

# Treating Child and Adolescent Depression

## A Handbook for Children's Mental Health Practitioners

Linda L. Baker, Ph.D., C.Psych.

Lynda Ashbourne, M.Sc., R.M.F.T.

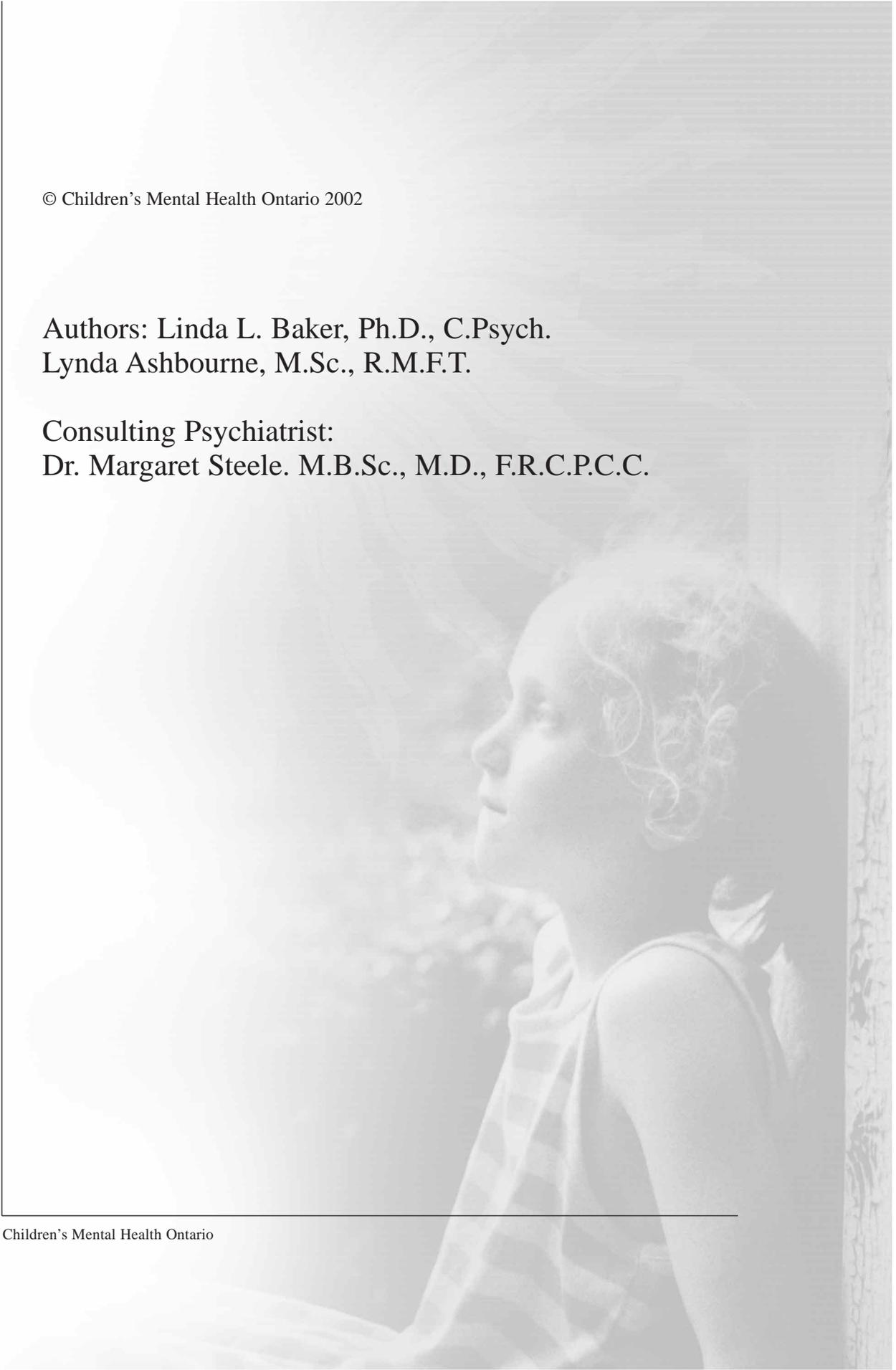
Consulting Psychiatrist

Dr Margaret Steele, M.B.Sc., M.D., F.R.C.P.C.C.

© Children's Mental Health Ontario 2002

**Authors: Linda L. Baker, Ph.D., C.Psych.  
Lynda Ashbourne, M.Sc., R.M.F.T.**

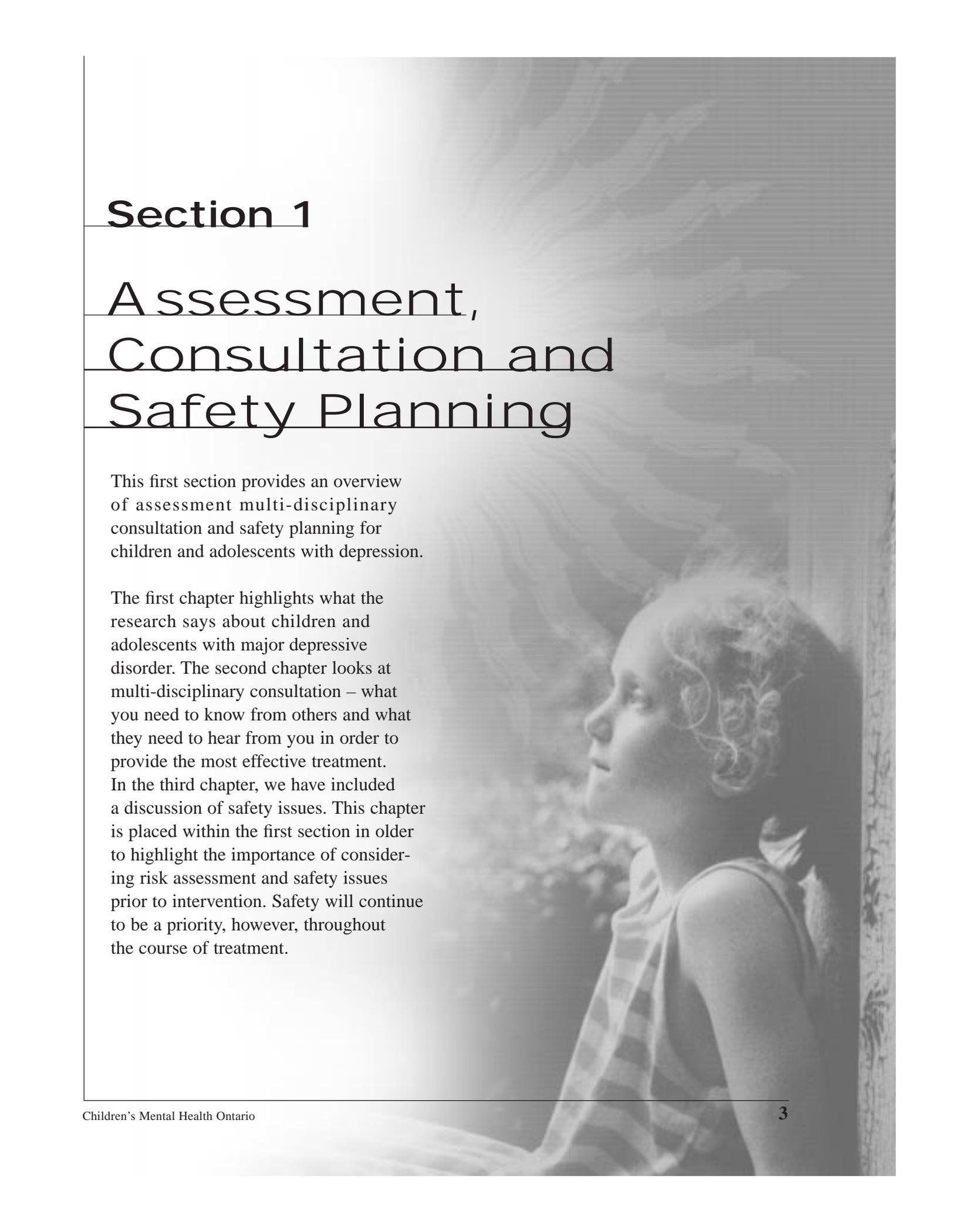
**Consulting Psychiatrist:  
Dr. Margaret Steele. M.B.Sc., M.D., F.R.C.P.C.C.**



# Table of Contents

<b>Section 1 - Assessment, Consultation and Safety Planning</b>	
<b>Chapter 1 - What is Depression</b>	5
1.1 Descriptive Definition	6
1.2 Diagnostic Criteria	8
1.3 Rate of Occurrence & Gender Differences	9
1.4 Disorders Which May Occur Along with Major Depressive Disorder	10
References	10
<b>Chapter 2 - Multi-disciplinary Consultation</b>	11
2.1 Who Provides Consultation	12
2.2 When to Access Consultation	13
2.3 How to Get the Most Out of Consultation	15
Case Example 1	16
Case Example 2	16
References	18
<b>Chapter 3 - Safety Planning</b>	19
3.1 Collaborative Practice	20
3.2 Risk Assessment	21
3.3 Safety Plans	23
3.4 Alternate Placement and Consultation with Physician	24
3.5 Ongoing Evaluation	24
Case Example	25
References	27
<b>Section 2 - Promising Interventions for Children &amp; Adolescents with Depression</b>	
<b>Chapter 4 - The Research on Treating Depression</b>	31
4.1 What is Evidence-Based Practice and Why is it Important?	32
4.2 Outcome Studies	32
4.3 Summary	34
References	35
<b>Chapter 5 - Promising Practices</b>	37
5.1 Cognitive Behavioural Therapy	38
5.2 Family Interventions	40
5.3 Pharmacotherapy	41
5.4 Integrative Approaches	42
References	44
<b>Chapter 6 - Identifying and Learning to Modify Cognitive Distortion</b>	45
6.1 Some Common Cognitive Distortions	46
6.2 Strategy for Modifying Cognitive Distortions	49
6.3 Applications	57
Case Example	58
References	61

<b>Chapter 7 - Modifying Maladaptive Behaviours &amp; Adopting Constructive Coping Mechanisms</b>	63
7.1 Descriptions of Maladaptive & Adaptive Behaviours	64
7.2 Strategies for Modifying Behaviours	66
7.3 Applications	74
Case Example	75
References	77
<b>Chapter 8 - Identifying and Addressing Issues Related to Loss and Trauma</b>	79
8.1 Description of Issues	80
8.2 Strategies for Addressing Issues Related to Loss & Trauma	82
8.3 Applications	86
Case Example	87
References	88
<b>Chapter 9 - Family Interventions</b>	89
9.1 Why Meet with the Family?	90
9.2 How to Include Family Members in Your Work	91
9.3 A Context of Respect	93
9.4 When Other Family Issues Get in the Way	93
9.5 Family Interactions	94
9.6 Education	95
9.7 Listening to What the Family Has to Say	96
9.8 Goals	96
9.9 Applications	99
Case Example	100
References	103
<b>Chapter 10 - Frequently Asked Questions</b>	105
<b>Glossary</b>	113
<b>Appendix I - Toolkit</b>	117



## Section 1

# Assessment, Consultation and Safety Planning

This first section provides an overview of assessment multi-disciplinary consultation and safety planning for children and adolescents with depression.

The first chapter highlights what the research says about children and adolescents with major depressive disorder. The second chapter looks at multi-disciplinary consultation – what you need to know from others and what they need to hear from you in order to provide the most effective treatment. In the third chapter, we have included a discussion of safety issues. This chapter is placed within the first section in order to highlight the importance of considering risk assessment and safety issues prior to intervention. Safety will continue to be a priority, however, throughout the course of treatment.



# **CHAPTER 1**

## **WHAT IS DEPRESSION?**

# WHAT IS DEPRESSION?

The following chapter summarizes information contained in the Children's Mental Health Ontario document, Evidence Based Practices for Children and Adolescents with Depressive Disorder. Information from other sources has been noted.

## 1.1 Descriptive Definition

The symptoms of depression may look different at different ages and stages of development, and may vary for different ethnic groups. Generally, however, depressed children and adolescents show a significant mood change (depressed, sad, irritable) or lack of interest. They may indicate that they are feeling worthless or considering suicide.

The following box lists some of the more typical symptoms of depression that you may see.<sup>1</sup> You are more likely to see some of these symptoms in adolescents, and others in younger children. It is possible, however, to see symptoms across age groups. See Toolkit pages 118 & 119 for a practitioner's checklist of these symptoms.

<sup>1</sup>Compiled from CMHO Evidence Based Practices for Depression in Children and Adolescents and Jacobsen, et al. (1994), as well as the authors' clinical practice and consultation with M. Steele.

---

---

## **SYMPTOMS OF CHILD AND ADOLESCENT DEPRESSION**

\* Symptoms more often seen in adolescent populations

† Symptoms more often seen in a younger population

- **Depressed appearance †**
- **Anxiety (e.g., separation anxiety)†**
- **Irritability and frustration (tantrums and/or behavioural problems)**
- **Lack of interest**
- **Lack of cooperation †**
- **Change in appetite / sleep patterns \***
- **Weight loss / gain**
- **Loss of energy**
- **Withdrawal from family and friends †**
- **Lack of self-care**
- **Negative feelings about self**
- **Blaming self inappropriately**
- **Feelings of sadness, hopelessness, worry**
- **Morbid thoughts**
- **Guilt \***
- **Aggressive or negative behaviour**
- **Physical complaints (e.g., headache and stomachache) †**
- **Refusing to attend school or poor school performance\***
- **Poor attention and concentration**
- **Auditory “hallucinations” †**
- **Delusions \***
- **Suicidal thoughts and feelings \***
- **Suicide attempts \***

## 1.2 Diagnostic Criteria

The Diagnostic Statistical Manual - Fourth Edition (DSM-IV) criteria for the diagnosis of major depressive disorder are<sup>2</sup> :

- The presence of five or more of the following symptoms for at least a two week period, representing a change from previous functioning and including either depressed or irritable mood or loss of interest or pleasure:
  - depressed or irritable mood
  - lack of interest or pleasure
  - significant weight loss or gain (or failure to make expected weight gains in children)
  - sleep difficulties
  - observable change in energy / activity level
  - fatigue or loss of energy
  - feelings of worthlessness or excessive and inappropriate levels of guilt
  - difficulty thinking or concentrating, indecisiveness
  - recurrent thoughts of death, suicidal ideation with or without a plan, suicide attempts
- The symptoms cause distress or difficulty performing regular activities.
- The symptoms are not a result of medication, substance abuse or a medical condition.
- The symptoms are not better accounted for by bereavement.

Episodes of major depressive disorder usually last an average of eight months for children and adolescents. Most youths recover within 1 to 2 years. Many youths experience a relapse within two months of recovery, or over a period of three to five years.

<sup>2</sup>DSM-IV-TR 2000

## 1.3 Rate of Occurrence & Gender Differences

Depression occurs in 2-4% of children and 4-8% of adolescents. Research suggests that, overall rates of depression are rising worldwide, and that there is a trend toward earlier ages of onset for depression.

During childhood, boys and girls appear to experience depression at an equal rate. Adolescent girls, however, are diagnosed with depression at twice the rate of adolescent boys.

---

---

### **Depressed adolescent girls appear to be a higher risk due to:**

- **an earlier onset of puberty**
- **approaches to problem-solving that are more introspective**
- **concerns about body image**
- **higher risk of sexual abuse**
- **pressures to conform to a more limited range of social roles**

### **Depressed adolescent boys are more likely to exhibit:**

- **risk-taking behaviour**
  - **substance abuse**
- 
-

## 1.4 Disorders Which May Occur Along With Major Depressive Disorder (Comorbidity)

Most children and adolescents who have major depressive disorder also have other disorders at the same time. The following disorders may be seen along with symptoms of depression:

- Anxiety
- Dysthymia
- Conduct Disorder
- Obsessive Compulsive Disorder
- Eating Disorders
- Attention - Deficit / Hyperactivity Disorder

---

---

### Toolkit Links:

**Practitioner** → **Symptoms of Child and Adolescent Depression** (See pages 118 & 119)

---

---

## References

Children's Mental Health Ontario. (2001). *Evidence Based Practices for Depression in Children and Adolescents*.

*Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR)*. (2000). Washington: American Psychiatric Association.

Jacobsen, L.K., Rabinowitz, I., Popper, M.S., Solomon, R.J., Sokol, M.S. and Pfeffer, C.R. (1994). Interviewing Prepubertal Children about Suicidal Ideation and Behavior. *Journal of the American Academy of Child and Adolescent Psychiatry*, 33:4, 439 - 452.

# **CHAPTER 2**

## **MULTI-DISCIPLINARY CONSULTATION**

# MULTI-DISCIPLINARY CONSULTATION

## 2.1 Who Provides Consultation

When assessing for depression and planning treatment for children, it is important to have an accurate picture of all aspects of their lives. It is also important to consider all possible underlying causes for the symptoms that you observe. In fact, the symptoms that are seen with depression can also be symptoms of other problems which are not related to mental illness, for example, sleep disorders or physical illness. It is essential that assessment and diagnosis be as thorough and accurate as possible, since this determines treatment planning and the successful outcome of your intervention.

---

---

**A thorough initial and ongoing assessment takes into account<sup>3</sup> :**

- **the child's medical and social history, and developmental stage**
  - **individual / parent / family psychiatric history**
  - **all possible underlying causes of symptoms**
  - **functioning at home with family**
  - **interaction with peers**
  - **behaviour and performance at school**
  - **functioning in other social settings**
- 
- 

The best way to get the most complete picture is to consult with people who have different perspectives based on their knowledge and observation of the child in different settings.

<sup>3</sup>For a more detailed list of assessment criteria, interview topics and differential diagnosis, see CMHO's *Evidence Based Practices for Depression in Children and Adolescents: Findings from the Literature and Clinical Consultation in Ontario*, pp.5-9.

The following list includes some suggestions for consultants. This is not a comprehensive list and you may think of others, depending on the availability of resources in your community and the needs of the child and family.

- Family members
- Primary Care Physician / Psychiatrist / Pediatrician
- Social Service and Health Professionals – Psychologists, Social Workers, Occupational Therapists, Speech Therapists, Physiotherapists, etc.
- Teachers
- Professionals with particular expertise in areas that may be related to the child’s difficulties, such as neurologists, specialists in hearing or sleep disorders, etc.

---

---

**Different people may have different areas of concern and/or different experiences with individual children. This information allows you to gain a clearer picture of these children and their response to treatment. Rather than complicating the picture, different perspectives improve its clarity.**

---

---

## 2.2 When to Access Consultation

Assessment and consultation should be seen as ongoing. It is important to know what has happened before treatment begins, what changes take place once treatment has started, and what might happen when planning for termination. Other people’s perspectives can be very helpful in making the best treatment plan, determining whether or not the current treatment is working, and planning for the necessary ongoing supports following treatment.

You should access multi-disciplinary consultation at the following times:

- during initial assessment
- when planning treatment (to ensure networking and co-ordination)
- during ongoing treatment (to determine what is working and not working, in what settings)
- at the end of treatment (to determine ongoing supports)
- for follow-up (to determine continued risk or recurrence of symptoms)

---

---

**It is also important to seek consultation from others who work with this child if you are:**

- **feeling stuck, frustrated or discouraged with the lack of progress you are seeing**
  - **over-identifying with the child or family, or feeling emotionally reactive (issues of transference or counter-transference)**
  - **concerned about safety and/or suicidal risk**
  - **observing psychotic symptoms (i.e., child is hearing voices or seeing things, or has delusions)**
  - **when something new occurs that you have not seen before, or others (e.g., family members or teachers) bring a new piece of information to you that is outside of your experience or training**
- 
-

## 2.3 How to Get the Most out of Consultation

As front-line staff who work directly with children and youth, you are in the best position to know and share some key things with other professionals. For example, if you are working within a residential setting, you are aware of a particular child's usual sleeping and eating patterns, and often are the first to notice any changes. You are also in a good position to observe a child's response to medication. If you are working with a family, you are most often the primary link to that family's day-to-day functioning. When a team is planning a change in treatment, you have knowledge about how this child has responded to interventions in the past (e.g., chronically resistant, most open to behaviour-oriented treatment, etc.). These are important aspects for the whole team to consider when assessing and planning. Your active role in multi-disciplinary consultations is therefore a key one. See Toolkit pages 120 - 122 for a practitioner's worksheet you can use in preparing for multi-disciplinary consultation.

Follow through is an important aspect of consultation. Remember to make a note of what you are responsible for after consultation, and know what others intend to do. You can ask for further information or consultation as necessary, and follow up with other professionals if they need information from you. It is best to ask during the consultation meeting who is going to do what, and how you can expect to get the information that you need (e.g., "Can I call your office next week for that information?" or "When can I expect to hear back from you?").

---

---

### **End a consultation meeting with a summary of:**

- **what has been decided**
  - **who is doing what and when**
  - **how information will be shared and who is responsible**
  - **when the next meeting will be, and who will be responsible for arranging and notifying participants**
  - **what you are watching for that will indicate progress or a set back**
- 
-

## Case Example 1

*Jessica is 12 years old, and was referred for a consultation at a children's mental health agency regarding suspected depression. She has recently been having difficulty getting up in the morning, yawns frequently at school, has become inattentive and is having difficulty completing her schoolwork and tasks which were not previously a problem. She is lethargic, irritable, and is showing a decreased interest in extracurricular activities.*

*Further questioning regarding sleep patterns, however, reveals that Jessica is experiencing severe sleep onset difficulties. She reports, and her parents confirm, that she often listens to her radio or reads so late that she is only getting about 2-3 hours of sleep each night.*

*Jessica is sent back to the family physician for further consultation and review. At this point a referral to a specialist in sleep disorders is made. A sleep disorder is confirmed and treated. The symptoms disappear.*

### **Discussion**

This example illustrates the importance of not having 'tunnel vision' regarding depressive symptoms. In this case, it is important to ask a broad range of questions to determine other possible explanations for the symptoms. The involvement of a specialist allows for a differential diagnosis and successful treatment.

## Case Example 2

*After a full assessment, Rachel, aged 16, is diagnosed with major depressive disorder and a possible eating disorder. Her parents have been arguing a lot for the past year, and have considered a trial separation. Her mother suggests that the conflict is mostly related to her husband's drinking. A consultation takes place with the staff of the children's mental health agency working with Rachel to determine the best way to proceed with this family. A telephone consultation occurs with the family physician and the dietitian from the local eating disorder clinic, both of whom strongly advocate for a referral to the eating disorder clinic.*

*A meeting takes place at the children's mental health agency, with the school counsellor, Rachel and her mother attending (her father was unable to attend due to work commitments). Rachel and her mother agree that a follow-up assessment at the eating disorder clinic would be helpful. The psychologist agrees to make the formal referral for this assessment. Rachel's school counsellor agrees to give her some ongoing support during the school day, and children's mental health practitioners from the agency agree to provide individual counselling and treatment for Rachel over the next several months.*

*Rachel's mother asks about, and receives, information regarding community mental health agencies that could provide support for her and her husband, including the local alcohol and drug assessment program. She agrees to follow up on these referrals and to talk to her husband about the possibility of assessment for couple counselling and/or alcohol treatment. The children's mental health practitioners agree to monitor the family situation and provide support and direction for Rachel's mother and father as requested and as necessary. They also agree to meet occasionally with the whole family during Rachel's treatment to provide education and support, and address ongoing family interactions.*

## **Discussion**

This example demonstrates one way in which other professionals can be involved in multi-disciplinary consultation in the early stages of treatment planning. If Rachel becomes involved in treatment for an eating disorder as well as the depression, it will be particularly important for staff at both agencies to co-ordinate their efforts over time. It will also be quite important that the family situation be monitored on an ongoing basis. Family or couple therapy, or individual counselling for mother or father, can be considered. Parents can be kept informed and involved in Rachel's treatment program.

---

---

**Toolkit Links:**

**Practitioner** → **Preparation for Multi-Disciplinary Consultation** (See pages 120 - 122)

---

---

**References:**

Children's Mental Health Ontario. (2001). *Evidence Based Practices for Depression in Children and Adolescents*.

# **CHAPTER 3**

# **SAFETY PLANNING**

# SAFETY PLANNING

## 3.1 Collaborative Practice

Risk assessment and safety planning require active involvement of:

- the child
- family, teacher, and important support people in the child's life
- children's mental health practitioner

As the primary worker, you can ensure that each part of this system is aware of potential risks and plans for safety. This can be accomplished by:

- talking with the child or youth about his concerns and your concerns
- asking parents and teachers what they have observed, or are concerned about, and sharing your concerns
- helping parents hear what their child is saying about concerns or plans
- working on a safety plan together with the child or youth and, when appropriate, with the parent or legal guardian
- sharing the safety plan with family and significant others
- making sure that each person knows what she can do as part of the safety plan
- ensuring that everyone has a written copy of the safety plan

It is also important that the professionals working with a particular child or youth collaborate with each other regarding safety. This can be carried out in the following ways:

- Have signed consents in place, as early as possible, in order to share risk and safety concerns.
- Share safety plans and ensure that they are consistent across workers (e.g., if you are planning to use mother's home as a 'safe place', then other professionals working with this child should be doing the same; if you know that there is access to weapons at father's home, then other professionals need to know that information as well so there is consistent direction given to the youth about where to go and who to seek help from).

## 3.2 Risk Assessment

### Indicators of Suicide Risk

When assessing for suicide risk, it is important to keep in mind the history of this particular youth, current threats or actions, and the level of depressive symptoms. There are other aspects of thinking and acting that also serve as clues to the level of risk.<sup>4</sup> See Toolkit page 123 for a practitioner's checklist of indicators of suicide risk.

### Key Elements of Risk Assessment

Key elements of a risk assessment are contained in the Toolkit pages 124 - 130. They include:

- suicidal intent
- degree of planning that has taken place
- level of danger and availability associated with intended method
- behaviour that the youth has been exhibiting
- substance use
- history of suicide attempts by youth, family members or significant others
- trigger events
- other risk factors
- factors that lower risk

Most of this information is best obtained from the youth directly. You may also have to obtain some of this information from other people who live or work directly with the child.

---

<sup>4</sup>The reader is directed to Shamo and Patros, (1990) (although this is directed toward parents, it is useful to clinicians as well) and Fremouw, W., de Perzel, M. and Ellis, T., (1990).

## **Types of Questions to Ask Children**

Ensure that your questions are at a developmentally appropriate level for the particular child with whom you are working. Be prepared for various levels of verbal ability and understanding of concepts such as time, cause and effect, and death. For example, some younger children may talk about their own death, but hold a belief that death is temporary or reversible. Children may understand better if you ask about “since the end of school” rather than “over the past three months.” You can ask “What did you think would happen when you did...?”, or “What do you think would happen if you died?”. It may also be useful to look at the content and approach to play for younger children. For example, content that repeatedly turns to children dying or being hurt, abandoned or carrying out dangerous acts, and a quality of play that is consistently aggressive, irritable or sad, may indicate risk. Children’s reports of what they were feeling or thinking during an episode of suicidal thought or action may be affected by their mood at the time of the interview, and this is important to take into account. For example, children may underestimate their intent if they are feeling safe now or making new friends in a residential setting.

## **How to Talk With Parents**

When you are talking to parents, it is important to recognize that this is a very difficult topic for them to consider. There may be feelings of guilt or self-blame, or parental depression or mental illness may be present. Parents do, however, have important information about what has occurred over time. Questions that ask for description rather than diagnosis are most likely to be helpful. For example, you might ask for parents to describe, step by step, what happened over the past week, rather than asking “Has your child been suicidal?”. It is also important to ask direct questions (e.g., “Has John hurt himself or tried to hurt himself?” “Tell me what he did.” “Do you think John might hurt himself?” “What makes you think this?”).

## Factors That Lower Risk

There may also be factors present that reduce the risk of suicidal action. These factors are listed in the Key Elements of Risk Assessment (Toolkit pages 124 - 130). It is important to view these along with other risk factors so that you can accurately assess overall risk. When you are able to identify the things that lessen the risk, you can act to enhance them and ensure they do not become lost in the safety planning. For example, if the presence of a pet is a deterrent, do not propose that the youth be moved to a setting where the pet could not be kept. If you have identified an important support person in the youth's life, ensure that this person is involved in providing ongoing support as part of the safety plan.

## 3.3 Safety Plans

In order to be effective, a safety plan has to be the result of planning that involves the young client as well as the adults who are concerned about his or her safety. Depending on the stage of treatment and the degree of risk, children may not be able to do this to a significant extent. In these cases, others may be more involved in supporting the child in following a safety plan. Other people, such as family members, who are an important part of the safety plan, need to be prepared and able to carry out their part. Professionals who are working with these youths should be aware of what support and encouragement will be necessary to maintain safety.

Once you have determined that there is a suicide risk, work to:

- decide who needs to be involved in the safety planning
- limit or remove the means and method of intended suicide
- provide adequate support and supervision

(See Toolkit pages 131 - 133 for a practitioner's safety planning checklist.)

You may find, in some cases, that a ‘Safety Agreement’ is useful in helping a young person commit to not attempting suicide over a limited period of time. It is important to remember that an agreement, verbal or written, cannot be a guarantee that the child will be able to follow through with that commitment. See Toolkit page 134 for a checklist of what a Safety Agreement should include.

A verbal agreement should be clearly stated and understood by the child or youth. A written agreement should use language that the child can understand. Have the youth sign the agreement. A sample format for a Safety Agreement is included in the Toolkit page 135.

A Safety Agreement does not take the place of safety planning, but can be a part of the plan. Remember to consider the stage of the youth’s treatment and level of risk in determining what additional support needs to be given, and what action can be taken by others to maintain safety.

### **3.4 Alternate Placement and Consultation with Physician**

If the assessed risk level requires more intrusive intervention (e.g., hospitalization, residential care), or persists despite intensive community-based intervention, then placement to increase safety should be considered until safeguards and treatment can be put in place. This decision should be weighed carefully and viewed as a short-term strategy that may need to be put in place on more than one occasion during the course of treatment. This is also a time when you should consult with the physician or psychiatrist who is working with this child, in order to have medication and treatment strategies evaluated and to determine placement options.

### **3.5 Ongoing Evaluation**

Risk assessment and safety planning are ongoing activities when working with depressed youth. Do not assume that a safety plan put in place prior to treatment starting will continue to be effective as the course of treatment unfolds. If the youth is moved to a different residence or school, there may be new risks or the absence of old ones. As treatment explores some of the factors contributing to depression, risk of suicidal action may increase where there was limited risk before.

---

---

**Throughout treatment, and during follow up, it is important to continue to:**

- **assess suicidal thought or action**
  - **consider safety and supervision**
  - **ask questions regarding thoughts and actions that put a youth at risk**
- 
- 

## Case Example

*Josh, aged 16, has been receiving non-residential treatment for diagnosed depression for the past month. The initial assessment did not indicate suicidal thoughts, however Josh was engaging in some high risk behaviours, including attending parties at which various drugs (marijuana, 'ecstasy', pills that Josh was unable to identify and alcohol) were being used by him and others. He has been described by his parents and other professionals who have worked with him in the past as "impulsive."*

*You have recently become concerned about his apparent lack of concern for his own safety and increased risk-taking activity. In your most recent session, Josh disclosed that he thinks about death often, wondering what his family's reaction would be to his death and considering what his friends would say about him after he was gone.*

*You further assess the level of his suicidal thoughts and determine that he is experiencing an increase in the frequency of these thoughts, and that he has considered how he could arrange his own death by taking his friend's car and driving off a nearby dead-end road at the top of a cliff. He states that he has been thinking about this idea a lot since coming up with the plan a few days ago and, in fact, is having difficulty getting the idea out of his head. He knows how to get his friend's keys, likely during a time when they are both at one of the drug parties that he continues to attend occasionally. He has not told anyone else about his plan, although he has considered letting his friend know.*

*You and Josh talk about who might be supportive in preventing his plan to kill himself. He knows that his father is quite concerned about his well-being,*

*although he is often out of town on business. He feels that his mother would get “upset” and does not think that she could help him. He thinks that his friend might care about what happens to him, but doesn’t think that he would be able to stop him if he wanted to put his plan into action. He has another friend who does not attend the drug parties who has expressed an interest in helping him out.*

*The two of you come up with some ideas about how he could increase his own safety, e.g., staying away from parties (this is something that he has been trying to do since starting treatment and has been somewhat successful at), letting his parents know, and planning to do more things with his friend who is not using drugs or attending parties. You also work together on some strategies to interrupt the repetitive suicidal thinking pattern. Josh agrees to sign a safety agreement, and you agree to meet in two days. Josh also has a phone number for the local teen crisis line that is staffed by trained counsellors.*

*You meet together with Josh’s parents and Josh to discuss the current situation and enlist the parents’ support in helping Josh find ways to plan safe activities for himself. You also advise the other professionals who are working with Josh about his increased risk and what the current safety plan is. You will be able to discuss this plan at an upcoming team meeting, and will, at that time, consider the advisability of residential treatment for Josh.*

## **Discussion**

This example demonstrates the importance of identifying potential high-risk situations and working with the youth to find ways to avoid these situations and increase safe activities. It also points to the value of bringing other people into the plan. One of the most critical aspects of working with Josh is not losing sight of the risk related to his impulsiveness. It is likely that Josh will be safer within a residential treatment situation, without access to drugs and former friends and with more controls in place for his impulsive behaviour. It will be important to continue to monitor safety on an ongoing basis, and to maintain contact with Josh’s parents and other workers to assess for increased suicidal thoughts and/or potential risk.

---

---

**Toolkit Links:**

- Practitioner** → **Indicators of Suicide Risk** (See page 123)
- **Key Elements of Assessment for Suicide Risk and Suicidal Ideation** (See pages 124 - 130)
- **Safety Planning** (See pages 131 - 133)
- **Safety Agreement Checklist** (See page 134)
- Client** → **A Safety Agreement** (See page 135)
- 
- 

## References

Children's Mental Health Ontario. (2001). *Evidence Based Practices for Depression in Children and Adolescents*.

Fremouw, W., de Perczel, M. and Ellis, T., (1990). *Suicide Risk: Assessment and Response Guidelines*. New York: Pergamon Press.

Love, A. (n.d.) Draft document on suicide risk assessment.

Shamoo, T.K. and Patros, P.G. (1990). *Helping Your Child Cope with Depression and Suicidal Thoughts*. New York: Lexington Books.



## Section 2

# Promising Interventions for Children & Adolescents with Depression

The second section of this manual looks more specifically at the work that children's mental health practitioners carry out with children and adolescents who have been diagnosed with depression. Chapters 4 and 5 contain an overview of what the research evidence tells us about effective interventions, and, in more detail, what these interventions look like. Outcome evaluation of various interventions for children and adolescents with depression indicates the most support for cognitive behavioural approaches. Chapters 6 and 7 take a detailed look at how to use these approaches to identify and modify thinking patterns and unhelpful coping strategies associated with childhood depression. Chapter 8 should be helpful to YOU in identifying and working with issues associated with loss and trauma which can often overlap or be interwoven with symptoms of depression. Chapter 9 outlines family interventions and approaches. The final chapter contains responses to questions that are frequently asked by front line staff working with children and adolescents who have been diagnosed with depression.



# **CHAPTER 4**

## **THE RESEARCH ON TREATING DEPRESSION**

# THE RESEARCH ON TREATING DEPRESSION

## 4.1 What is Evidence-Based Practice and Why is it Important?

Evidence-based practice refers to the use of therapeutic approaches shown to be effective by outcome evaluations that meet established research standards. Research that assesses the impact of various approaches provides us with the information we need to guide our practice as child and adolescent mental health practitioners. Evidence-based practice is important because it increases our ability to be accountable to our clients and to support them in accessing the most helpful service.

Unfortunately, there is relatively little evidence-based research on the treatment of depression in children. Most of the treatment recommendations are based on studies of adults with depression or on clinical experience. Although there are similarities to adult depression, particularly for older adolescents, many questions still remain about the actual course and outcome of depression in children and adolescents.

## 4.2 Outcome Studies

For more detailed information about outcome studies, see *Children and Adolescents with Depressive Disorder: Findings from the Literature and Clinical Consultation in Ontario*, Children's Mental Health Ontario, May 31, 2001. Highlights of this literature review are included here.

The research suggests that treatment can be discussed in terms of four phases: preparation for treatment, acute treatment, continuation treatment and maintenance treatment. The following section highlights what the research has to say about these four phases of treatment.

## **Preparation for Treatment:**

Studies show that during the preparation for treatment, educating parents, the child, other family members and teachers about depression and its treatment decreases later treatment dropout.

---

---

### **The effectiveness of treatment is determined by a number of factors:**

- **age at the time of the first episode of depression**
  - **severity of depression**
  - **presence of other disorders**
  - **availability of supports**
  - **parental mental illness**
  - **family conflict**
  - **stressful life events**
  - **socioeconomic status**
  - **quality of treatment**
  - **motivation on the part of the child or youth**
- 
- 

## **Acute Treatment:**

The research considers a number of different approaches and strategies used to treat depression in children and youth. These approaches include:

- Pharmacotherapy
- Interpersonal Therapy
- Cognitive-Behavioural Therapy
- Supportive Psychotherapy
- Family Therapy
- Integrative Approaches

The most promising of these practices will be described in Chapter 5.

### **Continuation Treatment:**

Studies consistently show that several factors predict the need for additional treatment following the acute phase. These factors include:

- severity of self-reported depression at intake
- presence of other disorders along with depression
- family problems

Research indicates that monthly ‘booster’ sessions are helpful in preventing relapse in adolescents or in assisting in the recovery of those who are still depressed at the end of the acute phase.

### **Maintenance Treatment:**

There are no published studies regarding ongoing maintenance treatment of children and adolescents with depression. Studies of depressed adults suggest that ongoing therapy of 1 to 3 years is required when there are multiple or severe episodes of depression, family history of bipolar disorder or recurrent depression, psychosis or severe impairment along with episodes of depression, and when medication is continuing.

## **4.3 Summary**

As indicated earlier, the literature primarily draws upon studies of adults and is not clear with respect to childhood depression. When considering the needs of depressed children and adolescents, it is important to take into account factors such as developmental stage, social context and level of dependency on parental support. It is also important to bear in mind that treatment approaches that work well for adults generally rely heavily on verbal interviews which may not be developmentally appropriate for some youth (e.g., young children).

The research reveals the most support for cognitive-behavioural approaches. At the same time, there is some evidence to suggest that aspects of other approaches (e.g., family therapy, pharmacotherapy) are useful when integrated into a multifaceted treatment program. Integrative approaches may offer a way to address the broad range of factors associated with childhood depression, including the important influences of biology, family and school. These factors may, in turn, help to sustain recovery.

## References

Children's Mental Health Ontario. (2001). *Children and Adolescents with Depressive Disorder: Findings from the Literature and Clinical Consultation in Ontario*.



# **CHAPTER 5**

# **PROMISING PRACTICES**

# PROMISING PRACTICES

In recognition of the support in the literature for cognitive therapies and the clinical evidence that suggests the importance of the inclusion of other aspects of treatment, we will now look in more detail at four promising practices: cognitive behavioural therapy, family interventions, pharmacotherapy and integrative approaches.

## 5.1 Cognitive Behavioural Therapy

Cognitive behaviourism brings together the rich traditions of cognitive theories and behaviourism to help us understand childhood disorders and provide strategies for treatment.

Cognitive behavioural therapy (CBT) is directed at the connections between thoughts, actions and feelings. Treatment is focussed on:

- changing negative thought patterns and beliefs associated with depression
- creating opportunities for, and reinforcing, success in order to address feelings of helplessness
- fostering skill development to increase social competency

Cognitive theories about childhood depression propose that depressed individuals engage in persistent negative thoughts about themselves, the world and the future. This has been termed the negative triad. The cognitive ‘schemata’ or filters through which they see and understand the world are viewed as contributing to and maintaining their depression.<sup>5</sup>

The principals of behaviour therapy are evident in cognitive behavioural approaches. In particular, positive consequences or rewards are used to shape behaviours and to reward efforts and successes. The positive experiences that result from this changed behaviour can then challenge negative beliefs held by the depressed person.

Self-monitoring, role playing and homework assignments are also used to achieve the goals of cognitive behavioural therapy.

---

<sup>5</sup>Beck was the first to formulate these ideas. Cognitive theorists have used them to describe the thought processes for both adult and childhood depression.

---

---

### **Applications of Cognitive Behavioural Therapy (CBT)**

- **Use CBT to increase the child's awareness of connections between thoughts, feelings and behaviours.**
- **Consider family factors.**
- **Ensure that you take into consideration age, stage of development and gender of child when planning treatment. Focus on behaviours with younger children. Older children and adolescents are more able to identify and work to change their thought patterns.**
- **Work collaboratively with the child, investigating thoughts, feelings and behaviours together and agreeing on what changes to make.**
- **Make therapy fun by using games, role play, and reinforcement.**
- **Find out about the child and make conversations, examples, homework, etc., relevant to his life.**
- **Be ready to meet challenges of lack of interest / energy, negative thinking, fatigue, etc., that are symptoms of depression. Use your knowledge of the positive environment for your work together.**

## 5.2 Family Interventions

Some of the family factors that have been related to childhood depression are:

- depression in parents and family members
- family history of mental illness
- substance abuse
- parental conflict
- parent-child conflict
- parental abuse and neglect
- chaotic or stressful family environment.

Children are dependant on their parents, and affected on a day-to-day basis by their family environment. Family therapy, as part of a treatment plan, is a way of addressing the difficulty of separating family influences from other aspects of a child's life. This systemic view proposes that it is not possible to understand children without attending to their family system and social context.

Family interventions can range from educating parents about depression and its impact on children to bring them on as supports for the child, to family therapy designed to treat more serious systemic problems within the family.<sup>7</sup>

There are several different family therapy approaches, ranging from structural or strategic interventions, to solution-focused and narrative approaches.<sup>8</sup> What the different approaches have in common is a view that the 'problem' (i.e., depression in the child or adolescent) has an influence on all family members at the same time that it is influenced by family dynamics. Thus, family therapy interventions are designed to help the family and individual family members understand the patterns of behaviour and interactions that are currently occurring, and make changes that will yield more positive outcomes. There are times when parental conflict, relationship violence or separation and divorce proceedings mean that meeting with the whole family is not advised.

<sup>7</sup>As an example of the ways in which family interventions can be integrated into cognitive behavioural approaches, the reader is directed to the work of Stark and his associates (Stark & Smith, 1995, Stark et al., 1991, 1994).

<sup>8</sup>There are many different approaches used within the field of family therapy. The reader is directed to Nichols and Schwartz (2001) as one text that provides a good overview of various approaches.

---

---

### **Applications of Family Interventions**

- **Family interventions are based on the premise that you can best understand children and the problem (in this case, depression) within the context of their family.**
  - **Interventions may range from briefer educational interventions designed to help the family understand depression and its impact, to family therapy designed to address challenges within the family system.**
  - **It is important to create a non-blaming context of caring concern and acceptance of multiple perspectives regarding what is happening within the family and for the child.**
  - **Include whoever is willing to become involved in helping the child and making positive change within the family system.**
  - **Be aware of times when a referral for couple or individual therapy beyond your work with the family is advised.**
- 
- 

## **5.3 Pharmacotherapy**

There have been very few studies on the use of antidepressant medications for children and adolescents. The use of medication is often combined with other interventions (e.g., supportive psychotherapy, family therapy) for children and adolescents. There is limited research suggesting that antidepressant medications may be useful when symptoms present an obstacle to psychotherapy, or when the child is not responding to other forms of treatment. If a child or youth is exhibiting severe depression, she may benefit from antidepressants to alleviate some symptoms (e.g., poor concentration), allowing the child to more easily engage in therapy.

---

---

### **Applications of Pharmacotherapy**

- **Drug therapy may be used when symptoms are severe.**
  - **Drug therapy should be considered in circumstances where symptoms of depression present an obstacle to psychological interventions, when the child has not responded to other forms of therapy, or when symptoms have worsened despite other therapies.**
  - **Close monitoring by an experienced child psychiatrist/ pediatrician / family physician is recommended during the treatment phase and when medication is being discontinued.**
  - **If the child / youth is psychotic or has extreme periods of ‘highs’ and ‘lows,’ he should be assessed by a child psychiatrist.**
- 
- 

## **5.4 Integrative Approaches**

Integrative approaches attempt to take the most helpful parts of other therapies and create a more complete treatment intervention. Integrative approaches use treatment strategies that target the following key areas:<sup>9</sup>

- Identifying cognitive distortions about self, the world and the future
- Learning strategies for changing these distortions
- Identifying grief issues and feelings
- Increasing self-esteem
- Changing problematic patterns of behaviour
- Improving social skills for interacting with others
- Learning ways to cope with conflicts and personal difficulties

<sup>9</sup>Source: Children’s Mental Health Ontario. (2001). *Evidence Based Practices for Depression in Children and Adolescents*.

These approaches also include multiple levels of intervention directed toward the child, family and school. Sequencing may be an important consideration when working within an integrative framework. For example, specific work with a child on social skills might be followed by work within the family or school system to provide opportunities and support for trying out these newly learned skills. Parent education about childhood depression at the onset of treatment might be followed up later with a parenting group, or couple therapy directed at patterns of interaction that may be maintaining the depression. Individual work with a youth may be offered initially when depressive symptoms do not allow for group participation, with group therapy provided later in the treatment process.

---

---

### **Application of Integrative Approaches**

- **Integrative approaches are those which use various aspects of different therapies to allow for treatment at several different levels.**
  - **These approaches use many positive aspects of cognitive, behavioural and family interventions.**
  - **Treatment can be adjusted based on the specific needs of children and their families.**
  - **Intervention with parents, family and school can enhance work with the depressed child.**
- 
-

## References

- Beck, A. T., Rush, J., Shaw, B. F. and Emery, G. (1979). *Cognitive Therapy of Depression*. New York: Guilford Press.
- Children's Mental Health Ontario. (2001). *Evidence Based Practices for Depression in Children and Adolescents*.
- Nichols, M. P. and Schwartz, R. C. (2001). *Family Therapy Concepts and Methods*, 5/e. Boston: Allyn and Bacon.
- Stark, K. D. and Smith, A. (1995). Cognitive and behavioral treatment of childhood depression. In H.P.G.van Bilsen, P.C.Kendall and J.H.Slavenburg (Eds.) *Behavioral Approaches for Children and Adolescents: Challenges for the Next Century*. New York: Plenum Press.
- Stark, K. D., Rouse, L. W. and Kurowski, C. (1994). Psychological treatment approaches for depression in children. In W. M. Reynolds and H. J. Johnston (Eds.) *Handbook of Depression in Children and Adolescents*. New York: Plenum Press.
- Stark, K. D., Rouse, L. W. and Livingston, R. (1991). Treatment of depression during childhood and adolescence: Cognitive-behavioral procedures for the individual and family. In P. C. Kendall (Ed.) *Child and Adolescent Therapy: Cognitive-Behavioral Procedures*. New York: Guilford Press.

# **CHAPTER 6**

## **IDENTIFYING AND LEARNING TO MODIFY COGNITIVE DISTORTION**

# IDENTIFYING AND LEARNING TO MODIFY COGNITIVE DISTORTION

Treatment of children or adolescents with depression often targets the distorted thoughts, attitudes and beliefs they hold that reflect a negative view of the world, themselves and their future. The goal of treatment is to identify these cognitive distortions and then work to ‘restructure’ them. This chapter highlights the most common of these distortions and outlines some ways to address them.

## 6.1 Some Common Cognitive Distortions

The following section lists some common cognitive distortions<sup>10</sup> associated with depression, and examples of what you might hear from the youth with whom you are working. It is important to note that some of these examples might be reflective of the child’s stage of development rather than cognitive distortion. For example, younger children often see themselves as central to their world and believe that there is a straight cause and effect relationship between what they do and what happens around them. This type of egocentric thinking from a six-year-old would not, by itself, be reflective of a depressive thought pattern. Taking incidents out of context, or personalizing events, may also be reflective of developmental stage. Caution and attention to other aspects of a child’s life are therefore necessary when identifying potential cognitive distortions.

---

<sup>10</sup>Much of the original work that identifies cognitive distortions is Beck’s, although the reader is also directed to Rehm and Carter, 1990 and Stark and Smith, 1995 for examples of cognitive distortions most commonly seen in childhood depression.

---

---

### Summary of Common Distortions

- **Paying more attention to the negative and ignoring or minimizing the positive**
  - **Negative self-evaluations**
  - **Faulty explanations for what happens**
  - **Details focussed on and taken out of context**
  - **Over-generalization**
  - **Personalization**
- 
- 

### **Paying more attention to the negative and ignoring or minimizing the positive**

Examples:

- *A negative view of the world:* seeing my problems as overwhelming; exaggerating problems; seeing no possible solutions; believing that I have no control over my environment; self-destructive behaviour; believing that more is expected of me than actually is.
- *A negative view of myself:* unrealistic expectations including “I must” or “I should”; excessive self-blame; guilt; shame.
- *A negative view of the future:* believing nothing will change positively; believing that even if things work out well it will be too late; believing that I have no options or control; seeing friends as able to make positive change but not me; believing that things will only get worse.

### **Negative self-evaluations**

Examples:

- Unrealistic and unreasonably negative evaluation of my performance, possessions and personal qualities.
- Statements about myself such as: I’m stupid; I’ll never succeed; It’s always my fault; I’m bad; I’m ruining his life.

## **Faulty explanations for what happens**

Examples:

- Jumping to conclusions which the evidence doesn't support (e.g., My parents are getting a divorce because I'm a bad kid).
- Seeing my own actions as more powerful than they are (e.g., My mom is sick because I got home late).
- Seeing my actions as having no influence (e.g., It doesn't matter if I do my homework, I won't get it right anyway; not seeing my own part in fights).

## **Details focussed on and taken out of context**

Examples:

- A focus on one negative detail while ignoring other more positive aspects of experience (e.g., We had a horrible time on our trip because we got lost – after a two week driving vacation with a half-hour delay when Mom had to ask for directions; I did really badly on my test – I got one answer wrong; I should have been able to win all of the games – not three out of four).

## **Over-generalization**

Examples:

- Making an assumption about what 'always' happens based on a single incident.
- Statements such as: It always rains on our holidays (after one day of rain); I will never get to school on time (after one late arrival).

## Personalization

Examples:

- Relating outside events to myself, even when there is no reason to.
- Statements such as: “I knew that would happen to you because everyone who gets close to me has something bad happen to them”; “I knew that team would lose because I was cheering for them.”

## 6.2 Strategies for Modifying Cognitive Distortions<sup>11</sup>

When you begin to work with children or adolescents to modify cognitive distortions, start by identifying what you are hearing or seeing from the child or youth. Approach this in a tentative way at first by inviting the child to look at his thinking patterns. Children’s responses to your invitation will give you an idea of their readiness for change. As you continue to work together, the task of identifying and restructuring cognitive distortions will become one which you and the child share.

You will both begin to see themes across thinking patterns (e.g., “I can’t do it”; “It’s pointless”). These themes will give you ideas about some of the underlying ‘schemata,’ and you can begin to target these in your work. Cognitive behaviourists believe that getting the child or youth to act differently is the most powerful tool for changing thinking patterns. See Toolkit page 136 for a practitioner’s worksheet you can use to record the child’s cognitive distortions.

---

<sup>11</sup>These strategies have been written about by a number of cognitive-behaviourists. The reader is referred to Stark et al. (1991, 1994, 1995) and Kendall (2000) for specific discussion of cognitive-behavioural strategies for use with children. This section is reflective of these authors’ ideas as well as our own clinical experience and that of our colleagues.

---

---

**Approach to Modifying Cognitive Distortions:**

- **Listen and look for cognitive distortions that the child is using.**
- **Invite the child to look at these thinking patterns (assessing readiness for change).**
- **Continue to identify and restructure distortions collaboratively with the child.**
- **Identify ‘themes’ that link thoughts or thinking patterns together (e.g., hopelessness, nothing can help, self criticism, negativity).**
- **Use themes to identify the ‘schemata’ or lens through which the child views the world.**
- **Address problem thinking by restructuring distortions.**
- **Use behavioural changes to strengthen changes in thinking patterns.**

---

---

The following section outlines some useful approaches to modifying cognitive distortions. See Toolkit pages 137 & 138 for a practitioner’s worksheet to record the treatment strategies you plan to use.

**Self Monitoring:**

---

---

**Self Monitoring involves asking children to ‘tune into’ their own thoughts, identify the negative thought patterns and redirect their attention in more positive ways.**

---

---

The first step in modifying cognitive distortions is to identify them. You can listen for them in a session, and ask the child to ‘tune into’ her own thoughts. In the session, ask what the child is thinking. This can be particularly useful when you notice a mood change.

Actually, depressed children can generally self-monitor quite well – but what they are self-monitoring is negative. They can benefit from learning what to self monitor and how to redirect their attention to the positive.

After children have gained some ability at ‘tuning into’ their thoughts, ask them to record their thoughts throughout a day or during the week. A checklist or sheet of paper with faces expressing different emotions or thoughts to circle can be easy to use. Older children and adolescents might want to carry a small notepad and pen with them. For younger children, you may need to enlist the help of parents or teachers in reminding them to notice what they are thinking.

---

---

**Children and adolescents often tell you that they are not thinking. Help them understand that we are thinking most of the time, but often are not aware of our thinking. Part of their goal is to become aware of their thoughts. It is the first step in having greater control over their feelings and actions. Some ideas to help young people:**

- **Ask what they think someone ‘might’ think in the same situation.**
- **Agree on a possibility and explore it. You can then, together, select another possibility and explore it as well.**
- **Attempt to identify what they were *not* thinking; generate prompts if necessary (e.g., “Were you thinking that you were beautiful?”).**
- **Ask them to think about what ‘tapes’ might be playing in their heads when they are in a certain situation (e.g., “Do you hear your mother’s voice at those times? What is she saying?”).**

Initially, ask the child or youth to write down or notice when positive events or pleasant emotions occur. This teaches the method of self-monitoring, and starts to break the cycle of attending to the negative.

As time goes on, you can set self-monitoring assignments that fit best for the child's specific needs. Define together what to 'tune into.' Practice in sessions by choosing thoughts that are likely to occur during the session, and then noticing them. You can play games together and encourage 'thinking out loud.'

### **Cognitive Modelling (Thinking Out Loud):**

---

---

**Cognitive Modelling allows you to model more helpful ways of thinking about things and approaching problems by 'thinking out loud' in the presence of the youth with whom you are working.**

---

---

Cognitive modelling occurs when you yourself 'think out loud' with more adaptive thoughts that might replace the child's negative ones. Once you have done this, ask children to put the more adaptive thought in their own words and practice saying it out loud (e.g., I'll bet that I can do at least part of this, or, maybe I need a bit more time to think about each step).

### **Self - Instructional Training:**

---

---

**Self-instructional training helps children build a new internal dialogue to guide the way they think and act in difficult situations.**

---

---

Help children build a vocabulary and steps for thinking about certain situations. This can be especially helpful for children with a verbal deficit or poor impulse control. For example, you might help youths find some things to say when they do not know the answer to a question in class, and also a way for them to ask for help or where to get the information they need. They can also be taught self-instruction for managing the way they think about difficult situations (e.g., I'm going to be okay; I know that I can do this; All I have to do is my best; They're just fooling around). This can provide a more positive alternative to getting angry and feeling shut down or acting impulsively.

### **Problem Solving Training:**

**Problem Solving Training allows you to help children think about how to approach situations in their lives in more positive and constructive ways. Teach youths how to break down tasks into manageable steps and consider several alternatives when facing a problem. Use of education, modelling, coaching, role play, rehearsal and feedback are helpful in training youths in problem-solving.**

Building on the idea of approaching situations differently, help children and youth think about how to solve simple, and then more complex, problems. Problem solving skills help to overcome feelings of hopelessness. Children can be taught to consider alternative solutions and the costs and benefits of each. Problem solving allows youth to experience some successes and build a sense of mastery. This can have a positive influence on self-esteem and self-confidence. You can teach problem-solving using the following methods:

- *Education*: teaching the child how to approach problems.
- *Modelling*: showing how you approach different situations; talking about what you are thinking about as you problem solve.
- *Coaching*: helping youths through a problem-solving situation by encouraging; asking them to consider alternatives; making suggestions about what to look at next, etc.

- *Rehearsal*: role playing or talking through an imaginary situation; practising what they would say or do in certain circumstances.
- *Feedback*: letting children know when they are making positive steps in problem-solving; letting them know what they might have missed in considering consequences of decisions.

Games such as checkers, puzzles, completing mazes, Jenga, etc., allow children to consider the next few moves. Playing these games in session with them allows you to help them look at all the possibilities, consider alternatives, and predict the results of their choice. See Toolkit pages 148 & 149 for a client worksheet on problem solving.

### Setting Realistic Standards:

**Helping youths set more realistic standards for themselves can begin to challenge unhelpful thought patterns. This allows more room for success and helps them set attainable goals.**

Identify the standards that youths are setting for themselves. You can do this through the use of a questionnaire or written assignment, verbally, through play or drawing. If standards are unrealistically high, the outcome will be failure. Begin to look at the ‘evidence’ with them – what supports such a high standard? Help them set more realistic standards.

You can help youths use self monitoring to look for evidence that supports this new self-evaluation. For example, if the standard changes from making sure that all the chores for the week are done, to making sure that the chores for today are done, there is more likelihood of a successful outcome. If tasks are broken down into manageable steps, there is also more likelihood of success (e.g., cleaning the whole room may seem overwhelming, but making the bed may seem more possible). These observations then work to strengthen the new standard and set a more positive self-evaluation.

Later in treatment (when youths are able to recognise changes on their own), work with them to set new standards and then to set realistic goals and make a plan for attaining them. You can use problem-solving skills to plan

and to consider what might be an obstacle and how to handle it. See Toolkit page 146 for a client worksheet that can be used for setting goals and making plans to reach them.

### **Cognitive Restructuring:**

---

---

**Cognitive Restructuring refers to work that challenges the ways in which depressed children are seeing themselves and the world. Children learn to use a series of questions to check out their own thinking: What’s the evidence?; What’s another way to look at it?; What if that did happen?**

---

---

You can work to change faulty schemata (the filter through which individuals see and understand the world and themselves) through the use of cognitive restructuring. This strategy asks the child or youth to consider three questions:<sup>12</sup>

- What’s the evidence?
- What’s another way to look at it?
- What if that did happen?

Children are taught to use these three questions for themselves. At first, you and the child or youth can ask these questions about automatic thoughts, beliefs and attitudes that you identify together. Later on, consider themes contained in these thoughts, beliefs and attitudes. The themes will lead you to identify the schemata or lens through which the youth is viewing the world. When working with younger children, you will play a lead role in identifying what the schemata are, and then check it out with the child (e.g., “Do you think it

<sup>12</sup>This series of questions is based on Beck’s original work. For a further description of the use of these questions with children, the reader is directed to Stark et al. (1991).

might be that you're seeing it this way . . . ?"). With older children and adolescents, you may be able to work more collaboratively in defining the schemata or guiding principles that are being used.

When you have agreed on what the schemata is, work together to recognise when it is guiding the child's or youth's thoughts and responses. Then use the series of questions to challenge the faulty thinking. See Toolkit page 147 for a client worksheet on challenging faulty thinking.

### **Behavioural Changes:**

**Behavioural changes help to strengthen changes in thought patterns. "Doing something different" will change the outcome. Use your creativity and knowledge of the child to come up with alternative actions that will more likely lead to a positive outcome.**

Suggest behavioural changes once you have targeted cognitive distortions (e.g., "What if you did something different?"). This will change the outcome, and provide immediate feedback to the child that shows the old thought patterns to be flawed. It requires creativity from you, and knowledge of the child with whom you are working, to think of different behaviours that will lead to helpful outcomes. You might consider using role play to make sure that the child understands what he is going to do differently. It will also be important to talk about the outcome in your next session to ensure that the child is not distorting the results.

## 6.3 Applications

### **Identify cognitive distortions or faulty thinking patterns:**

- Attending to the negative and ignoring the positive
- Negative self-evaluations
- Faulty explanations
- Focus on details, details taken out of context
- Over-generalization
- Personalization

**Invite the child to look at these distortions (assessing readiness for change).**

### **Work collaboratively with the child to identify and change patterns of thinking. Use:**

- Self monitoring
- Cognitive restructuring
- Problem solving training
- Setting realistic standards
- “What’s the evidence? / What’s another way to look at it? / What if that did happen?” line of questioning
- Behavioural changes

### **Identify ‘themes’ that link individual thoughts together and identify the ‘schemata’ or lens through which the child is viewing the world.**

Focus on these problem schemata in your ongoing work using the “What’s the evidence? / What’s another way to look at it? / What if it did happen?” line of questioning.

**Use behavioural changes to strengthen changes in thinking patterns.**

## Case Example

*You are working with Andy, aged 10. He is small for his age and has been the target of teasing and bullying in his classroom. He was recently diagnosed with depression.*

*When you met with Andy for the first time, he was quiet and withdrawn and it was difficult for you, at first, to get him to respond to your questions. However, he became somewhat more comfortable when you suggested a game of checkers. As you played together, he started to talk a bit about how he is unable to do most of the things that other kids can do. He talked about being sick a lot as a younger child, not really very good at making friends. During this session, you were most aware of Andy's negative thoughts about himself and his abilities. Although you were aware that he had been doing well at school, and that his parents viewed him as a creative and bright young boy, he made statements such as "I can't do anything well"; "The other kids see me as a weakling, and I guess I am"; and "I don't really have a favourite thing to do, mostly because I can't do anything." You asked Andy to try to notice what he was thinking as you were playing checkers together, and you started to ask him, before or after a move, what he was thinking at that moment. Sometimes he said things like "That was a stupid move" and "I don't have any good ideas for what move I can make now." You asked him if it might be that he was being quite hard on himself, or looking only at what he cannot do, rather than what he can. He indicated that this might be the case, although he was not sure. As an experiment, you asked him to notice how he is thinking about things over the next week. You gave him a little notepad that he could carry with him, and asked him to write down when he is telling himself that he cannot do something.*

*The next time you met, you asked Andy if he was able to notice what he was thinking over the past week. He showed you his book, and talked about noticing how often he had been telling himself that he was not able to do things. During your checkers game in this session, you began to think out loud, saying things like "This might not work, but I think I'll try it anyway"; "If this doesn't work, I can always try something else"; and "I think this will be a good move." You both continued to monitor what Andy was thinking.*

*In your third and fourth sessions, you started to talk to Andy about these thoughts and what evidence there is for them. The two of you decided that there was some evidence that there are things that Andy cannot do (e.g., some sports), but there*

*are also some things that he can do very well (e.g., schoolwork, checkers, helping his parents with work around the house). You asked Andy if there were other ways to look at the statement "I can't do anything." He suggested that a better statement might be "There's some stuff I can do, and some stuff I can't." You then asked him what would happen if he were to begin to replace the automatic "I can't do this" with "I might be able to do this, or I might not." His first response to this was that it would make no difference, because he still would not be able to do it, but you challenged this response and asked him what would be the worst thing that could happen if, for example, he were to try this out at home. He thought about how his mom and dad might respond, and what would happen if he tried something new and it did not work out perfectly the first time. The two of you agreed that home might be a good place to try out the new thinking.*

*During the time that you have been meeting with Andy, you have also met with the school and with his parents. Andy's parents have helped him to monitor his thoughts and they are quite happy about his desire to try out some new things at home. His dad agreed to invite Andy to work on a woodworking project with him. The school has been working on solving the bullying situation, and Andy has been having some more positive experiences at school, although the problem is not solved completely.*

*In your later work with Andy, you both continue to work on noticing and addressing the automatic thoughts that are linked to what you have both come to refer to as "Only looking at the can't" (a way of talking about the schemata of selectively attending to the negative). You both come up with some strategies for finding ways to spend time with other children who share Andy's interests. He joins the Environmental Club at school and begins to make some new friends with whom he can spend time at recess and lunch time. As he begins to pay more attention to what he likes to do, and what he can do, he finds it easier to replace the automatic negative thoughts. His parents continue to help him monitor these thoughts, and he has decided to get a larger journal for himself in which he can write down more of his thoughts, both the "can's" and the "can't's."*

### **Discussion**

Notice the way in which checkers is used as an opportunity to engage Andy, as well as to talk about and tune into his thoughts. Later the game is also used for cognitive modelling. It is important to find a 'safe training ground' for Andy to try something new. If the bullying problems continue to exist at school, home is a safer place to begin to take some risks. Behavioural changes, such as joining the club, etc., help anchor and strengthen the cognitive changes.

---

---

**Toolkit Links:**

- Practitioner** → **Identifying Cognitive Distortions** (See page 136)
- **Treatment Strategies for Modifying Cognitive Distortions** (See pages 137 & 138)
- Client** → **Setting Goals** (See page 146)
- **Challenging Faulty Thinking** (See page 147)
- **Problem Solving** (See pages 148 & 149)
- 
-

## References

- Beck, A. T., Rush, J., Shaw, B. F. and Emery, G. (1979). *Cognitive Therapy of Depression*. New York: Guilford Press.
- Kendall, P.C.,(Ed). (2000). *Child and Adolescent Therapy: Cognitive - Behavioral Procedures 2<sup>nd</sup> Edition*. New York: Guilford Press.
- Rehm, L. P. and Carter, A. S. (1990). Cognitive components of depression. In M. Lewis and S. M. Miller (Eds.) *Handbook of Developmental Psychopathology*. New York: Plenum Press.
- Stark, K. D. and Smith, A. (1995). Cognitive and behavioral treatment of childhood depression. In H. P. G. van Bilsen, P. C. Kendall and J. H. Slavenburg (Eds.) *Behavioral Approaches for Children and Adolescents: Challenges for the Next Century*. New York: Plenum Press.
- Stark, K. D., Rouse, L. W. and Kurowski, C. (1994). Psychological treatment approaches for depression in children. In W. M. Reynolds and H. J. Johnston (Eds.) *Handbook of Depression in Children and Adolescents*. New York: Plenum Press.
- Stark, K. D., Rouse, L. W. and Livingston, R. (1991). Treatment of depression during childhood and adolescence: Cognitive-behavioral procedures for the individual and family. In P. C. Kendall (Ed.) *Child and Adolescent Therapy: Cognitive-Behavioral Procedures*. New York: Guilford Press.



# **CHAPTER 7**

## **MODIFYING MALADAPTIVE BEHAVIOURS AND ADOPTING CONSTRUCTIVE COPING STRATEGIES**

# **MODIFYING MALADAPTIVE BEHAVIOURS AND ADOPTING CONSTRUCTIVE COPING STRATEGIES**

## **7.1 Descriptions of Maladaptive and Adaptive Behaviours**

When you are looking at changing maladaptive or problem behaviours, the first step is to identify those behaviours that may be helping to maintain the child or youth's depression. Youths will require some assistance to change behaviours that have negative consequences. Direct your attention to helping youths replace some of these less helpful behaviours with more helpful ones. Adopting positive coping behaviours is likely to lead to positive outcomes and help children to think about themselves and their world in a more positive light.

---

---

## **Maladaptive Behaviours**

**Maladaptive behaviours are unhealthy, unhelpful or have negative consequences for an individual. Depressed children and youth may exhibit a wide variety of these types of behaviours. These may include:**

- **frequent crying spells**
- **inability to enjoy any regular activities, either because pleasurable activities are limited, or because the child is unable to find pleasure in previously enjoyable activities**
- **suicidal attempts, either because of a genuine wish to die, or an attempt to make changes in how the child is treated or viewed by others**
- **rebelliousness**
- **withdrawal from peers and/or family members**
- **inactivity and difficulty performing simple day-to-day tasks, leading to increased dependency on others or withdrawal from peer interaction**
- **increased or decreased sleeping or eating.**

## **Adaptive Behaviours**

**Adaptive behaviours contribute to an individual's sense of control in her own life, lead to more positive outcomes in day-to-day interactions, and reinforce more helpful ways of thinking about herself and the world. You may wish to help depressed children begin to carry out some of the following adaptive behaviours:**

- **identifying satisfying, pleasurable activities and making them part of their daily plan**
  - **learning ways to cope with feelings of self-destruction, hopelessness, loss, etc., by focussing on positive problem-solving strategies**
  - **setting goals to increase motivation for school attendance, recreational activities, and interaction with peers**
  - **setting daily plans and actions to regulate sleeping and eating patterns**
- 
-

## 7.2 Strategies for Modifying Behaviours

The following section focusses specifically on strategies for changing maladaptive behaviours.<sup>13</sup> See Toolkit pages 140 - 143 for a practitioner's worksheet to list maladaptive behaviours that the child is exhibiting, list more adaptive replacement behaviours, and record the strategies you plan to use to modify behaviours.

---

---

**Some of the strategies you can use in modifying unhelpful or problematic behaviours include:**

- ***Education:*** teaching ways of behaving differently; pointing out the implications of doing something else; talking about the ways in which the responses of others may be linked to the youth's behaviours.
- ***Modelling:*** using your own responses and interactions with the child or youth to demonstrate alternative behaviours.
- ***Role play:*** setting up a hypothetical situation in session or in a group treatment situation, and allowing the youth to try something different, practice an approach you have talked about, etc. These types of activities keep children and youth involved and participating in therapy.
- ***Feedback:*** giving youths direct feedback when they have behaved in a way that leads to a more positive outcome; letting them know when the problem behaviour is occurring or about to occur.
- ***Social reinforcement:*** using the group to give positive feedback when changes take place in a group context; looking for ways in which youths can change their behaviours that are likely to lead to positive reinforcement in 'real-life' situations.
- ***Positive counselling context:*** continue to build rapport and provide ongoing reinforcement for small steps and successes.

---

<sup>13</sup>Many cognitive-behaviourists have written about these strategies. The reader is directed to Stark et al. (1991, 1994, 1995) and Kendall (2000). This section is reflective of these authors' ideas as well as our own clinical experience and that of our colleagues.

The following section outlines several specific ways of modifying a child's behaviour:

- Social Skills Training
- Pleasant Events Scheduling
- Self-Reinforcement
- Managing Intense Emotions
- Changing Acting Out Behaviour
- Relaxation Training

### **Social Skills Training:**

---

---

**Social skills training helps children to read social situations more accurately and provides them with more skills for feeling comfortable and interacting appropriately in social settings. These skills can lead to behaviours that challenge some of the distorted thinking related to negative self-concept.**

---

---

Prior to beginning social skills training, observe the child in social situations. Talk to teachers, parents and family members about what they have observed. When a child or youth reports having difficulties with social interactions, it is difficult to tell how much of this report is based on fact and how much is based on her beliefs which may be inaccurate. Often the reality is a combination (e.g., a child may misperceive others' intentions and respond in a way that leads to rejection; a youth may be feeling rejected and isolated and acting in a way that increases isolation; the family may be modelling socially inappropriate ways of interacting with others). Keep these possibilities in mind as you talk to children and their families about their experience.

Once you have identified the child's experience in social situations, use some combination of teaching, modelling, role play, coaching, feedback and homework designed to meet the specific needs of the child. Some of the things you might consider are:

- Help the child more accurately perceive what is going on in social situations. This may include addressing some of the problematic thinking patterns listed in the previous chapter.
- Think of strategies that the youth can use to feel more comfortable in social situations. Reducing anxiety will help children feel more able to try out some new behaviours.
- Focus on basic assertiveness: making eye contact, being aware of facial expression, giving compliments, asking people to stop when they are doing something that bothers you, conversational skills, and conflict resolution skills.
- Use the therapeutic relationship between you to teach how to trust. When you accept a youth the way he is, this can contribute to his sense of being worthy and likeable.
- Educate youths about social skills in group therapy and practice these skills immediately in a safe peer setting.
- Use games during therapy sessions to practice taking turns, following rules, interacting with others, playing.
- Encourage the youth to begin to use a regular exercise program, either as part of treatment or between sessions, to lead to an increased sense of accomplishment and a positive sense of her own ability.
- Encourage social problem solving by considering several possible solutions to problems that arise in social settings. Choose between the possibilities, put one into effect and monitor the results. This can be used in role play situations or as homework assignments. Recall previous successful solutions and consider what led to success. See Toolkit page 139 for a practitioner's outline for use of role plays.

## **Pleasant Events Scheduling:**

---

---

**When youths are not receiving enjoyment from most activities, feeling overwhelmed by symptoms of depression, and experiencing boredom and inactivity, it is useful to consider with them how to add more enjoyable activities to their daily life. The purposeful scheduling of enjoyable and goal-directed activities can lead to positive reinforcement and challenge withdrawal and inactivity.**

---

---

Together with youths, consider what enjoyable activities might include. Plan together how and when these activities could be included in their daily routines. It is helpful to get parental support, particularly for younger children. It is also important to ensure that the activities will be acceptable in the youth's family or treatment setting, and that safety has been taken into consideration. Follow up at the next session, or in a group session, to see how this scheduling worked from the youth's perspective.

It may be helpful to consider projects that have a purpose or goal. These types of activities can lead to an increased sense of competence and personal mastery. You might consider, either as a homework assignment or in-session tasks, using hobby kits, a household project, carpentry, sewing, photography, etc. Approach these projects in a step-by-step fashion, making a schedule and developing motivational self-talk to address negative thoughts when they arise. If you are working with a larger group, consider a group project.

## **Self-Reinforcement:**

---

---

**Youths can learn to reward themselves when they have completed a step towards an agreed-upon task. This can lead to improved levels of motivation, self-satisfaction and sense of self-control.**

---

---

Parents can be involved in a child's self-reinforcement as well, particularly with younger children. This allows for parents and children to work together toward positive goals of behavioural change. In teaching self-reinforcement, consider the following:

- Set realistic goals jointly. Break the goals down into manageable steps that are geared for success. Find ways to reward oneself along the way.
- Use activity scheduling to arrange for pleasurable activities to be used as rewards. Consult with parents about what they feel comfortable with when planning rewards. Ensure they are not feeling coerced and are supportive of the reward plan.
- Identify other reinforcers. This can be difficult with some children, especially those who have withdrawn and are quite passive, expressing limited enjoyment of most aspects in their life. Talk with them about activities, favourite snacks, people they enjoy being with, objects (toys, books, etc.) and places that give them pleasure and thoughts that are rewarding to them. It is important to know whether or not these potential rewards are available to them and can be self-administered. Make a list (like a menu) so that children can remember and use them.
- Involve parents in the 'menu-making' as children do not typically have independent means for providing their own rewards.
- Teach children about the concepts of reinforcement and punishment. Encourage them to think about self-reward as a way of making themselves feel good.
- Rank the rewards you have listed with respect to value. Help youths to think about rewarding themselves with highly ranked rewards following completion of a difficult task, lesser value for simpler tasks, etc.
- Consider hypothetical situations. Ask children to think about what reward would be appropriate and have them demonstrate. Use homework to record the use of self-reinforcement and follow up during the next session.

## Managing Intense Emotions:

---

---

**Helping children identify and manage emotions that often feel overwhelming, such as anger or sadness, can lead to an increased sense of self control. Youths have more alternative actions available to them when they are able to effectively regulate emotions. This can lead to new outcomes that challenge negative patterns of thinking.**

---

---

Help children to recognise early cues of intense emotions – both physical and cognitive: How are they feeling?; where do they feel it?; what are they thinking?; etc. Teach them to take action to change the situation if it can be changed, or to cope with the feelings that arise. Help youths to consider their options. For example, they can:

- leave
- go do something pleasant
- use words rather than actions to express their feelings
- do something physically demanding
- express emotion through drawing or writing
- use relaxation skills

Involve parents and teachers in helping children cope with intense and overwhelming feelings. They may be able to help cue the child that they are getting angry or sad, or they may be able to use a reward system for encouraging positive responses. It is difficult for both parents and children to intervene when emotion builds to extreme levels. It may be useful to carry out some pre-planning with parents and children together, and consider what cues they will be looking for, how parents can let children know what they are noticing, and how children can respond to these reminders. Role play or rehearsals in session help illustrate how this might work for youths and their families.

## Changing Acting Out Behaviour:

---

---

**Children often engage in acting out behaviour when they and the system are locked in a negative pattern. It is important to identify what the acting out behaviour does for children. If the behaviour is getting them attention, even if it is negative, it may be getting them what they want. It may also work within their peer group or family, may fulfill a negative view of themselves, or may serve to relieve anxiety or depression.**

---

---

Once you have identified what purpose the behaviour is serving, work with the child or youth to meet that goal in a healthier way. Discuss with children what you think or have observed, consider alternatives together, and make a plan to do something different. You can use role plays that involve the replacement behaviour and follow up in the next session. Get children to observe what happens differently when they do something different. You may also need to create a 'cost' for the acting out behaviour, but remember to maintain, as much as possible, a positive environment for youths to work on more constructive ways to meet their needs. Costs or consequences should only be put in place once youths have mastered the most constructive behaviour.

## Relaxation Training:

---

---

**Relaxation is a coping skill for addressing the anxiety that often accompanies depression, new situations, new tasks, etc. When children are relaxed, they have positive feelings and are in a peaceful state. Achieving a state of relaxation is helpful for youths who are trying to visualize themselves successfully carrying out an assignment for rehearsal purposes. Achieving a relaxed state can also be helpful to cope with feelings of anger, anxiety, hopelessness or helplessness.**

---

---

You can carry out relaxation training in individual or group sessions, and encourage practising at home. Make your own relaxation tapes or use a favourite purchased tape. Youths may find your voice familiar and soothing if you have been practising in sessions, and tapes made using your own voice may be helpful for them to take home and practice. You can teach deep breathing and progressive muscle relaxation, as well as visualization and imagery exercises. You can also help children find ways to replace tension and worry with relaxation behaviours.

The key to successful relaxation training is to engage the youth in the strategy and to find a relaxation exercise that can be used routinely (e.g., at bedtime), as well as a brief exercise that children can use without drawing attention to themselves in emotionally arousing situations. For example, teach youths to tighten every muscle, while sitting at their desk (perhaps only tighten the parts of the body that are behind or beneath the desk), hold, breathe out and relax, or ask them to take three deep breaths before responding in a difficult situation. In these cases, you are not asking children to engage in a full relaxation exercise, but rather helping them learn how to ‘pause’ in a distressing situation to give themselves an opportunity to consider their response.

## 7.3 Applications

**Identify behaviours which may be unhealthy, unhelpful or lead to negative outcomes for the child.**

Especially focus on behaviours that may be contributing to and/or helping to maintain the depression.

**Consider what behaviours might be more helpful or healthy, or would lead to more positive outcomes.**

**Take into consideration what parents, teachers and others have observed about this child in various situations.**

Remember that children's perceptions may be coloured by their negative thought patterns and that this may be contributing to negative peer interactions, etc. Take this into account in planning the treatment approach.

**Use a combination of the following approaches to address problematic behaviour and help children learn new behaviours for more constructive coping:**

- Social Skills Training
- Pleasant Events Scheduling
- Self-Reinforcement
- Managing Intense Emotions
- Changing Acting Out Behaviour
- Relaxation Training

**Use education, modelling, role play, feedback and social reinforcement to teach and encourage changed behaviour.**

**Assign homework that allows children to put into practice some of the skills that they are learning in sessions.**

**Use follow-up sessions to find out from the youths how their attempts have worked out.**

Ensure that they are viewing outcomes realistically and challenge negative styles of evaluating outcomes. Help youths to see how outcomes may be different from what has happened in the past.

## **Case Example**

*Steve, aged 16, has been working on addressing his depression and managing his anger. You have been working with Steve and his mother, stepfather and 14-year-old brother. When you meet with Steve individually, you help him to identify some of the cues that he is starting to feel angry. In particular, he has noticed that his chest starts to feel tight and he starts to clench his fists when he is angry. He has also noticed that his face gets hot and he feels as if his head is going to “explode” sometimes when he is really angry. Steve says that his thoughts at these times are mostly concerned with not being made to look like a fool.*

*A colleague of yours is leading a group in which Steve is participating, and during one of their meetings they role play situations that could lead to angry confrontations. Steve plays the role of the angry person, and by stopping and starting the role play, and asking the group for ideas about alternative thoughts and actions, he is able to learn more about what works for him in redirecting his thoughts and actions. They have also been learning some relaxation skills in the group, and Steve has found that these strategies are useful in addressing the tightness in his chest and head, and his clenched fists.*

*You have been working together for a while with the focus on relaxation, changing his thoughts to a more productive line of “Does this matter? What else can I do? Do I need to stay here?,” and taking a walk or talking to a friend about what he is feeling before trying to deal with the situation that he is angry about.*

*You have invited the family to attend a family session to start to talk about the lines of communication in the family. Steve’s stepfather is attending unwillingly*

*at the request of Steve's mother. Steve and his stepfather do not get along well, and they have heated arguments about rules, curfews, school, etc. During the course of the family session, you notice that Steve is beginning to clench his fists. You stop the dialogue and ask each family member to take a moment to 'check in' with how they are feeling and what they are noticing about their physical response to what they have been talking about. Steve's mother identifies that she feels like crying when there is so much tension in the room and that she feels as if her stomach is upset. Steve's stepfather admits that he has a 'terrible headache' just like he always does when family fights erupt. Steve's brother talks about wanting to leave and feeling his legs cramping up as he sits here. Steve is able to identify his physical response of tightened chest and fists, and how his head feels like it is going to explode. He then begins to talk about how he is trying to relax to address those symptoms of feeling angry. He also starts to talk to both of his parents about how he does not want to look foolish, and how he sometimes feels as if they are trying to make him be a little boy again. This admission from Steve opens up a new avenue to explore with the family and creates an opportunity for them to talk about their responses to tension and conflict, and alternatives for dealing with these situations as a family.*

### **Discussion**

This work with Steve takes place in a couple of different ways. In particular, the observations in individual and group treatment about his physical responses help him to identify what he can be paying attention to in various situations. The group therapy gives him some opportunities to learn more about possible responses in social situations. You have a wonderful 'teachable' moment arise during a family session and this provides you with an opportunity to help Steve and his family gain more self-awareness and self-control.

---

---

### Toolkit Links:

- |                     |   |   |
|---------------------|---|---|
| <b>Practitioner</b> | → | <b>Changing Behaviours</b> (See pages 140 - 143)          |
|                     | → | <b>Strategy Plan for Use of Role Plays</b> (See page 139) |
| <b>Client</b>       | → | <b>Setting Goals</b> (See page 146)                       |
|                     | → | <b>Problem Solving</b> (See pages 148 & 149)              |
- 
- 

### References:

Kendall, P.C.,(Ed). (2000). *Child and Adolescent Therapy: Cognitive - Behavioral Procedures 2<sup>nd</sup> Edition*. New York: Guilford Press.

Stark, K.D. and Smith, A. (1995). Cognitive and behavioral treatment of childhood depression. In H.P.G.van Bilsen, P.C.Kendall and J.H.Slavenburg (Eds.) *Behavioral Approaches for Children and Adolescents: Challenges for the Next Century*. New York: Plenum Press.

Stark, K.D., Rouse, L.W. and Kurowski, C. (1994). Psychological treatment approaches for depression in children. In W. M. Reynolds and H. J. Johnston (Eds.) *Handbook of Depression in Children and Adolescents*. New York: Plenum Press.

Stark, K.D., Rouse, L.W. and Livingston, R. (1991). Treatment of depression during childhood and adolescence: Cognitive-behavioral procedures for the individual and family. In P. C. Kendall (Ed.) *Child and Adolescent Therapy: Cognitive-Behavioral Procedures*. New York: Guilford Press.



# **CHAPTER 8**

## **IDENTIFYING AND ADDRESSING ISSUES RELATED TO LOSS AND TRAUMA**

# IDENTIFYING AND ADDRESSING ISSUES RELATED TO LOSS AND TRAUMA

## 8.1 Description of Issues

Depression often coexists with other issues and challenges in children’s lives (e.g., a family breakdown, exposure to violence, living outside of the family home, history of trauma or sexual abuse, immigration, etc.). Often these challenges leave young people coping with grief and loss.

---

---

**Because the symptoms of grief and loss may parallel those of depression, and be interwoven with them, it is important to be aware of each child’s experience and to be able to place the symptoms of depression within the larger context of his or her life. In fact, for many children you may be unable to say which symptoms are related to depression solely and which are only related to other underlying issues such as loss or the experience of trauma.**

---

---

Children who have been exposed to violence in their homes or communities can demonstrate symptoms of post-traumatic stress disorder (PTSD). They may be experiencing flashbacks of some aspects of the violence they have witnessed or experienced. They may actively avoid reminders of the violence. They may be in a state of increased arousal or hyper-vigilance, or they may show a general numbing of their responses. Some coping strategies that these children may use include selective inattention, rigid “black and white” thinking, or reduced motivation to attempt something new or achieve goals. It is easy to see how some of these symptoms and strategies could be mistaken for signs of depression, or how signs of depression might mask the impact of trauma or witnessing violence.

When children experience the death of someone close to them under traumatic circumstances (e.g., accidental death viewed by a youngster; a child survivor of automobile crash; children witnessing torture and/or murder of their parents), the mourning process is very difficult. In fact, these children may demonstrate permanent sadness or depressive symptoms.<sup>14</sup>

Abusive treatment and parental rejection in some home environments can also contribute to children believing that the world is unsafe and they are unlovable. This can lead to attitudes that again are difficult to separate from similar cognitive distortions associated with depression.

Children who are having problems with grieving following a significant loss (e.g., death of a parent or sibling, loss of a friend, death of a pet), may show behavioural symptoms which are similar to those of depression. These may include withdrawal from peers, lack of interest in daily activities, difficulties with sleeping, eating or school performance.<sup>15</sup>

Other losses may be more “ambiguous.”<sup>16</sup> The concept of ambiguous loss refers to a lack of information about a loss (e.g., a missing person who may or may not be dead) or conflicting ideas from family members about whether or not someone is still ‘present’ in the family (e.g., parental separation). In these situations, confusion exists about how to resolve the loss. This confusion is not a result of some difficulty or flaw on the part of the child, but is a reflection of the confusing situation itself, and can get in the way of resolving the loss.

For example, withdrawal or temper tantrums when a parent is excluded may be a normal reaction for children who know that their parent is part of their family and not part of their family at the same time (e.g., an abusive parent who is living in a separate dwelling). If a sibling has run away from home, and the family does not know if he is still alive, there are no rituals (such as a funeral) to mark this passing. Other examples of ambiguous loss may be seen in immigrant families, families in which a family member has been diagnosed with an illness such as Alzheimer’s disease, cases of incest where there has been a loss of the ‘protective’ part of a parent, adoption, etc. When the loss is ambiguous, the symptoms of prolonged grieving, as listed above, may be seen. The difficulty that children have in coping with the ambiguity or uncertainty of the loss may be demonstrated (e.g., withdrawal, temper tantrums, symptoms of depression or anxiety, nightmares, guilt, etc.), and can often intensify or confound the grief reaction.

<sup>14</sup>The reader is directed to the work of Lenore Terr, who has written about the impact of unexpected and uncontrollable trauma on children.

<sup>15</sup>Source: Children and Grief - AACAP Facts for Families #8

<sup>16</sup>The reader is directed to the work of Pauline Boss with respect to the concept of ambiguous loss. We feel that these ideas have great applicability to working with children and their families who have experienced trauma and loss.

It is important for professionals who are working with depressed children and youth to attend to symptoms of loss and traumatic stress as well as those of depression. Effective intervention will take all aspects of the child's experience into account.

## **8.2 Strategies for Addressing Issues Related to Loss and Trauma**

The following section outlines some strategies for working with depressed children and youth who have experienced trauma and loss. It is important, in these cases, to work with the family or caregiver who may also have experienced similar loss. Providing support for caregivers around their own loss, and allowing family members to acknowledge together the extent of losses, ensures a more positive home environment in which children can resolve their losses.

### **Divorce**

Divorce is often an ambiguous loss for everyone in the family. It is important to address with children what has been lost as well as what will continue. "Mom and Dad don't love each other anymore, but they both love you" only gives a partial answer to distressed youth. They also need a way to acknowledge what they have lost with the new family arrangement. Perhaps, for younger children, drawing a picture or making a collage of who the child considers to be in their family will be helpful. Older youths may be able to decide how to honour existing relationships and choose how to spend their time with the people they consider to be their family members, or how to say 'good bye' to those family members they may never see again. It may also be useful to talk with the whole family (or family members who are willing to participate) about the impact of the divorce and how each person likely has a different perspective of who is 'in' or 'out' of the family now. You can use drawing, puppets, or role play activities when younger children are involved. Using the concept of ambiguous loss helps all family members relate to the confusing aspects of the changes, and to recognise that each person is likely to cope with this in a different way.

## **Other Ambiguous Losses**

Adoption, immigration, and illness in the family can all be situations that create an internal confusion for children. Working with children and families to identify the confusing aspects of the situation can be helpful. It is also useful to look at what the losses are, and what has not been lost (e.g., family home and familiar country lost, but some family members still together and some familiar customs maintained). Again, working with other family members regarding these issues can be most helpful. If adoptive parents are aware of what is difficult for their adoptive child, they may be able to be supportive, or provide some information, as appropriate, about biological parents, etc. If illness in a family has been treated as a family secret, there may be benefits for everyone to talking more openly about the changes and losses that this illness creates.

## **History of Experiencing Violence in Home or Community**

Children who have witnessed or experienced violence can be helped by professionals who have been trained in the area of trauma. This work may include helping the child re-experience the trauma and what it means, in manageable doses and within a safe context. The re-experiencing may be through re-telling, drawing, puppets, etc., with an opportunity to process the emotional aspects of the events in manageable steps over a period of time. This process requires sensitivity, ongoing clinical consultation and training on the part of the professional. Other children will benefit from reassurance that they and their loved ones are safe, and may not benefit from addressing the trauma in direct ways. Careful consideration must be given to safety issues, especially when the perpetrator still poses risk. In these situations, children are often unable to bring closure or work to resolve trauma because of continued risk.

It is also important to find ways to address the cognitive distortions that may have developed around the experience of violence (e.g., It was my fault because I'm bad; I should have been able to stop it). Highlighting the distortions and educating children regarding accountability for violence, their own responsibilities, etc., can be helpful. You can also use some of the ideas contained in the earlier discussion of addressing cognitive distortions associated with depression.

Finally, you can address the loss issues for the child and others in the family associated with the experience of violence. Losses related to witnessing violence may be ambiguous, and linked to a changed perception of a parent or significant adult in a child's life. There may also be losses associated with having to move out of the family home, not being able to see other family members, etc. A family-centred approach that allows for intervention at different levels to support children, their caregiver(s) and other family members can be most helpful in these situations.

- **Depression can co-exist with Post Traumatic Stress Disorder (PTSD). It is therefore important to look for depressive symptoms when working with individuals who have PTSD.**
- **It is also important to distinguish between normal grieving and symptoms of major depressive disorder. (See DSM-IV criteria in Chapter 1)**

## **Coping Strategies**

**In addition to processing the impact of losses and the experience of trauma, work with children and youth to build on their own sense of personal agency (knowledge of what is within their control, how to take action for themselves).**

You can help youths to think about who would be in their own personal support system and how to access that system. This can be helpful in addressing the sense of isolation and aloneness that often comes with loss. Older children and youth might find strategies that are helpful for them such as writing in a journal, listening to music, writing poetry or song lyrics, etc., that allow them to express some of the feelings associated with their loss. Younger children may need to know with whom they can talk, and may benefit from learning some self-soothing activities that they can do on their own.

Children and youth can be educated about what they can do for themselves in situations where their safety may be at risk. A personal safety plan or personal safety skills can include a place to go, a phone number to call, and adults to trust. Having a plan and knowing what they can do helps increase their sense of personal agency.

They can also be taught about where their personal responsibility begins and ends (i.e., not being responsible for someone else's violence; taking responsibility for their own safety; safely expressing their own feelings of anger and frustration). Again, this helps children know what they have control over and what they do not have to try to manage.

Work with children and their families to come up with practical solutions or strategies for addressing some of the confusing aspects of their lives. For example, help immigrant families find ways to continue familiar traditions and adapt them to their new surroundings. Help children talk about what they need from parents and stepparents, and help the family to determine ways to address those needs. Help children and their families come to terms with the uncertain aspects of their situation and support each other in that uncertainty.

## 8.3 Applications

**Be aware of the impact of issues in children’s lives such as a family breakdown, history of trauma or sexual abuse, exposure to violence, significant losses, etc.**

**Consider how underlying issues of loss or trauma may be connected to childhood depression, and how symptoms may overlap with those of depression.**

**Provide support for families and caregivers who may have their own related experience of loss or trauma.**

**Be sensitive to ambiguous losses.**

When working with children who have experienced divorce or separation of their parents, consider the potential for ‘ambiguous loss’ and work to provide ways for them to honour existing family relationships and the new family structure. Be aware of other ‘ambiguous losses’ that may accompany experiences such as immigration, adoption, illness in the family, etc., and provide vehicles for children and their families to acknowledge what is lost and what still exists for them.

**Consider the child’s needs when there is a history of trauma.**

Professionals who work with children who have experienced trauma require training, skill and sensitivity, as well as an awareness of ongoing safety concerns.

**Teach coping strategies to children who have experienced loss and/or trauma.**

These include:

- identification of a personal support system and how to access these people
- ways of expressing some of the feelings associated with loss (e.g., journaling, poetry, music, someone to talk to)
- a personal safety plan including a place to go, adults to trust, a phone number to call
- knowledge of where personal responsibility begins and ends
- specific strategies with respect to maintaining and adapting familiar traditions, negotiating needs within the family, acknowledging confusing aspects of the current situation, etc.

## Case Example

*Estella is 12 years old. She and her family moved to your community from Central America about one year ago. Her father is working shift-work and her mother is often home alone with Estella and her four younger siblings. Estella has been having difficulty sleeping, and her appetite has decreased markedly over the past three months. Her teachers noticed that she was quite withdrawn at the beginning of the school year, but expected that by now, almost six months later, she would be more relaxed and settled into the school community. Estella speaks of being very sad almost all of the time. She spends most of her time outside of school helping her mother look after the younger children. She has not made friends in her neighbourhood or at school.*

*When you meet with Estella, you talk with her about what her life was like before she moved here. She talks about her best friend, and about missing the countryside around where she lived. Estella has learned a lot of English since moving, although she still has some difficulty with understanding what the other children at school are saying when they talk quickly. Her mother still speaks very little English, and takes Estella with her when she has to go to the store, or to the school for meetings. Estella talks about her mother being sad and lonely since moving away from her own family and friends. It is almost Easter, and Estella tells you about the big celebrations that used to take place near her old home at this time of year.*

*You decide to help Estella find some ways to deal with the loss of her friend, her home and her former way of life. You also decide to help Estella's mother connect to the drop-in centre for women from Central and South America, where she can speak Spanish with other women but also enroll in some English classes. This drop-in centre provides childcare and parenting resources, as well as a clothing exchange. When Estella's mother makes this connection, she is invited to bring her family along for the upcoming celebration they are planning. When Estella joins her family at this gathering, she is able to participate in a familiar celebration, although some of the traditions have been changed, and she is able to meet some other girls her age who share some common experiences with her.*

*As you talk with her about her old and new life, Estella decides that she would like to do a school project on her home country. She finds some pictures on the internet at school. The librarian helps her download them and she prepares to put the pictures up in her room, along with some school pictures of her new country.*

## Discussion

In this situation, you have worked to identify the loss and ways to honour what is gone and what still exists. Listening to Estella gives you clues for how to design rituals for dealing with her losses. This example also demonstrates the use of family and larger systems as supports for the child.

## References

American Academy of Child & Adolescent Psychiatry (AACAP). (1998). AACAP *Facts for Families # 8: Children and Grief*. <http://www.aacap.org/publications/factsfam/grief.htm>

Boss, P. (1999). *Ambiguous Loss: Learning to Live with Unresolved Grief*. Boston: Harvard University Press.

Terr, L. (1990). *Too Scared to Cry: Psychic Trauma in Childhood*. New York: Harper & Row.

# **CHAPTER 9**

# **FAMILY INTERVENTIONS**

# FAMILY INTERVENTIONS

## 9.1 Why Meet With the Family?

As we outlined earlier, depression in children and adolescents is difficult to separate from the family context in which children live. Children are dependant on their family environment, and their parents in particular, for physical and emotional support. While depressed children may be affected by parental mental illness, family stress, parenting difficulties, etc., their behaviours can also contribute to the overall level of stress in the family. Children are generally unable to control a difficult family situation, and they may have difficulty making sense out of family interactions. This lack of control and confusion can contribute to an overall sense of helplessness. Family work is generally seen to be an important part of a treatment plan for depressed children. (See Toolkit pages 144 - 145 for a practitioner's worksheet to record your plans for intervening with families of the youths with whom you are working.)

---

---

### **Confidentiality**

**When you meet with youths and with their families, it is important to discuss the issue of confidentiality ahead of time. Letting youths know that you will not be sharing information that they share with you in confidence is important. Let them know what the limitations are to that confidentiality. If there is information that you are obligated to share, it is best to advise them ahead of time. Talk to youths about information that you think would be useful to share with parents or the rest of the family, and work together to figure out how best to share that information in a family session.**

**Be clear with parents about your obligations with respect to confidentiality. Clarifying ahead of time what you can and cannot discuss or share with them, as well as what you must report to child protection agencies, will allow them to know what to expect from you.**

---

---

## 9.2 How to Include Family Members in Your Work

There are a number of ways to include the family system in your work with children:

- Work with the entire family in ongoing family sessions.
- Work with the parents on their own, or parents and stepparents as appropriate, focussing on parenting challenges and the particular needs of their child.
- Include other significant family members who are supportive of positive changes for the child or youth. Other significant family members may include aunts or uncles, grandparents, caregivers, etc. It will likely be helpful to talk to youths about who they see as part of their family.
- Invite some family members to participate in occasional sessions that occur during the course of ongoing individual / group work with the child.
- Consider the larger system in which this child lives, and invite teachers, clergy, mentors, peers, etc., to attend occasional sessions with the child. This decision should be made in consultation with the client and depends on the nature of the changes that the youth is trying to make and who, in the larger system, may have the most positive influence in his life.

---

---

**You may find that parents and other family members are initially ‘resistant’ to the idea of being involved in family sessions. This ‘resistance’ may arise from anxiety about who or what is going to be ‘blamed’ for the problems that exist. It may also indicate an unwillingness or reluctance to change. Parents and family members may also see the problem as isolated to the child, and think that it does not involve them at all. In these cases, it is important to approach a first session with:**

- **a recognition that these are normal ways for them to be thinking and feeling**
- **an acknowledgement that depression affects family members**
- **the assumption that people typically want to make changes that will improve situations**
- **the knowledge that change itself is hard work**

**If you can create a context of respect for this family as you meet with them, you will be able to address their anxiety and concerns as they arise.**

---

---

You may find that there are some family members who are not willing to participate at any level. In this case, you can still work with those people who are willing to come. It is good information for you, and for the youth with whom you are working, to know that there is likely little change that can be expected from those family members who are not willing to participate. You may find ways to acknowledge the nonparticipating family members during your family work by asking: “What do you expect \_\_\_\_\_ would have to say about this?” or “Has \_\_\_\_\_ been responding differently since you have made these changes?”. In this way, you continue to be aware of all the family members who have a day-to-day influence on family life for this child.

It is important to remember that you can facilitate positive change even when not all family members are in attendance. As the family members who are present begin to understand what they can change or not change, and think about how they can respond to each other and the absent family members, they begin to make their own moves leading to more positive choices and interactions.

## 9.3 A Context of Respect

Create a context of respect from the very initial stages of your work by inviting family members to give you their ideas about what has been happening over the past few weeks and months. Ask these questions in initial meetings or telephone calls as part of assessment and treatment planning. When you are able to set up a family meeting, begin by asking each person present to talk a bit about what they understand the problem to be and what they would see as solutions. Model respectful communication that avoids blaming and labelling people as the problem, and reframe or restate complaints or explanations that are blaming or put-downs.

If your focus is on what is working for this family and individual family members, as well as on what their strengths are and how to use them, then family members will begin to feel safe in expressing their concerns and working towards solutions. From this perspective, problems look more like attempts at solutions that have not worked out rather than problems embedded in people or the family itself.<sup>17</sup>

## 9.4 When Other Family Issues Get in the Way

Not surprisingly, other issues may arise as you meet with families to discuss the depressed youth's problems. It is important to attend to these issues and look for connections to what is happening for the child. For example, issues of loss or ongoing illness in the family are likely having an impact on each family member in a different way. It may be that the depression exhibited by the child you are working with is the way in which the child is responding to these issues, or that the depressive symptoms are complicated by other people's responses or interactions. Sometimes the other issues that arise are having an impact, but cannot be processed in a family context. For example, individual or couple issues that are not appropriate topics for full family consultation may be relevant.

---

<sup>17</sup>For more ideas regarding working within a strengths-based framework with families, see Waters and Lawrence (1993).

---

---

**It is important for you to have an awareness of appropriate boundaries within the family. With this awareness, you can encourage individuals or couples to seek further outside support as necessary. In this way, you can encourage individuals to take responsibility for what is within their own control, and encourage the parents / couple to strengthen their own relationship without relying on the children to do that for them.**

---

---

You may decide, either in consultation with your team or other professionals who have worked with this family, or based on what you learn from the family history and from the youth directly, that it is best not to have all family members present in the same room. For example, in cases of domestic violence or high conflict, it is best to meet with each parent separately. You may also be making some decisions about whether or not it is best to include new partners. Stepparents involved in the child's day-to-day life are probably important participants in family therapy.

You may believe, following an initial meeting with the family, that there are important couple issues that need to be addressed outside of family therapy. These issues may result in ongoing arguments, put-downs or 'getting off topic' during family sessions, and may get in the way of the work that you want to do with the child. Referral to another agency or practitioner for couple work at this point will likely be helpful, as will setting ground-rules for family sessions that maintain the child-focus during your time together. Be prepared for couples to not follow through with couple work. Sometimes problems have existed for many years and patterns are difficult to change. If you have set clear ground-rules for family sessions, you can start to take a more directive role to keep the focus on what is happening for the child and still continue with the family sessions.

## **9.5 Family Interactions**

As you gather information from family members, help them see that there are different perspectives about what is happening and what it means.

---

---

**Help family members recognise patterns of interaction and begin to look at what they might do differently. Encourage respectful listening, and help individual family members take personal responsibility for their own actions.**

---

---

Help the family explore the meanings of their current challenges, and whether they are helpful or present obstacles to change. For example, parents may have fears that their child is going to ‘end up just like Aunt \_\_\_\_\_’ who was mentally ill. This fear may put up roadblocks to being supportive or understanding and may create more distance and isolation for the child. Helping this family to see the differences between the aunt’s experience and the current situation for the child may allow for more connection, support and positive change.

## **9.6 Education**

Use family meetings as an opportunity to educate all family members about depression and its impact on children and adolescents. Help them know what to expect. Teach them what they can do to be helpful and what to look for that indicates positive or negative change.<sup>18</sup>

---

---

**Information can help families feel more in control and less vulnerable. It can help them decide what is and is not helpful or supportive to their child and them.**

---

---

You may suggest that parents and stepparents attend a parenting group to learn some new strategies for approaching parenting. You can also set aside some meeting times for parents, without the children present, to talk about parenting and think about more helpful approaches they might take.

<sup>18</sup>For examples of the inclusion of family education in a depression treatment program, see Stark et al. (1994).

## 9.7 Listening to What the Family Has to Say

When building on the positives and strengths that a family demonstrates, it is important to also pay attention to what family members talk about as problems. If your focus is solely on the positive, and does not make room in the counselling session for discussion of worries and concerns, the family will feel disrespected and unheard.

---

---

**Allowing people to talk about what is not working, as well as what is, gives you and the family more information about what is happening and what might work better in the future.**

---

---

Take into account the literacy and developmental level of the family members who are attending sessions. Your questions should be easily understood by all of the participants, and restate or clarify if you think an answer has been misunderstood by other family members. Feel free to ask questions for clarification (e.g., “Are you saying that...”; “I think that you mean...; is that right?”) that allow you and other family members to understand what is being said. You may also wish to ask other family members what they think they are hearing, or what they understand another family member to be saying. Questioning and clarifying not only leads to clearer communication and understanding in the session, but it also models respectful ways of communicating and appreciation for difference.

With very young children, you may use some play therapy techniques while parents and older family members are observers or participants. Use drawing, puppets, and role play to explore family interaction and understanding of loss, trauma, family history, etc.

## 9.8 Goals

For family interventions to be successful, it is important that both you and the family have some ideas about what success or progress will look like.

---

---

**Be clear at the outset about why you are meeting with the family and collectively agree on the changes that are needed.**

---

---

For example, you may be meeting with a family to educate them about a youth's needs with respect to depression. In this instance, a measure of success would be that the family listens to the information you have to share and begins to interact with the youth in more helpful ways based on that information. In another situation, you may be meeting with the family to explore the impact of recent losses on the family system and individual family members. In this case, your measure of success might be that individual family members gain a better understanding of how recent losses have affected them, and that the youth with whom you are working has a better understanding of his own response within the family context.

---

---

**It is important that the family has a sense of why family work is being offered and how they will know that it is being helpful.**

---

---

Begin an initial session by describing some of your reasons for inviting the family to participate. Then ask each family member to talk about their needs and how they will recognise positive change. Sometimes it is helpful to ask what change will 'look' like (e.g., "If you could fast-forward a video of your family life to a time when this problem was resolved, what would you be doing differently? What would others be doing differently?"). Use their responses and your own ideas about positive change to set some goals collaboratively with the family. It is important to be able to state the goals back to family members and check whether or not they agree with these goals. For example, "So, it sounds as if one of our goals for working together is to find new ways to resolve arguments that do not involve yelling, slamming doors or insulting each other. Is that a goal you would like to work towards?" At the beginning of the second session, you might restate the goals as you understand them, and ask the family if they have had time to think about these goals and whether or not they want them to be changed. This invites the family to become engaged in the process in an ongoing way, and ensures that each participant sees value in the work that is being done.

---

---

**You may also provide an opportunity for yourself and the family to revisit the goals from time to time to decide whether or not progress is being made and/or if the goals have shifted. It is easier to assess change when goals have been set in response to the question, “How will you know that you’re doing that, or that you are making progress in meeting that goal?” You can also ask family members to scale their responses (e.g., “You stated, when you first came in, that the family was a ‘2’ on a scale of 1 to 10, with 10 being respectful communication. Where would you say that you are most of the time now?”). Different family members may see different changes, and that will allow you to talk about differing perspectives and validate different experiences within the family. Helping the family to see that they view things differently and that change can still be occurring, even when they do not see it, can be quite useful. Again, revisiting goals ensures a collaborative and respectful climate for working with families, and provides for ongoing engagement in the therapeutic process by all involved.**

---

---

## 9.9 Applications

**Family work is generally seen as an important part of a treatment plan for depressed children.**

**Discuss issues of confidentiality at the onset of family interventions.**

- What information will and will not be shared?
- Legal requirements to report information to child protection agencies.

**Include some or all family members in any of the following ways:**

- Ongoing family sessions
- Occasional meetings during the course of treatment for the child
- Meetings with parents / stepparent to address parenting issues
- Psycho-educational sessions with the family about depression
- Inclusion of other significant people as appropriate

**Use family interventions to:**

- Educate family members about depression and its potential impact on the family.
- Work with the family to address family interactions or patterns that may be contributing to the problem.

**Be aware that ‘resistance’ on the part of parents may arise due to:**

- concern about being blamed
- an unwillingness to change
- a belief that the problem has nothing to do with them

**Work collaboratively with families, modelling and encouraging:**

- respectful communication and interactions
- problem-solving that sees people as separate from problems
- appropriate boundary-setting that separates individual and couple issues from full family consultation

## **Maintain a child-focus and recognize that some family patterns may be difficult to change.**

Be aware of the impact of family violence, power and control dynamics, etc., and make decisions to meet with some family members separately when appropriate.

## **Set goals collaboratively with the family.**

Together with family members, revisit the goals from time to time to see what change has occurred or to adjust them as necessary.

## **Case Example**

*Dave is 14 years old. He has been referred for treatment following a diagnosis of depression. He has experienced a significant drop in his school performance over the past year, moving from being an 'A' student to failing two of his courses and needing to go to summer school. He reports that he argues with his parents all the time, and that they do not understand him. The assessment pointed to some history, over the past year, of suicidal ideation and one attempt about two months ago.*

*You set up an appointment to meet with Dave on his own, during which you learn more about how he has been thinking and what has been happening in his life over the past year. You assess for suicide risk and determine that risk is limited at the present time. Dave indicates that he did not want to kill himself when he took a mild overdose of over-the-counter pain medication, only that he wanted to get his parents' attention. He said that, although he has thought about suicide occasionally over the past year, he doesn't think that it was a serious consideration. He describes wondering what it would be like to die and who would care if he did. You let him know that you are concerned about his safety, and that you will be checking in with him throughout your work together to see whether or not he is considering harming himself.*

*You suggest to him that you think it would be useful for you to meet with his parents and explain confidentiality and its limits. In particular, you let him know that you would have to tell his parents if you believed his risk of harming himself to be increased, and that they would also be informed of any safety plans that the two of you make. Dave agrees, although he tells you that he does not think that his father will attend. He says that his dad thinks that therapy is a waste of time.*

*You phone Dave's mother and talk to her, at some length, about her concerns about Dave's suicide attempt and the conflicts they are experiencing at home. She tells you that she would be willing to meet with you, and that she will ask her husband but doubts that he will come. You suggest that she tell him that you would like to know what he thinks about the current situation, and you would be open to talking with him on the phone if he could call you. Much to your surprise, he does call you two days later. He is blunt on the phone and tells you that he thinks this depression diagnosis and the therapy idea is just "coddling" Dave, and what Dave really needs is more discipline. You let him know that you really appreciate hearing his point of view, because it is obviously a very important part of understanding what is going on for Dave. You also state that it is clear to you that he has given this situation a great deal of thought. You let him know that you had thought about inviting him to join his wife and son, and you, to talk about the best direction to take in order to deal with the problems that they are facing. He grudgingly indicates that he could come to one meeting, but that it had better be short and he hopes that it will be helpful.*

*At the family meeting, you ask each family member to talk about how they see the current situation. You ask them to listen carefully to what each other has to say, and to not interrupt. Dave's mother talks about her concerns about Dave's well-being, and his father talks about his sense that Dave is just not trying hard enough at school, or at home. Dave says very little, but indicates that he doesn't know what the problem is. You respond to the family with an acknowledgement that the situation is likely very different for each of them, and that a solution depends on taking into account what each of them has to say. You spend some time educating Dave's parents about depression and its impact on the person who has it, as well as on the people around him.*

*It turns out that Dave's father's brother has struggled with depression for most of his adult life and, as a result, has had difficulty holding down jobs and supporting himself. Dave's father talks about his frustration with the fact that treatment hasn't appeared to help his brother, and that his theory is that if he just "pulled up his socks and got to work" he would get better. He also indicates that his wife is "too easy on Dave," and that this is a problem as well. Dave's mother responds quite strongly to this statement and there is some heated debate between the couple about what is best for Dave. You ask Dave what it feels like to be an observer to this kind of discussion. He talks about feeling 'lost' in the family sometimes, and unsure about what his parents want from him.*

*You end the session by summarizing what you have heard: that Dave's parents are both very concerned about what happens to Dave; that they have different ideas about what is best for him; and that Dave sometimes feels lost or ignored by his parents. You normalize the various responses and let the parents know that it is very difficult to parent under these circumstances. You suggest that you meet together with the parents to give them some ideas that might be helpful and have been helpful to others, and let them know that you will be suggesting some 'experiments' they could try so that they would only end up doing what actually works in the longer term. You acknowledge Dave's father's scepticism about therapy, and tell him that you want him to let you know if your suggestions do not make sense or if the 'experiments' are not working out. You also suggest that Dave and his father think about what they enjoy doing together, and how they might plan some time to get 'reacquainted' with each other now that Dave is no longer a child. Because Dave's mother has indicated her concern about his safety, you ask Dave to talk to her about his own sense of safety, and let her know that you share this concern and have been talking to Dave about ways to keep himself safe and monitor risk. You let both parents know about any safety plans that you have made with Dave, and advise them that you will be letting them know if you feel that Dave may be at increased risk of harming himself.*

*Your plan for your work with this family includes some parenting education for the parents, and some individual work with Dave to increase his ability to communicate with his parents as well as addressing symptoms of the depression. Following this, you plan to meet with the family or refer them for family counselling, depending on your own skill level and training, to facilitate communication between Dave and his parents, and to encourage some relationship building among the three of them.*

## **Discussion**

Notice the ways in which all family members are invited to participate. When you invite Dave's father to consult, and accept his reluctance and scepticism, you are more likely to engage him in at least considering some changes. It is important not to overload either Dave or his family. The first priority is safety. Improving the level of communication in the family and letting everyone know you are concerned about how safety is addressed is an important step, even if there is little change beyond this. Educating them about depression is helpful as well. Ideally, you may also be able to help Dave be more assertive and able to talk to his parents about what he needs.

---

---

**Toolkit Links:**

**Practitioner** → **Family Interventions** (See pages 144 & 145)

---

---

## References

Stark, K. D., Rouse, L. W. and Kurowski, C. (1994). Psychological treatment approaches for depression in children. In W. M. Reynolds and H. J. Johnston (Eds.) *Handbook of Depression in Children and Adolescents*. New York: Plenum Press.

Waters, D. and Lawrence, E. (1993). *Competence, Courage and Change: An Approach to Family Therapy*. New York: Norton & Co.



# **CHAPTER 10**

## **FREQUENTLY ASKED QUESTIONS**

# FREQUENTLY ASKED QUESTIONS

## 1. **Doesn't the use of medication get in the way of effective treatment for depression?**

When drug therapy is indicated, it is likely to benefit the youth by reducing or alleviating the symptoms of depression. Research suggests that many clients benefit most, especially over time, when medication for depression is combined with effective psychotherapeutic interventions such as cognitive or cognitive behavioural therapies. Safe and healthy messages and practices about the responsible use of medication should be taught and modelled.

## 2. **What about the risk of addiction when using drug therapy?**

Antidepressant medications are not addictive.

It is important to address your questions directly to the people who have expertise in and up-to-date information on this area. If you or your clients have a concern related to the medication that has been prescribed, speak directly with the prescribing physician or psychiatrist. The prescribing doctor must be told of all the medications their client is taking to ensure potential interactions between drugs are considered.

Pharmacists are also a good source of information when you, or your clients, have questions about a prescribed medication. If the client wants to take an over-the-counter medication or a homeopathic substance, he should discuss these medications with the pharmacist first.

## 3. **Is there a risk of overloading a youth when using integrated or multifaceted approaches?**

This is a risk in some cases, and it is important to be aware of the possibility, particularly in complex situations, of 'over-treating.' Guard against unrealistic expectations about how much change can happen over a short period of time. It is also important to be aware of what you are asking parents to do, especially when there are other children in the family. Be aware of other demands being placed on the family and youth.

You do not want to be inadvertently creating a set-up for failure on the part of the child or family. Set priorities in your work and think about sequencing. Some treatments, such as medication and residential treatment, work well when offered at the same time. Other times, addressing one aspect before introducing the next phase may make the most sense. For example, you may choose to address problem-solving strategies prior to working on social skills, or you may introduce some social skills concepts early and follow-up with more skill building after doing some problem-solving work. For instance, consider focussing on one thing in order to get through an exam period, and work on other areas after exams are over.

Overload is an important consideration to bring up in supervision or consultation, as well as to evaluate during team and multi-disciplinary consultation. Be flexible and responsible to the reality of your clients' lives.

**4. When you are working with a child or youth who has been or could be suicidal, how do you balance safety concerns with the need to work on the depression?**

Pacing is important whenever you are working with depressed youths. It is necessary that you engage youths in their therapy, and this may take some time and creativity. Working together to address safety and assuring youths that you are concerned about their safety and well-being because you believe in their ability to deal with the depression allows you to begin to work on this engagement. Talking with youths about what they are thinking about when they feel suicidal, their beliefs regarding why committing suicide seems like a reasonable or the only alternative, their understanding of the impact their death would have on others, etc., will provide an opportunity for you to work on identifying and challenging cognitive distortions. Rather than seeing the safety concerns and risk assessment as a detour, use them as a focus that allows you to think about how the depression is affecting the child. Remember that you can address other issues in time, once the risk of suicide has decreased.

**5. If I talk with a youth about the possibility of suicidal thought or intention, am I not taking a risk of implanting the idea with him?**

It does require sensitivity on your part when approaching this issue with a youth. We would stress again the importance of pacing your interventions and questions with depressed youths. Approach your clients in a step-wise fashion, building on their answers to previous questions. Asking first, for example, how the youth would scale her level of depression, or sadness, or hopelessness, begins to take you down a path toward further exploration of risk. You might follow up with questions, based on the youth's response to the scaling question, about what thoughts or actions might accompany these feelings. Exploring thoughts and actions allows you to begin to ask about risk-taking, intention and beliefs about what might happen. Talking about safety and risk-taking allows you to express your own concern and explore the youth's beliefs about himself. Rather than implanting ideas, this line of questioning should allow you to both assess risk and focus on the youth's own safety, sense of self-control and personal agency. It is important to note, as well, that if the youth discusses suicide first, you should address it right away and not wait.

**6. What about larger systemic contributors to a child's depression that we can't address?**

It is important, during assessment and treatment, to be aware of the context in which children live. At the same time, it is important to be realistic about your ability to intervene and change the larger system. For example, if you are working with a child who has been bullied in a school, work with the school to address the bullying and, at the same time, recognise that the child is going to need coping skills to deal with bullying that may still occur. Even though you are working to change the larger system, you need to be aware that you cannot be with the child all of the time, nor prevent difficult situations from occurring, particularly in the short-term. A child-focussed approach that develops a 'coping template' allows children to manage in the present and builds skills for coping in the future.

**7. What do you do about depressed children and youth who are difficult to engage in therapy due to symptoms of depression, e.g., lack of interest, negative thinking, etc.?**

The symptoms of childhood depression do present a challenge to people working with them. This is especially true when you are trying to work from a cognitive-behavioural perspective, which relies on the client being actively involved in the therapy. When children are withdrawn and unresponsive, it is difficult to work collaboratively with them. It is important that you take the time, at the beginning of your work together, to build a solid therapeutic relationship. This can be done by making sure that your discussions are directly linked to the youths' lives and experiences. Making this initial interaction and your questions directly applicable to their lives makes the experience more meaningful and real for them. Presenting information for them to listen to is unlikely to be as effective as asking them to draw on their own experience to demonstrate the connection between thoughts, feelings and actions, for example. Making treatment fun, by using role-play, games and other activities, is more likely to engage children.

When planning homework assignments, think small and brief at first, increasing size and difficulty gradually over time. Also, remember to present assignments as 'practice' or an 'experiment,' so that being unable to complete the task successfully can be seen as helpful information rather than failure. Sometimes the 'hopelessness' of depressed children leads to uncompleted homework or lack of involvement in sessions. Think of ways to help a child understand about the interaction of thoughts, feelings and actions and see how that may be part of what they are experiencing when they think "why bother?." Memory difficulties, indecision and fatigue may also lead to them not finishing agreed-upon tasks.

Make sure that you create, as much as possible, a positive and rewarding tone during your time together. Building on rewards and positive-reinforcement helps to create a positive environment. Use your own clinical experience to build a solid connection with a child. Active listening, conveying genuine concern for the child, a sense of humour and creativity are valuable tools for you.

**8. What can I do wrong when working from a cognitive behavioural perspective with children or adolescents with depression?**

There are a couple of ways in which you can be unhelpful to depressed children when using cognitive behavioural approaches. Both of these potential errors are in the area of the tone that you use and the way you approach the children with whom you are working.

It will not help children deal with their depression if you move far ahead of them instead of working collaboratively at their pace. If you move from being a ‘coach,’ who encourages positive risk-taking and making small steps, to being a ‘referee’ who enforces the rules and hands out consequences, you will not be helping depressed children build new skills.

Cognitive behavioural approaches rely heavily on the use of questions. It is important that you not ask questions that sound ‘accusatory,’ leading children to feel guilty about their thoughts / feelings / actions, or feeling as if they have failed.

Your role is to be supportive and encouraging, creating a context in which children believe in their own ability to think, act and feel differently.

**9. You have described issues of trauma in this manual. Are you saying that I can address all of these issues as a children’s mental health practitioner?**

Because you work on the front-line with children and youth, you have the most contact with children and youth who may have experienced trauma. This exposure means that it is important that you recognise the symptoms and impact of trauma. It does not mean that you alone are responsible for carrying out all treatment interventions yourself.

Many of the strategies outlined in this manual are ones which children’s mental health practitioners can use (for example, cognitive modelling and addressing maladaptive behaviours).

Skill and training allow you to identify which strategies you feel comfortable and skilled to carry out, and what situations require referral to and consultation with other professionals. You should not be afraid to consult and ask questions when you are faced with situations that are new or confusing to you. In particular, we would highlight two cautions. When safety concerns are present, either with

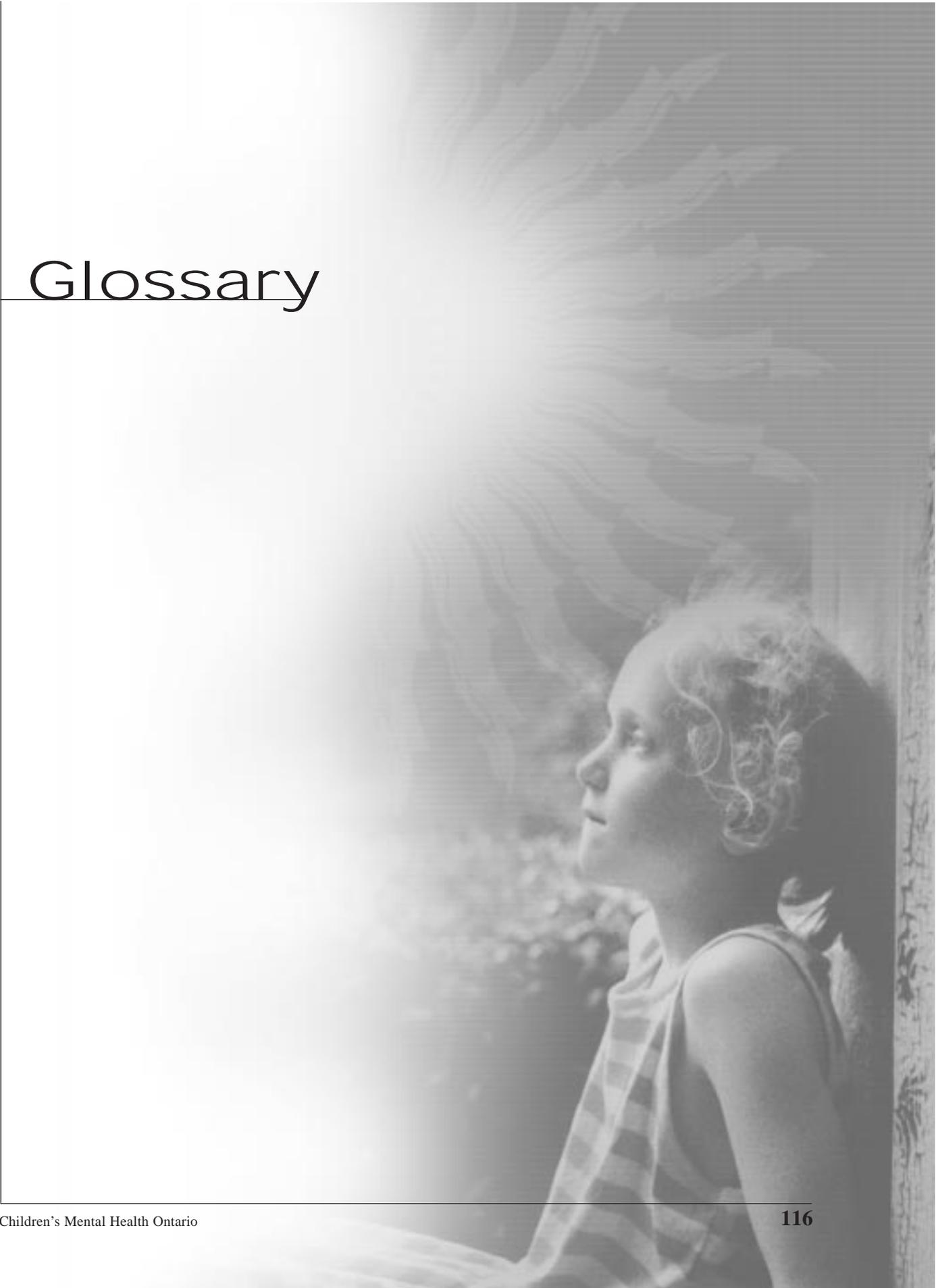
suicide risk or the presence of violence in youths' lives, and when there is a history of trauma, it is very important that you use supervision and consultation with others to consider the best intervention.

In our work, we should first “do no harm” to our clients. This often means consulting and referring to others with specific skill in the area of a child's problems. It always means being accountable to our clients, to our colleagues and the agency with whom we are employed, and to our professional associations.

Ongoing professional development, training and supervision are helpful for staying informed about strategies for working with children or adolescents with depression.



# Glossary



[Terms defined in the text of the manual have not been included in this glossary]

- Ambiguous** → Something which may have more than one meaning, or which may be doubtful or uncertain.
- Auditory Hallucinations** (see Hallucinations)
- Bereavement** → Sadness experienced following a death or loss.
- Co-morbidity** → Disorders which may occur along with another disorder.
- Cognitions** → Thoughts, perceptions, values, and beliefs.
- Cognitive Distortions** → Thoughts, attitudes and beliefs that support a negative view of the world, and are generally unsupported by reality. These typically result from selective attention, faulty explanations or over-generalizations.
- Cognitive Restructuring** → Changing the negative thought patterns and beliefs associated with depression by identifying cognitive distortions and replacing faulty thoughts, attitudes or beliefs with more realistic and positive cognitions.
- Cognitive Schemata** → Filters through which one sees and understands the world.
- Countertransference** (see Transference)
- Delusion** → A false belief that is held strongly in spite of there being no supporting evidence for the belief.
- Differential Diagnosis** → When symptoms may fit within more than one possible diagnosis, a differential diagnosis involves selecting the most appropriate diagnosis and the one which best accounts for all of the information available.
- Dysthymia** → Mild symptoms of depression experienced over a period of at least one year.
- Hallucinations** → Auditory or visual perceptions that have no external source, e.g., hearing voices, seeing things that are not actually there.
- Homework** → Tasks or assignments given to a client to complete between sessions or meetings.

<b>Integrative Approaches</b>	→	Approaches which use aspects of several different approaches for a multiple level intervention. For example, some cognitive behavioural interventions along with family interventions.
<b>Internal dialogue</b>	→	A thought process. The way in which one talks to oneself, labelling actions or perceptions.
<b>Interpersonal Therapy (IPT)</b>	→	This form of therapy focuses on problems in interpersonal relationships and is directed at decreasing depressive symptoms and improving social functioning.
<b>Introspective</b>	→	Self-examination, personal reflection and self observation.
<b>Lethality</b>	→	Ability to cause death.
<b>Multi- disciplinary Consultation</b>	→	Case consultation with others who have training in professional disciplines other than one's own (e.g. psychology, social work, medicine, etc.).
<b>Pharmacotherapy</b>	→	Treatment of a disorder through the use of medication.
<b>Psychosis</b> (see Psychotic Symptoms)		
<b>Psychotic Symptoms</b>	→	Symptoms of psychosis including delusions and hallucinations (generally auditory when co-occurring with depression).
<b>Recurrent (recurrence)</b>	→	Happening again or repeatedly.
<b>Relapse</b>	→	To return to an earlier problem or disease.
<b>Remission</b>	→	Medical term referring to the absence of symptoms.
<b>Schemata</b> (see Cognitive Schemata)		
<b>Transference</b> (and Countertransference)	→	Transference occurs when early experiences, attitudes or expectations are projected onto the professional, counsellor or therapist by the client. Countertransference occurs when the counsellor's own attitudes, experiences or beliefs are projected onto the client. These projections can lead to emotional reactivity or over-identification with children or family members.



# Appendix 1

## Toolkit



# SYMPTOMS OF CHILD AND ADOLESCENT DEPRESSION

Practitioner: \_\_\_\_\_

Client's Name: \_\_\_\_\_

**1) Typically seen in younger children (but may be seen in older youths as well):**

- Depressed appearance
- Anxiety
- Lack of cooperation
- Withdrawal from family and friends
- Physical complaints (headache and stomachache)
- Auditory hallucinations

**2) Typically seen in adolescents (but may also be seen in younger children):**

- Change in appetite / sleep patterns
- Guilt
- Refusing to attend school or poor school performance
- Delusions
- Suicidal thoughts and feelings (complete Risk Assessment)
- Suicide attempts (complete Risk Assessment)

**3) Other symptoms which may be present across ages:**

- Loss of energy
- Irritability and frustration (tantrums and behavioural problems)
- Lack of interest
- Negative feelings about self

- Weight loss / gain
- Blaming self inappropriately
- Feelings of sadness, hopelessness, worry
- Morbid thoughts
- Aggressive or negative behaviour
- Poor attention and concentration

**4) Has a DSM-IV diagnosis of major depressive disorder been made?**

Yes  No

**5) Who made diagnosis and when was diagnosis made?**

---

---

---

---

---

**6) Are there any co-occurring disorders that have been diagnosed?**

- Anxiety
- Dysthymia (so called “double depression”)
- Conduct Disorder
- Obsessive Compulsive Disorder
- Other \_\_\_\_\_

# PREPARATION FOR MULTI-DISCIPLINARY CONSULTATION

Practitioner: \_\_\_\_\_

Client's Name: \_\_\_\_\_

**1) YOUR OBSERVATIONS REGARDING THIS CHILD'S CURRENT FUNCTIONING:**

Sleeping \_\_\_\_\_

\_\_\_\_\_

Eating \_\_\_\_\_

\_\_\_\_\_

Peer Interaction \_\_\_\_\_

\_\_\_\_\_

Response to Medication \_\_\_\_\_

\_\_\_\_\_

Compliance with Current Treatment \_\_\_\_\_

\_\_\_\_\_

School Performance \_\_\_\_\_

\_\_\_\_\_

Risk Behaviour \_\_\_\_\_

\_\_\_\_\_

**2) CHANGES YOU HAVE NOTICED IN ANY OF THE ABOVE-NOTED AREAS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3) THIS CHILD'S RESPONSES IN THE PAST TO:**

Change in Treatment \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medication (and Changes in Medication) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Change in Setting \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Changes \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4) QUESTIONS I HAVE:**

About what I have observed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

About treatment I am involved in: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

About treatment I am not involved in: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

About this child: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## INDICATORS OF SUICIDE RISK:

Practitioner: \_\_\_\_\_

Client's Name: \_\_\_\_\_

- Prior suicide attempt
- Current threats or gestures of suicide
- Depressive symptoms
- Feelings of hopelessness and helplessness
- Talk of death or despair, preoccupation with thoughts of death
- Anxiety and tension
- Withdrawal from family and friends
- Violent or rebellious behaviour
- Drug or alcohol abuse
- Giving away valued possessions or making final arrangements
- Suicide of someone close or someone with whom youth identifies
- Abrupt behaviour changes, e.g., sudden high after depression, poor school performance, failure to attend school
- Recent or impending loss, e.g., removal from home, loss of a friend, death of significant other or pet, a family breakup
- Impulsive behaviour
- Recent experience of a shameful event (especially for adolescents) or negative reaction of others to gay/lesbian sexual orientation

# KEY ELEMENTS OF ASSESSMENT FOR SUICIDE RISK AND SUICIDAL IDEATION<sup>1</sup>

Practitioner: \_\_\_\_\_

Client's Name: \_\_\_\_\_

## INTENT

Is youth thinking about killing him or herself?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do these thoughts occur all of the time? Are there times when they are more/less likely to occur?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does youth ever feel so upset that he/she wishes he/she was not alive, or wants to die?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has youth been talking or writing about suicide?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<sup>1</sup>Source: Love, A. draft document re: Suicide Risk Assessment. With additions based on authors' and colleagues clinical experience, and feedback from CMHO project committee members.

**PLAN**

Is there a plan?                      Yes       No

---

---

---

Is it detailed with respect to how, when and where?

Yes       No

---

---

---

Is it realistic / possible?      Yes       No

---

---

---

Is there a likelihood that the youth would be rescued or discovered, (e.g., planning to overdose at the cottage when alone)?

Yes       No

---

---

---

Has any action been taken, e.g., stole keys to gun cabinet, making arrangements for impending death such as giving away valued possessions?      Yes       No

---

---

---

**METHOD**

**(a) LETHALITY**

Is the intended method likely to be lethal? (*Firearms and hanging are the most lethal. However, if intent is strong, it is important not to be dismissive of less lethal methods.*)

---

---

Does the child think the intended method is lethal?

---

---

**(b) AVAILABILITY**

Are guns / knives / rope / poison / drugs available at home?      Yes       No

**BEHAVIOUR**

Is this an individual who is impulsive or typically engages in high-risk behaviour? *This type of child / youth is not necessarily suicidal, but is at risk of accidental death. A more impulsive youth who is suicidal may be more likely to engage in intentional risk-taking that could lead to accidental death.*

---

---

Has there been a recent change in behaviour that includes more risk-taking? *Intentional risk-taking or dangerous behaviour may include such activities as dangerous driving, 'tempting fate' by swerving into oncoming traffic while riding a bicycle, having sex with strangers or in unsafe settings, accepting rides or offers to spend the night with strangers, alcohol or drug use, etc.*\_\_\_\_\_

---

---

**SUBSTANCE USE**

Alcohol use, how often / how much?

---

---

Drug use, how often / what?

---

---

Increase in past 30 days?

---

---

**HISTORY**

Have there been previous suicide attempts by the youth? How?

---

---

---

Have any family members (including extended family) committed or attempted suicide?

---

---

---

Have friends or role models from media / pop culture committed suicide?

---

---

---

Is there a diagnosis of Major Depressive Disorder or Major Depressive Disorder and Conduct Disorder together?

---

---

---

### **TRIGGER EVENTS**

Have any of the following occurred?

- Recent break up with a boyfriend / girlfriend
- Suicide of someone known or admired
- Loss of family member or close friend
- Anniversary of loss
- Fight with parents that led to feeling hopeless or humiliated
- Parental separation / divorce
- Change in family status, e.g., sibling moved out, parental job loss, etc.
- Trouble at school – suspension, discipline
- Bullying, ridicule, rejection by peers
- Trouble with law
- Physical / sexual abuse

### **OTHER RISK FACTORS**

Are there other factors such as:

- Mental health problems such as schizophrenia, bipolar disorder, conduct disorder or personality disorder
- Family history of depression or other mental health problems, or parent currently diagnosed as depressed
- Conflict at home
- Problems that can be associated with sexual orientation and identity
- Marginalization as a result of culture, ethnicity, physical disability
- Learning difficulties and/or learning disability
- Isolation

### **FACTORS THAT LOWER RISK**

- Deterrence factors

What prevents the child from attempting suicide? (e.g., No one to look after pet, Mom would be hurt)

---

---

---

How stable are these factors? (e.g., Is pet likely to still be living with the family after upcoming separation? What if the person who is the “reason to live” is moving away or seriously ill?)

---

---

---

Supportive environment

Is there adequate parental, caregiver supervision?

---

---

---

Are there nurturing / caring others to talk to?

---

---

---

Is there a lack of opportunity factors, e.g., weapons, isolation?

---

---

---

# SAFETY PLANNING

Practitioner: \_\_\_\_\_

Client's Name: \_\_\_\_\_

**WHO NEEDS TO BE PART OF SAFETY PLANNING, E.G., CAREGIVER, TEACHER?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **ACTION:**

- Limit or remove means.**

For example, enlist the parent's or caregiver's help in removing guns, knives, pills, poisons, etc. from the home, limit access to vehicles if youth is threatening to drive off a bridge. If removal is not possible, have someone responsible for locking up potential weapons and maintaining control of keys, etc.

- Develop safe coping strategies to replace suicidal ideation and gestures.**

1) What can the child / youth do instead? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) What would the child / youth need to do in order to proceed with the safe alternative? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3) Who/what could help remind the child / youth to do that?  
Provide youth with phone numbers and a list of people to  
contact if feeling unsafe (e.g., therapist, distress line,  
children’s mental health practitioner). \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Increase level of safety for youth.**

For example, if exposure to domestic violence, abuse, family  
conflict or peer drug and alcohol abuse is contributing to a  
chaotic situation, consider ways to intervene.

Plan: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Provide supervision and support.**

Establish a support network that the youth agrees to – these  
would be adults who he or she trusts and will talk to. Ensure that  
people who are part of the support network are aware of the risks,  
ready to be available and in agreement with the safety plan. The  
youth should not be left alone or isolated.

Who: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Plan: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Is there a need to consider alternate placement?**

If it is not possible to reduce the risks, then placement to increase safety should be considered until safeguards and treatment can be put in place. This decision should be weighed very carefully and viewed as a short-term strategy that may need to be put in place on more than one occasion during the course of treatment. While helpful in many cases, alternate placement could increase the risk for some young people (for example, it could increase feelings of loss, hopelessness or remove the deterrence that has been preventing a youth from carrying out a suicidal plan, e.g., caring for a pet).

Plan: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# SAFETY AGREEMENT CHECKLIST

Practitioner: \_\_\_\_\_

Client's Name: \_\_\_\_\_

- A statement about the child or youth's safety being the primary concern.
  
- Alternative action that the child or youth can take:  
I can call my counsellor at \_\_\_\_\_  
I can call the Crisis Line at \_\_\_\_\_  
I can call \_\_\_\_\_ at \_\_\_\_\_  
I can talk to \_\_\_\_\_
  
- Set a limited time during which the agreement is in place. This should be between now and the next time they will be meeting with a professional (you or someone else) and can be renewed or amended at that next meeting.

## Wallet sized card to photocopy for youth:

I can call my counsellor at \_\_\_\_\_

I can call the Crisis Line at \_\_\_\_\_

I can call \_\_\_\_\_ at \_\_\_\_\_

I can talk to \_\_\_\_\_

## A SAFETY AGREEMENT

This safety agreement is being put in place to make sure that I, \_\_\_\_\_  
\_\_\_\_\_ am safe.

I want to keep myself safe and healthy. I know that other people want me to  
be safe and healthy as well. These people are: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I promise to put my safety first and, when I feel as if I am going to harm  
myself, I will do this: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I know that when I feel as if I am going to harm myself,

I can call my counsellor at \_\_\_\_\_

I can call the Crisis Line at \_\_\_\_\_

I can call \_\_\_\_\_ at \_\_\_\_\_

I can talk to \_\_\_\_\_

(dd/mm/yy)

I promise to follow this plan, and keep myself safe until \_\_\_\_\_  
when I will be meeting with \_\_\_\_\_. At that time we  
will make a new contract if necessary.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Counsellor/Witness

# IDENTIFYING COGNITIVE DISTORTIONS

Practitioner: \_\_\_\_\_

Client's Name: \_\_\_\_\_

What cognitive distortions are you hearing from this child / youth?

Paying more attention to the negative and ignoring or minimizing the positive  
Examples: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Negative self-evaluations  
Examples: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Faulty explanations for what happens  
Examples: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Selective attention to details / Details taken out of context  
Examples: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Over-generalization  
Examples: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Personalization  
Examples: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# TREATMENT STRATEGIES FOR MODIFYING COGNITIVE DISTORTIONS

Practitioner: \_\_\_\_\_

Client's Name: \_\_\_\_\_

Check off which treatment strategies you will use to help the client modify cognitive distortions. Outline your plan for how you will use the treatment strategies.

- Self-monitoring

Plan: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Cognitive modelling (thinking out loud)

Plan: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Self-instructional training

Plan: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Problem-solving training

Plan: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Setting realistic standards

Plan: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Cognitive restructuring - What's the evidence? What's another way to look at it?

What if that did happen?

Plan: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Behavioural changes

Plan: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# STRATEGY PLAN FOR USE OF ROLE PLAYS

Practitioner: \_\_\_\_\_

Client's Name: \_\_\_\_\_

1) Teaching goal of role play: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) Describe scenario: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3) List "roles" to be played: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4) Possible problems that could arise: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5) Plan for responding to problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6) Key themes to be emphasized: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# CHANGING BEHAVIOURS

Practitioner: \_\_\_\_\_

Client's Name: \_\_\_\_\_

## WHAT'S NOT WORKING?

Identify behaviours that are unhealthy, unhelpful or lead to negative consequences: \_\_\_\_\_

---

---

---

---

---

---

---

## WHAT WOULD WORK BETTER?

What behaviours would be more helpful or healthy, or would lead to more positive outcomes? \_\_\_\_\_

---

---

---

---

---

---

---

**WHAT'S THE PLAN?**

Check off the strategies you plan to use to help the client change his/her behaviour.

- Social skills training
  - Education
  - Modelling
  - Role Play
  - Feedback
  - Social Reinforcement
  - Other \_\_\_\_\_

Plan: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Pleasant events scheduling
  - Education
  - Modelling
  - Role Play
  - Feedback
  - Social Reinforcement
  - Other \_\_\_\_\_

Plan: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WHAT'S THE PLAN?** (cont'd.)

Check off the strategies you plan to use to help the client change his/her behaviour.

- Self-reinforcement
  - Education
  - Modelling
  - Role Play
  - Feedback
  - Social Reinforcement
  - Other \_\_\_\_\_

Plan: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Managing intense emotions
  - Education
  - Modelling
  - Role Play
  - Feedback
  - Social Reinforcement
  - Other \_\_\_\_\_

Plan: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WHAT'S THE PLAN?** (cont'd.)

Check off the strategies you plan to use to help the client change his/her behaviour.

Changing acting out behaviour

Education

Modelling

Role Play

Feedback

Social Reinforcement

Other \_\_\_\_\_

Plan: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Relaxation training

Education

Modelling

Role Play

Feedback

Social Reinforcement

Other \_\_\_\_\_

Plan: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## FAMILY INTERVENTIONS

<b>Practitioner:</b> _____	
<b>Client's Name:</b> _____	
1)	List immediate family members: _____ _____ _____
2)	List others whom the youth views as significant members of his/her family: _____ _____ _____
3)	Are there other people from this youth's larger system (i.e., teachers, friends, etc.) who might be included in future meetings with the youth's permission? _____ _____ _____
4)	From the above lists, who is likely to attend one or more sessions with you? _____ _____ _____
5)	Have confidentiality guidelines been discussed with the youth and with family members?      Yes <input type="checkbox"/> No <input type="checkbox"/>
6)	What particular considerations have been made? (e.g. suicidal risk, non-custodial parent with no access, etc.) _____ _____ _____

**Goals for family intervention:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Outline your plan for inclusion of family members in your work with this youth:**

- Ongoing family therapy sessions  
Plan: \_\_\_\_\_  
\_\_\_\_\_
- Meetings with parents / stepparents with a focus on parenting  
Plan: \_\_\_\_\_  
\_\_\_\_\_
- Occasional meetings to inform about treatment progress  
Plan: \_\_\_\_\_  
\_\_\_\_\_
- Educational sessions about depression  
Plan: \_\_\_\_\_  
\_\_\_\_\_
- Other  
Plan: \_\_\_\_\_  
\_\_\_\_\_

# CLIENT WORKSHEET - SETTING GOALS

Name: \_\_\_\_\_

## WHAT I WOULD LIKE TO CHANGE:

Thoughts: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Actions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## WHAT I WOULD LIKE TO BE DOING INSTEAD:

Thoughts: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Actions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLAN:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# CLIENT WORKSHEET - CHALLENGING FAULTY THINKING

Name: \_\_\_\_\_

1) WHAT WAS I THINKING? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) WHAT'S THE EVIDENCE? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3) WHAT'S ANOTHER WAY TO LOOK AT IT? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4) WHAT IF THAT DID HAPPEN? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# CLIENT WORKSHEET - PROBLEM SOLVING

Name: \_\_\_\_\_

**WHAT IS THE PROBLEM?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## POSSIBLE SOLUTIONS:

My ideas about what I can do: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Other person's ideas about what I can do: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

My favourite solutions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Other person's favourite solutions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## ACTION:

I agree to: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Time line: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## CLIENT WORKSHEET - PROBLEM SOLVING

Other person agrees to: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Time line: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### OUTCOME:

1) What happened? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2) Did you think that this worked well? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3) Did other person think that this worked well? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

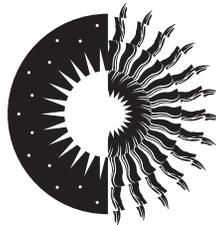
4) What would you do differently next time? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_







C H I L D R E N ' S M E N T A L H E A L T H O N T A R I O

---

40 St. Clair Avenue East, Suite 309, Toronto, Ontario M4T 1M9

Tel: 416-921-2109 • Fax: 416-921-7600 • E-mail: [info@cmho.org](mailto:info@cmho.org) • Website: [www.cmho.org](http://www.cmho.org)