Cognitive Behavioral Therapy for Adolescent Depression

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Description
Cognitive Behavioral Therapy (CBT) seeks to identify and monitor thoughts, assumptions, beliefs and behaviors related to negative emotions and replace them with more realistic and useful thoughts and feelings. In therapeutic jargon, CBT replaces a “dysfunctional cognitive-affective-behavioral process or habit with a more reasonable and adaptive one.” The original form, developed by Albert Ellis in the 1950s, was called Rational Emotive Therapy. CBT is a modern derivative of Rational Emotive Therapy.

The term “cognitive” refers to a focus on changing the thinking patterns that are making the person unhappy instead of focusing on underlying causes as do other forms of therapy (e.g., Freudian psychodynamic therapy). The term “behavioral” refers to the methods used to reduce or eliminate negative thoughts and emotions. Common methods include self-awareness techniques such as self-monitoring and journaling to identify the circumstances that trigger problematic thoughts, followed by a gradual association of those triggers with more positive thoughts and emotional responses.

CBT is a successful therapy for adults for a number of mental health problems, including clinical depression, obsessive compulsive disorders, post-traumatic stress disorders and bulimia. Because of its effectiveness with depression, CBT is indicated for suicidal ideation that is often present in clinical depression. When CBT is used to treat clinical depression before suicidal ideation or suicide attempts begin, it can be considered suicide prevention.

Cognitive Behavioral Therapy for Adolescent Depression (CBT-AD) is an adaptation of the adult Cognitive Behavioral Therapy (CBT) model to be compatible with the thinking styles and emotional needs of adolescents. CBT-AD begins by educating the adolescent about the positive aspects of therapy and addressing negative perceptions about receiving mental health treatment. The general CBT practice of self-monitoring for negative thoughts and feelings and associating those triggers with more positive thoughts and feelings is maintained in CBT-AD. However, CBT-AD uses concrete examples instead of abstract examples (“Would you think it fair if this happened to you,” vs. “Which is more just?”) and takes on a summarizing style like that used by teachers in the classroom, restating and reiterating the main points again and again. CBT-AD can also include problem solving and social skills training if indicated.

Characteristics
- Population
  - Ages – 13 – 17 (Adolescent) and 18 – 25 (Young adult)
  - Races – Predominantly tested with white participants (83%)
- Risk, Protective & Causal Factors
  - Clinical depression
  - Risk of suicide associated with clinical depression
- IOM Category (level of care)
  - Indicated – multiple risk factors suicide or mental health issues that might predispose the person for suicide.

Effectiveness
Compared to control groups, participants in the CBT-AD treatment group:
- Showed a 25.3% reduction in major depressive disorder symptoms (to 17.1% for the treatment group vs. 42.4% for the randomized control)
- Had a higher remission of the depression than participants in the randomized control groups (60.0% remission of depression for CBT-AD compared to 37.9% remission for nondirective therapy and 39.4% remission for systemic family behavior therapy)
• Showed faster reduction of depression symptoms and better clinical response to CBT-AD than with other forms of therapy (e.g., nondirective therapy, systemic family behavior therapy) in a pseudo-randomized study.

Program delivery
CBT-AD was designed to be delivered in an out-patient, clinical setting as individual or group therapy. It was found to be more effective during clinical trials than when implemented in a community based practice. The effects of CBT-AD have been found to work well in conjunction with anti-depressants and mood stabilizing medications.

Considerations for use in Idaho
The CBT-AD program appears to be a well researched and valuable tool for CBT therapists and staff under their supervision. However, the relative lack of qualified CBT therapists in Idaho and the lack of training resources to educate other social work and mental health providers in the use of the CBT-AD program limit its potential to reduce suicides among Idaho’s adolescents and young adults.

Training & costs
CBT-AD and the materials were developed for use by therapists trained in the overall CBT model. The program developers do not offer seminar-based training. There are public domain manuals available that a CBT therapist can use to implement the CBT-AD program.

The CBT-AD program developer estimates that it can be conducted in 16 hours of therapy by staff with social worker credentials and above at locally determined rates.

Dissemination & support
Dissemination of the CBT-AD program is currently limited to research publications and a published manual. See the bibliography below for a sampling of journal articles. Organizational and practitioner trainings for the CBT-AD are not currently available.

The manual may be ordered from the CBT-AD program developer for a nominal cost:

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The website listed on the NREPP page, http://www.moodykids.org, is no longer active.

Other program synopses
• NREPP – SAMHSA’s National Registry of Evidence-based Programs & Practices
Selected Bibliography


