression among children and adolescents (e.g., Burwell & Shirk, 2007), and that females tend to ruminate more than males. Interestingly, cognitive behavioral treatments for depression typically begin by teaching patients to monitor and reflect upon their negative moods and their accompanying thoughts. It has long been recognized that the introduction of mood monitoring techniques may be accompanied by an initial increase in depressive symptoms. Cognitive therapists, in essence, may be encouraging some patients to ruminate about their concerns. Our clinical impression is that it is not rumination per se that places youth at risk for depression, but "unproductive thought" or "nonsolution-focused thinking." With this in mind, we frequently ask adolescents to reflect briefly (5–10 min) upon their feelings of sadness, the causes and consequences of their distress, and the meanings attached to their experiences. At the end of this period, they are asked to answer a simple question: "And the solution to this is ...?" Solution-focused thinking – the ability to identify and evaluate possible solutions – is often accompanied by a rapid decrease in feelings of sadness. This is followed by a discussion of how the teen learned to ruminate (i.e., "Where did you pick this up?") and the ways in which it is adaptive or maladaptive for him or her.
24.6.8 Advanced Competencies of the Treating Psychologist

We propose that advanced competencies in the conduct of psychotherapy sessions can be observed, rated, and improved through supervision and case consultation. Because both of us practice CBT and have more familiarity with rating levels of competence within that treatment model, we will restrict the focus in this section to advanced competencies in CBT. It seems likely that advanced competencies in IPT would be similar, albeit within a different framework.

When considering advanced competencies in the conduct of CBT sessions, we find it helpful to rely on rating scales used by CBT supervisors in training or research contexts. In particular, we rely on the Cognitive Therapy Rating Scale (CTRS; Young & Beck, 1980) and on the Treatment for Adolescents with Depression CBT Quality Assurance Scale (CBT-QA; Curry, 2000). The former is a frequently used measure that assesses adherence to and competence in cognitive therapy; the latter has been used in only one study, but focuses on CBT treatment of adolescents.

Considering first the 11 items rated on the CTRS and the CTRS manual, advanced competencies in the conduct of treatment sessions include the following dimensions. First, CBT is based on an intervention model of collaboration between therapist and patient. Both work together to experiment with new behaviors and test the accuracy of key cognitions. Beck referred to this fundamental aspect of CBT as "collaborative empiricism" (Beck et al., 1979). At an advanced level, collaboration requires transparency on the part of the therapist as well as therapist skill in facilitating session-related disclosure by the patient. Therapist transparency here refers not to self-disclosure about the therapist's life or subjective experiences, but to the therapist's ability to make clear to the patient the rationale for therapist directions, guidance or decisions, the rationale for any skill training introduced by the therapist, and the reason for any shifts in session focus that are introduced by the therapist. Simply put, the therapist should never "mystify" or puzzle the patient during sessions. Conversely, the therapist elicits from the patient relevant disclosures about treatment. Thus, the therapist listens carefully, demonstrates an accurate understanding of the patient's internal experience, and communicates this empathic understanding to the patient.

In addition to transparency and the facilitation of session-related disclosure, collaboration requires that the therapist socialize the patient into a progressively more active role over the course of CBT. The therapist makes it clear that therapist and patient constitute a team, encourages the patient to bring into sessions those current concerns and problems that the patient wants to resolve, and works with the patient to formulate "homework" assignments for practice between sessions. With adolescents, this aspect of CBT may be quite puzzling initially. Having been socialized primarily in the role of student, adolescents may enter therapy expecting to be taught in a primarily didactic model. It is helpful for child and adolescent therapists to use the role of "coach" (Kendall et al., 2006) as an understandable analogy. Like a coach, the CBT therapist will work with the adolescent to develop the adolescent's skills, will engage in dialogue with the adolescent, and will work together to shape "practice" assignments. Collaboration is expected to have a temporal dimension, in that the patient should become progressively more self-directed and active over a typical 8–20-week course of CBT.
A second major advanced competency in the conduct of CBT sessions is the ability to structure sessions so as to provide a reliable yet flexible context in which the patient can complete the necessary work of treatment. In contrast to the specific problem focus or the specific skill training that will change across the course of treatment, session structure should remain relatively consistent throughout treatment. In the TADS CBT-QA procedure, we considered the following elements to be critical to session structure: monitoring the adolescent's mood, setting a session agenda, reviewing any homework from the previous session, introducing or reviewing and practicing a particular skill, completing part or all of the agenda, and formulating a new homework. Advanced competence in conducting sessions is reflected in particular qualities associated with each of these elements.

Mood monitoring with adolescents can be completed with a brief questionnaire or in the context of the session. A key feature of mood monitoring with adolescents is to conduct this structural element without demand characteristics, i.e., in a manner that emphasizes openness and honesty and decreases social desirability. A cursory approach diminishes the importance of mood monitoring in the eyes of the adolescent. An approach that directly or indirectly reinforces the reporting of improved or positive mood or discourages the reporting of negative mood increases social desirability demand and precludes useful integration of mood monitoring with understanding and skill training.

Agenda setting is critical to the overall problem-solving model inherent in CBT. Adolescents must often be encouraged to bring in items for the session agenda, since this element of CBT differs rather dramatically from their experience as students in school and also from any experience they may have had with other more nondirective forms of psychotherapy. Advanced competency in agenda setting involves allowing some time for the adolescent to name problems or concerns that he or she wishes to work on or talk about in the session. It also involves having the therapist designate any item that he or she wants to include in the session, including training in a particular skill. The link from agenda setting to skill training is of particular importance. As the therapist helps the adolescent to learn the skills that are theorized as key to overcoming depression (e.g., behavioral activation, problem-solving, cognitive restructuring), advanced competence is demonstrated by the therapist's ability to link skill training to items on the adolescent's agenda. Finally, advanced competence is demonstrated by good therapeutic judgment: the therapist helps the adolescent to identify the most important agenda items and address these first, with the recognition that not all items may be covered during a particular session. For example, an increase in suicidal ideation represents an urgent problem that must be addressed before any less urgent issues.

Homework review is essential if the therapist is to convey to the adolescent the importance of between-session skill practice. A well-conducted review will allot time to exploration of what the adolescent did or did not complete in the previous assignment, what practical restrictions, negative cognitions, or deficits in prerequisite skills interfered with task completion. Based on such a review, subsequent in-session skill training and between-session homework assignments can be adapted to maximize the likelihood of success for the depressed adolescent. The CBT therapist needs to avoid making the same kind of judgments about incomplete homework that the adolescent has likely experienced as a student. Instead, advanced competence is demonstrated by using whatever has happened with regard to the homework as an opportunity to learn and adjust the treatment plan.

Skill training, which is inherent in the multifactorial model of CBT and perhaps more indirect in cognitive therapy, was used in the TADS CBT. Advanced competence in skill training is
reflected first by its integration with the overall treatment plan and with the rest of the current
session. Thus, the therapist introduces skill training with a clear rationale that ties it to the
therapist's and patient's mutual understanding of the adolescent's depression, explains how the
particular skill will be helpful in overcoming depression, and ideally, how it will serve to address
one or more items that the adolescent has placed on the session agenda. Second, advanced
competence in skill training is reflected in bringing the skill to life. Training should not be pas-
sive or overly didactic. The therapist needs to use the full range of CBT's "educational technol-
gy" to convey the skill: rationale explanation (why to learn the skill), didactic instruction (how
to perform the skill), demonstration (therapist performs or models the skill), and role-playing
(adolescent and therapist together practice or enact the skill). If the therapist is using a treat-
ment manual, the therapist must have an understanding of the relevant skill and be able to
convey it beyond simply presenting material from the manual. Instead the therapist should be
able to modify manual material to fit the developmental level and individual needs of the ado-
lescent, and generate more than one way to "teach" the skill.

Completion of the session agenda and formulation of a new homework should also be
integrated with skill training. Advanced competence is demonstrated when the therapist can
help the adolescent to see the connections between the new skill and how to solve problems on
the agenda. An ideal homework assignment is one that applies the newly learned skill to a
manageable, not excessively challenging, problem that the adolescent has identified. The
advanced therapist can bring the treatment model to bear on the adolescent's agenda items by
showing the adolescent how treatment-based skills can help to resolve problems that are con-
tributing to depression. In this way, the overall advanced in-session competence of the practi-
tioner is what might be termed treatment integration: all elements of a session are interrelated
in a meaningful way that makes sense to the adolescent and that actively and directly addresses
the problems she or he has brought into the session.

24.7 Transition from Basic to Expert Competence

We propose that there are a number of pathways from basic to advanced competence in clinical
work with depressed adolescents. The key foundation for this process is an attitude of lifelong
learning, which is one of the objectives of doctoral training in psychology. First, a clinician
should maintain an adequate (but not excessive) caseload of adolescent cases so as to gain
exposure to some range of depressed adolescents, their differential diagnosis and common
comorbid conditions, and their patterns of response to treatment. Second, clinicians benefit
from supervision or case consultation with more advanced colleagues. This can be facilitated
in some work settings or projects, such as clinical trials or specialty clinics, but may require
active pursuit of supervision opportunities in the local community.

Third, training workshops and continuing education opportunities offered in conjunction
with state licensure requirements are of some value in learning evidence-based intervention
practices and new assessment methods, but consolidated learning will very likely require
follow-up supervision. Fourth, specialty training certification programs, such as that offered
by the Beck Institute, involve comprehensive didactic, experiential, and supervised practice
components leading to certification. Fifth, involvement in professional or scientific societies
often leads to additional training and professional development options. For example, the
Association for Behavioral and Cognitive Therapies and the Academy of Cognitive Therapy
facilitate continued growth in clinical expertise based on science. In psychology, board certification by the American Board of Professional Psychology (ABPP) requires a process that is intended to lead to improved knowledge of the scientific basis of practice, ethical issues in practice, and evidence-based assessment and intervention practice. In particular, the ABPP Child and Adolescent Psychology Board emphasizes integration of science and practice. Advanced competence can be pursued by following one or several of these paths.

24.8 Summary

MDD was once thought to be restricted to adults, but has been demonstrated to be one of the more frequently occurring diagnoses among adolescents, and also to occur in a substantial number of children. Over the past 30 years, as the diagnostic criteria for MDD have been applied to young people, an expanding body of knowledge has accumulated concerning its prevalence across genders and age groups, its variable course, and its status as a risk factor for subsequent mood disorders in adulthood. The clinical psychologist who works with depressed youth needs to have not only those personal characteristics essential for clinical service delivery, but also those competencies in the areas of knowledge, assessment, and psychotherapy that are associated with addressing this disorder. The clinician's scope of knowledge includes theories of depressive psychopathology, the evidence base associated with these theories, and knowledge of effective treatments. Currently, evidence-based psychological treatments for adolescent MDD include CBT and IPT. In this chapter, we have reviewed supportive evidence for these interventions as well as their proposed targets, the maintaining factors associated with depression in young people. In general, these can be categorized as cognitive, behavioral, and familial/interpersonal factors.

Basic competencies are those required for entry into practice, whereas advanced competencies imply a highly integrative approach to assessment and intervention based not only on experience but also on supervision, consultation, continuing education, and markers of advancement in the profession, such as board certification. Advanced competency also implies the ability to construct a comprehensive treatment plan and the awareness of how best to involve other professionals in that plan.

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